

# International Psychiatry

<i>Guest editorial</i>	
Challenging times for mental health services Matt Muijen	1
<i>Thematic papers – Mental health services in primary care</i>	
Introduction David Skuse	3
Integrating mental health into primary care: the policy maker's perspective and experience in China Yu Xin, Liu Jin and Ma Hong	3
Integrating Egyptian mental health services into primary care: the policy maker's perspective Nasser Loza	5
Mental health in primary healthcare in Chile Alfredo Pemjean	7
<i>Country profiles</i>	
Psychiatry in Jamaica Frederick W. Hickling	9
A decade of mental health services in Timor-Leste Zoe Hawkins	11
Mental healthcare in Serbia Dusica Lecic Tosevski, Saveta Draganic Gajic and Milica Pejovic Milovancevic	13
<i>Original papers</i>	
Alcohol dependence syndrome in women: an Indian perspective Chauhan Ashutosh, Bapat Radhika, Tharoor Hema, Sinha Mrigaya, Chauhan Sudhindra and Sharma Podilla Satya Venkata Narsimha	15
Pattern of attempted suicide in Babylon in the last 6 years of sanctions against Iraq Ali Abdurrahman Younis and Hamdy Fouad Moselhy	18
<i>Special paper</i>	
Cultural influence on psychoeducation in Hong Kong Vanessa Wong	20
<i>News and notes</i>	22
<i>Correspondence</i>	23
<i>Forthcoming international events</i>	26

## Editor

Hamid Ghodse

## Deputy editor

David Skuse

## Associate editor

Christopher Szabo

(Editor, *African Journal of Psychiatry*)

## Editorial board

John Cox

Rachel Jenkins

Nasser Loza

Amit Malik

Shekhar Saxena

## Administrative support

Joanna Carroll

## International Advisory Board

Dr Michel Botbol *France*

Prof. Haroon Rashid Chaudhry  
*Pakistan*

Prof. George Christodoulou  
*Greece*

Prof. Tatiana Dmitrieva *Russia*

Dr Donald Milliken *Canada*

Dr Gholam Reza Mir-Sepassi *Iran*

Prof. R. N. Mohan *UK*

Dr Olufemi Olugbile *Nigeria*

Dr Vikram Harshad Patel *India*

Dr Allan Tasman *USA*

Prof. John Tsiantis *Greece*

Prof. Yu Xin *China*

## Subscriptions

*International Psychiatry* is published four times a year.

For subscriptions non-members of the College should contact:

Publications Subscriptions Department,  
Maney Publishing, Suite 1C, Joseph's Well,  
Hanover Walk, Leeds LS3 1AB, UK  
tel. +44 (0)113 243 2800;  
fax +44 (0)113 386 8178;  
email [subscriptions@maney.co.uk](mailto:subscriptions@maney.co.uk)

For subscriptions in North America please contact:

Maney Publishing North America, 875  
Massachusetts Avenue, 7th Floor, Cambridge,  
MA 02139, USA  
tel. 866 297 5154 (toll free);  
fax 617 354 6875;  
email [maney@maneyusa.com](mailto:maney@maneyusa.com)  
Annual subscription rates for 2010 (four  
issues, post free) are £28.00 (US\$50.00).  
Single issues are £8.00 (US\$14.40), post free.

Design © The Royal College of Psychiatrists  
2010.

For copyright enquiries, please contact the  
Director of Publications and Website, Royal  
College of Psychiatrists.

All rights reserved. No part of this publication  
may be reprinted or reproduced or utilised  
in any form or by any electronic, mechanical  
or other means, now known or hereafter  
invented, including photocopying and  
recording, or in any information storage or  
retrieval system, without permission in writing  
from the publishers.

The views presented in this publication do not  
necessarily reflect those of the Royal College  
of Psychiatrists, and the publishers are not  
responsible for any error of omission or fact.

The Royal College of Psychiatrists is a charity  
registered in England and Wales (228636) and  
in Scotland (SC038369).

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

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

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

## Notice to contributors

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

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

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

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

### About our peer-review process

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

### Mission of *International Psychiatry*

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

# Challenging times for mental health services

**Matt Muijen MD PhD**

Regional Adviser for Mental Health, World Health Organization Regional Office for Europe, email [mfm@euro.who.int](mailto:mfm@euro.who.int)

**W**e are living in significant and challenging times for mental health services across the world. On the one hand, many countries are in the middle of comprehensive reforms of their mental health systems, and these require funding (WHO Europe, 2008). On the other, they are affected by the global financial crisis as regional and national economic recessions threaten to herald a social crisis in many countries. Governments have had to come up with multi-billion-dollar rescue packages. At an individual level, debt status is already high in many countries, owing to falling house prices and high consumption levels, combined with rising commodity prices during the past few years, before the onset of the recession. At a public level, countries will be forced to make stringent cuts in public sector expenditure.

## Consequences of the crisis

The crisis has several consequences for the mental health of the population. Loss of employment and risk of unemployment are associated with increases in stress, anxiety, depression and psychotic disorders. An economic crisis and loss of employment are also associated with an increase in suicide (Stuckler *et al*, 2009). Debt is particularly important as a factor causing depression. In a national survey of private households in England, Scotland and Wales, a clear link between debt and poor mental health was found (Jenkins *et al*, 2008).

In low-income countries, loss of jobs can cause absolute poverty (in contrast to the relative poverty it causes in high-income countries), with potentially disastrous consequences for health, including mental health (Commission on Social Determinants of Health, 2008). Access to healthcare can be restricted, and the risk of debt increased, especially in the many lower-income countries where assessment and treatment, including the purchasing of medication, demand some out-of-pocket payment, whether formally or not.

For people with severe mental disorders, the large majority of whom are already unemployed and at risk of living in poverty (Aro *et al*, 1995; Harvey *et al*, 2009), the consequences will be different. There is less evidence that the prevalence of these disorders is directly affected by an economic crisis, but opportunities for integration may diminish yet further, and stigma and discrimination may grow. Unemployment increases competition for placements in protected workplaces or social firms, which will be tempted to select the more able, and this heightens further the risk of exclusion for the most vulnerable people. The emphasis on finding paid employment for those with mental health problems, so important for their self-respect and social inclusion, may be undermined in an increasingly restricted job

market. Companies struggling to make a profit may become more sensitive to any perceived risks of lower productivity on the part of present or future employees, even if that perception is based on irrational grounds in many instances, such as a history of depression.

## Mental health services

These social and economic developments are taking place at a point in time when mental health services are in transformation. The past 5 years have seen a high level of mental health policy and service development (WHO Europe, 2008). Almost all of the 53 European member states of the World Health Organization (WHO) now have mental health policies that aim to deliver community-based mental health services along the priorities of the Helsinki Declaration (WHO Europe, 2005). There is consensus that crisis and home care services need to be established alongside small-scale hospital units, empowering users and carers. Many countries are now at the point where investments are essential if these policies are to be put into practice, rather than remaining aspirational. Only a few countries presently have supported the development of community services targeting vulnerable groups, and these are typically the countries where investment in mental healthcare was high even before any reform.

A particular challenge at an international level is the tremendous variation in existing provisions, despite the convergence of policies. Whether one considers numbers of hospital beds, admissions, psychiatrists or nurses, all vary many-fold, even between neighbouring countries. Particularly in poorer countries, staff essential for the effective operation of community services, such as social workers and psychologists, hardly exist. Unsurprisingly, the strongest predictor of provision of services is the level of funding, which is in turn correlated to the wealth of the country (Shah, 2009), but efficient investment is equally important. Many poor countries spend a very large proportion of their mental health budget on a relatively small number of hospital beds, benefiting few (WHO Europe, 2008).

Although further investment is essential at this stage of development, many governments are facing the need to reduce expenditure. Public sector spending will be scrutinised and cuts made in areas not considered a political priority, and the severity of the cuts will depend on the overall economic health of the country as much as the perceived importance of the service.

Unfortunately, mental health services are interdependent, and the closure of one component will affect all other parts. For example, cuts in social services can shift some of the burden of care to health services, particularly for

young and elderly people. The most dependent are particularly vulnerable, since the evidence of efficiency of intensive support services is rarely available or accepted, especially in lower-income countries. Specifically, community mental health services are often cut, since their disappearance does not involve the closure of hospitals on which local economies depend. The consequence will be that services which aim to reduce the need for admission will have reduced capacity, putting growing demand on more expensive institutional services. This in turn means that primary care services will be swamped by people with severe mental disorders, and will therefore not be able to deal with common problems that are particularly important from a population and economic perspective, such as depression and anxiety. The effects on health as a whole and on mental health specifically are both inequitable and inefficient.

## Effective interventions for mental health during a financial crisis

How a nation protects its health has a significant effect on its economic competitiveness and prosperity. An example of a sensible response is the high profile given to the consequences for the economy of the spread of the H1N1 flu virus, and the willingness of countries to invest in prevention and early intervention. If the comparative burden of disease and the social and economic impact of mental disorders are considered, a strong case is made for investment in mental health capital.

Effective approaches are needed to respond to the damaging consequences of an economic recession and its negative impact on mental health at individual and societal levels. Interventions must therefore address social, public health and individual needs.

At a societal level, considering the direct link between employment, income, status and mental health, supply-side economic measures will benefit mental health, especially infrastructure investments that create jobs, and the provision of universal and free health coverage (Sen, 2009).

At a provider and individual level, a recession is a time to protect essential community services for the most vulnerable and to advocate the development of additional evidence-based interventions, such as the provision of meaningful activities for unemployed people with mental health problems, the screening of people at risk, the training of family doctors in the detection and treatment of depression, and better access to therapies.

A future is not some place we are going, but one we are creating. The paths to it are not found but made and the activity of making them changes both the maker and the destination.

*John Schaar*

The economic crisis requires us to focus on mental health priorities and effective interventions if we are to make a convincing case for sustained, let alone additional investment. The temptation for politicians, who are facing tough decisions about cuts in healthcare, is to select 'soft' areas that do not result in public outcries, and to ignore existing inequalities such as the conspicuous high mortality rates of people with mental disorders (Hiroeh *et al*, 2008). Our challenge is to change mental health into a 'deserving' priority area by demonstrating existing inequities, the further damage of cuts to individuals and society, and the benefits of new investment. There is place for some optimism, since an increasing number of countries are committed to mental health reform, which now has to be accelerated and sustained. This will prove to be a crucial test for mental health advocates, but the increasing effectiveness of international networks in raising awareness makes successful reform more likely.

## Acknowledgement

I would like to acknowledge the support of Dr Anja Baumann in the preparation of an earlier version.

## References

- Aro, S., Aro, H. & Keskimäki, I. (1995) Socio-economic mobility among patients with schizophrenia or major affective disorder. A 17-year retrospective follow-up. *British Journal of Psychiatry*, **166**, 759–767.
- Commission on Social Determinants of Health (2008) *Closing the Gap in a Generation*. WHO.
- Harvey, S. B., Henderson, M., Lelliott, P., *et al* (2009) Mental health and employment: much work still to be done. *British Journal of Psychiatry*, **194**, 201–203.
- Hiroeh, U., Kapur, N., Webb, R., *et al* (2008) Deaths from natural causes in people with mental illness: a cohort study. *Journal of Psychosomatic Research*, **64**, 275–283.
- Jenkins, R., Bhugra, D., Bebbington, P., *et al* (2008) Debt, income and mental disorder in the general population. *Psychological Medicine*, **38**, 1485–1493.
- Sen, A. (2009) Capitalism beyond the crisis. *New York Review of Books*, **5**, 27–30.
- Shah, A. (2009) The relationship between socio-economic status and mental health funding, service provision and national policy: a cross-national study. *International Psychiatry*, **6**, 44–46.
- Stuckler, D., Basu, S., Suhrcke, M., *et al* (2009) The public health effect of economic crises and alternative policy responses in Europe: an empirical analysis. *Lancet*, online DOI: 10.1016/S0140-6736(09)61124-7.
- WHO Europe (2005) *Mental Health Declaration for Europe*. WHO Europe. Available at <http://www.euro.who.int> (accessed October 2009).
- WHO Europe (2008) *Policies and Practices for Mental Health in Europe*. WHO Europe. Available at <http://www.euro.who.int> (accessed October 2009).

It may seem a strange principle to enunciate as the very first requirement in a Hospital that it should do the sick no harm.

*Florence Nightingale, English nurse,  
Notes on Hospitals (1863 edn), preface*

# Mental health services in primary care

David Skuse

Behavioural and Brain Sciences Unit, Institute of Child Health, London, UK, email [dkuse@ich.ucl.ac.uk](mailto:dkuse@ich.ucl.ac.uk)

In the UK, only 13% of people with long-term mental health problems are in employment, compared with 35% generally of people with a disability (Royal College of General Practitioners, 2005). Nearly 2.6 million individuals receive incapacity benefit and/or severe disability allowance and, of these, close to 1 million are claiming incapacity benefit due to mental ill health. The management of this enormous number of people – providing support to them and helping them get back into employment – is an issue that cannot be addressed adequately by our specialist mental health services. Accordingly, other models of service delivery need to be considered. The three thematic papers in this issue look at this issue from the perspective of three highly contrasting societies.

First, there is a fascinating report by Professor Yu Xin together with colleagues Liu Jin and Ma Hong. They are based in Beijing, and discuss the way in which China is attempting to deal with such problems in the decades after the end of the Cultural Revolution and the emergence of a very different social revolution. As the structures of the old society disintegrated, both literally and metaphorically, health services became increasingly hospital-based; the model of the barefoot doctor was consigned to history. But it has recently been recognised that building a strong primary care infrastructure is essential, especially in mental health. We learn how this is being implemented.

In Egypt, which is not particularly well supplied with psychiatric services relative to the size of its population, people with mild mental health problems are supported primarily by their extended families, whereas those with more serious disorders are admitted to hospital. An ambitious plan, by which

mental healthcare was to be integrated with primary care, came about through a collaboration with the government of Finland. Unfortunately, as Nasser Loza points out in his report, the principle of treating people with serious mental illnesses in the community was not welcomed by the population at large, nor by psychiatrists, who felt they were at risk of losing influence and income. The subject is still under discussion, with no clear progress.

Finally, we do have a remarkable success story, in the form of an initiative in Chile, which could serve as a model for countries with far better developed health services. Alfredo Pemjean reveals the way in which bold and novel moves to reorganise mental healthcare have empowered primary care practitioners and enabled them to work more closely with specialist colleagues from hospital services, in order better to serve the population with mild to moderate disorders. While there are many strengths in the Chilean system, Dr Pemjean also points out that there are still outstanding weaknesses, which will need to be addressed in due course. One important problem, a recurring issue in these thematic papers, concerns the necessity of integrating community self-help with professional services; the value of building links between the public and psychiatric services is easier said than done.

## Reference

Royal College of General Practitioners (2005) *Position Statement: Mental Health and Primary Care*. RCGP. Available at [http://www.rcgp.org.uk/PDF/clinspec\\_printed%20version%20mental%20health.pdf](http://www.rcgp.org.uk/PDF/clinspec_printed%20version%20mental%20health.pdf) (accessed November 2009).

## THEMATIC PAPER – MENTAL HEALTH SERVICES IN PRIMARY CARE

# Integrating mental health into primary care: the policy maker's perspective and experience in China

Yu Xin, Liu Jin and Ma Hong

Peking University Institute of Mental Health, China, email [yuxin@bjmu.edu.cn](mailto:yuxin@bjmu.edu.cn)

In China, 'community' was an alien word. Many people used to live in dormitories (*Danwei*), to which they were assigned by government according to their work units. 'Dormitory form' community was closely linked to where

people worked, and thus administration and supervision were simple, as was the provision of health services. In each *Danwei*, a clinic provided basic healthcare not only for its employees but also for the other residents of the

dormitory. The old primary care service was based on this. In fact, the 'golden age' of community mental healthcare was at that time, when psychiatric hospitals extended their service to communities via the *Danwei's* clinics in the cities and via 'barefoot doctors' in the rural areas. Home beds, occupational therapy stations and shelter factories were set up in some cities and mobile mental health teams played important roles in the villages. Although this did not really represent the 'integration' of mental health into primary care, it was a good example of maximising the utilisation of the very limited mental health resources by stretching the psychiatric service, using administrative power, and mobilising family members (Shen *et al*, 1990; Zhang & Yan, 1990; Zhang, 1999).

## Period of reform

The economic and political reform in China that started in the 1980s brought many Chinese people wealth but promoted the collapse of old communities and the formation of new communities to which people can freely choose to move, if they can afford it. However, the construction of primary healthcare services has never caught up with this expansion of new communities (Liu *et al*, 2006). Since the health input mainly went to the big hospitals, primary healthcare, including mental healthcare, was largely ignored by the medical service (Li *et al*, 2005). Patients with a mental illness were invisible, other than if they murdered someone or did some other awful act in the neighbourhood. Part of the job of the local police was to identify any mentally ill people deemed prone to violence and to send them to a psychiatric hospital.

The pathway from community-based care to tertiary care was not well-established. The deficiency was exposed during the outbreak of SARS (severe acute respiratory syndrome, which nearly became pandemic in 2002–3): because the primary healthcare system did not work as a gatekeeper, people were able to rush directly to tertiary hospitals, where they could either become infected or infect others (Hu, 2003; Li & Hu, 2004). The government was aware of the importance of community healthcare and prepared to reform the whole system (Central People's Government, 2006). However, the challenges were huge, especially in the case of mental health. First, primary health provision in the communities faced the twin barrier of poorly trained staff (most of them had never received any training in mental health) and poorly equipped clinics. Second, neither social security nor medical insurance covered any expenses except for medication and hospitalisation – mental health services in communities such as follow-up, day care, family support, occupational therapy and social training were not covered. Third, social stigma was the big barrier: primary clinics were reluctant to provide mental healthcare and most communities were not happy to share health resources with patients who were mentally ill (Yang *et al*, 1998).

## Trials of integration

There are presently two big trials in China investigating the integration of mental health into primary care. Both are led by the Ministry of Health but under different departments.

One trial is trying to lead psychiatric institutions to extend their service into the communities. Mental healthcare in China is mainly hospital-based: individuals are admitted to psychiatric hospitals at their first episode, on either a voluntary or an involuntary basis. There they are medicated and there they return at the second and subsequent episodes. They may eventually become permanent residents of these institutions. It has been estimated that, of the moderately or severely disabled individuals with a diagnosable mental illness, only 8% have ever sought professional help, and only 5% have ever seen a mental health professional (Phillips *et al*, 2009).

It was high time to change the hospital-based mental health service model to the community-based one so as to cover more untreated individuals with psychoses. The trial known as the '686 Programme' started in 2005 to explore a hospital–community integrated service model for people with psychoses (Ma *et al*, 2009); it has now spread to 112 sites with a catchment population of 96.88 million.

A national public health policy which is being implemented aims to improve the competence of primary health workers in the care of people with chronic diseases such as hypertension, diabetes and psychoses (Ministry of Health, 2009). The financing of this policy is on a per capita basis: 15 yuan per person yearly. The fund will subsidise primary health workers for disease management according to their performance (Ministry of Finance, 2009).

## Prospects for further reform

We do not know which model the government will apply to build up the community mental health system. What we do know is that the Chinese government is determined to accomplish this.

Psychiatric institutions themselves need to figure out how to move on. They face two disadvantages: first, most Chinese psychiatric institutions are isolated from mainstream medicine, both academically and geographically; and second, the training curriculum for psychiatrists is mainly biologically orientated (Ministry of Health, 2008). The two factors make Chinese psychiatry difficult to transform.

The integration of mental health into primary care requires not only organisational restructuring: it also requires a competence and willingness to undertake the obligation. Psychiatrists should be good communicators, collaborators, educators, organisers and leaders when they walk out of their hospital office into the community. Billions of yuan will be reallocated to community health construction in the next 3 years and billions more were due to be earmarked for disease management in the community at the end of 2009. However, the building of a qualified workforce has not been included in any financially aided projects or programmes.

The switch from hospital-based mental health services to primary care services in the most populous country in the world is certainly a tough job. Lessons and experiences learnt from Italy, Commonwealth countries and the United States may smooth the process, however. We expect that, as a result of the transition, patients' rights will be protected, continuity of treatment ensured, social stigma decreased and social recovery promoted.

## References

- Central People's Government (2006) Premier Wen Jiabao addressing the National Conference on Preventing and Treating SARS. Available at [http://www.gov.cn/ztl/content\\_355339.htm](http://www.gov.cn/ztl/content_355339.htm) (in Chinese) (accessed 1 September 2006).
- Hu, J.-T. (2003) President Hu Jintao addressing the National Conference on Preventing and Treating SARS. *Chinese Rural Health Services Administration*, **23**, 3 (in Chinese).
- Li, S. & Hu, S.-Y. (2004) Discussion on crisis and rebuilding of the Chinese public health system. *Chinese Health Services Management*, **20**, 335 (in Chinese).
- Li, Y.-H., Yao, X.-W. & Zhang, M.-Y. (2005) Investigation and suggestion on community rehabilitation facilities for psychotic patients in Shanghai. *Shanghai Archives of Psychiatry*, **17** (suppl.), 35–37 (in Chinese).
- Liu, Z.-J., Legge, D., Pei, L.-K., et al (2006) Developing community health services, revitalizing urban primary healthcare. *Chinese General Practice*, **13**, 1047–1049 (in Chinese).
- Ma, H., Liu, J. & Yu, X. (2009) Development and interpretations of Chinese mental health policies in the last decade. *Chinese Journal of Mental Health*, **23**, 840–843.
- Ministry of Finance (2009) Central finance allocating RMB10.4 billion of subsidy for basic public health service in 2009. Available at [http://www.mof.gov.cn/mof/zhengwuxinxi/caizhengxinwen/200907/t20090706\\_176613.html](http://www.mof.gov.cn/mof/zhengwuxinxi/caizhengxinwen/200907/t20090706_176613.html) (in Chinese) (accessed 30 October 2009).
- Ministry of Health (2008) *China. Report Compilation of Policy Researches on Mental Health*. People's Medical Publishing House (in Chinese).
- Ministry of Health (2009) National basic public health service criteria. Available at <http://www.moh.gov.cn/publicfiles/business/htmlfiles/mohfybjysqwss/s3577/200910/43183.htm> (in Chinese) (accessed 30 October 2009).
- Phillips, M. R., Zhang, J.-X., Shi, Q.-C., et al (2009) Prevalence, treatment, and associated disability of mental disorders in four provinces in China during 2001–05: an epidemiological survey. *Lancet*, **373**, 2041–2053.
- Shen, Y.-C., Zhang, W.-X. & Chen, C.-H. (1990) Familial and social prevention and treatment, and social rehabilitation of psychotic patients. *Shanghai Archives of Psychiatry*, **2**, 108–111 (in Chinese).
- Yang, W.-Y., Su, L., Wang, H.-J., et al (1998) Comparison of attitudes and views of psychiatric patients between lay persons and mental health professionals. *Journal of Clinical Psychological Medicine*, **6**, 333–335 (in Chinese).
- Zhang, M.-Y. & Yan, H.-Q. (1990) Community rehabilitation, and prevention and treatment work for psychoses in Shanghai. *Shanghai Archives of Psychiatry*, **2**, 114–118 (in Chinese).
- Zhang, W.-X. (1999) Observation of community rehabilitation in 926 cases of schizophrenia in trial cities. *Chinese Journal of Rehabilitation*, **14**, 255–256 (in Chinese).

### THEMATIC PAPER – MENTAL HEALTH SERVICES IN PRIMARY CARE

# Integrating Egyptian mental health services into primary care: the policy maker's perspective

Nasser Loza

Secretary General for Mental Health, Ministry of Health, Egypt; Director, Behman Hospital, Cairo, Egypt, email [nloza@behman.com](mailto:nloza@behman.com)

Egypt has a population of roughly 80 million, served by about 9000 psychiatric beds, 1000 psychiatrists (one psychiatrist per 80 000 citizens), 1900 psychiatric nurses and about 200 clinical psychologists (Okasha, 2004). Service providers fall into three main sectors: public, private, and not-for-profit non-governmental organisations (NGOs). The public sector is managed essentially by the Ministry of Health and bears the brunt of service provision.

Egypt has 15 state psychiatric hospitals, with a capacity of roughly 7000 patients. Sixty per cent of in-patients have been continuously resident for 5 years or more. Out-patient services are hospital-based, with no community input. Psychiatrists run the clinics, with minimal multidisciplinary input. NGOs offer mostly out-patient services. Their affiliations to socio-political or religious groups often influence the treatment philosophy. Private psychiatry offers a contrast: with a population of patients well supported by their family networks and a collaborative, multidisciplinary approach, these institutions offer services that are not affordable for the average Egyptian.

## System reform

The Health Sector Reform Programme was started in 1997 and is funded until 2018 by the United States Agency for International Development, the European Union, the World Bank and the African Development Bank. This programme is the backbone of the development of healthcare and health financing in the country and is a high priority at the Ministry of Health. It emphasises family-oriented primary healthcare. However, until recently, mental health received little attention from the programme and the donor community.

A long-term bilateral developmental programme between the Egyptian government and the government of Finland initiated a Mental Health Programme in Egypt in 2002. Growing international interest and the World Health Organization's declaration of the year 2001 as the Year of Mental Health helped to bring mental health to the forefront of healthcare. With so few mental health professionals working in the field, primary healthcare was recognised as a resource capable of delivering services in the community. The

Table 1 Length of stay of patients in Abasseya psychiatric hospital

	Duration of stay (years)								Total
	0–5	6–10	11–15	16–20	21–30	31–40	41–50	51–60	
Number (%) of patients	618 (54.0%)	129 (11.3%)	139 (12.2%)	86 (7.5%)	110 (9.6%)	41 (3.6%)	9 (0.8%)	12 (1.0%)	1144

collaboration between the Ministry of Health, represented by the Mental Health Secretariat, the Finnish donors and the Health Sector Reform Programme identified goals for improving mental health. These included the integration of mental health into primary care and into the Basic Benefit Package for family health, with its essential drug list, which included antidepressants and anxiolytics. The collaboration produced a strategy for mental health and provided a comprehensive assessment of needs, which was used for revising mental health policy in Egypt.

The strategy for mental health addressed issues of basic training, continuing education, practice guidelines, supply of medication, support, supervision, health information systems, liaison between primary care and specialist care, and links to other sectors in an acceptable cultural and social context. It was designed to meet local needs and to use the strengths of existing services and personnel. However, the strategy did not gain public or political acceptance, because it did not address the lack of public awareness of mental health issues, the stigma of mental illness or, most importantly, the need to move psychiatric care from the asylums to the community. The current situation remains one of essentially hospital-based services, with patients staying up to 60 years in hospital (Table 1 illustrates this with the case of patients in Abasseya, Cairo's largest psychiatric hospital).

In 2006, a public awareness project was started by the Mental Health Secretariat to address this. Marketing and image consultants were commissioned to design a national campaign targeting the general public and specific groups, namely school children and patients' relatives. One of the achievements of this cultural change was the ratification of the Mental Health Act in May 2009 by the Egyptian Parliament. The parliamentary debates and the accompanying media attention presented an opportunity to highlight the needs of psychiatric patients and the importance of care in the community and hence the role of primary care in providing services to psychiatric patients.

## The role of primary care in the delivery of mental healthcare

A number of psychiatric illnesses of mild to moderate severity can be diagnosed and managed by trained general practitioners (Culpepper, 2002). This can reduce the stigma of mental illness, a worldwide problem but particularly relevant in the Middle East. Bringing services closer to patients in the community facilitates access, consistent with the principles of equity of access to care. It also encourages adherence to treatment and follow-up.

Attempts to integrate psychiatry into primary healthcare have not been straightforward. Psychiatry in Egypt is viewed by the public as a highly specialised branch of medicine, and patients do not consider it part of primary healthcare.

Primary care physicians do not receive adequate training to prepare them for the task; medical curricula offer limited training in psychiatry and there is little postgraduate training in general practice. There was also a degree of resistance from psychiatrists, keen on protecting their practice.

The current Ministry of Health policy is to include mental health in the Basic Benefit Package of family health practice and some psychotropic medications are now included in the essential drug list. The new guidelines for mental health in primary care for physicians are based on guidelines from the World Health Organization and the training curricula for physicians, nurses, social workers and health educators.

Recently, a pilot project for the integration of mental health into primary care was started in five governorates as part of the Health Sector Reform Programme. This included training conducted with follow-up, supervision and a referral system to secondary care in order to support primary care physicians. So far the programme has trained 642 physicians, 959 nurses and 468 social workers and health educators in 300 primary healthcare units.

Egyptian psychiatrists are in the enviable position of being venerated by their patients; however, this culture has hindered the promotion of primary care for those who are mentally ill and made the empowerment of patients in the new Mental Health Act a difficult task. Long sessions were spent in debating the concept of second opinion, as clinicians perceived it a slur to the dignity of the profession. On the other hand, the stigma of psychiatric consultations has contributed to diverting patients to primary care. Had that sector had sufficient numbers of trained clinicians, the provision of care might have been reasonable.

Ratification of the Act faced similar conceptual difficulties. Supporting the role of the primary care physician and social worker and promoting a multidisciplinary approach to the care of people with mental illness proved difficult in a patriarchal society that has revered physicians for millennia. The Act authorises primary care physicians to compulsorily detain individuals but, unlike psychiatrists, they need to report involuntary admissions to the judicial authorities. It also limits social workers to a consultative role, with no power to stop the process. Developing the 2009 Mental Health Act and its code of practice was not only a legislative process but also an opportunity to promote public awareness of the rights of patients.

Changing clinical practices and public attitudes is a lengthy process. In Egypt we are witnessing the very beginning of this change.

## References

- Culpepper, L. (2002) Generalized anxiety disorder in primary care: emerging issues in management and treatment. *Journal of Clinical Psychiatry*, 63 (suppl. 8), 35–42.
- Okasha, A. (2004) Focus on psychiatry in Egypt. *British Journal of Psychiatry*, 185, 266–272.



# Mental health in primary healthcare in Chile

Alfredo Pemjean

Department of Mental Health, Ministry of Health of Chile; Professor of Psychiatry and Mental Health, Universidad Diego Portales, Santiago, Chile, email [alfredopemjean@vtr.net](mailto:alfredopemjean@vtr.net)

Chile has two major national health systems, the public one, which serves nearly 80% of the country's close to 17 million population, and the private one, which serves the other 20%. The public primary healthcare system has been developing in Chile since before the Alma Ata Conference in 1978 (which produced the first international declaration on the importance of primary healthcare).

There are local out-patient general health centres throughout the country. The system has been designed as a network, comprising larger and smaller units: the larger units are the 294 family health centres and 257 general dispensaries, which are intended to serve localities with 20 000–30 000 inhabitants, although several in big cities provide care for populations of up to 60 000, while others serve fewer than 6000; the smaller units are the more than 1500 rural health clinics, which serve localities with 150–2500 people.

In the early 1960s, health centres were staffed by four professionals in a general health team (general practitioner, nurse, midwife and social worker). Since then, the range of expertise has increased and diversified, particularly in the past 10 years. Nowadays, it is usual to find physiotherapists, dentists, nutritionists and psychologists working at these centres, especially in urban areas.

## Primary mental healthcare

In Chile, the recent health administrations have given high priority to supporting primary health centres, with the intention that they respond to a wider variety of health needs, including mental health (Ministerio de Salud, 2000). Between 2003 and 2008, at the national level, the number of full-time medical jobs in the centres increased by 146%, and the number of full-time psychologists increased by 344%.

Early in the 1990s, several mental health surveys gave cause for concern about the high proportion of users of primary healthcare facilities who were affected by mental health problems (Araya *et al*, 1994, 2001; Ustun & Sartorius, 1995; Florenzano *et al*, 1998). As a consequence, primary health expanded the definition of its role to include mental healthcare, covering anxiety and depressive symptoms and disorders, psychosocial problems (such as pregnancy among adolescents), family violence, child abuse and drug misuse. This initiative facilitated a rapidly growing provision of training, leading to gains in experience and self-confidence among general health teams in the management and treatment of patients with psychosocial and psychiatric problems.

Today, one or more general practitioners, with variable levels of mental health training, participate in mental health

teams within every urban primary health centre. They work jointly with psychologists and social workers, receiving referrals from other professionals at the same centre, and act as a first level of screening, making preliminary diagnostic and treatment decisions.

Some of the tools they use include the 'integral diagnosis session', which is a half-hour interview by three professionals. This is much longer than the usual 12-minute session the patient would receive from a general health attendant. After this initial session, the professional team comes to a consensual decision on the best treatment plan for the patient, which may include medical and psychological input by appropriately trained professionals. There may be: individual or group psychosocial interventions; individual or group psychotherapy undertaken by psychologists; and home visits and interviews by social workers, nurses, midwives, or others.

## Interface between primary and secondary care

In the 'mental health consultation' form of assessment, the patient is the subject of a discussion between two or three specialists, who make regular visits to the primary care centre for the purpose of having a clinical meeting on difficult clinical cases. Sometimes this happens in the presence of the patient; on other occasions there may be a review of a set of clinical records and, sometimes, a meeting on technical or administrative issues. This is the inverse of the patient going to the specialist, which was the usual route in the health system before the introduction of this new arrangement.

By this means, a common space for discussion by generalists and specialists is gradually being created in order to meet patients' individual needs, and it should lead to an increase in treatment adherence, by reducing dropouts in the transitional phase between initial consultation and the implementation of therapy.

There are over 60 community mental health centres, which work closely with the primary healthcare centres, a system that has been evolving over the past 15 years. Staff in the two types of institution in many cases cooperate in the overall planning process for mental healthcare, and they are in frequent contact. Community mental health centres will become the main means of delivering secondary-level psychiatric care in the country in the near future.

In 2004, a plan for health reform defined a protected pathway of care for 56 illnesses, which assures access, opportunity, quality and financial support to all people, in

both public and private health systems (an 'explicit health guarantees system'). The choice of illnesses covered by this scheme was made on the basis that they involved a major burden of disease, that there was evidence-based treatment available, and that it was feasible for the health system to cope with them. Mental health problems included in this scheme are: schizophrenia, from the first episode (with both early detection and continuity of care); depression; and alcohol and drug misuse in people under 20 years of age.

In the management of these conditions, the primary health centres play a crucial role. They provide early detection ('diagnosis suspicion') for all of them. They also provide treatment according to clear clinical guidelines (Ministerio de Salud, 2005, 2006, 2007). Treatment of less severe cases is specified in a primary care protocol in some instances. However, if there are signs of bipolar disorder, suicide risk, violent behaviour, psychosis or severe comorbidity, the arrangements require referral to specialty care. Secondary referral is also required if treatment in the primary care centre has failed over a defined period.

This policy has meant that mental healthcare is a key aspect of the identity of primary healthcare in Chile, and such services now provide care to more than 80% of the 500 000 people who are receiving mental healthcare in the whole of the public health system.

## Weaknesses of the system

There are some weak components of mental health management within the primary care system. First, adherence to treatment, follow-up and clinical outcome indicators are not evaluated adequately; there is no system for recording them in the regular administrative procedures of the health system. This deficiency represents a serious gap, which hinders a reliable estimate of the outcomes and quality of care. In the case of depression, audits which were done up to 5 years ago found that, of the 30% of patients remaining in treatment 6 months after entering the depression programme in primary healthcare centres (mainly moderate and severe cases), between 7% and 10% had subsequently been referred to specialists, and 7% had been discharged. A significant improvement in symptoms, with patient satisfaction, was found in those receiving both pharmacological and/or psychosocial interventions (Alvarado *et al*, 2005). Within the national public health network there is a complex system for monitoring the course of all the diseases treated under the health plan; this allows professionals to know, for instance, how many people with depression are under treatment, or waiting for treatment, within or outside of the scheduled waiting time (guarantee of opportunity). However, crucial data such as outcomes (including partial recovery, relapses and critical events) are not yet being recorded comprehensively.

Second, community participation is scarce, even now. Communities do not have enough influence in the planning decisions of health authorities, local or national. In this way, cultural and social resources cannot contribute to these processes, which is a loss because they could be a valuable complement to health system activities. For example, community self-help groups could provide support to those who are misusing alcohol and drugs or who suffer from depression and anxiety. Suggestions of this nature rarely

evoke a positive response from the professionals involved, and there is often no clear procedure by which such groups could work together with primary healthcare professionals.

Third, clinical academic teaching and research remain remote from the change in the nature of primary care. Except for some isolated examples, the undergraduate medical teaching and psychiatric specialty training programmes continue to be focused on a biomedical approach to medicine and on psychopharmacological treatments. They disregard the value of taking an interdisciplinary approach to the treatment of mental health disorders and ignore the community mental health model, even though it is explicitly defined to be the foundation of the Mental Health and Psychiatry National Plan.

## References

- Alvarado, R., Vega, J., Sanhueza, G., *et al* (2005) Evaluación del programa para la Detección, Diagnóstico y Tratamiento Integral de la Depresión en la Atención Primaria en Chile. [Evaluation of the Programme for Depression Detection, Diagnosis, and Comprehensive Treatment in primary care in Chile.] *Revista Panamericana de Salud Pública*, **18**, 278–286.
- Araya, R., Wynn, R., Leonard, R., *et al* (1994) Psychiatric morbidity in primary health care in Santiago, Chile. Preliminary findings. *British Journal of Psychiatry*, **165**, 530–533.
- Araya, R., Lewis, G. H., Rojas, G., *et al* (2001) 'Patient knows best' – detection of common mental disorders in Santiago, Chile: cross-sectional study. *BMJ*, **322**, 79–81.
- Florenzano, R., Acuña, J., Fullerton, C., *et al* (1998) Estudio comparativo de frecuencia y características de los trastornos emocionales en pacientes que consultan en el nivel primario de atención en Santiago de Chile. [Comparative study of the frequency and features of emotional disturbances in patients in primary care clinics.] *Revista Médica de Chile*, **126**, 397–405.
- Ministerio de Salud (2000) *Plan Nacional de Salud Mental y Psiquiatría*. Available at <http://www.minsal.cl> (accessed October 2009).
- Ministerio de Salud (2005) *Guía Clínica. Primer Episodio Esquizofrenia*. [Clinical Guide. First Episode Schizophrenia.] Available at [http://www.redsalud.gov.cl/archivos/guiasges/EsquizofreniaR\\_Mayo10.pdf](http://www.redsalud.gov.cl/archivos/guiasges/EsquizofreniaR_Mayo10.pdf) (accessed October 2009).
- Ministerio de Salud (2006) *Guía Clínica. Tratamiento de Personas con Depresión*. [Clinical Guide. Treatment of Persons with Depression.] Available at <http://www.redsalud.gov.cl/archivos/guiasges/depresion.pdf> (accessed October 2009).
- Ministerio de Salud (2007) *Guía Clínica. Consumo Perjudicial y Dependencia de Alcohol y Drogas en Menores de 20 Años*. [Clinical Guide. Detrimental Consumption of and Dependency on Alcohol and Drugs in Minors Under 20 Years.] Available at <http://www.redsalud.gov.cl/archivos/guiasges/GPCGes-OHyDrogas-2007-rev26junio.pdf> (accessed October 2009).
- Ustun, B. & Sartorius, N. (1995) *Mental Illness in General Health Care: WHO International Study*. Wiley.

As you pass from the tender years of youth into harsh and embittered manhood, make sure you take with you on your journey all human emotions! Don't leave them on the road, for you will not pick them afterwards!

*Nikolai Gogol, Dead Souls (1842), translated by David Magarshak*

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

# Psychiatry in Jamaica

**Frederick W. Hickling DM MRCPsych(UK) DFAPA**

Professor of Psychiatry, Department of Community Health and Psychiatry, University of the West Indies, Mona, Kingston 7, Jamaica  
email [frederick.hickling@uwimona.edu.jm](mailto:frederick.hickling@uwimona.edu.jm)

The intense historical relationship linking Jamaica and Britain to 300 years of the transatlantic slave trade and 200 years of colonialism has left 2.7 million souls living in Jamaica, 80% of African origin, 15% of mixed Creole background and 5% of Asian Indian, Chinese and European ancestry. With a per capita gross domestic product of US\$4104 in 2007, one-third of the population is impoverished, the majority struggling for economic survival. The prevailing religion is Protestant, although the presence of African retentions such as Obeah and Pocomania are still widely and profoundly experienced, and the powerful Rastafarian movement emerged as a countercultural religious force after 1930. The paradox and contradictions of five centuries of Jamaican resistance to slavery and colonial oppression have spawned a tiny, resilient, creative, multicultural island people, who have achieved a worldwide philosophical, political and religious impact, phenomenal sporting prowess, astonishing musical and performing creativity, and a criminal underworld that has stunned by its propensity for violence.

## Policy and service

Hickling & Sorel (2005) discuss mental health policy and legislation in Jamaica and the English-speaking Caribbean, and the development of the Lunatic Asylum in Kingston.

Mental health legislation originated from colonial Britain in 1872, cementing the draconian policy of police arrest for lunacy and incarceration in the oppressive lunatic asylums that has dogged the history of mental healthcare in the UK, with successive attempts at legislative reform in that country in the 20th century. Jamaica broke with this British tradition in 1974 by virtually abandoning the custodial approach to the treatment of mental illness, and by the creation of a nationwide system of care that marginalised police involvement in the management of people with a mental illness, and placed their treatment squarely in the purview of the medical and nursing professions. As a result, a community mental health system has now evolved that is situated firmly in the primary healthcare system of the country, with seminal links to public sector medical and nursing professionals.

A network of over 300 clinics in the island of 4400 square miles provides a full range of mental health services, delivered primarily by community mental health nurses (called mental health officers), supervised by 30 psychiatrists. More than 40 000 patients are treated annually. Treatment is provided free of charge, with the full range of internationally available

psychotropic medications and psychiatric treatments. The community mental health service provides a mobile community follow-up service that keeps track of the hundreds of patients who have problems with medication adherence, and provides emergency services, crisis intervention and acute hospitalisation when necessary.

More than 60% of those patients requiring hospital admission for acute mental illness are admitted to the medical wards of the 13 general hospitals island-wide (Hickling *et al*, 2000). The generally trained medical and nursing practitioners who work in these hospitals provide care for those admitted for psychiatric treatment, side by side with those with diabetes and heart disease, under the supervision of the community psychiatrist and mental health officers assigned to those hospitals. A Cochrane review (Hickling *et al*, 2007) found that this remarkable therapeutic reality is unique to Jamaica.

The remaining 40% or so of patients requiring hospital admission are admitted to specialised psychiatric units in three major hospitals serving the two major urban centres of Kingston and Montego Bay. The average length of hospital stay for acutely ill patients is about 14 days. The Mental Health Law of 1997 provides the legal statute that allows patients to be admitted and detained involuntarily for up to 14 days. The majority of all admissions are voluntary, and no facility outside of prison exists where a patient can be detained involuntarily for a longer period. Community treatment orders and legal sections that can determine the involuntary incarceration of a patient for up to 6 months at a time, as exist in countries such as England, do not exist under Jamaica's mental health legislation.

After 37 years of measured deinstitutionalisation, the Bellevue Mental Hospital is now a 700-bed institution with 100 acute beds serving a catchment area of 90 000 persons in the city of Kingston, with custodial facilities for more than 600 indigent patients over the age of 65.

Although the island's mental health service accounts for 5% of the health budget, which in turn is 6.5% of the national budget, vibrant private treatment facilities in psychology and psychiatry now exist island-wide.

## Training

The Jamaican mental health success story is due in no small measure to the effect of the medical, psychiatric and nursing training at the University of the West Indies (UWI), Mona. The UWI, which was established in 1948 as a school of the

University of London, has trained nearly 6000 medical practitioners since its inception. In addition, its School of Nursing (UWISON) has provided the undergraduate and postgraduate training for many thousands of nurses in Jamaica. Psychiatric training was introduced for all nurses and medical students in 1965, thus providing a comprehensive primary and secondary medical care programme provisioned by 3000 medical and 5000 nursing practitioners, which buttresses the psychiatric service in the island. Psychiatric residents and medical students receive apprenticeship and academic tutoring in the 20-bed open ward unit run on therapeutic community principles at the University Hospital of the West Indies. The accident and emergency department and the in- and out-patient services of the University Hospital reinforce the broad, eclectic secondary care training experience, with practical primary care training being provided in the government-run community mental health services.

Recent postgraduate training programmes for clinical psychologists (Hickling & Matthies, 2004) now provide the basis for the development of psychological assessment and psychotherapy services.

A robust child and adolescent service has emerged around the country in tandem with the adult mental health services, and the UWI is now implementing a training programme in child and adolescent psychiatry to provide the specialists to further develop these services. Similar training programmes in substance misuse and forensic psychiatry are being developed at the UWI. UWISON also conducts a robust nurse practitioner and mental health officer training programme.

## Specialist services and research

In 2005, the UWI launched the Caribbean Institute of Mental Health and Substance Abuse (CARIMENSA) for delivering primary prevention in mental health across the country and the region. Aimed at developing programmes to reduce national problems such as violence, substance misuse, teenage pregnancy, HIV/AIDS and other chronic diseases, this Institute, situated in the Faculty of Medical Sciences, has developed a novel cultural therapy programme (Hickling, 2004), which incorporates innovative ethnographic group methods with creative arts therapies for risk reduction for people of all ages, classes and ethnicities. A 3-year 'Dream-a-World' cultural therapy pilot programme (Hickling, 2006) was initiated with a cohort of 9-year-old inner-city primary school children who were exhibiting behavioural and academic problems. The preliminary results of this programme indicated significantly higher scores on the government grade-6 achievement test for the study group compared with a control group, as well as a reduction in behavioural problems, more significantly in boys. In 2008, CARIMENSA implemented a novel MSc in cultural therapy at the UWI, to train cultural therapists in primary prevention processes for the nation.

The UWI has had a seminal influence on mental health research in Jamaica. The institutional public policy at the beginning of the new millennium of appointing Caribbean psychiatrists with a high-output research record to lead mental health at the university certainly paid dividends in terms of mental health research output (Hickling *et al*, 2008). This strategy has resulted in considerable increases in overall psychiatric research output (Gibson *et al*, 2007).

Collaboration with the Pan American Health Organization has highlighted Caribbean mental health research (Hickling, 2005) in the areas of epidemiology, public policy, treatment outcomes and service evaluation.

Recent quantitative (Gibson *et al*, 2008) and qualitative (Arthur *et al*, 2008) studies have demonstrated a profound reduction in stigma regarding mental illness in the island, related to a 'psychological deinstitutionalisation' process over the past 40 years, described by Whitley & Hickling (2007). The establishment of the CARIMENSA Press in 2005 has triggered the launch of a Mental Health Observatory and the publication of five books on Caribbean psychology and psychiatry.

## Conclusion

Detailed information on the mental health profile of Jamaica can be found in the World Health Organization's mental health atlas (2005) and in the book edited by Hickling & Sorel (2005). The revolutionary transformation of the mental health landscape in Jamaica highlights the practical possibilities for efficient liberalisation of mental health practices worldwide, but especially in low- and middle-income countries. This transformation into an affordable, humane, modern and efficient system integrated into primary healthcare services, for all Jamaicans, is largely unrecognised at home and abroad and the comprehension of many people seems stuck at the image of the custodial 'snake pit' lunatic asylum that existed in the early 1960s. Old myths and legends are hard to eradicate, and no doubt this image will persist until the deinstitutionalisation process of the Bellevue Mental Hospital, started in 1972, is completed.

## References

- Arthur, C., Hickling, F. W., Gibson, R. C., *et al* (2008) The stigma of mental illness in Jamaica. In *Perspectives in Caribbean Psychology* (eds F. W. Hickling, B. K. Matthies, K. Morgan, *et al*). CARIMENSA Press.
- Gibson, R. C., Morgan, K. A. D., Abel, W. D., *et al* (2007) Changing the research culture at the Section of Psychiatry, the University of the West Indies, Mona. *West Indian Medical Journal*, **56**, 171–177.
- Gibson, R. C., Abel, W. D., White, S., *et al* (2008) Internalizing stigma associated with mental illness: findings from a general population survey in Jamaica. *Revista Panamericana de Salud Pública/Pan American Journal of Public Health*, **23**, 26–32.
- Hickling, F. W. (2004) Popular theatre as psychotherapy. *International Journal of Postcolonial Studies – Interventions*, **6**, 45–56.
- Hickling, F. W. (2005) The epidemiology of common mental disorders in the English-speaking Caribbean. *Pan American Journal of Public Health*, **18**, 256–261.
- Hickling, F. W. (ed.) (2006) *Dream a World: CARIMENSA and the Development of Cultural Therapy in Jamaica*. CARIMENSA Press.
- Hickling, F. W. & Matthies, B. (2004) The establishment of a clinical psychology postgraduate program at the University of the West Indies, Mona. *Caribbean Journal of Education*, **25**, 25–36.
- Hickling, F. W. & Sorel, E. (eds) (2005) *Images of Psychiatry – the Caribbean*. Department of Community Health and Psychiatry, University of the West Indies Mona, and World Psychiatric Association.
- Hickling, F. W., McCallum, M., Nooks, L., *et al* (2000) Treatment of first contact schizophrenia in open medical wards in Jamaica. *Psychiatric Services*, **51**, 659–663.
- Hickling, F. W., Abel, W., Garner, P., *et al* (2007) Open general medical wards versus specialist psychiatric units for acute psychoses. *Cochrane Database of Systematic Reviews*, issue 3, CD003290.
- Hickling, F. W., Gibson, R. C. & Abel, W. D. (2008) Public policy and mental health research at the University of the West Indies, 1995–2005. *Journal of Education and Development in the Caribbean*, **10**, 87–96.

Whitley, R. & Hickling, F. W. (2007) Open papers, open minds? Media representations of psychiatric de-institutionalisation in Jamaica. *Trans-cultural Psychiatry*, 44, 659–671.

World Health Organization (2005) Jamaica. In *Project Atlas: Resources for Mental Health*, pp. 254–256. WHO. Available at [http://www.who.int/mental\\_health/evidence/atlas/](http://www.who.int/mental_health/evidence/atlas/) (accessed October 2009).

## COUNTRY PROFILE

# A decade of mental health services in Timor-Leste

Zoe Hawkins BM BCh MA

Advisor to the Ministry of Health for Mental Health, Epilepsy and Health Research, Democratic Republic of Timor-Leste  
email [zoe.hawkins@doctors.org.uk](mailto:zoe.hawkins@doctors.org.uk)

The Democratic Republic of Timor-Leste (East Timor) occupies the eastern half of the island of Timor, which lies north-west of Australia and within the eastern Indonesia archipelago. The population is approximately one million, of whom 45% are below the age of 15. Average life expectancy is 59.5 years and 50% of the population live below the national poverty line of US\$0.88 per day. The official languages are Tetun and Portuguese, with Indonesian also used. The majority of the population are Catholic but also hold traditional animist beliefs.

Timor-Leste, a Portuguese colony for over 400 years, was invaded by Indonesia in 1975 following Portugal's rapid decolonisation. During the following 24 years of occupation, anti-insurgent and terror campaigns were carried out by the Indonesian military, with mass internal displacements of people and war-induced famines. Following a majority vote for independence in a 1999 referendum, a violent backlash from pro-Indonesia groups caused further deaths and mass destruction of buildings and infrastructure. Intervention by Australian-led peacekeeping forces restored stability, and the territory was administered by a United Nations mission until full independence was gained in 2002.

## History of mental health services

During the years of Indonesian administration there were no mental health services in East Timor. In 1999, Psychosocial Recovery and Development in East Timor (PRADET) was founded by a partnership of mental health practitioners from Australia. Sixteen Timorese health workers underwent basic mental health training in Australia and returned to form the core staff of PRADET (Zwi & Silove, 2002). In addition to providing assessment, diagnosis and treatment for people with mental illness, the staff of PRADET trained district health nurses in their follow-up care.

In 2002, the government established the East Timor National Mental Health Project (ETNMHP) as its mental health service, with technical support and training provided by a team of Australian mental health workers. PRADET continued as a local non-governmental organisation (NGO) to complement government services by providing psychosocial

support, counselling and community education. In 2008, the ETNMHP became the Department of Mental Health within the Ministry of Health.

## Psychiatric morbidity

An epidemiological study conducted in 2004 reported a point prevalence of psychosis (meeting DSM-IV criteria) of 1.35% and post-traumatic stress disorder of 1.47% (Silove *et al*, 2008). Since January 2008, the mental health service has seen a total of 3881 clients, of whom 1026 (26%) have had a primary diagnosis of epilepsy. There are no data on the prevalence of different mental disorders within the remaining case-load. However, mental health workers report that psychotic disorders form the majority of cases, followed by depressive disorder.

## Mental health policy and legislation

The government has a national mental health strategy (Ministry of Health Timor-Leste, 2005), which emphasises both a primary care approach to mental health services and partnerships with non-government service providers. There is currently no mental health legislation.

## Infrastructure

The 260-bed National Hospital (Hospital Nacional Guido Valadares) is located in Dili, the capital, and provides secondary and tertiary healthcare services. There are also five regional referral hospitals in the districts. The National Hospital acts as the national referral centre and is the principal clinical training centre for health personnel studying in Timor-Leste. At present there is no mental health bed allocation and no psychiatric hospital.

Each of the 13 districts in Timor-Leste has a district health office, where clinical services for the area are coordinated and supervised.

Sixty-five community health centres (CHCs) – approximately one per subdistrict – provide primary healthcare services, including out-patient clinics, simple laboratory testing, health promotion and preventive health services such as immunisations. Eight CHCs have in-patient facilities.

There are 193 health posts located across Timor-Leste, which are smaller health centres staffed by midwives and nurses. Basic drugs are available but there are no laboratory or in-patient services. In addition, a programme called Integrated Community Health Services (Servisu Integradu da Saúde Comunitária, SISCa) provides monthly community-based health services within each village, including health promotion, and interventions in areas such as nutrition, maternal and child health, infectious disease prevention and environmental health.

## Mental health services

All basic health services, including mental health and medication, are provided free of charge to Timorese people. Two internationally recruited psychiatrists (from Cuba and Papua New Guinea) work in Timor-Leste. Both are based in Dili, although one makes brief visits to the districts. Essentially, there are 1.14 psychiatrists per 100 000 population in Dili, and 0 in the rest of the country.

Each district has an allocated mental health worker with basic training in mental health and a background in nursing or public health. In addition, 25% of CHCs have a general nurse who has also received basic training in mental health. These nurses form the primary service for people presenting with mental illness, with more difficult cases referred to the mental health worker for case management. Referrals for initial assessment can also be made directly to counsellors working in PRADET. District case-loads range between 100 and 200 clients, with referrals coming from the police, families, the church and village chiefs. There are no social workers or psychologists working in the government or NGO services.

### Pharmaceutical interventions

Psychotropic medication is ordered by the district health office from the central medical stores in Dili (Serviço Autónomo de Medicamentos e Equipamentos de Saúde, SAMES), based upon calculations of monthly use from each CHC. The medication is delivered by truck to each district every 3 months and distributed to CHCs. Clients or family members must then collect the prescription from the CHC themselves. Basic psychotherapeutic drugs are available and can be prescribed by the two psychiatrists, the district mental health workers and more senior general nurses.

## Health workforce training

### Pre-service training

The Ministry of Health, through the Institute of Health Sciences (Instituto de Ciências da Saúde, ICS), provides pre-service training to health workers in the country. This includes upgrading nurses and midwives to diploma 3 level, and providing courses in laboratory technology, pharmacy

technology, anaesthetics nursing, eye-care nursing and radiography at diploma 1 level.

Currently, two out of every three doctors in the country (162 out of 243) are from Cuba. This is a result of a joint initiative between the governments of Cuba and Timor-Leste known as the Cuban Medical Brigade, which provides primary care physicians and other health staff from Cuba to fill vacant posts within Timor-Leste.

The Ministry of Health collaborates with the Cuban Medical Brigade and the National University of Timor-Lorosae (Universidade Nacional Timor-Lorosae, UNTL) in providing pre-service courses in medicine (currently 150 students), nursing (50 students per year) and midwifery (50 students per year). Two private universities provide undergraduate training in public health.

In addition, through assistance from the Cuban government, a pre-service medical training programme for nearly 700 Timorese students is provided in Cuba. Psychiatry is taught in a 10-week block during the fifth year. A small number of Timorese students have donor-funded scholarships to attend medical schools in other countries.

### Postgraduate training

There is no formal postgraduate training of health personnel in Timor-Leste. However, there are more than 100 scholarship holders pursuing postgraduate training courses in Indonesia, Fiji, Malaysia and Papua New Guinea. There is currently one Timorese doctor completing postgraduate training in psychiatry in Papua New Guinea.

## Traditional healers and religious beliefs

There are strong animist beliefs in Timorese culture. People with mental illness (*bulak*) and their families may feel they are being punished by an ancestral spirit for causing offence, perhaps by walking across a sacred area or swimming in a sacred river. The spirit takes the form of a tree or stone in the village. People who suffer from epilepsy (*bibi maten*, literally 'dying goat') are sometimes thought to have an angry ancestor spirit within them. Traditional healers use herbal treatments, which may include berries from the 'spirit' tree. An animal might be sacrificed and its blood poured over the stone or tree. The healers use trances, smoke, chanting and beating the person with a mental illness to remove the angry spirit. These actions are used in parallel with Catholic practices, with the family praying for forgiveness at the graveyards of the ancestors, and attending church to pray for healing.

## The way ahead

Conflict, violence, large-scale human rights abuses and civil unrest are all elements of Timor-Leste's recent history, and have been shown to be associated with poor mental health (Mollica *et al*, 2005). In the context of this history, and as a young, low-income country, Timor-Leste is addressing significant challenges in the areas of infrastructure, human resources, financial constraints (short- and long-term prioritisation of resources) and poverty.

The mental health system can begin to address these challenges by improving access to mental healthcare, strengthening and expanding the mental health workforce, and prioritising long-term funding for mental health.

Mental health education and promotion activities must be maintained and further developed to reduce stigma and discrimination. The implementation of appropriate and comprehensive mental health legislation is necessary to protect the human rights and dignity of Timorese people with mental disorders.

## References

- Ministry of Health Timor-Leste (2005) *National Mental Health Strategy for a Mentally Healthy Timor-Leste*. Ministry of Health, Democratic Republic of Timor-Leste.
- Mollica, R. F., Cardozo, B., Osofsky, H., *et al* (2005) Mental health in complex emergencies. *Lancet*, **364**, 2058–2067.
- Silove, D., Bateman, C. R., Brooks, R. T., *et al* (2008) Estimating clinically relevant mental disorders in a rural and an urban setting in post-conflict Timor Leste. *Archives of General Psychiatry*, **65**, 1205–1212.
- Zwi, A. & Silove, D. (2002) Hearing the voices: mental health services in East Timor. *Lancet*, **360**, s45–s46.

## COUNTRY PROFILE

# Mental healthcare in Serbia

Dusica Lecic Tosevski,<sup>1</sup> Saveta Draganic Gajic<sup>2</sup> and Milica Pejovic Milovancevic<sup>2</sup>

<sup>1</sup>Professor of Psychiatry, School of Medicine, University of Belgrade, Serbia, email [dusica.lecictosevski@eunet.rs](mailto:dusica.lecictosevski@eunet.rs)

<sup>2</sup>School of Medicine, University of Belgrade, Institute of Mental Health, Belgrade, Serbia

**S**erbia is located on the Balkan peninsula, which served for centuries as a vulnerable crossroads between the East and the West. At the beginning of the 1990s, some of the republics of the former Yugoslavia, including Serbia, were involved in disastrous civil conflicts. In 2006 Serbia became a sovereign republic. At the 2002 census, its population was 7 498 000.

The country has been exposed to many severe stressors, such as civil war in neighbouring countries, United Nations economic sanctions, which lasted for 3.5 years, and 11 weeks of NATO bombing in 1999. As a consequence, Serbia has experienced the destruction of infrastructure, large numbers of refugees and internally displaced people (currently there are half a million of them in Serbia), social instability, economic difficulties and deterioration of its healthcare system. In addition, a serious problem is the brain drain, since around 300 000 people, mostly young intellectuals, have left the country in recent years (Lecic Tosevski & Draganic Gajic, 2005).

After 2000, the country underwent economic liberalisation, and experienced relatively fast economic growth: gross domestic product per capita rose from US\$1.160 in 2000 to US\$6.782 in 2008, according to the International Monetary Fund (2008). The country is now passing through social transition and harmonisation with the European Union (EU). At present, the main problems are the high unemployment rate (18.8% in 2008 and currently rising due to the economic crisis) and the large trade deficit (US\$11 billion). The major source of finance for public health is the national Health Insurance Fund, to which is allocated 6.1% of gross domestic product.

## Mental disorders

The events outlined above caused a steady rise in mental and behavioural disorders. The prevalence of mental disorders increased by 13.5% between 1999 and 2002 and they now

represent the second largest public health problem, after cardiovascular disease. The incidence rates of stress-related disorders, depression, psychosomatic illnesses, substance misuse and suicide are still high, as are rates of delinquency and violence among young people (Lecic Tosevski *et al*, 2007). Furthermore, the burnout syndrome is pronounced in many physicians, who have shared adversities with their patients and experienced secondary traumatising (Lecic Tosevski *et al*, 2006). An international multicentre study carried out 7 years after major trauma has shown that the prevalence of chronic post-traumatic stress disorder (PTSD) is still very high (current, 18.8%; lifetime, 32.3%), as is that of major depressive episode (current, 26.2%; recurrent, 14.4%) (Priebe *et al*, 2009).

## Mental health policy and legislation

In 2000, when the international community decided to take a proactive attitude rather than intervening only during crises, nine countries entered the Stability Pact for South-Eastern Europe (SEE): Albania, Bosnia and Herzegovina, Bulgaria, Croatia, the Former Yugoslav Republic of Macedonia, Moldova, Montenegro, Romania and Serbia. The mental health project 'Enhancing social cohesion through strengthening community mental health services' (Mental Health Project for SEE, <http://www.seemhp.ba/index.php>) brought together experts from the region with the aim of harmonising national mental health policies and legislation. The renewal of collaboration was also important for conflict resolution and reconciliation.

The National Committee for Mental Health was established in January 2003 by the Serbian Ministry of Health. As a coordinating body of the SEE Mental Health Project, the Committee prepared a national policy and action plan, and drafted a law on the protection of rights of persons

with mental disorders. Both documents were reviewed by distinguished international experts. The National Strategy for Development of Mental Healthcare was approved by the government in January 2007 (Ministry of Health of the Republic of Serbia, 2007). A national programme for substance misuse has also been prepared and approved.

## Mental health services

The oldest psychiatric institution in the Balkans was established in Belgrade (capital of Serbia) in 1861 (the 'Home for Insane People'), with 25 beds. Nowadays, there are 46 in-patient psychiatric institutions in Serbia (specialist hospitals, psychiatric institutes and clinics, clinics for child and adolescent psychiatry, and psychiatric departments in general hospitals) and 71 out-patient services in municipal health centres. The entire mental health sector has 6247 beds, approximately half of which are in large psychiatric hospitals. Admissions in 2002 totalled 5833. The number of psychiatrists (neuropsychiatrists) in the country is 947, but some of them are involved in the treatment only of patients with neurological problems and do not deal with persons with a mental disturbance. A third of them work in the capital, Belgrade. About 5% of psychiatrists are engaged in child and adolescent psychiatry (Lecic Tosevski *et al*, 2005; Lecic Tosevski & Pejuskovic, 2005).

Healthcare in Serbia is free of charge and is provided through a wide network of public healthcare institutions, controlled by the Ministry of Health. The private provision of healthcare services, although limited, is on the rise, particularly in certain specialties, such as drug addiction.

Mental healthcare is well integrated with the primary healthcare system, at least in larger cities, which have mental health and developmental counselling units within municipal health centres. The first community mental healthcare centre was opened in 2005 in the southern part of Serbia. However, the widening of the network of community centres is rather difficult because of the economic crisis. There are other problems in mental healthcare, such as a lack of residential homes, as well as the poor condition of some of the large psychiatric hospitals. There are five of these in Serbia, and some patients have been hospitalised in them for many years, since they have no relatives, or the community would not accept them. Many patients with chronic mental disabilities are accommodated in social care homes, which are in need of deinstitutionalisation.

Non-governmental organisations are also involved with mental healthcare. Their role was invaluable during years of conflict since they supported local experts in preventive programmes for refugees and internally displaced persons, ex-detainees and torture victims. Non-governmental and para-professional groups have an increasing role within the mental health system, through various psychosocial programmes for deinstitutionalisation, destigmatisation, domestic violence, human rights and so on.

Until recently, prevention was not financed by the state and was carried out by enthusiastic professionals. Fortunately, the government has recently recognised its importance and is now supporting programmes for the prevention of suicide and violence among children and young people, as well as the prevention of substance misuse and alcoholism.

## Training

The specialties of psychiatry and neurology were separated in 1993, and child psychiatry was established as a separate specialisation. The duration of training for adult and child psychiatry is 4 years. Both curricula are developed according to European standards and are accredited (Pejovic Milovancevic *et al*, 2009).

Postgraduate psychiatry training is well developed – there are subspecialties in psychoanalytical psychotherapy, forensic psychiatry, clinical pharmacology and so on. Psychotherapy has a long tradition and many psychotherapists were trained abroad, primarily in England and France, in various approaches – psychoanalytical, group analysis, systemic, cognitive-behavioural, and so on. Continuing medical education has become obligatory for all mental health professionals.

## Research

Professionals from Serbia are publishing in leading psychiatric journals, books and textbooks. Serbia was included in two multicentre studies, supported by the EU, which have been carried out in the Balkans – STOP and CONNECT (Priebe *et al*, 2002, 2004). It is hoped that the results of these studies will represent an empirical basis for adequate programmes for people with PTSD.

The Belgrade Institute of Mental Health is a partner in the exciting EU project 'Copy number variations conferring risk of psychiatric disorders in children'. The aim of the project is to identify genetic variants that confer an enhanced risk of major mental disorders on children and adolescents.

## Professional associations

There are several psychiatric associations in Serbia, including the Serbian Psychiatric Association, the Serbian Association of Psychiatric Institutions, the Association for Child and Adolescent Psychiatry and Allied Professions of Serbia, and the Serbian Psychotherapeutic Association. These associations collaborate closely with international organisations such as the World Psychiatric Association, the European Psychiatric Association and the European Association of Psychiatry. Collaboration with the World Health Organization (WHO) is also flourishing and the Serbian Institute of Mental Health was recently nominated to be the WHO Collaborating Centre for Workforce Development.

## Human rights issues

The human rights of all patients in Serbia are protected by the Healthcare Law. The Mental Health Act is expected to be approved shortly. In 2006, the government introduced the concept of 'carer of patient's rights' and now each hospital has a professional with such a duty, usually with a legal background. In addition to this, most institutions have ethical committees and are obliged to apply an ethical code in treatment and research.



## Conclusion

The organisation of mental healthcare in Serbia has many advantages, as well as disadvantages. The main advantages are a balanced territorial coverage of psychiatric departments in general hospitals, well-educated professionals, as well as a relatively low proportion of institutionalised patients at the onset of the mental healthcare reform. Of special importance is a long tradition of psychosocial orientation, with day hospitals in clinics of all larger towns.

However, there is insufficient cooperation between primary, secondary and tertiary healthcare. This is exacerbated by a lack of catchment areas and patients' legal right to choose their own doctor (often by affinity or reputation of doctors), as well as lack of skills of general practitioners in mental healthcare. Stigma in relation to mental illness is prevalent among the public, which hinders early recognition and treatment. Furthermore, there is a lack of cooperation between the psychiatric and the social welfare institutions, a lack of community mental healthcare centres and other out-patient psychiatric services in the community (rehabilitation and professional orientation services), as well as insufficient information systems for registering and monitoring mental disorders.

The ongoing psychiatric reform certainly represents a challenge and opportunity for mental health professionals. The process of reform is not easy, especially in a country facing social transition, so it is expected that the implementation of the national strategy and action plan will take time.

## References

- International Monetary Fund (2008) *World Economic Outlook (WEO): Financial Stress, Downturns, and Recoveries*. Available at <http://www.imf.org/external/pubs/ft/weo/2008/02/weodata/index.aspx> (accessed October 2009).
- Lecic Tosevski, D. & Draganic Gajic, S. (2005) The Serbian experience. In *Disaster and Mental Health* (eds J. J. Lopez-Ibor, G. Christodoulou & M. Maj, et al), pp. 247–255. Wiley.
- Lecic Tosevski, D. & Pejuskovic, B. (2005) Mental health care in Belgrade – challenges and solutions. *European Psychiatry*, **20**, 266–269.
- Lecic Tosevski, D., Curcic, V., Grbesa, G., et al (2005) Mental health care in Serbia – challenges and solutions. *Psychiatry Today*, **37**, 17–25.
- Lecic Tosevski, D., Pejovic Milovancevic, M., Pejuskovic, B., et al (2006) Burnout syndrome of general practitioners in postwar period. *Epidemiologia e Psichiatria Sociale*, **15**, 307–310.
- Lecic Tosevski, D., Pejovic Milovancevic, M. & Popovic Deusic, S. (2007) Reform of mental health care in Serbia: ten steps plus one. *World Psychiatry*, **6**, 51–55.
- Ministry of Health of the Republic of Serbia (2007) *Strategy for the Development of Mental Health Care*. Available at <http://www.imh.org.rs> (accessed October 2009).
- Pejovic Milovancevic, M., Lecic Tosevski, D., Popovic Deusic, S., et al (2009) Mental health care of children and adolescents in Serbia: past steps and future directions. *Epidemiologia e Psichiatria Sociale*, **18**, 262–265.
- Priebe, S., Gavrilovic, J., Schützwohl, M., et al (2002) Rationale and method of the STOP study – study on the treatment behaviour and outcomes of treatment in people with posttraumatic stress following conflicts in ex-Yugoslavia. *Psychiatry Today*, **34**, 133–160.
- Priebe, S., Jankovic Gavrilovic, J., Schützwohl, M., et al (2004) A study of long-term clinical and social outcomes after war experiences in ex-Yugoslavia – methods of the 'CONNECT' project. *Psychiatry Today*, **36**, 111–122.
- Priebe, S., Bogic, M., Ajdukovic, D., et al (2009) Mental disorders following war in the Balkans – a study in five countries. *Archives of General Psychiatry* (in press).

ORIGINAL PAPER

# Alcohol dependence syndrome in women: an Indian perspective

**Chauhan Ashutosh,<sup>1</sup> Bapat Radhika,<sup>1</sup> Tharoor Hema,<sup>2</sup> Sinha Mrigaya,<sup>3</sup> Chauhan Sudhindra<sup>1</sup> and Sharma Podilla Satya Venkata Narsimha<sup>2</sup>**

<sup>1</sup>Department of Behavioral Science and Mental Health, Sahyadri Hospitals Ltd, Pune, Maharashtra, India  
email [ashutoshchauhan@hotmail.com](mailto:ashutoshchauhan@hotmail.com)

<sup>2</sup>Department of Psychiatry, Kasturba Medical College, Manipal, Karnataka, India

<sup>3</sup>Department of Clinical Psychology, National Institute of Mental Health and Neurosciences, Bangalore, Karnataka, India

The estimated prevalence of alcohol misuse among Indian women is less than 5%. Misuse has been associated with the upper socio-economic classes, primitive tribal cultures and certain rural traditions. The problem of substance misuse in India has been underdiagnosed and underreported, but various health agencies and media reports suggest it is increasing.

The term 'abuse' has been used interchangeably in the literature for both dependence and harmful use; this is due to a lack of clarity in the diagnostic criteria used in most of the studies quoted in this article. However, the results of

the current study are described only in terms of the ICD–10 criteria for dependence. In this paper we present findings which may contribute to our understanding of the prevalence of alcohol dependence in women in India.

## Literature review

Indian studies that have looked at the prevalence of alcohol misuse in males (Mohan et al, 1978; Sethi & Trivedi, 1979; Agarwal, 2004) have reported rates ranging from 19% to

82.5% (the wide range might be attributable to cultural differences across geographical locations as well as differences in methods and definitions). There has, however, been little mention of use or misuse of alcohol among females (Murthy & Chand, 2005), although Neufeld *et al* (2004) reported that men were 9.7 times more likely than women to use alcohol regularly. Epidemiological surveys reported that the early 1980s saw negligible drug misuse (including of alcohol), which by the 1990s was a predominantly male phenomenon. Recent data from treatment centres show that only 1–3% of those seeking help are female (Murthy & Chand, 2005).

In a study conducted at the National Institute of Mental Health and Neurological Sciences, Bangalore, India, one of the largest addiction treatment centres in India, only 77 females qualifying for an ICD–9 diagnosis of alcohol dependence, with a mean (s.d.) age at onset of alcohol intake of 32 (9) years, sought treatment within a span of 11 years. The male:female ratio was 57:1. The majority of females were single and were from families of lower socio-economic status. The duration of dependent alcohol use before first contact with a treatment agency was 4.5 (3.8) years, and there were high rates of family (64.9%) and spousal (65.8%) alcohol dependence. Two-thirds were introduced to alcohol by friends or family. Psychiatric morbidity preceding alcohol dependence was present in 33.8% of the women – 28.6% had depression – and up to 68.7% had a concurrent physical disorder (Murthy & Benegal, 1995).

From 14 urban sites of the 1999 Rapid Assessment Survey (RAS) on substance misusers in the community, 371 women were identified, giving a prevalence rate of 8%. Alcohol was misused by 4.8% of the entire population. Separate data on alcohol misuse by women were not available (Ray, 2004). There was a trend for misuse to be seen more commonly in single, educated women (Murthy & Benegal, 1995).

A study from rural India indicated that most of these women were not formally educated, were engaged in unskilled work, started drinking because they liked the feeling of being drunk and drank at home (Kumar & Parthasarathy, 1995).

The Focused Thematic Study (FTS) on drug misuse in women had a sample of 75 women, and found that opiates, alcohol and minor tranquillisers were the main drugs of misuse. No specific alcohol-related data were obtained.

A global status report on alcohol misuse from the World Health Organization (2004) gave the rates of heavy and hazardous drinking among females as 0.4% and 1.4%, respectively ( $n = 9540$ ). There was a variable pattern in women's drinking habits wherein two divergent patterns of drinking were seen: a 'traditional' pattern, in rural settings, featured bingeing and intoxication, usually not within social contexts; the other pattern, in affluent, educated, urban women, generally younger than the former group, featured drinking primarily in social settings.

## Method

The present study was conducted at Kasturba Medical College, Manipal, a university hospital that serves a catchment area with rural, suburban and urban populations as well as the university student population. The study was a retrospective chart review of females presenting to the Department of Psychiatry between September 1999 and September 2005 with an ICD–10 diagnosis of alcohol

dependence syndrome (ADS). Those with both primary and secondary dependence were included. A total of 1539 charts were reviewed, of which 38 were women's.

## Results

The male:female ratio was 39.5:1. Women presenting to the hospital with a diagnosis of ADS represented 2.5% ( $n = 38$ ) of all patient registrations for ADS. Their mean (s.d.) age at presentation to the hospital was 48.3 (12.9) years, mean age of initiation of alcohol use 30.7 (10.8) years, and mean duration of dependent alcohol use before their first contact with a treating agency 39.0 (11.1) years. Mean overall duration of alcohol use was 17.6 (11.6) years and mean duration of dependence 9.3 (7.6) years. The mean number of ICD–10 criteria fulfilled was 3.7 (0.8). Past psychiatric illnesses were seen in six women (16%).

A majority of the 38 women (22; 58%) were married; 30 (79%) were first-born children. Twenty-one (55%) were Hindus and the other 17 (45%) were Christians; none was from the Muslim community. Twenty-six (68%) had had some sort of formal education and 21 (55%) were classified as urban.

Twenty-eight (74%) had a family history of ADS and 4 (11%) a history of other psychiatric disorders; there was a history of spousal substance misuse in 21 of the 22 (95%) married women. Thirty-three (87%) had been introduced to the substance of misuse by a family member or spouse (Table 1). Six (16%) had a history of psychiatric illness.

**Table 1** Variables related to family and occupation of women diagnosed with alcohol dependence syndrome

Variable	Frequency ( $n = 38$ )
<i>Demographic</i>	
Family type	
Nuclear	30 (79%)
Extended	8 (21%)
Head of the family	
Patient	20 (53%)
Other	18 (47%)
Income source	
Patient	25 (66%)
Other	13 (34%)
Occupation	
Homemaker	14 (37%)
Professional	24 (63%)
<i>Clinical</i>	
Family history of alcohol use	28 (74%)
Family history of psychiatric illness	4 (11%)
Substance misuse in the spouse	21 (55%)
Who introduced the person to alcohol? <sup>a</sup>	
Family	20 (53%)
Spouse	13 (34%)
Peer	3 (8%)
Experimentation	4 (5%)

<sup>a</sup> The total is more than 38 as there is an overlap between some variables.

**Table 2** Distribution of psychiatric comorbidities

Psychiatric comorbidity <sup>a</sup>	Frequency ( $n = 38$ )
Primary depression	25 (66%)
Substance-induced depression	4 (11%)
Organic psychiatric syndromes	4 (11%)
Tobacco dependence syndrome	16 (42%)
Benzodiazepine dependence syndrome	1 (3%)
Opioid dependence syndrome	1 (3%)
None	2 (5%)

<sup>a</sup> The total is more than 38 as there is an overlap between some variables.

Symptoms of craving and tolerance were reported by all 38 women, withdrawal by 29 (76%), use despite knowing it would do harm by 24 (63%), loss of control by 8 (21%) and narrowing of repertoire by 2 (5%). Twenty-two (58%) had a diagnosable medical problem, with alcoholic liver disease (fatty liver disease, hepatitis or cirrhosis) in 23 (61%), hypertension in 9 (24%), anaemia in 5 (13%), diabetes mellitus in 4 (11%), peripheral neuropathy in 2 (5%), pancreatitis in 1 (3%) and migraine in 1 (3%).

A coexisting ICD-10 psychiatric syndrome was seen in 36 women (95%). A primary mood disorder was seen in 25 (66%), followed by other substance misuse in 18 (47%) (Table 2). None qualified for a personality disorder; however, an abnormal personality trait – anankastic 9 (24%), anxious avoidant 3 (8%) or emotionally unstable 2 (5%) – was seen in 14 of the 38 women.

A factor precipitating the onset of alcohol use was identifiable in 24 (63%), and 30 (79%) women had an ongoing stressor in their life. The majority (37, 97%) had overlapping psychological (36, 95%), physical (30, 79%), social (13, 34%), financial (5, 13%) or legal (1, 3%) problems secondary to alcohol use/dependence.

## Discussion

The current study is one of the few of its sort conducted in India. Despite changing socio-economic conditions, the present study, with its limitations, might serve as a window to the important issue of alcohol dependence in women and its relation to a selection of variables. The biggest problem we faced was reviewing the scarce literature, which lacks clarity in definitions, with the terms 'use', 'abuse' and 'dependence' being used interchangeably.

The following causes can be suggested for the scarcity of reports: gender stereotypes manifesting in the attitudes of health professionals, leading to low identification rates in clinics; underreporting as a result of stigma; a lack of structured data entry; and overall low attendance rates of female clients in tertiary care centres in India. The figure of 38 females over 6 years is in stark contrast to the 1501 males seeking treatment for an addiction from the same centre, which is a reflection of gender role discrepancies.

Women with ADS had a later age at onset, presenting to the hospital around their 40s, with secondary alcohol dependence. The male:female ratio of individuals seeking help was 39.5:1, as against a comparable figure of 57:1 in the only other study in the Indian setting (Murthy & Benegal, 1995). The rate of 2.5% is in keeping with the figure reported by the World Health Organization (2004). The sociodemographic profiles of the study women are consistent with those in these two other reports (Murthy & Benegal, 1995; World Health Organization, 2004), but the family history of alcohol use was significantly higher than the figures quoted by Murthy & Benegal (1995).

Interestingly, a majority of the women with dependence belonged to a nuclear family set-up and contributed to the family income, and indeed a significant number (20, 53%) acted as head of family. This could be attributed either to their 'single' status, with the absence of a male member who might interfere with decision making, or to the matrilineal system of inheritance prevalent in the southern Indian states.

The striking presence of precipitating factors and stressors validates the importance of exogenous factors and corresponds with Indian literature (Ray, 2004) that has hinted at the importance of dysphoria-related craving and the self-medication hypothesis (Khantzian, 1985). A look at the nature of the stressors might have given us further important insights.

Dependence was seen only in Hindus and Christians. This demographic finding, along with the later age at onset of alcohol dependence, and later age of presentation to the hospital for help, is similar to the study done at the National Institute of Mental Health and Neurological Sciences (Murthy & Benegal, 1995) and points to a higher probability of late-onset secondary alcohol dependence in females, where exogenous non-genetic factors form an important link. We also saw a rural-urban divide. Despite the catchment area covering divergent populations, the primary urban representation was from the university, which suggests the possibility of stigma interfering with help-seeking in local urban dwellers, unlike in the rural population from the same catchment area. Future studies focusing on the causes of the postulated differences between the help-seeking behaviours of these communities might have some interesting findings. The above results to some extent validate the two divergent patterns of alcohol misuse proposed earlier for the Indian female population (World Health Organization, 2004).

Future research has to be planned with a few important factors in mind, including lack of uniformity in records, definitions used and most importantly the bias in collecting data. The current study gives, we believe, an underestimate of the actual problem and highlights the gender bias in the approach of healthcare professionals and society in general. Investigations into the reasons for fewer women seeking treatment, the pattern, course and outcome of misuse/dependence, comorbidities and stressors might help us to understand alcohol dependence in women in India.

## References

- Agarwal, S. P. (2004) *Mental Health: An Indian Perspective 1946–2003*. Ministry of Health and Family Welfare. Reed Elsevier India.
- Khantzian, E. J. (1985) The self-medication hypothesis of addictive disorders: a focus on heroin and cocaine. *American Journal of Psychiatry*, **142**, 1259–1264.
- Kumar, U. G. S. & Parthasarathy, R. (1995) Alcohol drinking in rural areas: some observations. In *Indian Journal of Psychiatry* (supplement, *Alcohol Dependent Female: A Clinical Profile*), **37**, 2–18.
- Mohan, D., Sharma, H. K., Drashan, S., et al (1978) Prevalence of drug abuse in young in rural males in Punjab. *Indian Journal of Medical Research*, **68**, 689–694.
- Murthy, P. & Benegal, V. (eds) (1995) *Alcohol Dependent Female: A Clinical Profile*. Supplement, *Indian Journal of Psychiatry*, **37**.
- Murthy, P. & Chand, P. (2005) Substance use disorder in women. In *Substance Use Disorder: Manual for Physicians* (eds R. Lal, R. Rao & I. Mohan), pp. 170–177. National Drug Dependence Treatment Centre, All India Institute of Medical Sciences.
- Neufeld, K. J., Peters, D. H., Rani, M., et al (2004) Regular use of alcohol and tobacco in India and its association with age, gender, and poverty. *Drug and Alcohol Dependence*, **77**, 283–291.
- Ray, R. (2004) *National Survey of Extent, Pattern and Trends of Drug Abuse in India*. Ministry of Social Justice and Empowerment, Government of India & United Nations Office of Drug and Crime, Regional Office for South Asia.
- Sethi, B. B. & Trivedi, J. K. (1979) Drug abuse in rural populations. *Indian Journal of Psychiatry*, **21**, 211–216.
- World Health Organization (2004) *WHO Global Status Report on Alcohol*. WHO.

# Pattern of attempted suicide in Babylon in the last 6 years of sanctions against Iraq

Ali Abdurrahman Younis<sup>1</sup> FRCPsych and Hamdy Fouad Moselhy<sup>2</sup> MRCPsych

<sup>1</sup>Consultant Psychiatrist, Al Ain General Hospital, United Arab Emirates

<sup>2</sup>Associate Professor of Psychiatry, Department of Psychiatry and Behaviors Sciences, Faculty of Medicine and Health Sciences, UAE University, Al-Ain, United Arab Emirates, email hamdy.fouad@uaeu.ac.ae

Suicide among Muslims and in Muslim countries is rare (Hocaoglu *et al*, 2007). Although much of the research has comprised simple descriptive studies, and despite the possible underreporting of suicidal behaviour in countries where such behaviour is illegal, suicide rates do appear to be lower among Muslims than among the followers of other religions, even in countries which have populations belonging to several religious groups (Lester, 2006). However, rates of attempted suicide do not appear to be lower in Muslims than in non-Muslims (Pritchard & Amanullah, 2007), possibly because although there are strong religious sanctions against suicide, there are no clear principles regarding attempted suicide.

Iraqis (most of whom are Muslims) were generally subject to great worry regarding life domains such as finance, security and politics during the period of sanctions. Sanctions against Iraq were imposed by the United Nations on 6 August 1990, following the invasion of Kuwait in 1990, and they continued until the US-led invasion of Iraq in 2003. The economic sanctions resulted in high rates of malnutrition, lack of medical supplies and diseases from lack of clean water. They seriously hampered the Iraqi healthcare system in many ways: cutting imports of drugs and equipment; slowing resumption of local drug production; causing an exit of foreign medical and nursing staff; and restricting contacts between Iraqi doctors and outside experts.

In this study we aim to describe the pattern of attempted suicide in the Babylon governorate of Iraq during the last 6 years of sanctions.

## Method

We conducted a retrospective case-note review, looking at attempted suicide over 6 years. The study population consisted of all persons referred to Merjan General Hospital, Al-Hilla City, in the Babylon governorate, between May 1996 and May 2002, following self-poisoning or self-injury. The hospital receives all referred cases from Al-Hilla City and the surrounding area. Patients who are believed to have attempted suicide are routinely referred from the accident and emergency department to the psychiatric service in the hospital. All patients so referred receive a detailed psychosocial assessment by the only psychiatrist (AAY). The psychiatric service in the hospital is the only one for the whole governorate. Merjan General Hospital has an open referral policy (i.e. it is free of charge) and has 400 beds. It serves the whole Babylon governorate (1 200 000 people).

A specially designed data sheet was developed and a pilot analysis undertaken on 20 sets of medical notes. The data sheet was then revised and all the admissions taken on by the service in the study period were reviewed. Demographic data, descriptive psychopathology prior to presentation and mental state examination on assessment were recorded.

The review board of Merjan General Hospital approved the study.

## Statistical analysis

Analyses were performed using the Statistical Package for Social Sciences (SPSS, version 14). Descriptive statistics were used to summarise the sociodemographic and clinical characteristics of the sample. A chi-square test was used to compare non-parametric data. All statistical tests were considered significant at  $P = 0.05$ .

## Results

### Characteristics of participants

In the 6-year study period, 90 individuals who had attempted suicide were seen at the accident and emergency department. Females outnumbered males by 4.6:1 (74:16). The mean age was 24 years (range 14–45 years) and most (77) (86%) of all attempters were young adults aged 14–34 years. There were significantly more housewives than other categories of occupation (59, 66%,  $\chi^2 = 64.8$ ,  $P = 0.001$ ); other categories were: employed (6, 7%), student (14, 16%) and unemployed (11, 12%). Most of the women were single (34, 38%); 21 were married (23%), two divorced (2%), one widowed (1%) and the marital status was unknown for 32 (26%). Thirty-eight came from an urban and 52 from a rural area.

Of all the attempts, 96% (86 of 90) were by self-poisoning, 56% (50) with organophosphates (usually pesticide), 40% (36) with drugs (34 paracetamol and 2 psychotropic medications); 48% (43) of the pesticide self-poisonings were by women. Only 4 females attempted suicide by self-immolation (4%). Many suicide attempts were impulsive: of the 61 patients in the study sample treated as in-patients, 42 (69%) reported considering suicide for less than 30 minutes before their attempts.

### Psychiatric diagnosis and prescribed psychotropic medications

Of the 90 individuals, 73 (81%) received a psychiatric diagnosis that met ICD-10 criteria. Fifty-eight (64%) had an

adjustment disorder, 12 (13%) had post-traumatic stress disorder and 3 (3%) a severe depressive disorder; none of the rest had syndromal psychopathology.

Only two patients had previously been involved with the psychiatric service. Both had a depressive disorder; one was on imipramine (125 mg daily) and the other on imipramine (175 mg daily) and haloperidol (10 mg daily). None of the other patients was on any prescribed psychotropic medication. There was no drug or alcohol use problem among the whole sample.

On admission to the hospital, consciousness was clinically impaired in 38 patients (42%) and 23 patients (26%) had lost consciousness.

There was a statistically significant peak in suicide attempts in the year 1997 (27 patients, 30%,  $\chi^2 = 30.6$ ,  $P = 0.001$ ). Winter was the season with the most suicide attempts among males and spring among females ( $\chi^2 = 6.9$ ,  $P = 0.03$ ); students also had a significantly higher rate in spring ( $\chi^2 = 33.7$ ,  $P = 0.001$ ).

The disposal of the patients after assessment was as follows: 8 patients (9%) were referred to the psychiatric out-patient department, 21 (23%) were admitted as psychiatric in-patients and 61 (68%) continued to be looked after on the medical ward, but were seen in the psychiatric out-patient department at least once for follow-up.

## Discussion

The study characterised suicide attempts in a small city in Iraq during the last half of the sanctions period, which proved the most difficult time. The study sample was marked by a high proportion of psychiatric diagnoses (81%). However, only two patients had previously been treated by the mental health service. Reasons for psychiatric patients in our culture not accessing services include fear of stigma, the absence of a national mental health service and resort to traditional healers. Stress-related diagnoses were the most frequent (96% of all diagnoses). The study supports the substantial roles of impulsive behaviour (Phillips *et al*, 2002) and acute stressors (Staehr & Munk-Andersen, 2006) in suicidal behaviour.

As in other countries, suicide attempts in the present study were more common among women than men (Prosser *et al*, 2007). However, the ratio of 4.6:1 here is higher than the international average ratio of around 2:1 (Schmidtke *et al*, 1996). This is possibly because, although war creates acute and long-lasting health problems in both men and women, many aspects of war affect the health of women disproportionately, through societal changes that may subordinate them and not prioritise their life and health (Arcel & Kastrup, 2004). Furthermore, cultural norms affect what is acceptable behaviour and, despite the vital importance of women's work on farms, in factories and in civil defence, they were expected to retain their femininity. In Iraqi society, a failure to perform one's role as wife, mother or daughter may be interpreted as failure as a person (Kastrup, 2006).

Many similar studies internationally have reported high rates of substance use or intoxication with alcohol among people who attempt suicide. However, this was not the case in our sample, possibly for religious and social reasons.

Additionally, legislation at that time prohibited the drinking of alcohol in public places.

The limited availability of prescribed medications, including psychotropics, as a consequence of the economic sanctions would have reduced their use as a means of attempting suicide (only 2%) compared with international studies, in which overdoses often predominate. Globally, legal restrictions on harmful organophosphates and herbicides have seen reductions in their use for attempted suicide, but in our sample a high proportion of suicide attempters ingested pesticide, possibly because more than half the sample came from rural areas (Merjan General Hospital is the receiving hospital for a predominantly agricultural hinterland) and the Iraqi government was supplying farmers with subsidised organophosphates. Self-immolation is a method of suicide generally used only by women from the Middle East (Al-Dabbas, 2006) and Central Asia (Campbell & Guiao, 2004); it has been reported in another Iraqi study (Carini *et al*, 2005). In our study it was limited to female patients (4%) who suffered adjustment disorder. Little is known about this phenomenon and further research is needed.

The findings in this study are subject to at least three limitations. First, it was retrospective in design, and therefore vulnerable to bias related to missing data. Second, the nature of the work and the relatively small sample size make it difficult to generalise from these results. Finally, this retrospective study was limited to one hospital from a relatively small geographical district of Iraq, which may not be representative of the entire country.

## References

- Al-Dabbas, M. H. (2006) Deliberate self-burning: the psychosocial and clinical patterns among patients admitted to burn unit in King Hussein Medical Center, Jordan. *Arabic Journal of Psychiatry*, **12**, 254–256.
- Arcel, L. T. & Kastrup, M. (2004) Women and health. *Nordic Journal of Women's Studies*, **12**, 40–47.
- Campbell, E. A. & Guiao, I. Z. (2004) Muslim culture and female self-immolation: implications for global women's health research and practice. *Health Care for Women International*, **25**, 782–793.
- Carini, L., Grippaudou, F. R. & Bartolini, A. (2005) Epidemiology of burns at the Italian Red Cross hospital in Baghdad. *Burns*, **31**, 687–691.
- Hocaoglu, N., Kalkan, S., Akgun, A., *et al* (2007) A retrospective evaluation of analgesic exposures from Izmir, Turkey. *Human Experimental Toxicology*, **26**, 629–636.
- Kastrup, M. (2006) Mental health consequences of war: gender specific issues. *World Psychiatry*, **5**, 33–34.
- Lester, D. (2006) Suicide and Islam. *Archives of Suicide Research*, **10**, 77–97.
- Phillips, M. R., Li, X. & Zhang, Y. (2002) Suicide rates in China, 1995–1999. *Lancet*, **359**, 835–840.
- Pritchard, C. & Amanullah, S. (2007) An analysis of suicide and undetermined deaths in 17 predominantly Islamic countries contrasted with the UK. *Psychological Medicine*, **37**, 421–430.
- Prosser, J. M., Perrone, J. & Pines, J. M. (2007) The epidemiology of intentional non-fatal self-harm poisoning in the United States: 2000–2004. *Journal of Medical Toxicology*, **3**, 20–24.
- Schmidtke, A., Bille Brahe, U., De Leo, D., *et al* (1996) Attempted suicide in Europe: rates, trends and sociodemographic characteristics of suicide attempters during the period 1989–1992. Results of the WHO/EURO Multicentre Study on Parasuicide. *Acta Psychiatrica Scandinavica*, **93**, 327–338.
- Staehr, M. A. & Munk-Andersen, E. (2006) Suicide and suicidal behaviour among asylum seekers in Denmark during the period 2001–2003: a retrospective study. *Ugeskrift for Laeger*, **168**, 1650–1653.

# Cultural influence on psychoeducation in Hong Kong

Vanessa Wong

Hong Kong College of Psychiatrists, email vtcwong@gmail.com

In Hong Kong, it is estimated that there are 1.2 million people with different types of mental illness, comprising one-sixth of the total population (Rehabilitation Division, Health and Welfare Bureau, 1999). Hong Kong has a well established mental health service and community support, yet many people still hold a biased view of psychiatry.

Mental illness is especially stigmatising in Asian cultures (Hong Kong Council of Social Services & Mental Health Association of Hong Kong, 1996; Kramer *et al*, 2002). Many of these notions about psychiatry have a strong Chinese cultural influence. Chinese explanations for mental health problems differ from, and indeed often conflict with, the Western concept of psychiatry. This can lead to distress for individuals affected by mental health problems. Bartlett (1928) suggested that the ideas and values of a new culture are more likely to be accepted if they can be accommodated within an existing belief continuum ('preferred persistent tendency'), whereas those that conflict with tradition are more likely to be ignored. Therefore it is important to understand why effective communication between healthcare providers and the general public concerning mental health issues may be hindered.

## Culture and psychoeducation

Culture provides the context in which an illness is experienced, and shapes an individual's illness explanatory model that affects his or her interpretation of symptoms (Kleinman, 1980). 'Mental health' is a Western expression with no exact equivalent in traditional Chinese (Yip, 2004) and only in recent years has the idea of a bio-psychosocial model for mental illness been introduced. To give an illustration, there was a middle-aged woman who suffered from generalised anxiety disorder. She refused to take any tablets prescribed by psychiatrists because she did not think she was 'crazy'. Despite repeated explanations, she would not be convinced otherwise. She eventually went to a Taoist temple to ask the gods for advice by means of a ritual called *Qiu Qian*, which involves shaking a cylindrical case of sticks with special codes written on them until one falls out; it is believed that an answer from the gods is thereby delivered to the person seeking guidance. Through the interpreter at the temple, the message from the special code was related to her. She was told that the deity instructed her to 'follow her doctor's advice' and she diligently took her medications from then on. The use of concepts and languages that are in line with people's personal and cultural beliefs may be more effective in achieving a desired outcome.

Confucianism, Buddhism and Taoism are the three pillars of Chinese philosophy. These systems constitute six

perspectives on mental illness: moral, religious, cosmological, traditional Chinese medical, psychosocial and personality perspectives (Pearson, 1993). Some differences in the cultural conceptualisation of mental illness arising from each of these perspectives are outlined below (Wong *et al*, 2004).

- Traditional moral beliefs of Chinese people suggest mental illness is a punishment for the misconduct of their ancestors or family members. Common beliefs about the hereditary nature of mental illness also implicate the family as pathogenic or having a moral defect.
- From a religious perspective, traditional Chinese thinking suggests that mental illness is a fate inflicted by supreme beings, and that one should accept it as inevitable.
- A cosmological concept is that supernatural forces are at work, and that inauspicious people or evil spirits have a bad influence on one's karma, or fortunes.
- The traditional Chinese medical view of illness emphasises the proper balance of yin and yang forces and the correct proportion of the five elements: metal, wood, water, fire, earth. Although the Western and Chinese concepts of psychosis are quite similar, when it comes to non-psychotic illnesses Chinese patients and carers often do not accept the validity of Western psychiatric diagnoses (Hsiao *et al*, 2006a). These illnesses are conceptualised as psychological problems that arise when one is faced with hardship but has a weak character, an imbalance of yin and yang, bad luck brought on by inauspicious people around, or even punishment for one's ancestors' mistakes. As a result, Western dualism, which separates the body and the mind, is unlikely to convince people of the concept of a psychological illness.
- The psychosocial perspective maintains that excessive life stresses borne by an individual, which surpass that person's stress tolerance threshold, will exert negative effects on his or her mental health. Thus one accepts fate as it is, and simply endures hard times, in a manner akin to learned helplessness.
- Lastly, the Chinese also consider personality characteristics to be a cause of mental illness. A flawed personality and a weak character lead people to develop such illnesses, whereas if they were robust and willing to suffer in silence, they would again simply endure the hard times and come out a better person. The tendency to shift the blame to the patient, for being weak or inadequate, will lead to more conflicts and greater burden on patients and their carers.

For comparison, in the Indian cultural context, maturation of the person is attained through coming into harmony within social relationships. Self-identity is extended into a familial self by fulfilling a complex system of obligations and responsibilities towards others throughout one's life. Beliefs

concerning the nature of health and illness stem from this extended sense of self. Disease is not just localised in the individual. Well-being is viewed as a balance or harmony of forces maintained by the proper observance of social obligations and other interpersonal behaviours.

## Help-seeking behaviour

An unwillingness to approach others for help may be due to a strong belief in self-reliance and stigmatisation of mental illness in Chinese communities. Carers and patients often do not conceptualise the problems as mental illness, and consequently neither are inclined to access Western mental health services (Hsiao *et al*, 2006b). Also, the 'loss of face' and high level of shame felt by the whole family contribute to treatment being sought late (Hsiao *et al*, 2006b).

Traditional coping mechanisms, such as *Feng Shui* (to utilise the laws of both heaven and earth to help one improve life by receiving positive *Qi*), *Yuan* (that events happen as deigned by the laws of nature) and endurance are used in facing stress (Yip, 2004). In Confucian ideals, interpersonal harmony is the key element in maintaining a healthy state of mind. Those who fail to fulfil culturally expected roles, such as that of a parent, offspring, partner or even friend, contribute to disturbance in interpersonal relationships, diminished self-worth and increased sense of guilt and shame (Hsiao *et al*, 2006b). For example, a man would be expected to be good to his parents and take care of them in their later years, be caring towards his wife and children, be the breadwinner and decision-maker in the family, and be cordial towards colleagues and respectful towards seniors. Any role reversal or out-of-tune behaviour would be seen as the man being inadequate and failing to perform his duties.

In Chinese culture, the family is the 'great self' and an individual is embedded in the family. This contrasts with the Western idea of self, which emphasises an individual's autonomy. Instead of self-actualisation and self-development, Chinese people will be more inclined towards being harmonious with the laws of nature; thus inaction, self-endurance and tolerance with respect to hardship and suffering are preferred (Yip, 2004). Treatment, such as psychotherapy, which emphasises an individual's growth and autonomy may conflict with the importance of maintaining interpersonal harmony in Chinese culture.

The lay system exerts a great influence on the help-seeking pathway of Chinese people (Pearson, 1993; Kramer *et al*, 2002). In a society with a collectivist and familial orientation, elders in the family still strongly believe that they are responsible for taking care of their offspring (Young, 1996). Chinese family collectivism leads people to sacrifice their own goals to provide care for an ill relative and to maintain harmony in the family; occasionally, some of them even become victims of the violence of members with mental illness (Yau, 2003). Moreover, the decision to seek help does not rest with the individual (Wong *et al*, 2004) but incorporates the views of different members of a family or friends. It is often difficult to adhere strictly to patient confidentiality when relatives request details of the illness, sometimes going as far as to ask the doctor not to divulge the information to the patient. Many management decisions need to be endorsed by the family before the doctor can proceed, so as to minimise

antagonistic relationships with the patient and family. This in turn hampers education on the nature of the illness, drug adherence and precautionary measures to be taken by the patient and relatives. With this in mind, psychoeducation should be focused not only on the patients but also on family members and carers, who greatly influence both drug adherence and recovery.

Often the attitude towards coping with a family member with a mental health problem is to ignore it, to cope within the family for as long as possible or even overtly to deny its presence. People are reluctant to see a psychiatrist as it suggests that they are *Feng* (crazy) or *Dian* (psychotic) (Hsiao *et al*, 2006a), while those who have long-standing psychotic illnesses would insist they are seeking treatment only for 'milder' complaints such as insomnia or anxiety. Internalisation of these negative conceptions of mental illness in Chinese societies leads to anticipation of social rejection and discrimination towards those who are mentally ill.

## Conclusion

The government and local community in Hong Kong have put great effort into mental health awareness programmes in recent years, but healthcare providers still struggle to help patients understand what psychiatry is all about. Perhaps Chinese healthcare professionals who are familiar with Western medicine are not aware of how difficult it may be for others to accept a different model of mental illness. It would be more effective to introduce Western concepts of psychiatry in a way that is initially more palatable to the lay person, and to build on those foundations to modernise the way psychoeducation is provided in primary care. A simple example would be to use the term *Tiao Li* (the restoration of the yin and yang balance by medicinal means) when explaining how antidepressant or antipsychotic drugs work, rather than saying they alter the neurotransmitters in the brain, as *Tiao Li* is generally felt to be more harmonious with nature and therefore less damaging to the body. By drawing parallels to similar beliefs, hopefully the gap between Western and local concepts of mental health can be bridged.

## References

- Bartlett, F. (1928) *Psychology and Primitive Culture*. Cambridge University Press.
- Hong Kong Council of Social Services & Mental Health Association of Hong Kong (1996) *Public Attitudes Towards Mental Health Patients in Hong Kong: A Follow-Up Study Over Two Years*. Hong Kong Council of Social Services.
- Hsiao, F. H., Klimidis, S., Minas, H. I., *et al* (2006a) Folk concepts of mental disorders among Chinese-Australian patients and their caregivers. *Journal of Advanced Nursing*, **55**, 58–67.
- Hsiao, F. H., Klimidis, S., Minas, H., *et al* (2006b) Cultural attribution of mental health suffering in Chinese societies: the views of Chinese patients with mental illness and their caregivers. *Journal of Clinical Nursing*, **15**, 998–1006.
- Kleinman, A. (1980) *Patients and Healers in the Context of Culture*. University of California Press.
- Kramer, E. J., Kwong, K., Lee, E., *et al* (2002) Cultural factors influencing the mental health of Asian Americans. *Western Journal of Medicine*, **176**, 227–231.
- Pearson, V. (1993) Families in China: an undervalued resource for mental health? *Journal of Family Therapy*, **15**, 163–185.

Rehabilitation Division, Health and Welfare Bureau (1999) *Hong Kong Rehabilitation Program Plan (1998–99 to 2002–03)*. Government Secretariat.

Wong, D. F., Tsui, H. K., Pearson, V., et al (2004) Family burdens, Chinese health beliefs, and the mental health of Chinese caregivers in Hong Kong. *Transcultural Psychiatry*, **41**, 497–513.

Yau, M. K. S. (2003) Mental illness and families in contemporary Hong Kong: an ethnography of mental illness and Chinese families in Hong

Kong at the time of transition of sovereignty. *Australian Occupational Therapy Journal*, **50**, 48–49.

Yip, K. S. (2004) Taoism and its impact on mental health of the Chinese communities. *International Journal of Social Psychiatry*, **50**, 25–42.

Young, K. P. H. (1996) Social work with families and children. In *Social Work in Hong Kong* (eds I. Chi & K. C. Su), pp. 11–23. Hong Kong Social Workers' Association.

## NEWS AND NOTES

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

## President's international activities 2009

2009 was a busy year for the President, Professor Dinesh Bhugra, not least because of the many international visits he made in order to support and promote psychiatry and mental healthcare around the world and to meet a few of the 2684 members of the Royal College of Psychiatrists who reside outside the UK. The President attended and spoke at a variety of conferences, including the World Health Organization's Mental Health Gap Action Programme Forum in Geneva, and conferences in India, Singapore, the USA and Hong Kong. Professor Bhugra was also honoured with an International Fellowship by the American Psychiatric Association at its annual meeting in San Francisco and was conferred as a Fellow of the Academy of Medicine of Singapore at the 43rd Singapore–Malaysia Congress of Medicine. Professor Bhugra said 'the Royal College of Psychiatrists is committed to supporting its members in the UK and around the world and it is our goal to be at the forefront in setting and achieving the highest standards through education, training and research. We lead the way in developing excellence and promoting best practice in mental health services.'

As part of realising that goal, the President and the Registrar, Professor Sue Bailey, took a study tour, run by the Health Foundation, to Boston, Massachusetts, in October 2009. Many senior figures from other medical Royal Colleges and the UK National Health Service attended the tour. Its purpose was to explore the potential held by the Royal Colleges to improve quality across the National Health Service, both for clinicians' working lives and for patient outcomes. The trip included visits to a youth development organisation, a cancer institute and a media lab to see what could be learned from different systems. The President said: 'This was a unique opportunity to learn from organisations that you would not normally expect to learn from and to gain greater insight into our role as a medical Royal College in improving the health system for our members and our patients.'

## International activities of the Faculty of Psychiatry of Old Age

The Faculty of Psychiatry of Old Age, since its inception as a Section in 1978 and Faculty in 1988, has been a forerunner in maintaining standards for mental health services for older people and improving education and training. The Faculty

has been eager to use this expertise for the benefit of people outside the UK and become a true player in globalisation, pursuing the recent change in College policy. In 2007/8, the Faculty established links with the Geriatric Section of the Indian Psychiatric Society and offered help with the curricula and training in old age psychiatry in India. Some final details are still being sorted out.

In 2009, the Faculty's annual residential conference was held in Barcelona and there were two pan-European symposia, with speakers from different parts of Europe. This was a good opportunity to come to an agreement with the Sociedad Española de Psicogeriatría (SEPG) (Spanish Old Age Psychiatry Association) about improving the interaction between the two organisations in exchanging speakers, training postgraduate students in old age psychiatry and utilising research opportunities.

The Faculty has recently established a bursary (£1500) open to old age psychiatrists in low- and middle-income countries for attending and presenting research at the Faculty's residential conference. The first recipient of the bursary was Dr Xia Li from China, who presented her work on suicide in older people in China.

Also in 2009, the Faculty signed an agreement on education and training with the Old Age Psychiatry Faculty of the Royal Australian and New Zealand College of Psychiatry.

## Legislative innovation in Northern Ireland

Northern Ireland is set to become the first jurisdiction in the world to introduce a single piece of legislation for mental health and mental incapacity, so that people who are unable to make decisions for themselves, whether this is for physical reasons or because of mental health conditions, will come under the same legislation. The law will be based on the assumption of capacity, and will have four core principles, of autonomy, justice, benefit and least harm. The Royal College of Psychiatrists' Northern Ireland Division had lobbied hard for this, arguing that it is necessary not only because there is such a strong interface between the two pieces of legislation, but also because it is important to tackle the stigma for a person who is detained under mental health legislation.

Dr Philip McGarry, Chair of the Northern Ireland Division, said a single piece of capacity-based legislation is a step towards equality for people with mental health problems. 'The modernised legislation promises to be better for people



with mental health problems, and better for society as a whole. Only a small proportion of people with mental health problems will ever need to be detained, usually because they want to harm themselves, and on some occasions because they are at risk of harming others. These people should have the same rights and protections as anyone else to whom capacity legislation applies,' he said.

## Mental health day in the Middle East

On 10 October 2009, Iraq celebrated a Mental Health Day in Baghdad. The celebration was hosted by the Al-Rashad Mental Hospital with the support of the Al-Mada Media Agency. It was attended by the Minister for the Environment, the National Advisor for Mental Health, the Health Director General for Baghdad, the President of the Iraqi Psychiatric Association, the Chairman of Middle Eastern Division of the Royal College of Psychiatrists, and a large number of non-governmental organisations, mental health professionals, patients, families and the media. Dr Jameel Muslim, Hospital Director, welcomed the guests, gave a historical account of the hospital, and with his colleagues highlighted activities and developments, particularly in the areas of rehabilitation and continuing professional development in the hospital and throughout Iraq.

Dr Sabah Sadik, Chairman of the Middle Eastern Division, congratulated all on the progress and reiterated the Royal College of Psychiatrists' commitment to mental health services in the Middle East. Patients in the hospital

contributed to the event through musical and recreational activities.

The celebration ended with an art exhibition by patients followed by lunch by the lake at the hospital. The event was well publicised by the media, enjoyed by all and had a positive impact on the public.

## Regional meeting of the Middle Eastern Division

The regional meeting of the Royal College of Psychiatrists' Middle Eastern Division took place in Baghdad from 12 to 14 October 2009, in collaboration with the Ministry of Health, the International Medical Corps and the Iraqi Psychiatric Association. His Excellency the Minister of Health opened the meeting; in attendance were heads of organisations, officials, psychiatrists and other mental health professionals. The scientific programme included keynote speeches, panel discussions, lectures and workshops. The conference covered a variety of topics, including integrating mental health into primary care, trauma, undergraduate and postgraduate education, clinical quality and substance misuse. Around 700 delegates attended the meeting, from the UK, Europe, the USA, Egypt, Jordan, Syria, Bahrain, UAE and Oman, as well as Iraqi mental health professionals.

The security situation has improved in Iraq and the meeting passed without incident. The feedback from delegates was very positive and it is hoped the meeting will herald the beginning of a new era of collaboration and development in the region.

### CORRESPONDENCE

Correspondence should be sent to:

Amit Malik MRCPsych, Consultant Psychiatrist, Hampshire Partnership NHS Trust, UK, email [ip@rcpsych.ac.uk](mailto:ip@rcpsych.ac.uk)

## The mental health needs of the UK's Chinese children

**Sir:** In 2005, the Department of Health for England set a five-year action plan, *Delivering Race Equality in Mental Health Care*. The aim was to encourage the development of services that were more appropriate and responsive to the needs of both adults and children in Black and minority ethnic communities.

The Chinese community is the third largest immigrant group in the UK. Despite this there are few existing data concerning the mental health of Britain's Chinese population and a recent systematic review concluded that there was insufficient evidence to make any meaningful comment on the prevalence of common mental health disorders in Chinese children and adolescents in the UK (Goodman *et al*, 2008).

Why do we know so little about this significant population of children? First, it is difficult to collect information from the Chinese community. In contrast to other ethnic minority groups, which often coalesce in urban areas, resulting in a high population density, the dispersed nature of the Chinese

population makes data-gathering difficult (Cowan, 2001). Moreover, many data were collected via Chinese community organisations and may have therefore been subject to many different forms of bias (e.g. some people who identify themselves as Chinese may never attend community activities).

Paradoxically, although Chinese children are educationally among the highest achievers in the UK, many of their parents have limited literary skills and some of them are working unsociable hours in the catering business, which further limits their opportunities to develop their English language skills. This language barrier could impair the ability

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

of Chinese children to receive input from health professionals. For example, some Chinese parents may not feel confident in bringing a young person with a suspected mental health difficulty to see a general practitioner, and Chinese carers may find it difficult to understand concerns regarding their child's emotional well-being as communicated to them by professionals such as teachers. Furthermore, systemic (e.g. family therapy) or parenting-based work may be difficult, especially in the absence of an independent (non-family) interpreter.

In addition to language issues, cultural factors may also shape help-seeking behaviour. Although present across cultures, the problem of stigma remains prominent among the Chinese population. For example, a preliminary assessment of the mental health needs of Chinese young people in Birmingham revealed that the majority of them perceived mental illness as being 'crazy' and 'associated with violence' (Fung, 2005). Such cultural and individual attitudes could serve to prevent or at least delay young people and their families from engaging with mental health services.

Research is urgently needed in order to develop an understanding of the mental health needs of Chinese children in the UK. This should feed into developing programmes of public education and more culturally acceptable services in order to increase the Chinese community's access to timely help for young people. Without this, UK health services will find it difficult to meet agreed racial equality goals.

#### W. Cheng<sup>1</sup> and P. A. Tiffin<sup>2</sup>

<sup>1</sup>Specialty Registrar in Child and Adolescent Psychiatry, Northumberland, Tyne and Wear NHS Trust, email wilson.cheng@ntw.nhs.uk;

<sup>2</sup>Clinical Senior Lecturer and Honorary Consultant in the Psychiatry of Adolescence, Durham University and Tees, Esk and Wear Valleys NHS Foundation Trust

Cowan, C. (2001) The mental health of Chinese people in Britain: an update on current literature. *Journal of Mental Health*, 10, 501–511.

Fung, R. (2005) Stigma of mental illness among Chinese people. *Psychiatric Bulletin*, 29, 193.

Goodman, A., Patel, V. & Leon, D. A. (2008) Child mental health differences amongst ethnic groups in Britain: a systematic review. *BMC Public Health*, 8, 258.

## Proportionality of legal discrimination

**Sir:** The article by Zigmond (2009) made for interesting reading. Mental health law is about balancing the need to detain people in order to protect them or other people from harm and the need to respect people's human rights and autonomy. In the UK, there was much concern during the development of recent mental health legislation, in particular the Mental Capacity Act 2005, that the government had got this balance wrong. Many of these concerns have been addressed in the updated Code of Practice to the 1983 Mental Health Act, which is an essential guide to practising under the Act (Department of Health, 2008). There is no legal duty to comply with the Code, but professionals must have regard to it and record the reason for any departure from the guidance (which can be subject to legal challenge).

Safeguards regarding deprivation of liberty, which address the 'Bournewood gap' concerning the detention of compliant incapacitous individuals, in the Mental Capacity Act have been one of the highlights of the changes introduced (Hall & Ali, 2009). The mental health legislation in England and Wales is based on risk. One of the arguments for having risk as the main focus is the fact that mental illness leads to loss of insight, which makes it impossible for the sufferer to make an informed decision. The proponents of the other view argue that having a different criterion for compulsory treatment (risk rather than capacity) for mental illness results in further discrimination against people who are mentally ill and can only help to enhance stigma.

The European Court of Human Rights has had some impact on the Mental Health Act 1983 and its interpretation; it has not, however, set a high standard for modern mental health services. Some judgements may strike present-day clinicians not so much as protecting patients' rights but as permitting undesirable practices. This is perhaps not surprising when it is considered that the European Convention on Human Rights, signed in 1950, harbours old prejudices against those with mental illness (Bindman *et al*, 2003). These are apparent in the language of Article 5, which groups persons of 'unsound mind' with 'vagrants' and 'drug addicts' as being exempted from the protections afforded to others. In incorporating the European Convention on Human Rights, the UK Human Rights Act 1998 perpetuates rather than challenges the lesser regard for the autonomy of patients with mental illness than of other medical patients, which is at the heart of conventional mental health legislation (Szmukler & Holloway, 2000). If the courts do begin to scrutinise the proportionality of clinical decisions – a function currently carried out only haphazardly by mental health review tribunals (Perkins, 2000) – the impact could be considerable. Many of the cases involving the European Convention on Human Rights to date have concerned patients in maximum security settings or with significant forensic histories, and it is not surprising that compulsory treatment is often found to be justified or the infringement of rights to be proportionate. However, a decision, for example, to compel a 'revolving door' patient without a history of offending to accept community treatment might be judged to be disproportionate if founded on weak scientific evidence of risk or benefit.

#### Dr Partha Gangopadhyay

Clinical Teaching Fellow and Honorary Specialty Registrar in Forensic Psychiatry, University of Aberdeen, UK, email p.gangopadhyay@abdn.ac.uk

Bindman, J., Maingay, S. & Szmukler, G. (2003) The Human Rights Act and mental health legislation. *British Journal of Psychiatry*, 182, 91–94.

Department of Health (2008) *Code of Practice, Mental Health Act 1983*. TSO (The Stationery Office).

Hall, I. & Ali, A. (2009) Changes to the Mental Health and Mental Capacity Acts: implications for patients and professionals. *Psychiatric Bulletin*, 33, 226–230.

Perkins, E. (2000) Decision-making in mental health review tribunals. In *Shaping the New Mental Health Act: Key Messages from the Department of Health Research Programme*, pp. 29–32. Department of Health.

Szmukler, G. & Holloway, F. (2000) Reform of the Mental Health Act: health or safety? *British Journal of Psychiatry*, 177, 196–200.

Zigmond, T. (2009) Mental illness and legal discrimination. *International Psychiatry*, 6, 79–80.

## Mental illness and legal discrimination

**Sir:** Tony Zigmond's editorial is categorical in condemning the detention of people who are competent but mentally ill (Zigmond, 2009). He notes that the driver for this is risk, in both UK and international legislation. He contrasts this with physical treatment, for which he, and the judicial authority he quotes, believe competency gives an absolute right to refuse.

I would point out that this overlooks the widespread international use of public health legislation to detain, and even treat, individuals with infectious diseases, on the basis of risk to others. Consequently, Dr Zigmond is wrong, in part, that there is discrimination here. Where they pose a risk to others, physical and mental health patients are both liable to detention. A more interesting question is whether risk of suicide is a sufficient reason to override competency.

**Professor Philip Sugarman MSc MBA PhD FRCPsych**

CEO and Medical Director, St Andrew's Healthcare; Honorary Senior Lecturer, Institute of Psychiatry, King's College London; Visiting Professor, School of Health, University of Northampton, email [psugarman@standrew.co.uk](mailto:psugarman@standrew.co.uk)

Zigmond, T. (2009) Mental illness and legal discrimination. *International Psychiatry*, 6, 79–80.

## Author's reply

**Sir:** I am a little surprised by Professor Sugarman's letter, as my editorial does not condemn, categorically or otherwise, the detention of people who are competent but mentally ill. Furthermore, I am not aware (I accept this may be my ignorance) of any country having a law which permits treatment of, to use Professor Sugarman's example, infectious diseases, in the face of capacious refusal (my editorial refers, at this point, to treatment rather than detention). It is certainly not permitted in England and Wales.

I have merely asked why we need different laws for the two populations of ill people. There may be good reasons. I really want to know.

**Tony Zigmond**

Consultant Psychiatrist, Leeds Partnerships NHS Foundation Trust, Leeds, UK, email [Anthony.Zigmond@leedsptf.nhs.uk](mailto:Anthony.Zigmond@leedsptf.nhs.uk)

## Language, politics and psychiatry

**Sir:** In psychiatry as in politics, it is important to use terms correctly, to be precise. One sentence, one phrase or sometimes even one word can destroy a doctor-patient relationship, or can cause a war between two countries.

I have no intention to start a verbal war or an endless discussion, but in the January 2009 issue of *International Psychiatry* I came across one term which made me think again about the importance of using terms correctly. I am referring to the term 'former Soviet Union', which was used for the 'Thematic papers' section ('Mental health services in the former Soviet Union', vol. 6, pp. 2–10).

On 10 March 1997, the then British Foreign Secretary, Malcolm Rifkind, speaking in Washington, DC, to the Carnegie Endowment for International Peace, said that Western leaders should stop referring to the group of countries that emerged from the collapse of the USSR as the 'former Soviet Union'. Rifkind argued that such references are 'unwise' because they carry with them 'the unconscious legitimisation' of the possible return of Russian rule there in the future (Ziugzda, 1999).

The problem is that some people see 'former Soviet Union' not only as a term but also as an idea. Moreover, when people write 'former Soviet Union', I am not sure if that is intended to include my country (Lithuania) and the other two Baltic states. Yes, the Baltic states were occupied by the Soviet Union on the basis of the secret protocols of the Molotov-Ribbentrop Pact (Visulis, 1990). However, the UK (along with other countries) did not recognise *de jure* the incorporation of the Baltic states into the Soviet Union (UK Foreign and Commonwealth Office, 2009). Thus the term 'former Soviet Union' is even more confusing and in my personal opinion politically incorrect.

Why we should look at the complicated history when we want to name those countries? Why we should bring more confusion and maybe even mislead our younger colleagues? I would recommend that authors follow the international media and use terms which are based on the countries' geographical locations, such as the Baltic states (Estonia, Latvia and Lithuania), trans-Caucasian (Armenia, Azerbaijan and Georgia) or Central Asian (Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan).

**Norbert Skokauskas MD PhD**

Senior Registrar in Child and Adolescent Psychiatry, National Children's Hospital, Dublin, Ireland, email [n\\_skokauskas@yahoo.com](mailto:n_skokauskas@yahoo.com)

UK Foreign and Commonwealth Office (2009) See <http://www.fco.gov.uk/en/about-the-fco/country-profiles/europe/lithuania?profile=all> (accessed October 2009).

Visulis, I. (1990) *The Molotov-Ribbentrop Pact of 1939*. Praeger.

Ziugzda, D. (1999) Baltic states in the perspective of Russia's security policy. See <http://www.lfpr.lt/uploads/File/1999-4/Ziugzda.pdf> (accessed October 2009).

Many of the faults you see in others, dear reader,  
are your own nature reflected in them.  
As the prophet said,  
'The faithful are mirrors to one another.'

Jelaludin Rumi  
1207–73

# Forthcoming international events

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/>

21–23 January 2010

**WPA Regional Meeting**  
Dhaka, Bangladesh  
Bangladesh Association of Psychiatry  
Contact: Prof. A. H. Mohammad Firoz  
Email: bap@agni.com

24–29 January 2010

**International Conference on Child and Family Maltreatment**  
San Diego, USA  
Organiser: The Chadwick Center for Children and Families  
Contact: Linda Wilson  
Email: ChadwickCenter@rchsd.org  
Website: <http://www.chadwickcenter.org>

1–4 February 2010

**2nd International Conference on Drug Discovery and Therapy**  
Dubai, United Arab Emirates  
Organiser: Eureka Science  
Email: info@eureka-science.com

3–6 February 2010

**38th Annual Meeting of the International Neuropsychological Society (INS)**  
Acapulco, Mexico  
Organiser: INS  
Email: ins@osu.edu  
Website: <http://www.the-ins.org>

11–12 February 2010

**Lifelong Learning and Empowerment in Mental Health**  
Paris, France  
Organiser: EMILIA Consortium  
Contact: Ian Dawson  
Email: ian.dawson@nlsh.no  
Website: <http://www.lifelonglearninginmentalhealth.net>

13–14 February 2010

**5th International Conference on Sexology**  
Chennai, Tamil Nadu, India  
Organiser: Indian Association for Sexology/  
Indian Institute of Sexual Medicine  
Email: hi@drkamaraj.net  
Website: <http://www.internationalconferenceonsexology.com>

27 February – 2 March 2010

**18th European Congress of Psychiatry**  
Munich, Germany  
Organiser: European Psychiatric Association (EPA)  
Email: epa@kenes.com  
Website: <http://www2.kenes.com/epa/Pages/home.aspx>

4–10 March 2010

**Workshop on Neuropsychopharmacology for Young Scientists in Europe**  
Nice, France  
Organiser: European College of Neuropsychopharmacology (ECNP)  
Email: secretariat@ecnp.eu  
Website: <http://www.ecnp.eu/emc.asp>

10–13 March 2010

**25th International Conference: Dementia – Making a Difference**  
Thessaloniki, Macedonia, Greece  
Organiser: Alzheimer's Disease International (ADI)  
Contact: Ben Stanley  
Email: adi2010@mci-group.com  
Website: <http://www.adi2010.org>

17–20 March 2010

**4th Biennial Meeting of the International Society for Bipolar Disorders (ISBD)**  
São Paulo, Brazil  
Organiser: ISBD  
Email: isbd2010@icms.com.au  
Website: <http://www.isbd2010.org>

17–20 March 2010

**XVIII World IFTA Congress**  
Buenos Aires, Argentina  
Organiser: International Family Therapy Association  
Contact: Shirley Dinenson  
Email: ifta2010@paragon-conventions.com  
Website: <http://www.paragon-conventions.net/IFTA2010/>

18–20 March 2010

**World Congress for Psychiatric Nurses**  
Vancouver, Canada  
Organiser: Registered Psychiatric Nurses of Canada  
Contact: Jacqollyne Keath  
Website: <http://www.worldcongress.ca>

18–20 March 2010

**International Congress on Epilepsy, Brain and Mind**  
Prague, Czech Republic  
Organiser: International League Against Epilepsy  
Contact: Professor Ivan Rektor  
Email: epilepsy2010@guarant.cz  
Website: <http://www.epilepsy-brain-mind2010.eu>

19–20 March 2010

**Self, Selves and Sexualities: An Interdisciplinary Conference**  
Dublin, Ireland  
Organiser: Dublin City University  
Contact: Mel Duffy and Jean-Philippe Imbert  
Email: Mel.Duffy@dcu.ie;  
jean-philippe.imbert@dcu.ie  
Website: <http://www.dcu.ie/salis/conferencesexualitystudies2010/index.shtml>

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

Volume 12, Number 4, November 2009

<b>Guest editorial</b>	
Work phobia and sickness leave certificates <i>M. E. Smith</i>	249
<b>Letter from the Editor</b>	
<i>C. P. Szabo</i>	253
<b>Regional meeting report</b>	
The World Psychiatric Association Regional Meeting in Abuja, Nigeria <i>S. Rataemane</i>	261
<b>Review</b>	
Neural correlates of consciousness <i>B. L. Negrao, M. Viljoen</i>	265
<b>Original articles</b>	
Screening for HIV-related PTSD: sensitivity and specificity of the 17-item Posttraumatic Stress Diagnostic Scale (PDS) in identifying HIV-related PTSD among a South African sample <i>L. Martin, D. Fincham, A. Kagee</i>	270
Sleep and daytime sleepiness in methylphenidate medicated and un-medicated children with attention-deficit/hyperactivity disorder (ADHD) <i>K. Cockcroft, J. Ashwal, A. Bentley</i>	275
Profiles of referrals to a psychiatric service: a descriptive study of survivors of the Nairobi US Embassy terrorist bomb blast <i>D. M. Ndetei, A. Omar, V. N. Mutiso, F. A. Ongecha, D. A. Kokonya</i>	280
The psychological impact of vitiligo in adult Sudanese patients <i>A. M. Osman, Y. Elkordufani, M. A. Abdullah</i>	284
Screening for and monitoring of cardio-metabolic risk factors in outpatients with severe mental illness in a primary care setting <i>J. J. Ludwick, P. P. Oosthuizen</i>	287
Perceived economic and behavioural effects of the mentally ill on their relatives in Kenya: a case study of the Mathari Hospital <i>D. M. Ndetei, M. Pizzo, L. I. Khasakhala, H. M. Maru, V. N. Mutiso, F. A. Ongecha-Owuor, D. A. Kokonya</i>	293
<b>Scientific letter</b>	
Psychological morbidity and job satisfaction amongst medical interns at a Nigerian teaching hospital <i>P. O. Ajiboye, A. Yussuf</i>	303

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