

International Psychiatry

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Leadership, decision-making and errors: cultural factors

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As clinicians, we are used to making often fast and life-altering decisions. As professionals, the clinical decisions we make depend upon our training, knowledge base, supervision, expertise and experience. Sociodemographic factors such as age, gender, ethnicity and cultural background can also influence our views. However, rarely do we step back to think about the mental processes behind our decision-making. In cognitive-behavioural therapy and in our general dealings with patients, we aim to help them identify their cognitive schema and attribution errors as a way forward; but we rarely reflect on our own cognitive schema and possible misattribution in making decisions. Both patients and healthcare professionals are affected by cultural norms, mores and expectations.

Leadership and management

As clinicians, we have responsibilities for developing our skills as leaders. Not all psychiatrists are born clinical leaders and not all have the role of or responsibility for being a team leader. However, the role of the leader in the clinical context goes beyond patient care and looks at service development, planning and delivery. More significantly, clinicians have to look both at patients' proximal contexts – such as family, employment and housing – and at the wider/distal contexts – like culture and society. The doctor-patient interaction is heavily influenced on both sides by cultures, healthcare systems and expectations of the therapeutic encounter. Under similar clinical situations, patients in one culture might wish to be equal partners in the clinical encounter and decision-making, whereas in another they may look up to the clinician for a much more directive approach. Therefore, it is inevitable that the leadership styles and components of leadership will differ across cultures. Even within the same culture, leadership styles depend upon organisational culture. The role of culture in the therapeutic encounter and in service development cannot be underestimated. Cultures dictate how patients are looked after, what resources are provided and what outcomes are needed. Cultures also influence caring as well as coping styles, although, in Hippocratic terms, the role of the professional remains paramount where patient welfare is crucial.

Leadership needs to be differentiated from management: the latter is about coping with complexity, whereas the former is about coping with change (Kotter, 1998). Leadership is not necessarily about having charisma or other exotic personality traits, but it has to do with having a broader vision, one which can be applied to service planning, delivery and evaluation. It

is definitely not about micro-management. Management is about responding to, and dealing with, complex situations and chaos, and the ability to bring about order and consistency. It is inevitable that management will be influenced by cultural patterns and cultural expectations. Administration, on the other hand, is about carrying out tasks set by someone else.

Leaders need to have a vision, a passion for the cause they are espousing, confidence (peppered with humility), curiosity, creativity, a sense of purpose, determination and courage. The ability to innovate and to be emotionally intelligent will help in certain circumstances. Leaders have to work with others collaboratively, by motivating, empowering and enabling teams and others to share in a vision. For a good and successful leader, vision, passion, focus and respect for opposing views are critical. Leaders must inspire others and, here again, cultural nuances become important. In socio-centric cultures, kinship is important and individual political dynasties are likely to emerge.

Although Kotter (1998) suggested that leadership is about coping with change (in business settings at least), it is also to do with the competitive volatile business environment, with ever faster technological change, international competition, deregulation, overcapacity and changing demographics of the workforce. Similarly, changes in healthcare across the globe – with increased connectedness through globalisation, internal and external competition in healthcare delivery, technological advances, increasing patient expectations and a decreasing doctor-patient power differential – will all contribute to changes in doctors' roles. This is where changes in leadership roles and styles come into play. Thus, good leadership skills must include the ability to cope with the complexities of healthcare delivery as well as associated change. More importantly, it is the overall vision of patient care and service delivery and how to deal with technical developments that marks out a leader.

Clinical decision-making: knowledge and error

Clinical decision-making comes with experience and expertise. However, within the broader field of leadership linked with decision-making, the role of the culture from which the clinician hails becomes important, as does the organisational culture in which professional practices are embedded. Knowledge, skills and competencies contribute only to a certain extent. The ability to deal with more complex cases differentiates a novice from an expert. Interestingly, knowledge and

error both flow from the same mental sources; only success can tell the one from the other (Mach, 1905).

Reason (1990, p. 9) suggested that 'error' be taken as a generic term to encompass all those occasions when a planned sequence of mental or physical activities fails to achieve its intended outcome and when these failures cannot be attributed to the intervention of some chance agency. Here the intention becomes important. Errors in clinical settings can be those of omission, commission, repetition or misordering, and can also be classified as cognitive (errors in planning, execution and storage) or primary (mistakes, slips, lapses) – similar to what Reason (1990, p. 10) has argued.

One of the tasks of the leader is to minimise the number of errors. This may involve regular discussions with peers to identify what could have been done differently, what lessons can be learnt, and how these can be employed and communicated so that others may learn. Self-monitoring with checklists, error suspicion, error detection and acknowledgment can be used to reduce the number of errors.

Factors such as depression and anxiety among clinicians can increase the likelihood of errors, and we as clinicians have to be aware of our own levels of stress and depression. Irritability and anger among doctors can lead to cognitive problems in decision-making and can increase clinical errors. Both personal and organisational factors can cause stress (Firth-Cozens, 2006a). Ghodse & Galea (2006) point out that doctors are 30–100 times more likely than the general public to misuse drugs and alcohol. Of these, general practitioners show the highest prevalence of addictive behaviours, followed by internists, psychiatrists, gynaecologists and emergency physicians. Social attitudes and the availability of alcohol will determine the rate of alcohol misuse.

Cognitive errors among clinicians will also influence the rates of clinical mistakes (Gibson *et al*, 2006). These errors may result from simple things like tiredness or from substance misuse. Firth-Cozens (1996b) suggests that positive attributes of leadership such as intelligence, benevolence, emotional stability, awareness of limitations, integrity, ability to delegate appropriately, good communication skills, creating a sense of justice and anticipating events can all contribute to better leadership and consequently better decision-making and lower levels of clinical errors. Negative attributes of a leader, according to Firth-Cozens (2006b), include being arrogant, dictatorial, hostile, boastful or *laissez-faire*.

Decision-making is affected by the way information is framed (Newell *et al*, 2007). A complicating factor in clinical decision-making is when the information provided by patients and carers is inadequate, inappropriate, of poor quality or poorly communicated, as this leads to deficient decision-making. Yates *et al* (2003) propose that good judgement depends upon discovering information, acquiring and searching through information and then sharing and combining information and feedback.

Reason (1990) suggests that there are three basic types of error: skill-based slips and lapses; rule-based mistakes; and knowledge-based mistakes. Both over-attention and inattention, as well as perceptual confusions and omission, among other factors, contribute to increased levels of error. Misapplication of good rules, information overload, rigidity and application of bad rules are types of problem related to rule-based performance. Also significant are knowledge-based performance, which is affected by selectivity,

confirmation bias, over-confidence, problems with complexity and the halo effect (Reason, 1990, p. 69).

Sometimes it is best to learn through trial and error, or from mistakes in one's decision-making, but in medicine the leeway for errors is small: whatever the level of error, it will cause a great deal of distress to all involved. Not all adverse events are due to poor decision-making, though. A blame culture and litigious societies have pushed medicine to a more prescriptive, defensive mode, which is not necessarily in the best interest of patients. For example, a 'number needed to treat' analysis in relation to people with mental health problems who are admitted against their will to prevent one injury will tell the story. However, few psychiatrists would want to be at the receiving end of the consequences of such an event. There is a great need for leadership within the psychiatric community to balance views on this sensitive issue.

Who should be responsible for making decisions? How much of this responsibility should be shared? The degree varies with each patient, with individual situations and with the cultural setting and wider society. Too much diffusion of responsibility can lead to chaos, while excessive narrowing is likely to lead to patronising attitudes and even arrogance. This is where leadership becomes important. It involves making decisions, often tough ones, using experience, knowledge and skills, while ensuring the participation of all involved and maintaining awareness of the culture and expectations of society in general.

No matter where in the world one practises, errors do occur. These may be complicated by cultural norms, expectations and resources. The interactions between the individual, the organisation or the healthcare system and society at large will determine how errors occur and how these are dealt with. There are lessons from Western Europe and the USA, where human errors in medicine have been studied for a long time; these lessons are applicable elsewhere.

Leadership involves learning from both successes and failures. Decision-making in the business context has been described in terms of five steps: establishing a context for success; framing the issue properly; generating alternatives; evaluating the alternatives; and choosing the alternative that appears best (Harvard Business School Press, 2006). Applied to medicine in general and to psychiatry in particular, this would be: establishing the criteria and the context for success (i.e. getting the patient better, whether that is symptom reduction or better social functioning); framing the issue (diagnosis and management, but going beyond that by discussing with patients their priorities); generating alternative diagnoses and management strategies; and regularly evaluating the diagnosis and outcome. Across cultures, the basic principles of diagnosis and management remain the same, even though the clinical presentation may be culturally influenced; but healthcare systems differ and the role of the leader is to influence and change systems in order to improve healthcare delivery.

Are leaders born or made?

Doctors are medical experts and are expected to be good at clinical decision-making. Their entire training is geared towards this prime objective. Leadership skills in medicine, on the other hand, are not a part of the medical curriculum and are often left to individual interests. Leaders in the

clinical world have traditionally progressed via the academic or clinical route, and often seemingly through seniority alone. For a long time, leadership was seen as 'management', a term equated with a challenge to medical authority and primarily aimed at cutting costs. Those clinicians who move into management roles, certainly in the UK, were seen as changing sides and giving up clinical duties. This scepticism and the resultant lack of involvement by clinicians in management and leadership roles led to a schism between the medical profession and those in charge of managing services, which only served to make both sides easier targets for the political agenda and the manipulation of public opinion through the media. This distrust has had a detrimental effect on some health services, especially when corporate models of services from other industries have been attempted with little involvement of clinicians. The resulting powerlessness felt by clinicians has affected the morale of the workforce and made medicine a less attractive career option.

Leaders are not born as leaders. They utilise their strengths for their purpose. Personality traits can be suppressed, weaknesses hidden and strengths can be played up. Understanding organisational culture is not always intuitive, although intuition may enable the individual to deal with challenges. For psychiatrists, certain skills required for leadership are inherent in training, such as understanding of human dynamics, dealing with groups and collaborating with teams. One can learn about business planning, assessing risks, dealing with others, identifying resources and being flexible, but inspiration and vision may not be learnt as such.

Conclusions

Medical training requires a high level of intellectual functioning. Confident decision-making and knowledge are important

aspects of one's clinical skills. These skills are central to being a leader, as is the ability to reflect on one's own decision-making processes. Psychiatrists are in an advantageous position of having skills they learn through clinical work which they can use to develop their own leadership abilities through reflective practice. However, there is a great need to provide opportunities for those clinicians with leadership abilities to develop. Greater say in how services function and deliver will lead to greater confidence among clinicians in general that patient care remains central to changes and longer-term planning and is not being hijacked by an external agenda.

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THEMATIC PAPERS – INTRODUCTION

Care for elderly people with mental illness: a global problem

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As the median age of populations around the world increases, due to the provision of better diets and better medical care, the number of elderly persons vulnerable to mental illness will inevitably increase too. We are not good at providing high-quality geriatric care, even in high-income countries. For example, Age Concern (a UK-based charity) states on its website: 'Health and social care services have made some progress in tackling age discrimination, but older people still report feeling that they have had second class treatment and care simply because of their age' (www.ageconcern.org.uk/AgeConcern/ageism-in-healthcare.asp). How much worse these matters are in

low- and middle-income countries is the subject of our theme in this issue. We have drawn articles from three distinct geographic regions: India, Africa and South-East Asia. We often assume that cultural factors in lower-income areas lead to greater respect for, and better care of, the elderly than we experience in many parts of the Western hemisphere. This appears to be a misapprehension, and attitudes towards the elderly are changing as the impact of industrialisation increases.

Dr Henry and colleagues discuss the importance of supporting those caring for elderly people in India, and the services that could be provided for a geriatric population with

a range of dementias, psychoses and emotional disorders. Group sessions aimed primarily at supporting the carers of elderly relatives appeared to be of some benefit.

The article by Drs Clausen and Wilson addresses a wider issue: the prospect of an ageing population in Africa. They point out that health budgets are severely limited for all African countries, and that priority is given to the needs of the younger generations, who are economically active. As the longevity of African adults increases in years to come, it is essential to maintain as high a proportion as possible of the ageing population in economic activity. This will entail a trade-off between the cost of providing social and medical care, and the ability of that population to contribute to wealth generation. Currently, the provision of services to older patients with mental illnesses in most African countries is non-existent.

Finally, Professor Kua Ee Heok discusses the hidden burden of dementia among the elderly in South-East Asia. There is evidence that a very small proportion of all cases have been identified, and this is in part attributable to inadequate training of general practitioners. But even if identification were to be improved, would this lead to a higher priority being given to the care of elderly people with mental illness in the health services of that region? There is a change coming in the attitude of young people, who traditionally have cared for their extended families in multigenerational homes, such as the hutongs in Beijing. These young people want to live apart from their parents nowadays, in modern apartments, and community services have yet to compensate for that rapid change in cultural attitudes.

THEMATIC PAPER – CARE FOR ELDERLY PEOPLE WITH MENTAL ILLNESS

Group intervention for carers of geriatric patients: experiences from a clinic in India

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Sixty per cent of the global elderly population live in low- and middle-income countries, and this proportion was expected to rise to 70% by 2010 (International Institute of Ageing, 2001; Ferri *et al*, 2005). The 2001 Indian census found over 70 million people aged 60 years or more (considered senior citizens according to the Indian National Policy on Older Persons). Most of those senior citizens live with younger family members and are dependent on them for financial and social support. Hence, any physiological and psychological changes in the older family members affect the younger supportive members as well.

According to the findings of the 10/66 Dementia Research Network (Shaji *et al*, 2003), older people in low- and middle-income countries are 'indivisible from their younger family members'. Despite larger households being associated with lower levels of carer strain, this was in fact as high as in high-income countries. Prince (2004) found that many family members had to cut back on work in order to care for an older individual with dementia.

The need to provide respite care for family members in the Indian context has been highlighted by Rao & Shaji (2007). Collaborative care, through the use of support groups for carers that provide both information as well as outlets to vent pent up emotions, has become increasingly popular across countries. Group interventions that are educational and problem-focused and that discuss behavioural management have been found to be particularly useful (Haley, 1997) and they serve to delay nursing-home placement (Mittelman *et al*, 1996).

This article describes the development and pilot testing of a group intervention module for the carers of geriatric patients at a tertiary-care hospital in India. The work reported in this paper was conducted at a specialty out-patient geriatric clinic run once a week by the Department of Psychiatry at a tertiary centre, the National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore. The catchment area comprises both urban and rural areas of four adjoining southern states of India (Karnataka, Andhra Pradesh, Tamil Nadu and Kerala) and the centre receives referrals from the rest of the country. The clinic team comprises four geriatric psychiatrists, four social workers, a neurologist and two psychologists. The clinic provides services for a heterogeneous geriatric population with diagnoses that include dementia, psychosis, mood disorders and other psychiatric disorders.

Method

The geriatric clinic team planned a regular group intervention programme for the carers of the patients who attend the clinic. Initially, three focus group discussions were held with 17 carers. 'Cue questions' on the recognition of symptoms, behavioural management, medical care and follow-up, use of support systems, carer burden and social welfare measures for senior citizens were used to facilitate these discussions. The findings from the focus groups and inputs from experts in the field of geriatric psychiatry were then used to prepare an intervention module.

The module was divided into three sessions, with content as follows:

- session 1, psychoeducation on health problems related to old age
- session 2, psychosocial management of the aged person
- session 3, welfare measures available for the aged in India.

The module was then pilot-tested with 16 families, after which further changes were made. These changes included a shorter time span per session and simplifying the language. Group processes were then observed and recorded over 2 years of use of this module.

Results

Characteristics of group sessions

Each group session was conducted by at least two psychiatric social workers, working on rotation (these social workers were all members of the multidisciplinary team providing services at the geriatric clinic). The groups were heterogeneous in nature and comprised the carers of patients with varied neuropsychiatric diagnoses. Entry to and exit from the groups was open owing to the fluid nature of the out-patient department and the fact that families from outside the state of Karnataka were also accessing these services. Each session lasted 30–45 minutes and was repeated for 3 weeks, when it was followed by the next session (i.e. on a 3-weekly cycle). This pattern continued for 3 months, after which the whole intervention was repeated.

Up until December 2007, more than 65 group sessions had been conducted over the space of 2 years. On average, 8–10 family members attended the groups, which had a minimum of 4 and a maximum of 26 participants. The most common languages used were Kannada, Tamil, Hindi, Malayalam, Telugu and English. Sometimes more than one language was used, in which case translators helped. Of a total of 967 carers who attended the groups, 43% were spouses, 35% were adult children of the patient and 23% were 'other' (these included daughters-in-law, sons-in-law, and brothers/sisters, as well as a few friends, neighbours and other attendants).

Group observations

All the group sessions were helpful in allowing participants to share their experiences and burdens. The sessions helped carers to clarify their doubts and to learn new strategies of care; carers also had the benefit of being reassured that they were part of a large group who had experienced similar demands and stress. The researchers could elicit four main themes across all the group sessions (Table 1).

The specifically educational sessions (1 and 3) generated a number of questions among the carers. Of the three sessions, a higher degree of participation was found in session 2, when the group discussed the psychosocial management of aged persons. Compared with sessions 1 and 3, which adopted a psychoeducational methodology, session 2 was more of an interactional and experiential session. In this session, family members of patients with dementia often became very emotional and would cry while narrating their experiences. They were able to recollect the premorbid personality of the patient and this, they said, kept them going during times when the patient's symptoms were at their worst. Some family members were found to be extremely critical of their ill relative and expressed their anger at the degree of deterioration, even though they understood this to be caused by the disease. A few others who had been tending to an ill older relative for several years had a sense of resignation and seemed mildly depressed (sub-clinical). They spoke of their aged family members as a responsibility they recognised was theirs, and seemed to be resigned to their role as carers.

Discussion

Caring for a person with geriatric problems is very demanding. In order to develop any programmes to cater to the needs of carers in a cultural context, it is first essential to understand the needs, mental health issues and problems faced by carers with responsibility for an older person with psychiatric problems. In the group sessions, we found there were four main themes expressed by such carers (Table 1): emotional and cognitive responses; concerns about the patient's future; specific concerns of female spouses; and specific concerns of male spouses.

Carers expressed various emotional and cognitive responses to the care of a person with geriatric problems, such as anger, sadness, frustration, embarrassment, hypervigilance, acceptance, denial/disbelief, blame, criticality and curiosity. Stress often leads to problems with carers' mental and physical health (Ras & Opala, 2001). Certain factors predict carer distress, such as behavioural problems in the patient, the nature of the carer's social support and their ability to cope with difficult situations (Ras & Opala, 2001).

As most geriatric problems (notably dementia) are deteriorating conditions, carers had a number of queries about the patient's future, such as their ability to care for themselves (bathing, eating, grooming, personal hygiene), their ability to take on household responsibilities, their ability

Table 1 Emergent themes from the group process

Carer's emotional/cognitive responses	Carers' concerns about the patient's future	Specific concerns of female spouses	Specific concerns of male spouses
<ul style="list-style-type: none"> • Anger • Sadness • Frustration • Embarrassment • Hypervigilance • Acceptance • Denial/disbelief • Blame • Criticality • Curiosity 	<ul style="list-style-type: none"> • Ability to care for self (bathing, eating, grooming, personal hygiene) • Ability to take on household responsibilities • Ability to socialise • Patient's deteriorating biological functioning (sleep, appetite, bowel/bladder) 	<ul style="list-style-type: none"> • Burden of increased responsibility • Difficulty understanding erratic behaviour • Loss of a breadwinner • Loss of sense of protection and security • Increased dependence on adult children and extended family • Being blamed by society for spouse's condition 	<ul style="list-style-type: none"> • Difficulties with household chores • Loss of routine • Difficulty understanding erratic behaviour • Increased dependence on adult children and extended family

to socialise with the extended family and the wider community and, finally, how to cope with their deteriorating biological functioning (sleep, appetite, bowel/bladder). As the burden of caring directly correlates with the level of independent functioning of the patient (Ryden, 1998), it was understandable that the carers were worried about the future ability of patients to care for themselves.

Gender sensitivity is required in understanding carers' problems in dealing with an ill relative. We found that male and female carers had different requirements and concerns in caring for a spouse with geriatric problems. The specific concerns of female spouses centred on the burden of increased responsibility, the difficulty in understanding erratic behaviour, the loss of the family's breadwinner, a loss of sense of protection and security, their increased dependence on adult children and the extended family, and being blamed by society for their spouse's condition. The specific concerns of male spouses who were carers included difficulties with household chores, a loss of routine, difficulty understanding erratic behaviour and increased dependence on adult children and the extended family. Among the wider group of carers, the needs of children of patients differ from those who are spouses. Programmes should be developed to address different needs, depending upon the gender of the carer and the relationship to the patient.

The results need to be understood in the light of certain limitations to the study, such as the short duration of the group sessions (30–45 minutes, due to limited resources and lack of infrastructure). Further, as it was an open group session for out-patient carers, the group composition varied, and not all carers were able to attend all three group sessions.

In conclusion, the geriatric group programme was acceptable to the carers of out-patients with geriatric ailments. Further development and distribution of group intervention

materials, such as handouts on the various topics discussed, could be helpful for carers. Future programmes need to deal with gender-specific issues in taking care of patients with geriatric disorders before the efficacy of these group sessions is tested in a larger, controlled intervention study.

Memoriam

The primary researcher in this study, Dr Udaya Kumar GS, passed away in June 2007. The authors dedicate this paper to him.

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THEMATIC PAPER – CARE FOR ELDERLY PEOPLE WITH MENTAL ILLNESS

Twenty-five years of expectation: where are the services for older people with mental illness in Africa?

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Mental health disorders account for about 14% of the global burden of disease. Neuropsychiatric disorders may be responsible for more than 1.2 million deaths annually (Prince *et al*, 2007). Around 80% of those affected live in low- and middle-income countries. Yet, despite the fact that older persons carry a disproportionate burden of non-communicable disease and mental disorder, they are not seen as priority issues for healthcare provision in these countries. Logically and ethically, older persons should be prioritised for targeted interventions,

alongside the generic strengthening of primary and community health provision. African governments, spurred on by the specific agendas of non-governmental and parastatal organisations, continue with more urgent tasks; their healthcare provision is oriented towards the 'younger generations' (maternal and child healthcare, and infection). In most African countries, the expenditure specifically targeted for mental health is below 1% of the total healthcare budget, that is, effectively non-existent (Saxena *et al*, 2007).

Should the mental health of older persons receive a higher priority?

Some 8–18% of older adults live alone in Africa, and the probability of living alone is greater for older women than it is for men (Bongaarts & Zimmer, 2002). Today, approximately 3–5% of Africans are aged 60 years or more and are, in broad terms, widowed females with little or no formal education who live in relative rural poverty. Urbanisation, the transforming effect of wage-based economies on rural extended families and their subsistence lifestyles, and migration will increase the tendency for older Africans (especially women) to be left alone and unsupported within rural areas.

Although the proportionate rise in the population aged 60 and over in Africa in coming decades will be relatively modest, the absolute number of individuals in this age range is predicted to rise from 48 million in 2005 to 207 million by 2050 (Ferreira, 2008). This increase poses dramatic prospects for African healthcare planners. As population ageing progresses, the number of older persons with mental health problems will proportionately increase too.

The next four decades will witness more than 150 million newly recruited older Africans without adequate provision of mental healthcare. More than 20 million older Africans may be living alone by 2050. As informal care inevitably erodes, the prospects for the older person with a mental illness must be poor. In today's world of rapid demographic transition, there is no certainty that the care of older persons, previously taken for granted within the informal social system of the extended family, will be sustained (Levkoff *et al*, 1995). Indeed, all evidence points to the contrary: in order to survive, most older Africans need to be economically active to the end, as informal financial support and retirement pensions are available to only a tiny minority. With no parallel increase in the provision of formal social or health services to cater for the associated increased need, evidence points to increasing numbers of premature and avoidable deaths among older persons with treatable mental health conditions (Clausen *et al*, 2007).

The demographic change towards benefits that accrue from increased life expectancy will be transient in Africa. An opportunity now exists for countries to experience 'the longevity dividend', but this will be short-lived. An increase in healthy life expectancy will initially provide a national economic benefit and, beyond this, it could also lead to a better fulfilment of life and to an increase in the older person's meaningful participation in the community. Countries in which this capacity to capitalise on longevity is not achieved, however, will experience an increase in the gap between healthcare demand and their capacity to deliver healthcare to the ageing population.

Is mental illness in older Africans different from that elsewhere?

Literature from Africa is scant, and even regular monitoring of mental illness and mental healthcare delivery is non-existent in most African countries. There may be variation in the distribution of causal mechanisms that contribute to risk of mental illnesses, such as dementias, in Africa compared with high-income countries (Hendrie *et al*, 2001). While there is little evidence that older Africans experience Alzheimer's disease,

vascular dementias or other degenerative dementias, cognitive impairment is relatively common, although it is typically observed to be at a lower prevalence than in Europe and the USA. In Botswana, cognitive impairment has been found in 9% of those aged 60 years and over, and the prevalence increases with age (Clausen *et al*, 2007). In addition, older Africans experience a higher risk of depression, of hereditary, nutritional and infective dementias, and, especially, of alcohol dependence (Prince *et al*, 2007). In Botswana, up to 25% of older persons experience one or more of these three common patterns of mental illness. The afflictions render them vulnerable to ostracism, social isolation, elder abuse and reduced physical function (Gureje *et al*, 2007). When they are accompanied by institutional prejudice and neglect, and an increased burden of other non-communicable disorders and physical disabilities, it is easy to see why the perceived need for provision of care may be low. Affected people simply die, and often do so alone (Clausen *et al*, 2007).

Thus, although the prevalence of a range of mental illnesses may be somewhat differently distributed across cultures, mental disorders of the elderly are potentially common in Africa. They may be relatively unrecognised because of the high attrition rates from these illnesses, which are due to a total lack of care provision.

In high-income countries, ageing and the loss of function in older citizens are addressed through the provision of targeted health and social care. Social care systems may differ between nations, but they always require central financial support. Governments usually provide a mix of cash transfers and formal care services, such as pension schemes, meals, home-based care and, ultimately, institutionalisation. It is likely that culturally sensitive approaches and systems will be required in Africa, but currently the only 'systematic response' to the needs of older Africans with a mental illness is near total neglect, in terms of formal service provision (Saxena *et al*, 2007).

What has been promised?

It is necessary to review and assess the effect of all the statements, resolutions, promises and commitments from a succession of international fora on this subject. On the part of the World Health Organization and the United Nations they include the First World Assembly on Ageing (Vienna, 1982), the Year of the Older Person (1999), the *World Health Report* (2001), entitled *Mental Health: New Understanding, New Hope*, and the Second World Assembly on Ageing (Madrid, 2002); there was also the African Union's *Policy Framework and Plan of Action on Ageing* (2003). Together these amount to an enormous quantity of work and expertise. But to what end?

How has Africa benefited? Can Africa meet the challenge?

On the face of it, there has been scant, if any, tangible benefit for older Africans with mental illness in the past quarter century. Of course, it is always possible to cite individual projects that have been notable and effective, but these invariably were local and driven by particular individuals. They

often withered as time passed. At governmental policy and planning levels, if the problem of mental health remains unrecognised and unacknowledged, then there is little that can be achieved. However, if a commitment to the implementation of carefully constructed and targeted community-based interventions were possible, harnessing the rich tradition of community support (*ubuntu*) that persists in rural Africa, a transformation is viable. Hope for the new cohorts of older Africans rests on those brave policy-makers who acknowledge the need to allocate resources to mental health.

If, instead, African governments continue to fail to meet this challenge, there is little point in rehearsing the specifics of appropriate interventions. The intentions, guidelines and suggested interventions already exist in thick documents carefully constructed by numerous international experts (United Nations, 2002; Patel *et al*, 2007). African countries can still prepare to meet the challenge of increasing numbers of dependent older persons with mental illness, by training personnel and preparing adequate health service systems, before these problems reach overwhelming proportions. Health service improvement cannot be cost free, but the provision of appropriate community care services and the training of lay persons who could assist older persons in maintaining independent function for as long as possible would be a cost-effective starting point.

We do not need more good intentions; older Africans now deserve commitment and action.

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THEMATIC PAPER – CARE FOR ELDERLY PEOPLE WITH MENTAL ILLNESS

Elderly people with mental illness in South-East Asia: rethinking a model of care

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The report *World Population Ageing 1950–2050* (United Nations, 2002) estimated that in 2005 there were 37.3 million elderly people (i.e. aged 65 years or more) in South-East Asia (a region incorporating Brunei, Cambodia, Indonesia, Laos, Malaysia, Myanmar, the Philippines, Singapore, Thailand and Vietnam). There are only a few epidemiological studies on mental disorders among elderly people in this region and the published data are mainly from Singapore, Malaysia and Thailand. Using Singapore's prevalence rate of 3% for dementia and 5.7% for depression, the numbers of elderly people with dementia in this region would be 1.2 million and with depression 2.12 million (Kua, 1992; Kua & Ko, 1995). However, even in Singapore, we have identified only 10% of all potential cases of dementia and depression – meaning that the large majority of elderly people with mental disorders are not detected, although they may be known, for other reasons, to the health services.

The under-diagnosis partly arises because most doctors are not taught geriatric psychiatry in the undergraduate curriculum, and even those with some training have difficulty recognising the early signs and symptoms. Medical students are often given clinical teaching in the context of a general hospital or mental hospital, where cases of dementia or depression are of moderate to severe degree. However, within primary care the clinical presentations are usually mild and may not yet fulfil the criteria (DSM or ICD) that apply to the diagnosis of more advanced disorders.

Access to services

In most South-East Asian countries there is a dearth of mental health services and human resources (Tasman *et al*, 2009). Unfortunately, the priority accorded to geriatric care is often low; geriatric psychiatry is never a popular

subspecialty for mental health professionals, including psychiatrists and nurses.

Many elderly Asian people prefer to see traditional healers whenever they are unwell. Cultural perceptions of illness, and societal attitudes towards the elderly and family support, may explain such people's health-seeking behaviour (Ng *et al*, 2004; Ma *et al*, 2009). Traditional healers are popular with the elderly not only because of the accessibility of their services but also because they share the same sociocultural beliefs about illness and health (Kua, 2004).

The focus of elderly mental healthcare should be in the community. Anchoring the service to a mental or general hospital generally leads to institutionalisation, sluggish bureaucracy and dislocation of family contact. There will inevitably be an associated stigma because of the mental institution, and an associated sense of anxiety concerning abandonment.

A day hospital or centre in the community can be the nucleus of a geriatric service in which doctors, nurses, psychologists and other mental health therapists work as a team. The Nottingham model, developed by Professor Tom Arie, has a combined geriatric medicine and geriatric psychiatry unit, which facilitates referrals, reduces costs and allows for integration of the two services. Having separate centres for geriatric psychiatry and geriatric medicine often leads to a duplication of services, the division of essential personnel like physiotherapists and nurses, and eventually to spiralling costs. Being in the community encourages referrals from primary care doctors. Elderly people are more motivated to go to the centres during the day and return home at night.

On the basis of accepting referrals of suitable geriatric patients from a general hospital, the day hospital or day centre can provide a step-down care programme, and this may reduce bed shortages in acute hospitals.

In Singapore there is tremendous support for such a service from voluntary organisations like religious groups, those representing retired persons and other charitable organisations. Galvanising community support is critical to ensure the success of mental health services for elderly people.

Training and service provision

There should be regular training workshops for staff working with these groups and educational programmes for the public to promote preventive psychiatry, to identify early symptoms and to de-stigmatise mental illness.

It has been suggested that to assist primary care doctors in identifying dementia, a screening questionnaire like the Mini-Mental State Examination (MMSE; Folstein *et al*, 1975) can be helpful. However, the MMSE is lengthy (it takes some 20–30 minutes to complete). In most primary care clinics in South-East Asia, doctors have just 10–15 minutes per patient. The MMSE is also culturally and educationally biased. Based on research conducted by the World Health Organization (WHO), we have constructed a short instrument, the Elderly Cognitive Assessment Questionnaire (ECAQ), which is more appropriate for those elderly people who are less well educated (Kua & Ko, 1992). The ECAQ can be administered in 10 minutes.

Of course, it is important for mental health services for elderly people to solicit feedback and evaluation. Such health

service research will provide valuable information on how to improve future programmes.

An increased connectedness between mental health services, voluntary organisations and family carers has seen a gradual decline in suicide rates among elderly people in Singapore (Kua *et al*, 2003). In 1995, the suicide rate among the elderly Chinese population in Singapore was at an all-time high of about 60 per 100 000. We identified those at greatest risk, especially elderly people who were disabled and living alone. In teaching primary care doctors we informed them where they could refer these patients to for social service assistance or treatment. Prevention programmes were run by non-governmental organisations like the Gerontological Society. A telephone helpline was started by a voluntary group called the Singapore Action Group of Elders. The Department of Psychological Medicine in the National University of Singapore provided training for retired persons to act as peer counsellors. There were discussions with the health authorities, with the aim of creating more day centres – some of which were managed by religious organisations – and to have more training opportunities in geriatric psychiatry for doctors, nurses, social workers, psychologists and other therapists. Since 1995 the suicide rate in the elderly population has fallen gradually, to the present level of about 17 per 100 000.

Family support

There is a growing concern about caring for an increasing number of frail elderly people in South-East Asia, not only because their number is increasing but also because there is a diminishing number of carers – traditionally, carers are the women in the family. The present concern emanates partly because of the social transformation of the Asian family. Young couples today prefer to live away from their parents. Women are better educated now and prefer to go out to work rather than to remain at home. Kua & Tan (1997) studied 50 family carers of patients with dementia in Singapore and found 56% had symptoms of anxiety and depression.

With the global economic crisis, there may well be an increase in the number of elderly people with depression, since many are dependent on their families for financial support (Phua & Kua, 2009).

The future

Care for the frail elderly population in South-East Asia will continue to rest on the family for the foreseeable future. Carers need to seek help outside the home. Support networks typically have the family at their core but should also include friends, neighbours and home-helpers. Community and governmental supports are necessary to alleviate the burden on the family. Although there are only a few old people's homes and day centres in most Asian countries, families may not be eager to use them because to send an elderly relative to such services implies a rejection of responsibility. However, with the change in family structures, many carers may have to turn to the community services in caring for their elderly relatives.

To ensure the detection of early or mild disorders, training of medical students should include work at primary care clinics. In the forthcoming new editions of ICD and DSM, the criteria for diagnoses must include mild disorders. Early diagnosis and a comprehensive management plan will improve the quality of life of elderly people with mental illness.

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COUNTRY PROFILE

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

Mental healthcare in Hungary: contradictions and possibilities

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The Republic of Hungary is a landlocked country of 93 000 km² in central Europe; it is bordered by Austria, Slovakia, Ukraine, Romania, Serbia, Croatia and Slovenia. Its official language is Hungarian. Hungary joined the European Union (EU) in 2004. About 90% of the population of c. 10 million is ethnically Hungarian, with Roma comprising the largest minority population (6–8%). Currently classified as a middle-income country with a gross domestic product (GDP) of \$191.7 billion (2007 figure), Hungary's total health spending accounted for 7.4% of GDP in 2007, less than the average of 8.9% among member states of the Organisation for Economic Co-operation and Development (OECD, 2009). The proportion of the total health budget for mental health is 5.1%, which is low when compared with, for instance, the UK (England and Wales 13.8%, Scotland 9.5%) (World Health Organization, 2008, p. 118, Fig. 8.1).

Hungary has long been a major contributor to the development of psychiatry, psychology and psychotherapy, through the works of Sándor Ferenczi, Géza Róheim, Melanie Klein, Michael Bálint, Lipót Szondi, Ferenc Mérei, Iván Böszörményi-Nagy, Kálmán Pándy, László von Meduna, Pál Juhász, Mihály Arató and the recently deceased István Degrell (Bánki, 1991; Rihmer & Füredi, 1993).

Status of general and mental health in Hungary

The average life expectancy for a Hungarian citizen at birth is only 73.3 years, more than 5 years below the OECD average of 79 years. The mortality rate presently exceeds the birth rate, which means the population is declining. More than half the mortality is due to cardiovascular disease (coronary heart disease is the leading cause of death). As elsewhere, drinking, smoking, obesity, unhealthy eating habits and lack of physical activity undermine the health of the population (Skrabski *et al*, 2005; Tringer, 2005).

The prevalence of both mental disorders and substance use disorders is on the rise. About 300 000–400 000 people (around 4% of the population) experience depression, but only 40 000 of them have a medical diagnosis (European Commission, 2008). A study applying DSM–IV criteria found the current rate for depression to be 18.5% among people attending primary care, while the rate for major depressive episode was 7.3% (Torza *et al*, 2008).

The suicide rate in Hungary remains the highest (after Lithuania) in the EU despite the fact that between 2000 and 2005 the decrease in Hungary's suicide rate was the second

largest after Denmark's, not only in Europe but in the world (Rihmer & Akiskal, 2006).

Hungary has among the highest rates in the world of alcohol-related mortality and morbidity (chronic liver disease, cirrhosis and alcoholism). After Moldavia, Hungary has the second highest mortality rate of liver disease and cirrhosis. This rose from 5.0 per 100 000 in 1950 to a peak of 83.9 in 1994, although it has fallen since, to 54.8 per 100 000.

Between 2003 and 2008, the numbers of patients entering treatment for addiction varied from 13 500 to 15 500, with between 4000 and 6300 new patients per year. The most common illicit drug was cannabis, followed by opiates, amphetamines and fewer cases of cocaine usage (OSAP, 2008).

Healthcare system and mental health resources

Hungary's healthcare system is primarily financed through the Health Insurance Fund. The current system of insurance-based funding has contributed to the ongoing funding problems of most mental health programmes and has impaired the ability of psychiatry departments and universities across Hungary to function.

There is no specific law regulating mental health services in Hungary but, on the whole, legislation regarding mental health issues, including protection of the human rights of mental patients, conforms to EU requirements (Tringer, 2005).

In terms of government policy, whereas both the National Programme for the Prevention and Treatment of Cardiovascular System Diseases and the National Cancer Programme have been recently revised, the National Programme for Mental Health was accepted in 2009 but has yet to be financed. In addition, with the Hospital Law of 2006, the government further reduced the number of psychiatry beds (from the previous 4.8 to 3.1 active/acute psychiatry beds per 10 000 population) and the same law also closed the National Psychiatry and Neurology Institute, which was the country's largest in-patient mental hospital, as well as an essential research, information-gathering and training centre.

Attempts to strengthen the mental health of children and adolescents have been made, under the National Infant and Children Health Programme (2007–2013). In addition, a Substance Misuse Policy was formulated in 2000 that ran until the end of 2009. The National Psychiatry Centre was established in 2009 to collect accurate, scientific data about the mental health of the population. Since 2008 the Ministry of Health has made greater efforts to participate in EU partnership programmes, including the European Pact of Mental Health (2008); it also hosted the EU Prevention of Depression and Suicide Thematic Conference in December 2009. The Hungarian College of Psychiatry and the Hungarian Psychiatric Association have been working in collaboration with the EU Directorate General for 'Health and Consumers' and the WHO Europe Regional Office to get through the National Programme of Mental Health (NPMH).

Activities in priority areas

Two successful current programmes should be noted: the Suicide Prevention Programme in Regions with a Very High

Suicide Rate, which aims to determine the effectiveness of an educational programme on the management of depression for general practitioners (Szántó *et al*, 2007); and a programme in Szolnok, which is part of the European Alliance Against Depression collaborative project (Hegerl *et al*, 2008).

Civil organisations have begun to play a more significant role in both health services and social care. The Hungarian Alzheimer Society, representing the interests of relatives of persons with Alzheimer's disease and other forms of dementia, is an example of an effective organisation supporting mental health in Hungary.

Research

Hungary has no central body coordinating mental health research. Major research centres include: Semmelweis University Budapest's Psychiatric and Psychotherapeutic Clinic (Simon *et al*, 2009); the Mental Hygienic Department, Institute of Behavioral Medicine; the Institute of Psychology of the Hungarian Academy of Science; Eötvös Lóránt University; Budapest University of Technology and Economics Research Centre for Cognitive Science; the University of Szeged; the Albert Szent-Györgyi Medical and Pharmaceutical Centre's Department of Psychiatry; the University of Pécs; the University of Debrecen; the University of Gáspár Károli; and Péter Pázmány Catholic University.

One of the major national sources of finance for scientific research is the National Scientific Research Fund (OTKA). In 2004, Hungary was second in terms of indexed impact factor for scientific publications on neuropsychiatry and psychology (Scheffler & Potucek, 2008, p. 236).

The Hungarian Psychiatric Association organises a congress every year, and over 2000 professionals from the mental health field participate. Its member societies (e.g. the Psychoanalytical Society, the Psychopharmacological Society and the Hungarian Family Therapy Association) also have annual meetings.

Training

Medical undergraduate training

There are four medical universities in Hungary, located in Budapest, Debrecen, Szeged and Pécs. Although undergraduate training in psychiatry is based on a national curriculum, the medical universities develop their own programmes. The 6-year medical training includes medical psychology, behavioural medicine and elective courses in psychotherapy.

Postgraduate training in psychiatry

Hungary is an active member of the European Union of Medical Specialists.

Postgraduate training in psychiatry is a 5-year programme with obligatory theoretical courses. Because of new EU regulations, child and adolescent psychiatry training has been a basic 5-year course in Hungary since 2005.

A secondary specialisation in psychotherapy is available only for medical doctors and psychologists. Psychotherapeutic training is efficiently organised in Hungary, and since 1990 a non-governmental organisation, the Hungarian Psychotherapeutic Council, has been coordinating the standards of

training and practice. The Council is an accredited member of the European Association of Psychotherapy.

Allied professions

Basic training for nurses (BSc) consists of 4600 hours in 3 years and for masters training in a specialty (MSc) another 3 years of training. Postgraduate psychology training for clinical psychology requires 4 years of training and clinical practice. There are accredited postgraduate courses for psychiatric social work.

Human rights issues

In terms of patient rights, Hungary follows international norms and the EU directives. There are few violations and those that do arise are, in general, a consequence of inadequate infrastructure, or more especially the low numbers of nurses and therapists.

Issues surrounding the treatment of high-risk and violent patients, their legal regulation and forensic management remain unresolved. Hungary has no high-security wards or units, nor does it have a forensic psychiatry institute. The profession has prepared concrete plans for the introduction of both, but these have yet to be officially endorsed.

Current obstacles, future challenges

Key areas for mental health policy and services are:

- integration with primary care
- the skills mix of the workforce
- the implementation of community services
- the collection of adequate information.

Although the National Programme for Mental Health addresses all of these challenges, there are still systemic problems to solve. For instance, community mental health services (community psychiatry, mobile teams, in-home treatment) – an essential part of the Programme, with an emphasis on civil and user-led services – have been introduced in only a few areas.

The overall number of mental health professionals is low and they are unevenly distributed across the country. Many psychiatrists and psychiatric nurses are leaving for jobs in the UK, Sweden and Denmark. As a consequence, there are places in Hungary where basic mental health services are in jeopardy.

Conclusions

Mental health must overcome party politics and become a government priority in Hungary. This is crucial in light of Hungary's comparatively poor mental health indexes. The programmes need adequate funding for training and research, otherwise the mental well-being of the population will deteriorate further. In addition, there needs to be a willingness to find new and creative ways to strengthen prevention and make treatment more effective.

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International electives in psychiatry for UK medical students

As part of the College's strategy for recruitment into psychiatry, we would like to enhance opportunities for UK medical students to undertake psychiatry electives overseas. This will entail developing a database of international members of the College willing to provide an elective in psychiatry. A notice with information on the initiative and how to get involved will be available in the next issue.

Further details can be obtained from Charlotte Cox, email ccox@rcpsych.ac.uk.

Russian Federation: mental healthcare and reform

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The Russian Federation is a country with an enormous territory, of over 17 million km². Its population is 141.9 million (2010 figure). The population was declining, especially at the end of the 1990s, but in more recent years the tendency has been towards stabilisation. Life expectancy has remained relatively low, although it has increased somewhat over the past few years, to reach 67.5 years in 2008 (61.4 for men and 73.9 for women), up from 65.3 years in 2004 (58.9 for men and 72.3 for women).

The budget for healthcare has remained low compared with that in other countries, both high-income and low- and middle-income ones, and constituted in 2009 about 5.5% of gross national product (GNP). However, it should be mentioned that the federal allocations during the same period had grown from 2.3% to 3.5% of GNP; the rest of the total budget was provided by the state medical insurance system. There are significant differences between different regions in the financial support for local healthcare from municipal budgets. Psychiatric care is financed from the federal budget and is not included in the state medical insurance system.

Psychiatric care

In general, the psychiatric care system is based on two main types of facility: the territorial psychiatric out-patient clinics, termed 'dispensaries' (in rural areas these are units located by general hospitals), which provide care for the population residing in a specific territory; and the psychiatric hospitals, which generally provide in-patient treatment for the population within a certain catchment area (district, city or region). As a rule, a dispensary district psychiatrist provides care for an adult catchment population of around 25 000, whereas child psychiatrists (who usually work in a child territorial polyclinic) provide care for a catchment population of 15 000 children and adolescents. These figures, though, will be adjusted for territories with a lower population density.

Psychiatric dispensaries may additionally provide specialist services such as psychotherapy, neurology, epileptology, sexology and gerontopsychiatry; they may also set up day hospitals. So-called 'narcology' services for people with alcohol and drug addiction were established in Soviet times, and until now they have mostly operated separately from regular mental health services.

A specific feature and principal defect of in-patient psychiatric care in Russia is its over-centralisation. The majority of psychiatric hospitals have more than 500 beds and some

more than 1500. Nevertheless, over the past few decades the total number of beds has decreased by 25% and this process is continuing gradually. However, the decrease in psychiatric bed numbers has not always been accompanied by an increase in the provision of extramural forms of psychiatric care (Table 1).

The system of psychiatric care has shown contradictory tendencies in its development. On the one hand, taking into account the shortages in state budget allocations, psychiatric care on the basis of local psychiatric dispensaries that are open to the general public and connected to local psychiatric hospitals is expedient. On the other hand, psychiatric patients' stigma and societal prejudices against psychiatry and psychiatric institutions hinder the development of psychiatric dispensaries.

Only about 30–35% of all patients with a mental illness apply for psychiatric assistance in the dispensary. However, recently the number of patients asking for an initial psychiatric consultation has started to increase. The prevalence of mental disorders registered in psychiatric institutions has reached 2978.7 per 100 000 population (Table 2). At the same time, the problem of mental disorders in primary care is becoming more and more serious, such that, at present, some 25–30% of primary care patients need a psychiatric consultation. The need has arisen to reform and develop out-patient psychiatric care.

Table 1 Extent of psychiatric care resources

Mental health resource, <i>n</i>	1999	2008
Psychiatric dispensaries	164	145
Dispensary departments in psychiatric hospitals	122	123
Narcological dispensaries (for people with alcohol and drug addiction)	171	144
Dispensary units in general hospitals (in rural areas)	2 322	2 078
Psychotherapeutic units in general out-patient clinics	1 118	1 107
Psychiatric hospitals	278	257
Narcological hospitals	13	12
In-patient departments in psychiatric dispensaries	107	88
Total psychiatric beds (in psychiatric plus general hospitals)	170 440	155 834
Total beds in general hospitals (included in total above)	14 015	13 890
Total beds in narcological hospitals	28 700	26 550
Total places in day hospitals	13 645	17 289

Table 2 Patient populations

Patient population, <i>n</i>	1999	2008
Persons with mental disorders (without substance misuse)	3 813 500	4 226 899
Persons with alcohol misuse	2 230 050	2 728 010
Persons with drug addiction	209 080	358 120

National data from state psychiatric and narcological dispensaries and psychotherapeutic units.

The suicide rate in Russia is one of the highest in the world, although in recent years it has decreased slightly, from 38.7 per 100 000 in 1999 to 27.1 in 2008. The figure for men is six times higher than that for women, which may be related to greater alcohol consumption among men. Alcohol consumption in Russia is approximately 14–15 litres per capita (Nemtsov, 2009). The prevalence of alcoholism, including alcohol psychoses, has been more or less stable over the past decade, but with a slight tendency to increase, up to 1922.4 per 100 000 population in 2008; the male:female ratio was 5:1 (Koshkin, 2009; see also Table 2). Addiction to other substances has also apparently increased in recent years. The prevalence rate was 252.2 per 100 000 in 2008 (Koshkina, 2009). Opioid dependence accounted for 87.5% of this group.

Over the past few years, the total number of people with a mental illness who are registered disabled has increased by 20%, and in 2008 reached 1 020 002 (in 1999 it was 826 036). This increase has arisen not merely through personal deterioration in health but also because social adaptation has become more difficult.

In the past decade, a significant number of psychologists, psychotherapists, specialists in social work and social workers have been incorporated into the staff of psychiatric institutions, which has created a basis for transition from a largely medical to a biopsychosocial model of mental healthcare and a team approach to its provision (Table 3).

In some regions mental health services have begun to give greater emphasis to care in the community, where a system of psychosocial rehabilitation is organised, hostels and other types of protected housing are set up, interaction with social services is developed, assertive treatment departments (teams) are set up, and 'hospital at home', employment, psychoeducation and psychosocial work with families are provided (Gurovich & Neufeldt, 2007). Non-governmental organisations (NGOs) are becoming more involved in mental health assistance, although not yet sufficiently so.

Table 3 Numbers of specialists providing psychiatric care

Specialists	1999	2008
Psychiatrists (including psychotherapists)	15 860	16 184
Psychotherapists (included in total above)	3 248	3 438
Narcologists (specialists providing care for people with alcohol or other substance misuse)	4 470	5 329
Specialists in social work (with higher education)	70	772
Social workers	840	1 857
Clinical psychologists (in psychiatric and narcological institutions)	1 407	3 652

Legislation and patients' rights

The Law on Psychiatric Care, adopted in 1992, works successfully enough at both federal and regional levels, and generally provides for patients' rights. However, social care services and guarantees regarding the provision of mental healthcare have not been implemented sufficiently.

Although there have been some notable omissions and errors in routine clinical practice in recent years (like the nationally well known Rakevich and Arap cases), these have not involved a deliberate violation of patients' rights. In some cases, especially connected with hospitalisation, mental health specialists do not pay enough attention to accounting for their actions to patients and relatives. It is not a matter of violation of the legislation, but rather a question of professional ethics. All such cases or conflicts in psychiatric care are discussed at meetings of the Russian Society of Psychiatrists and in professional journals.

Research

Because of the urgent need for reform in mental healthcare, Russian psychiatrists consider applied clinical/organisational studies to be the main scientific task in their work. Epidemiology, the formation and trials of new models, new approaches to treatment and rehabilitation on the basis of multiprofessional teamwork, with the involvement of NGOs, are the priority for most researchers and research groups.

The detection and treatment of depressive and anxiety disorders at primary level is also one of the important directions for research, alongside investigating optimal forms of multidisciplinary work and joint research with doctors, cardiologists, neurologists and other specialists (Smoulevich *et al*, 2005; Krasnov, 2008).

Socially oriented studies have been supported by a special federal programme. Studying the mental health of populations living for a long time under the strain of an emergency situation and then under reconstruction and reconciliation processes, as has been the case in the Chechen Republic (Idrissov & Krasnov, 2009), is supporting the development of appropriate mental healthcare in specific regions.

Recently, new branches of research and practical psychiatry have emerged in Russia, such as ecological psychiatry and ethnocultural aspects of mental health (Krasnov & Gurovich, 2007).

Education in psychiatry

Postgraduate education for clinical practice (after 6 years of formal medical education) comprises an additional 2-year course termed 'ordinature' and then 500 hours of specialisation in forensic psychiatry, narcology or psychotherapy (psychotherapy is possible only after at least 3 years of practical work in psychiatry). There are also courses on psychogeriatrics, child psychiatry, psychosomatics and the organisation of psychiatric services. All doctors have to validate their professional status in certificate confirmation courses, once every 5 years.

There is also a variety of training schemes for clinical psychologists and social workers.

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COUNTRY PROFILE

Mental health in the Democratic Republic of Congo: a post-crisis country challenge

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The delivery of mental healthcare in the Democratic Republic of Congo (DRC), formerly Zaire, is influenced by geography, politics, legislation and the structure of the health system, as well as traditional beliefs and culture.

The DRC is in Central Africa; the Central African Republic and Sudan border to the north, Uganda, Rwanda and Burundi to the east, Zambia and Angola to the south, and the Republic of Congo to the west; and it is separated from Tanzania by Lake Tanganyika to the east. The country occupies 2 345 408 km², which is slightly greater than Spain, France, Germany, Sweden and Norway combined. For administrative purposes the country is divided into 11 provinces, each with a provincial headquarters.

The population is over 66 million, with 47% aged under 15 years and 4% over 60. Average life expectancy at birth is 46 years for men and 49 years for women. There are around 350 ethnic groups; the largest groups are the Kongo, Luba and Mongo peoples. There are also around 600 000 Pygmies, the aboriginal people of the DRC. Although some 700 local languages and dialects are spoken, there is widespread use of French (the official language); the most common local languages are Kongo, Tshiluba, Swahili and Lingala. Eighty per cent of the population are Christian, 10% Muslim and 10% follow traditional beliefs or syncretic sects (Central Intelligence Agency, 2008).

Before independence in 1960, the DRC was under Belgian colonial rule. The economy, despite the country's vast natural resources, has greatly declined since the mid-1980s. Recent conflicts, which began in 1996, have dramatically reduced national output and government revenue and increased the external debt, as well as resulting in famine and disease and 5 million conflict-related deaths (US State Department, 2009).

Despite a current lull in overall violence, the plight of people across the eastern DRC remains dire. Thousands have been displaced following renewed violence or rumours of impending violence. Achieving mental health for the population of the DRC is a priority for its economic recovery, achievement of physical health goals and creating resilience among the local people.

Mental health policy and legislation

The DRC's mental health policy was formulated in 1999. Its essential components are advocacy, promotion, prevention, treatment, rehabilitation and education; there is also a substance misuse policy. The national mental health programme was also formulated in 1999 (World Health Organization, 2005). The Ministry of Health is responsible for the organisation, management and planning of mental health sectors, and it is represented at provincial, district and community level.

The DRC has ratified the international legal instruments concerning the rights and protection of people who are mentally ill, but there is as yet no DRC law defining the rights and protection of people with mental illness or regulating the procedures for voluntary or involuntary admission to a psychiatric hospital.

Mental disorders in the DRC

Popular beliefs persist about supernatural causes of disease in general and psychiatric problems in particular (Okitapoy, 1993; Okitapoy et al, 1996).

Mental disorders are probably at least as common in the DRC as they are elsewhere, but there are no national epidemiological data. Statistics from two psychiatric centres, the Soins de Sante Mentale (SOSAME) Psychiatric Centre in Bukavu (a post-crisis region) and the Katwambi Centre Neuropsychopathologique (CNPP) (in Kasai province), show the following:

- 80% of patients are under the age of 40, 36% aged 21–30
- there are 1.02 female patients for each male patient
- half the patients are without employment
- 6–15% of patients have schizophrenia
- 6–31% have other psychotic disorders
- 22% suffer from anxiety disorders (related to war trauma for 18%, to sexual abuse for 3.5% and to other factors for the remaining 0.5%)
- 13–23% of patients have mood disorders (manic episodes, depressive disorders and bipolar disorders).

Psychiatric services

Historical background

In 1926, a psychiatric institution situated along the Congo River called Mount Stanley Lazaret was created by order of the colonial authority, and from 1928 was open to patients with mental illness, tuberculosis and leprosy. In 1960, the centre became the Mount Stanley Psychiatric Institute but in 1969 it closed. It was replaced by the CNPP–Mount Amba in 1973, associated with the University of Kinshasa medical faculty. In 1957, the CNPP opened in Katwambi.

Current mental health services

Mental healthcare is delivered by private institutions as well as general and company hospitals. According to the current national health sector plan (Ministère de la Santé, 1999), mental health should be integrated into primary care. The national mental health programme is responsible for carrying out this integration. Under the general health decentralisation policy, it is planned to establish a mental health programme in each province and district, with support for the health zones and basic health units.

However, the mental health infrastructure still remains very centralised in Kinshasa, the capital, and some provinces. There are two university institutions: the CNPP–Mont Amba in Kinshasa and the Department of Neuropsychiatry of Sendwe Hospital in Lubumbashi. There is one state hospital, operated by the Roman Catholic Brothers of Charity (the CNPP–Katwambi). In addition, there are mental health centres, 90% of which are run by Roman Catholic organisations. There are also some private clinics run by Congolese neuropsychiatrists in Kinshasa.

There are no budgetary allocations for mental health. Primary funding comes in the form of out-of-pocket expenditure by the patient or the patient's family. The cost of psychiatric treatment is considered high in relation to average earnings (World Health Organization, 2005).

Mental health workforce

Specialist human resources in mental health are also very centralised. Currently, there are 34 neuropsychiatrists for a population of over 66 million, of whom only 2 are in the provinces – the other 32 are in Kinshasa. Thirteen Congolese

neuropsychiatrists are abroad (Belgium, France, Canada, the USA, and South Africa). In addition, four general practitioners have had 6 months' training in neuropsychiatry. There are 0.01 psychologist clinicians and 0.03 psychiatric nurses per 100 000 population, but again they are mainly in Kinshasa. There are no occupational therapists or social workers qualified in mental health (World Health Organization, 2005, 2006).

Education and training

Medical training lasts 7 years and is available at a number of universities, including Kinshasa, Lubumbashi and Kisangani. Specialist training in neuropsychiatry for doctors and nurses is available only at the CNPP, University of Kinshasa, and lasts 5 years. That CNPP is mandated: to provide care to the community; to act as a training centre for mental health professionals at all levels, including academic and scientific personnel working in the field of neurology and psychiatry; and to serve as a biopsychosocial research centre for the University of Kinshasa.

As mental health is being integrated into primary care, regular training of primary care professionals is carried out in the field of mental health. To facilitate access to mental healthcare despite the shortage of specialists outside Kinshasa, there is a training programme of 6 months in psychiatry (at the Kinshasa CNPP) for general practitioners.

There is no training available for occupational therapy or social work.

The government also partially supports some charitable organisations like SOSAME and some non-governmental organisations that provide mental health services and training (Réseau des ONG d'Action en Santé Mentale, 2007).

Human rights

Human rights violations have been perpetrated by rebels, militiamen and other armed groups. According to Amnesty International (2007), the transitional power-sharing government since 2003 has made little progress in advancing the law and respect that are essential to securing human rights. Meanwhile, the eastern DRC partially remains under the control of some armed groups. Insecurity, unlawful killings, human rights abuses, ethnic tension, widespread rape and sexual exploitation of women and girls, torture and illegal detention, as well as the recruitment and use of child soldiers continue in many parts of the country, in some instances perpetrated by government forces. Guarantee of the safety and dignity of people returning to the country, including refugees, remains difficult (Human Rights Watch, 2007; Integrated Regional Information Networks, 2009).

Conclusions

The DRC represents a chronic emergency, with endemic poverty, conflict, violence, forced displacement of ethnic groups, torture and rape as weapons of war, which have all had devastating effects on the population. These serious violations of international humanitarian law must be addressed to create peace, respect for human rights and dignity, equity

and accountability. These factors need also to be taken into account in mental health policy, legislation and implementation for the well-being of the Congolese population.

The national mental health programme needs to be allocated a government budget so that it can be implemented. It will then be possible to begin to work towards mental health promotion, training in mental health for staff at all levels, epidemiological research, improvement of infrastructure, effective integration of mental health in primary care, and liaison with family, traditional and religious healers in the management of people with mental problems.

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ORIGINAL PAPER

Community mental health provision in Pemba Island, Zanzibar: a cross-sectional survey of different stakeholder groups

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There is limited information about stakeholder perceptions of health service provision in low- and middle-income countries. We conducted a cross-sectional survey of 821 stakeholders of the community mental health services in Pemba Island, Zanzibar, Tanzania. The aim was to obtain systematic information about coverage, barriers, accountability and room for improvement as a baseline before implementation of a new mental health policy to strengthen mental health services.

Zanzibar lies off the coast of Tanzania in the Indian Ocean and consists of two main islands, Unguja (Zanzibar) and Pemba. It has served as a gateway into East Africa for traders from Arabia, Asia and Europe. Pemba has an area of approximately 900 km² and an estimated population of 500 000 (National Bureau of Statistics Tanzania, 2002).

A community mental healthcare programme was instituted for Pemba in 1994, to improve the detection and treatment of mental health disorders. However, there was no assessment of whether this was systematically established throughout the island. We therefore conducted a baseline

cross-sectional survey to study the views of major stakeholders about available facilities, staffing and medication through the community mental health services in Pemba, in order to assist the further development of services and implementation of the new mental health policy.

Method

The sampling frame consisted of three groups of residents of Pemba Island:

- community leaders and members
- health workers and traditional healers
- people attending psychiatric out-patient and general medical departments, either as users presenting with mental health problems or as carers.

A questionnaire was used to collect information on: socio-demographic details; views of current provision of mental health services; explanations of the different disorders; views on treatment; views on traditional healers; and views on

what could be done to promote mental health in Pemba. The views of users, carers and traditional healers about explanatory models for mental health problems have been reported elsewhere (Mirza *et al*, 2006).

From February to May 2001, participants were recruited from the out-patient department of the three-district referral hospital of Pemba Island, the psychiatric admission ward at Chake-Chake hospital and the consulting rooms of traditional healers. Consecutive patients were interviewed together with their relatives. The chairman of the traditional healers' association gave permission to conduct the survey among the association's members and provided a current list of healers in Pemba. A convenience sample was obtained both for traditional healers and for other stakeholders. Verbal consent was obtained prior to interviews.

Results

A total of 821 persons were interviewed. Their mean age was 37 years (95% CI 36, 38 years). There were 496 (60%) men and 311 (38%) women; 590 (72%) were married. Socio-demographic details according to category of stakeholder are given in Table 1.

The majority (range 50–84%) of respondents from all but one of the groups of stakeholders reported a lack of community mental health provision in their area; the exception was the group of carers, just under half of whom (46%) reported a scarcity of this resource (Table 2). Among those who described this shortage, a major reason reported was lack of staff, cited by 69% of traditional healers, 42% of community

members and 42% of community leaders, whereas health workers cited no interest from families (26%). There was little comment from users or carers about the reasons for this, as only 3% reported lack of staff, whereas others who had reported lack of facilities did not state any reasons for this. Of those who reported that services were present in their area, the majority of each stakeholder group reported that out-patient (range 61–96%) and counselling (range 48–86%) services were available, whereas very few had knowledge of any outreach services.

A majority (range 62–91%) reported a lack of availability of psychotropic medication, except for community leaders (36%). Similarly, the majority of each group (range 74–93%), except again for community leaders (41%), felt that the provision of psychotropic medication was the responsibility of the Ministry of Health.

All stakeholder groups reported that health workers had never visited their communities in order to undertake mental health activities (range 87–99%). The involvement of community members and leaders in the treatment and prevention of mental health problems was either the most or the second most frequent need mentioned by all the groups (detailed breakdown available on request).

Discussion

Our findings indicated that all stakeholders consider there is a need to improve coverage of existing services, and identified lack of space, trained personnel and mental health literacy as key barriers. There was considerable support among

Table 1 Sociodemographic profile of the study participants

	Community		Providers		Users and carers	
	Community members	Community leaders	Traditional healers	Health workers	Users	Carers
Number in sample	151	169	119	145	107	130
% of total	18.4	20.6	14.5	17.7	13.0	15.8
<i>Health community, n</i>						
Mkoani	3	10	7	41	3	1
Chake-Chake	98	122	100	31	91	107
Wete	42	29	7	35	10	20
Micheweni	4	0	0	38	3	2
Mean age (years)	36.0	41.2	50.6	33.4	30.9	31.7
(95% CI)	(34, 37)	(39, 43)	(48, 53)	(32, 35)	(29, 33)	(30, 33)
<i>Gender, n</i>						
male	71	135	101	81	50	58
female	76	31	16	62	55	71
<i>Marital status, n</i>						
single	31	23	12	36	41	29
married	112	136	100	98	52	92
divorced	7	2	5	9	12	6
widow(er)	1	0	1	1	2	3

Table 2 Views on level of available community mental health services and treatments in the locality

	Community members (n = 151)	Community leaders (n = 169)	Traditional healers (n = 119)	Health workers (n = 145)	Users (n = 107)	Carers (n = 130)
Lack of mental health services in their area	126 (84%)	106 (63%)	59 (50%)	100 (69%)	58 (54%)	60 (46%)
Never had community visit by health worker in relation to mental health	148 (98%)	147 (87%)	112 (94%)	131 (90%)	106 (99%)	125 (96%)
Lack of psychotropic medication	111 (74%)	61 (36%)	103 (87%)	133 (91%)	66 (62%)	114 (88%)
Ministry of Health responsible for supply of psychiatric medication	112 (74%)	70 (41%)	98 (82%)	114 (79%)	96 (90%)	121 (93%)

stakeholders for community mobilisation, and they thought that the Ministry of Health was responsible for the promotion of mental health services.

The strengths of this study are its relatively large size and its inclusion of multiple stakeholders. The findings are limited, however, by the possibility of response bias and selection bias, as it was a cross-sectional survey of consecutive consenting users and carers and a convenience sample of other stakeholders.

Our study showed that users, carers, providers, community members and leaders recognised the need to improve the coverage of community mental health services in order to improve outcomes. The high proportion of users reporting lack of knowledge of availability of services highlights the huge treatment gap for mental health, which is not uncommon in low- and middle-income countries (World Health Organization, 2008). A greater proportion of providers than users reported that psychiatrically trained staff were available. The users' and carers' relative lack of knowledge may be partly due to poor access, as all groups reported a lack of community psychiatric outreach work at the time of the survey. This lack of skilled staff and a lack of psychotropic medication at the community level have been previously described as a significant barrier to the improvement of community mental healthcare (Saraceno *et al*, 2007).

Our study found that there was considerable goodwill for community participation in dealing with mental health problems, as the majority identified the need to involve community resources such as community members, police, and traditional and religious healers in the treatment and

prevention of mental illness. They recognised that the resources for mental health are scarce, and this presents an opportunity to educate and involve these stakeholders in public health interventions targeting mental health. Therefore future work needs to include both community education and education of primary care teams to integrate mental health into primary care provision. Evidence from projects in Africa suggests that this is feasible, but requires sustained commitment from the Ministry of Health and local professional organisations (Muga & Jenkins, 2008a,b).

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ORIGINAL PAPER

Use of translated versions of the MMSE with South Asian elderly patients in the UK

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The elderly population is increasing all over the world, a trend expected to continue well into the next century, particularly in low-income countries (Levkoff *et al*, 1995). There is an established association between increasing age and cognitive decline (Fillenbaum, 1984) and dementias are common in this age group.

Many South Asian people migrated to the UK in the 1950s and 1960s, mainly as young adults, to meet the demands of a growing labour market. Initially, therefore, older people constituted a relatively small proportion of the UK's South Asian population. However, this proportion is now expected to grow (Rait *et al*, 1996).

South Asians in Britain are a heterogeneous group, with different religions, languages and cultures. Their mental health needs have been investigated to a lesser extent than their physical health needs. In this respect they have been

disadvantaged by communication difficulties and other barriers to diagnosis, lack of culture-sensitive research, poor access to psychiatric services (Manthorpe & Hettiaratchy, 1993) and the traditional stigma attached to mental illnesses in their communities (Rait *et al*, 1996).

To diagnose dementia it is necessary to have a valid and reliable tool with which to assess cognitive function. However, sociocultural factors may complicate both the use of these tools and the interpretation of their results (Kabir & Herlitz, 2000). Efforts have been made to improve the validity of instruments used to screen for dementias by producing adapted and translated versions for different cultures. Adapted and translated versions of the Mini-Mental State Examination (MMSE; Folstein *et al*, 1975) have been developed in five South Asian languages commonly spoken in the UK – Bengali, Gujarati, Hindi, Punjabi and Urdu (Ganguli

et al, 1995; Lindsay *et al*, 1997; Kabir & Herlitz, 2000; Rait *et al*, 2000). However, their use in routine clinical practice has not been widely reported.

The aim of this study was to determine the exposure of old-age psychiatrists in the West Midlands region of the UK to South Asian patients and their awareness and usage of translated versions primarily of the MMSE but also of any other assessment tools for cognitive impairment.

Method

Data collection was undertaken in an electronic and postal survey between March and April 2007. A brief questionnaire was developed that covered demographic details of respondents, their exposure to ethnic minority patients, and their awareness, previous experience with and views on the usefulness of translated or otherwise modified versions of the MMSE. Initially, the questionnaire was emailed to all the old-age psychiatrists working in the West Midlands. Those who did not respond were then sent a questionnaire by post, with a postage-paid reply envelope.

The West Midlands has a population of approximately 5.3 million. It has the largest Black and minority ethnic (BME) population outside London; 7.3% of residents are South Asian, whereas the national average for England is 4.6% (Office for National Statistics, 2009).

Results

Thirty-nine out of 66 questionnaires were returned completed, giving a response rate of 59%.

Fifteen (38%) respondents were female, 18 (46%) were male and 6 (15%) did not declare their gender. The ethnic background of the respondents was 16 (41%) White, 17 (44%) Asian and 6 (15%) Black.

In view of our response rate of approximately 60%, we tried to establish whether the responders were broadly representative of our original sample. For confidentiality reasons, we were not able to get a demographic breakdown of all the psychiatrists who were sent the questionnaire. We were, however, able to identify clearly the Asian names on our list. There were 28 of these, which represents 42% of the 66, which is similar to the percentage of responders (44%) who identified themselves as Asian. We therefore believe that the Asian responders were probably representative of the original sample.

Three respondents returned questionnaires that did not include information on frequency of contact with South Asian patients. Of the remaining 36 respondents, 3 (8%) had seen no patients from South Asian populations in the past 2 years, 20 (55%) had seen 1–9 patients, 8 (22%) had seen 10–20 and 5 (14%) had seen more than 20.

Eighteen (46%) psychiatrists believed that the number of South Asian patients they had seen underrepresented the morbidity in the population, 15 (38%) felt it reflected the true morbidity and 6 (15%) were not sure.

Thirty-two respondents (82%) identified barriers to detecting cognitive deficit in their South Asian patients. The most common barriers mentioned were: language and communication problems, sociocultural issues such as attitude of the carers to mental illness due to the stigma

attached, awareness of cognitive disorders, and educational status of the patients and carers. Lack of culturally sensitive tools to detect cognitive deficits was also commonly cited as a barrier. Some respondents questioned the validity or cultural appropriateness of commonly used assessment tools, even when translated. Other identified barriers included lack of education, fear of institutional racism, and poor access to and poor provision of services to these population groups.

Eleven consultants (28%) had used translated versions of the MMSE and 7 of these (64%) found them to be useful. Overall, 28 (72%) felt that clinicians should use the translated versions of standardised tools such as the MMSE when assessing patients from minority groups; only 6 (15%) could see no advantage in their use (5 did not respond to this item).

Effects of respondent ethnicity on the results

We were interested to see whether respondents' own ethnicity had any effect on their responses. The questionnaire results for Asian and White respondents are compiled according to ethnicity in Table 1. A larger proportion of White respondents (44%) than Asian respondents (23%) thought that their exposure to ethnic minority patients was a true reflection of the morbidity in this population. More White respondents than Asian thought that there were barriers in detecting cognitive deficits in this population (93% v. 77%). Interestingly, however, only 7% of the White respondents had used translated/modified versions of screening tools, compared with 23% of Asian respondents. We were, however, surprised that a majority of the respondents who used the translated versions did not find these useful (Asians 75% and Whites 100%). This, though, contrasts with answers to the next question, which indicate that the majority felt medical staff at both primary and secondary care level would benefit from using modified/translated versions of the MMSE: 88% of the White and 71% of the Asian respondents answered yes to this question. The pattern among Black respondents was even more surprising: all six of them

Table 1 Questionnaire results, by ethnic group

Questions	Response options	No. (%) of respondents	
		Asian (n = 17)	White (n = 16)
1. How many patients within South Asian minorities with cognitive deficits have you seen in past 2 years?	<10	9 (53%)	11 (69%)
	10–20	1 (6%)	4 (25%)
	>20	5 (29%)	0 (0%)
	No response	2 (12%)	1 (6%)
2. Does it reflect the true level of morbidity in this group?	Yes	4 (24%)	7 (44%)
	No	9 (53%)	7 (44%)
	Not sure	4 (24%)	2 (13%)
3. Are there any barriers to detecting cognitive deficits in this group?	Yes	13 (77%)	15 (93%)
	No	4 (23%)	1 (7%)
4. Have you used any translated/modified versions of screening tools for these patients?	Yes	4 (23%)	1 (7%)
	No	13 (77%)	15 (93%)
5. Did you find these useful?	Yes	1 (25%)	0 (0%)
	No	3 (75%)	1 (100%)
6. Would medical staff in both primary and secondary care benefit from using translated/modified versions?	Yes	12 (71%)	14 (88%)
	No	2 (12%)	0 (0%)
	No response	3 (17%)	2 (12%)

had used the translated version and found them useful but only a third considered their use as beneficial at both primary and secondary care level.

Discussion

This research is the first we know of to have looked at the use of an existing tool for the cognitive assessment of minority ethnic elders in clinical settings in the UK.

Our findings indicate that most psychiatrists have seen South Asian patients, although the level of exposure was variable. This may reflect the demographic composition of the individual psychiatrist's catchment population. However, nearly half of those who responded felt that their exposure to BME patients underrepresented the level of morbidity in that population. This may reflect the reported barriers to healthcare for the BME population (Commander *et al*, 1997).

Some respondents had used translated versions of the MMSE. However, the majority believed that translated versions had a wider potential and that both primary and secondary care medical staff would benefit from using them.

We were, however, disappointed to see that many psychiatrists were still unaware of the availability of standardised and validated adapted versions of these screening tools. It is possible that these translated versions, while commonly used for research, have not been made available to service providers for clinical use. Even when psychiatrists were aware of them, these tools were not being routinely used to overcome linguistic barriers, possibly owing to the unavailability of linguistically competent individuals, such as interpreters, in the process of assessment; this also probably accounts for the dissatisfaction of those who used these tools.

Therefore, the observation by Rait *et al* (2000) that 'there remains an obvious need for a cross-national approach to improve detection, educate practitioners and improve services for older south Asians in the UK' still holds true. We do, however, recognise that the use of translated versions of

the MMSE is only one measure among many to improve the overall assessment process.

Acknowledgements

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SPECIAL PAPER

The British Federation of University Women: helping academic women refugees in the 1930s and 1940s

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In early 1933, the members of the British Federation of University Women (BFUW), an organisation which was established in 1907 to provide a supportive network for the growing number of academic women, embarked upon a unique humanitarian mission to aid their counterparts in Europe (Sondheimer, 1957; Dyhouse, 1995). This remarkable undertaking, which came to provide academic women

refugees with professional, financial and practical support, was in direct response to the growing threat from Fascism and Nazism. Almost from the moment that Hitler came to power in Germany in January 1933, the BFUW Executive Committee began to receive a steady stream of calls from German members of the International Federation of University Women (IFUW), whose lives and careers were

affected by restrictions imposed upon them by the Nazi regime. Some were seeking help finding work and settling in Britain, while others were looking for temporary help as trans-migrants on their way to the USA, New Zealand or Australia.

The annexation of Austria in March 1938 exacerbated the refugee crisis and the calls for assistance increased exponentially as IFUW members in Austria, Czechoslovakia and Poland joined their German counterparts in desperately seeking help to escape Nazi tyranny. Up until this point, the BFUW's Executive Committee had dealt with refugee matters as part of its overall business, but the numerical increase called for a change of strategy. Their response was to establish an Emergency Sub-Committee for Refugees (ESCR), which, in May 1938, took over responsibility for dealing with all refugee-related issues. As the workload increased, the ESCR members realised that they needed support, and decided to appoint a secretary for 13 weeks – long enough, they assessed, for the backlog to be cleared. The person chosen was Dr Erna Hollitscher, a 41-year-old language graduate from Vienna, who had come to Britain following the annexation of Austria in March 1938. She, like so many Jewish women forced to migrate, had initially worked as an *au pair* before contacting the BFUW and receiving its help. Holly, as she became known, stayed in post rather longer than anticipated, and was still with the BFUW after the refugee committee disbanded in 1950.

By May 1939 the ESCR had received 226 applications for help and a further 119 names had been added to the list by July 1940, but after that any chance of migration from Europe had all but ceased, and the 45 or so who subsequently applied were women who were already in Britain.

Limited resources – funding was dependent on the generosity of a variety of sources, both private and organisational – inevitably informed the scope of the ESCR's mission, so that hard decisions had to be made about whom it could assist. The outcome was that priority was given to those whose academic work was important enough to continue and in other cases age was taken into account, on the basis that younger women – most of the applicants were in their 30s and 40s – were more flexible and likely to adapt more easily to a new life.

To help assess a case, applicants had to complete a form which, besides asking for personal, academic and professional details, enquired about domestic skills. This was not as odd as it seems, for residential domestic service posts in private households were the one area of work for which Home Office permits were readily available.

It was not until after Kristallnacht, the pogrom against Jews that erupted throughout Germany and Austria on the night of 9–10 November 1938 (Friedlander, 1997), that the form asked about a refugee's religion. By then it was evident that many of the women were Jewish, or of Jewish descent, and, as such, might have more specific needs. To put this in context, the minutes of the BFUW Refugee Committee for May 1939 show that, of 69 new adult applicants, 57 were Jewish.

Up until the outbreak of the Second World War, much of the ESCR's work involved obtaining entry visas for the women academics, but as a voluntary organisation it was restricted from making applications to the Home Office. To overcome this problem, Holly collaborated with another

refugee organisation, the Society for the Protection of Science and Learning (SPSL), whose indefatigable secretary, Esther Simpson, applied on behalf of the BFUW refugees. Meanwhile, guarantors had also to be found, for the British government had made it clear that it would not take on financial responsibility for any refugee. (Correspondence between Holly and Esther Simpson is held in the Bodleian Library, Oxford, SPSL Papers, Box 98, folder 2.)

One of the first tasks that the ESRC had to deal with for new arrivals was to organise hospitality and friendship, both priceless commodities for a refugee. Many of its members, as well as those of local BFUW associations up and down the country, offered accommodation in their own homes. There were also the facilities of Crosby Hall, the BFUW headquarters in Chelsea, which proved to be invaluable as a reception centre for many of the newcomers (Sondheimer, 1957, pp. 47–48).

The range of professional credentials held by the refugee women was impressive. A typical list of 56 new applicants in October 1938 included nine medical women, one dentist, two psychologists, an art historian, four scientific researchers, a journalist, two lawyers, seven laboratory assistants and ten teachers of various disciplines. Most had either a PhD or held an MD qualification, but this did not necessarily make finding an appropriate job any easier. This was, in part, due to the strong anti-alien hostility demonstrated by some middle-class British professional groups, including doctors and dentists (Zamet, 2006), who pressurised the government from as early as 1933 to limit the numbers of immigrants. Besides this prejudice, foreign qualifications were not generally recognised in Britain; in nursing, for example, the highest grade that a fully trained refugee nurse could be employed at, without going through the prescribed British training, was assistant nurse (Stewart, 2003). Some of the BFUW refugee women benefited when a specialist nursing and midwifery sub-committee was set up in late 1938, at the request of the Home Office, by the Central Co-ordinating Committee for Refugees, based at Bloomsbury House, London. It was also possible for a very small number of refugee women doctors (two a year) to train as midwives, thanks to the initiative of London's General Lying-in Hospital, which, as recorded in the *Nursing Mirror and Midwives Journal* (18 March 1939, p. 839), proposed 'a scheme to train Austrian refugees as midwives', an idea which was then taken up by the Royal Infirmary of Edinburgh. A few BFUW women refugee doctors were referred to Edinburgh, where the examination requirement for clinical study had been reduced from 3 years to 2, so that they were able to re-qualify more speedily. Social work was a profession whose doors were virtually closed to women refugee academics until after 1941, and it was not until 1944/45 that the BFUW minutes noted that financial assistance had been given to two students taking a mental health course, and to another for 6 months' training to qualify her for child guidance work as an educational psychologist (recorded in the BFUW's annual reports for 1940/41, p. 18, and, 1944, p. 20).

Besides helping to fund training courses and covering tuition, examination and registration fees, the ESCR also ensured that language classes were available to those refugee women who needed them, for an inability to speak English seriously affected a refugee's employment prospects and ability to integrate into wider society (Stewart, 2003, p. 159).

Grants were also regularly provided to help with such things as accommodation, pocket money, medical costs and travel expenses. No less important to the refugee women were the carefully selected gifts of clothing that Holly was able to distribute among her 'little lambs', as she affectionately called her academic colleagues. The garments proved to be a veritable godsend to women who desperately needed them but who were suffering real financial hardship. This initiative would never have come about without the generosity of the Canada Association, which regularly sent parcels of clothes to Britain (BFUW annual report, 1942/43, p. 17).

It is hard to imagine the trauma experienced by those who were fleeing their homes, families and established academic and professional careers to settle in a new country – one which offered sanctuary but within a very different cultural milieu and with a different language. The strength of character of the refugee women, their resourcefulness and determination to make a new life for themselves is to be admired and remembered. Similarly, the success of the ESRC was due in no small measure to the humanitarianism of Holly and the 19 committee members who devoted themselves to the welfare and rescue of their European counterparts, providing them with a truly supportive network. It certainly fulfilled the objective set out in the IFUW's charter, which was 'to promote understanding and goodwill between university women of all nations, regardless of race, religion or political creed' (Nash, 1985).

By March 1950, the work of the refugee subcommittee had drawn to a close. Most of the graduates in Britain had acquired citizenship, and the term 'refugee' no longer

applied. This was not the end of the story though, for the BFUW continued to work closely with the IFUW Relief Committee and its convenor, Dr Hegg-Hoffet, and with the British Council for Aid to Refugees, founded in 1950, providing advice, introductions and friendly support. The plight of graduate women in the displaced persons' camps in Europe was of particular concern and led to collaboration between Holly and Dr Hegg-Hoffet in supporting many who came to settle in England, by giving them 'the very special encouragement and comfort which friendship with women of their own kind could bring'. The Hegg-Hoffet Fund for Displaced Women Graduates, established in 1936 as the IFUW Emergency Fund, continues to support academic women refugees from countries such as Sudan, Colombia, Pakistan, Zimbabwe, Ethiopia and Afghanistan.

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NEWS AND NOTES

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

Royal College of Psychiatrists' International Congress, 21–24 June 2010, Edinburgh EICC

This year's theme, 'Advancing Science', is inspired by Robert Burns (1759–96), who wrote in 'Address to Edinburgh':

There learning, with his eagle eyes,
Seeks Science in her coy abode.

Over 200 years on, and learning still seeks out science in the beautiful city of Edinburgh. The President, Professor Bhugra, opens the Congress with a plenary talk. He has stated that the Royal College of Psychiatrists' goal is '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'. The International Congress programme was designed with these inspirational aims in mind, to be of the highest quality. The Congress offers the opportunity to update learning, knowledge and skills and to seek out international experts from across the breadth of psychiatry.

This year's programme has moved away from the Institute Days of previous years and towards topic-based streams and

the inclusion of training courses. All training courses and refreshments are included in the Congress fee, as is media training, access to the Psychiatrists' Support Service and attendance at the Welcome Reception.

A broad range of topics are covered, including streams on: psychosis, mood disorders, psychopharmacology, clinical skills, communication skills, and neurodevelopment.

Training courses at the Congress include: treatment-resistant psychosis (run by the Maudsley Hospital's National Psychosis Unit, London); core clinical skills in neuropsychiatry (run by Dr Alan Carson, Edinburgh); appraisal and revalidation; and a physical health update training course for psychiatrists (the last two are brought via the College Education and Training Centre).

We have retained the ever-popular morning and lunch-time plenary sessions. It is impossible to mention all of our excellent plenary speakers here, so to list but a few: Mr John Bowis, MEP for London, talking about the future of psychiatry in Europe; Professor Max Fink, from the USA, giving a talk entitled 'The enigma of ECT: its Darwinian survival'; Professor Ramachandran, from India, and Professor Munk-Jorgensen, from Denmark, speaking on the physical health needs of patients with a mental illness; and Professor Bailey, from England, talking about families ('The elephant in and out of

the room'). Professor Goldberg will update us on DSM-V and ICD-11. The Blake Marsh lecture is to be given by Professor Baron-Cohen on 'The fetal testosterone theory of autism'. The POP Club lecturer this year is Professor Bird, from the Wellcome Trust Centre for Cell Biology in Edinburgh.

Free online access to *Evidence-Based Mental Health*

Evidence-Based Mental Health is a digest of the most important clinical research of relevance to mental health professionals. Reading *EBMH* is the equivalent of reading around 25000 articles from over 50 journals each year. The College has now arranged for members to be able to access this important resource online free of charge via the members' area of the College website. The journal, co-published by the College with the British Medical Association and the British Psychological Society, surveys a wide range of international medical journals, applying strict criteria for the quality, validity and clinical relevance of research. Practising clinicians present the key details of the best studies in a succinct, informative abstract with an expert commentary on its clinical application.

Members will also be able to subscribe to the print edition for the vastly reduced price of just £10. This offer will be available shortly. If you would like to be sent details at no obligation please register your interest at <http://www.rcpsych.ac.uk/publications/journals/ebmhinfo1.aspx>

College a certified member of the Information Standard

The Royal College of Psychiatrists has been certified as a quality provider of health and social care information by the Information Standard – a new certification scheme for health and social care information. The College has demonstrated that it has the necessary processes and systems to ensure its information meets the rigorous quality criteria of the Information Standard. It has consequently been awarded the Information Standard quality mark, which it can display on its information materials as a mark of quality and reassurance for the public.

The College has been producing mental health information for almost 20 years. Its award-winning leaflets provide evidence-based information on common mental health problems and treatments, and are used by millions of people in the UK and worldwide. The College is delighted to be recognised as a quality provider of information. It means that people can be confident that the information produced by the College is always reliable and up to date.

Many of the College's leaflets have been translated into 14 different languages, from Arabic to Welsh. The College is lucky to have members and staff from all over the world who have been keen to help in this complicated task. These translations mean that user-friendly and evidence-based information can be easily accessed by people in more than 200 countries around the world. The College has been working closely with the Department of Psychiatry at the Aga Khan University Karachi in translating materials into Urdu, and

Castle Peak Hospital in Hong Kong for Chinese translations. The College is also grateful to St Andrew's Healthcare, which has donated funds to enable the College to translate many of these materials into languages where members have not been forthcoming in taking this important work forward. If you are interested in working with the Public Education Editorial Board in this capacity, please email dhart@rcpsych.ac.uk.

Department of Health launches the International Health Advisory Board

In November 2009 Professor Hamid Ghodse was appointed the inaugural Chair of the International Health Advisory Board. The new Board will support the Chief Medical Officer in his capacity as Chief Medical Advisor to the UK government on areas of international health, led by the Department of Health. Its work will include acting as a source of independent, expert advice, establishing a network of expertise and raising the profile of the work on international health undertaken with the Department of Health.

Professor Ghodse said:

Many of today's health issues need to be considered in an international context and it is essential that the UK plays a full role in the relevant international forums, both learning from the experience of others and making an effective contribution based on 60 years' experience of a National Health Service and acknowledged expertise in research and policy analysis. I feel honoured to have been given the opportunity to lead the new International Health Advisory Board.

Professor Ghodse CBE is a world leader in international drug policy and addictions, Director of the International Centre for Drug Policy based at St George's, University of London, immediate past President of the United Nations International Narcotics Control Board, past Director of International Affairs of the Royal College of Psychiatrists and current Editor of *International Psychiatry*. He has also recently been elected to International Fellowship of the American Psychiatric Association and will receive his medallion at the Distinguished Fellows Convocation in New Orleans in May 2010.

Congratulations to Professor Richard Williams, TD, Consultant Child and Adolescent Psychiatrist, Aneurin Bevan Health Board, who was awarded an OBE for services to medicine. Professor Williams has been the Professor of Mental Health Strategy in the University of Glamorgan and a consultant child and adolescent psychiatrist in the Gwent Healthcare NHS Trust since 1998. Much of his research relates to workforce development and user and carer participation in service design. He has published widely on matters relating to healthcare strategy and evidence-based and value-based service design, and on strategic approaches to developing child and adolescent mental health services. He has a special interest in the physical and psychological impacts of trauma, conflict and post-conflict recovery.

Turmoil for medical doctors in Greece

Sir: Things were far from calm in the Greek medical community in the last months of 2009. The reason for this turmoil was a 3-month delay in the overtime payments of medical doctors working in hospitals throughout the country. Many doctors went on strike, which may seem like an extreme measure to some other citizens of the European Union (EU), but in Greece it is considered 'common policy'.

The general feeling has been that healthcare funding in Greece is less than adequate, with most hospitals being under-staffed and under-equipped, and Greek medical doctors cannot help but feel under-paid in comparison both with other professionals in Greece and with medical doctors in most other EU countries. A 20% rise in salaries in January 2009 did not hide the fact that Greek medical doctors' salaries are significantly below the EU average, while the cost of living in Greece is relatively high, and many doctors depend on their overtime payments to cover their basic expenses. Trainees, being the lowest-paid doctors, yet old enough to have their own families, have struggled the most.

In the psychiatric hospital of Attica, the largest psychiatric facility in Greece, with more than 100 psychiatrists and trainees, overtime was unpaid for 5 months, and doctors felt compelled to apply extreme measures, like closing the gates of the hospital. In mid-December there was finally some financial compensation, but the question had already been raised by some: are we stigmatised like our patients? The answer to that question requires much debate.

Problems concerning medical doctors in Greece seem to continue. There is an over-supply of medical professionals in Greece and an extremely long waiting-list for doctors to begin specialisation, both caused by an overproduction of medical graduates over the past 15 years. The future does not seem bright and sometimes loving what you do is the only thing keeping you going. Fortunately, it is enough, isn't it?

Rafail Psaras

President of the Hellenic Association of Psychiatric Trainees; Psychiatric Hospital of Attica, Athens, Greece, email rafailpsaras@yahoo.gr

Clinical Assessment of Skills and Competencies examination

Sir: In October 2009, we had the pleasure of visiting the Clinical Assessment of Skills and Competencies (CASC) examination conducted by the Royal College of Psychiatrists in Sheffield. We were impressed by what we observed and left with the conviction that we in the USA have much to learn from the Royal College.

Both of us have participated extensively in psychiatric education and in the corresponding assessment processes conducted in psychiatry by the American Board of Psychiatry and Neurology. We were struck by the remarkable quality of the content of the College examination, as well as the efficiency and economy of the design and implementation. Each candidate performed an assigned clinical task in interaction with a simulator in each of 16 stations. The atmosphere was one of cheerful hard work and cooperation, with a shared sense of the importance of the assessments.

Each of the case vignettes was specifically constructed to assess core psychiatric clinical skills and we were impressed by the consistently clear internal validity. The four sets of linked simulations were especially creative and true to life for a psychiatrist practising in the community; they assessed skills in interviewing, diagnosis, psychoeducation and treatment, with a breadth and depth we have not seen before. Dr Anthony Bateman and his team of writers have done a superb job in this area. As participants in exam-writing teams for the American Board, we felt both envious and inspired.

We also noted the clarity of the roles of examiners and simulators, and the careful delineation of criteria for evaluating the candidates. Each examiner would observe the performance of a candidate in a station without interacting with him or her. Each simulator would interact with the candidate and simulate a patient or a family member or a consultant, without evaluating the candidate; those who took on the former roles were professional actors with long experience of simulations, while experienced psychiatrists simulated consultants (but, again, did not participate in evaluating the candidates). Examiners provided the simulators with feedback concerning their performance in the roles, but they did not discuss candidate performance with the simulators.

The grading process is described on the College website, but as outside observers we were impressed with the description of specific skills and competencies to be tested in each station, as well as the written criteria for the evaluation of performance. We found these descriptions to be specific, articulate and readily applicable, and we understood that they were written and rewritten in a well-organised process. The final phase in criterion development consisted of a 'calibration' conference at the beginning of the CASC day. In this discussion, examiners from each station addressed each other's questions and worked out the specific elements of a candidate's performance that would constitute a pass.

The CASC is an appropriately challenging and comprehensive evaluation process, which has required and benefited from a tremendous amount of effort and expertise on the part of the Royal College.

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Forthcoming international events

13–15 April 2010

New Models of Psychiatric Management – The 6th International Conference on Psychiatry
Jeddah, Saudi Arabia
Email: psy1.jed@sghgroup.net
Website: <http://www.sghgroup.com/sghg-Events-en-Jeddah-54.html>

4–7 May 2010

15th International Conference Neuropsychiatric, Psychological and Social Developments Today
Athens, Greece
Email: congress@appac.gr
Website: <http://www.appac.gr>

6 May 2010

RANZCP 2010 Congress
Auckland, New Zealand
Email: ranzcp2010@tcc.co.nz
Website: <http://www.ranzcp2010.co.nz/>

11 May 2010

State-of-the-Art Treatment for Children's Mental Health Problems: A Conference
Reading, UK
Organiser: Charlie Waller Institute
Website: <http://www.reading.ac.uk/charliewaller>

12–14 May 2010

10th International Review of Bipolar Disorders Conference
Budapest, Hungary
Organiser: European Bipolar Forum (EBF)
Email: rp@cortexcongress.com

25–27 May 2010

10th Annual Conference of the International Association of Forensic Mental Health Services (IAFMHS)
Vancouver, Canada
Email: info@iafmhs.org

6–10 June 2010

International College of Neuropsychopharmacology (CINP) Conference
Hong Kong
Organiser: CPO Hanser Service
Website: <http://www.cinp2010.com>

10–12 June 2010

International Conference on Eating Disorders
Salzburg, Austria
Organiser: Academy for Eating Disorders
Email: info@aedweb.org

16–19 June 2010

20th World Congress of Psychotherapy: 'Psychotherapy – Science and Culture'
Luzern, Switzerland
Organiser: International Federation for Psychotherapy
Email: I-F-P@t-online.de

21–24 June 2010

International Congress of the Royal College of Psychiatrists
Edinburgh, UK
Email: conference@rcpsych.ac.uk
Website: <http://www.rcpsych.ac.uk/events/annualmeeting2010.aspx>

30 June–3 July 2010

XXVIII European Conference on Psychosomatic Research (ECPR)
XIII Annual Scientific Meeting European Association for Consultation–Liaison Psychiatry and Psychosomatics (EACLPP)
Innsbruck, Austria
Organiser: European Association for Consultation–Liaison Psychiatry and Psychosomatics (EACLPP)
Email: stefan.hoefer@i-med.ac.at
Website: <http://www.eaclpp-ecpr2010.org/cms/index.php>

5–6 July 2010

4th International Asian Health and Wellbeing Conference
Auckland, New Zealand
Organiser: Centre for Asian Health Research and Evaluation
Website: <http://www.fmhs.auckland.ac.nz/asianhealthconference>

30 August–4 September 2010

15th World Congress of Psychophysiology – The Olympics of the Brain – IOP 2010
Budapest, Hungary
Organiser: International Organization of Psychophysiology (IOP)
Website: <http://www.world-psychophysiology.org/iop2010>

14–16 September 2010

3rd Global Conference – Madness: Probing the Boundaries
Oriental College, Oxford, UK
Website: <http://www.inter-disciplinary.net/probing-the-boundaries/making-sense-of/madness/call-for-papers/>

5–7 October 2010

Mental Health in a Socio-cultural Perspective
Al-Khobar, Saudi Arabia, Saudi Arabia
Organiser: Saudi Psychiatric Association
Website: <http://saudipsych.org/eng/>

19–21 October 2010

Coming of Age: Dementia in the 21st Century
London, UK
Organiser: Dementia Services Development Centre
Website: <http://www.dementia.stir.ac.uk/London2010>

2–4 September 2011

14th ICPP: Ethic, Experience and Evidence: Integration of Perspectives in Psychiatry
Gothenburg, Sweden
Organiser: Swedish Association for Philosophy and Psychiatry
Website: http://www.phil.gu.se/sffp/sffp_eng.html

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