Volume 6 Number 1 January 2009

ISSN 1749-3676

International Psychiatry

Journal affiliated to *International Psychiatry*: *African Journal of Psychiatry*

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

Subscriptions

International Psychiatry is published four times a year.

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

For subscriptions in North America please contact:
Maney Publishing North America, 875 Massachusetts Avenue, 7th Floor, Cambridge, MA 02139, USA
tel. 866 297 5154 (toll free);
fax 617 354 6875;
email maney@maneyusa.com
Annual subscription rates for 2009 (four issues, post free) are £28.00 (US$50.00). Single issues are £8.00 (US$14.40), post free.

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

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

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

Notice to contributors

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

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

A declaration of interest must be given and should list fees and grants from, employment by, consultancy for, shared ownership in, or any close relationship with, any organisation whose interests, financial or otherwise, may be affected by the publication of your submission. This pertains to all the authors.

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

About our peer-review process
All articles submitted as 'special papers' will be peer-reviewed to ensure that their content, length and structure are appropriate for the journal. Although not all papers will be accepted for publication, our peer-review process is intended to assist our authors in producing articles for worldwide dissemination. Wherever possible, our expert panel of assessors will help authors to improve their papers to maximise their impact when published.

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.

Leadership

N. Sartorius MD PhD

President, Association for the Improvement of Mental Health Programmes, Geneva, Switzerland

Leadership is a term that is used for many purposes. Its definition varies from one person to another and from one point in time to another. It is a relatively new term: although leaders have existed ever since humans began to migrate out of Africa, the definition of leadership as a set of personality traits that make it probable that people will follow the person who has such traits, almost regardless of the direction that the leader takes, is of a much more recent origin.

Among the features likely to characterise most leaders are self-confidence (i.e. behaviour that gives the impression that the leader knows where to go and how best to get there), determination in the pursuance of goals, willingness to make personal sacrifices in order to make progress, and endurance and energy that are superior to those of the other members of the group. Not all these traits are present in all leaders – indeed, sometimes only one is sufficient.

The notion that leaders are necessary to progress has led to a variety of efforts to create leaders, usually without much success. There is a huge literature on leadership qualities and many highly commercialised agencies provide training that – they promise – will make the participants become leaders.

While it is probably unrealistic to expect that leaders can be created, it is certainly true that those who have leadership potential can be equipped with skills that will make them more effective once they take a leadership position. Most of these skills will also be useful for those who are not leaders, nor want to become one.

A first group of skills that can make leadership more effective and easier are communication skills. These include the skill of listening to others and understanding what they are saying or want to say; the skill of presenting one's plans or goals in a way that will make others want to participate in them or share them; and the skill of limiting to digestible quantities the amount of information being offered to others. Some people seem to have been born good communicators; the majority, however, have to be taught communication skills, which can be acquired in a relatively short time.

The second group of skills concerns the discovery of those who are likely to share the vision and to participate in the venture that the leader wishes to undertake. It is rarely possible and usually not necessary to have all members of a group become enthusiastic about a particular goal or plan: convincing a small proportion of the group to follow the leader's ideas is usually sufficient. Penfield, a social scientist in Canada, once analysed voting behaviour and established that, in groups of people who are not committed to any particular line of action, it usually suffices to have on one's side the square root of the total number of those who need to accept a proposal. Thus, to move a group of 100 people in a particular direction, it is sufficient to have 10 who believe in the proposal made by the leader. The corollary of this rule is, of course, that the proportion of people whom a leader should convince in order to move the mass in a particular direction will diminish with the growth of the group as a whole. Thus, to convince 25 people, the leader has to convince 5 – or 20% – to become fervent followers; to lead one million people, the leader has to be certain of having 1000 people on side – or only 0.1% of the total. This rule explains how it is possible for leaders to get very large groups of people to accept their proposals while relying on a relatively small group of firmly committed followers.

The third group of skills concerns the timing of a leader's action. This is probably the most difficult skill to acquire because it depends on several other skills that need to be developed – such as the ability to simultaneously assess (several) trends of behaviour in a particular group of people and to interpret these assessments in the context of the leader's plans and of the broader environment that might influence the members of the group that is to be steered in a particular direction.

In addition to having skills, there are other characteristics of leaders that are important but that usually cannot be gained through training. These include behaviour shaped in early childhood, personal experience, physical and mental stamina, cognitive capacity and the ability to handle competing demands on time. These characteristics cannot be changed much by leadership courses, which, however, can help students to recognise themselves better, that is, to know both their strengths and their weaknesses in relation to leadership.

Providing knowledge about the area in which the leaders are to work – which is so often the central part of so-called leadership courses – is of little value in leadership development, regardless of how useful the knowledge gained may be to a leader. Further, adding knowledge will have only a minimal effect on shaping the value system of the students of leadership. An important shortcoming of many leadership courses providing knowledge is that the avalanche of information they cover does not leave enough time to study the value system of future leaders and to shape it in a manner that will ensure that leadership skills are used in fulfilling socially useful tasks.

Leadership training that focuses on the acquisition of skills and on shaping values can be immensely helpful to students and to society. It should be a routine part of the postgraduate training of mental health professionals. Not all of those trained will become leaders, but those who have leadership potential will be much better able to lead and to achieve the goals they have set. For those who do not become leaders, the skills which they were taught will still be useful, not least because they will be better able to judge whom to follow.

Mental health services in the former Soviet Union: decline and despondency

David Skuse

Behavioural and Brain Sciences Unit, Institute of Child Health, London WC1N 1EH, UK, email dskuse@ich.ucl.ac.uk

Since the collapse of the Soviet Union in 1990/91, there have been major changes in the political landscape of the former Soviet states. These have been mirrored in less publicised reforms of the way in which healthcare has been delivered. Here we focus on the way in which psychiatric services have developed in Ukraine and Moldova.

Igor Martsenkovsky and colleagues discuss the state of Ukrainian health services since the final years of the USSR, when, they report, there was increasing corruption and a deterioration in funding. Investment in health services since then has, they argue, been inadequate. Certainly, the current government is not functioning as well as it should, in part because of tensions between the pro-Western Yulia Tymoshenko, the prime minister, and Viktor Yushchenko, the president. There is high inflation, and Ukraine is dependent upon Russia for oil and gas, which has made its rulers nervous of becoming too closely allied to the West. Readers will recall that it was in Ukraine, in 1986, that a reactor at the Chernobyl nuclear power plant exploded, with devastating health consequences for the people of that country.

The authors report a recent move to reform healthcare in Ukraine, and to build an extended primary care network. This is going to mean, according to the report published here, that primary healthcare practitioners will be given greater responsibility to assess and treat mental illness, although it is not clear who is going to train them to do so. There may be, as a consequence, a reining back of the extensive secondary care provisions which had been built up within the Soviet system.

A similar theme, but with a different emphasis, is explored in the article by Andriy Samokhvalov and colleagues on the subject of alcohol misuse in Ukraine. Consumption of alcohol is much higher than in many other European countries, and among the top 5% of all countries globally. Heavy drinking starts young, in early adolescence, and virtually nobody is teetotal. The historical background to this situation, over the past 40 years, is fascinating. There appears to have been a national loss of confidence, demoralisation, and sense of helplessness that continue to this day. We learn that one of the most effective campaigns to counter alcohol misuse was introduced by Mikhail Gorbachev, in the mid-1980s, but after 10 years its unpopularity had led to its abandonment.

The third article concerns mental healthcare reform in Moldova, which became independent in 1991 upon dissolution of the Soviet Union. Moldova is a small, poor country, where the healthcare system has deteriorated since 1991 because of social and economic problems. It is tucked under the southern border of Ukraine, and has many of the same aspirations. It also neighbours Romania, and would like to be part of the European Union. In Moldova, like Ukraine, there are serious problems with alcohol misuse. The article contains detailed information about the parlous state of services, which was gathered by the authors during an official visit to mental healthcare institutions 2 years ago. Sadly, the low salaries paid to psychiatrists (even by Moldovan, let alone international, standards) mean that barely any doctors train to enter our profession.

Delivering psychiatric services in primary care: is this the right way to go for Ukraine?

Igor Martsenkovsky,[1] Volodymyr Martyniuk[2] and Dennis Ougrin[3]

[1]Head of the Department of Medical-Social Rehabilitation of Children and Adolescents with Mental and Behavioural Disorders, Ukrainian Institute of Social and Forensic Psychiatry and Drug Misuse, Kiev, Ukraine; [2]Head of the Department of Child Neurology and Medical-Social Rehabilitation of the P. L. Shupik National Medical Academy of Postgraduate Education, Kiev, Ukraine; [3]Kraupl-Taylor Research Fellow, Department of Child and Adolescent Psychiatry, Institute of Psychiatry, King's College London, London, UK, email dennis.ougrin@iop.kcl.ac.uk

Ukraine is a newly independent state with a population of about 48 million. It inherited its national health system from the USSR. The Soviet system was conceived as part of a massively expensive socialist planning economy that was generally delivering poor value for money. Some aspects of the Soviet health system were, however, undoubtedly sound and certain public health measures were superior to those in the West. For example, infant mortality,

despite possible underreporting, was probably lower in the USSR than in many Western countries (Anderson & Silver, 1986). The health system became increasingly corrupt and inefficient during the final years of the USSR's existence. Since independence, the health system has not been a state priority and has been chronically under-funded. In the past few years of rapid economic development in Ukraine, the share of the state budget allocated to the health system has remained static, leaving Ukraine in a disadvantaged state compared with other European countries (United Nations, 2007).

The Ukrainian health system

The basis of Ukrainian service provision is a system of highly specialised secondary care. There is also a network of general doctors (called district physicians and paediatricians) responsible for a given urban catchment area. Services are delivered by a network of acute hospitals and polyclinics that provide primary and secondary out-patient services. It is of interest that, in the UK, Lord Darzi, the Parliamentary Under-Secretary of State at the Department of Health, has recommended that there be greater access to secondary care in the community (Department of Health, 2007), a system not dissimilar to the polyclinics that have long been in operation in the USSR but which are now being dismantled in Ukraine.

Regional authorities fund the local health services and so the system is largely decentralised and relies on local budgets.

Healthcare reforms and the delivery of mental health services in primary care

The primary objective of healthcare reform in Ukraine, as in other post-Soviet countries (Saxena & Maulik, 2003), is to develop a primary care system from existing resources, and so it has an opposite focus to the health reform currently proposed in the UK. One of the most important questions about the proposed strategy adopted by the Ukrainian Ministry of Health concerns the delivery of mental health services in the new primary care setting.

There are more than 5000 general practitioners in Ukraine, called family doctors. Their numbers increase every year. However, the role of these doctors in the treatment and prevention of mental disorders remains controversial. Three conceptually different views on this matter are currently being discussed.

The ortho-psychiatric view

The first approach the authors would call 'ortho-psychiatric'. A significant minority of senior psychiatrists and psychiatric academics seem irritated by the mere suggestion of the reforms going ahead and family doctors diagnosing and managing psychiatric disorders. Some psychiatrists argue that family doctors are not adequately trained to deliver high-quality psychiatric services and consider this to be a fundamentally dangerous public health situation. They fear a significant reduction in the funding of secondary mental health services. If any compromise is possible, they would probably agree with a possibility of family doctors diagnosing and managing mild depressive disorders and mild somatoform conditions (Lipelis, 2007).

An important factor supporting the ortho-psychiatric approach is the presence of an autonomous, populous and well-structured secondary psychiatric service in Ukraine. There are roughly 5000 psychiatrists and substance misuse specialists (who have separate training in Ukraine) and over 500 child psychiatrists. There is also a myriad of psychiatrists working for different governmental services.

The process of diagnosing, engaging and treating patients with psychiatric disorders is still governed by a stigmatising and over-controlling system of 'registration' and compulsory follow-up. Some local authorities try to isolate psychiatric patients even further, by demanding that psychiatrists be responsible for the general medical needs of their psychiatric patients. For instance, one of the major psychiatric hospitals in Kiev has a 'somatic' polyclinic delivering general practice services to psychiatric patients. This polyclinic was opened following an initiative by the Kiev city government.

The official stance

The second conceptual approach we would call 'formal–legal'. This is the approach widely adopted by the authorities and is reflected in the current legislation. The authorities are trying to accommodate the general public's desire for a balance between the highest qualification of the doctors providing psychiatric care on the one hand, and de-stigmatising and de-institutionalising psychiatric care on the other.

Addressing this dilemma in legislation is not easy (Yudin, 2007). According to the 2000 legislation on psychiatric services (Supreme Rada of Ukraine, 2000), psychiatric services can be delivered only by psychiatrists at appropriate institutions. However, according to a separate government instruction (Cabinet of Ministers of Ukraine, 2000) and a Ministry of Health instruction (Ministry of Health of Ukraine, 2001), family doctors are supposed to be competent in diagnosing and managing urgent psychiatric conditions, 'masked' depressions, substance misuse disorders and so on. The instruction of the Ministry of Health has a lower status than the legislation and therefore cannot address the problems described.

There is a valid view among the Ukrainian population that general practitioners' care may be the least stigmatising and may improve access to psychiatric services. Many patients who would not accept a psychiatric diagnosis would agree to a psychological or neurological formulation. In fact, most Ukrainian psychiatric clinics are still officially called 'neuropsychiatric'. Nearly 30% of individuals with schizophrenia consult a neurologist in the first instance (Mikhailov *et al*, 2001), before being referred to a psychiatrist.

The family doctors' view

The third conceptual approach to this problem is reflected by the family doctors themselves (Serdiuk, 2006). At the moment, many family doctors feel unprepared for the diagnosis and management of psychiatric conditions and continue to refer most psychiatric patients to secondary care. Many family doctors do, though, appear to favour a broader role for primary care in the management of psychiatric conditions. But the main focus is seen as the prevention of mental

illness, especially in high-risk groups. Family doctors, according to this approach, may focus on prevention, but also be able to make preliminary diagnoses of and manage common psychiatric conditions and maintain close links with secondary care for treatment-resistant and complex cases.

How provision of mental health services might fit with the current work of family doctors

Are Ukrainian family doctors prepared to face these challenges? Using standardised monitoring cards, researchers at the Department of Social Medicine, Health Governance and Management of Kharkiv Medical Academy of Postgraduate Studies, under the supervision of the first author (IM), carried out an analysis of the working time structure of family doctors in rural areas of Kharkiv region. They analysed 36 working weeks of the family doctors who worked in the 24 out-patient departments of that region. Of note, only 38% of the working time was spent delivering diagnostic and treatment services, the rest being classified as 'prevention'.

Surprisingly, each doctor delivered psychiatric services to only 1.2 patients a week on average, and each consultation lasted an average of 28.4 minutes. Only 1% of the working time was dedicated to delivering psychiatric services. Although the total number of patients to whom family doctors were delivering psychiatric services was low, each patient required a longer consultation on average than the medical patients. This analysis would suggest that an increase in the numbers of psychiatric patients seen may change the current working time schedules significantly and may be associated with significant opportunity cost.

What is the way forward?

There is a tension between the views of psychiatric professionals, family doctors, officials and the general public on the delivery of psychiatric services in primary care in Ukraine. This is a problem common to most post-Soviet countries and it deserves serious consideration. On the one hand, increasing the expertise of the primary care clinicians in the delivery of psychiatric services is urgently needed. On the other hand, it seems unwise to dismantle a well-developed, albeit inefficient, psychiatric secondary care system, certainly not before primary care professionals develop sufficient expertise and experience.

The modernisation of secondary care should be coordinated with the development of primary care. National legislation is one of the driving forces of reform and different legislative acts need to be urgently revised in order to be consistent with, yet responsive to, the views of both service users and the general public. This is a task that is currently only beginning to be addressed in Ukraine. Closer international cooperation may provide some assistance in addressing this issue. In particular, wider information exchange through conferences, training and publications may inform the reforms in Ukraine and other post-Soviet countries.

Acknowledgements

This work was supported by the Psychiatry Research Trust.

References

Anderson, B. & Silver, B. (1986) Infant mortality in the Soviet Union: regional differences and measurement issues. *Development Review*, **12**, 705–737.

Cabinet of Ministers of Ukraine (2000) Postanova Kabinetu Ministriv Ukrayiny vid 20 chervnia 2000 roku N 989 pro komplekshi zakhody vprovadzhennia simeynoyi medytsyny v systemu okhorony zdorovya. [Comprehensive plan of the development of family medicine in the health system, N989, 20 June 2000.] *Official Journal of Ukraine*, **25**, 130. Available at http://uiph.kiev.ua/ua/..%5Cua%5Cextra%5Crez_5.html (last accessed 18 March 2008).

Department of Health (2007) *Our NHS Our Future: NHS Next Stage Review – Interim Report*. Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/dh_079077 (last accessed 18 March 2008).

Lipelis, G. (2007) Obosnavannoye primeneniye antidepressantov v terapii depressivnykh rosstroystv. Natsionalnoye soveshchanije ekspertov. [Evidence-based use of antidepressants in the management of depression. National experts' meeting.] *Neuronews*, **5**, 40. Available at http://neuro.health-ua.com/article/40.html (last accessed 18 March 2008).

Mikhailov, B., Serdyuk, O. & Kanischev, A. (2001) Shliakhy rozvytku konsultatyvnoyi psykhiatriyi v Ukrayini [Ways of developing consultation psychiatry in Ukraine.] *Ukrainian Psychoneurology Journal*, **4**, 62–63.

Ministry of Health of Ukraine (2001) Instruction of the Ministry of Health 'About approval of certain documents regarding family medicine', N7, 23 February 2001. Available at http://www.kmu.gov.ua (last accessed 18 March 2008).

Saxena, S. & Maulik, P. K. (2003) Mental health services in low- and middle-income countries: an overview. Services research and outcomes. *Current Opinion in Psychiatry*, **16**, 437–442.

Serdiuk, O. (2006) Psykhiatrychna dopomoha v praktytsi spetsialistiv zahalnoyi praktyky ta simeynoyi medytsyny. [Psychiatric services in the practice of general physicians and family doctors.] *Neuronews*, **1**, 8–11.

Supreme Rada of Ukraine (2000) Zakon Ukrayiny pro Psychiatrychnu Dopomohu. [Law of Ukraine on Psychiatric Aid.] *Supreme Rada of Ukraine Journal,* **19**, 143–165. Available at http://zakon.nau.ua/eng/doc/?uid=3020.133.0 (last accessed 18 March 2008).

United Nations (2007) *World Population Prospects* (2006 revision). Available at http://www.un.org/esa/population/publications/wpp2006/WPP2006_Highlights_rev.pdf (last accessed 18 March 2008).

Yudin, B. (2007) Pravovyye aspekty okazaniya psikhiatricheskoy pomoshchi vrachami somaticheskogo profilia. [Legal aspects of delivering psychiatric services by general physicians.] *Neuronews*, **5**, 21. Available at http://neuro.health-ua.com/article/21.html (last accessed 18 March 2008).

Alcohol use and addiction services in Ukraine

Andriy V. Samokhvalov PhD,[1] Valerii S. Pidkorytov PhD,[2] Igor V. Linskiy PhD,[2] Oleksandr I. Minko PhD,[2] Oleksii O. Minko MD,[2] Jürgen Rehm PhD[1] and Svetlana Popova PhD[3]

[1]Public Health and Regulatory Policies, Centre for Addiction and Mental Health, Toronto, Canada; [2]Institute of Neurology, Psychiatry and Narcology of the Academy of Medical Sciences of Ukraine, Kharkiv, Ukraine; [3]Public Health and Regulatory Policies, Centre for Addiction and Mental Health, 33 Russell Street, Room T510, Toronto, Ontario, Canada M5S 2S1, email lana_popova@camh.net

Ukraine, with a population of 46.2 million, is the second largest country in Europe, with an area of 603 700 km^2. It is still recovering from the collapse of the Soviet Union in 1991, following the Soviet stagnation era (since the mid-1960s) and perestroika (from 1986), as well as the 1998 Russian financial crisis and Ukraine's 2004 Orange Revolution. These events have resulted in high levels of socio-economic disparity, political instability and a degraded healthcare infrastructure. These issues, in addition to traditionally high levels of alcohol consumption, have made binge drinking and alcoholism, among other addictions, major problems in Ukrainian society (Voloshin *et al*, 2003).

Rates of disorder

According to estimates, the average annual recorded consumption of the equivalent of pure alcohol per capita among the population aged 15 and over is about 5 litres; however, unrecorded per capita alcohol consumption for this population is double that figure (10.5 litres) and is the highest among European countries (Popova *et al*, 2007); the overall alcohol consumption in Ukraine ranks among the top 5% of all countries globally (see http://www.who.int/globalatlas/default.asp). The preferred beverage in Ukraine is spirits. The Ukraine 2002 World Mental Health Survey revealed that 'lifetime alcohol use' was reported by 97% of the respondents (total sample size = 1719). That was the highest consumption in the World Health Organization's Mental Health Survey of 17 countries (WHO World Mental Health Survey Consortium, 2004). Similarly, Degenhardt *et al* (2008) reported that more than 39% of young adults in Ukraine have started to drink by age 15 and almost all (99%) by age 21. One out of every three men and one out of every 12 women consume alcohol heavily (for men, over 80 g of ethanol in a typical drinking day, or either over 60 g every 3–4 days per week or over 40 g nearly every day; for women, these dose criteria were reduced by 25%) (Webb *et al*, 2005). Over 90% of the male heavy alcohol users had consumed at least 80 g of ethanol in one day at least once per month in the past year.

About one-third of the Ukrainian population has experienced at least one mental disorder in their lifetime, diagnosable according to DSM–IV criteria. About one person in six (17.6%) has experienced an episode in the past year, and 10.6% are diagnosed with a current disorder (Bromet *et al*, 2005). There is no gender difference in the overall prevalence rates, but the prevalence of individual diagnoses varies markedly by gender. The most common lifetime diagnoses among men are alcohol-related disorders (26.5%). These comprise alcohol misuse without dependence (19.7%) and alcohol misuse with dependence (6.7%). In contrast, women more commonly experience mood disorders (20.8%) and anxiety disorders (7.9%) (Bromet *et al*, 2005).

Historical perspective

Official statistics for the incidence and prevalence of alcohol dependence in Ukraine from 1955 to 2007 are presented in Fig. 1. These data, as well as the stages of development of Ukrainian addiction services, correlate with the most important socio-economic and political changes in Ukraine (Bolotova *et al*, 2001).

The inexorable rise in rates of alcohol dependence from 1955 until 1971 reflects the active development of the addiction services, which were officially created by an Act of the Ministry of Health in 1959. It is interesting to note that before this Act was passed, there were only 40 beds and 8 offices for addiction treatment in the entire country. Due to the scarcity of beds and specialists, most patients with alcohol psychoses and non-psychotic forms of alcohol dependence were treated in general psychiatric hospitals. The Act led to the creation of the first addiction in-patient and out-patient departments and the growth of an addiction support network, as well as increases in the number of specialists in this field of psychiatry. An increase in the number of beds for the treatment of addictions was made possible, and these patients were predominantly treated for alcohol dependence (tobacco was not considered an addiction, and addictions to illegal drugs and medical drugs were rare).

During the period 1972–86, there was an exponential growth in the incidence and prevalence of alcohol dependence reported by official statistics. This period, the 'stagnation era' (*zastoy*) in the former Soviet Union, was associated with economic failure, long-term demoralisation and a declining quality of life and life expectancy. All these factors contributed to widespread alcoholism and crime (Laqueur, 1994). Addiction services implemented new, socially based methods for the prevention of binge drinking and alcoholism. During this period, cooperation between addiction services and the governmental, party, societal and institutional structures was introduced. Special commissions for the prevention of alcoholism and binge drinking

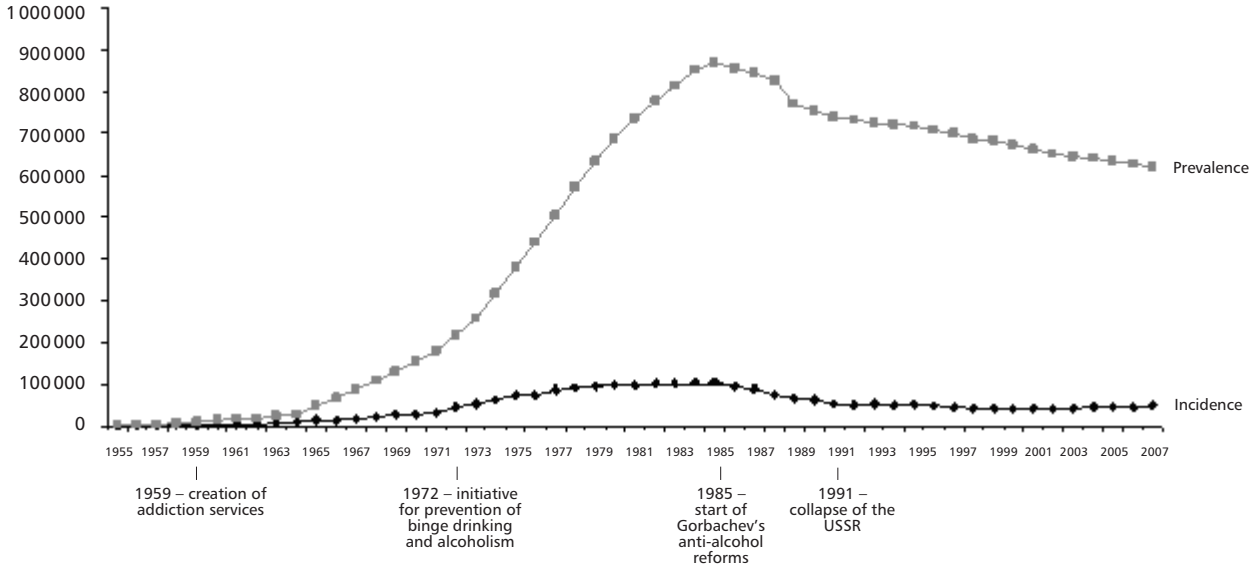

Fig. 1 Incidence and prevalence of alcohol dependence (AD, ICD–10 code F10.2) in Ukraine, 1955–2007 (Ministry of Health of Ukraine, unpublished data).

were created in large industrial enterprises and administrative establishments. These commissions assisted the coordination of governmental and societal institutions to control binge drinking and alcoholism. Addiction services were separated from mental health services. A legislative basis for compulsory treatment and 'vocational correction' was created, and this led to special labour institutions. The control of binge drinking became an important national task. Consequently, health providers lowered their thresholds for diagnosing alcohol use disorders. This change is reflected in the diagnoses assigned: the ratio of alcohol dependence to alcohol psychoses increased seven-fold, from 4.6 in 1968–71 to 32.2 in 1986.

Over 1986–89, there was a large decrease in the incidence and prevalence of alcohol dependence (Fig. 1) and alcohol psychoses, due to Gorbachev's anti-alcohol campaign, which, in spite of all criticisms, proved effective. The campaign started in May 1985; the prices of alcoholic beverages were raised, their sales were severely restricted, vineyards in the wine-producing republics were destroyed, the sale of alcohol in restaurants before 2 p.m. was prohibited, drinking in public places and alcohol advertising on television and in cinemas were banned, and people who were caught drunk in public were prosecuted.

During 1990–96, this anti-alcohol campaign was wound down, owing to its unpopularity among the population at large, as well as the inability of the Soviet Union's bureaucratic machine to continue running it; rates of alcohol psychoses then almost returned to what had been observed in 1984–85.

Global social and political changes in the country (notably the collapse of the Soviet Union in 1991, following ruination of industry and an economic crisis) have since led to a severe decrease in the capacity of the addiction services network in almost all regions of Ukraine. Former networks of cooperation, for all subdivisions of the addiction services, have been disrupted. The numbers of beds and staff have decreased. The organisation of addiction control has changed radically – the role of compulsory treatment, for example, has diminished, while anonymous forms of treatment and consultation have become much more popular.

Official statistics appear to show a gradual decrease in alcohol dependence (Fig. 1) and in alcohol psychoses since 1997. However, experts in the field of addiction believe that the official figures are misleading and that rates of alcohol dependence are actually increasing. They base their concerns on observed rates of alcohol-attributable morbidity and mortality, the decrease in life expectancy, negative demographic trends, and the high demand for addiction treatment since the collapse of the Soviet Union.

The fact that the official statistics are misleading could be attributable to a lack of epidemiological validity. The apparent gradual decrease in the incidence and prevalence of alcohol dependence may be explained by the incomplete restructuring of healthcare, coupled with financial and social instability. Consequently, medical services are no longer in a position to supply accurate data. There has been a breakdown of financing, disorganised and contradictory regulation of addiction services, and a lack of medication and equipment. Experts believe that social changes have also diversified the population of alcoholics. Some of them, mostly those with less severe dependence, have been able to change their drinking patterns to less harmful ones as a result of the new opportunities that the post-Soviet era has brought (e.g., owning businesses, self-realisation, increasing role of religion). Those with severe dependence have often died from alcohol-related disorders, an outcome that is supported by official statistics reporting an increase in alcohol-attributable mortality.

From 1990 (before the collapse of the USSR) to 2004 there was an increase in rates of acute alcohol intoxication of over 97%; the figure was over 70% for alcohol-related disorders in general. Mortality due to alcohol psychoses and alcoholic liver cirrhosis increased 8- and 11-fold correspondingly (Fig. 2). In addition, the index of in-hospital mortality increased fourfold over Ukraine's first 15 years of independence.

Service use

An analysis of bed usage in specialised alcohol dependence care from 1990 to 2007 (unpublished data) reveals both

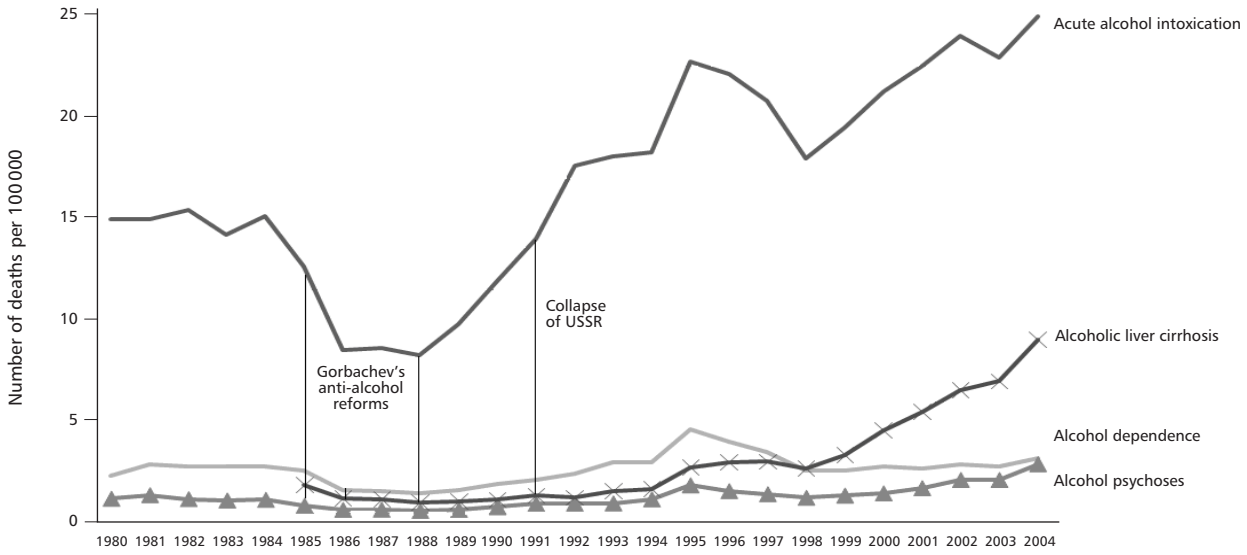

Fig. 2 Crude alcohol-attributable mortality rates per 100 000 in Ukraine, 1980–2004 (Ministry of Health of Ukraine, unpublished data): acute alcohol intoxication (ICD–10 code F10.0); alcohol psychoses (ICD–10 code F10.5); alcohol dependence (ICD–10 code F10.2); alcoholic liver cirrhosis (data available only from 1985; ICD–10 code K70.3).

a reduction in the capacity of addiction services (due to budgetary problems) and high demand.

- There had been a decrease in the total number of dedicated beds (–66%) as well as in the number of beds per 100 000 population (–63%).
- There had been a 26% increase in the active use of beds.
- There had been an increase in the number of patients per hospital bed, per unit time, from 6.1 in 1994 to 22.4 in 2007 (+268%).
- The length of stay in hospital had shortened by 66%, from 46.1 days in 1990 to 15.8 days in 2007.
- There had been a 268% increase in mortality in hospitals.

It should be noted that some of the above changes (e.g. the decrease in the total number of hospital beds and the corresponding increase in the number of patients per bed) could also be partially explained by a shift in treatment practices from long-term to short-term in-patient treatment and from in-patient to out-patient treatment in general (as has been seen in North America and Western Europe). There were also some financial benefits for hospital administrations and physicians that favoured shorter patient stays and more intensive bed usage.

Overall, the number of hospital admissions for alcohol dependence increased by 24%, from 110 123 in 1990 to 136 091 in 2007, which clearly demonstrates a high demand for addiction treatment, and these figures run counter to official statistics, which have consistently underreported the prevalence and incidence of alcohol dependence in Ukraine.

Conclusions

The rates of both alcohol consumption and alcohol use disorders have remained high in Ukraine for the past few decades. The official prevalence statistics depend heavily on the state of addiction services and socio-economic factors. Ukrainian addiction services have not yet recovered from the problems the country has experienced since 1991. Structural changes, better financing and staffing, and improved infrastructure and supply are needed to allow the health system to continue to meet the high demand for the effective treatment of addictions in contemporary Ukraine.

References

Bolotova, Z. N., Minko, O. I., Artemchuk, A. F., *et al* (2001) Major stages of the creation and development of addiction services for the population of Ukraine (1959–2000). *Arkhiv Psykhiatrii*, **4**, 129–135.

Bromet, E. J., Gluzman, S., Paniotto, V., *et al* (2005) Epidemiology of psychiatric disorders in Ukraine: findings from the Ukraine Mental Health Survey. *Social Psychiatry and Psychiatric Epidemiology*, **40**, 689–690.

Degenhardt, L., Chiu, W. T., Sampson, N., *et al* (2008) Toward a global view of alcohol, tobacco, cannabis, and cocaine use: findings from the WHO World Mental Health Surveys. *PLoS Medicine*, **5**, e141 DOI: 10.1371/journal.pmed.0050141.

Laqueur, W. (1994) *The Dream That Failed: Reflections on the Soviet Union*. Oxford University Press.

Popova, S., Rehm, J., Patra, J., *et al* (2007) Comparing alcohol consumption in Central and Eastern Europe to Southern and Western Europe, Russia and Ukraine. *Alcohol and Alcoholism*, **42**, 465–473.

Voloshin, P. V., Linskiy, I. V., Minko, O. I., *et al* (2003) State of narcological health in the population of Ukraine and activities of addiction services in 2002. *Ukrainskiy Visnik Psykhonevrologii*, **2**, 5–6.

Webb, C. P. M., Bromet, E., Gluzman, S., *et al* (2005) Epidemiology of heavy alcohol use in Ukraine: findings from the World Mental Health Survey. *Alcohol and Alcoholism*, **40**, 327–335.

WHO World Mental Health Survey Consortium (2004) Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. *JAMA*, **291**, 2581–2590.

Launch of the RCPsych Awards 2009 – celebrating excellence in psychiatry

The RCPsych Awards have been designed to recognise the very best practice within psychiatry today. More information, application forms, category criteria and rules of entry can be downloaded from:

http://www.rcpsych.ac.uk/members/currentissues/rcpsychawards.aspx

or can be obtained by email from Nicola Boyce at nboyce@rcpsych.ac.uk.

Mental healthcare reform in the Republic of Moldova

Martin Zinkler,[1] Larisa Boderscova[2] and Jana Chihai[3]

[1]Consultant Psychiatrist, East London NHS Foundation Trust, Newham Centre for Mental Health, Cherry Tree Way, Glen Road, London E13 8SP, UK, email martin.zinkler@eastlondon.nhs.uk;
[2]Country Project Manager, Stability Pact Mental Health Project 'Strengthening Social Cohesion Through the Fortification of Community Mental Health Services in South-East Europe', Chisinau, Republic of Moldova;
[3]Director of the Community Mental Health Centre, President, SOMATO, Psychiatrist–Psychotherapist, Balti, Republic of Moldova

Mental healthcare in the countries of the former Soviet Union faces considerable challenges as result of the socio-economic transition. In this article we look at the changes in the Republic of Moldova. We identify weaknesses and strengths in the traditional hospital-based system and describe examples of the successful implementation of modern mental health services. We follow the reform process in mental health law and service provision in view of the recommendations from the Council of Europe (2004) for the protection of human rights of persons with mental disorder. Some of the information in this article was gathered during official visits to mental healthcare institutions in the Republic of Moldova in 2006.

The Republic of Moldova lies between Romania to the west and Ukraine to the east and south. Formerly part of the Soviet Union, it became independent in 1991. It is a densely populated country, with just under 3.4 million people in an area the size of Belgium. It has one of the lowest per capita gross domestic products in Europe, at US$2374.

Mental health in Moldova has deteriorated since the breakdown of the USSR, with the emergence of severe social and economic problems. In particular, the rates of alcohol and drug misuse and of domestic violence have increased. At the same time, services have also deteriorated. There are now fewer psychiatric beds and fewer out-patient consultations than in the Soviet era. Table 1 gives some statistics comparing present provision in Moldova with that elsewhere in Europe.

Three large psychiatric hospitals in Moldova provide in-patient and out-patient treatment. Encounters with this system do not cover all needs and may result in long-term stigmatisation because of the compulsory registration procedures, the subsequent limitations on the right to practise certain types of professional activities or long-term hospitalisation. After patients have been discharged, their families carry the financial and moral burden in the community. Psychiatrists and nurses dominate the workforce, as the emphasis is on a biomedical model.

Table 1 Comparative statistics for Moldovan service provision

	Moldova	Europe	UK
Psychiatrists/100 000 population	9.0	9.0	11
Psychiatric nurses/100 000 population	30.5	27.5	104
Psychologists/100 000 population	0.7	3.0	9.0
Social workers/100 000 population	0.5	2.35	58
Psychiatric beds/10 000 population	6.7	8.7	5.8
% of health budget spent on mental health	6.5	5.8	10.0
% of GDP spent on health	3.6	9.0	7.7

Source: World Health Organization (2001).

Transition from hospital-based care to community care

The psychiatric hospital of Chisinau, the largest in the country, currently has 1200 beds, for a population of about 2 million people. It used to house 2000 beds. Many of the old hospital buildings (from 1895) were destroyed by an earthquake in 1976. The hospital operates an out-patient department where 400 patients are seen per day, mainly by doctors. Some of the patients are on community treatment orders; most, though, attend voluntarily. The in-patient department is organised in a traditional asylum style, with acute locked wards for men, acute locked wards for women and mixed open wards for male and female 'neurotic' patients. There are about 70 patients per ward, in bedrooms for up to 12 patients. About 10% of patients on the acute wards are on detention orders. Mental healthcare in hospital (in-patient and out-patient) is provided free of charge. Even by Moldovan standards, trained psychiatrists have very low salaries – around US$50 a month. In recent years, hardly any doctors trained to become psychiatrists; most young doctors left the country to work abroad. Generally, when a psychiatrist resigned, the post remained vacant.

More than 2500 Moldovan citizens with long-term mental health problems live in traditional long-term institutions, so-called psycho-neurological institutions or social care homes, funded by social budgets and local municipalities. The steady increase in the number of people in these institutions since independence is widely interpreted as resulting from socio-economic stress, particularly for vulnerable people, during the transition from socialism to a free-market economy. For many people, the institution saves them from homelessness.

The social care home of Balti, for example, situated in the north of Moldova, accommodates 550 people. A third of the residents are over 65 years of age. People are institutionalised because of mental disabilities, intellectual disabilities or simply because no one looks after them. There are no daytime activities for residents. The director of that home explained that 'people here entertain themselves'.

Some wards are locked, while others are open; residents on locked wards have no personal possessions at all. A retired cleaner still attends 'her ward' every day because no one else would speak to the residents and she regards them as 'her children'. To get discharged, residents have to prove that someone will look after them. The institution does not employ any social workers who could facilitate a rehabilitation or discharge process.

Joint action by the Council of Europe and the World Health Organization's Regional Office for Europe in 2001 created the Health Network for South-Eastern Europe. The basis for this was the information on access to healthcare for the vulnerable population from the region. In September 2001, the 'Dubrovnik Pledge' was signed to protect vulnerable populations in south-eastern Europe and, through this, to contribute to peace, development, democratisation, stability and reconciliation. Medical assistance was introduced into the Stability Pact Initiative for Social Cohesion (http://www.stabilitypact.org). The objective was to develop community mental health services by amending mental health legislation to comply with European standards, by establishing a model for community mental health services, and by establishing a region-wide network for training and collaboration in community mental health, primary care and social work.

The first state-run community mental health centre in Moldova was created with financial support from the Greek government. The centre still has to become fully operational, however; difficulties arise from the fact that only the building and equipment were funded by the South-Eastern Europe Stability Pact, while operational costs and personnel will have to be paid by the national government. The community centre, when fully staffed, will provide assessment, treatment (including medication and psychotherapy), psychosocial support and legal advice free of charge for the 120 000 inhabitants of the capital. There are currently no other state-run community mental health centres in the capital or indeed elsewhere.

Mental healthcare in primary care settings

In 2000, Moldova started the transition to a health service based upon primary care, and 35% of the health budget is now spent on primary care. There are now 2100 doctors working in primary care, each serving populations of 1000–2000; some previously worked as specialists such as internal physicians and psychiatrists. A new 3-year specialist training course in family medicine has been implemented, which includes 140 hours of training in mental healthcare. Primary care workers, such as nurses, go through internship programmes that include mental health. Guidelines for the treatment of depression in primary care are being developed.

Non-governmental organisations

Moldova Philantropie, in Chisinau, was founded in 2000 and provides a rehabilitation programme for 25–40 people, close to the city centre. Funding ended in April 2003 and the centre is struggling to continue with its activities, which include social events, art, English lessons, information, mental health and legal advocacy and psychotherapy. The centre operates like a club; membership and services are free of charge and it has now developed into a service user organisation, the first of its kind in Moldova.

A community mental health centre called Somato, in Balti, 135 km north of Chisinau, was also founded in 2000, with funds from the Soros Foundation and other organisations. Its director used to work as a psychiatrist at the nearby social care home (described above) and has managed to set up a comprehensive community-oriented mental health project with close links to the local administration and the local population. Situated in a two-storey house in a residential neighbourhood, the centre provides assessment, treatment, daytime activities and respite care (short-term admission) for people aged 14 years and older. Service users are involved in running the service, maintaining the building and engaging in mental health promotion activities, but they also receive psychotherapy, occupational therapy, art therapy, advocacy and meals, 7 days per week. Medication is prescribed, but it has to be paid for by the service users themselves. In December 2004, this centre was donated to the local public administration (LPA), Balti municipality. Through a memorandum of understanding between Somato and the LPA, this centre now has dual control (i.e. between Somato and the LPA). It is still quite complicated to integrate this type of service into the present healthcare structure.

Legal reform

Moldova has a relatively new mental health law (Law Regarding the Rendering of Psychiatric Care, number 1402-XII, of 16 December 1997). People with mental disorders have all the rights and freedom of citizens stipulated by the Moldovan constitution and other laws. Restrictions are allowable only in cases provided by the present law and other statutory acts.

A person with a mental disorder may be detained in a psychiatric hospital without consent or without the consent of a lawful representative (assigned by the court) if examination or treatment is possible only in hospital, and the mental disorder is severe and causes:

- direct danger to the patient or to associates
- an inability to satisfy personal basic vital needs
- essential harm to health if psychiatric help is not rendered.

The criteria for involuntary treatment are the same as those above for involuntary admission (danger, inability to satisfy basic vital needs, essential harm). A judge must authorise involuntary admission within 3 days. The patient, a lawful representative, the head of the psychiatric hospital and the public prosecutor all have the right to appeal against the decision of the court for involuntary admission. The involuntary patient has to be reviewed no less than once a month by a commission of psychiatrists. After 6 months, the decision goes back to the judge. Thereafter, a judicial review is conducted annually. In-patient psychiatric care has to be provided under the least restrictive conditions that will ensure the safety of the hospitalised person and other persons.

Moldovan mental health law is mostly compliant with the latest recommendations from the Council of Europe (2004). However, there is no requirement for a written care plan and

the conditions for involuntary placement and treatment do not include a therapeutic purpose. The law does not provide free legal representation for detained patients. The legal situation of people in social care homes remains largely unclear, as they are *de facto* detained but without the requirement for judicial reviews or other legal safeguards. A major concern for non-governmental organisations is that the new law has not been fully implemented.

References

Council of Europe (2004) Recommendation No. Rec(2004)10 of the Committee of Ministers to member states concerning the protection of the human rights and dignity of persons with mental disorder and its explanatory memorandum. See https://wcd.coe.int/ViewDoc.jsp?id=775685 (last accessed November 2008).

World Health Organization (2001) *Atlas – Country Profiles on Mental Health Resources 2001*. WHO.

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

The organisation of mental health services in post-war Bosnia and Herzegovina

Osman Sinanovic,[1] Esmina Avdibegovic,[2] Mevludin Hasanovic,[2] Izet Pajevic,[2] Alija Sutovic,[2] Slobodan Loga[3] and Ismet Ceric[3]

[1]Department of Neurology and [2]Department of Psychiatry, University Clinical Centre Tuzla, Medical Faculty, University of Tuzla, 75000 Tuzla, Bosnia and Herzegovina; [3]Department of Psychiatry, Clinical Hospital Centre Sarajevo, Medical Faculty, University of Sarajevo, 71000 Sarajevo, Bosnia and Herzegovina

Bosnia and Herzegovina (BH) is located on the western part of the Balkan Peninsula. It has an area of 51 210 km^2 and a population of 3 972 000. According to the Dayton Agreement of November 1995, which ended the 1992–95 war, BH comprises two 'entities' – the Federation of Bosnia and Herzegovina (FBH) and the Republic of Srpska (RS) – and the District of Brcko. The administrative arrangements for the management and financing of mental health services reflect this. The FBH, with 2 325 018 residents, is a federation of 10 cantons, which have equal rights and responsibilities. The RS has 1 487 785 residents and, in contrast, a centralised administration. Brcko District has just under 80 000 residents.

Mental health policy and legislation

Healthcare systems in BH are regulated basically by the entities' different laws on healthcare and on health insurance. Each entity and Brcko District is responsible for the financing, management, organisation and provision of healthcare. The health administration is centralised in RS, through the Ministry of Health and Social Welfare, but in FBH is decentralised – each of the 10 cantonal administrations has responsibility for healthcare through its own ministries. The central Ministry of Health of the FBH, located in Sarajevo, coordinates cantonal health administrations at a federal level. The District of Brcko provides primary and secondary care to its citizens. The mental health policies and national programmes for mental health were created in 1999 and adopted in 2005. A law on the protection of persons with mental disorders was adopted in 2001 and 2002 in FBH (*Official Gazette of BH*, Nos 37/01 and 40/02), and in 2004 in RS (*Official Gazette of RS*, No. 46/04). These laws define the rights of people and regulates the procedure for voluntary or involuntary admission to a psychiatric hospital.

Mental health service delivery

There are no private mental health institutions. Psychiatric services are available for all citizens, paid from a special national fund for healthcare, financed by mandatory health insurance. The reform of mental health services began in 1995. The focus has been on care in the community, limiting the use of psychiatric hospital beds, establishing a network of community mental health centres (CMHCs), and developing other services in the community, a multidisciplinary approach and teamwork, as well as cooperation between sectors. Each CMHC is responsible for general mental health in a catchment area of 50 000–80 000 inhabitants; each has 10 psychiatric beds, intended for the acute admission of patients (these beds are in fact on neuropsychiatric wards of regional general hospitals). The CMHCs have many different functions, including the promotion of mental health, early detection of mental disorders, and the provision of multidisciplinary care (Ceric *et al*, 2001).

Psychiatric services are provided throughout BH through the network of 55 CMHCs and family medicine services at primary care level. Secondary and tertiary mental health services are provided in three psychiatric clinics, one department of a university clinical centre, two general psychiatry hospitals, two institutions for the treatment, rehabilitation and social care of patients who are chronically mentally ill, and neuropsychiatric wards in general hospitals in major cities. In the reform of the mental health services, mentioned above, new out-patient services were established, the existing

Table 1 Numbers of psychiatric beds and staff

	Federation of Bosnia and Herzegovina	Republic of Srpska	Brcko District
Total number of psychiatric beds per 10 000 residents	3.6	3.93	3.5
in psychiatry hospitals	2.4	0.91	
in general hospitals	1	0.68	3.5
in other institutions	0.2	2.33	
Numbers of professionals per 100 000 residents			
psychiatrists[a]	–	2.3	–
neuropsychiatrists[a]	1.8	1.2	7.0
nurses in psychiatry	10	19.4	21.8
psychologists	0.5	0.86	1.8
social workers	0.03	0.66	1.8

[a] In Bosnia and Herzegovina until 1992 there was education in 'neuropsychiatry' only; during the war (1992–95), medical doctors from the Republic of Srpska were trained in Belgrade (Serbia), where they could gain a qualification in 'psychiatry'.
Source: World Health Organization (2005).

primary care services were adapted to mental healthcare and, in addition to the CMHCs, sheltered housing services for patients with a chronic mental illness were established.

The reform of mental health services had a direct impact on the development of users' initiatives in BH: there are now several user associations, which are provided with professional support and education from CMHCs and psychiatry clinics.

There are only two wards and two specialists for child and adolescent psychiatry within the psychiatry clinics. There are four institutions for the care of adults and children with special needs and chronic mental disorders, mainly financed from social welfare. Persons with drug addiction are treated in a specialist institute and two other centres for addiction; methadone is the predominant form of treatment.

There are no specific programmes for the mental healthcare of minorities and the elderly in BH. There are programmes for refugees and war victims of torture, through a network of non-governmental organisations developed during the war.

The provision of forensic psychiatry services is insufficient. Individuals with mental health problems who commit criminal acts are treated in one forensic ward of a general psychiatry department of a prison psychiatry hospital.

According to the Regional Office of the Mental Health Project for South Eastern Europe (2004), in 2002 in FBH there were 159 neuropsychiatrists, in RS 67 and in Brcko District 6. The number of psychiatric beds in FBH was 632, in RS 640 and in Brcko District 30. These data differ from those in Table 1, from the World Health Organization (2005) and based on data collected from 2001 to 2004.

Treatment of traumatised persons

At the beginning of the war (1992) knowledge about the psychological consequences of war and therapeutic approaches to post-traumatic stress disorder (PTSD) in BH was rather poor. The therapeutic approach was based on the experience of psychiatrists and their receptiveness to the ideas suggested by the foreign literature and the many foreign workers (Jensen & Ceric, 1994; Hasanovic *et al*, 2006). At the end of the war, various psychosocial programmes were organised by the government and international non-governmental organisations (de Jong & Stickers, 2003; Nelson, 2003). The psychosocial approach to trauma aimed to reduce not only the risk of serious mental disorders but also stigma, through mass education about the psychological consequences of trauma. Working with traumatised people during the war, we perceived that religious people coped more successfully with difficulties than those who were not religious. In selected cases, spirituality and religion are therefore used in the process of healing, and so they found their place in educational programmes and psychotherapeutic treatment. In hospitals, adequate rooms for the spiritual and religious needs of patients were allocated (Pajevic *et al*, 2005).

Psychiatric training

There are five medical faculties, two in RS and three in FBH, with different education programmes, all lasting 6 years. At four medical faculties, the undergraduate courses include only two semesters of psychiatry, while at one medical faculty the undergraduate course has only a neuropsychiatry element. Medical schools are associated with psychiatric clinics. After graduation from the medical faculty and a 1-year internship, specialisation in neuropsychiatry/psychiatry is available, authorised by the entity's Ministry of Health.

Specialist training is different in the two entities. In FBH there is specialisation in neuropsychiatry, which takes 4 years, with 20 months of psychiatry, while in RS there is a programme of education in psychiatry only, which also lasts 4 years. There is no unified national programme of psychiatric education for residents.

Psychiatric sub-specialties and allied professions

The educational programme for the specialisation in neuropsychiatry/psychiatry does not include psychotherapy. Residents from neuropsychiatry/psychiatry are familiar with the theoretical basis of psychotherapy mainly from their undergraduate education. There are no institutions for education in psychotherapy in BH, and there is no regulation of psychotherapy licences. Education in psychotherapy is organised from psychiatry clinics and by psychologists' associations, in cooperation with psychotherapist educators from other European countries.

The only recognised sub-specialisations are in social psychiatry and alcoholism and drug addiction, each taking 1 year. There is undergraduate education in psychology, but no specialisation in clinical psychology. Furthermore, there is no specialist training for psychiatric nurses. Additional psychiatric education for nurses is provided through special education programmes organised at the psychiatric hospitals.

Main areas of research

Psychiatric research in BH is insufficiently developed. There is no professional psychiatry journal, nor a particular institute for research in psychiatry. Existing research projects are undertaken at the psychiatric hospitals and medical faculties. The main areas of research are currently related to the psychosocial consequences of war trauma. Lack of a uniform

database and insufficient development of entity and cantonal public health services represents big problem for research, particularly epidemiological studies.

References

Ceric, I., Loga, S., Sinanovic, O., *et al* (2001) Reconstruction of mental health services in Bosnia and Herzegovina. *Medicinski Arhive*, **55** (suppl. 1), 5–23.

de Jong, K. & Stickers, R. (2003) Early psychosocial interventions for war-affected populations. In *Early Interventions in Emergencies* (eds R. Orner & U. Schnyder), pp. 184–192. Oxford University Press.

Hasanovic, M., Sinanovic, O., Pajevic, I., *et al* (2006) Post-war mental health promotion in Bosnia and Herezgovina. *Psychiatria Danubina*, **8**, 74–78.

Jensen, B. S. & Ceric, I. (1994) *Community-Oriented Mental Health Care in Bosnia and Herzegovina: Strategy and Model Project*. WHO Office for Bosnia and Herzegovina.

Nelson, B. S. (2003) Post-war trauma and reconciliation in Bosnia and Herzegovina: observations, experiences, and implications for marriage and family therapy. *American Journal of Family Therapy*, **31**, 305–316.

Pajevic, I., Sinanovic, O. & Hasanovic, M. (2005) Religiosity and mental health. *Psychiatria Danubina*, **17**, 84–89.

Regional Office of the Mental Health Project for South-Eastern Europe (2004) *Mental Health Policies and Legislation in South-Eastern Europe*. Available at http://www.euro.who.int/document/E88509.pdf (last accessed November 2008).

World Health Organization (2005) Mental Health Atlas, Bosnia and Herzegovina. Available at http://www.who.int/globalatlas/predefinedReports/MentalHealth/Files/BA_Mental_Health_Profile.pdf (last accessed November 2008).

Peru: mental health in a complex country

Marta B. Rondon

Assistant Professor, Department of Psychiatry and Mental Health, Universidad Peruana Cayetano Heredia and Attending Psychiatrist, Hospital E Rebagliati, Essalud, Lima, Peru

Peru is a land of mixed cultures, multiple ethnic heritages and severe economic inequities. Its history goes back thousands of years, from accounts of the first inhabitants of the continent to the impressive Inca Empire, the rich Viceroyalty of Peru and the modern republic, which boasts one of the highest economic growth rates in South America. Yet, in spite of such complex cultural development, or perhaps because of it, 21st-century Peruvians have substantial difficulties establishing a national identity and recognising each other as members of the same community.

Persons with mental illness represent with poignant clarity 'the other' which we seem to have so much trouble accepting as equals in terms of dignity and rights. When we look at mental health in terms of legislation, services and human rights, therefore, we are faced with exclusion and discrimination, unequal and inefficient use of resources, and lack of public interest.

Mental health as a component of public health

Peruvian psychiatrists have traditionally had a bio-psycho-social approach to mental health and illness. Social psychiatry studies, under the leadership of Rotondo and Mariategui in the 1950s and early '60s, were fundamental in the conceptualisation of mental health as a cultural construct (Perales, 1989). Another interesting development is that of psychosomatic medicine, under the leadership of Seguin, which originated in the establishment of a psychiatric ward in a general hospital, long before the Declaration of Caracas so suggested, and which also is the precursor of the current interest in women's mental health and in the consequences of violence in the country.

As far back as the 1960s, pioneers such as Baltazar Caravedo and Javier Mariátegui saw mental illness as a major obstacle to the development of the country, and they pointed to the need to devote public effort and money to the promotion of mental health and the prevention and treatment of mental illness. Others have followed this path, especially after the results of a large epidemiological study by the National Institute of Mental Health were made public (Rondon, 2006).

Mental health and disorders

Anxiety, depression and schizophrenia are considered to be the most relevant psychiatric disorders in Peru. The use of alcohol, the prevalence of interpersonal violence and the high tolerance of psychopathic attitudes have also been identified as important (Instituto Especializado de Salud Mental, 2002).

Perhaps more striking than the prevalence of disorders is the large number of people (14.5–41.0% of those surveyed), mostly women, who report feelings of unhappiness, preoccupation and pessimism (Instituto Especializado de Salud Mental, 2004).

Interpersonal violence, in all its modalities, plays a significant role in the production of psychiatric morbidity. Gender-based violence is widely tolerated, with roots in the complex culture of the country (Rondon, 2003). According to a World Health Organization multi-country study on violence against women, adult women in the Andean region of Cusco are the most physically abused females in the world, with those in Lima faring just slightly better (García-Moreno *et al*, 2005).

In the 1980s, the country suffered much political violence, largely targeted against the civilian population. This led eventually to the establishment of the Truth and Reconciliation Commission at the turn of the century. It has recognised that exposure to political violence during the internal armed conflict in the 1980s has inflicted severe psychological

damage to the population involved, and has left sequelae of 'fear, as an everyday experience, both at the individual and the collective levels, the disintegration of familial and communal bonds, loss of the ability to protect and nurture children, a negative impact on social cohesion, and damage to the personal identity'. The plight of the victims is, therefore, a major mental health concern (Peruvain Truth and Reconciliation Commission, 2003).

Policy and legislation

After a long story of failure to implement mental health plans and due to the intervention of the Pan American Health Organization (PAHO) and reiterated demands of non-governmental organisations and relatives of users of services, the Guidelines for Action in Mental Health were promulgated by the Ministry of Health in 2004. The guidelines adhere to certain principles: respect for the rights of 'persons' (not 'human rights', careful wording in keeping with restrictive abortion laws), equity, integrality, universality, solidarity, shared responsibility and dignity and autonomy. According to this document, the Peruvian policy on mental health includes:

- direction from the Ministry of Health's specialised office (the Direccion Ejecutiva, although it has no budget of its own for service delivery)
- integrated services for mental and physical health
- prevention and treatment integrated in a new efficient way of delivering services
- promotion of mental health, human development and citizenship
- multi-sectoral coordination for mental health
- creation of an information system
- human resources development
- planning, monitoring, evaluation and systematisation of all mental health actions
- participation of users and their relatives in mental health services.

Two years later, the National Committee of Health, a part of the National Health Council, produced and obtained approval for the National Plan for Mental Health, which set objectives and goals for the policy guidelines. The objectives of the plan were stated as positioning mental health as a fundamental right of all persons, strengthening the normative role of the Ministry of Health, ensuring universal access to mental health services via the re-engineering of existing services and promoting equity in mental healthcare, with special attention given to vulnerable populations. The plan set forth three general objectives, 12 specific objectives and 31 actions. It is not being implemented, however, because of constant changes within the Ministry of Health.

There is no mental health law and several issues such as involuntary hospitalisation and treatment and informed consent are not sufficiently covered by appropriate legislation, with consequent risks for both patients and providers.

Service delivery

Mental health services are mostly provided in psychiatric hospitals: 75% of psychiatric beds are in the three large psychiatric hospitals in Lima, with other beds in psychiatric centres in Piura, Arequipa and Iquitos. General hospitals belonging to the Ministry of Health in Lima have psychiatric out-patient services but do not have any beds, whereas general hospitals in five regions do have in-patient facilities, although there is concern over the quality of services provided. Several regions lack psychiatric services of any kind, and so patients have to travel long distances. Mental health episodes represent 1.15% of the annual total of all episodes of patient care.

In the social security sector (which is based on health insurance for people in formal employment and their dependants only) all national referral hospitals and several national hospitals have beds, and there are psychiatric out-patient services in all tertiary establishments.

There is no mental healthcare at the primary level. The Ministry of Health has organised itinerant teams to attend to the needs of those affected by political violence with the purpose of supporting people in the affected communities; this includes promotion, prevention, attention and rehabilitation in mental health, as well as education in mental health with members of the community, especially primary health workers (Kendall *et al*, 2006).

The provision of psychiatric medications is very unequal: atypical antipsychotics and novel antidepressants are available in Lima and other large cities for insured patients, but outside the big urban centres not even the substances listed in the World Health Organization's list of essential medications can be obtained.

Staffing and training

There are 602 psychiatrists registered with the Peruvian College of Physicians, eight of whom are child and adolescent psychiatrists. Seventy per cent of them live in Lima. Psychologists and specialised nurses are also located mostly in Lima, as are the few psychiatric social workers.

Of the 31 medical schools in Peru, five offer specialisation in psychiatry: three in Lima, one in Arequipa and one in Trujillo. Nonetheless, all undergraduate medical students receive a course on psychological medicine (centred on the doctor–patient relationship) and one course in clinical psychiatry.

Specialisation in psychiatry takes 3 years. Junior doctors have a chance to spend some time abroad to complete their training. The curriculum does not follow the World Psychiatric Association's core curriculum. The only recognised sub-specialty is child and adolescent psychiatry, training for which lasts 2 years.

Research

Between 2005 and 2008, there was a project funded by the Japanese International Cooperation Agency that involved physicians, other health personnel in secondary and primary care and members of the community in five Andean regions in the integral care of people affected by political violence.

After 2000 there was a strong impulse for epidemiological research in psychiatry and the Lima Metropolitana, Sierra, Selva and Fronteras studies were completed. There is some ongoing work using the data from these important studies, such as the cross-country comparison of gender-sensitive mental health indicators. There is also some interest in participating in multicentre drug studies, and some psychiatrists participate as patient recruiters in fourth-stage studies.

Human rights issues

The unavailability and inaccessibility of mental healthcare is the most important human rights issue. For those who do receive services, the poor quality of care, the high cost of medication, the generally miserable condition of the hospitals and the lack of attention to safety conditions are prominent concerns. Mental Disability Rights International published in 2004 a very critical report on the conditions of mental hospitals, after which both the ombudsman and the Ministry of Health, with the participation of the Peruvian Psychiatric Association, looked into providers' awareness of human rights and the conditions of the service (Ministry of Health, 2005). The Peruvian Psychiatric Association provided workshops on human rights for psychiatrists and other mental health providers and drafted the Declaration of Cusco, which calls for special concern for patients' rights. However, only the establishment of a national health system and universal health insurance with clear, state-of-the-art and consensual practice guidelines will improve current conditions.

References

García-Moreno, C., James, H. A. F. M., Ellsber, M., *et al* (2005) *Multi-country Study on Women's Health and Domestic Violence: Initial Results on Prevalences, Health Outcomes and Women's Responses*. WHO.

Instituto Especializado de Salud Mental (2002) Estudio epidemiologico metropolitano de salud mental. Informe general. *Anales de Salud Mental*, **18**, 1–2.

Instituto Especializado de Salud Mental (2004) Estudio epidemiológico en salud mental en ayacucho 2003. *Anales de Salud Mental*, **20**, 1–2.

Kendall, R., Matos, L. & Cabra, M. (2006) Salud mental en el Peru luego de la violencia politica: intervenciones itinerantes. *Anales de la Facultad de Medicina*, **67**, 184–190.

Ministry of Health (2005) *Comisión Especial para la supervisión del cumplimiento de los derechos humanos de las personas con enfermedad mental. Informe Final*. Ministry of Health.

Perales, A. (1989) Concepto de salud mental: la experiencia peruana. *Anales de Salud Mental*, **5**, 103–110.

Peruvian Truth and Reconciliation Commission (2003) *Final Report*, Vol. 6. Available at http://www.cverdad.org.pe (last accessed November 2008).

Rondon, M. B. (2003) From Marianism to terrorism: the many faces of violence against women in Latin America. *Archives of Women's Mental Health*, **6**, 157–163.

Rondon M. B. (2006) Salud mental: un problema de salud pública en el Perú. *Revista Peruana de Medicina Experimental y Salud Publica*, **23**, 237–238.

COUNTRY PROFILE

Psychiatric services in Bahrain: past, present and future

M. K. Al-Haddad[1] and Adel Al-Offi[2]

[1]Professor of Psychiatry, Arabian Gulf University, Bahrain; [2]Consultant Psychiatrist, Ministry of Health, Bahrain

The Kingdom of Bahrain is an archipelago of 33 islands, located in the Arabian Gulf, covering 2400 km^2. The main island, Manama, is the nation's capital. The total population stands at 742 562, 62.3% of whom are local Bahrainis and the remaining 37.7% expatriates (Central Statistics Organisation Directorate, 1991). Bahrain first entered the historical stage around 3000 BC, and for almost 2000 years was the centre of the old Dilmun civilisation (Bibby, 1969). Dilmun was perceived as a sacred land by the Sumerians and Babylonians; it was a burial ground for their dead, and Bahrain has over 100 000 burial mounds each containing 200–250 bodies. In the old Babylonian epic of Gilgamesh, which antedates Homer's Iliad, Dilmun is described as a paradise where the worthy enjoy eternal life (Clarke, 1981).

Psychiatric services

Al-Haddad & Al-Offi (1996) provide a history of Bahraini psychiatric services. Before 1930, no institution cared for psychiatric patients in Bahrain. Left to look after an ailing relative, families often devised their own form of therapy. One of the most common remedies was conducting a *Zar* ceremony, which was thought to help rid a person of the demons or *jin* believed to be responsible for mental ailments. Other forms of treatment included reciting verses from the Holy Quran, as well as cautery applied on either the occipital or parietal regions of the head.

In 1930, Charles Belgrave, the English counsel to Bahrain's ruler, suggested the creation of a place for local 'lunatics' which would safely put them under the direct supervision of the Municipal Council. In 1932 a small house was rented in the capital to host 14 patients (12 male, 2 female). The residence was named the 'Mad House' and psychiatric patients were looked after by 'attendants' (who were essentially labourers rather than nursing staff). The Municipal Council continued supervision of the asylum until 1948, when responsibility was transferred to the Department of Health. A report by Dr Snow, chief of the Department of Health at the time, illustrates improvements to the asylum; the building was refurbished and newly painted with pleasant colours, and patients were encouraged to spend more time outside their cells.

In 1964 Dr Butler, an English internist, started to run regular daily psychiatric out-patient clinics, recruited trained psychiatric nurses from India and Lebanon, and introduced the first drug (chlorpromazine) for the treatment of mental illness.

The 1970s witnessed many changes, such as the establishment of a child and adolescent out-patient unit (1975),

community psychiatric services and a day hospital (1979), and an 88-bed unit for both chronic patients and psychogeriatric patients (1979). In the same year, a liaison service was established with Bahrain's main general hospital, which hosted two general admission units for psychiatry, with a capacity of 48 beds divided equally between males and females. In 1984 a new out-patient complex with lecture halls, teaching facilities and office space was built. In 1987 an alcohol and drug rehabilitation unit was separately developed, with an initial capacity of 17 beds, which had reached 29 beds in 2008.

Current mental health services

Today, there is still only one dedicated psychiatric hospital in Bahrain. Private general hospitals employ psychiatrists who mainly work with out-patients, although they do occasionally admit non-psychotic patients, but there are no private beds specifically for psychiatry. The psychiatric hospital has 296 beds for all psychiatric specialties, divided into general psychiatry (114 beds), long-term and rehabilitation (104 beds), psychogeriatrics (10 beds), drug and alcohol rehabilitation (29 beds), adolescents (15 beds), children (12 beds) and forensic psychiatry (12 beds). The same community and day hospital service (in existence since 1979) covers the entire adult and elderly population via three community teams. There are two specialised out-patient clinics, one for anxiety disorders and one for intellectual disability.

The hospital employs 49 full-time psychiatrists, 14 consultants, 11 chief residents, 9 senior residents and 15 residents. There are in total 276 trained psychiatric nurses, 12 occupational therapists, 7 social workers, 4 clinical psychologists, and 2 physiotherapists. There are also 9 consultant-level psychiatrists working in the private sector and a further 2 in the Bahrain Defence Force Hospital. Thus in total there are 60 psychiatrists.

For the past 20 years, psychiatric services have been successfully incorporated within primary care services in Bahrain. Family physicians are also afforded access to psychiatric medications. This is the first such initiative in the Arab world.

Resources

The Royal College of Psychiatrists' (2002) recommended consultant norms are: 5.4 per 100 000 population for general psychiatry, 1 consultant per 10 000 for the elderly population, 1.5 per 100 000 for children and adolescents, 0.9 per 100 000 for substance use, 8 per 1 000 000 for forensic psychiatry and 1 per 600 general beds for liaison psychiatry. These norms can be applied to Bahrain's population of 742 562. The population above 65 years is 18 756, and so requires 2 psychiatrists, but there is in fact only one consultant in psychogeriatrics. The child and adolescent population has reached 202 565, and so requires 3 consultants, which there are now. The general adult population is 521 238, requiring 28 consultants but there are only 11 consultants currently working in the field. The registered substance misuse population is 4270, covered by 3 consultants instead of the recommended 4.6. In forensic psychiatry the need is for nearly 6 consultants, but there is only 1 practising. For liaison psychiatry there are 2 consultants serving 1714 public sector beds, and another 323 beds are covered by psychiatrists working in the private sector; there is a need for a further 3 consultants in that field.

Mental health programme

A 12-year mental health programme was drafted in 1988, covering Bahrain up to the year 2000 (Al-Haddad, 1988). More than 95% of the set targets were achieved ahead of time. Accordingly, another plan was drafted in 1997 with an ambitious set of 88 objectives (Al-Haddad, 1997).

Mental health legislation

Over the past 20 years, many attempts have been made to pass a mental health act in Bahrain. This has still not been achieved. Currently, psychiatrists work within the limited rules related to psychiatry made available in court regulations; some of these date back to when Bahrain was a British protectorate.

Training

The psychiatric hospital runs a 4-year training programme leading to qualification with the Arab Board of Psychiatry. After qualifying with the Arab Board a further 2 years of clinical training in the UK or USA in general psychiatry or sub-specialties is required.

Research and publications

Many local psychiatrists are actively involved in research. The establishment of the Medical School as part of the Arabian Gulf University in 1984 was an important catalyst in promoting this. To encourage research, the Ministry of Health stipulates a minimum of two publications for doctors to obtain a consultant post.

Service development

Progress has been achieved in three key areas:

- In February 2007 the Parliament passed legislation to establish a separate centre for the treatment and rehabilitation of substance misusers. The number of drug users registered in the drug rehabilitation unit is 4270. A 10-year follow-up study found a 100% relapse rate among them (Derbas & Al-Haddad, 2001). The seroprevalence rate of HIV among drug users was 21.1% (Al-Haddad *et al*, 1994).
- The Ministries of Education and Health agreed in 2007 to appoint a psychiatrist with a team of nurses, social workers and psychologists in public school health services to provide counselling and treatment for school children with intellectual disabilities or psychiatric problems.
- One of the unachieved objectives of the 1997 mental health programme was to establish independent specialist teams of psychiatrists, nurses and social workers in the areas of affective disorders, schizophrenia and other sub-specialties. The plan was to establish a separate admission area for each and to encourage research and specialised management. However, a specialist neurosis team and clinic have been established, and have been active since 1998.

There are four areas of service in which further progress is needed:

- The current day hospital is under the management of the community team and it renders its services to adult populations only. Other categories of psychiatric patients needing such services are the elderly, people with an intellectual disability and adolescents.
- Another challenge is the establishment of sheltered employment for all categories of psychiatric patient. The Bahraini labour law stipulates that 5% of the working population's employment opportunities should be allocated to people with special needs. In a competitive job market this is difficult to attain, making sheltered employment a challenging but helpful solution.
- Both community and day patient facilities still need to be expanded.
- Improvement is still needed in psychiatric services in primary care (by furthering family physicians' training in psychiatry).

References

Al-Haddad, M. K. (1988) *Bahrain Mental Health Programme Till the Year 2000*. Ministry of Health.

Al-Haddad, M. K. (1997) *Mental and Psychological Health Plan*. Ministry of Health.

Al-Haddad, M. K. & Al-Offi, A. (1996) History of psychiatric services in Bahrain. *Journal of the Bahrain Medical Society*, **8**, 127–131.

Al-Haddad, M. K., Khashaba, A. S., Baig, B. Z., *et al* (1994) HIV antibodies among intravenous drug users in Bahrain. *Journal of Communicable Diseases*, **26**, 127–132.

Bibby, G. (1969) *Looking for Dilmun*. New American Library.

Central Statistics Organisation Directorate (1991) *Bahrain in Figures*. Government of Bahrain.

Clark, A. (1981) *The Island of Bahrain*. Historical and Archeological Society, Bahrain

Derbas, A. & Al-Haddad, M. K. (2001) Factors associated with relapse among opiate addicts in Bahrain. *Eastern Mediterranean Health Journal*, **7**, 473–480.

Royal College of Psychiatrists (2002) *Model Consultant Job Descriptions and Recommended Norms* (occasional paper OP55). RCPsych.

ORIGINAL PAPER

Sudan's national mental health programme and burden of mental illness

Ehab Ali Sorketti MBBS Sudan MPM (Psychiatry) UM Malaysia

Mandag General Hospital, Mandag PO Box 117, Al Baha Region, Kingdom of Saudi Arabia

Sudan occupies 2 500 000 km² in East Africa. It has borders with nine countries, two of which are Arab: Egypt, Libya, Kenya, Uganda, Congo, Chad, the Central African Republic, Ethiopia and Eritrea. Sudan is the largest country in Africa. The heart of the country, in terms of population, lies at the confluence of the Blue and White Niles. The complex of the 'three towns', comprising the three largest cities, Khartoum, Khartoum North and Omdurman, is situated there and contains almost 20% of the population. The total population of Sudan is about 35.4 million (projected from the 2005 census). The urban population was estimated at 33% of the total. About 2.2 million are still entirely nomadic. Sudan's peoples are as diverse as its geography. There are 19 major ethnic groups and 597 subgroups.

The Sudanese population is very young, with 43.1% below the age of 15 years and only 2.7% above the age of 65 (1994 figures). In 2000, the total adult literacy rate and the female adult literacy rate were estimated at 50% and 49% respectively. The crude annual death rate is 11.5 per 1000 population and the crude birth rate is 37.8 per 1000 population (2004). The infant mortality rate is estimated at 68 per 1000 live births, and the under-5 mortality rate is 104 per 1000 live births. Total life expectancy at birth was 56.6 years in 2000. The maternal mortality rate is estimated at 50.9 per 10 000 live births (2000).

Widespread poverty and the erosion of household coping capacities due to war make a large segment of the population vulnerable to food insecurity brought on by crises such as flooding, drought, conflict and displacement. Regional and urban/rural disparities in economic resources have clear implications for health and nutrition as well as service provision.

Psychiatry in Sudan began in the 1950s under the guidance of the late Professor Tigani El Mahi, the father of African psychiatry. He pioneered, among other things, rural services and the open-door policy. His successor, Dr Taha A. Baasher, shouldered the responsibility and further extended services to the periphery.

The national mental health programme

Targets of the programme

The guiding principles are: close integration of essential mental healthcare with the general health system, and in

particular the primary care setting; development of training programmes for health personnel at all levels of the health service; development of an appropriate referral system, with comprehensive recording of information; provision of essential drugs; and community involvement and close collaboration with other social sectors, agencies and organisations.

Progress
In 1990, a mental health unit in the Ministry of Health was established. There is now a mental health board, supported by the Sudanese Psychiatric Association, which acts as an advisory body to the Minister of Health. Decentralisation to district general hospitals occurred in the early 1960s, and has now been implemented at the primary care level. Training courses are available for undergraduates, psychiatric specialist trainees and medical officers.

Attention has been given to special groups such as migrants, vagrants, the elderly, refugees and the displaced, as well as uncared for children. School mental health has been incorporated into the Mental Health Programme. A list of essential drugs has been formulated.

Administrative and managerial issues
In view of the fact that in the past 2 years the number of states in the country has increased from 10 to 25, an essential priority in the plan of action is the establishment of mental health services in these new states. An important priority in this respect is logistics.

Human resources development
In the plan of action for the programme, training is the foremost priority. A 4-year postgraduate course leading to an MD in psychological medicine was initiated in 1989. The postgraduate training programme is a current priority.

Evaluation
Though efforts have been made to evaluate the implementation of the mental health programme, more systematic planning and follow-up are required.

Research

Mental health research in Sudan has a long history, including collaboration with the World Health Organization and other bodies.

Mental health policy

Sudan's mental health policy was initially formulated in 1998. The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation.

Substance misuse policy
The substance misuse policy was initially formulated in 1995.

National therapeutic drug policy
The national therapeutic drug policy, which includes a list of essential drugs, was formulated in 1970.

Mental health legislation

The most recent legislation is the Gezira Mental Health Law of 1998. Mental health is also the subject of one chapter of the Public Health Act of 1973, which was revised in 1985. A Mental Health Act has been drafted and has gone to parliament for approval.

Mental health financing

There are budget allocations for mental health, but details of expenditure on mental health are not available. The primary source of mental health financing is taxation. The country has disability benefits for persons with mental disorders.

Mental health facilities

Primary care
Treatment of severe mental disorders is not available at primary care level.

Traditional healers are often used for the provision of mental health services. In Sudan, a symbiotic working relationship has been developed with faith healers over more than 30 years, as part of community-based mental health programmes. There was a great deal of initial resistance from the faith healers, who saw mental health professionals as competitors, but a non-confrontational approach brought home the message that indeed there are areas, particularly cases of emotional disorder, where collaboration between the two is possible. Such collaboration has gradually been formalised in order to set up referral channels for people with mental and neurological illnesses, particularly psychoses and epilepsy.

There are no community care facilities for patients with mental disorders. Community care is absent due to the lack of transportation, lack of social workers and poor health education.

Psychiatric beds and professionals
Many mental health professionals, including most psychiatrists, have left for other countries (World Health Organization, 2006). The numbers remaining are shown in Table 1.

Table 1 Numbers of beds and mental health professionals in Sudan

	National provision
Numbers of psychiatric beds per 10 000 population	
Total number of psychiatric beds	0.20
of which in mental hospitals	0.18
of which in general hospitals	0.02
Psychiatric beds in other settings	0
Numbers of professionals per 100 000 population	
Psychiatrists	0.09
Neurosurgeons	0.007
Psychiatric nurses	0.2
Neurologists	0.014
Psychologists	0.17
Social workers	0.1

Table 2 Patient numbers in Sudan, 2005 and 2006, by gender and diagnosis

	Male	Female	Total
Total numbers of patients discharged			
Schizophrenia			
2005	530	308	838
2006	1175	788	1963
Other psychosis			
2005	867	718	1585
2006	1575	1237	2812
Epilepsy			
2005	505	334	831
2006	564	825	1419
Out-patient attendance			
Schizophrenia			
2005	3157	2072	5229
2006	4136	2739	6875
Other psychosis			
2005	4331	4342	8673
2006	10134	9525	19659
Epilepsy			
2005	2812	2204	5016
2006	4357	3682	8039

The burden of mental illness

Total numbers of patients, by diagnosis and gender, for both 2005 and 2006, are given in Table 2.

References

Ahmed, I. M., Bremer, J. J., Magzoub, M. M. E., *et al* (1999) Characteristics of visitors to traditional healers in central Sudan. *Eastern Mediterranean Health Journal*, **5**, 79–85.

Sudan Federal Ministry of Health National Information Centre. *The Annual Health Statistical Report 2005–2006*.

World Health Organization (2001) *Sudan Country Profile*. WHO.

World Health Organization (2001) World Health Day Documents 2001. Mental Health as Part of Primary Health Care: Highlights from the Region. WHO, EMRO.

World Health Organization (2006) *Mental Health in the Eastern Mediterranean Region: Reaching the Unreached.* WHO Regional Publications, Eastern Mediterranean Series.

ORIGINAL PAPER

Use of participatory, action and research methods in enhancing awareness of mental disorders in Kariobangi, Kenya

Caleb J. Othieno,[1] Nelly Kitazi,[2] James Mburu,[1] Anne Obondo,[1] Muthoni A. Mathai[1] and Rene Loewenson[3]

[1]Department of Psychiatry, PO Box 19676, Kenyatta National Hospital, 00202 – KNH, Nairobi, Kenya, email cjothieno@uonbi.ac.ke; [2]Mathari Hospital, Nairobi, Kenya; [3]Training and Research Support Centre, EQUINET

Worldwide, mental disorders affect 450 million people and account for 15% of the overall burden of diseases from all causes (World Health Organization, 2001). Two-thirds of those affected do not receive adequate care owing to stigma, discrimination, neglect and poverty. The World Health Organization (2001) found that only 1% of the total health expenditure went to mental health in most countries.

In Kenya, service provision is further impeded by limited facilities and lack of mental health workers. Milder forms of psychiatric disorder (especially those affecting children, who comprise a large part of the population) are not adequately identified (Kiima *et al*, 2004). Plans to increase access to mental health services mainly use the top-down approach, instead of involving community members in planning. The First Kenya National Mental Health Programme of Action, in 1996, emphasised the need for the development of infrastructure and the training of mental health workers but gave little detail on community involvement, although it recognised the need to improve community services. This paper describes an attempt to involve community members and primary health workers in identifying and working out solutions to mental health problems in a socio-economically disadvantaged area in Nairobi, Kenya, using participatory, reflection and action (PRA) methods. PRA methods empower people to share, analyse, enhance their knowledge and plan further actions after evaluation and reflection (Wadsworth, 1998). Although the methods have been used successfully in other areas of rural development, their use in relation to psychiatric services has not been reported in Kenya.

Method

Over a 6-month period, in 2007, 30 community members from Kariobangi and community mental health workers based at Mathari Hospital were selected and engaged in a PRA process to identify mental health challenges and to enhance the community's problem-solving capacity. During the first meeting, a baseline questionnaire was administered to assess the participants' perception of mental health and the stigma associated with it, and the role of families and social organisations in promoting mental health. Thereafter, concepts of mental health were discussed using health pictures. Through brainstorming and group discussions, the mental health problems were ranked and scored on charts

by the participants. Working in groups, they drew up lists of stakeholders in the community and a community map. The relationships between the various institutions were shown in Venn (chapatti) diagrams and possible entry points were identified. They further identified important areas, which they later visited during a walk in the community (transect walk), and important people, whom they interviewed. Using the information gathered and the insights gained, the participants discussed and agreed on what could be done to reduce mental health problems in the community. The actions were ranked using beans arranged on paper to help them visualise the process. After a period of intervention, the actions were assessed by the participants using a wheel chart. This is a quick, qualitative method of measuring progress, using lines drawn in a circle (Loewenson *et al*, 2006).

Results

The baseline survey showed that the mental health workers' knowledge of mental disorders was moderate, while those from the community thought they had poor knowledge. However, the scores of the two groups did not differ significantly. Over 80% of the participants thought that mental illness in the community was extremely common. The majority attributed mental illness to afflictions of the mind and poverty. They identified stress and depression followed by alcohol and substance use and epilepsy as major problems in the community. Childhood psychiatric disorders, apart from intellectual disability, ranked lower. Obstacles identified included lack of support from the local administration, inadequate medication, high cost of drugs, stigma, long distance to the referral hospital and inappropriate clinic timing.

A social map of the area revealed several organisations dealing with children, youths, widows, orphans, the elderly, and those with HIV/AIDS. In addition, there were privately run schools that provided free meals. They felt that apart from the health institutions, other organisations offered little help to people who are mentally ill.

Key people interviewed included the chief, church leader, community clinic workers, and teacher. Their views on common mental disorders were similar to those described above. They agreed that more collaboration was needed and that tighter controls on alcohol and drug use were necessary. Children with an intellectual disability and orphaned children in the community needed more support. The participants felt that the administrative and security officers were very important, as they had a big role to play in regulating drugs in the community and licensing outlets to sell alcohol.

Reflecting on the findings, the group agreed that, with the available resources, they could increase awareness of mental health problems through public education, establish an additional community clinic, provide adequate drugs at the existing clinics, advocate tighter controls on the sale of alcohol, and provide sheltered workshops and day care centres for people with an intellectual disability. The participants suggested that they should start a mental health promotion and support group within the community. The family members of those with mental illness would organise themselves into groups with the help of the health staff. These groups would identify available resources and coordinate mental health programmes within the community. The participants could not agree on how to alleviate poverty, although they regarded it as a major cause of mental ill health. Options considered included starting income-generating small-scale businesses and strengthening self-help groups with the resource of invited experts. At the meeting, individuals volunteered for the various actions.

Follow-up meeting

A feedback meeting was held 6 months after the initial assessment. The community members' perception of mental illness had changed and they believed the burden of mental illness was greater than they had initially thought. They had increased awareness of mental illnesses and their causes.

Some of the specific targets identified earlier had been met. Hospital psychiatrists had given talks on mental health to the local school and church. A community health nurse had been invited to the local chiefs' meeting and mental health personnel had participated in meetings of local social groups. An occupational therapist from Mathari Hospital had started working with children with intellectual disabilities in one of the community organisations. A request had been made to the Ministry of Health for adequate supplies of anti-depressants and anti-epileptic drugs for the clinics.

Discussion

The results show the three phases of the PRA process – participation in identifying problems, reflection on possible solutions using local resources, and action. The community members welcomed the project and were more confident in discussing mental health disorders and possible interventions at follow-up. Initially, the participants had high expectations of outside aid. Being unfamiliar with PRA methods, they were at first surprised that they were expected to come up with solutions to their problems but, after explanation, this was overcome. The PRA methods used, such as ranking, scoring, drawing and the group discussions, were easily implemented, unlike reflective discussions. Most of the participants expected the facilitators to give them the solutions while they played a more passive role. They were repeatedly reminded that the community affected had better knowledge of the problems and could offer useful solutions.

Lack of coordination and poor communication between the various social groups in the community resulted in poor care for people who are mentally ill. Community members are willing to work with mental health workers to improve healthcare in the community but need to be given support.

Conclusions

Further interventions and evaluation of the impact of the PRA methods as a means of giving the community a voice in mental health issues are needed. The next phase of the project will focus on substance use in the community.

Acknowledgements

We thank Kariobangi community members and the staff of Mathari Hospital, especially Lorna Osendi, Teresia Mbugua, Jesca Papi and Pastor Erastus Omuhanga, for their important contributions to this work. This

work was implemented under the theme 'work on participatory methods in health' in the Regional Network for Equity in Health in East and Southern Africa (EQUINET) with support from SIDA Sweden.

References

Kiima, D. M., Njenga, F. G., Okonji, M. M. O., *et al* (2004) Kenya mental health country profile. *International Review of Psychiatry*, **16**, 48–53.

Loewenson, R., Kaim, B., Mbuyita, S., *et al* (2006) *Participatory Methods for People Centred Health Systems: A Toolkit for PRA Methods.* TARSC, Ifakara (Harare).

Wadsworth, Y. (1998) What is participatory action research? Action Research International, Paper 2. Available at http://www.scu.edu.au/schools/gcm/ar/ari/p-ywadsworth98.html (last accessed November 2008).

World Health Organization (2001) The World Health Report: mental disorders affect one in four people. Available at http://www.who.int/whr/2001/media_centre/press_release/en/index.html (last accessed November 2008).

SPECIAL PAPER

Psychiatric practice for intellectual disability in the USA: challenges and advances

Stephen Ruedrich MD

Associate Professor of Psychiatry, Case School of Medicine, MetroHealth Medical Center, 2500 MetroHealth Drive, Cleveland, Ohio 44109, USA, email sruedrich@metrohealth.org

Individuals with intellectual disability are thought to make up at least 1% of the population, and it is estimated that approximately one-third of them have a comorbid psychiatric disorder (Harris, 2006). These 'dually diagnosed' individuals present a particular diagnostic and therapeutic challenge. A difficulty facing psychiatry in the USA over the past several decades has been to interest and educate a sufficient number of psychiatrists to meet the mental health needs of this group of patients (Department of Health and Human Services, 2002).

Most individuals with the dual diagnosis of intellectual disability and psychiatric disorder live in community settings, with families, or in small congregate facilities such as group homes, or in individual apartments with supported living assistance (Harris, 2006). Even at a peak in the mid-1960s, only about 190 000 of the estimated three million persons with intellectual disability resided in large institutional settings in the USA, and over the past 40 years this number has shrunk to about 40 000 (Prouty *et al*, 2007). Some states have completely closed such large institutions, and all states have focused on keeping persons with intellectual disability living and working in their own communities. This evolution to primarily community-based care has increased the need for adequate psychiatric services in both rural and urban settings, and provided an impetus for expanded education.

The challenges

Unfortunately, this need goes largely unmet, as there are insufficient numbers of psychiatrists with education, experience and skills in this area. In a 1965 survey conducted by the American Psychiatric Association (APA), 144 of 16 500 psychiatrists (nearly 1%) identified intellectual disability as their main area of work (Whiting, 1969). Since then, interest in the psychiatry of intellectual disability has seemingly attenuated in the USA, at least as revealed by membership and participation in professional organisations dedicated to this specialty. The National Association for the Dually Diagnosed (NADD), perhaps the US group most closely allied with dual diagnosis issues, has fewer than 100 psychiatrist members, and some of them are from outside the USA (NADD, 2007). Other professional organisations have similar or smaller numbers of psychiatrists who identify intellectual disability as their professional focus.

One possible reason for this lack of interest is confusion regarding whether the care of persons with intellectual disability and dual diagnosis should be the province of general psychiatry, or whether post-residency specialised training and certification in intellectual disability should be provided. Currently, the Residency Review Committee (RRC) for Psychiatry of the Accreditation Council for Graduate Medical Education (ACGME) in the USA provides no specific requirement for education in intellectual disability in general psychiatric training programmes (ACGME, 2007). This means many or even most general psychiatrists have little or no exposure to, or experience with, persons with intellectual disability during general residency education.

The situation is little better with regard to post-residency specialised training. Only in child and adolescent psychiatry fellowship training does the RRC for Psychiatry mention any need for specialised education: 'There must be an organized teaching and clinical experience in pediatric neurology, mental retardation, and other developmental disorders' (ACGME, 2007). However, the American Board of Psychiatry and Neurology (ABPN) reports that, at present, there are no accredited post-residency fellowships in the psychiatry of intellectual disability in the USA (ABPN, 2007). Perhaps the closest equivalent is fellowship training in neurodevelopmental disabilities, which is considered a sub-specialty of neurology. The ABPN approved fellowship education in neurodevelopmental disabilities in 1999, and held the first qualifying examination in 2001 (ABPN, 2007). Applicants for the certifying examimation must complete 2 core years

of paediatrics, followed by 4 years of neurology. There are currently seven ACGME-approved training programmes, and 55 fellows have been certified since 2001 (ABPN, 2007). Unfortunately, at present, there is no psychiatric pathway to an equivalent certification for intellectual disability and dual diagnosis in the USA (ACGME, 2007).

This situation can be contrasted with that found in the UK, where many senior house officers have experience in intellectual disability before admission to the Royal College of Psychiatrists, and intellectual disability is one of six sub-specialties recognised by the College. With regard to provision of service to individuals with intellectual disability, the College has recommended a ratio of one (sub-specialist) consultant in intellectual disability per 80 000 population (Royal College of Psychiatrists, 2003). Extrapolating this number to the USA, with a population of just over 300 million, would require nearly 3800 psychiatrists practising in this clinical arena. These needs should be contrasted with the fewer than 100 self-identified psychiatrists in the USA who, through their connections to professional organisations, declare their interest in the psychiatry of intellectual disability (see above). In the USA, there is no formal sub-specialist credentialing or 'certification' in the psychiatry of intellectual disability. As a result, most psychiatric care of persons with intellectual disability and dual diagnosis is provided by generalist psychiatrists, a few with on-the-job experience, but most of whom feel inadequately prepared to treat these persons.

Positive developments

There are, however, several positive developments in the psychiatry of intellectual disability in the USA that may ultimately provide the impetus for reversing these trends. The first is the change that has taken place recently in recharacterising 'mental retardation' as 'intellectual disability', with the hope of further destigmatising persons with this particular challenge (Schalock *et al*, 2007). Over the past 200 years, the method of identifying and labelling individuals with intellectual disability has gone through a number of evolutions. Before the 1950s, pejorative terms were used, such as idiocy, imbecility and feeble-mindedness, all subsumed under the collective title of mental deficiency. After the Second World War, these were gradually replaced by the term mental retardation in the USA (Schalock *et al*, 2007). In the past 4 years, intellectual disability has replaced the term mental retardation in some official language, most notably in the President's Committee on People with Intellectual Disability (2003) and the American Association on Intellectual and Developmental Disabilities (2007). However, many jurisdictions continue to use the term mental retardation in designations of official state departments, and it appears in many statutes and laws, which may take much longer to adopt less stigmatising language (National Association of State Directors of Developmental Disabilities Services, 2007). This is in contrast to the UK, where the term mental handicap was replaced by learning disability in the early 1990s and where the term intellectual disability has recently been adopted by the Royal College of Psychiatrists.

A second positive development has been the recent introduction of a new psychiatric diagnostic system applicable to persons with intellectual disability (Royal College of Psychiatrists, 2001). It has long been recognised that, although psychiatric disorders in persons with intellectual disability are common, they are often not appropriately identified, and determining an accurate psychiatric diagnosis becomes especially difficult as the level of intellectual functioning declines (Harris, 2006). To address these needs, the NADD, in association with the APA, has developed a diagnostic manual for persons with intellectual disability, designed as an adaptation of DSM–IV (NADD, 2007). Officially titled the *Diagnostic Manual for Intellectual Disability* (DM–ID), the text offers a description of each psychiatric disorder, a review of relevant research, an evaluation of the strength of evidence and a discussion of the aetiology and pathogenesis of specific disorders, all followed by adaptations of the DSM–IV diagnostic criteria for persons with mild/moderate and severe/profound intellectual disability (NADD, 2007). DM–ID follows the introduction of the *Diagnostic Criteria for Psychiatric Disorders for Use with Adults with Learning Disabilities/Mental Retardation* (DC–LD) in the UK in 2001 by the Faculty for the Psychiatry of Learning Disability of the Royal College of Psychiatrists and the Penrose Society (Royal College of Psychiatrists, 2001). Both manuals introduce the important concept of behavioural phenotypes, which are based on observations that a particular genetic aetiology of intellectual disability is often associated with, or predictive of, a specific developmental and behavioural course (Harris, 2006).

Finally, recent effort in the USA has focused on the issue of healthcare disparity for individuals with intellectual disability. In 2002, the US Surgeon General sponsored a major conference and position paper entitled *Closing the Gap: A National Blueprint for Improving the Health of Persons with Mental Retardation* (Department of Health and Human Services, 2002). The report was based on the repeated observation that 'people with MR [mental retardation] had poorer health and far less access even to basic screening and corrective treatment for vision, hearing, and oral health problems than others; and that diagnosis and treatment of mental illnesses and other serious disorders in this population were often delayed, inadequate, or not provided at all.' The blueprint outlined six goals to address healthcare disparity, one of which involved increasing the training and availability of healthcare professionals working in the field of intellectual disability.

Conclusions

Although there has never been a more exciting time for research and practice in the broad area of intellectual disability, our field remains challenged to provide mental health services for the more than three million persons with intellectual disability living in the USA. Currently, there are insufficient numbers of educated and experienced psychiatrists to address this challenge. It is hoped that the advent of new and less stigmatising language, new evidence and consensus-based diagnostic and therapeutic approaches, and a new blueprint for improving health can reverse this situation.

References

ABPN (2007) Initial Certification in the Subspecialty of Neurodevelopmental Disability. See http://www.abpn.com (last accessed May 2007).

ACGME (2007) See http://www.acgme.org/acWebsite/downloads/RRC (last accessed May 2007).
Department of Health and Human Services (2002) *Closing the Gap: A National Blueprint to Improve the Health of Persons with Mental Retardation*. See http://www.surgeongeneral.gov/topics/mentalretardation/retardation.pdf (last accessed May 2007).
Harris, J. C. (2006) *Intellectual Disability: Understanding Its Development, Causes, Classification, Evaluation, and Treatment*. Oxford University Press.
NADD (2007) See http://www.thenadd.org (last accessed May 2007).
National Association of State Directors of Developmental Disabilities Services (2007) See http://www.nasddds.org (last accessed May 2007).
Prouty, R., Coucouvanis, K. & Lakin, K. C. (2007) State institution populations in 2006 less than 80% of 40 years earlier: 'real dollar' per person costs more than 10 times greater. *Intellectual and Developmental Disability*, **45**, 143–145.
Royal College of Psychiatrists (2001) *DC–LD: Diagnostic Criteria for Psychiatric Disorders for Use with Adults with Learning Disabilities/Mental Retardation* (Occasional paper OP48). See http://www.rcpsych.ac.uk/publications/collegereports/op/OP48.aspx.
Royal College of Psychiatrists (2003) *Meeting the Mental Health Needs of Adults with a Mild Learning Disability* (College report CR115). See http://www.rcpsych.ac.uk/publications/collegereports/cr/cr115.aspx.
Schalock, R. L., Luckasson, R. A., Shogren, K. A., *et al* (2007) The renaming of mental retardation: understanding the change to the term intellectual disability. *Intellectual and Developmental Disabilities*, **45**, 116–124.
Whiting, J. F. (1969) *Psychiatric Services, Systems Analysis, and Manpower Utilization*. American Psychiatric Association.

NEWS AND NOTES

Contributions to the 'News and notes' column should be sent to: Amit Malik MRCPsych, Consultant Psychiatrist, Hampshire Partnership NHS Trust, UK, email ip@rcpsych.ac.uk

Training in primary care psychiatry and psychosocial rehabilitation in Mongolia

Mongolia, with a population of over 2 million, has a per capita income of about US$400, while doctors' salaries seldom exceed US$1800 per annum. In mental health, some 120 psychiatrists are distributed in most of the 22 *aimags*, or provinces, but resources exclude the provision of basic mental health services to populations outside the provincial capitals. Vast areas of Mongolia have no mental health services, although feldshers and primary care doctors are more widely distributed in most districts.

With financial support from the Board of International Affairs, Dr Parameshvara Deva, Secretary of the Western Pacific Division, ran a training course in December 2008, for about 25 physicians, neurologists and psychiatrists, who will then train other doctors and feldshers throughout Mongolia.

College contribution to the National Conference on Mental Health in Iraq

On invitation from the Minister of Health for Iraq, a delegation from the Royal College of Psychiatrists attended the 3rd Iraqi National Mental Health Conference, held in Baghdad, 17–18 October 2008. The delegation, which included Mohammed Al-Uzri, Rizkar Amin and Mohammed Abbas, also took part in the workshops in preparation for the conference. The objective of the conference was to draft the Ministry of Health's strategy on mental health, and it achieved its objective of providing a vision for mental health services in Iraq. It was attended by more than 300 persons, including ministers and members of the Iraqi parliament, and attracted media attention. Holding this conference for the first time in Iraq since 2003 was itself an achievement and a milestone in the recovery of health services in Iraq. The role of the College was acknowledged by the health community in Iraq, as well as by international organisations working there.

College's Faculty of the Psychiatry of Old Age

The fact that UK mental health services discriminate against older people was confirmed in major reports published in 2007 and 2008. In the 'need not age' argument for the organisation and delivery of services, the College's Faculty of the Psychiatry of Old Age has been vocal in defending the right of older people to access services designed to meet their needs. With other professional and consumer organisations, the Faculty published a consensus statement about need and action in 2008 (see http://www.olderpeoplesmentalhealth.csip.org.uk). This is a global issue. The Faculty is strongly represented in the landmark National Dementia Strategy for England, which was due to be published in December 2008.

Following a jointly organised conference in Dublin in 2008, the College Faculty is now affiliated with the International Psychogeriatric Association. The conference in Barcelona in 2009 will involve members of the European Association and an international bursary has been created to help overseas psychiatrists attend these meetings. Closer links are being developed with the Indian section of old age psychiatry and the Royal Australian and New Zealand College of Psychiatrists.

The Faculty has produced a new training curriculum and its website receives substantially more hits than does any other Faculty of the College. The profile of older people's mental health has never been higher and the expansion of a specialism for older people never more important.

Dave Anderson

Chair, Faculty of the Psychiatry of Old Age, Royal College of Psychiatrists

2008 annual general meeting of the British Indian Psychiatric Association

The British Indian Psychiatric Association (BIPA), an association for UK-based psychiatrists of Indian origin, but open to any interested psychiatrist, was established in 1995 and held its 12th annual general meeting on 14–15 June in Nottingham. The BIPA took pride in receiving Professor Dinesh Bhugra, a life member of the BIPA, to celebrate his election as the College President. The BIPA trainee award was awarded this year by Professor Sheila Hollins, to Dr Karthik Thangavellu.

The scientific programme was aimed at sharing contemporary developments in the area of the measurement of brain function. In addition to a keynote speech by Professor Harry T. Chugani, Chief of Paediatric Neurology from Michigan, other speakers included Dr Avdesh Sharma, from New Delhi, Professor K. N. Roy Chengappa from Pittsburg, Professor Diane Chugani from Michigan and Dr Lakshmi Vijayakumar from Chennai. The next morning saw a series of workshops after the formal business meeting. The event was attended by more than 120 members, their families and invited guests. BIPA activities are reported regularly on its website, www.BIPA.org.uk

Ranjit K. Baruah
Immediate Past Chair, BIPA

Leadership and professional skills courses for young psychiatrists

The Association for the Improvement of Mental Health Programmes has developed a curriculum for courses of leadership development that is based on the provision of skills through a process of active learning and participation. A number of such courses have been held in low-, middle- and high-income countries, in the north and the south of the globe, in English and in other languages.

They are of short duration because it is often difficult for young psychiatrists to be absent from their place of work for more than a few days. The courses include a variety of topics, ranging from 'How to present a paper' and 'How to write a curriculum vitae' to work on vignettes presenting ethical problems and discussions about obtaining support for a project and implementing it. A faculty, usually composed of four teachers – two foreign and two from the host country – spends all the time of the course with the students, thus offering ample opportunity for informal contacts between teachers and students in addition to discussions in the more formal setting of the agenda of the course. Professor Sir David Goldberg has been immensely useful as one of the foreign members of the faculty in a considerable number of the courses, but many other leading experts – including Professors J. Füredi, H. Helmchen, C. Höschl and M. Sato – have been involved in their organisation and conduct, and have made splendid contributions to their success.

The courses are being organised by the Association for the Improvement of Mental Health Programmes, a non-governmental not-for-profit organisation with its seat in Geneva; support for the travel and accommodation of the students and teachers has come from various sources, including several pharmaceutical companies (notably Eli Lilly and Company and Servier), universities, scientific institutions, governments and donations.

The next international course will be held in Singapore in February 2009.

Professor Norman Sartorius
President, Association for the Improvement of Mental Health Programmes

Report on the assembly of the World Psychiatric Association

Professor Sheila Hollins attended the Ordinary and Extraordinary Assemblies of the World Psychiatric Association (WPA) in Prague on 22 September 2008. The College President, Professor Dinesh Bhugra, was an observer, as was Professor Hamid Ghodse, as a member of the Planning Committee. Professor Sheila Hollins presented a brief paper on behalf of the College on the global mental health implications of climate change.

During the general assembly, Professor John Cox, past Secretary General of the WPA, received an Honorary Fellowship for his contribution to the WPA. Professor Sheila Hollins, immediate past President of the College, received an Honorary Membership for her services to the WPA.

Dr Pedro Ruiz from the United States is now President-elect and Dr Levent Küey from Turkey is the new Secretary General.

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

Ongoing changes in Irish psychiatry: trainees' perspectives

Sir: Your readers might be interested to know about the changes to Irish training. Currently, the Irish Psychiatric Training Committee (IPTC) is the statutory body regulating psychiatric training in Ireland. Alongside the IPTC, the Royal College of Psychiatrists provides accreditation and educational approval to training schemes and programmes. There are currently 12 training schemes in Ireland, with approximately 500 trainees. The Certificate of Satisfactory Completion of Training (CSCT) and entry onto the specialist register of the Irish Medical Council are awarded after 3–4 years of basic training as a senior house officer/registrar followed by another 3–4 years of higher training as senior registrar.

Irish psychiatry is presently in a process of restructuring. On 1 January 2009, a new College of Psychiatry of Ireland, autonomous from the UK Royal College, came into being,

and an indigenous training and assessment programme is expected to be in place from 2010. This change provides a unique opportunity for recent advances in medical education to form the basis of the new training programme. Steering groups are now developing the new training programme and its delivery. As part of this process, a pilot on workplace-based assessments is already under way in Dublin.

For Irish trainees, the initial anxieties brought on by these changes are fast giving way to corresponding levels of enthusiasm and a motivation to shape the changes as they occur. In this regard, the Trainees' Section of the Irish College has recently embarked on a project to explore ways of optimising the awareness and participation of all trainees in College activities at this time of change, and to position themselves as key stakeholders in the emerging new College.

One key issue of concern for pre-membership trainees has been the prospect of being ineligible to sit the MRCPsych examinations after spring 2010 under the current eligibility criteria. However, the Royal College and its Irish Division are working to ensure that Irish trainees continue to meet eligibility criteria until the 'Irish exams' become fully established. Of note, as the Irish College emerges, Irish trainees will retain their entitlement to join the Royal College as international members, and thereby continue to enjoy the benefits that come with it, such as access to journals and rebates on conference fees.

We feel that collaboration and exchange of experiences with our peers both in the UK and in the wider European context, as occurs at the European Federation of Psychiatric Trainees (EFPT), will be beneficial. We would welcome an opportunity to retain our seats at the Psychiatric Trainees Committee of the Royal College, since we are likely to continue to sit the MRCPsych exams in the foreseeable future and an ongoing forum for exchange of ideas and experiences with our UK colleagues would be invaluable, especially in these initial stages of the Irish College's inception.

For psychiatric trainees in Ireland, the time ahead is both challenging and exciting. We look forward to the advent of the new College of Psychiatry of Ireland – one that is committed to providing training that is comparable with the best in the world. This will ensure that Irish patients continue to enjoy the highest standards of mental healthcare.

Izu Nwachukwu MBBS MRCPsych[1]
and Elizabeth Barrett MB DCH MRCPI[2]
[1]Chair, Trainees' Section, Irish College of Psychiatrists, Senior Registrar/Lecturer in Psychiatry, St Vincent's University Hospital, Elm Park, Dublin 4, Ireland; [2]PTC Representative, Trainees' Section, Irish College of Psychiatrists

Correspondence is welcome either on articles published in *International Psychiatry* or on aspects of current policy and practice in psychiatry in different countries. Letters (of up to 500 words) should be sent to: Amit Malik MRCPsych, Consultant Psychiatrist, Hampshire Partnership NHS Trust, UK, email ip@rcpsych.ac.uk.

Supervision – an issue in Portuguese psychiatric training

'Better than a thousand days of diligent study
is one day with a great teacher.' (Japanese proverb)

Sir: There are rising concerns regarding postgraduate medical training in Portugal. The lack of supervisors is one critical factor adversely affecting psychiatric training. In the past few years, employment in the public sector has been considerably reduced. New appointments for consultants have been frozen. Recently qualified specialists either look for a job in the private sector or accept insecure contracts in the public sector. Unable to compete with the private sector in terms of employment benefits, public services are losing consultant psychiatrists, and this has led to shortages in every setting, from outpatient clinics to hospital wards, from emergency rooms to rehabilitation units. This inevitably has an impact on current psychiatric training. In a process of teaching and learning, adequate supervision is an essential element of training. With its clear implications for patient safety, supervision must be carried out within clearly defined lines of responsibility.

Unfortunately, the current laws and regulations on training do not provide a clear definition of supervision, its frequency, structure and contents, or the trainee's responsibilities. As each training institution uses its own interpretation of the law, training standards become inconsistent, with some trainees being directly and regularly supervised while others receive almost no supervision at all. There are reports of a lack of supervision in most settings, including in-patient and out-patient clinics. The situation is particularly critical in emergency rooms, where trainees, especially in their last years of training, are often left unsupervised.

A vast majority of consultant psychiatrists are in their fifties, prompting speculations that the lack of supervisors may become acute in a few years' time, when they retire.

The situation is exacerbated by recent proposals to change the way the healthcare system in Portugal is financed and managed. There are major concerns that the model of healthcare provision based on commercial insurance will focus primarily on short-term profitability rather than maintaining high standards of medical training.

To address these concerns, the Portuguese Medical Association has begun to assess training institutions on a regular basis, while the Portuguese Psychiatric Trainee Association is monitoring the trainees' satisfaction with supervision.

More needs to be done, however, to increase the quality of supervision. Without clearly defined laws and regulations on supervision in training, describing the roles of the trainee, the trainer and the training institution, and defining competencies for each stage of training, we cannot hope to maintain high standards in training. Compliance with those laws and regulations must be regularly monitored to motivate senior doctors to play an active role in training.

For great teachers to provide great teaching, we have to give them the proper conditions to teach.

Luis Mendonça
Portuguese Association of Psychiatric Trainees (APIP)

An overseas trainee's experience at the College annual conference, London, 2008

Sir: As an invited speaker from the Western Pacific Division of the Board of International Affairs, and as a third-year trainee from Hong Kong, I attended the College annual conference in London, 1–4 July 2008. It was truly an eye-opening experience and I took home with me many wonderful memories and invaluable knowledge.

During the four days of the conference, I met eminent professors, respected psychiatrists, specialists and trainees from all over the world. I attended meetings of the Board of International Affairs, where many issues were raised, ranging from disaster management to organising training programmes and various campaigns. This was an area of psychiatry that I had not been exposed to before, and it was an introduction to what psychiatry on a global scale entails.

As for my presentation, the title was 'Getting it across: psycho-education in primary care'. There was a lively question-and-answer session afterwards, and the feedback was positive and encouraging.

Last but not least, the conference offered a myriad of symposiums and talks to suit everyone's specialties and particular interests. The presentations were done in a very personal and interactive manner, which made learning much more interesting than the standard lectures.

As for social events, I attended the trainees' reception and met others from different levels of training in the UK. It gave me an opportunity to reflect on the situation in Hong Kong, and to learn about the changes and current situation in UK training as well. The highlight of the week was the cocktail reception at the House of Lords for overseas delegates. After a welcoming speech from Lord Crisp, who has been involved in mental healthcare issues for many years, we were given a guided tour around the famous parts of Parliament: the House of Lords, House of Commons and various other rooms and halls. It was an unforgettable evening spent in the company of many great people.

I realised that a career in psychiatry is more than just passing exams, getting a training post, or even publishing papers. There are so many ways in which we, even as trainees and younger members of the psychiatric profession, can serve our community. Getting into volunteer programmes, raising money for low-income countries, coordinating response protocols for disaster-stricken areas, and advancing psychiatric training and education globally are but a few ways in which we can get help, and the College provides a platform for us to participate in such activities. The satisfaction and personal experiences I gained from this conference gave me motivation to be a better psychiatrist, and provided me with a sense of direction in my professional career.

Vanessa T. C. Wong
Resident, psychiatrist trainee, Hong Kong, email vtcwong@gmail.com

Sensitising primary care physicians to common mental disorders using a problem-based learning approach

Sir: We conducted a series of 1-day sensitisation workshops on common mental disorders for primary care physicians in Delhi. The workshops were conducted as part of the National Mental Health Programme of the government of India. The workshops were kept to 1 day because of the busy clinical schedules of the medical officers. The learning objectives were that the medical officers would be able to diagnose and manage these disorders in their clinical practice using both pharmacological and basic non-pharmacological interventions, such as reassurance, encouragement and psychoeducation.

The programme consisted of three sessions, one each on anxiety disorders, depressive disorders and somatoform disorders. These conditions were chosen because they are common, often remain undetected, are associated with significant dysfunction and medical comorbidity, and are easy to treat in primary care. Three workshops were conducted and 102 primary care physicians attended. To encourage the active involvement of participants, a problem-based learning approach was used (Wood, 2003).

The participants were divided into groups of six to eight. Each session comprised a group task, presentation of the problem solution by one of the group members and a brief discussion. Each group was given a problem in the form of a case vignette along with five questions related to diagnosis and management. The groups were given 10 minutes for the task followed by 5 minutes for presentation and discussion. This was followed by an interactive presentation on the topic by one of the psychiatrists, followed by general discussion.

At the end of the presentation, 10 minutes were given for feedback from administrators and participants. The programme format was found to be very useful by most people, as it had made them participate in the learning, and they had an opportunity to discuss the difficulties of dealing with such cases during day-to-day clinical practice.

Under the National Mental Health Programme, 2-week training programmes have been conducted in different places in India and have been found useful in improving primary care workers' knowledge of mental health issues (Sriram *et al*, 1990). But it has often been found difficult for doctors working in primary care to be sent for 2 weeks' training. Most of the earlier programmes have been in the form of didactic lectures. The present programme in the form of interactive sessions lasting just 1 day can serve as a useful training strategy for use in low- and middle-income countries, where there is a major shortage of health personnel.

Sriram, T. G., Chandrashekar, C. R., Isaac, M. K., *et al* (1990) Development of case vignettes to assess the mental health training of primary care medical officers. *Acta Psychiatrica Scandinavica*, **82**, 174–177.
Wood, D. F. (2003) ABC of learning and teaching in medicine: problem based learning. *BMJ*, **326**, 328–330.

Rakesh K. Chadda, Mamta Sood and Nand Kumar
Department of Psychiatry, All India Institute of Medical Sciences, Ansari Nagar, New Delhi 110029, India, email drrakeshchadda@hotmail.com

Forthcoming international events

2–6 February 2009
'Cultura y Salud Mental' Congress
Havana, Cuba
Organiser: World Psychiatric Association; Cuban Society of Psychiatry
Contact: Dr Cristobal Martinez
Email: crisma@infomed.sld.cu

23–24 February 2009
Teachers of Psychiatry (TOP) Conference
Organiser: Department of Psychological Medicine, National University of Singapore
Contact: Ms Jasmine Tan
Email: pcmnglk@nus.edu.sg

26–27 March 2009
XVI International Symposium About Current Issues and Controversies in Psychiatry: Suicidal Behaviour
Barcelona, Spain
Email: barcelona@geyseco.es

26–28 March 2009
1st International Conference on Psychology and Education – Practices, Training and Research
Covilha, Portugal
Organiser: University of Beira Interior
Website: http://www.icped.ubi.pt

26–28 March 2009
Sixth International Conference on Positive Behavior Support
Jacksonville, Florida, United States
Organiser: Association of Positive Behavior Support
Website: http://apbs.org

27–29 March 2009
Ninth Workshop on Costs and Assessment in Psychiatry – Quality and Outcomes in Mental Health Policy and Economics
Venice, Italy
Organiser: WPA Section on Mental Health Economics
Contact: Dr Massimo Moscarelli
Email: moscarelli@icmpe.org

31 March–4 April 2009
11th International Neuroscience Winter Conference
Sölden, Austria
Email: philipp.tsolakis@i-med.ac.at

1–4 April 2009
WPA International Congress – Treatments in Psychiatry: A New Update
Florence, Italy
Organiser: Italian Psychiatric Association
Contact: Dr Mario Maj
Email: majmario@tin.it
Website: www.wpa2009Florence.org

21–23 April 2009
Challenges in the Outcome of Psychiatric Disorders
Jeddah, Saudi Arabia
Email: moh.khaled.hamed@gmail.com

5–8 May 2009
14th International Conference Neuropsychiatric, Psychological and Social Developments in a Globalised World
Athens, Greece
Organiser: Association of Psychology and Psychiatry for Adults and Children (APPAC)
Website: http://www.epsep.org.gr

14–15 May 2009
Mental Health and the Issues Facing Society: Rehabilitation, Social Involvement and Professional Integration
Mondorf-les-Bains, Luxembourg
Organiser: ATP asbl
Website: http://www.social-psychiatry.eu

15–17 May 2009
International Conference on Alzheimer's Disease and Related Disorders in the Middle East
Limassol, Cyprus
Organiser: World Events Forum
Email: meetings@worldeventsforum.com

27–31 May 2009
IV Macedonian Psychiatric Congress and International Meeting
Ohrid, Macedonia
Organiser: Psychiatric Association of Macedonia (FYROM)
Contact: Dr Antoni Novotni
Email: anovotni@yahoo.com
Website: www.mpaohrid2009.com.mk

3–6 June 2009
XXIV Congreso de la Asociacion Española De Neuropsiquiatria
Cadiz, Spain
Organiser: Spanish Society of Neuropsychiatry
Contact: Dr Fermin Perez
Email: presidente@ann.org.es
Website: www.24congresoaen.com

15–19 June 2009
16th ISPA Congress Differentiation Integration and Development
Copenhagen, Denmark
Organiser: International Society for Psychological Treatment of Schizophrenias and Other Psychosis (ISPS)
Contact: Dr Erik Simonsen
Email: es@regionsjaelland.dk
Website: http://www.ISPS2009.ics.dk

24–27 June 2009
IASSID 2nd Annual Asia Pacific Conference
Singapore, Singapore
Organiser: International Association for the Scientific Study of Intellectual Disability (IASSID)
Website: http://www.iassid.org

28 June – 2 July 2009
9th World Congress of Biological Psychiatry
Paris, France
Organiser: World Federation of Societies of Biological Psychiatry (WFSBP)
Website: http://www.wfsbp-congress.org

5–10 July 2009
1st Central and Southeast European Regional Congress & Summer School of Social & Community Psychiatry
Gura-Humorului, Romania
Contact: Dana Catargiu
Email: congress2009@apsro.ro
Website: http://www.apsro.ro/

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

Volume 11, Number 4, November 2008

The African Journal of Psychiatry is published by:
In House Publications, PO Box 412748, Craighall, 2024, Johannesburg, South Africa
Tel: +27 11 788 9139 Fax: 088 011 788 9139
Email: inhouse@iafrica.com Website: www.ajpsychiatry.co.za