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

Complaints: pathology or talking cure?

Ann Abraham

UK Parliamentary Ombudsman and Health Service Ombudsman for England

A recent conference organised by the Royal College of Physicians in London took as its theme the notion of 'multiple medico-legal jeopardy'. Its purpose was to explore the implications for doctors of their 'multiple accountability', ranging from professional disciplinary proceedings to professional negligence claims and, in extreme circumstances, even criminal charges. The implicit assumption was that 'multiple accountability' of this sort is not only unfair but also potentially counterproductive: too much accountability simply leads to defensive practice and impoverished service delivery to patients.

My experience as UK Parliamentary Ombudsman and Health Service Ombudsman for England suggests otherwise. It is certainly true that my office sits at the pinnacle of a rather diffuse health-service complaints pyramid. To that extent, its very existence might be seen as yet another level of 'jeopardy', a final trap to be avoided in a perennial game of professional snakes and ladders. Such a view, however, betrays a misunderstanding both of the act of complaining and of the role of the Ombudsman.

It is tempting to think of complaining as an irritating form of weakness or even of personal psychopathology. Yet, at its best, complaining is rooted not in self-interest or a false sense of self-importance but in the recognition of things being out of order and of their needing to be put right. Complaining has a noble modern history, from Emmeline Pankhurst to Martin Luther King and Nelson Mandela. However, just as the severity of a medical complaint should be measured not by how loudly it draws attention to itself but by the extent to which the mind and body really are damaged, so we should not mistake the loudness of a complaint for its importance. It is with complaints that really do express the sense of 'mind and body damaged' that I am most concerned, not least because such complaints, when directed at the quality of healthcare, contain within them a vision of what 'the mind and body', in this instance healthcare services, should look like when in proper working order.

In England, the government has recently developed a constitution for the National Health Service, which establishes the principles and values of the Service and provides a useful vision of the healthcare 'mind and body' when in good working order. Its distinguishing characteristic is the desire to put the individual at the centre of things. That desire is given expression in a number of references to 'respect', 'dignity' and 'compassion' and in the assertion that 'everyone counts'. It is present also in the aspiration to 'work together' for patients and to 'improve lives'. This is not, as I see it, a technocratic vision of targets, mechanised systems and impersonal efficiency. Of course, excellence and professionalism are part and parcel of the vision, but they are presented very much as a means to an end, and not as technical ends in themselves.

That recognition of the primacy of the individual is, I would suggest, where the Ombudsman comes in. The role of Ombudsman originated in Sweden in 1809. At the very heart of the Ombudsman concept, as originally imported from Scandinavia, is the idea of 'lay' oversight, of being a representative of ordinary people, of seeing things from their perspective, unencumbered by all the misperceptions that can go with too much specialised experience and too much arcane expertise. The danger of a too narrowly focused expertise is, of course, that we can end up missing the wood for the trees.

Conversely, the task of seeing the wood and not being overwhelmed by the beauty and intricacy of the individual trees – the task, in other words, of an Ombudsman – is all about the bigger picture afforded by seeing the patient as an individual and medical intervention as part of a whole range of social factors that make up the complex possibilities of well-being.

It is the need to keep that bigger picture in view that has led to an important initiative in my office over the past couple of years: the production of a trilogy of basic principles governing our work with public authorities. The trilogy comprises concise statements of principle in respect of good administration, of remedy and of complaints handling. These are not rules of the sort you might expect a court to be concerned with. They do not prescribe desirable behaviour in any detail, nor do they tailor their application to particular sectors. The key principles outlined are these:

- getting it right
- being customer focused
- being open and accountable
- acting fairly and proportionately
- putting things right
- seeking continuous improvement.

These key principles of legality, flexibility, transparency, fairness and accountability are, if you like, my rule of thumb for evaluating the performance of public authorities, including those in the healthcare sector. They underpin my assessment of performance, my approach to remedy and my vision of good complaints handling. Other Ombudsmen, both within the UK and internationally, will apply similar standards to the public authorities they oversee.

Does this Ombudsman intrusion then represent an example of 'multiple jeopardy'? Certainly, it might be seen that way, since it is perfectly possible for a health authority to resist a claim of professional negligence yet find itself on the wrong side of a finding by the Ombudsman. To that extent, there is no escape. But there is a big difference between an Ombudsman's findings and those of a court or of a professional association, for example. And that big difference is that, at the end of an investigation, an Ombudsman, typically, does not make a final enforceable judgement

that must be complied with for fear of legal consequences. Instead, an Ombudsman makes recommendations, which may or may not be complied with. Naturally, my fellow Ombudsmen and I expect that in most cases our recommendations will be complied with, and in fact in 99% of cases that expectation turns out to be justified. Nevertheless, it remains open to a public authority to refuse and to face the music instead. The Ombudsman has, to put it in the jargon, a 'mandate of influence' rather than a 'mandate of sanction'.

A mandate of influence of this sort can, outside the legal or disciplinary process, work very effectively in practice. In one recent case investigated by my office, a staff-grade psychiatrist for older people decided to withdraw an anti-dementia drug from an elderly patient. My investigation uncovered a failure to communicate significant changes in the patient's treatment plan to those members of the family most closely involved in the patient's care, and the omission of any planning for deterioration. This was not a case of the clinical decision itself being wrong, but rather of a failure to see the bigger picture of which that clinical decision formed just one part. As a result, the trust in question agreed to apologise to the patient and family and to remind senior medical staff of the importance of careful monitoring of patients where medication is discontinued. The trust also agreed to conduct an audit of 'consensus-meeting documentation' to ensure that this format was properly used in future and that the requisite level of information was recorded.

Another case concerned the treatment of an adolescent girl with anorexia nervosa, who regularly absconded from hospital and whose parents despaired of the level of treatment offered to her, even to the extent of removing her to private care after 18 months with the National Health Service. My investigation found that the adolescent unit had inadequate systems in place for care planning, communication, risk assessment and risk management. These omissions denied the patient and her family any real sense of engagement in her treatment. As a result, she lost weight and her health and safety were compromised. The trust in question apologised, paid compensation for distress and reimbursed the full cost of the private treatment incurred. Just as importantly, the trust also ensured that it would in future have clear policies that could be shared with patients and their families, and that it would implement the latest national clinical guidelines on eating disorders.

These examples reinforce my view that exposure to complaints should not be a source of professional trepidation. The process of complaining should instead be seen as part of the necessary dialogue between patient, professional healthcare staff and the healthcare 'system' as a whole. It is, in other words, part of the process for diagnosing the state of those healthcare services and prescribing the proper remedial treatment. At its best, it is nothing less than a 'talking cure' in action, the Ombudsman cast in the role more of therapist than of judge. Which is not to say that there will not be a place for 'tough love' on occasions. But it is to say that the whole business is ultimately about a shared quest for excellence much more than the unilateral ascription of individual blame.

THEMATIC PAPERS – INTRODUCTION

Mental health and poverty

David Skuse

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We are all too well aware that there is a link between poverty and mental health in the Western world, which can work in two directions: those with low incomes are more likely to suffer from poor mental health; and people with mental health problems are more likely to experience poverty. In this issue, we consider the link between poverty and mental health from the perspectives of the Caribbean, East Africa and Mexico. In each situation, the relationship between them is complex and dynamic.

Fred Hickling challenges us to consider the possibility that the legacy of colonial rule in the Caribbean has led to a political and economic system that ignores the potential contribution of its most talented citizens, and which engenders a sense of helplessness and hopelessness that can lead to violent crime and mental disorder. Those who escape from this legacy (the so-called Caribbean Diaspora) find little comfort in their hoped-for paradise in Europe or the United States, and are at greater risk of developing mental illness there than is the indigenous population. He concludes that 'poverty has become too costly to maintain for any society' – a challenging view indeed.

Fred Kigozi and Joshua Ssebunnya draw our attention to the troubles of East Africa (that cluster of countries around Lake Victoria). In an area of 130 million km^2, there are fewer than a dozen psychiatrists. The population is growing rapidly and poverty is increasing. In the countries comprising this region, there have been and continue to be terrible wars and internal conflicts – especially in Rwanda and Uganda. To make matters worse, refugees from beyond their borders are coming in. Not surprisingly, many of these refugees have major mental health problems associated with their experiences and the trauma of dislocation. Objective evidence

of post-traumatic stress disorder affecting more than half the adult population in some areas of East Africa has been adduced. How to begin to cope with that mental health burden is an urgent question for those countries affected and for the international community of psychiatrists with an interest in the region. What resources are available, or could be made available, to alleviate the suffering of these people? Dr Kigozi is involved in a mental health and poverty project that has produced a detailed account of services and need in Uganda, in collaboration with the WHO (see http://workhorse.pry.uct.ac.za:8080/MHAPP/public/index_html); it is to be hoped similar reports – serving as the basis for action in adjacent countries – could be prepared too.

Finally, we move across the Atlantic to Mexico and the concerns expressed by Shoshana Berenzon and colleagues that the extreme inequity of income distribution in Latin America is responsible for engendering mental health disorders. After Brazil, Mexico has the largest economy in Latin America and is undergoing rapid development, yet one in six of the population lives in extreme poverty, without easy access to sanitation or drinking water, and many of these people are in urban areas. The reason for much mental illness, according to the surveys reviewed by the authors, is the relative socio-economic status of the sufferer, who feels unable or unwilling to seek professional help – even if that help is potentially available. The authors point out that there may be quite a discrepancy between the perceived needs of the population suffering from the consequences of extreme poverty and the relatively academic approach to the assessment and treatment of mental illness by professionals. This is, of course, an issue that is not peculiar to Mexico, and bears on a critical aspect of the theme addressed by all our contributors.

THEMATIC PAPERS – MENTAL HEALTH AND POVERTY

The high cost of poverty: mental health perspectives from the Caribbean Diaspora

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> 'Globalization is an objective reality – underlying the fact that we are all passengers on the same vessel – the planet where we all live.' (Fidel Castro, 2000, p. vii)

A Caribbean Diaspora has emerged worldwide after 500 years of European colonial exploitation of the Caribbean geopolitical region. This exploitation has a two-tiered social legacy: the 'haves'; and the 'have-nots', characterised by poor educational achievement, underdevelopment and unemployability of the many. The Caribbean Diaspora is a product of ever-increasing fantasies of escape from poverty by migration to greener 'First World' pastures. The complex, contradictory Caribbean society generates a crucible of misery and violence amid opulent wealth and luxury, which requires a burgeoning private and public police and military apparatus for its containment, and an ever-increasing health, mental health and penal correctional system to buttress the casualties of this conflict that is spiralling out of organisational and economic control. This two-tiered society was inherited from the hierarchical legacy of European colonialism. The colonisers existed in a system of high productivity and order, which imposed its will on the colonised, who lived in relative disorganisation and need. The resultant vector of this unequal yoke is the virtual anarchy of present-day Jamaica and other Caribbean territories, characterised by a subculture of violence and increasingly violent crime. The physical, psychological and economic costs of this seeming conundrum are bewildering and unaffordable.

The dialectic relationship between European wealth and African (and other) poverty is inescapable. In a recent study, Nunn (2007) concluded that slavery played an important role in Africa's underdevelopment; for example, the largest numbers of slaves were taken from areas that were most underdeveloped politically at the end of the 19th century and these areas are the most ethnically fragmented today. Without the slave trade, 72% of Africa's income gap with the rest of the world would not exist today. In a landmark study, Jamaican economist George Beckford (1972) identified that Latin America and the Caribbean, Africa and Asia, popularly described as the 'Third World', although vast in area and rich in resources, do not provide adequate levels of living for their populations. Beckford suggested that the dynamics of underdevelopment – both of the plantation economy and of society – form the basis for 'persistent poverty' for low- and middle-income countries and economies.

There is an increasingly strident discourse that is demanding a contemporary worldwide resolution of this dialectic of underdevelopment. This is inevitable in the global transformation that is required for the resolution of the crisis of global capitalism. A study by Trinidadian economist Eric Williams (1944) established that African slavery was the midwife to industrialisation in Europe and the slave trade was abolished in order to broaden the base of the global market

for the products of industrialisation. A similar contemporary economic metamorphosis is now demanded for worldwide economic survival (Castro, 2000; Hart, 2007).

Poverty and mental illness in the Caribbean Diaspora

A plethora of studies have revealed higher risk ratios of schizophrenia in African–Caribbean migrants to the UK, the USA, Canada and Europe, confined mainly to the lower socio-economic classes (Cantor-Graae & Selten, 2005). However, similar studies in the Caribbean consistently indicated that the incidence of schizophrenia, between 2 and 3 per 10 000 persons, is well within the range of those reported in the native populations of Britain and The Netherlands, and globally (Hickling, 2005). In a case–control study (Hickling, 1996), the diagnoses of a sample of 49 White mentally ill immigrants to Jamaica were compared with those among a sample of mentally ill Jamaicans matched for age, gender and social class, who had never migrated. The study showed that White mentally ill immigrants to Jamaica did not develop schizophrenia at a higher rate than the native-born, contrary to the finding of Cochrane & Bal (1987) of consistently increased rates of schizophrenia in immigrant populations worldwide. This Jamaican study indicated White first-generation migration to the Caribbean was characterised by immediate and marked upward social mobility, a factor which rarely, if ever, occurs for immigrants, whether Black or White, to White majority higher-income countries.

A study of 36 condemned murderers (Hickling *et al*, 1976) in the Jamaican penal system in 1976 indicated that 83% had originated from very low socio-economic developmental conditions. There were significantly more Jamaican murderers with ‘superior’ and ‘very superior’ IQs in this cohort than would be expected in the normal population. Thus, a very high proportion of Jamaican men with exceptional intellectual functioning end up in a life of crime and murder owing to their early poverty and educational and social deprivation. Jamaican society suffers a dual consequence: it loses some of its brightest men to a life of crime, and so has to expend significant resources on policing and correctional facilities to contain these brightest minds; and it is deprived of these superior intellects in its conventional productive capacity. Instead, they lead the wave of violent crime in Jamaica. The hidden costs of poverty have become the burgeoning costs of criminal violence and social containment.

It is suggested that the political/economic system in post-colonial countries of the Caribbean engenders severe mental illness in the poorest native-born socio-economic classes, but protects White immigrants from the social stress of migration; contrarily, the political structure of White ‘First World’ countries seems to create psychosocial stress factors that predispose to the development of schizophrenia in Caribbean migrants. It is advanced that existing poverty in people of the Caribbean Diaspora follows the ravages of indigenous genocide and African slavery in the Caribbean, and has emerged as a dialectic antipode of European colonisation and wealth creation that has now become socio-economically unaffordable. O’Higgins (2001) suggests that an unbalanced labour demand structure exists in low-income countries like Jamaica, where the pattern of unemployment indicates that the jobs being generated by current development strategies call for relatively low skill levels, which contrasts starkly with the characteristics and aspirations of young people who are entering the labour market with some secondary schooling and who are aspiring to higher-skilled or white-collar jobs. He suggests that countries such as these need to shift production to a more advanced technological level, both for future economic growth and for job creation.

Conclusions

The sobering challenges encountered in the analysis of the historical and sociological antecedents of the high and hidden cost of poverty require the development of a new vision of the psychology of economic deprivation and suffering being experienced by low- and middle-income countries and new paradigms for their resolution. The evidence indicates that poverty has become too costly to maintain for any society, and that radical dialectical transformation of the distribution and delivery of wealth are required for sustainable development and the resolution of the harsh problems of environmental degradation, migration, criminality and violence being experienced worldwide. For small Caribbean states like Jamaica, radical new institutional approaches to education and psychological transformation of the burgeoning youthful population, and especially the youth ‘at risk’ (Hickling, 2007), must become a *sine qua non* for governments and civic society, which must drive a vision for survival and development for all in the future.

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Chronic poverty, wars and mental health: the East African perspective

Fred Kigozi[1] and Joshua Ssebunnya[2]

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Globally, poverty has been noted to be a high risk factor for mental disorder. Although there is limited information on the baseline prevalence of mental disorders in low- and middle-income countries, the known risk factors for poor mental health, such as poverty and violence, afflict many of these areas (Miller, 2006). It is clear that poverty and the mental health consequences of war and displacement significantly hinder the achievement of the Millennium Development Goals (Njenga *et al*, 2006).

East Africa comprises Burundi, Kenya, Rwanda, Tanzania and Uganda. According to the World Bank rankings, all these are low-income countries, where close to half the population lives below the poverty line. East Africa has an estimated population of 130 million and one of the highest population growth rates in the world. The region is, however, grossly underresourced. This is particularly true in relation to human resources for mental health; for example, it has an average of only 0.08 psychiatrists per 100 000 population (World Health Organization, 2005).

The most pressing problems in East Africa relate to HIV/AIDS, extreme poverty and poor governance, as well as equity in the distribution of resources. Poverty is both a cause and consequence of high prevalence rates of AIDS in East Africa (Njenga *et al*, 2006). Poor governance links to chronic poverty through corruption, lack of infrastructure and lack of opportunities. Moreover, over 40% of the population live below the poverty line in East Africa, and this proportion is expected to grow (Njenga, 2002).

Poverty and mental health

Poverty has been described as the biggest enemy of health in low- and middle-income countries. The *World Health Report 2001* pointed to the relationship between poverty and mental disorders (World Health Organization, 2001). Countries in Africa are facing a double burden of disease and insufficient resources, with almost 80% of the continent's countries spending less than 1% of their health budgets on mental health (Njenga, 2002).

In a situational analysis of the mental health system in Uganda, conducted recently as part of the Mental Health and Poverty Project (Kigozi *et al*, 2007), most study participants identified poverty as a major risk factor for mental illness. Poverty was reported to be a strong causative and mediating factor for mental health problems such as stress, frustrations, anxiety and depression. According to participants, many poor and unemployed people, especially the uneducated, attempt to cope with their frustrations and social problems by resorting to alcohol and other illicit substances, which make them more susceptible to mental health problems. It also emerged that delayed help-seeking and incomplete treatment dosages are common among poor persons with mental illness, who have access to medication only intermittently and often only to the cheap drugs, which usually have disabling side-effects.

Some of the participants described the relationship as a vicious cycle and maintained that while poverty is a contributory factor for mental illness, poverty can also be a result of mental illness; hence a strong two-way relationship exists. Service users noted that, in addition to people with mental illness being unproductive during the time they are hospitalised or on treatment, carers also spend much time nursing sick relatives. This lowers their productivity, resulting in significant economic decline. One user specifically described the recurrent nature of mental illness as characterised by high expenses and no productive work, often leading to financial loss (Kigozi *et al*, 2007). It was further reported that people with mental illness sometimes become destructive, leading to strained relationships with family and neighbours, and a need to spend money on the resolution of disputes at local courts. This further encroaches on their meagre resources.

Consequences of wars on mental health

The East African region has been characterised by war, conflict and genocide over the past three decades. There have been massive internal and external displacements of people due to strife in the region, resulting in a considerable number of internally displaced persons (IDPs) and refugees. It is also home to some of the largest refugee populations in the world, mainly from the neighbouring countries of Ethiopia, the Democratic Republic of Congo, Somalia and southern Sudan. Studies conducted in the region and elsewhere indicate that post-traumatic stress disorder (PTSD), depression, suicide, alcohol and drug use markedly increase in post-war environments (Musisi, 2004).

Wars have a catastrophic effect on the health and well-being of nations. Studies have shown that conflict situations cause more mortality and disability than any major disease. The effect on the mental health of the civilian population is among the most significant consequences of war. Studies of the general population in post-conflict situations show an increase in the incidence and prevalence of mental disorders (Srinivasa & Lakshminarayana, 2006). Conflict situations trigger stress and are usually associated with excessive substance misuse as a coping strategy.

Several studies have reported the frequency of mental disorders in the war-affected populations of East Africa, the most common ones being PTSD, depression, anxiety, somatisation disorder, and alcohol and substance use disorders (Neuner *et al*, 2004; Njenga *et al*, 2006); the reported prevalence of PTSD has ranged between 28% and 80.2% of the study populations. The World Health Organization (2001) estimated that, in the context of armed conflict, 10% of the people who experience traumatic events will have serious mental health problems and another 10% will develop behaviour that will hinder their ability to function effectively, and thus be unable to contribute significantly to the economic growth of that population. The most common conditions are similar to those reported above.

Northern Uganda, which has seen war for the past two decades, and which has nearly 50% of its population on the move or categorised as IDPs, has one of the world's highest rates of mental illness. In a study in two northern Uganda districts, more than 54% of the adults screened had PTSD (Njenga *et al*, 2006). Furthermore, the physical and mental health problems of the survivors of the genocide in Rwanda have been well documented. In a community-based study examining 2091 people, 24.8% met the DSM–IV symptom criteria for PTSD (Srinivasa & Lakshminarayana, 2006).

Conclusions

Although there is a paucity of local data on poverty and mental ill-health, there is sufficient evidence of a significant association between the two. It is therefore imperative that mental health is given as much weight as any other development issue, so that appropriate programmes can be designed to address the socio-economic challenges resulting from or causing mental disorders. Furthermore, it will be only through a greater understanding of the causes of conflicts that coherent and effective strategies for dealing with the resulting mental health consequences, discussed above, can be developed.

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Inequity and poverty: everyday emotional disturbances and mental disorders in the Mexican urban population

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Recent decades have seen renewed interest in the study of poverty and its repercussions on various health problems, including mental disorder (Patel, 2007). There are various ways of measuring poverty; some approaches define it in economic terms, whereby health is included only as an asset that must be given to those defined as poor (Damián & Boltvinik, 2003). Other conceptions propose definitions based on the capacity of the poor to improve their standard of living, and consider health and education as essential elements in this process. This is the case of the Human Development Index (HDI), which, in addition to the economic dimension, measures other social indicators such as life expectancy, literacy and school enrolment and drop-out rates, among others (United Nations Development Programme, 2000). On the basis of the HDI, Mexico ranks 52 out of 177 countries. According to its percentage of gross domestic product invested in health, it is regarded as a country with a medium/high income level.

Despite these data, inequity continues to be one of the main problems in Mexico, and indeed in Latin America more widely. The region's population is polarised socio-economically, and access to opportunities is markedly different for the various social sectors. According to the Economic Commission for Latin America (ECLA, 2008), the region has an extremely unequal income distribution, with the richest 10% of individuals earning 40–47% of total income in most Latin American societies, and the poorest 20% earning just 2–4%.

Poverty and inequity levels exert a direct influence on the population's health. In this respect, Frenk *et al* (1999) suggest that the poorest families, who do not have social security (health insurance given by the state), use a larger proportion of their income to pay for services, 5.2%, compared with just 2.8% for the richest sector of the population.

This paper seeks to analyse the impact poverty and inequity have on the mental health of the Mexican population. The information analysed is drawn from three studies undertaken on the urban population inhabiting Mexico: the National Survey on Psychiatric Epidemiology (Medina-Mora *et al*, 2003) and two studies carried out on different communities in Mexico City (Berenzon & Mora-Ríos, 2005).

Factors that produce stress and emotional disorders

The constant economic and social crises that Mexico tends to experience mean that the main sources of concern in people's everyday lives are related to financial problems (when they do not have enough money to cover their basic needs and debts, and it is difficult to find or keep a steady job); 'suffering' is a term commonly used to describe this sort of worry.

Poverty has particularly affected men. For example, unemployment affects them especially, not only because of the economic problems it causes but also because it undercuts their social validation in their role as providers, which is their main source of self-esteem. Unemployment is widely perceived as equivalent to failure.

For women, poverty tends to be linked to their biological condition (e.g. nutritional shortages, frequent pregnancies, inadequate care), coupled with excessive responsibilities (both inside and outside the home) and the social role that has been assigned to them.

Factors in the environment, such as violence and lack of safety on the streets, are also major sources of concern to those with scant financial resources; for example, robbery, assaults and other forms of crime predominantly occur in the communities where they live. Other sources of concern include intra-familial conflict and violence.

Emotional distress is extremely common among this population and can be seen as a natural reaction to the stressful social circumstances these people face, derived from living in a context of inequity and poverty. In many cases, it would be inappropriate to give such individuals a clinical diagnosis. However, it is not easy to decide where to draw the distinction between a genuine psychiatric disorder (depression and anxiety) and normal responses – emotional distress – to stressful social conditions. A diagnosis based on the assumption that symptoms alone indicate the presence of psychiatric disorder overestimates prevalence. The only way of distinguishing normal suffering or distress from a true disorder is to take into account the context in which symptoms emerge (Horwitz & Wakefield, 2007).

Poverty and mental disorders

Inequity and poverty increase the risk of psychiatric disorder. Data from transnational surveys undertaken in Brazil, Chile, India and Zimbabwe show that the rate of the most common mental disorders is approximately twice as high among the poor as among the rich. Similar results have been observed in the United States, Latin America and Europe.

The results from our studies show that, regardless of the type of distress involved, interviewees with a family income of less than one 'minimum salary' displayed higher prevalence rates (Berenzon & Mora-Ríos, 2005). The evolution of disorders is also heavily influenced by the individual's socio-economic status. Our data show that among people of low socio-economic status (SES), only one out of every five persons with an affective disorder receives care, while only one out of every ten with an anxiety disorder is treated. Affective disorder was the diagnosis that elicited the greatest use of specialised services, followed by anxiety and substance misuse. The length of time patients of low SES take to seek care varies between 4 and 20 years, depending on the type of disorder (Medina-Mora *et al*, 2003). This low service use is more common among the uninsured population with limited resources, for whom purchasing medicine entails exorbitant expense.

In addition to the shortage of mental health services, there is a lack of information about these services. Moreover, the population fails to seek available help because of the discrepancy between their felt needs and the type of assistance offered by public health services. While the population has a definition of the need for care based on its everyday problems, which constitute major sources of distress, public health services offer care based on psychiatric diagnoses. The lack of fit between the population's felt needs and the care available also hinders people's access to treatment (Berenzon *et al*, 2006).

How do people cope with their problems?

In localities with scant financial resources, self-care strategies are commonly used, ranging from the use of herbs and diets to self-control behaviour strategies to eliminate the disorder, such as will-power or 'gritting your teeth' until the problem goes away on its own. People also often take part in religious rituals associated with a strong belief in God's healing power. Another important source of help is the social network, which can provide, in addition to advice, financial resources and/or other types of support, such as child care. Still other forms of support include faith healers, alternative therapists and general practitioners. People usually resort to mental health specialists such as psychologists or psychiatrists only when the problem persists and is regarded as unmanageable. The type of strategy adopted is influenced by: social and cultural factors; political and economic restrictions; the available treatments and interventions; and the characteristics of the problem and the perception of its severity (Berenzon & Mora-Ríos, 2005).

Unlike what happens with other disorders, for which the population is able to identify the affected organ (such as the heart) and therefore the specialist who should deal with it (such as a cardiologist), people with mental afflictions fail to identify their problem and to realise that they need to see a psychiatrist. These and other factors mentioned earlier keep patients away from services, increasing costs for the health system and unnecessarily prolonging the suffering of the people affected and their families. There is therefore a need

to offer services based on the population's felt needs and to implement actions based on informing the population about mental disorders, their expression and treatment.

Discussion

That part of the Mexican population living in inequity and poverty experience many stressful situations, such as instability, lack of safety, violence, desolation and family problems, resulting in frequent emotional distress. It is important to distinguish between this emotional distress as a natural response to adverse situations (and to treat it as such) and 'psychiatric disorder'. On the other hand, poverty also increases the risk of the occurrence of mental disorders, which need proper detection and treatment to reduce the burden they place on this population.

The main questions arising are:

- where to draw the line between distress and disorder
- how to deal with emotional distress without pathologising suffering yet preventing the risk of mental disorders from increasing
- how to increase awareness among mental health professionals regarding the population's distress, concerns and needs, which are not always described in psychiatric manuals
- how to sensitise and educate people of low SES about mental disorders to reduce the period of latency between the onset of the disorder and their seeking care.

Achieving better mental health coverage entails both increasing the supply of services, especially in primary care, and adapting them to the population's needs, which are clearly linked to social and economic inequities, gender discrimination, violence and other health conditions. In this respect, as Desjarlais *et al* (1995) suggest, 'the link between the social context and public health is a social event and should be acknowledged as such'. Thus, no mental health strategy can be proposed outside a state policy that guarantees minimum conditions of well-being for vulnerable groups in relation to the satisfaction of basic needs, such as food, housing and the right to education and health.

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COUNTRY PROFILE

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Psychiatry in Kuwait

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This paper describes the historical background, development and current status of psychiatric services in Kuwait. In addition, present practices and the outlook for further development of services are outlined.

Kuwait is a rich oil-producing country with a gross domestic product (GDP) of US$74.6 billion and an area of 17 820 km^2. The mid-year population of Kuwait in 2007 was 3 399 637, of whom 30.75% were Kuwaitis, while expatriates, mainly from the Indian subcontinent (39%) and other Arabs (22%), made up the rest (Public Authority for Civil Information, 2007).

The Ministry of Health (MOH) has, over the years, been the principal care provider in the country. Although a number of private hospitals (albeit regulated by the MOH) have taken up some of the load, delivery of psychiatric services is limited to the MOH hospitals. The health services are provided through five general hospitals (one for each health region), nine specialised hospitals, 78 primary healthcare clinics and 38 diabetes clinics, distributed uniformly across the country (Ministry of Health, 2006).

Prevalent beliefs and practices

Like all Arab communities, Kuwaitis believe in spiritual (*jinni*) possession, the 'evil eye' and sorcery; these are not

uncommonly invoked to explain changes in human behaviour (El-Islam, 1982). For example, obsessional ruminations are invariably attributed to the devil. Faith healers ('sheikhs' or 'masters') are the first source of help chosen by many Kuwaitis. They may recite Koranic verses, tie written verses to the patient's body in the form of amulets or offer the 'washings' of the verses (written on a plate) for drinking. Elaborate anti-sorcery practices by native healers involve the use of 'traces' of material that belong to the victim, to negotiate disengagement by the responsible adverse spirit. Cautery is used to counter painful conditions and also to drive away the *jinni*, presumed to have overwhelmed the minds of psychotic individuals. Many patients afflicted with mental illness never get to see a psychiatrist and are instead dealt with by faith healers.

Historical background

The MOH in 1950 first decided to provide psychiatric care for people who are mentally ill. The first asylum was built in Sharq, a district next to Kuwait City. An Egyptian psychiatrist and some Lebanese and Palestinian nurses were entrusted with responsibility for providing custodial care for patients with a mental illness, who were often chained. Shortly after his appointment, the same psychiatrist escorted a patient for treatment to the Al-Asfouria Hospital in Lebanon, one of the modern hospitals at the time. Having witnessed the humane treatment being given to patients there, he decided to introduce similar trends in the management of psychiatric patients in Kuwait. In 1954/55, a barrack-style facility, named the Hospital for Mental and Neurological Diseases, was opened in Sulaibikhat Governorate, to which all psychiatric patients were transferred. Extensions to the hospital over the next decade increased the number of beds from 100 to 400. There were, though, only eight psychiatrists and one assistant registrar to staff the facility.

The psychiatric services remained more or less unchanged during the 1970s. Two major developments took place during the mid-1980s. First, an Amiri Decree (Law No. 74) led to the opening of a 60-bed drug addiction treatment centre. Secondly, the MOH agreed to set up out-patient psychiatric clinics in all the general hospitals.

By the end of 1989, the psychiatric services had begun to look fairly comprehensive. The hospital had more than 400 beds, and provided both an out-patient clinic service 5 days a week and ran a round-the-clock emergency service. Unfortunately, the psychiatric services, like all other institutions of the country, suffered a major setback on 2 August 1990 when Iraqi forces invaded the country. The addiction centre was demolished, all but severely disturbed patients were sent home, the hospital services were restricted to the minimum basic level and the staffing level was reduced to about 10%.

After the liberation of Kuwait on 24 February 1991, the hospital was in moribund state: it had no water supply and no air-conditioning system, and there was severe air pollution resulting from the burning of oil wells by the retreating Iraqis. The country's infrastructure had been ruined. Within 2 months, however, the MOH managed to recruit the necessary staff, and the delivery of the basic medical and psychiatric services was resumed. A specialist centre, the Al-Riggai Centre for Post Traumatic Stress Disorder (PTSD), was established and a Danish group was recruited to identify, evaluate and help patients suffering from PTSD.

In 1993, the main psychiatric hospital was renovated and the addiction centre reopened. Hospital services were regulated by dividing the staff into five units, each responsible for about a fifth of the population of the country. A forensic psychiatry unit was opened. The out-patient clinics in the general hospitals were resumed. A sleep laboratory with an electroencephalogram facility was established. The social services and psychology departments evolved over time, and began making substantial contributions to the delivery of services at all levels.

In 1996, the UK-based Priory Group was hired for 4 years to upgrade services. It was a welcome change. A rehabilitation unit was established. The hospital's policies and procedures were documented. A department of audit and quality assurance was established. The Royal College of Psychiatrists was approached for accreditation of the services, which prompted multiple visits by College delegates.

The Department of Psychiatry

The Department of Psychiatry, Faculty of Medicine, Kuwait University, established in 1984, is currently staffed by one associate professor, two assistant professors and two technicians. The Department's responsibilities include undergraduate and postgraduate teaching; conducting, supervising and promoting research; and the provision of clinical services in MOH hospitals. It provides block teaching to sixth-year undergraduate medical students, who attend psychiatric rotation in groups of 30–32 for 6-week periods three times a year. Consistent with the curriculum reform programme initiated in the year 2003 by the Faculty of Medicine, the Department has introduced a system of objective structured clinical examination (OSCE) and a clinical problem-based short-essay paper in its teaching programme. The teaching consists of 24 didactic lectures, 25 case conferences in which students are encouraged to present patients and 16 hours weekly of tutor-supervised contact with patients. The assessment procedures include in-course assessments (30%), consisting of a multiple-choice question (MCQ) paper and six OSCE stations, and an annual examination (70%), consisting of an MCQ paper, short-essay questions, eight OSCE stations, and a long case presentation.

The Department, assisted by two senior registrars, eight registrars, one psychologist and a social worker, provides comprehensive psychiatric services to its designated catchment area. Additional hospital-based responsibilities of the Department include organising the programme of continuing medical education (CME) and promoting research.

Training opportunities

Psychiatry has been the least favoured field for most young local graduates. Nonetheless, the recent improved provision described in the next section seems to have attracted a number of local young graduates. Four graduates, having successfully completed their residency programme abroad, have already returned and joined the MOH. Three more young Kuwaiti undergraduates are undergoing their residency

programmes in Canada. Another is currently doing her internship at Harvard Medical School. All of them completed the 1-year internship at the psychiatric hospital before proceeding abroad for higher psychiatric training. The recruitment of suitable supervisory senior staff and the documentation of general psychiatry and its sub-specialty training posts should lead to the development of a local postgraduate training scheme in the country.

Current status of services

The psychiatric services took a quantum leap with the completion of a new extension to the hospital in 2005. A new block with 262 beds (bringing the hospital's total to 691) was added and the old drug addiction treatment centre with 100 beds was replaced by a newly built facility with 225 beds. In addition to the existing forensic psychiatry and rehabilitation units, child and family, and old age psychiatry out-patient services were set up. The hospital staff offers advisory, supervisory and consultancy services to the Ministries of Social Affairs, Education and the Interior. The Ministry of Social Affairs has developed institutions for geriatric patients and those with intellectual disability. The Ministry of Education has developed special schools for children with intellectual disability. The Ministry of the Interior has set up a once-weekly out-patient clinic for detainees. All in all, the hospital runs 23 extramural psychiatric clinics organised by the respective ministerial facilities.

Human resources and adequacy of services

The main psychiatric hospital is staffed by 100 psychiatrists, 61 psychologists, 7 social workers and 451 nurses (Ministry of Health, 2006). There are 20.32 psychiatric and 6.61 substance misuse beds per 10 000 population, and 0.29 psychiatrists, 0.18 psychologists, 0.02 social workers and 1.32 psychiatric nurses per 10 000 population. This is grossly insufficient. Moreover, community psychiatric services are virtually non-existent. The services are restricted to the main psychiatric hospital, albeit with some out-patient clinics in general and specialist hospitals. The provision of services at primary health and community level is absent.

Psychiatric research in Kuwait

The Department of Psychiatry, together with the hospital staff at the MOH, has largely been responsible for psychiatric research in the country. It has generated more than 50 publications in peer-reviewed international journals during the past 10 years. The research areas have varied with epidemiological, social and biological psychiatry constituting the dominant themes.

Outlook

The past decade has witnessed substantial development of psychiatric services in Kuwait. The hospital delivers fairly comprehensive psychiatric and substance misuse services and a number of sub-specialties have been established. Psychiatry in Kuwait is regarded as a small specialty and there is room for development of allied disciplines, including psychology, social work and occupational therapy. The decentralisation of services to the level of general hospitals, polyclinics and setting up community psychiatric services and the drafting of a mental health act are some of the areas requiring much needed attention. The recruitment of suitably qualified staff to develop the general and the sub-specialty services and set up postgraduate training facilities is needed.

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COUNTRY PROFILE

Psychiatry in Ireland

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Ireland is the third largest island in Europe and the twentieth largest island in the world, with an area of 86 576 km^2; it has a total population of slightly under 6 million. It lies to the north-west of continental Europe and to the west of Great Britain. The Republic of Ireland covers five-sixths of the island; Northern Ireland, which is part of the United Kingdom, is in the north-east. Twenty-six of the 32 counties are in the Republic of Ireland, which has a population of 4.2 million, and its capital is Dublin. The other six counties are in Northern Ireland, which has a population of 1.75 million, and its capital is Belfast. In 1973 both parts of Ireland joined the European Economic Community. This article looks at psychiatry in the Republic of Ireland.

Health spending and organisation

The Health Service Executive (HSE) is responsible for managing and delivering health and personal social services in the Republic of Ireland. It is the largest employer in the state. The €12.4 billion budget in 2006 was the largest of any public sector organisation (Health Service Executive, 2008). In Ireland, nearly 80% of health spending is funded by government revenues, above the average of 73% among member states of the Organisation for Economic Cooperation and Development (OECD). In 2001, public spending accounted for roughly 78% of all money spent on healthcare. Spending has been increasing in recent years on a per capita basis but is lower as a percentage of gross domestic product (GDP) (7.1%) or gross national product (GNP) (8.5%) than the OECD average (8.9%) (Health Research Board, 2008). The 2004 Health Strategy estimated that Ireland's health spending per capita in 2004 was US$2596 and thus slightly above the average in the rest of the European Union (EU) (US$2550) (Health Research Board, 2008).

In Ireland, as in the UK, general practitioners (GPs) act as gatekeepers of the psychiatric services and specialists can generally be approached only through GPs. As of 1 January 2003, there were 276 permanent consultant psychiatrist posts (171 general adult, 49 child psychiatry, 21 old age psychiatry, 30 learning disability and 5 forensic psychiatry) and 439 non-consultant hospital doctors (NCHDs) (40 senior registrars, 164 registrars and 235 senior house officers) in the public sector and it was proposed that a national target of 421 consultant psychiatrists by the year 2009 and 596 by the year 2013 should be achieved to implement the European Working Time Directive (Department of Health and Children, 2003). This target has not yet been reached.

Irish psychiatry is organised around sectors or catchment areas, based on zones of 25 000–30 000 inhabitants for general psychiatry. Within each sector a multidisciplinary team is in charge of all the mental health needs of the population, from prevention through to rehabilitation, under the direction of a consultant psychiatrist.

Government policies and planning

In the modern era there have been only two national planning documents for mental health, one a report of a commission of inquiry into mental illness (1966) and another entitled *Planning for the Future* (1984). Both promoted a move to community care. *Planning for the Future*, in particular, was a prescriptive document, describing in detail the mechanisms for phasing out traditional mental hospitals and placing considerable emphasis on the relocation of acute units in general hospitals. That, though, is a quarter of century old and can no longer respond to new developments in psychiatry such as advanced community models of care.

A Vision for Change is a strategy document which sets out the direction for mental health services in Ireland (Department of Health and Children, 2009). It describes a framework for building and fostering positive mental health across the entire community and for providing accessible, community-based, specialist services for people with mental illness.

Mental health legislation

Mental health legislation in Ireland has not been given priority. A replacement for the 1945 Mental Treatment Act has only recently been implemented: the Mental Health Act 2001, signed into law in July 2001, was implemented on 1 November 2006. The purpose of this Act is to provide a modern framework within which people who are mentally disordered and who need treatment or protection, either in their own interest or in the interest of others, can be cared for and treated (Mental Health Commission, 2008). The Act brings Irish legislation in relation to the detention of patients with a mental disorder into conformity with the European Convention on the Protection of Human Rights and Fundamental Freedoms (Mental Health Commission, 2008).

The Act also has a second purpose, which is to put in place mechanisms by which the standards of care and treatment in mental health services can be monitored, inspected and regulated. The main vehicle for change will be the Mental Health Commission, which was established on 5 April 2002 under the terms of this Act. Mental health tribunals, operating under the aegis of the Mental Health Commission, will conduct a review of each decision by a consultant psychiatrist to detain a patient on an involuntary basis or to extend the duration of such detention. The Inspector of Mental Health Services, as provided by the Act, will be putting in place a system of annual inspections and reports (Mental Health Commission, 2008).

Mental health service delivery

We have seen major changes in the delivery of mental health services in Ireland in recent years. Enormous strides have been made and continue to be made in developing a service that is comprehensive, community based and integrated with other health services. This shift in the delivery of services from predominantly hospital-based care has been extremely successful. Under the National Development Plan, approximately €190 million in capital funding has been made available for the provision of acute psychiatric units attached to general hospitals, additional day care, mental health centres and community residences throughout the country.

The development of psychiatric services in Ireland has mirrored the developments taking place internationally. There has been a move from institutional to community care and a marked decline in hospitalised morbidity. This decline has resulted primarily from a reduction in the number of long-stay patients. At the same time, however, admissions to mental hospitals have risen substantially, placing considerable pressure on acute psychiatric beds. A phenomenon has developed of rapid turnover, with a cycle of readmission, short length of stay and often premature discharge, leading to further readmissions (Health Research Board, 2007).

In Ireland, the rate of private health insurance has increased steadily over time, from around 22% in 1979 to around 50% currently (Health Research Board, 2008). Private hospitals in psychiatry are not very numerous in Ireland compared with other high-income countries: there are in fact only two, St Patrick's Hospital and St John of God Hospital, both in Dublin. Very few psychiatric patients with severe and long-term illness have private insurance.

Central Mental Hospital is probably the oldest forensic secure hospital in Europe, having opened in 1850. The hospital admits approximately 150 patients per year, from the criminal justice system and also from the psychiatric services under the provisions of the Mental Health Act. It also provides a consultative assessment service for the prison service and for hospitals throughout the country. As the prison population has expanded in recent years, the services of the Central Mental Hospital have come under increasing pressure, resulting in delays in the transfer of prisoners with a mental illness to the hospital (National Forensic Mental Health Services, 2008).

The voluntary sector plays an integral role in the provision of health and personal social services in Ireland. The Commission on Health Funding in 1989 highlighted the immensely important role of voluntary organisations in Ireland. A recently published Amnesty International report acknowledged the funding which is being made available by the Department of Health and Children to support groups and organisations such as Schizophrenia Ireland, Mental Health Ireland, GROW and AWARE to heighten awareness and develop support services for mental health service users and carers (Department of Health and Children, 2008).

Training and education

The academic departments of psychiatry in all medical schools have undergraduate training programmes, which feature 6 weeks of clinical attachments as well as classroom teaching of psychiatry.

In Ireland, psychiatric specialisation follows the Royal College of Psychiatrists' guidelines in terms of training and assessment. There is no specialisation examination in Ireland at present, except the Diploma in Clinical Psychiatry (DCP), which is designed for GPs. There is the possibility of an MD, which is usually research based, and which most psychiatrists do after they have passed the membership examination. After an overhaul of training, assessment and accreditation in the UK, Ireland has to develop its own system of psychiatric specialisation before 2011, but work is very slow, probably owing to lack of financial resources for educational research.

The All Ireland Institute of Psychiatry arranges two scientific meetings every year.

Since 1 January 2009, the College of Psychiatry of Ireland has been fully operational as the sole body responsible for continuing professional development (CPD), postgraduate training, mental health policy and external relations.

Research and publications

Lack of indigenous research has been a major hindrance to the rational planning and allocation of resources; however, over the past few years a number of research papers have been published.

'Reach Out – A National Strategy for Action on Suicide Prevention', a 10-year strategy, was launched on September 2005, which was developed by the HSE and National Suicide Review Group (Department of Health and Children, 2008). The National Office for Suicide Prevention is committed to supporting research in the areas of suicide research/prevention and mental health promotion (National Office for Suicide Prevention, 2009).

The Health Promotion Research Centre is located at the National University of Ireland, Galway. The Centre was established in 1990 to conduct research on health promotion in an Irish context. It is the only designated research centre in Ireland dedicated to health promotion. The Centre collaborates with regional, national and international agencies on the development and evaluation of health promotion strategies and has published widely in the field of mental health promotion (National University of Ireland, Galway, 2009)

The quarterly *Irish Journal of Psychological Medicine*, Ireland's only peer-reviewed psychiatric journal, has been supporting and encouraging original Irish psychiatric and psychological research. Irish psychiatric literature has a low international impact factor and Irish psychiatry is relatively underresourced in terms of research.

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Mental health in Zambia – challenges and way forward

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Zambia, previously called Northern Rhodesia, was a colony of Great Britain until 1964, when it gained independence and changed its name. It is a landlocked country located in southern Africa and shares its borders with Zimbabwe, Namibia, Botswana, Mozambique, Malawi, Tanzania, Congo and Angola. It has an area of 752 612 km^2, about three times the size of Britain, but a population of only 12 million.

The country is divided into nine provinces for administrative purposes, each with a provincial headquarters. Although there are 72 languages spoken in Zambia, there are seven main ones: Nyanja, Bemba, Lunda, Luvale, Kaonde, Lozi and Tonga. The official language is English, which is spoken by most citizens. Zambia is largely a youthful country, with 90% of its population less than 45 years old; only 2% are over 65.

Policy and legislation

Since 1992, the country has had five national development plans; the latest was the Fifth National Development Plan (FNDP) in 2006. In the first four plans, there was no mention of mental health. There is only a casual mention in the FNDP, in which the health agenda is dominated by infectious diseases (HIV, tuberculosis, malaria and diarrhoeal diseases) followed by child health and reproductive health. The strategy for mental health is less than coherent.

Zambia still uses the 1951 Mental Disorders Act in which patients are referred to as idiots, imbeciles and invalids. Since the early 2000s, there has been some effort to reform the Act and this reached the stage of a parliamentary draft bill in 2006. However, the draft bill is far from perfect as it is not based on the United Nations human rights charter, which is the bedrock of most current mental health legislation. The limited availability of mental health professionals to spearhead this agenda has contributed to the lack of progress. It has to be said, however, that there is almost no recourse to the Act in clinical practice, as most people are too ignorant to challenge their detention for treatment against their will.

Personnel

Zambia has only three psychiatrists for a population of 12 million. Two of these are not in clinical practice but are attached to the local university. There are no graduate psychologists, occupational therapists or mental health social workers. The bulk of the work in mental health is carried out by clinical officers, who are specially trained medical assistants (see below).

Infrastructure and services

Zambia has only one psychiatric hospital, Chainama Hills Hospital, which is based in the capital city of Lusaka. It was opened in 1962 as a national referral centre. It has a capacity of 500 beds, divided into 380 general adult and 120 forensic. It is modelled after the asylums that characterised English mental healthcare more than 50 years ago. The wards are large halls with many patients in each. The beds are usually just mattresses placed on the floor.

Apart from Chainama, there are smaller units, called annexes, in seven provincial headquarters: Ndola, Mansa, Kasama, Kabwe, Chipata, Mongu and Livingstone. These provide a few extra beds and are staffed by clinical officers and psychiatric nurses.

In Zambia, therapy almost exclusively comprises the use of psychotropics; talking therapies are non-existent. However, this is not as problematic as it might be, given that almost all admissions are for psychotic illness (mostly acute psychotic episode, followed by schizophrenia and bipolar disorders). It is rare to see patients with depression unless they have psychotic symptoms as well. The country has no specific forensic, drug and alcohol or children's services.

Education and training

The University of Zambia's School of Medicine is the country's only medical school. It produces 40 graduates every year, half of whom never practise locally but leave the country. Whereas there is postgraduate training in surgery, medicine, paediatrics and obstetrics and gynaecology, there is no such training in psychiatry. To become a psychiatrist, one has to go abroad and herein lies one of Zambia's problems: the few who go for such training rarely return. (There are at least six Zambian psychiatrists working abroad.)

Similarly, there is no graduate training for psychologists, social workers or occupational therapists. What is available is training for psychiatry clinical officers and nurses. This is based at Chainama Hills College of Health Sciences, which is located in Lusaka just adjacent to Chainama Hospital. Clinical officers are the mainstay of mental health services in Zambia.

These are medical assistants who spend 3 years studying medicine before graduating to work in general medicine. After about a year, some of the clinical officers return to Chainama College for an extra year, to become psychiatry clinical officers.

Challenges and way forward

Government policy and legislation

While some progress has been made in putting forward the mental health agenda for government policy, much remains to be done to convince not only government but also parliament of the importance of a robust mental health policy and infrastructure. Successful lobbying cannot be achieved by locals alone but requires the help of international partners such as the World Health Organization and the World Psychiatric Association.

Human resources

There is a serious deficit of trained personnel in the medical field. This is even more pronounced in mental health. Zambia needs more psychiatrists just to help build capacity in the mental health services, let alone to run such services. There is also a need for other mental health professionals, including psychologists and occupational therapists. To address this deficit, local training must be developed. Training people overseas, as has been proved over the years, is not a viable option. The establishment of training facilities will be expensive, nonetheless.

Infrastructure

There is a need to have mental health beds in every district. Every district has a general hospital and, to keep costs down, some of these could be allocated to psychiatry.

Stigma

High levels of stigma exist not only against those who are mentally ill but also against their families and those working in the mental health services. Many patients are disowned by their families. Most long-stay patients in Chainama Hospital have no contact with their family members. The 'out of sight out of mind' mentality is prevalent.

Public awareness campaigns are needed. These could be targeted at schools, colleges, workplaces and other public areas. One or two charities are trying but, with limited capacity, little is being achieved. The government may decide to make this one of the priorities for mental health. It is certainly an achievable goal which, unlike the above, does not require massive funding.

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ORIGINAL PAPER

Correlates of lifetime alcohol abuse and dependence among older community residents in Brazil

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Misinterpretation in major surveys of alcohol use disorder as described by DSM–IV (Hasin *et al*, 2007) has raised serious questions regarding the extent of alcohol use disorder, and the relationship between alcohol abuse and alcohol dependence. While the adverse social, physical and mental effects of alcohol misuse are well known (Council on Scientific Affairs, 1996), there is little information on the determinants of alcohol abuse (societal impact) and alcohol dependence (physiological impact). We therefore examined their separate and combined associations with demographic, social and health characteristics in a representative community-resident sample aged 60 years and over. We hypothesised that, while for each of the three groups (those with alcohol abuse, those with alcohol dependence, and those with both) there would be associated demographic characteristics, abuse would be more closely associated with social characteristics, dependence with health characteristics, and the combined presence of abuse and dependence with both social and health characteristics.

Methods

Data were gathered by carefully trained and monitored interviewers in 1995 using face-to-face structured household surveys of 7920 representative community residents aged 60 years and over, in nine regions covering the southernmost Brazilian state of Rio Grande do Sul (a wine-producing area). Information from one region was problematic and was dropped, resulting in a sample of 7040 persons, of whom 79 (1.1%) declined to participate, yielding an analysis sample of 6961 (Conselho Estadual do Idoso, 1997). The ethics committee of the Federal University of São Paulo approved the study.

Dependent variable: evaluation of alcohol use

Use of alcohol was evaluated according to participants' yes/no responses to each of the following questions (asked in Portuguese):

1 Has a family member, friend, physician, priest ever commented or suggested that you were drinking too much?
2 Have you ever tried to stop drinking but been unable to do so?
3 Have you ever had trouble at work or school because of alcohol, such as drinking or missing work?
4 Have you ever been involved in fights or arrested for being drunk?
5 Has it ever seemed to you that you were drinking too much?

While not constituting an established measure, the individual items are comparable to those commonly used in similar surveys. A positive response to question 1, 3 or 4 was accepted as indicating lifetime abuse of alcohol. A positive response to question 2 or 5 indicated lifetime dependence (Hasin *et al*, 2007). Participants were not asked when the problem occurred. The sample was classified into four mutually exclusive groups: abuse only, dependence only, both abuse and dependence, neither abuse nor dependence.

Independent variables

The independent variables are listed in Table 1.

Physical activity (i.e. exercise) was assessed by asking: 'In the last 3 months have you practised regular physical activity?' Responses were recorded as 'yes' (once a week or more) or 'no'. Employment status was recorded as 'employed' if the participant was still working (the type of work was immaterial) or 'not employed' if not working or did not know the answer. Problems with activities of daily living (ADL) were assessed using a five-item unidimensional scale. The number of impaired activities was recoded as 0, 1 or 2, or 3 or more.

Preliminary analyses of 18 self-reported physical health conditions indicated that only vascular conditions, respiratory problems, kidney problems and osteoporosis were relevant. Vascular conditions include any mention of heart disease, hypertension, diabetes, stroke or varicosities. Respiratory problems include any mention of bronchitis or pneumonia.

The presence of a psychiatric condition was assessed by a validated Brazilian modification of the Short Psychiatric Evaluation Schedule (Blay *et al*, 1988).

Statistical analysis

Percentages were used to describe the sample, and χ^2 to compare each of the three alcohol use groups with the group recording neither lifetime abuse nor lifetime dependence. Because of the small size of the abuse-only group, separate blockwise logistic regression analyses were first run to identify the significant variables within each block (demographic, social, health characteristics – see Table 1). These significant variables were then entered into an initial multivariable polytomous logistic regression, and a final model was run using only the variables found to be significant. Analyses were performed using SPSS 13.0.

Results

Lifetime alcohol abuse was recorded for 734 participants (10.6%), of whom 103 (1.5%) reported abuse only, 244 (3.5%) dependence only, and 387 (5.6%) both abuse and dependence. Two-thirds of the sample were female, the majority were aged 60–69, of low education and low income, rural birth, White (84%) and Catholic (75%) (Table 1). In univariate analyses (Table 1) the 'abuse only' group differed from those with neither abuse nor dependence on 5 of the 21 characteristics examined (male, use tobacco, married, less likely to participate in religion-affiliated activities, and less likely to have osteoporosis). In addition to all these characteristics except religion-affiliated activities, 'dependence only' participants were more likely to be younger, of 'other' race/ethnicity, employed and to have a respiratory condition, but less likely to report a vascular condition. Participants reporting abuse and dependence additionally had little education, were less likely to participate in social activities, and were more likely to have ADL problems, kidney problems and psychiatric problems.

The final controlled analysis (Table 2) yielded a more restricted set of significant variables, but showed a similar increase in number and type of associations, going from 'abuse only' to 'dependence only' to 'abuse and dependence'. The significant associates of 'abuse only' were male gender and tobacco use. 'Dependence only' was additionally associated with 'other' race/ethnicity (as compared with White), increased likelihood of respiratory and psychiatric problems, and decreased odds of vascular conditions. The same associations held for 'abuse and dependence', but with more marked odds ratios.

Discussion

The data come from a large community-resident sample aged 60 years and over, representative of the state of Rio Grande do Sul in Brazil, who provided information on multiple aspects of ageing. The five-item questionnaire permitted a rough assessment of lifetime alcohol abuse (three items) and alcohol dependence (two items). According to the responses to these items, 10.6% of the sample (men, 25.4%; women, 2.9%) reported alcohol-related problems, with 1.5% reporting abuse only, 3.5% dependence only, and 5.6% abuse and dependence.

Comparison with other studies in Brazil is difficult. Focus on lifetime use is infrequent; the samples rarely include participants aged 60 and over, are often small, resulting in questionable findings, and have used different measures to assess alcohol use. Our finding of a 10.6% prevalence rate

Table 1 Basic descriptive characteristics of the sample by report of alcohol abuse only, dependence only, and abuse and dependence: numbers (%) of participants

	Total sample (*n* = 6961)		Abuse only (*n* = 103)		Dependence only (*n* = 244)		Abuse and dependence (*n* = 387)	
Demographic characteristics								
Gender								
Male	2368	(34.0)	74	(71.8)***	193	(79.1)***	332	(85.8)***
Female	4593	(66.0)	29	(28.2)	51	(20.9)	55	(14.2)
Age (years)								
60–64	1866	(26.8)	32	(31.1)	84	(34.4)***	147	(38.0)***
65–69	2085	(30.0)	23	(22.3)	82	(33.6)	111	(28.7)
70–74	1067	(15.3)	19	(18.4)	38	(15.6)	55	(14.2)
75–79	1216	(17.5)	23	(22.3)	24	(9.8)	51	(13.2)
80+	727	(10.4)	6	(5.8)	16	(6.6)	23	(5.9)
Education								
<4 years	4594	(66.0)	73	(70.9)	162	(66.4)	293	(75.7)***
>4 years	2344	(34.0)	30	(29.1)	81	(33.2)	93	(24.0)
Income								
Low income (<US$200)	4323	(62.1)	61	(59.2)	147	(60.2)	238	(61.5)
Higher income (>US$200)	2414	(34.7)	40	(40.8)	93	(38.1)	134	(34.6)
Race								
White	5862	(84.2)	84	(81.6)	194	(79.5)**	275	(71.1)***
Afro-Brazilian	473	(6.8)	8	(7.8)	14	(5.7)	58	(15.0)
Other	625	(9.0)	11	(10.7)	36	(14.8)	54	(14.0)
Religion								
Catholic	5245	(75.3)	83	(80.6)	184	(75.4)	290	(74.9)
Evangelical	1077	(15.5)	10	(9.7)	38	(15.6)	51	(13.2)
Other	609	(8.7)	10	(9.7)	21	(8.6)	45	(11.6)
Place of birth								
Urban	2363	(33.9)	31	(30.1)	76	(31.1)	121	(31.3)
Rural	4529	(65.1)	69	(67.0)	167	(68.4)	264	(68.2)
Social characteristics								
Physical activity								
No	4316	(62.0)	61	(59.2)	149	(61.1)	247	(63.8)
Yes	2608	(37.5)	42	(40.8)	95	(38.9)	140	(36.2)
Use tobacco								
Yes	1302	(18.7)	37	(35.9)***	102	(41.8)***	182	(47.0)***
No	5632	(80.9)	66	(64.1)	142	(58.2)	205	(53.0)
Marital status								
Married	3161	(45.4)	63	(61.2)***	138	(56.6)***	219	(56.6)***
Never married	471	(6.8)	10	(9.7)	20	(8.2)	38	(9.8)
No longer married	3328	(47.8)	30	(29.1)	86	(35.2)	130	(33.6)
Children								
Yes	6492	(93.3)	101	(98.1)	224	(91.8)	364	(94.1)
No	445	(6.4)	2	(1.9)	20	(8.2)	21	(5.4)
Living arrangements								
Live with someone	5893	(84.7)	93	(90.3)	207	(81.9)	328	(84.8)
Live alone	1056	(15.2)	10	(9.7)	37	(18.1)	59	(15.2)
Employed								
No	5992	(86.1)	92	(89.3)	196	(80.3)**	290	(74.9)***
Yes	940	(13.5)	11	(10.7)	46	(19.7)	96	(24.8)
Participate in social activities								
No	4221	(60.6)	70	(68.0)	156	(63.9)	260	(67.2)***
Yes	2736	(39.3)	33	(32.0)	88	(36.1)	127	(32.8)
Participate in religion-affiliated activities								
No	1977	(28.4)	40	(38.8)*	80	(32.8)	161	(41.6)***
Yes	4964	(71.3)	63	(61.2)	164	(67.2)	225	(58.1)
Health characteristics								
Activities of daily living problems								
0	4238	(60.9)	62	(60.2)	151	(61.9)	234	(60.5)**
1 or 2	2195	(31.5)	30	(29.1)	79	(32.4)	108	(27.9)
3 or more	526	(7.6)	11	(10.7)	14	(5.7)	45	(11.6)
Vascular conditions								
Yes	4390	(63.1)	60	(58.3)	124	(50.8)***	190	(49.1)***
No	2542	(36.5)	43	(41.7)	120	(49.2)	197	(50.9)
Respiratory conditions								
Yes	2059	(29.6)	31	(30.1)	95	(38.9)***	166	(42.9)***
No	4902	(70.4)	72	(69.9)	149	(61.1)	221	(57.1)
Kidney problems								
Yes	897	(12.9)	16	(15.5)	27	(11.1)	77	(19.9)***
No	6066	(87.1)	87	(84.5)	217	(88.9)	310	(80.1)
Osteoporosis								
Yes	1047	(15.0)	6	(5.8)**	25	(10.2)*	42	(10.9)**
No	5916	(85.0)	97	(94.2)	219	(89.8)	345	(89.1)
Psychiatric problem								
Yes	2722	(39.1)	42	(40.8)	110	(45.1)	192	(49.6)***
No	4241	(60.9)	61	(59.2)	134	(54.9)	195	(50.4)

Values may not total to *n* and percentages may not sum to 100 because of missing data.
Chi square test: *$P < 0.05$; **$P < 0.01$; ***$P < 0.001$ ('abuse only', 'dependence only', 'abuse and dependence' each compared with 'no abuse or dependence').

Table 2 Polytomous logistic regression comparing alcohol abuse only, alcohol dependence only, and both abuse and dependence with no reported alcohol abuse

	Abuse only		Dependence only		Abuse and dependence	
	OR (95% CI)	*P*	OR (95% CI)	*P*	OR (95% CI)	*P*
Demographic characteristics						
Gender						
Male	6.32 (4.04, 9.18)	0.001	9.08 (6.57, 12.54)	0.001	15.44 (11.40, 20.89)	0.001
Race						
White	0.86 (0.45, 1.64)	0.644	0.64 (0.44, 0.95)	0.025	0.63 (0.45, 0.89)	0.007
Afro-Brazilian	1.25 (0.49, 3.17)	0.639	0.73 (0.38, 1.40)	0.340	2.16 (1.38, 3.36)	0.001
Other	Reference		Reference		Reference	
Social characteristics						
Use tobacco	2.21 (1.45, 3.37)	0.001	2.44 (1.85, 3.22)	0.001	2.77 (2.20, 3.49)	0.001
Health characteristics						
Vascular condition present	0.99 (0.65, 1.50)	0.944	0.71 (0.54, 0.94)	0.017	0.65 (0.51, 0.82)	0.001
Respiratory condition present	0.94 (0.61, 1.47)	0.797	1.35 (1.02, 1.78)	0.038	1.51 (1.20, 1.91)	0.001
Psychiatric problem present	1.50 (0.98, 2.30)	0.063	1.91 (1.43, 2.54)	0.001	2.36 (1.85, 3.00)	0.001

The variables considered are the demographic, social and health conditions listed in Table 1. The significant variables identified in a blockwise analysis were entered into a penultimate polytomous multivariable logistic regression model, from which the resulting significant variables were then selected for the current, final model.

compares with reports ranging from 2.7% in Campinas, south-eastern Brazil (based on 93 participants aged 60 and over) (Barros *et al*, 2007) to 12% for frequent or heavy drinkers in a sub-sample aged 60 years and over in a national survey (Laranjeira *et al*, 2007).

The demographic and health associations of alcohol misuse we found are comparable to those reported elsewhere, which implicate male gender, younger age, tobacco use, adverse physical health conditions except for vascular status, and adverse psychiatric status (National Institute on Alcohol Abuse and Alcoholism, 2002), providing confidence that the five alcohol questions have both content and criterion validity.

We hypothesised that 'abuse only' would be associated with demographic and social variables, and 'dependence only' with health-related characteristics. In controlled analyses, our hypothesis regarding 'abuse only' held, but characteristics associated with dependence included both health conditions (as hypothesised) and characteristics encompassed by 'abuse only'. The same 'dependence only' characteristics held for 'abuse and dependence', but the associations were stronger.

Our findings also address two key questions: whether 'abuse only', 'dependence only' and 'abuse and dependence' are hierarchically associated; and whether they represent unique, non-progressive, manifestations of alcohol misuse. We argue for hierarchical association based on the finding that, in these older persons, dependence is uniquely associated with health effects *in addition* to the effects associated with alcohol abuse, and that these associations are intensified among those reporting abuse and dependence. We argue for the possibility of non-progression by noting that nearly half of those reporting lifetime alcohol misuse report only lifetime abuse, or only lifetime dependence. Since lifetime alcohol abuse has consistently been reported to decline with age (a finding further confirmed even in this older sample), we assume (but cannot confirm) that alcohol abuse occurred at an earlier time and may not necessarily progress. In support, Hasin *et al* (1990) found that, over 4 years, only 30% progressed from alcohol abuse only to alcohol dependence, while 39% with alcohol dependence had remitted.

Our data have significant limitations. Our measure does not meet diagnostic criteria, so our findings must be interpreted cautiously. Information is self-reported; however, self-report has been found to be valid for alcohol use and problems (Bongers & Van Oers, 1998) and for various health conditions (Beckett *et al*, 2000). We have no information on when problems with alcohol use occurred and whether they were still present. This cross-sectional design cannot distinguish between cause and effect.

Nevertheless, these data suggest that, while there is a gradient of associations and of adverse effects going from 'abuse' to 'dependence' to 'abuse and dependence', progression to a more serious stage need not necessarily occur.

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ORIGINAL PAPER

The relationship between socio-economic status and mental health funding, service provision and national policy: a cross-national study

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A recent editorial in *International Psychiatry* (Cox, 2008) described the importance of a new initiative by the *Lancet* (Horton, 2007) to promote the development and delivery of mental health services and treatments in low- and middle-income countries (LMICs). This initiative was supported by a series of outstanding papers (Chisholm *et al*, 2007; Jacob *et al*, 2007; Patel *et al*, 2007; Saraceno *et al*, 2007; Saxena *et al*, 2007).

The availability of generic mental health services in individual countries is contingent upon several factors. First, there is a need for a national mental health policy (Jacob *et al*, 2007; Saxena *et al*, 2007). Although 80% of countries had a national mental health policy, LMICs were less likely to have one (Jacob *et al*, 2007). Second, there is a need for a national plan for the implementation of that policy (Saxena *et al*, 2007). Third, mental health services actually need to be developed and delivered (Saxena *et al*, 2007). LMICs, compared with high-income countries (HICs), have poor resources, including fewer psychiatric beds and fewer doctors, nurses, psychiatrists and other mental health professionals (Jacob *et al*, 2007), per head of population. Fourth, the availability of effective and cost-effective treatment interventions is important in the design, development and delivery of mental health services (Chisholm *et al*, 2007; Patel *et al*, 2007). All these sequential steps are underpinned by satisfactory funding (Jacob *et al*, 2007; Saxena *et al*, 2007). LMICs, compared with HICs, spend a lower proportion of their gross domestic product (GDP) on health, are less likely to have a dedicated mental health budget and, when such a dedicated budget exists, it forms a lower proportion of the total health budget (Jacob *et al*, 2007; Shah, 2007).

The five seminal *Lancet* papers primarily used the World Bank categorisation of LMICs and HICs as a categorical variable in their data analyses. Similar analyses are repeated in this study instead using GDP (a continuous variable) as a measure of socio-economic status. Additionally, similar analyses were repeated using a measure of income inequality, the Gini coefficient.

Methods

Data on GDP for the year 2002 were taken from the website of the World Health Organization (WHO) (http://www.who.int/countries/en). The website of the United Nations Development Programme (http://hdr.undp.org/en/reports/nhdr) provided data on the Gini coefficient; a higher Gini coefficient suggests greater income inequality. The median (range) year when the latest data on the Gini coefficient were available was 2000 (range 1983–2003).

Box 1 lists the precise parameters examined for national policy on mental health, funding for mental health services and mental health service provision. Data on mental health funding, service provision and national policy were ascertained from the Mental Health Atlas 2005 (http://www.who.int/GlobalAtlas) published by the WHO.

The relationship between GDP and the Gini coefficient and the continuous variables (see Box 1) was examined using Spearman's rank correlation coefficient (rho). The relationship between GDP and the Gini coefficient and the dichotomous variables (see Box 1) was examined using the Mann–Whitney *U*-test (reported below with the *Z* statistic).

Results

A total of 192 countries were listed on the WHO website. Data on the different measured parameters were available for a median (range) of 187 (100–191) countries. With the exceptions of the Gini coefficient ($n = 125$) and percentage of the health budget spent on mental health ($n = 100$),

Box 1 Parameters of mental health funding, service provision and national policy

A. National policy on mental health
1. Presence of a national mental health policy
2. Presence of a national mental health programme
3. Presence of mental health information-gathering system
4. Presence of substance misuse policy
5. Presence of mental health legislation
6. Presence of national therapeutic drug policy and essential list of drugs

B. Funding mechanisms for mental health
1. Presence of a specific budget allocation for mental health
2. Percentage of the total health budget spent on mental health

C. Service provision
1. Total number of psychiatric beds per 10 000 population
2. Number of psychiatric beds in mental hospitals per 10 000 population
3. Number of psychiatric beds in general hospital per 10 000 population
4. Number of psychiatric beds in other settings per 10 000 population
5. Number of psychiatrists per 10 000 population
6. Number of psychiatric nurses per 10 000 population
7. Number of psychologists per 10 000 population
8. Number of social workers per 10 000 population
9. Mental health being part of primary healthcare system
10. Availability of acute treatment for severe mental disorders in primary care
11. Availability of mental health training to professionals in primary care
12. Availability of community care for mental health
13. Involvement of non-governmental organisations in mental health
14. Availability of special programmes for the elderly
15. Availability of special programmes for children
16. Availability of special programmes for refugees and displaced people

Items A1–6, B1 and C9–16 were categorical variables measured as present or absent. Items B2 and C1–8 were continuous variables.

data on all other parameters were available for at least 165 countries (86%).

GDP was significantly higher in countries with a national policy on mental health ($Z = -2.4$, $P = 0.015$), a national substance misuse policy ($Z = -3.2$, $P = 0.003$), mental health legislation ($Z = -2.2$, $P = 0.03$) and a mental health information-gathering system ($Z = -2.7$, $P = 0.006$); it was significantly lower in countries with a national therapeutic drug policy and essential list of drugs ($Z = -3.7$, $P < 0.00001$). There was no significant relationship between GDP and the presence of a national mental health programme.

The Gini coefficient was significantly higher in countries with a national mental health programme ($Z = -1.98$, $P = 0.047$) and was significantly lower in countries with a mental health information-gathering system ($Z = -1.95$, $P = 0.052$). There was no significant relationship between the Gini coefficient and the presence of national policy on mental health, mental health legislation and national therapeutic drug policy and essential list of drugs.

GDP was significantly higher in countries with a specific budget allocation for mental health ($Z = -2.3$, $P = 0.023$). There was a significant positive correlation between GDP and percentage of the total health budget spent on mental health (rho = +0.48, $P < 0.00001$). There was no significant relationship between the Gini coefficient and a specific budget allocation for mental health. There was a significant negative correlation between the Gini coefficient and the percentage of the total health budget spent on mental health (rho = –0.43, $P < 0.00001$).

Table 1 The relationship between GDP, the Gini coefficient and some measures of service provision

	GDP	Gini coefficient
Total number of psychiatric beds		
Rho	+0.48	–0.43
P	< 0.00001	< 0.00001
Number of psychiatric beds in mental hospitals		
Rho	+0.51	–0.42
P	< 0.00001	< 0.00001
Number of psychiatric beds in general hospitals		
Rho	+0.53	–0.49
P	< 0.00001	< 0.00001
Number of psychiatric beds in other settings		
Rho	+0.2	–0.33
P	0.009	0.001
Number of psychiatrists		
Rho	+0.75	–0.45
P	< 0.00001	< 0.00001
Number of psychiatric nurses		
Rho	+0.62	–0.5
P	< 0.00001	< 0.00001
Number of psychologists		
Rho	+0.67	–0.19
P	< 0.00001	0.038
Number of social workers		
Rho	+0.67	–0.2
P	< 0.00001	0.047

Table 1 illustrates the relationship between GDP, the Gini coefficient and several measures of service provision. There were significant positive correlations between GDP and the total number of psychiatric beds, the number of psychiatric beds in mental hospitals, the number of psychiatric beds in general hospitals, the number of psychiatric beds in other settings, the number of psychiatrists, the number of psychiatric nurses, the number of psychologists and the number of social workers. GDP was significantly higher in countries where mental health was part of the primary healthcare system ($Z = -3.6$, $P < 0.00001$), acute treatment for mental disorders was available in primary care ($Z = -2.65$, $P = 0.008$), community care was available ($Z = -5.56$, $P < 0.00001$), non-governmental organisations were involved in mental health ($Z = -2.6$, $P = 0.009$) and special programmes for the elderly ($Z = -6.9$, $P < 0.00001$) and children ($Z = -4.48$, $P < 0.00001$) were available. GDP was not significantly associated with the availability of regular training in mental health for primary healthcare professionals and special programmes for refugees.

There were significant negative correlations between the Gini coefficient and the total number of psychiatric beds, the number of psychiatric beds in mental hospitals, the number of psychiatric beds in general hospitals, the number of psychiatric beds in other settings, the number of psychiatrists, the number of psychiatric nurses, the number of psychologists and the number of social workers (Table 1). The Gini coefficient was significantly lower in countries where regular training in mental health was available to primary healthcare

professionals ($Z = -2.46$, $P = 0.016$) and special programmes for children ($Z = -1.92$, $P = 0.055$) and refugees ($Z = -2.26$, $P = 0.024$) were available. The Gini coefficient was not significantly associated with mental health being part of the primary healthcare system, availability of acute treatment for mental disorders in primary care, availability of community care, involvement of non-governmental organisations in mental health, and special programmes for the elderly.

Discussion

The findings of this study, using a different methodological approach, are consistent with the findings reported in the *Lancet* series of papers (Jacob *et al*, 2007; Patel *et al*, 2007; Saraceno *et al*, 2007; Saxena *et al*, 2007). The current findings were that higher GDP was associated with the presence of national mental health policy, national substance misuse policy, mental health legislation and a mental health information-gathering system, mental health being part of the primary care system, treatment for mental disorders being available in primary care, availability of community care, involvement of non-governmental organisations in mental health, higher percentage of the health budget spent on mental health, and greater density of psychiatric beds, psychiatrists, psychiatric nurses, psychologists and social workers. Additionally, albeit previously unreported, broadly similar associations were observed with greater income inequality (measured by the Gini coefficient). Thus, in addition to the socio-economic status of countries, the degree of income inequality may also influence the development and delivery of mental health services. This is an important observation because it does not necessarily follow that lower socio-economic status implies greater income inequality.

The challenge for international organisations, including the WHO, the World Psychiatric Association and the World Bank, and for national governments, is to encourage fair and equitable mental healthcare budgetary provision and the development of national mental health policies, including mental health legislation, with effective national implementation programmes in both LMICs and in countries with greater income inequality. This will require political will to give mental healthcare priority and support through satisfactory funding, although it may be difficult to achieve owing to poor socio-economic status, income inequality and different healthcare sectors competing for scarce resources. Otherwise, vulnerable patients with mental disorders, who are more likely to be at the receiving end of the effects of poor socio-economic status and greater income inequality, will continue to suffer in silence. The recent initiative by the *Lancet* (Horton, 2007) will no doubt assist in meeting this challenge.

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SPECIAL PAPER

Fairness, liberty and psychiatry

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According to Beauchamp & Childress (2001) the fundamental principles of biomedical ethics include 'justice'. But how do we approach 'justice'? Justice may be thought of in relation to an individual or society. An individual may be just or unjust. Justice in society may be thought of as 'retributive justice' (fair punishment), 'civil justice' (fair recompense), 'distributive justice' (fair shares) or 'social justice' (a fair social contract for citizens of a society).

The present paper introduces *A Theory of Justice* (1972), written by John Rawls (1921–2002), which looks at social justice. Because Rawls' first principle of justice is the 'liberty principle', some thoughts on liberty are also offered. The aim is not to be comprehensive but to stimulate further interest and debate in these issues among psychiatrists. A more extensive summary of Rawls' theory has been provided by Ikkos *et al* (2006).

John Rawls' theory of justice

The two fundamental principles of social justice, according to Rawls, are the 'liberty principle' and the 'difference principle':

- according to the liberty principle, 'Each person [should] have equal right to the most extensive system of equal

basic liberties compatible with a similar system of liberty for all'.
- according to the difference principle, 'Social and economic inequalities are to be arranged so that they are both: to the greatest benefit to the least advantaged … and attached to offices and positions open to all under conditions of fair equality of opportunity'.

The term 'fair equality of opportunity' means that everyone should be given an equal opportunity to succeed in society, irrespective of status at birth.

Rawls was a *prima facie* egalitarian. He believed that inequality in society was morally objectionable and that some people should not get more because of an accident of birth. He believed that all individuals should share equally in 'primary social goods'. His primary social goods include: rights, liberties, opportunities, powers, income and wealth, and a sense of one's worth. Although an egalitarian, Rawls stated that inequality is morally justifiable when, according to the difference principle, it promotes the welfare of the least well off in society.

When making specific policy decisions, principles of social justice may appear to be in conflict with each other. Rawls believed that a fair social contract would reflect the following 'priority rules' in attempting to work through such conflict:
- the first priority rule – the priority of liberty – stipulates that liberty can be restricted only for the sake of liberty
- the second priority rule – the priority of justice over efficiency and welfare – is lexically prior to the principle of efficiency and to that of maximising the sum of advantages; and fair opportunity is prior to the difference principle.

The first priority rule is self-explanatory, but what about the second? What Rawls seems to be saying is:
- the welfare of the least advantaged in society should take precedence over efficiency
- all individuals must be treated fairly and their legitimate interests must not be sacrificed in the pursuit of the welfare of the least advantaged.

Liberty

If liberty is the foremost principle that underpins social justice, then psychiatrists need to have some understanding of what it is. This section summarises four approaches to liberty.

One approach is to equate it with unencumbered expression of one's will or volition according to one's nature. The 17th-century English Enlightenment philosopher Thomas Hobbes (1588–1679) adopted such a definition (see Pink, 2004, ch. 4). The problem with this approach is that one person's unencumbered freedom may restrict that of another.

A second approach is to think of liberty as the autonomous exercise of choice on the basis of free will. The most influential discussion of autonomy is that of the 18th-century German Enlightenment philosopher Immanuel Kant (1724–1804). Kant identifies human dignity with autonomy. Rawls' emphasis on liberty as fundamental to social justice is predicated on this identification. Rawls' theory is strongly influenced by Kant but not identical with it. Autonomy as defined by Kant is a highly complex concept (Wood, 1999). According to Kant, autonomy is dependent on 'free will'. Free will, in turn, depends on the capacity to make choices. Furthermore, according to Kant, the truly autonomous subject does not make choices according to his or her own nature or volition, but according to the 'moral law', which Kant takes to be objective in the same way as the laws of physics are. True autonomy, according to Kant, is an act of free choice in accordance with the moral law. To be free, Kant says, is to do the right thing when you have a choice to do the wrong thing. To be free also requires the capacity to act against one's nature. We can see now that Kant's definition of human freedom is diametrically opposite to Hobbes' freedom.

A third approach is that of George Agich (1993), a contemporary American medical ethicist. He contrasts autonomy as defined by Kant with what he calls 'actual autonomy'. Agich argues that the autonomy that matters in everyday life is not that of deliberating and making choices but that of spontaneous action. According to Agich, 'identification, the ability to reflexively recognize as one's own the constituents of an action, is logically prior to freedom…. Expressions of autonomy are thus enactments of who the individual is as she is becoming.' In contrast to Hobbes, who emphasises the free expression of one's nature, Agich points out that education and training may enhance one's freedom by enlarging the scope and range of the kind of activities that one may do and identify with.

Perhaps the best-known discussion of liberty in the 20th century was that of Isaiah Berlin (1909–97). He proposed a distinction between 'positive liberty' and 'negative liberty'. Positive liberty is the 'freedom to…'. Positive freedom may be the freedom to express one's volition (e.g. Hobbes) or make autonomous choices (e.g. Kant) or be educated to do more things one feels good about doing (e.g. Agich). As we have seen, the promotion of positive liberty for some may place the liberty of others at risk. Berlin was particularly interested in negative liberty, therefore. Negative liberty is 'liberty from…'. Berlin (2002, p. 41) summarised his thoughts as follows:

> The extent of a man's negative freedom is, as it were, a function of what doors, and how many, are open to him; upon what prospects they open; and how open they are. The formula must not be pressed too far, for not all doors are of equal importance…. Consequently the problem of how an overall increase of liberty in particular circumstances is to be secured … can be an agonising problem, not solved by any hard and fast rule.

Implications for psychiatrists

If we follow Kant, Rawls and others, we may accept that liberty is at the heart of human dignity and social justice.

In relation to psychiatric practice, liberty is a complex and neglected topic. Relevant issues include freedom, freedom of expression, free will, free choice, autonomy as defined by Kant, actual autonomy as defined by Agich and negative liberty as defined by Berlin. Education and rehabilitation may be vital in promoting the liberty of our patients. Conversely, the absence of these, as well as treatment, may limit their liberty and autonomy, often unfairly.

Restriction of liberty is consistent with a fair social contract, but can be justified only on grounds of liberty itself. It cannot be justified on other grounds. Psychiatrists must

never participate in coercive forms of treatment that are not fair to the individual patient.

Where restriction of the liberty of a patient is necessary, arrangements must be fair to the patient in ways that maximise his or her liberty (and dignity) and do not subsume these to considerations of efficiency. Where restriction of the liberty of a psychiatric patient is being considered for the protection of others, the restriction should be proportionate to the threat and respectful of the liberty and dignity of the patient.

We have thus far focused on liberty in light of the primary importance of the liberty principle. The 'difference principle', however, is also important for psychiatrists. Its emphasis on ensuring the best outcome for the worst off in society puts psychiatrists in a strong position to advocate greater funding for public mental health services. Indeed, it can be said that the fairness of any society can be assessed in large part by the social outcomes of people with intellectual disability or mental illness.

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NEWS AND NOTES

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

College mental health leaflets in other languages

Over the past couple of years the College has had huge support from members and staff to translate the College mental health leaflets into 14 different languages. There are well over 100 translated leaflets available to the public, in paper form and on the College website. The web pages for the Arabic series, coordinated by Dr Sabry Fattah, attracted over 44 000 visits in 2008. The pages with Farsi translations attracted 32 000 visits and these leaflets are also hosted on the website of Mashhad University of Medical Sciences, Iran. The College is collaborating with Dr Syed Ahmer and Prof. Murad Khan at the Department of Psychiatry, AKU, Karachi, who have organised the translation of many College leaflets into Urdu, and are printing them for free distribution in Pakistan.

In Europe, in 2008 the mental health information page of the College website had 14 000 visitors viewing the French leaflets and 13 000 reading Polish translations. The College is now planning to extend this exciting and challenging work in 2009 and welcomes more volunteers to help with translations.

News from the Pan-American Division

The Pan-American International Division of the Royal College of Psychiatrists has again organised an international symposium at the American Psychiatric Association's annual meeting in San Francisco in May 2009, for members of the College from around the world. The symposium, entitled 'The effects of city life on mental health around the world', is on Tuesday 19 May, 2–5 p.m., in the Moscone Center, Room 122, Exhibit Level North. The presenters are from Cairo (Nasser Loza), Mexico City (Elena Medina-Mora), Mumbai (Amresh Shrivastava), São Paulo (Paulo Menezes), Singapore (EE-Heok Kua) and Australia (Helen Herrman). Rachel Jenkins (London) will be the discussant and Nigel Bark (New York City) is chair.

That same evening (6–8 p.m.), the Pan-American Division and the College will have their annual reception (check the venue in the Directory of Allied Meetings). All members and friends of the College are very welcome.

The Pan-American Division's session at the Royal College's 2009 annual meeting in Liverpool is on 2 June, 9.45–11 a.m. entitled 'A fair deal in North America?' It will feature 'Stigma in Canada' (Roumen Milev), 'Services in the Bronx' (Nigel Bark) and 'Cross-border training in Mexico' (Richard Swinson).

The next steps for Kenya

Following a situational needs analysis in Nairobi, a 5-day working conference, 'Working with children and young people with mental health problems in the juvenile justice system', was hosted by the Royal College of Psychiatrists. Participants were drawn from various disciplines, including the police and judiciary, probation officers, special-needs teachers, psychiatrists, nursing staff from the Mathari Hospital, social workers and children's department staff and administrators from the Ministry of Health. Throughout the week, a number of recurring themes emerged:

- there is a need for systematic training in recognition of mental health problems in young offenders across all agencies and at all levels of staffing
- there is a need for formalised systems of inter-agency collaboration
- child protection services have to be developed
- protocols for all agencies have to be produced.

Following that programme, the next steps are to disseminate training in Mombassa and Kiiushu; all agencies are expected to participate. Training is to be delivered by Dr Tina Arani and Mr Paul Tarbuck.

With regard to developments in Nairobi, following the training, colleagues in all agencies decided that a youth offending service is to be developed; psychiatry is to take the lead along with probation. Another development is establishing a probation office in the grounds of Mathari Psychiatric Hospital; this is to ensure that young people leaving hospital are provided with assistance.

Revalidation

The General Medical Council is introducing licensing and revalidation. Licences will replace registration as the basic instrument doctors will need to hold in order to practise. Licences will have to be revalidated periodically, typically every 5 years. All doctors who require one will receive a licence this autumn.

For those doctors on the specialist register, there will be a separate form of revalidation known as recertification. The College has a role in setting standards for specialists in each specialty and is devising methods of assessing specialists against those standards. It will be necessary for every specialist to meet College standards in order to be recertified. Pilots are currently being run on some assessment methods and others will follow later in the year. It is hoped that recertification of specialist psychiatrists will be piloted from the beginning of 2010, with the programme being rolled out to all in 2011.

Action on Health and Social Care for Migrants and Ethnic Minorities in Europe (HOME)

On 14 and 15 January, the Centre for Psychiatry at the Wolfson Institute of Preventive Medicine in London hosted the London COST (European Cooperation in Science and Technology) meeting as part of the European Union's 'Health and Social Care for Migrants and Ethnic Minorities in Europe' (HOME). The topic of the meeting – 'Life course and developmental perspectives on young people's health and well-being' – attracted delegates and speakers from Lithuania, Sweden, Denmark, Holland, Turkey, Finland, Israel, Belgium, Malta and Canada.

The recent increase in the numbers of migrants in Europe has generated a growing volume of research on their state of health and the need to adapt care services to their needs. Scientific progress in this field, however, is held up by a lack of interdisciplinary and international collaboration. Moreover, the addition of a cross-national perspective can yield new insights into the causes of ill-health and can further the exchange of good practice. In southern, central and eastern European countries, work on migration and health is in need of strengthening and encouragement.

The presentations considered ethnographic, qualitative and epidemiological approaches to understanding life course impacts on the well-being and health problems of young people. The meeting was not focused only on mental health; it was evident that mental health and health risk behaviours were central to well-being and health in general. Controversies included the role and relevance of risk and protective factors, such as cultural identity, social support, diaspora, language, religion, national migration and health policies and EU policy to manage migrants. Data on substance misuse, obesity, physical activity, infectious disease and cardiovascular disease were presented and discussed critically. Different national perspectives on how to tackle health emerged, but a common thread was oppressive and unhealthy policies for managing migrants in the EU compared with the US.

Overall, this COST action brings together 88 experts in 29 different countries to consolidate and review work carried out so far, identify blind spots and persistent problems, and recommend ways forward. Its three working groups are concerned with policies, state of health and healthcare. Members work together to organise workshops, conferences and training activities, as well as producing publications and developing joint research proposals.

The COST website is http://www.cost.esf.org and the HOME page http://www.cost.esf.org/domains_actions/isch/Actions/HOME. The meeting was followed by the launch of mighealthnet, a wiki-based resource of understanding healthcare problems among migrants, including policy and practice, at http://mighealth.net/uk/index.php/Main_Page for the UK pages.

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Sir: *International Psychiatry* is widely read, not only by psychiatrists but also by other doctors and healthcare professionals around the world. Although all sections of the journal are very informative, the country profiles are particularly well received, because they provide an excellent outline of mental health services, education, training, research and policy in the respective countries. The country profile on Bahrain was comprehensive and informative. However, Bahrain's location was given as the 'Arabian Gulf', which might be confusing for some readers, particularly those outside the Middle East region. The formal location of Bahrain according to the United Nations, the International Geographical Society and various international atlases is the Persian Gulf. It will be a shame if this undermined understanding of Bahrain's very good mental health services.

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The Royal College of Psychiatrists is keen to attract high-calibre doctors to the specialty of psychiatry and to foster good attitudes towards psychiatry and the College as a whole. The Psychiatric Trainees Committee and the Board of International Affairs therefore offer bursaries for medical students looking for financial support with their electives in psychiatry or to undertake research in the UK or overseas. Three recipients of these bursaries have contributed correspondence on their experiences.

Psychedelics and psychiatry

Sir: In 2008 I received a bursary from the Royal College of Psychiatrists to contribute towards expenses incurred during my medical elective in the USA, 'Psychedelics and psychiatry'. This letter gives an overview of my experience to date and plans for the remainder of my project.

Psychedelic drugs, medicine and popular culture have a turbulent past. Intense research into hallucinogenic substances followed Albert Hofmann's legendary ingestion of LSD-25 in 1943 (Hofmann, 1980). The potential of psychedelics as psychiatric drugs led to several undergoing diverse trials, ranging from adjuncts to psychotherapy to the treatment of addictions (Abramson, 1967; Passie, 1997). Over 2000 papers documenting the safe use of psychedelics in more than 40 000 patients had been published by the mid-1960s (Sessa, 2005). Although the scientific rigour of some work is questionable by today's standards (Grob, 1994), enough potential was shown to warrant follow-up. This never happened; LSD was adopted by the counter-culture and subsequently blamed for the social unrest of the time (Grob, 1994; Dyck, 2005). By the early 1970s, increasingly strict legislation and lack of government support halted research into psychedelic substances.

Psychedelic medicine is now experiencing a renaissance, however, with several active groups worldwide (Sessa, 2005). I chose to join Dr John Halpern's Laboratory for Integrative Psychiatry, Addictions Division, at McLean Hospital, Harvard, as a research assistant for 2 months. Dr Halpern has over 10 years' experience in the field, McLean is world renowned for psychiatric research, and Harvard has historical links with past psychedelic studies.

The first part of my elective has focused on non-clinical work. I have been actively involved in the construction of a new trial, learning about study design, proposals, applications, protocols, informed consent, legal requirements, institutional review board (IRB) approval and funding issues. The trial is a randomised, placebo-controlled study of psilocybin for the treatment of episodic cluster headache. Psilocybin is the hallucinogenic active ingredient of 'magic mushrooms'. It is an indole of the tryptamine family of compounds.

I will have the chance to discuss the prospect of psychedelic therapy with potential patients, and meet leading European psychedelic researchers as part of this project. This new trial is currently under IRB consideration and their feedback will provide a valuable learning opportunity.

The second part of my elective focuses more on clinical experience. Recruitment is ongoing for another trial, in which patients with refractory anxiety related to a diagnosis of cancer undergo a number of psychotherapy sessions while under the influence of MDMA (or active placebo). MDMA (3,4-methylenedioxymethamphetamine) is a member of the amphetamine class of drugs, and is more commonly known by its street name 'ecstasy'. I will be able to observe psychotherapy under these unique circumstances and learn some of the practicalities of running experimental sessions.

My last task will be designing an online survey for MDMA users with autism-spectrum disorder to help gather data for a series of case reports as groundwork to support future clinical trials.

Finally, I have just learned that work on an unexpected offshoot of my elective project has led to my first academic publication (Halpern *et al*, 2008).

My brief experience of psychedelic research has exposed me to a diverse array of subjects beyond the core medical curriculum, as it touches upon medical, ethical, philosophical, spiritual, social and legal issues. Over 60 years since 'Bicycle Day' (Hofmann, 1980), these fascinating substances still prove controversial. Technology has now made it possible to visualise the brain in action; psychiatric research is on the brink of a revolution. Nevertheless, with a history of shamanistic use dating back millennia (Schultes *et al*, 2001), perhaps current psychedelic research is rediscovering what could arguably be described as the oldest branch of medicine.

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The doctor–patient relationship in Australia's Northern Territory

Sir: In the summer of 2007 I spent 6 weeks in the northern Australian city of Darwin. During this period I had the privilege to work in the Royal Darwin Hospital alongside the renal medicine team. While undertaking this placement, I was exposed to the fascinating lives, and plights, of the Aborigine people who heavily populate this region.

During my stay I became intrigued by the differences that I observed in the doctor–patient relationship between Western Australians and this sub-population, in particular, the nuances that were adopted by the medical professionals in their struggle to accommodate Aborigine traditions, beliefs and culture while they were attempting to employ mainstream (biomedical) Western medical concepts. My work focused on observed differences in both verbal and non-verbal methods

of communication, such as the intentional absence of eye contact or expected discussion of a patient's condition with the elder of a community group. These exchanges were particularly revealing, as it became evident that not only verbal communication but also body language is culturally specific and, as such, open to misinterpretation.

Further to this, I engaged in meetings with the hospital's translator services, consultants, nursing staff and patients. Through them I was made aware of the educational tools used to strengthen communication between staff and patients. These included posters, books, leaflets, radio broadcasts and community meetings, all established in an attempt to integrate the healthcare paradigms of the Aborigines with the Western approach to medicine.

Throughout the study it became apparent that the Aborigine people had suffered serious psychological damage from decades of displacement and were finding it difficult to cope in a climate of change and cultural overhaul. For example, the relatively new abundance of alcohol has led to its frequent misuse by this group. This has become such a problem that, on 17 September 2007, the Federal Government of Australia imposed a drinking ban in certain Aborigine districts. Many in, and out, of the region feel that these measures are too quick, easy and generalising, and miss the root of the problem.

There is a specific need within the mental healthcare system to understand the normal behaviour and health patterns for a population, so that professionals can intervene more appropriately. For example, to diagnose a patient as suffering from delusions, a physician is required to have an adequate understanding of what is a normal belief for that patient's culture and society. It is difficult to feel confident in such diagnoses if, at very basic levels, there is inherent miscommunication and misunderstanding.

The challenges in communication between Western medics and Aborigine patients in Australia's Northern Territory affect the mental well-being of this population and in many cases have led to patients absconding from the hospital system. They have resulted in much neglect of health, both physical and mental. Through a lack of efficient communication between the health system and the Aborigine community, and the subsequent frustrations suffered, malnutrition, depression, child abuse, alcoholism and substance misuse are rife in this region.

Although, in Britain, we are fortunate not to have such an obviously displaced sub-population, I am reminded through this work of the continual need to assess cultural differences when recommending healthcare pathways to patients. There is, I believe, evidence that good mental health begins with a feeling of being understood.

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Correction

Helping each other help children – worldwide research networks in child and adolescent mental health. *International Psychiatry*, **5**, 84–86. The authorship of the paper should have read: 'Stefan Ehrlich, Nicolas Jefferson-Lenskyj and Paul L. Plener'. The second author's affiliation is: '4th-year medical student, University of Queensland, Australia'.

The mental health initiative of the Association for Health and Welfare in Nilgiris

Sir: I spent my medical school elective placement in the foothills of the Nilgiris valley in the southern Indian state of Tamil Nadu. The mental health initiative of ASHWINI (Association for Health and Welfare in Nilgiris) works among the Adivasis 'original inhabitants' of the Gudalur and Pandalur Taluks. I was particularly interested in understanding the indigenous influences on the delivery of mental healthcare. The opportunity to conduct qualitative interviews with community mental health workers and practitioners gave me an insight into native experiences of mental health within a specific environment.

Although there was strong representation of biomedical ideas among the community mental health workers, a biomedical model inadequately represents the complexity of individual concepts of illness. Care was delivered in a combination of mystic models (more akin to community ways of thinking) and biomedical models (representative of allopathic medicine). This combination forms a holistic medium in which patients are cared for with spiritual, physical and social welfare considered. I found ASHWINI's healthcare delivery impressive, arguably affording patients a better prognosis when managed within a community rehabilitation system, than did the frequently fragmented care and social isolation I have witnessed in the UK.

Adivasi culture is very inclusive, with exclusion from society a rarity. It struck me that the minutiae of mental disorders appearing in Western criteria may represent behaviours in Adivasi societies accepted within the spectrum of normality. There is a danger in introducing Western classifications into mental health practice in diverse populations. The distinction between disease and psychiatric disorder has been confused, and the mapping of criteria for pathology onto culturally diverse experiences may be false and clinically useless. Research has highlighted the need to understand common vignettes of mental illness and social pressures acting on society in the creation of effective services. The overwhelming need is not to develop a universal gold-standard model of care, but one that is culturally conducive. The most valuable lessons from this research are the cultural insights offered about Adivasi communities, for example the need for prevention and assessment of suicide risk (suicide has been the most common outcome of those with mental illness) and acknowledgement of the central role of the family unit within the community when diagnosing and managing psychiatric illness.

Ultimately, the greatest priority in mental health is appropriate and accessible services. In order to create effective, community-orientated interventions there is a need for exploration and understanding of community dynamics. I hope that the research I conducted with the aid of the bursary will both provide further perspective on the delivery of effective mental healthcare and contribute to the development of culturally sensitive interventions.

Lauren Hill
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Brighton and Sussex Medical School

Forthcoming international events

16–17 April 2009
8th International Conference on the Care and Treatment of Offenders with a Learning Disability
Preston, Lancashire, UK
Organiser: University of Central Lancashire
Contact: Liz Kelly
Website: http://www.ldoffenders.co.uk

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

23–26 April 2009
XXV Argentinean Psychiatric Congress
Mar del Plata, Argentina
Organiser: Argentinean Psychiatrists Association (APSA)
Contact: Dr Alfredo H. Cía
Email: alfredocia@apsa.org.ar
Website: http://www.apsa.org.ar

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

24–28 May 2009
RANZCP 2009 Congress – Living in Interesting Times
Adelaide, Australia
Organiser: Royal Australian and New Zealand College of Psychiatrists
Contact: WaldronSmith Management
Website: http://www.ranzcp2009.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: http://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: http://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
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
Gura-Humorului, Romania
Contact: Dana Catargiu
Email: congress2009@apsro.ro
Website: http://www.apsro.ro/

13–14 July 2009
Fourth International Conference on Child and Adolescent Psychopathology
London, UK
Organiser: School of Human and Life Sciences, Roehampton University
Contact: Professor Cecilia Essau
Website: http://www.roehampton.ac.uk/staff/CeciliaEssau/

14–16 October 2009
Fifth International SIVUS Conference on Mental Retardation
Dhaka, Bangladesh
Organiser: SIVUS International
Website: http://sivusconference.synthasite.com

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