

International Psychiatry

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Mental illness and legal discrimination

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Why do so many countries have a mental health act? What is it about mental disorders which warrants that people who suffer from them be subject to different laws from the rest of society? The issues of stigma and discrimination against people with a mental disorder have moved up the agenda in many parts of the world. So why persist with a legal framework for the non-consensual medical treatment of those who are mentally ill which is different from that for those who are physically ill?

In 2002, in a court judgement, Dame Elizabeth Butler-Sloss, one of the most senior judges in England, said:

A competent patient has an absolute right to refuse to consent to medical treatment for any reason, rational or irrational, or for no reason at all, even when that decision may lead to his or her death. (*Re B (adult: refusal of medical treatment)*, 2002)

But she was wrong. A competent adult, in England and Wales, may be detained in hospital and forcibly treated, for a mental illness, against the patient's capacitous wishes.

The law in England and Wales, in relation to an adult with a physical illness, is set out in the Mental Capacity Act 2005:

- The doctor, or other health professional, must gain the consent of an adult patient, if that person retains decision-making capacity, before examining or carrying out any procedure on that patient. If the doctor performs a medical procedure without the patient's consent, it is a criminal assault and a civil trespass (the doctor can be charged with an offence by the police and sued for compensation by the patient).
- The doctor must start by presuming the patient has capacity, unless there is evidence to the contrary.
- If the patient lacks capacity, then the doctor has to act in the patient's 'best interest'. Lack of capacity means the patient has an impairment of, or a disturbance in the functioning of, the mind or brain and is unable to understand the information relevant to the decision, to retain that information, to use or weigh that information as part of the process of making the decision, or is unable to communicate the decision, or fails to make the decision.
- The lack of capacity is both time and decision specific.
- In determining what is in the patient's 'best interest', account must be taken of any previous wishes the patient has expressed, if known.
- An advance decision to refuse treatment, made by the patient when capacitous, must be honoured (because a capacitous person's refusal to accept treatment must be honoured). Advance requests for treatment should be given due consideration but are not binding (because a capacitous person's request for treatment does not place an obligation on the doctor).

- Adults may, if they wish, give another adult the authority to consent to, or decline, future medical treatment should the patient lose the capacity to make the decision.
- No matter what risks people may present to themselves or others, they cannot normally be deprived of their liberty unless they have been charged with, or convicted of, a crime. They can only be restrained for brief periods to prevent imminent serious danger. The degree of any restraint must be proportionate to the risks.

These rules exist because of the importance attached to the autonomy of the individual.

What are the equivalent provisions if the patient is given a diagnosis which sits in the 'mental and behavioural disorders' chapters of the *International Classification of Diseases*? That is, what are the rules for the non-consensual detention and treatment of a person with a mental illness? For England and Wales, the Mental Health Act 1983 says that a person may be detained if he or she:

is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons.

There is no suggestion that patients should be unable to make the decision for themselves. It is solely based on risk. In relation to treatment for a mental disorder, patients can be forced to have treatment they do not want, because the doctors think it is in their best interest, even when patients say it is not and retain the capacity to make that decision and the only risk is to their own health. Advance refusals of treatment are not honoured.

This, as explained above, is not permitted in relation to treatment for physical illness. Oddly, it is the disorder that is to be treated which determines whether or not the capacitous adult retains autonomy, not the person's mental state.

Imagine two people, one with schizophrenia and one with cancer. In both cases it is clear that they are able to make rational judgements about their treatment. They both recognise that they are ill and that their illness can be treated and that there are consequences to not receiving treatment. In the case of the former, the fact that he has capacity has no relevance and even if fully capable his unwillingness to consent can be overridden. In the case of the latter, it is central, and for treatment to proceed without the consent of this person with capacity would be an assault. If the patient with schizophrenia also has cancer, and retains decision-making capacity, he is entitled to refuse treatment for the cancer – but not for the schizophrenia.

The Mental Health Act for England and Wales is perhaps unusual in taking no account of patients' ability to make decisions for themselves. The equivalent Scottish act, the

Mental Health (Care and Treatment) (Scotland) Act 2003, does require some impairment of decision making – ‘because of the mental disorder, the patient’s ability to make decisions about the provision of medical treatment is significantly impaired’ – but does not require that the person lacks the capacity to make the relevant decision in the way that is required for adults suffering from physical illnesses.

For patients in both jurisdictions, total control of the patient, including deprivation of liberty, is authorised if the criteria for detention are met. The authority is not limited to providing care and treatment solely in relation to the specific decision about which the patient is incapacitous.

The Irish Mental Health Act 2001 includes a similar requirement:

because of the severity of the illness, disability or dementia, the judgment of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission.

The Irish act also makes reference to ‘best interests’ but it is qualified:

In making a decision under this Act concerning the care or treatment of a person (including a decision to make an admission order in relation to a person), the best interests of the person shall be the principal consideration with due regard being given to the interests of other persons who may be at risk of serious harm if the decision is not made.

In New Zealand, the Mental Health (Compulsory Assessment and Treatment) Act 1992 requires that the disorder either causes a ‘serious danger to the health or safety of that person or of others’ or ‘seriously diminishes the capacity of that person to take care of himself or herself’. This is similar to the law in Queensland, Australia (Mental Health Act 2000), which states that the person must either ‘lack the capacity to consent to be treated for the illness’ or ‘has unreasonably refused proposed treatment for the illness’.

The mental health acts that make provision for compulsory treatment in the community tend to have a similar lack of regard for patient autonomy. A rare exception is from Canada, where the criteria for a community treatment order

set out in Saskatchewan’s Mental Health Services Act 2006 include the following:

The person is unable to understand and to make an informed decision regarding his or her need for treatment, care or supervision as a result of the mental disorder.

Ontario has a similar criterion: the person ‘has shown or is showing a lack of competence to care for himself or herself’ while living in the community,

It is not only nationally that the legal framework for the non-consensual care and treatment of people with a mental illness differs from the framework that applies to people who are physically ill. Article 5 of the European Convention on Human Rights (1950) is highly discriminatory. It groups together those of unsound mind, drug addicts, alcoholics and vagrants, as people who may legitimately be locked up, without any requirement that they have committed an offence or are incapable of making decisions for themselves, or even that they will personally benefit from the intervention.

The United Nations (UN) starts better with its Declaration of Human Rights (1948):

Recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world.

Unfortunately, while it does better than most, it fails to maintain this high ideal. The UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (UN General Assembly Resolution 46/119 of 17 December 1991) set out the grounds for compulsion:

- that, because of the mental illness, there is a serious likelihood of immediate or imminent harm to that person or to other persons; or
- that, in the case of a person whose mental illness is severe and whose judgement is impaired, failure to admit or retain that person is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can be given only by admission to a mental health facility in accordance with the principle of the least restrictive alternative.

I return to where I started. Why? Why do people who are mentally ill need a different legal framework for their non-consensual care and treatment?

THEMATIC PAPERS – INTRODUCTION

Reproductive risk to maternal mental health: international perspectives

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Despite the emphasis placed, in international comparisons of obstetric management, on the perinatal mortality rate as a measure of excellence of care (or otherwise), there has been relatively little discussion of the impact of birth on maternal mental health. When thinking

about this issue, we need to consider both the mental state of the mother during the antenatal period as well as the subsequent impact of the birth on her mood and risk of major mental illness. According to the authors contributing to the theme discussed here, that risk is much higher

than we might have predicted, in diverse communities in Pakistan, Nigeria and India. None of these communities has access to the professional support services that might ameliorate the consequences of reproductive risk.

Atif Rahman and Siham Sikander discuss work they have done in Pakistan to identify the prevalence of depression among women in selected rural districts, both before and after delivery. No less than a quarter had depression before the birth, and the great majority continued to be depressed soon afterwards. In follow-up studies, it appeared that in over half of these women the depression persisted for at least a year. As we might expect, the care given to their newborn children was suboptimal, contributing to poor infant growth and child morbidity. Important conclusions are reached about the nature of appropriate interventions and the implications for policy – highlighting the perennial problem that mental health is a low priority on the healthcare agenda in many parts of the world.

In the second of our themed articles, Abiodun Adewuya and Olutayo Aloba address the misconception that emotional distress after birth is rare in sub-Saharan Africa. Their work in Nigeria with pregnant women has shown that both depression and severe symptoms of anxiety are relatively common during the antenatal period, affecting up to a third of women. During the post-partum period, there is probably a similar proportion of Nigerian women with mild to moderate depressive symptoms to that found in other cultures around the world. As in Pakistan, mothers with persisting depression

after childbirth are likely to have children who grow less well and who may be more susceptible to morbidity. In Nigeria, as in Pakistan, there is a social premium placed on male children and failure to produce a son is associated with social exclusion and marital disharmony.

Finally, Vikram Patel provides a fascinating insight into the association between gynaecological complaints and mental health among women in India. Remarkably, it appears that about half of all women interviewed in community surveys in that country complain of a gynaecological problem, most commonly an abnormal vaginal discharge. While it was assumed at one time that such discharges are related to sexually transmitted infections, evidence is emerging that throws doubt on that assumption. Why, then, do so many women in Indian rural communities complain of this symptom, which is often physiological and quite normal? The author presents data on the association between common mental disorders and the complaint of abnormal vaginal discharge, collected during a series of studies that attempted to clarify the natural history of the condition. The findings clearly indicate there is a complex relationship between worries and tensions in the everyday lives of women in rural India and their focus of concern on this symptom, which can be associated with diverse somatic symptoms. Vikram Patel makes recommendations for the integration of effective mental healthcare within emerging reproductive health programmes in India, with the objective of intervening in a vicious cycle that connects rising anxiety with an increased discharge.

THEMATIC PAPER – REPRODUCTIVE RISK TO MATERNAL MENTAL HEALTH

Reproductive risk and its role in maternal mental health – perspectives from Pakistan

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There is now an increased awareness of the high rates of depression among women with young children in impoverished communities. Poor maternal mental health affects the home environment, family life, child care and parenting. This paper summarises some of the issues related to the determinants, consequences and management of maternal mental health during and after pregnancy in Pakistan, a low-income country.

Maternal mental health in pregnancy and after childbirth

The mental health problem with the greatest public health implications is unipolar depression. Globally, clinical depression affects about 10–15% of women around the

time of childbirth. Contrary to previous beliefs, high rates of depression, between two and three times greater than in industrialised countries, have been observed in women after childbirth in low-income countries (Rahman & Prince, 2009).

We conducted a prospective study in rural Pakistan to determine the prevalence, outcome and risk factors associated with perinatal depression in a sample of 700 pregnant women (Rahman *et al*, 2003). The study was conducted in two rural sub-districts of Rawalpindi. The women were assessed for depression in the third trimester using culturally valid tools, and re-evaluated 3 months after they had given birth. Of 632 mothers assessed antenatally, 160 (25%) met the ICD-10 criteria for a depressive episode. Of 541 mothers assessed postnatally, 151 (28%) were diagnosed with ICD-10 depressive episode. Twenty-two mothers (4%) developed a *de novo* depressive episode in the postnatal period, while 8

(1.5%) who had depression in the antenatal period had recovered. Events and difficulties in the previous year associated with antenatal depression included an earning member of the family being made redundant, housing problems, arguments or relationship difficulties with a significant member of the extended family, and serious marital problems. No associations were found with bereavement, major illness in the family, changes in social role, or lack of a confiding relationship. Support from the extended family was negatively associated with depression. Practice of the traditional *chilla* ritual (post-delivery confinement of mothers for 40 days, when all responsibilities for running the household are taken over by other female family members) was a protective factor. Help from family members with routine child care and the presence of the infant's grandmother were both protective factors. The risk of depression was less if the woman lived in a joint family (three generations, or one or both parents with married sons, their wives and children). Interestingly, there was no association between postnatal depression and the husband's monthly income or poor socio-economic status.

Too few women were employed for a meaningful assessment to be made of the impact of employment status, but a significant negative association was found between the financial independence of the women and depression. Financial independence was measured by asking women if they were given money to spend on running the household by the head of the household, and if they could take independent decisions on how to spend it.

Women who had two or more female children were at a higher risk of developing depression after the birth of another female child. Other South Asian studies have found that women who already had a female child faced greater stress because of their wish that their new infant be a boy, reflecting the preference for male children inherent in South Asian culture.

Outcome of depression in the first postnatal year

Few studies have examined the longer-term outcome of postnatal depression. Reviews from high-income countries suggest that in about 30% of women with postnatal depression, symptoms persist for up to 1 year after the birth. We carried out a 6-month and a 1-year follow-up of the 160 mothers who were depressed in the third trimester of pregnancy to determine their outcome (Rahman & Creed, 2007). Of the 129 women who were followed up, 98 (76%) were depressed at 6 months and 80 (62%) at 12 months; 80 (62%) were depressed 12 months postnatally but 7 of these had not been depressed at 6 months; thus, 73 (57%) were depressed at all time points. In summary, over half the mothers depressed during pregnancy continued to be depressed at 6 months and 1 year after giving birth.

The low rate of recovery could be due to the adverse circumstances experienced by many women in low-income countries. Persistent depression was associated with several factors that preceded the birth: poverty, already having five or more children, having an uneducated husband, and lack of a friend or confidant. Persistent depression was also strongly associated with a greater severity of depressive symptoms during pregnancy.

Impact of perinatal depression on the physical health of the infant

Depression is a debilitating disorder, with symptoms such as low mood, tiredness, insomnia, lack of energy, low self-esteem and a lack of interest in the environment. It is also a disabling disorder. Maternal competence in child care is likely to play a greater role in the child's physical well-being and survival chances in low-income countries, as the environment is frequently more hostile than in higher-income countries. Overcrowding, poor sanitation and food insecurity are common, and so suboptimal maternal care may result in a greater risk to the physical health of a child. There is likely to be a particularly high risk during the first year of life, not only because this is a time of increased susceptibility of mothers to a depressive episode (a state which often becomes chronic), but also because it is during this period that the infant requires most care. Unlike a 2-year-old, and certainly a 5-year-old child, who might be able to seek food for him- or herself, the young infant is completely dependent on the mother (or other carer). It is therefore at this age that deficiencies in care are most likely to manifest in a child's physical well-being.

We carried out a case-control study of healthy and age-matched infants brought to an immunisation clinic for their 8-month measles vaccine (Rahman *et al*, 2004a). The mothers of 82 malnourished and 90 well nourished infants were administered the Self-Reporting Questionnaire (SRQ-20), a psychiatric screening instrument. Mental distress, as determined by the SRQ-20, was associated with increased risk of undernutrition in infants. The association remained significant after adjustment for birth weight, economic status, maternal age and literacy, gender of infant and family structure.

Stronger evidence of the link between maternal depression and infant outcomes was provided by our 1-year prospective cohort study of 320 mothers and their infants in Rawalpindi (Rahman *et al*, 2004b). It showed that infants of mothers with antenatal depression had poorer growth than controls, the risk of being underweight or stunted at 6 months being four times higher in infants of mothers who were depressed compared with controls. Chronic depression (depression persisting for over 1 year) carried a greater risk of poor infant outcome than episodic depression. The associations remained significant after adjustment for confounders by multivariate analyses. Infants of mothers with depression also had lower birth weight (Rahman *et al*, 2007a) and higher rates of diarrhoea (Rahman *et al*, 2007b). Thus, it is likely that maternal depression makes an important and possibly major contribution to poor infant growth outcomes and morbidity in poorer countries.

Treatment of perinatal depression

There is considerable potential for interventions aimed at promoting the mental health of mothers not only to reduce the burden of disease in these mothers, but also to improve the physical well-being and development of their offspring. A number of individual and group interventions targeting maternal depression have been developed and tested, mostly in higher-income countries. However, differences between both health systems and cultures make it difficult for such

interventions to be extrapolated from higher-income to lower-income countries. Treatments are unlikely to be adopted by professionals and policy makers unless they are shown to be efficacious, cost-effective, integrated into existing community health services, and linked to high-priority health problems.

To address these issues, we carried out extensive formative research to develop an intervention delivered by community health workers to mothers with depression and their infants living in rural Pakistan (Rahman, 2007). This was called the Thinking Healthy Programme, which included a supportive component (non-directive empathic listening), an educational component (nutritional and healthcare advice, delivered within a cognitive-behavioural framework) and a mother-infant relationship component (warmth, attentive listening, stimulation and support for exploration and autonomy for the infant). The objective was to help mothers feel supported, empowered and confident about their parenting abilities, and through this process to influence their mood. Rather than the directive approach of the medical model, health workers were trained to adopt a more patient-centred approach, tailoring the three components according to the individual needs of the patient.

We conducted a randomised controlled trial which showed that the intervention halved the rate of depression in prenatally depressed women compared with those receiving routine care (Rahman *et al*, 2008). In addition to symptomatic relief, the women receiving the intervention had less disability and better overall and social functioning, and these effects were sustained after 1 year. The intervention also had benefits for the infants: they had fewer episodes of diarrhoea and were more likely to be immunised than those in the control group. The mothers were more likely to use contraception (birth spacing is an important factor in reducing infant morbidity) and both parents reported spending more time playing with their infants.

Policy implications

There is a widespread lack of awareness of mental health issues in lower-income countries, and mental illness carries a stigma that hinders treatment seeking. Mental health remains low on the agenda of planners and policy makers in these regions. Evidence that maternal mental health and child physical health are linked may help bring maternal mental health up the healthcare agenda in a culturally and socially acceptable manner.

In the Thinking Healthy Programme, the mental health intervention was provided by community health workers who were not trained in mental healthcare. This has implications for low-income countries, where trained mental health professionals are scarce and generally concentrated in big cities. The study showed that it was possible to train community health workers to deliver mental health interventions effectively. Such community-based approaches are likely to be more accessible to most mothers with mental health problems, and less stigmatising. We found it more beneficial to integrate the mental health component into the routine work of the health workers rather than introduce it

as a vertical programme. Health workers were more likely to accept the intervention as part of their day-to-day activity.

Another issue concerns the effectiveness of child health programmes in low-income countries. Programmes such as the World Health Organization's Integrated Management of Childhood Illness strategy (which involves infant feeding advice, sanitation, immunisation and health education) rely heavily on the mother. Unless attention is given to maternal mental health, the effectiveness of these programmes will be much reduced.

The association between maternal depression and child health could also help build bridges between disciplines in healthcare. Health policy and research are often narrowly focused – mental health professionals focus on strategies for mental healthcare provision and child health professionals on strategies for reducing child morbidity and mortality. Integrated interventions would, by definition, derive their theoretical and practical framework from many disciplines, including paediatrics, psychiatry, primary care, sociology, public health, epidemiology and medical anthropology. Such multidisciplinary and holistic approaches to healthcare are more likely to succeed than a narrowly focused one.

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Reproductive mental health risk in Nigeria: myths, facts and challenges

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It is widely known that Africans and especially Nigerians place much emphasis on childbearing. It has been said that the effect of childbirth relates to the society and culture's response to parenthood and the existing family structure. Many rituals exist in African societies to signify the changes in women's identity, roles and status during pregnancy and following childbirth. Earlier studies have suggested that perinatal emotional distress is rare among women in sub-Saharan Africa, with the supposed intact family structure in the region acting as a protective factor.

But the fact on ground is that urbanisation has eroded the seemingly intact family structure in Nigeria and the previously perceived low rates of perinatal emotional problems are actually due to the dearth of studies in the region. Also, the instruments and scales used to diagnose emotional problems may not be appropriate to sub-Saharan African peoples, who are known to somatise their emotional problems.

Pregnancy

Although the majority of Nigerian women enjoy a happy and healthy pregnancy and are considered to 'bloom' during this period, studies have shown that pregnancy does not protect them from depression and anxiety. On the contrary, there are increases in psychiatric morbidity during pregnancy. In a study of 180 Yoruba women in south-western Nigeria in late pregnancy, Adewuya *et al* (2006a) found that 8.3% met the DSM-IV criteria for current (2 weeks) depressive disorder. The factors independently associated with depression included being single, divorced/separated, polygamous, having a history of stillbirth and perceived lack of social support.

In another study in Nigeria, the rate of anxiety disorders (again meeting DSM-IV criteria) was found to be 39.0% among women in late pregnancy. This was significantly higher than in the non-pregnant population. The correlates of anxiety disorders included younger age, primiparity and the presence of medical problems (Adewuya *et al*, 2006b).

Postpartum problems

Maternity blues

Maternity blues, or 'baby blues', are transitory mood changes that may begin within the first few days after delivery and last from 1 day through the first 10 days postpartum or longer. Questions have been raised about the cross-cultural validity of this phenomenon but a study of 502 postpartum women

with normal delivery in Nigeria (Adewuya, 2005) revealed a rate of 31.3%, with the predictors of maternity blues being significant mood changes in pregnancy, admission during the pregnancy, female baby and single motherhood. Also, maternity blues and mood changes in the early postnatal period have been found to be strong predictors of postnatal depression in Nigerian women (Adewuya, 2006).

Postnatal depression

Postnatal depression (PND) is the most common mood disorder associated with childbirth. Apart from inflicting profound psychological suffering on new mothers, PND affects marital relationships and adversely affects the emotional and cognitive development of the infant.

The prevalence of PND does not seem to vary across cultures. Using the non-patient version of the Structured Clinical Interview for DSM-III-R (SCID-NP) to assess 876 newly delivered mothers at 6 weeks postpartum, Adewuya *et al* (2005) found a rate of 14.6%, which is comparable with that obtained in other cultures. The correlates of PND included hospital admission during pregnancy, female gender of the baby, preterm delivery, instrumental delivery, Caesarean section and single motherhood.

Postnatal anxiety

Few studies have examined anxiety symptoms in the postpartum period, and still fewer in sub-Saharan Africa. This may be because postnatal anxiety is often assumed to be part of postnatal depression. However, anxiety disorders have differing symptoms and aetiological factors that require different approaches, identification, management and preventive strategies. Using the Zung Self-Rating Anxiety and Depression Scales in a repeated cross-sectional study of postpartum women, Adewuya & Afolabi (2005) found both anxiety and depressive symptoms more frequently in the first 3 weeks postpartum than later. Anxiety was more common than depression in the first 4 weeks, with reversal of the trend subsequently, though with both types of symptom persisting through to the late postpartum period.

Postnatal post-traumatic stress disorder

Several authors have proposed that post-traumatic stress disorder (PTSD) may occur after a distressing labour or delivery; that is, a difficult or traumatic birth may act as a significant stressor and living through the experience might trigger the symptoms of PTSD. Obstetric practice is generally poor in Africa. There are high rates of delivery at home, in mission houses and with the traditional birth attendants,

and these are associated with higher maternal mortality and morbidity. In an assessment of 876 women at 6 weeks postpartum, Adewuya *et al* (2006c) found a prevalence rate of 5.9% for PTSD after traumatic childbirth, with the correlates including hospital admission due to pregnancy complications, instrumental deliveries and poor maternal control during childbirth.

Effect on infants

Poor infant growth and under-nutrition are prevalent in sub-Saharan Africa, especially in Nigeria. Adewuya *et al* (2008) examined the contribution of maternal depression to this in a longitudinal case-control study and found that infants of mothers with depression had significantly poorer growth than infants of non-depressed mothers after 3 and 6 months. Mothers who are depressed are likely to stop breastfeeding earlier and their infants are more likely to have episodes of diarrhoea and infectious illnesses.

Screening

In Nigeria medical personnel are scarce, but the identification of depression in pregnant women and newly delivered mothers could be improved by systematic screening in primary care centres, using self-report questionnaires. The Edinburgh Postnatal Depression Scale (EPDS) is intended for this purpose and has been found useful in both the antenatal (Adewuya *et al*, 2006d) and the postnatal period (Adewuya *et al*, 2005).

Aetiological factors

There are several explanations for this seemingly higher reproductive mental health risk among Nigerian women. A review of the literature revealed that the possible correlates and associated factors could be grouped into three categories: obstetric practice factors, baby factors and family factors.

Obstetrics practice factors

Obstetric practice is still very poor in Nigeria. Most women do not use any health services when pregnant, which makes detection of health problems in pregnancy difficult; there is a high rate of delivery outside hospital. In hospital, most of the operative deliveries are unplanned and mainly done for unbooked patients who have complications either in pregnancy or during delivery. Most Nigerian women want to deliver by themselves because of the pride associated with unassisted delivery in Nigeria and the loss of self-esteem associated with mothers who have operative deliveries (Loto *et al*, 2009). Furthermore, operative procedures in the country are still associated with high rates of maternal sepsis, morbidity and mortality.

Baby factors

Nigerians have a deep-rooted preference for male children. In Nigeria, women are blamed for the gender of the baby, so that giving birth to a girl, especially if the woman is delivering for the first time or has not had a male child, could threaten

her mental health. Lack of a male child is a frequent cause of marital break-up or of the husband marrying another wife.

Another baby factor is preterm delivery or low birth weight. Poor maternal nutrition during pregnancy and prematurity may result in low birth weight. There are few neonatal intensive-care units in Nigeria and so a much reduced chance of survival for preterm and low birth weight babies, and most mothers have a fatalistic attitude towards ill or preterm neonates.

Family factors

Topmost on the list of family factors is single motherhood. This may suggest an association between depressive symptoms and a lack of intimacy or support from partners. In a traditional Nigerian setting, any woman who becomes pregnant while not having a husband is viewed as promiscuous, and single parenting is socially unacceptable. The stigma associated with this may contribute to depressed mood.

Another family factor is polygamy, which is practised widely in Nigeria and is a potential source of marital disharmony. Women from polygamous homes tend to receive less spousal support than their counterparts from monogamous homes. In most polygamous marriages, the new mother (who is busy attending to her baby) is often left alone by the father, who seeks sexual gratification with his other wives.

Conclusion

The primary thing we need is more education regarding maternal and child health in the perinatal period. There should also be a cultural reorientation regarding the family and the gender of the baby. Maternal and infant health policies, a priority in low-income countries, should integrate perinatal mental health as an issue of public importance. Interventions should target mothers in both the antenatal and the postnatal periods. When planning healthcare services or formulating a predictive model for perinatal emotional distress, attention needs to be paid to socio-demographic and obstetric risk factors that are specific to sub-Saharan Africa.

Screening is essential. Routine screening using the EPDS or other instruments should be incorporated into perinatal health services. Prompt referral and treatment of identified cases should be institutionalised.

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THEMATIC PAPER – REPRODUCTIVE RISK TO MATERNAL MENTAL HEALTH

The Stree Arogya Shodh: investigating gynaecological morbidities and women's mental health in India

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Gynaecological complaints have long been associated with poor mental health, in particular depression and anxiety, in higher-income countries. Lower abdominal pain (both menstrual and non-menstrual) and pelvic pain are considered the hallmark gynaecological symptoms associated with somatoform, stress-related and neurotic disorders (the 'common mental disorders', CMDs). Cultural and social factors heavily influence the expression of somatic symptoms and metaphors for emotional distress, but little is known about gynaecological psychosomatic clinical syndromes in non-Western cultures, despite the enormous global health significance of gynaecological symptoms. This paper considers the specific example of the syndrome of abnormal vaginal discharge (AVD) in India.

Abnormal vaginal discharge

Community studies in India show that about half of all women have at least one current gynaecological complaint, of which AVD is the most common. It is characterised by the complaint of vaginal discharge being 'abnormal' on account of increased volume, colour (most often 'white') or malodour. The complaint is associated with considerable self-reported disability, health seeking and associated costs of illness. The standard clinical approach to AVD is syndromic, which is based on the assumption that the complaint is the result of sexual tract infections (STIs), notably *Chlamydia trachomatis* infection, gonorrhoea or trichomoniasis. Sexual tract infections are potential markers for unsafe sexual behaviour and increased vulnerability to HIV/AIDS, and are associated with adverse health outcomes such as infertility, intrauterine growth retardation, pelvic inflammatory disease, stillbirth and premature labour. Although identification and treatment of STIs are priorities in reproductive health programmes, their diagnosis is hampered by the absence of cheap, simple and

accurate diagnostic tests. Thus, the World Health Organization developed the syndromic management guidelines for the treatment of STIs in resource-poor settings. The primary target for the syndromic management of STIs is the complaint of AVD. However, the evidence suggests that the association between the complaint of AVD and the presence of STIs is weak (Patel & Oomman, 1999). A review of community surveys from South Asia reported that although over half of women have gynaecological complaints, less than half of them have laboratory-confirmed STIs. Studies in clinical settings in South Asia, where one might expect a higher proportion of women with STIs, also show that only about a quarter of women with AVD have a laboratory-confirmed STI. Thus, the current syndromic approach, which assumes AVD to be a marker for STI, is ineffective for the management of both the clinical syndrome and STI. The economic cost of syndromic management per true case of STI is enormous, while the social cost of incorrectly labelling a woman as having an STI is incalculable (Patel & Oomman, 1999).

The Stree Arogya Shodh

Why so many women in South Asia complain of AVD was the primary research question of the Stree Arogya Shodh (SAS; 'women's health study' in the Konkani language). This study, funded by the Wellcome Trust, was carried out in the state of Goa on the west coast of India between 2001 and 2004. The SAS was implemented through a partnership between a UK academic institution (the London School of Hygiene and Tropical Medicine), the government of Goa's health services department and Sangath, a Goan community-based non-governmental organisation pioneering mental health research projects (see <http://www.sangath.com>). The study was one of the largest population-based cohort studies of women's health in South Asia; it involved the collection of both interview-based

data and biological specimens. Altogether, 3000 women aged 18–45 years were randomly selected from the family registers of a primary health centre. Participants who consented were contacted by the research team on three occasions over a 1-year period: at enrolment, and 6 and 12 months later. Participation entailed a face-to-face interview (which lasted 40 min to 1 h) and collection of biological specimens (urine sample and/or vaginal swabs) for the diagnosis of STIs. The interview included the Revised Clinical Interview Schedule, a structured interview for use by lay interviewers which generates ICD-10 diagnoses of depression and anxiety disorders, and a checklist for somatic symptoms considered key features of somatoform disorders. In total, 2494 of the 3000 randomly selected women (i.e. over 80%) consented to participate, and over 80% of these women completed the 6- and 12-month reviews.

The aim of the study was to test the hypothesis that CMDs are associated with AVD. The findings of the study have been published in a number of key publications, which form the basis of this commentary. These publications report the baseline prevalence of AVD and CMDs and their association with each other (Patel *et al*, 2006a), as well as the risk factors for new episodes of AVD and CMDs observed during the follow-up phase (Patel *et al*, 2006b,c). Nested in the cohort was a qualitative study investigating the illness narratives of women with AVD (Patel *et al*, 2008).

Key findings

The baseline prevalence rates and 12-month incidence rates of the three health conditions are reported in Table 1. Abnormal vaginal discharge was confirmed to be a common complaint. In both cross-sectional and longitudinal analyses, independent associations were found (after adjustment for confounders) between AVD at baseline and poor mental health (both CMDs and other somatic complaints). In both cross-sectional and longitudinal analyses, younger age and indicators of social and gender disadvantage were associated with AVD. In turn, AVD at baseline was strongly associated with the onset of new episodes of CMDs. Sexually transmitted infections were not associated with AVD at baseline or longitudinally (though bacterial vaginosis, a little-understood endogenous reproductive tract infection, was).

In the qualitative study, women associated the onset of the complaint of AVD most often with menarche and the onset of menses. The complaint was felt to be closely associated with other physical complaints, especially weakness,

which was perceived to be both a cause and a result of the discharge. Multiple causal models were utilised; the most common causes were overwork and tension, two factors which were often related to each other. Biomedical causal models, including infections and contraception, were also commonly utilised. Many women sought healthcare, both biomedical and traditional, but treatments were often discontinued or changed due to lack of symptomatic relief, side-effects or costs.

Interpretation of findings

The complaint of AVD is very common, with more than 1 in 10 women experiencing it within the previous 3 months; STIs and CMDs affect about 1 in 20 women. Social disadvantage, particularly spousal sexual violence and economic difficulties, are important determinants of women's gynaecological and mental health. Current biomedical assumptions about the causes of gynaecological symptoms (for example, that the symptom of AVD is most commonly caused by STIs) are not valid in community settings. Poor mental health is an important correlate of such symptoms. Women who are suffering from CMDs and somatic complaints are more likely to develop new episodes of AVD; on the other hand, women with AVD are more likely to develop new episodes of CMDs. Thus, the relationship between AVD and poor mental health is bi-directional. The quantitative findings of this study match what women themselves tell us about their health: women closely link worries and tensions in their daily lives with their reproductive and sexual health. Several replications of this research are currently in progress, including studies in Palestine and Pakistan. One replication in Goa, with commercial sex workers, has also shown a strong association between mental ill-health and AVD (Shahmanesh *et al*, 2009).

Several mechanisms may explain these findings. Common mental disorders and poor mental health lead to gynaecological symptoms. We know that the most common illness experiences associated with CMDs are physical complaints. The process of somatisation, that is, the presentation of mental distress in physical forms, involves a number of mechanisms, including the misinterpretation of normal bodily experiences due to the heightened awareness associated with mental distress and heightened autonomic nervous system activity, which may increase the production of vaginal secretions. Gynaecological symptoms may be a cultural idiom to explain other physical complaints. Abnormal vaginal discharge is a genital secretion which is viewed with significance in terms of its perceived vitality in Asian cultures; in stressful life situations, women may perceive a normal physiological discharge as being abnormal, as a way to seek meaning for their unpleasant emotional and physical experiences (such as misery and tiredness, core features of CMDs) (Patel & Oommen, 1999).

The corollary syndrome of complaints of seminal discharge has been well documented among men in South Asia (the 'dhat' syndrome). Gynaecological symptoms can also lead to CMDs; this is more straightforward to understand. Thus, if a woman is experiencing AVD, this can be a source of personal distress and worry about its cause (e.g. whether it might be an infection). Such illness experiences and worries act as stressors, which make the woman more likely to develop a

Table 1 Baseline prevalence and 12-month onset rates (with 95% confidence intervals) of health conditions in the women participating in the Stree Arogya Shodh

Health problem	Baseline prevalence	12-month onset rates
Complaint of abnormal vaginal discharge	14.5% (13.1–15.9%)	6.9% (5.9–8.0%)
Sexually transmitted infection	4.2% (3.4–5.0%)	2.9% (2.3–3.7%)
Common mental disorder	6.6% (5.7–7.6%)	1.8% (1.3–2.4%)

CMD. Finally, it is plausible that both types of health problem, that is, both CMDs and AVD, are the result of severe social adversities in women's daily lives.

Implications of the Stree Arogya Shodh

The major implication of this study for health policy is that mental healthcare should be integrated in all health programmes targeted at women, in particular those for reproductive and sexual health. All health workers in reproductive and women's health programmes must be skilled in, and healthcare facilities adequately resourced for, the diagnosis and management of CMDs and somatoform disorders. There is a substantial evidence base that simple and affordable treatments (including antidepressant medicines and psychological treatments delivered by non-mental health professionals) are effective for the treatment of these disorders in low- and middle-income countries (Patel *et al*, 2007).

Further, there is a need to develop practical and affordable clinical algorithms for the management of AVD and STIs, and to improve the detection of CMDs; this would require the availability of cheap, bedside, diagnostic tests for STIs and bacterial vaginosis. At the very least, all primary health centres should have basic laboratory facilities and trained technicians for the diagnosis of bacterial vaginosis and should establish referral networks with appropriately equipped laboratories for diagnosis of STIs.

Programmes for mental health and reproductive health should enhance their focus on the needs of women living in socially disadvantaged circumstances, for example migrant women and those who live with violent partners. Assessment of violence should be made mandatory, particularly for married women; skills for delivering specific interventions to reduce sexual violence must be included in the training of health workers.

In conclusion, the complaint of AVD and STIs are among the most common health problems affecting women and are a priority in India's reproductive health programme. Although there is consensus that the syndromic approach is not suited

to the management of either health problem, there is, as yet, no evidence-based alternative approach. A critically important research priority is to evaluate the benefits of integrating mental healthcare within reproductive health programmes, targeting the syndrome of AVD. Ultimately, this will provide the most compelling evidence with regard to the importance of integrating mental healthcare within women's reproductive and sexual health programmes.

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COUNTRY PROFILE

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Psychiatry and mental health in Portugal

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Portugal is in the south-west of Europe; its territory includes the Azores and Madeira islands, giving it an area of 91 900 km². The total resident population of Portugal was 10 579 000 in 2006. The population density was 115 per km². The birth rate has been declining, from 20.0 per 1000 population in 1970 to 10.4 in 2004. Life

expectancy at birth in 2006 was 75 for males and 82 years for females. Healthy life expectancy at birth in 2003 was 67 and 72 years, respectively. The infant mortality rate decreased from 10.8 per 1000 in 1991 to 3.5 per 1000 in 2005. The median age of the population has been steadily rising.

Portugal has been a constitutional democratic republic since 1974. The main institutions of state are: President of the Republic, Parliament and government. First two are directly elected by the population. Since 2005, the Socialist Party has formed a government with an absolute majority of seats in Parliament.

Gross national income per capita is \$19960 (sums here and below are in international dollars, purchasing power parity, 2006). Total expenditure on health per capita is \$2080. The health budget represents 9.2% of gross domestic product.

Mental health policy

A mental health policy has been present since 1995, with advocacy, promotion, prevention, treatment and rehabilitation as aims. A substance misuse policy has been present since 1999, and an alcohol policy since 2000.

Ministerial Order 10464 (9 April 2008) set out the current national goals for mental health:

- permanent monitoring of the mental health status of the Portuguese population
- creation of programmes promoting the well-being, mental health, prevention, treatment and rehabilitation of people with mental illness
- organisation of mental health services for adults, children and adolescents
- articulation of psychiatric care with primary healthcare through an integrated continuous care network
- participation of both users and care providers in the rehabilitation and the social integration of patients with serious mental illnesses.

Mental health is one of the priority areas of the National Health Plan 2004–10. Special concerns are depression and alcohol misuse and dependence.

Mental health service delivery and resources

Decree Law 2118 of 1963 approved the principles of mental healthcare provision, and mental health centres were created in 1964. In the early 1970s, the need to integrate mental health services with the general healthcare system became obvious. Thus, in 1984, the General Directorate for Primary Healthcare was created, with a Division of Mental Health Services. Decree Law 127 of 1992 integrated these mental health centres into general hospitals, but this served to reveal problems within healthcare in relation to an over-dependence on the regional health authorities. After recommendations from the United Nations and the World Health Organization regarding an emphasis on community services, it was necessary to change the organisation of mental healthcare, to shift the focus to rehabilitation and social inclusion. Decree Law 36 of 1998 regulated the organisation of services in this sector and created a clear referral system alongside a community care network.

The following points summarise the current principles for the organisation of services, although these are still awaiting nationwide implementation:

- the referral model is that of community care

- local (or regional) mental health services are the base of the care system, together with primary care units and hospitals
- teams are multidisciplinary, and each serves a population of approximately 80 000
- primary care units are the basis for ambulatory services; in-patient and emergency care are both provided at hospitals
- social rehabilitation is carried out in conjunction with the state health sector, social security and employment departments
- psychiatric hospitals provide residential services and specialist in-patient care for patients who have no family or social support.

Portugal has 923 general psychiatrists (401 women, 522 men), 508 child and adolescent psychiatrists (242 women, 266 men), about 1000 psychiatric nurses, 160 social workers and 200 psychologists, organised in a mixed system where public (free) and private practice (supported either by the patients or by insurance companies) work together. Some private institutions and enterprises have service agreements with the public system. The majority of psychiatrists have their practice in both the public and the private domains. In private practice they are not obliged to have any type of service agreement with insurance companies or the public system.

In addition, psychiatric care is provided within the prison service and in the military forces.

Adult public psychiatric care is provided by 30 local health-care services, predominantly located in general hospitals. There are also one psychiatric hospital and three psychiatric centres (two in Lisbon and one in Coimbra).

Psychiatric training

Undergraduate psychiatric training is structured around two disciplines directly connected to psychiatry (general psychiatry and psychiatric practice) and two disciplines indirectly connected to psychiatry (basic psychology and medical psychology).

Postgraduate psychiatric training was recently modified. It is now focused not only on mental pathology but also on the influence of medical and surgical pathology on mental health and the influence of mental health on physical illness. We believe this will contribute to the humanisation of care and to the reinforcement of psychiatry's medical identity. The training is centred on diversity of professional experience. After 12 months of basic medical training, the trainee will have 60 months of training specifically in psychiatry. Of these, 48 months cover in- and out-patient care, day care facilities, drug addiction services, liaison psychiatry, old age psychiatry and forensic psychiatry. Three months are dedicated to neurology and another three to child and adolescent psychiatry. The last 6 months of training are on an optional area. Throughout, trainees must be integrated within a psychiatric emergency team.

Psychiatric subspecialties and allied professions

Child and adolescent psychiatry is organised as an autonomous specialty.

A new and first subspecialty of psychiatry – forensic psychiatry – is currently being developed by the College of Psychiatry of the Portuguese Medical Association (PMA).

Concerning allied professions, the public system offers professional careers to psychiatric nurses, psychologists, occupational therapists and social workers.

Psychotherapeutic training and certification are undertaken by the different psychotherapy societies.

Research and publications

Almost all research in psychiatry is undertaken within academia, with a few excellent exceptions coming from private research institutes. The main areas of research are focused on basic matters, on clinical domains and on mental health policies and services. There is no national policy or specific funding for this specialty. A few groups are involved in international research networks.

The first national Portuguese morbidity study is currently being conducted.

There are three well established and regularly published Portuguese journals of psychiatry and mental health (*Saúde Mental*, *Acta Psiquiátrica* and *Psiquiatria Clínica*) and a few internet-based facilities for exchange of scientific and clinical material.

Workforce issues

The PMA, through its Colleges of Psychiatry and Child and Adolescent Psychiatry, defines and supervises good psychiatric practice in both the public and the private domains. This is done through an ethical committee (elected every 3 years). The elaboration of the training programme and the nomination of three of the five examiners for the final examination of trainees (the one that credits them with the title of specialist) are also responsibilities of the PMA.

Several meetings of all psychiatrists have been held under the auspices of the PMA in order to help it better represent their professional interests.

Non-governmental organisations (NGOs) are involved with mental health and some of them have government support; they are active in areas such as suicide prevention, family support and anti-stigma programmes.

The pharmaceutical industry gives financial support to help general practitioners attend psychiatric training courses and offers information and supportive programmes on mental health and psychiatry for patients and their families.

Human rights issues

Several anti-stigma campaigns, mostly promoted by NGOs, have been implemented. Patients' rights are guaranteed by legislation, especially that concerning persons who are thought to need compulsory treatment (ambulatory or in hospital). Legislation has now begun to be applied to employment facilities for those with mental illness.

Future developments

Despite a profusion of legislation in recent years, the landscape of psychiatric care in Portugal remains almost unchanged. Apart from a few areas where community care exists and works, the reforms required for the better rehabilitation and social inclusion of chronic psychiatric patients remain the same as they were 20 years ago.

Palha & Marques-Teixeira (2009) conducted a national survey of rehabilitation facilities and practices for chronic psychiatric patients, and concluded that the present scenario is very far from patients' needs. Pita Barros & de Almeida Simoes (2007) similarly concluded that 'in Portugal we are still far from offering to all the population access to essential mental healthcare'. The main reason for this is the distance between mental health practice and the contents of the laws and guidelines.

Pressure from the profession will transform the current legislation into real psychiatric practice. However, some of these measures are already conceptually and practically out of date. Before implementation, their adjustment to the cultural, financial and traditional characteristics of Portugal is mandatory, as will be some adjustment to account for the experience of other countries that have already evaluated their outcome.

Finally, a national research policy is being demanded by Portuguese psychiatrists in the hope that, in the near future, the results of the reforms can be clearly evaluated.

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Mental health services in Croatia

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The Republic of Croatia is in central Europe, on the Mediterranean. A large majority of its 4 440 000 inhabitants are Croats (89.6%). The main religion is Roman Catholicism (88%). Sixteen per cent of the population is aged over 65 years. Croatia was a part of Yugoslavia after the Second World War until 1991, when Croatia declared independence. Following the declaration, Croatia was attacked by the Yugoslav army and by Serbia and suffered a devastating war (1991–95). The transition had consequences for mental health, for example a dramatic rise in the prevalence of post-traumatic stress disorder, especially among soldiers. The majority of soldiers received appropriate psychiatric treatment; there has, however, been an increase in claims motivated by secondary gain, as a result of government policy.

Croatia is a member of the United Nations, the Council of Europe and the North Atlantic Treaty Organization (NATO), and has applied to join the European Union (EU). The EU application is expected to help Croatia shift the focus of its mental health system to community psychiatry.

Mental health policy and legislation

Mental health policy is a construct of the overall health policy, under legislation from the Croatian Ministry of Health and Welfare (CMHW). Currently, two initiatives to define mental health policy are being developed by the CMHW and the Croatian National Institute of Public Health (CNIPH): the Croatian Alcohol Action Plan (2006) and the National Mental Health Strategy (2009).

The legislation stipulates that mental healthcare is to be provided at primary, secondary and tertiary levels. The primary level comprises general practitioners (GPs), school medicine specialists and mental health professionals in mental health centres and in public health institutes. The secondary level comprises mental health professionals, mainly psychiatrists. The tertiary level – the prevention of mental illness, the promotion of mental health, epidemiology and mental health statistics – is the responsibility of mental health professionals, the Croatian Institute for Mental Health and the CNIPH, and incorporates the Croatian Psychosis Registry, the Croatian Suicide Registry, and the Croatian National Registry of Treated Psychoactive Drug Addicts.

Other potential creators of the mental health policy, such as mental health professionals and mental service users' organisations, are only marginally involved.

The health budget is covered by social insurance and is tax based. There is no separate budget allocation for mental health, except for drug addictions. Basic healthcare is obligatory for all and is provided by the Croatian Health Insurance Institute. This covers the treatment of all mental illnesses and the cost of antipsychotic drugs. Supplementary and private insurance are possible but uncommon.

Mental health service delivery

Although GPs are highly accessible, psychiatric diagnoses comprised only 4.8% of all GP diagnoses in 2007 (CNIPH, 2008) and most service provision for serious mental illness is restricted to psychiatrists (Gater *et al*, 2005; Rojnic Kuzman *et al*, 2009a). For years, mental disorders have accounted for 6–7% of the overall hospital morbidity rate in Croatia. Most of these hospital admissions are for people aged 20–59 years, which makes mental illness one of the leading causes of hospital morbidity in the occupationally active age group and therefore one of the top health priorities (Fig. 1) (CNIPH, 2008).

Patients with a mental illness are largely cared for within hospital; 1 in 4–5 days of treatment provided in hospitals is for mental disorders (CNIPH, 2008). The therapeutic community movement has promoted the organisation of in-patient programmes and day hospitals. Today, the majority

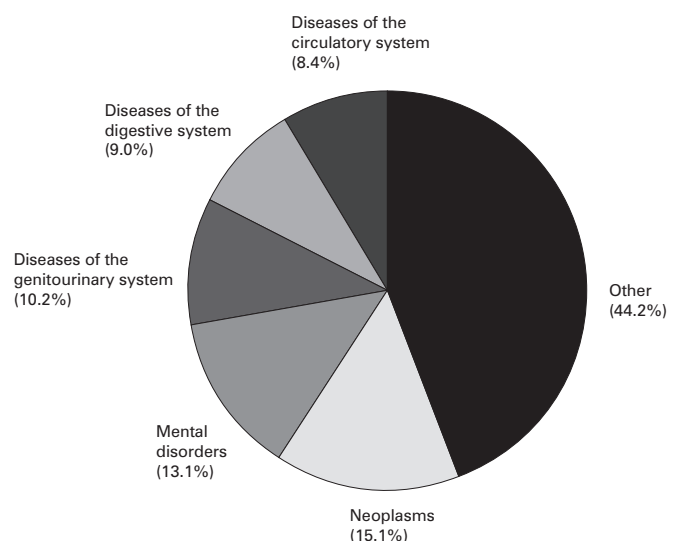


Fig. 1. Leading disease groups in hospital morbidity for the age group 20–59 years, Croatia, 2007.

of psychiatric wards and hospitals also offer day programmes for patients with various diagnoses. Unfortunately, this has not facilitated the deinstitutionalisation of patients as it did in the USA and Europe. After hospital discharge, the majority of patients are treated as out-patients; they generally visit a psychiatrist once a month, or more frequently in psychotherapy sessions. Group psychodynamic psychotherapy, for patients with various diagnoses, including psychosis, is practised in the majority of psychiatric institutions.

There are a total of 3421 psychiatric beds in psychiatric hospitals, plus 426 in psychiatric wards in general hospitals and 428 in university psychiatric departments. The average duration of hospital treatment is 48.8, 12.1 and 17.0 days in these institutions, respectively (CNIPH, 2008).

There are very few rehabilitation and employment programmes for those with severe mental illness. The exceptions include initiatives at the Mental Health Centre and the Community Rehabilitation Centre in Zagreb, some hospitals with programmes for patients in a first episode of psychosis, self-help groups for patients and interventions for the involvement of patients' families in therapy and case management programmes (Gruber *et al*, 2006; Ivezic *et al*, 2009). There are several active user groups for persons who are severely mentally ill and people with addiction problems, which may be able to offer more comprehensive programmes on housing and employment in the near future.

Child and adolescent psychiatry (CAP) services lack both infrastructure (adequate centres and hospitals) and specialists. Preventive work in the field of mental health and mental health promotion was delegated to the National Programme for the Prevention and Treatment of Drug Addiction and the Croatian National Programme Against Stigma (CNIPH, 2008; Ivezic, 2002), but the latter was never applied (Ivezic, 2002).

Overall, there is poor collaboration between care providers at the three levels of healthcare. Unfortunately, one of the most comprehensive mental health programmes, which was supported by the majority of mental health policy makers, was never implemented (Croatian Psychiatric Association *et al*, 2001).

Workforce issues

In Croatia, there are currently 389 psychiatrists, 47 neuro-psychiatrists and 105 psychiatric trainees. Psychiatrists work mainly in hospital in-patient and out-patient services. The few private psychiatrists in Croatia do not work additionally in the public health sector. Other mental health professionals include 1669 nurses, 130 psychologists, and 26 social workers and occupational therapists, working mainly in hospitals.

Education

The undergraduate medical programme is offered at four state medical schools; it lasts 6 years. After medical school and a 1-year internship, doctors obtain their licence by passing the state examination. Residency training usually follows. While waiting for a place on a residency programme, doctors usually work as GPs in specialised institutions or on scientific projects as research assistants. Postgraduate studies last 3 years.

Residency training in psychiatry follows the national programme developed by the Ministry of Health and Welfare. It lasts 4 years and comprises several parts: introduction (6 months), clinical psychiatry (18 months), alcoholism and addictions (3 months), psychological medicine (9 months), community psychiatry (5 months), forensic psychiatry (2 months), CAP (3 months) and neurology (3 months).

In two studies (Strkalj Ivezic *et al*, 2003; Rojnic Kuzman *et al*, 2009b), this programme was rated as generally unsatisfactory by the majority of residents. This is due to the lack of correlation between the training provided and the official programme outline, the inefficiency of the mentoring system, the lack of practical psychotherapy and funding issues. Together with training recommendations from the Union Européenne des Médecins Spécialistes (UEMS, European Union of Medical Specialists), these issues were addressed in the new residency training programme developed by an independent commission formed from representatives of the UEMS, academic staff and the Croatian Medical Chamber. This new programme was due to start in 2009.

To become a subspecialist, a psychiatrist enrolls in subspecialty training, according to a programme designed by the CMHW. There are five subspecialties in Croatia: biological psychiatry; child and adolescent psychiatry; forensic psychiatry; psychotherapy; and social psychiatry. In addition, national psychiatric associations continually organise education for the subspecialties.

The ability of nurses to specialise in psychiatry during their undergraduate study represents an advancement of the education system for mental health professionals.

Research and publications

Croatian residents show an interest in science – about a third of them attend postdoctoral studies and publish scientific papers during their residency training (Fig. 2) (Rojnic Kuzman *et al*, 2009b). However, research activities are somewhat discouraged among residents; for example, the majority of residents rarely go abroad for scientific education. Also, the cost of doctoral studies is high compared with salaries (Rojnic Kuzman *et al*, 2009b).

Research projects in the field of mental health are mostly funded by the Ministry of Science, Education and Sport and recently by international funding sources. As judged by the type of ongoing scientific projects and published scientific papers, the main areas of psychiatric research in Croatia include addiction, war-related anxiety disorders and post-traumatic stress disorder, pharmacogenetics and genomics, suicidality, pharmacotherapy, neuroscience, education and social psychiatry.

There are two professional scientific journals in the field of mental health: *Social Psychiatry* and *Psychiatria Danubina*.

International collaboration

Croatia is an associate member of the UEMS Board and Section of Psychiatry. The Croatian Psychiatric Association is a regular member of the World Psychiatric Association (WPA). In addition, Croatian residents and young psychiatrists are

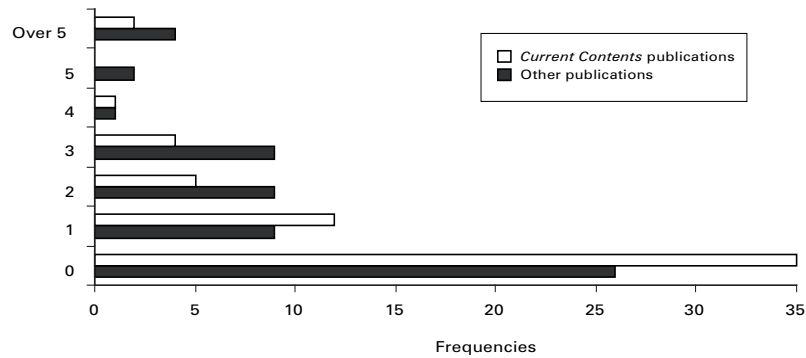


Fig. 2. Number of publications by Croatian residents, 2006 (n = 66, 89% of all psychiatric trainees in Croatia).

actively involved in the work of the European Federation of Psychiatric Trainees and thus the UEMS, and in the existing networks of young psychiatrists within the WPA and the European Psychiatric Association.

The World Health Organization (WHO) has an office in Zagreb. Croatia has a mental health representative in the WHO and collaborates with the WHO on many joint programmes, such the Stability Pact Initiative for the Development of Community Mental Health Centres, which resulted in the opening of the aforementioned Mental Health Centre and the Community Rehabilitation Centre in Zagreb.

On the other hand, few non-governmental organisations working in the field of mental health have participated in international programmes on stigma and human rights.

Conclusion

Despite the initiatives for the improvement of overall mental healthcare in Croatia in the past two decades, there is a need for organised mental health services in the community.

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COUNTRY PROFILE

Mental health services in Mexico

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Mexico is a culturally, socially and economically heterogeneous country, with a population of over 100 million. Although it is regarded as a country with a medium-high income according to World Bank criteria, inequality continues to be one of its main problems. In addition to this,

the country is going through a difficult period. Large parts of the population face economic insecurity, as a result of which feelings of despair, fear and impotence are common. It is hardly surprising, then, that mental disorders should constitute a major public health problem: depression is

the main cause of loss of healthy years of life (6.4% of the population suffer from it), while alcohol misuse is the 9th (2.5%) and schizophrenia the 10th (2.1%) most common health problem (González-Pier *et al*, 2006).

The Mexican health system

The Mexican health system is divided into three types of service provision.

First, social security provides services for the formal, salaried sector of the economy and covers 47% of the population. This type of security guarantees free access to healthcare and is financed through contributions from both employers and employees.

Second, those not covered by social security (45% of the total Mexican population), who are also the poorest, were long regarded as a residual group, for whom the Health Secretariat provided a poorly defined benefits package. In 2000, the Popular Insurance Scheme was created to provide protection for this vulnerable population. The intention was to expand the coverage of this insurance only gradually. Two kinds of mental health service are included under this scheme: preventive medicine and external consultation services. Beneficiaries of the Popular Insurance Scheme are entitled to receive treatment for the diseases included in the Universal Catalogue of Essential Health Services (CAUSES), which covers all the medical services provided at primary health centres and associated medication. In relation to mental health, CAUSES include: attention deficit disorder, eating disorders, alcohol misuse, depression, psychosis, epilepsy, Parkinson's disease and convulsive crises.

Third, there is a heterogeneous group of private service providers who attend non-insured families who are able to afford them and the population which, despite having some form of social security, is dissatisfied with the quality of services; this group accounts for just 4% of the population (Frenk, 2007).

Mental health services

Mental health policy and legislation

The main axes of the legislative and political actions related to mental health, formulated in 1983, were promotion, prevention, treatment and rehabilitation. In order to restructure these policies, consultations were carried out in 2001 with the participation of politicians, government officials, professionals, non-governmental organisations (NGOs) and patients. On the basis of these consultations, the 2001–06 Mental Health Programme of Action proposed an integrated care model. That programme, in addition to psychiatric hospitals, community health centres, day hospitals and intermediate residences, emphasises patients' rights and their social inclusion. Its main components are: strategies to reform existing services, mental health promotion and prevention, improving mental health training programmes for staff, and the encouragement of research work in this field.

The most recent National Health Programme (2007–12) proposes five social policy objectives:

- improve the population's health conditions
- provide efficient health services, guaranteeing quality, warmth and safety for the patient

- reduce health inequalities
- prevent the impoverishment of the population for health reasons
- guarantee that health will contribute to overcoming poverty.

On the basis of these objectives and in order to reinforce and lend continuity to the care model formulated in 2001, a proposal was made to create a national mental health network, comprising specialist units within primary care (UNEMES), organised on the basis of a community model. The aim is for these specialist units to offer out-patient services for timely detection, care and rehabilitation, while offering the necessary services for effective treatment. The aim is for UNEMES to function as the axis around which out-patient and community mental healthcare will function. They must therefore consist of multidisciplinary teams offering integrated care. In addition to their welfare functions, they will be an important space for health prevention and promotion, as well as offering training opportunities for other levels of care.

Although major efforts have been made in Mexico to advance the care of patients with mental disorders, the main challenge at present is to achieve the integration of mental healthcare into general healthcare programmes. This is the only way the gap between care and treatment needs will be bridged.

Mental health service resources

The Mexican mental health system has 0.667 psychiatric beds for every 10000 inhabitants. There are 0.51 beds in psychiatric hospitals plus 0.051 beds available at general hospitals for this same population rate. As for human resources, it is estimated that for every 100000 inhabitants there are 2.8 psychiatrists, 44 psychologists, 0.12 psychiatric nurses, 1.5 neurosurgeons, 1.2 neurologists and 0.20 social workers specialising in psychiatry (World Health Organization, 2005). As Fig. 1 illustrates, Mexico has a significant shortfall in resources compared with other countries on the American continent.

Organisation of services

There are three types of service at the primary healthcare level: mental healthcare modules integrated into general hospitals; health modules integrated into health centres; and psychiatric units integrated into general hospitals. However, many of these units or modules lack sufficient minimum personnel to be able to cover the demand for treatment; also, they are not uniformly distributed geographically.

At the secondary healthcare level, the Health Secretariat only has eight specialised mental healthcare units designed for out-patients and the provision of specialised psychological medical care. At this level of care, 41% of all institutional psychiatrists and psychologists are concentrated in Mexico City.

Lastly, there are the psychiatric hospitals. Mexico has 31 public institutions, distributed unevenly throughout 23 of the country's 31 states. The units operate on the basis of two main schemes: short and long hospital stays. Although these are their main activities, in recent years they have largely been devoted to specialist out-patient care, because of the high demand for and the limited supply of services of this nature. 'Day hospital management' is a concept that is currently being implemented at certain institutions. The experience has been satisfactory, since this form of management reduces the

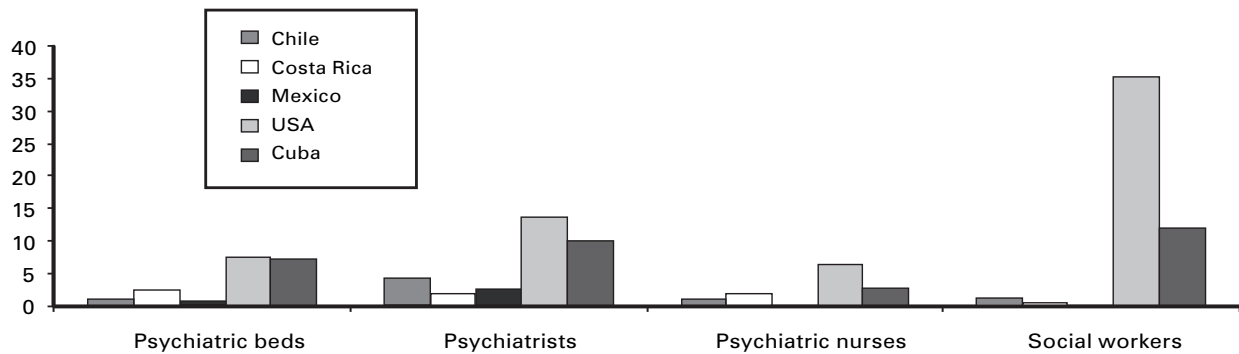


Fig. 1. Mental healthcare human resources per 100 000 inhabitants (does not include psychologists because the data are not available in Mexico) (World Health Organization, 2005).

number of relapses and increases patients' social inclusion (Secretaría de Salud, 2004).

In rural areas there are no local specialist mental healthcare institutions. A visit to the psychiatrist or psychologist may involve a day's travelling as well as considerable expense. Consequently, the rural population often consults traditional doctors and other informal agents.

Psychiatric training

The teaching of psychiatry in Mexico is relatively recent. The earliest psychiatry hospital residences began in 1948. In 1951 a clinical course was established at the National Autonomous University (Universidad Nacional Autónoma de México, UNAM); it is now a 3-year programme. Since 1971, the UNAM has offered specialist courses in the different areas of psychiatry and provides master's degree and PhD programmes.

In 1994, the UNAM with the National Academy of Medicine and other institutions created the Single Medical Specialisation Programme. This has been taught at all schools of medicine and medical faculties, which ensures that the academic course is standardised.

There is only one specialisation in psychiatric social work, taught at the National Institute of Psychiatry and coordinated by the UNAM. There are two formal courses for psychiatric nursing, one taught at the UNAM National School of Nursing and another at the Instituto Politécnico Nacional (IPN) School of Nursing. Courses are also taught after the basic nursing degree at Mexico's largest psychiatric hospitals and at the National Institutes of Neurology and Psychiatry.

Mental health research

Mental health research in Mexico faces difficulties due to the shortage of trained professionals and a lack of high-technology equipment. Despite this, various Mexican institutions undertake research in the clinical, neuroscience, epidemiological and social spheres of mental health.

The main clinical areas researched are genetics, clinimetry, neurochemistry, psychopharmacology, immunology, phyto-pharmacology, brain cartography and imaging. The most important fields of research in the field of neuroscience are: neurophysiology, chronobiology, neurobiology, bioelectronics, ethology and comparative psychology. The main lines of

research related to the epidemiological and social areas are: psychiatric epidemiology, health systems, drug dependence, suicide, violence, mental health in vulnerable groups and evaluation of intervention models.

Human rights and future challenges

In 1995, an official Mexican regulation for the provision of psychiatric services in medical care hospital units was issued. This regulation focuses on two areas: quality specialised medical care and the preservation of the user's human rights. This regulation fits in with the United Nations' Principles for the Protection of Persons Suffering from Mental Illness and for the Improvement of Mental Health Care (1991). One of the shortcomings of the Mexican regulation is that it fails to mention the rights of children and teenagers with mental illness, and it therefore needs revision.

Important advances have included increasing the budget to treat mental illness and the creation of innovative primary mental healthcare approaches. Nevertheless, the proportion of people suffering from mental diseases who receive treatment remains low. The greatest challenge is to expand coverage and achieve universal mental healthcare services, in order to reach the most neglected groups, but also to develop new, improved, culturally sensitive treatments that can meet the population's needs, fostering help seeking and treatment compliance.

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Psychotropic drug prescribing in a Nigerian psychiatric hospital

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Psychopharmacotherapy dominates the therapeutic arsenal of psychiatrists and, not surprisingly, psychotropic drugs are widely consumed in psychiatric practice. The pattern of prescribing of these drugs needs to be appraised in terms of 'rational drug use', which may be defined as 'the use of the least number of drugs to obtain the best possible effects in the shortest possible time and at a reasonable cost' (Gross, 1981).

Observations on prescribing practice can be the basis of useful biomedical research (Barbul & Tansella, 2005) and are a form of self-audit for hospitals (Edwards & Kumar, 1984). Several studies have noted variations in prescribing patterns in different settings (Xiang *et al*, 2007b). These variations (which may be related to poverty, lack of community resources and treatment adherence) and conformity with rational drug use in Nigeria were investigated in this study.

Methods

We enquired into the pattern of prescribing psychotropic drugs at the Uselu psychiatric hospital, Benin City, Nigeria, a 250-bed institution run by the federal government which serves an estimated population of 13 million.

We randomly chose a census day in March 2007 and extracted prescribing data on all 143 in-patients, none of whom had a physical disorder that might have influenced the psychotropic prescription. Five case files were excluded because the record was inadequate. The data collected were key demographic factors, type of medication, frequency of use and administration schedules of prescribed drugs, their mean daily doses, combinations, use of anticholinergics, 'when required' (p.r.n.) orders and monthly costs of the drugs to the patients.

The data were processed using SPSS version 10 and a 5.0% significance level was used for comparison of frequencies using chi-square statistics.

Results

Prescriptions of antipsychotics, anxiolytics, anticholinergics, antidepressants and mood stabilisers varied significantly across some demographic variables: gender, Kruskal–Wallis value (KW) = 13.76, d.f. = 4, $P < 0.001$; marital status, KW = 20.23, d.f. = 16, $P < 0.005$; age (10-year groupings), KW = 19.73, d.f. = 16, $P < 0.05$; and employment, KW = 21.51, d.f. = 8, $P < 0.05$. These distributions reflect the

characteristics of patients seen at the hospital rather than the specifics of prescribing practice there.

The survey revealed a high frequency of prescribing of conventional antipsychotics to all patients with functional psychotic disorders: 51.1% of these patients were prescribed haloperidol, 45.5% chlorpromazine, 38.5% trifluoperazine, 10.5% fluphenazine decanoate. There was less frequent prescribing of the atypical (second-generation) antipsychotics: 4.9% risperidone and 1.4% olanzapine.

Of the 15 patients with a depressive disorder, 10 were prescribed amitriptyline (a tricyclic antidepressant), three sertraline, one paroxetine and one fluoxetine. Regarding the mood stabilisers, for bipolar affective disorder, 15 patients were prescribed carbamazepine and 4 sodium valproate. One patient received a high dose (450 mg) of thioridazine.

The mean daily doses of all drugs prescribed were within acceptable therapeutic ranges for the respective diagnoses; however, there was a remarkable consistency in the p.r.n. duo of intramuscular chlorpromazine 150 mg and intravenous diazepam 30 mg for rapid tranquillisation of severely agitated patients. Generally we found no anomalies in the matching of drug types with diagnostic groups.

Polypharmacy was noted in 92.3% of all prescriptions, with 62.2% of patients being on antipsychotic/anticholinergic combinations (Table 1). The commonest adjunctive drug was an anticholinergic agent, benzhexol, which was noted in the prescriptions of 82.6% of patients placed on regular antipsychotics and was administered once or twice daily. The frequency of p.r.n. prescribing was 57.7% and was for patients with non-affective psychotic disorders, either for sedation or to control extrapyramidal reactions. The other major finding was that 36.4% of prescriptions were to be administered twice and 6.8% thrice daily.

The monthly costs of the typical antipsychotics prescribed varied between US\$2.44 for fluphenazine decanoate to US\$12.0 for thioridazine, while the generally preferred atypical antipsychotics cost much more: risperidone US\$17.00 and olanzapine US\$36.70. For the treatment of depression, the monthly cost of the most frequently prescribed antidepressant, amitriptyline, was US\$5.00, which is much cheaper than the selective serotonin reuptake inhibitors: sertraline US\$18.0, paroxetine US\$60.90 and fluoxetine US\$65.00.

Discussion

The most discernible practice was polypharmacy, as has previously been reported in Nigeria (Famuyiwa, 1988) and

Table 1 Drug combinations

Drug combinations	Number of prescriptions	Percentage of total
Antipsychotic alone	11	7.7
Antipsychotic + anticholinergic	89	62.2
Antipsychotic + anxiolytic	3	2.1
Antipsychotic + anxiolytic + anticholinergic	5	3.5
Antipsychotic + antidepressant	5	3.5
Anxiolytic + antidepressant	1	0.7
Antipsychotic + mood stabiliser	5	3.5
Antipsychotic + mood stabiliser + anticholinergic	13	9.1
Antipsychotic + antidepressant + anticholinergic	9	6.3
Antipsychotic + mood stabiliser + anticholinergic + anxiolytic	1	0.7
Anxiolytic alone	1	0.7
Total	143	100.0

in numerous other studies (see Cookson *et al*, 2002) but its rationale has been questioned, because of its high risk of dangerous interactions and the burden it imposes on both nurses and the patient, as well as carers. However, polypharmacy may be justified for some patients who are unresponsive to single-drug treatments, provided close monitoring for undesirable effects or toxicity is ensured (Broekema *et al*, 2007). Combinations of two or more drugs should generally be avoided, but if a combination is judged to be necessary then the drugs should belong to different chemical groups (Cookson *et al*, 2002).

The liberal use of anticholinergic drugs was probably due to the high rate of prescribing typical antipsychotics, as also reported in several other studies (Xiang *et al*, 2007a). Although anticholinergic drugs are useful in controlling extrapyramidal reactions, they may be misused by some patients, as they can give the experience of euphoria, and they can cause cognitive impairment (e.g. memory loss, particularly in the elderly), aggravate tardive dyskinesia and precipitate psychiatric symptoms (Cookson *et al*, 2002). The current consensus is that anticholinergic drugs should be administered only to patients who are experiencing extrapyramidal symptoms. However, the majority of patients on therapeutic doses of typical antipsychotics do not experience gross neurological side-effects.

Another significant finding was the high rate of p.r.n. prescribing, which was associated with high doses and polypharmacy, and should be discouraged. A Cochrane systematic review of randomised trials comparing 'as required' medication regimens with regular, fixed, non-discretionary regimens for schizophrenia found no evidence to support the common practice of p.r.n. prescription (Chakrabrati *et al*, 2007). The other objection is that the attending nurse may not have the requisite expertise to decide on the appropriateness and safety of extra doses. Thus, p.r.n. prescribing may be appropriate for unpredictable patients but, in terms of safety, it is good practice for the prescriber to specify indications for each p.r.n. dose, for example 'one hour delay in falling asleep', or to restrict the maximum number of doses within a given period, for example 'not more than 3 p.r.n. doses in 24 hours'.

Tranquillisation with parenteral antipsychotics should be avoided, although this is rather impracticable in a low-income country, due to staff shortages and high case-loads. Relating multiple administration to daily schedules (e.g. three times daily) is pharmacologically not justified because most psychotropic drugs have a long biological half-life; furthermore, it consumes considerable nursing time.

A notable feature was the low prescription rate for atypical antipsychotics, despite their efficacy and satisfactory side-effect profile. The clinicians were apparently aware that the large majority of patients had a low income (the minimum wage in Nigeria is US\$54 per month), hence they were unwilling to prescribe them, but curiously they are comparable in efficacy to some typical antipsychotics (Gureje *et al*, 2007).

Overall, the pattern of prescribing psychotropic drugs observed was similar to that in several other low- and medium-income countries. Increasing sensitivity to patients' needs had led to a number of ameliorative measures. For instance, education of prescribers by the use of a manual (Baker *et al*, 2008), routine checks by and feedbacks from pharmacists on adherence to rational drug use and a combination of education and reminders on medication charts (Thompson *et al*, 2008) have been found to be useful. However, presently in Nigeria, as perhaps elsewhere in sub-Saharan Africa, such feedback seems impracticable, in that most pharmacists are in private practice and hence have no statutory links with psychiatric hospitals. Alternatively, measures to stress the importance of rational drug use should be in place in psychiatric training curricula and prescribing guides for clinicians.

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State of indigenous mental health in Australia – a colonial legacy?

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The Aboriginal culture of Australia is one of the oldest cultures on earth, dating back 50 000 years. The Aboriginal and Torres Strait Islander (ATSI) people are the indigenous inhabitants of Australia, constituting 2.4% of the population. The health status of these 'First Australians' has been described as a source of national shame, with the life expectancy approximately 17 years lower than that of other Australians (Eades, 2000). This gap in life expectancy is also significantly larger than that of other countries with indigenous populations and a history of colonisation, such as the USA, Canada and New Zealand (Ring & Firman, 1998). This paper offers an overview of the impact of colonisation and its subsequent influence on the social and emotional well-being of ATSI people.

Culture and history

Colonial domination ... is made possible by the negation of national reality, by new legal relations introduced by the occupying power, by the banishment of the natives and their customs to outlying districts by colonial society, by expropriation, and by the systematic enslaving of men and women. (Fanon, 1963)

Aboriginal mental health cannot be separated from its historical context. Australia was colonised by the British in 1788. At this time there were 300 000 Aborigines with 250 distinct languages. Aboriginal society was collectivistic, with extended family clans and traditional kinship structures governed by a set of social laws, customs, rituals and cultural beliefs which differed from one clan to the other. Land was central to the concept of the Aboriginal self. The advent of the British led to the declaration of Australia as 'Terra Nullius' (no man's land), followed by several years of conflict, marginalisation and forced acculturation, with resultant loss of traditional society, religion, law, land and cultural identity. One of the most detrimental policies was the forcible removal of 'half-caste' Aboriginal children from their families and sending them away to work for non-indigenous

people with the aim that they would, over time, 'merge' with the non-indigenous population. This began in the 19th century and became public policy in the 20th century; it was still in place as late as 1970. Many hundreds of thousands of children suffered psychological distress through loss of family and culture, physical and sexual abuse, exploitation and institutionalism (HEREOC, 1997). The catastrophic effects of this policy have been highlighted in the *Bringing Them Home* report, some of which include identity issues, lack of trust and intimacy, delinquency, high rates of depression and suicide, and poor parenting and relationships, thus establishing a vicious circle, producing the 'stolen generations'. This policy, which has been described as genocide (Totten et al, 2007), continues to exert its influence on the psychological well-being of Aboriginal people through intergenerational transmission. It was only in 1967 that Aboriginals were afforded the status of citizens of Australia; previously they came under the Flora and Fauna Act.

Aboriginals continue to maintain strong links to their traditional culture and lands. Data from the 2002 National Aboriginal and Torres Strait Islander Social Survey revealed that 54% identified with a clan or tribal group, 22% currently lived on traditional lands, 68% had participated in cultural events in last 12 months and 14% did not speak English as their primary language (see <http://abs.gov.au/ausstats/abs@.nsf/cat/4714.0>).

Social and emotional well-being of Aboriginal Australians

Aboriginal concepts of mental health are holistic, as illustrated in the following quotation from the *Ways Forward* report on ATSI mental health:

Health does not just mean the physical well-being of the individual but refers to the social, emotional and cultural well-being of the whole community. This is a whole of life view and includes the cyclical concept of life–death–life. (Swan & Raphael, 1995)

This differs from the definition of health given by the World Health Organization (WHO), which does not include the cultural and spiritual dimensions. In view of this, the WHO in 1999 proposed a definition of health for indigenous peoples of the world that does encompass the spiritual, intellectual, physical and emotional domains.

There are significant cultural variations in the expression of psychiatric illness among Aboriginal people, which influences assessment, diagnosis and management. These variations stem from the fundamental difference in the concept of health, that is, a holistic concept as opposed to the Western mind–body dichotomy. Thus, Western models of mental illness do not always apply to Aboriginal illness beliefs and can lead to misdiagnosis and inappropriate treatment. Illness is often attributed to external forces linked to family, land, spirituality and culture, with healing proceeding through traditional methods underpinned by cultural explanatory models of illness. Many mental illnesses in Aboriginal people may fall under the DSM definitions of ‘culture-bound syndromes’ (Westerman, 2004).

Indigenous Australians are 1.5 times more likely than non-indigenous Australians to report at least one stressor, according to the Australian Bureau of Statistics General Social Survey (see <http://www.abs.gov.au/ausstats/abs@.nsf/cat/4159.0>). The most common stressors are the death of a family member or close friend (46%), serious illness or disability (31%) and inability to get a job (27%). The mortality rate from mental health conditions is twice that for other Australians. Half of all ATSI people who die are aged less than 50 years. This results in repeated grief for families, along with loss of significant elders to maintain the traditional culture. Their hospitalisation rates for mental illness are twice those of non-indigenous Australians (Centre for Mental Health, 2007).

Although the proportion of Aboriginals who drink is lower than that of the rest of the population, those who do drink do so at above recommended guidelines, in a binge-drinking pattern. They are also twice as likely to report being a recent drug user as non-indigenous Australians, with cannabis the main drug of misuse. Violence, child abuse and incarceration are more likely to be experienced by ATSI people and trends suggest that this may have become worse over the past decade (Australian Health Ministers’ Advisory Council, 2006).

The poor mental health of ATSI people is due to a combination of genetic, historical, political, cultural and social causes. These include the intergenerational transmission of trauma, unresolved identity issues, political policies resulting in sociocultural dislocation and high mortality rates from physical illness resulting in high rates of grief and loss in communities. From a service point of view, indigenous people do not access mental health services at a level that reflects their needs and the main burden is therefore taken over by primary care services. The causes of poor access to mental health services are summarised in Box 1.

Mental health policy

The current mental health policy is based on the Social and Emotional Well Being Framework 2004–09 and the National Mental Health Plan 2003–08. It has been recognised that health policies need to acknowledge the trauma and grief

resulting from past policies and that this should also be incorporated within their development. Furthermore, they should support self-determination, recognise historical and cultural diversities within communities and be based on culturally valid understandings of health. In addition, several other steps have been taken to acknowledge the grief and trauma experienced by ATSI people. These include the reconciliation policy, the *Bringing Them Home* report dedicated to the stolen generations, the ‘Close the gap’ policy aiming to close the life expectancy gap and, most recently, the apology on 12 February 2008 by the Prime Minister, Mr Kevin Rudd, on behalf of the federal government to the stolen generations for the past atrocities.

The future

Before colonisation, the Aboriginal people had an active lifestyle, with little indication of the high rates of obesity, diabetes, renal disease, hypertension and coronary heart disease that are so rife today (Jackson & Ward, 1999). For a discussion of the causes of poor health and low life expectancy I would refer readers to Durie (2003).

Aboriginal mental health is currently in a dire situation; there are high mortality rates due to mental illness, high rates of violence, substance misuse and child sexual abuse, in the context of poor socio-economic conditions. There are no clear solutions, but it has been acknowledged that there should be a greater focus on improving access to mental health services. Mental health services need to work closely with Aboriginal communities as principal stakeholders in order to develop culturally sensitive mental health services (Box 2).

However, as proposed by Durie (2003), political and socio-economic changes may be more important in changing the health status of ATSI people. Political policies continue to be controversial and perceived by many ATSI people as discriminatory and racist, with ongoing disputes over indigenous rights and sovereignty. On 21 June 2007, in response to a damning report about widespread child abuse, the federal government sent troops, police officers and medical teams to 73 indigenous communities in the Northern Territory, resulting in welfare payments being ‘quarantined’ and bans on alcohol and pornography introduced. There followed protests

Box 1 Barriers to mental health services

- 1 General attitude of mistrust due to past associations of health services with removal of children and discriminatory treatment perpetuated by current racism and negative staff attitudes
- 2 Limited ‘mental health literacy’ in Aboriginal communities
- 3 Inadequate Aboriginal mental health workforce
- 4 Relative poverty of Aboriginal people and geographical isolation
- 5 Culturally insensitive models of healthcare delivery (e.g. failure to use a holistic model of health)
- 6 Inadequate awareness by mental health services of the historical, community and cultural factors related to Aboriginal mental health
- 7 Lack of necessary knowledge and skills among non-Aboriginal mental health clinicians to work effectively with aboriginal young people

Source: Centre for Mental Health (2007).

Box 2 Components of a culturally sensitive mental health service for indigenous Australians

- 1 Increasing cultural competencies among mental health professionals (e.g. interviewing skills, cultural etiquette) to reduce the cultural disparity between client and practitioner
- 2 Developing and utilising culturally appropriate diagnostic tools (e.g. the Westerman Aboriginal Symptom Checklist, WASC)
- 3 Increasing mental health literacy by incorporating culture-specific models of illness in management
- 4 Utilising cultural consultants, Aboriginal mental health workers and community elders as standard practice throughout mental health services working with indigenous people
- 5 Incorporating culturally appropriate treatment options, which may include traditional methods of healing, at an appropriate level

Adapted from Westerman (2004).

throughout the country against the legislation, which has nonetheless been backed by the new government. The United Nations independent envoy, Professor James Anaya, was reported as saying on 27 August 2009 that Australia is breaching its international human rights obligations by continuing the Northern Territory intervention:

In my opinion, as currently configured and carried out, the emergency response is incompatible with Australia's obligations under the convention of elimination of forms of racial discrimination and the international convention on political rights. (See <http://www.abc.net.au/news/stories/2009/08/27/2668915.htm>)

Australia was also one of the four countries that voted against the Declaration of Rights of Indigenous Peoples (which sets out the individual and collective rights of the world's 370 million native peoples) adopted by the United Nations General Assembly in September 2007, although 143 countries voted for it. (On 3 April 2009 Australia did in fact reverse its previous policy and backed the Declaration, which is, however, not legally binding.)

Without political cooperation, a collective change in the societal psyche acknowledging the trauma and grief, and without social inclusion, it is difficult to see how the current negative health status can be reversed. If the current trend persists, Australia is staring at the disappearance of one of the most ancient cultural heritages in the world.

Acknowledgements

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NEWS AND NOTES

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

College African Division's session at the WPA regional meeting

From 22 to 24 October 2009, a regional meeting of the World Psychiatric Association (WPA) is due to take place, hosted jointly by the African Association of Psychiatrists and Allied Professionals (AAPAP) and the Association of Psychiatrists in Nigeria (APN), in Abuja, the capital city of Nigeria. The theme of the conference is 'Scaling Up and Reaching Down: Addressing Unmet Need For Service'. The sub-themes will focus on gender, poverty, HIV/AIDS and human rights.

It is certain to be a very special event, with psychiatrists and mental health workers expected from Africa, Europe, the USA and elsewhere. There will be a special Royal College of Psychiatrists session during the conference. There will be special programmes, such as a health policy roundtable, involving the ministers of health of countries in the region. There will also be a leadership training workshop for young psychiatrists, a training workshop on child and adolescent mental health, and a workshop on research methodology. Visitors will be able to enjoy guided tours of the scenic city of Abuja and surrounding areas. For more information, visit the conference website, <http://www.nomadafrica.com/wpinfo>.

European Pact on Mental Health and Well-Being

In June 2008, the European Pact on Mental Health and Well-Being, an intersectoral statement on mental health action in Europe, was launched at the High Level Conference 'Together for Mental Health and Well-Being' by the European Commissioner for Health. The Pact focuses on five thematic priority areas:

- prevention of depression and suicide
- youth, education and mental health
- mental health in workplace settings
- mental health and older people
- combating stigma and social exclusion.

Preparations for the High Level Conference included the writing of four background papers (consensus papers) in four of the priority areas, as well as a research paper on the fifth priority area. The papers were produced through a consultation process which aimed to include as many and as varied stakeholders in each priority area as possible.

The Pact is now entering its implementation phase, in which stakeholders and policy makers in each of the five areas are encouraged to promote mental health and well-being. This will continue through 2009 and 2010.

The Pact will be implemented through a series of five thematic conferences in each of the priority areas, which will be hosted by member states in partnership with European Commission bodies and other stakeholders.

- 29–30 September 2009, Mental Health in Youth and Education, Stockholm, Sweden
- 10–11 December 2009, Prevention of Depression and Suicide, Budapest, Hungary
- 21–22 April 2010, Mental Health in Older People, Madrid, Spain
- 8–9 November 2010, Mental Health in Workplace Settings, Berlin, Germany
- second semester 2010, Combating Stigma and Social Exclusion (details to be confirmed).

A wide variety of stakeholders and experts will be asked to engage with the process and get involved in these events.

Further information is available at <http://www.ec-mental-health-process.net/index.html> and http://ec.europa.eu/health/ph_determinants/life_style/mental/mental_health_en.htm.

Hong Kong College of Psychiatrists

The Hong Kong College of Psychiatrists is one of the 15 constituent colleges of the Hong Kong Academy of Medicine, which is the statutory body responsible for overseeing the provision of specialist training and continuing medical education. The objectives of the College include:

- to promote the study and advancement of the science and practice of psychiatry and ancillary sciences and branches of medicine
- to contribute to the improvement of mental healthcare for Hong Kong citizens through the provision of specially trained psychiatrists
- to ensure the highest professional standard of competence and ethical integrity in psychiatry.

This year, the Hong Kong College of Psychiatrists, in collaboration with the Institute of Psychiatry, King's College, University of London and Department of Psychiatry, University of Hong Kong, have co-organised the First Southeast Asia Maudsley Forum, scheduled for 3–5 December 2009 in Hong Kong. The course offers a friendly environment in which to learn about advances in psychiatric research. Similar courses have been established for a decade at the Institute of Psychiatry in London, and more recently also in Italy. The course is designed for junior specialists, psychiatric trainees and clinical psychologists. The programme will comprise a series of informal seminars focused on current research in a number of fields in psychiatry and clinical psychology. A panel of over 12 distinguished overseas and local clinician-scientists will discuss the most recent developments in clinical and academic psychiatry in an interactive setting. We hope that one outcome may be the establishment of future collaborations across Asia and the world.

News from the College Middle Eastern Division

The Middle Eastern Division announces the forthcoming regional meeting 'Mental Health: The Way Forward', to be held in Baghdad, 12–14 November 2009. For further information please email sabahsadiq@gmail.com.

Following a visit to Baghdad in July 2009 by Professor Robert Howard, Dean of the College, an agreement was reached with the Iraqi Council for Medical Specialisations to establish Baghdad as a training and examination centre for the international membership. Collaborative work is continuing with the College officers to put systems in place.

New mental health law in Egypt

In May 2009, the Egyptian Parliament adopted the new Law for the Care of Mental Patients. Mental health law reform is particularly timely in Egypt, given the country's ratification in April 2008 of the United Nations Convention on the Rights of Persons with Disabilities, which includes rights provisions for persons with mental health disabilities.

A civil society organisation, the Egyptian Initiative for Personal Rights, participated in a vigorous advocacy campaign with the Ministry of Health to ensure that the new law protects the rights of people with mental health disabilities. The Ministry of Health, through the Mental Health Secretariat, is committed to finalising the code of practice for the legislation by November 2009, with the following provisions:

- tight legal criteria specifying the circumstances in which a person can be detained in mental health institutions
- the right of a detained patient to have the lawfulness of detention reviewed by a local court
- an obligation upon mental health institutions to notify the public prosecutor within 24 hours of the involuntary admission of a patient
- a right to consent to treatment for 'voluntary' patients
- a requirement that doctors document and periodically review treatment plans
- a more restrictive definition of the circumstances in which solitary confinement and physical restraints can be used

- a bill of rights for patients in mental health facilities
- an obligation on mental health facilities to inform patients of their rights
- the creation of a patients' rights committee in every mental health facility to monitor the human rights of people receiving treatment in those institutions
- an explicit stipulation of the participation of civil society organisations in these patients' rights committees
- a range of sanctions for service providers who violate patients' rights
- monitoring bodies providing an independent review of involuntary admissions
- the establishment of a mental health fund to ensure sustainable financing for mental healthcare, including capacity building for those working in mental health.

Master's degree in mental health policy and services

The International Master on Mental Health Policy and Services is a Universidade Nova de Lisboa initiative, developed through the Faculdade de Ciências Médicas, in collaboration with the Department of Mental Health and Substance Abuse of the World Health Organization. The degree is a 2-year course in two parts: the first one, with 60 credit points under the ECTS (European Credit Transferring System), will award a diploma from the Universidade Nova de Lisboa; the second one, with another 60 ECTS, will award the master's degree, after approval of a scientific dissertation. The qualification will strengthen the capacity of low- and middle-income countries to improve the mental health of their populations. Further information is available at <http://www.fcm.unl.pt/masterint>.

CORRESPONDENCE

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EFPT conference

Sir: It was a privilege to assist in hosting the European Federation of Psychiatric Trainees (EFPT) conference this July, based in the historic setting of Clare College, Cambridge. The EFPT is an international psychiatry training organisation, composed of delegates from member countries' national training organisations. The UK hosted the conference this year, as the outgoing president of the organisation, Amit Malik, was a British delegate. Over 80 delegates attended, from 31 countries in an ever-broadening Europe.

Before the conference, delegates were invited to attend a local academic day, hosted by the University Department of Psychiatry. This included a tour of the old asylum in Cambridge, and a visit to the Personality Disorder Service and the modern hospital, as well as the new University Department of Psychiatry.

The conference programme began on 8 July, with talks about the EFPT's history and links with other psychiatric organisations. Country reports outlining the processes of training in member countries dominated the afternoon session, providing an overview of psychiatry training across Europe.

The academic session was held on the morning of 9 July. Distinguished speakers, largely from the Royal College of Psychiatrists, were invited to talk about their areas of expertise. Highlights included Professor Robin Murray, who talked about causes of psychosis; Professor Dinesh Bhugra, the College President, who challenged trainees to think about professionalism; and Dr Joan Marsh, who talked about how to get published.

Two further sessions were used for setting up working groups, where delegates from different nations brainstorm and come up with new insights into an area of common interest. These working groups do most of the work of the EFPT. Ideas are born and later bear fruit in the electronic contact between delegates following the meetings. They concentrate on a large range of topical issues, including research, establishing new trainee organisations, psychotherapy, and

child and adolescent psychiatry. Working groups were partly chaired by expert members of the College.

The General Assembly was held on 11 July, with minutes approved from last year's session in Gothenburg, and a taster of what is to come in Croatia in 2010. Board reports were received from the European Board of Psychiatry (UEMS). This was followed by election of the board.

The conference was extremely well organised, thanks largely to the efforts of Amit Malik and Clare Oakley, current chair of the Royal College's Psychiatric Trainees Committee. We were grateful to receive support from the Royal College of Psychiatrists and the University of Cambridge Department of Psychiatry. The chief executive of the local National Health Service trust as well as the deputy mayor attended the garden party. It was enlightening for members to compare training experiences and to work together to improve training standards. There was much to compare and contrast, for example access to psychotherapy, and training in child and adolescent psychiatry. Trainees were overwhelmingly positive and enthusiastic about sharing experiences and forging international links. The future of European psychiatry appears to be in safe hands, judging by the quality and commitment of EFPT delegates.

Meinou Simmons

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The mental health problems of Iraqi refugees

Sir: Despite the mass atrocities and organised violence experienced by millions of Iraqis since 2003, there is limited discussion and research on the impact of war on the mental health of displaced and exiled Iraqis, including those refugees living in neighbouring countries. This is surprising, since the effects of war

and traumatic life events on mental and physical health are well established. For instance, Bhui *et al* (2006) found higher rates of mental disorders among refugees who experienced life-threatening traumatic events than among those who did not experience such events. Similarly, Steel *et al* (2002) found that exposure to events in one or more trauma categories resulted in a twofold increase in risk of mental illness, but exposure to events in three or more trauma categories led to a four- to sixfold increase, compared with those exposed to no traumatic events.

The Pan Arab Conference of Psychiatry in 2008, held in Damascus, Syria, where most of the Iraqi refugees are, highlighted the plight of Iraqis with mental health needs (Essali, 2008). For example, one presentation of data from the UNICEF clinic in Damascus suggested that almost 11% of the refugee Iraqi children presented to this clinic with symptoms of post-traumatic stress disorder (Jahshan, 2008). Although there was no actual survey of the psychiatric problems of the Iraqi refugees, the meeting of the Arab Federation of Psychiatrists suggested that the main theme of the next Pan Arab Conference should be the mental health needs of Iraqis and Iraqi refugees. This is a reflection of the level of concern over the mental health needs of this group. The mental health and social care professionals working in the regions where there is a large presence of Iraqi refugees have been calling for improved mental health services for both displaced Iraqis and refugees, but there has been little international response to date (Essali, 2008).

There is a clear necessity for a comprehensive study to assess the mental health needs of Iraqi refugees. We need to know the scale of the problem. Data on gender and group vulnerabilities to psychological problems among Iraqis are limited. Much more information is urgently required to establish mental health services for these groups. The international community has a duty to address the mental health needs of traumatised Iraqis in order to reduce the kind of disability and impairment problems associated with war and conflict. There are also many Iraqi doctors and mental health professionals, who must be encouraged and mobilised to deliver culturally sensitive mental health services.

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Kerala fundraising trek, 2009

Sir: In January 2009 I was one of 14 who went to Kerala on a 5-day trek to raise money for the College Volunteers Programme. We were 11 psychiatrists and three non-psychiatrists (who happened to be carers

of family members with mental health problems). We started from coastal Kerala and climbed close to 9000 feet over the mighty mountains of Munnar into Tamil Nadu, covering almost 130 km. The walk was tough but the scenery was breathtaking. We had the opportunity to visit a village school in the mountains and make a contribution to their education. We also visited the Trivandrum Mental Health Centre, which gave us the opportunity to see what mental health services look like in India. We were impressed by what we saw and witnessed some examples of good practice, such as accommodation facilities for visiting relatives. We were also able to appreciate the challenges they faced in terms of funding and stigma. For many, this was the first time they saw what services in a low-income country looked like. We also were able to meet some patients. Part of the group went on to conduct a workshop in Sri Lanka, which was well received.

We stayed in tents for the entire duration of the trek and were looked after very well by our organisers and guides. The food was excellent. A few of us knew each other before the trek but many first met on the trip. Very soon, however, we got on really well and now feel as if we share a close bond with each other. It worked like the ultimate team-building exercise and we feel committed as a group to volunteer work in mental health and are already talking about the next trek. Some have suggested that it should be in the Shillong region in India, where I have started a volunteer project.

The trek was part of the College President's appeal when Professor Sheila Hollins was leaving office in 2008. She successfully completed the trek herself and handled many of its organisational aspects when in India. The trek raised an impressive sum – over £30 000 – for the Volunteers Programme. This will be used for bursaries for volunteers to visit to low- and middle-income countries. The Programme currently supports placements in Africa, Iraq and other parts of the world but has until now lacked funds. I was amazed by how successful the trek was and think that it is an excellent way not only to raise funds but also to raise the profile of the Programme. It brought together some committed people who can be called upon again in the future.

The trekkers were: Chris Dobson, Sally Pidd, Carol Henshaw, Elspeth Bradley, Adrienne Regan, Brian Martindale, Carola Mathers, Dale Mathers, Adil Akram, Sheila Hollins, Martin Hollins, Karen Stevens, Sally Browning and Allen Kharbteng.

Allen Kharbteng

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Correspondence is welcome either on articles published in *International Psychiatry* or on aspects of current policy and practice in psychiatry in different countries. Letters (of up to 500 words) should be sent to:

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email ip@rcpsych.ac.uk.

Forthcoming international events

22–24 October 2009

WPA Sponsored Regional Meeting

Abuja, Nigeria

Organiser: African Association of Psychiatrists

and Allied Professions in collaboration with the Association of Psychiatrists in Nigeria

Contact: Dr Oye Gureje

Email: ogureje@comui.edu.ng

Website: <http://www.nomadafrica.com/wpinfo>

27–30 October 2009

The 2nd Eastern European Psychiatric Congress

Moscow, Russian Federation

Contact: Vadim Morozov

Email: alex@travelmoscow.ru; paeeb2009@gmail.com

Website: <http://en.paeeb2009moscow.ru/invitation/>

4–8 November 2009

17th World Congress on Psychiatric

Genetics: 'Surfing the Wave of Discovery from Molecule to Mind'

San Diego, USA

Organiser: International Society of Psychiatric Genetics (ISPG)

Email: lynn.delisi@med.nyu.edu

Website:

<http://cme.ucsd.edu/psychiatricgenetics>

7–10 November 2009

2nd World Congress of Asian Psychiatry, 'Working Together for Excellence of Asian Psychiatry'

Taipei, Taiwan

Organiser: Asian Federation of Psychiatric Associations (AFPA) in collaboration with the Taiwanese Society of Psychiatry (TSP)

Contact: Prof. N. Shinfuku

Email: shinfuku@seinan-gu.ac.jp

Website: <http://www.2ndwcap.org.tw/>

12–15 November 2009

10th World Congress of the World Association of Psychosocial Rehabilitation

Bangalore, India

Organiser: World Association of Psychosocial Rehabilitation

Contact: Dr Afzal Javed; Dr T. Murali

Email: afzal@afzaljaved.co.uk;

muralithyloth@gmail.com

Website: <http://www.wapr.info>

19–22 November 2009

1st International Congress on Neurobiology and Clinical Psychopharmacology

Thessaloniki, Greece

Organiser: International Society of

Neurobiology and Psychopharmacology

Contact: Konstantinos N. Fountoulakis

Email: info@globalevents.gr

Website: <http://www.psychiatry.gr/congress/>

26–27 November 2009

The Forgotten Children – addressing the subject of children of parents with a mental illness

Vilnius, Lithuania

Organiser: European Federation of Associations of Families of People with Mental Illness (EUFAMI)

Email: incoming@westexpress.lt

Website: <http://www.eufami.org>

26–28 November 2009

XIV Annual Course on Schizophrenia

Madrid, Spain

Organiser: General University Hospital 'Gregorio Marañón' of Madrid; International Society for Psychological Treatments of Schizophrenias and Other Psychoses

Contact: Viajes Iberia Congresos

Email:

sec.tecnica@cursoesquizofreniamadrid.com

Website:

<http://www.cursoesquizofreniamadrid.com>

26–29 November 2009

First International Congress on Neurobiology and Clinical Psychopharmacology and European Psychiatric Association Congress on Treatment Guidance

Thessaloniki, Greece

Organiser: International Society on

Neurobiology and Psychopharmacology (ISNP)

Contact name: Dr Kostas N. Fountoulakis

E-mail: kfount@med.auth.gr

Website: <http://www.psychiatry.gr>

3 December 2009

4th International Congress on Brain and Behaviour and 17th Thessaloniki Conference

Thessaloniki, Greece

Organiser: International Society on Brain and Behaviour

Contact name: Mrs Athanassiadou

Email: salonica@triaenatours.gr

Website: <http://www.isbb.gr>

3–5 December 2009

The First Southeast Asia Maudsley Forum

Hong Kong, China

Organisers: Institute of Mental Health, King's College, University of London; Department of Psychiatry, University of Hong Kong; Hong Kong College of Psychiatrists

Contact: Ms Sabrina Hung

Website: <http://www.hkpsych.org.hk>

3–6 December 2009

AAAP 20th Annual Meeting & Symposium

Los Angeles, USA

Organiser: American Academy of Addiction Psychiatry

Email: annualmeeting@aaap.org

Website: <http://www.aaap.org>

10–14 January 2010

International Preparedness and Response to Emergencies and Disasters – IPRED 2010

Tel Aviv, Israel

Contact: Dr Bruria Adini

Email: info@ipred.co.il

Website: <http://www.ipred.co.il/English/>

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