

International Psychiatry

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Futures of psychiatrists 2020: external and internal challenges

George Ikkos

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The longer you can look back the longer you can look forward. (Winston Churchill speaking at the Royal College of Physicians, London, 1944)

At the turn of a new decade how might the futures of psychiatrists look? Here we address issues of social inclusion and, also, the professional identity and relationships of psychiatrists.

Social inclusion

Wolves can dress in sheep's clothes (Ikkos, 2010). Mental asylums and care in the community have been conceived with genuinely good intentions and high aspirations, but both have been associated with great disappointments at times. With respect to asylums, the lowest point was reached in Nazi Germany in the 1940s. Following certification by psychiatrists as having 'lives unworthy of life', 100 000 people with a mental illness, intellectual disability or epilepsy were exterminated in gas chambers in six so-called 'mental hospitals'. This was in the interest of 'racial hygiene', that is, in the interest of public mental health as conceived by the Nazis, including Nazi psychiatrists.

Extremes of libertarianism as well as authoritarianism can have negative consequences for people who have a mental illness. With respect to community psychiatry, the closure of asylums has been associated at times with reduced symptom control, the incarceration of those who are mentally ill in prisons instead of hospitalisation and increased suicide rates. Today in the UK, and perhaps especially in London, services sometimes maintain patients in the community in conditions that would have been severely criticised had they been found in asylums 30 years earlier. Increasing inequalities in the context of globalisation, resource constraints secondary to the 'credit crunch', competition for resources from other medical specialties and environmental pollution place our patients at risk in the next decade. The successful social inclusion of people with a mental illness will remain a key external challenge for the profession (Boardman *et al*, 2010).

Identity

Is psychiatry an endangered species (Katschnig, 2010)? Craddock & Craddock (2010) answer that 'patients must be able to derive maximum benefit from a psychiatrist's medical skills and broad training'. They decry 'often nebulous

and frequently indiscriminate implementation of the dictum that psychiatrists must embrace biological, psychological and social approaches'. They emphasise the training of psychiatrists in the biomedical sciences and their unique diagnostic skills among the mental health professions. These, together with training in 'psychological and social issues', contribute to psychiatrists being 'uniquely placed' to see the 'big picture'. Future advances in molecular genetics and brain imaging will bring further strengths.

If remedying the disorders of the nervous system requires the training and skills of the neurologist, what is the field that requires the training and skills of the psychiatrist? Panksepp (2009) proposes 'affect'. Affect refers to emotion and its manifestation in thought, impulses, behaviour and relationships in family and society. It is disturbance of affect (i.e. subjective distress or disturbed behaviour or disturbed relationships) that brings patients, voluntarily or not, to psychiatrists (Ikkos *et al*, 2010). Affect is rooted in biology and evolution but influenced by upbringing, relationships and culture. Kagan (2009, p. 81) remarks:

The influence of biology on human psychological functions is extensive, but not unlimited. Evolutionary psychologists like to write that genes keep cultures 'on a leash'. However, culture, like a large powerful dog, can pull the person holding the leash in new, unplanned directions.

Recent research suggests that psychological trauma to a mother affects development of the foetus and child. Trauma and abuse in childhood affect neurodevelopment and function in adulthood. Abuse in childhood increases the risk of psychosis in adulthood and high expressed emotion increases the risk of relapse in schizophrenia. Psychological interventions reduce relapse rates in affective, anxiety and eating disorders. In addictions, Stephens & Graham (2009) suggest, it is not the disturbance of biological function that is the problem but the hijacking of normal biological functions for pleasurable, i.e. psychosocial, ends. Finally, attendance to affect highlights the importance of continuity for the many patients who benefit significantly from longer-term care.

Psychiatrists will need to enhance their biomedical skills, and also their psychosocial skills, if patients are to benefit most from the forthcoming advances in molecular genetics and neuroscience. The future of psychiatry will be safeguarded by the successful management, not the elimination, of the tension between biomedical and biopsychosocial approaches. This will remain a key internal challenge for the profession.

Relationships

Identity and context define our relationships. Not all disturbances of affect require the skills of doctors. Most disturbances are taken care of by people themselves and their families and friends. Medical expertise in the management of disturbances of affect will be relevant when harmful departure from species-typical functioning (i.e. dysfunction) leads to medical necessity (Daniels, 2008). Debate will continue as to where the boundaries are.

Not all medically necessary interventions require the skills of psychiatrists. There is convincing evidence that much psychiatric morbidity may be managed in primary care. Well-informed primary care physicians and other health professionals will know when they have reached their limits. Ease of referral from colleagues to psychiatrists and availability of referral to a psychiatrist when patients have the need and choose that option merit advocacy from the whole medical community, not just psychiatrists.

Following referral to specialist mental health services, of fundamental importance are the quality of assessment, the process of care and the outcome. It may not be possible for every referred patient to be seen by a psychiatrist and, indeed, other professionals may have greater expertise in managing specific aspects of disturbed affect; related disciplines will be better equipped to deliver some interventions. However, psychiatrists do have unique training and skills to see the 'big picture', especially in complex cases (Craddock & Craddock, 2010). Ease of referral to a psychiatrist is likely to be essential when a colleague on the multidisciplinary team is uncertain in an assessment or about a patient's progress with treatment. Psychiatrists will need to play leading roles in developing teams and treatment pathways and in ensuring that there is easy access to their skills when necessary. A particular challenge will be to develop flexible and effective protocol-based approaches that take full account of comorbidity.

Societies vary in how they invest in health. All health systems have to be tested against criteria of effectiveness, efficiency, fairness and choice. Carbon costs will also inform service funding in the future! The reality of wide variations in practice and the lack of a close association between investment and outcomes will lead to increasing demands for quality assurance, improvement and accreditation (Lelliott, 2010). These are complex areas. A review by leaders in the field of professionally led accreditation indicated that 'there is generally a lack of good evidence either to show that accreditation is effective or that is it not' (Lelliott *et al*, 2009). Nevertheless, systemic factors will ensure that, if psychiatrists do not engage effectively in this area, others will, perhaps with demonstrably adverse effects. To function effectively in these areas, psychiatrists will require new skills, in addition to biomedical and psychosocial skills.

Professionalism and authority

Physical and mental health, an adequate standard of living, good education and opportunities for work, leisure and rest are universal human rights. The fundamental principles of professionalism in medicine centre on patient autonomy, welfare and social justice. Psychiatry's commitment to socially

excluded citizens makes psychiatrists' lives more difficult sometimes but also gives the profession special value within medicine and this should be advertised.

The fundamental characteristics of professionalism in psychiatry have been summarised (McQueen *et al*, 2010) as the 'seven Es':

- empowerment of the patient
- evidence-based practice
- ethical practice
- emotion and relationships
- expertise through synthesis and clinical practice
- engagement with service development and delivery
- education and research.

In changing and increasingly complex external environments, the security psychiatrists have in an evolving identity will empower them to enhance their confidence and authority.

Reference to authority may appear odd at a time when it seems fashionable to challenge it. On the other hand, frequent recent references to the need for leadership in medicine suggest that it may have a place. Authority here does not mean arbitrariness and coercion but the confidence and respect that arise out of knowledge and trusting relationships. It is these that will inspire patients and carers to consider psychiatrists and mental health services a natural choice at times of distress, rather than a last resort.

Ultimately, the future of any profession depends on the young graduates who join it. Katschnig (2010) highlights a crisis in recruitment in some countries. A number of reasons have been suggested for this, including stigma within the medical profession and beyond, lower rates of remuneration compared with other medical specialties and competition from other health professions. Perhaps the greatest reason, however, has been the loss of confidence within the profession and consequent loss of authority. Bright and idealistic young men and women, when choosing a career, want to see models that inspire them and this requires of their teachers a secure identity and confident relationships. In judging this, medical students do not ask for our opinion, nor do they take our proclamations at face value; rather they attend to how our patients, their carers and our colleagues judge us.

References

- Boardman, J., Currie A., Killaspy, H., *et al* (eds) (2010) *Social Inclusion and Mental Health*. RCPsych Publications.
- Craddock, N. & Craddock, B. (2010) Patients must be able to derive maximum benefit from psychiatrists' medical skills. *World Psychiatry*, 9, 30–31.
- Daniels, N. (2008) What is the special moral importance of health? In *Just Health: Meeting Health Needs Fairly*, pp. 29–78. Cambridge University Press.
- Ikkos, G. (2010) Psychiatry, professionalism and society: a note on past and present. In *Psychiatry's Contract With Society* (eds D. Bhugra, A. Malik & G. Ikkos), ch. 2. Oxford University Press.
- Ikkos, G., Bouras, N., McQueen, D., *et al* (2010) Medicine, affect and mental health services. *World Psychiatry*, 9, 35–36.
- Kagan, J. (2009) *The Three Cultures: Natural Sciences, Social Sciences, and the Humanities in the 21st Century*. Cambridge University Press.
- Katschnig, H. (2010) Are psychiatrists an endangered species? Observations on internal and external challenges to the profession. *World Psychiatry*, 9, 21–28.
- Lelliott, P. (2010) The role of psychiatrists and their professional associations in the regulation and performance management of mental health services. In *Psychiatry's Contract With Society* (eds D. Bhugra, A. Malik & G. Ikkos), ch. 11. Oxford University Press.

Lelliott, P., Young, E. & Burgess, R. (2009) *A Core Model for Professionally Led Clinical Service Accreditation*, Version 2:26TH. Available at <http://www.hqip.org.uk/assets/Core-model-for-clinical-service-accreditation.doc> (accessed 3 August 2010).

McQueen, D., Ikkos, G., St John-Smith, P., et al (2010) Psychiatry's contract with society: what do clinical psychiatrists expect? In *Psychiatry's Contract With Society* (eds D. Bhugra, A. Malik & G. Ikkos), ch. 8. Oxford University Press.

Panksepp, J. (2009) A non-reductive physicalist account of affective consciousness. In *The Neuropsychology of Mental Illness* (eds S. Wood, N. B. Allen & C. Pantelis), ch. 28. Cambridge University Press.

Stephens, G. L. & Graham, G. (2009) Mental illness and the consciousness thesis. In *The Neuropsychology of Mental Illness* (eds S. Wood, N. B. Allen & C. Pantelis), ch. 27. Cambridge University Press.

THEMATIC PAPERS – INTRODUCTION

Alcohol misuse by the young: problems and solutions

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Back in April 2006 (vol. 3, no. 2) we published papers on the theme of misuse of alcohol by young people, 3 years after the UK government had introduced the option of 24-hour drinking. The British Medical Association (BMA) subsequently recommended that there should be a programme of research to examine the consequences of this change to our drinking culture. In 2008, it reported on current trends in alcohol misuse (BMA Board of Science, 2008). An appendix to that report summarises the different alcohol control strategies pursued by the governments of England, Wales, Scotland and Northern Ireland in the past few years. These are outlined in the document *Safe. Sensible. Social. The Next Steps in the National Alcohol Strategy* (HM Government, 2007).

In England, there is an emphasis on controlling alcohol misuse by the young through 'sharpened criminal justice for drunken behaviour', which contrasts sharply with the equivalent, more education-oriented strategies pursued by other regions in the UK. The distinction raises important questions about the evidence base for the relative effectiveness of persuasion and punitive action to curb substance misuse.

The UK ranks among the heaviest alcohol-consuming countries in Europe. Overall, the majority of the UK adult population drinks alcohol, but the prevalence varies considerably by ethnic group. While just 9% of White British people abstain, the equivalent proportions are 48% of people of Black African origin and over 90% among those of Pakistani and Bangladeshi origin. Cultural differences in alcohol consumption among the young are reflected in our choice of papers for this issue's theme.

To start, we have a fascinating report by doctors in Pakistan who studied attitudes to alcohol among medical students in Lahore. Nazish Imran and colleagues observed that medical students the world over are notorious for their liberal consumption of alcohol, so they conducted a local survey, which had an excellent response rate. They found surprisingly liberal attitudes to alcohol consumption among Pakistani students, but because social attitudes to drinking are in general very

conservative, it was not possible to discover how many students themselves were users.

A second report on attitudes to alcohol among the young comes from Drs Nkire and Nwachukwu, in Ireland. They express concern that the average age of drink initiation in that country is just 13 years, and is falling. An amazing 25% of children claim to get drunk regularly. They discuss potential influences on this highly undesirable behaviour, and make some stark observations about the considerable gap between the aims of Irish government policy initiatives that are designed to curb alcohol misuse, and the vigour with which they have been implemented.

Finally, we have good news from Iceland. In the late 1990s there was a serious drink problem among adolescents in that country, a situation not dissimilar to the current experience of the UK. Inga Dora Sigfusdottir and colleagues outline the collaborative community-based approach that evolved to deal with the issue. We learn how 'joined up thinking' by governmental and non-governmental organisations allowed them to put in place novel strategies of primary prevention. Their approach was based upon published evidence and was underpinned by theories from social science. Key to the remarkable success of the programme was its broad-based community support, in particular the willingness of parents to take responsibility for, and to closely supervise, their children's social activities. Alcohol misuse among the young was halved in just 10 years. We should be listening.

References

- BMA Board of Science (2008) *Alcohol Misuse: Tackling the UK Epidemic*. Available at http://www.bma.org.uk/images/Alcoholmisuse_tcm41-147192.pdf (accessed August 2010).
- HM Government (2007) *Safe. Sensible. Social. The Next Steps in the National Alcohol Strategy*. Available at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_075219.pdf (accessed August 2010).

Perceptions of and attitudes to alcohol use among Pakistani medical students

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Studies worldwide have reported alarming rates of alcohol misuse among medical students (Webb *et al*, 1996; Kuo *et al*, 2002; Akvadar *et al*, 2004). These reports are surprising as well as of extreme concern, as medical professionals are supposedly more educated on the harmful effects of excessive alcohol consumption. The majority of studies exploring the knowledge and attitudes of medical students regarding alcohol have been from the USA and the UK, with only few from lower-income countries and the Islamic world (Kumar & Basu, 2000; Akvadar *et al*, 2004).

Medical students' perceptions of alcohol use may be determined by various factors, including cultural, societal and religious background. Pakistan is an Islamic state, and alcohol use is religiously and legally forbidden; nevertheless, alcohol use is seen as socially acceptable in some sections of Pakistani society. As alcohol is a taboo issue and addiction medicine is not an integral part of the undergraduate curriculum in Pakistan, it may be plausible that Pakistani medical students' knowledge of alcohol use is overestimated. Knowledge is said to influence attitudes and behaviour, so we aimed to assess the knowledge and attitudes regarding alcohol of medical undergraduates in the city of Lahore in Pakistan.

Method

This was a cross-sectional study, approved by the ethical review board of the King Edward Medical University. Informed consent was obtained from all the participants (undergraduate students at a public and a private medical university in Lahore). A structured questionnaire based on a literature review in this area was constructed by the research team in the English language. It was piloted on 20 students and then modified to address identified deficiencies.

The first part of the questionnaire sought demographic information. The second part covered the perceptions of medical students regarding alcohol. These included predisposing and risk factors for alcohol misuse, factors protecting against it and beliefs regarding the adverse and beneficial effects of alcohol. Their views on possible solutions to alcohol misuse among medical students were also sought. Participants were also briefly asked about their own practice regarding use of substances, including alcohol. All possible measures were taken to ensure confidentiality.

The questionnaire was distributed and then collected by the data-collection team. Data were analysed using SPSS 10.0 software. The chi-squared test was used to examine associations between perceptions and various variables. For all purposes, a *P* value of <0.05 was considered significant.

Results

Out of 1500 questionnaires distributed, 1299 filled questionnaires were received (response rate of 86.6%); 1024 (78.8%) were from students at the public medical university and 275 (21.2%) from students at the private medical college. There were 457 males and 842 females. Almost half the respondents were in the age group 18–20.

Twenty-one per cent of respondents believed daily alcohol intake constituted a serious problem, while 38% believed even once in a lifetime use represented a serious problem.

When asked about what would predispose students to take alcohol, consumption of alcohol by friends was the most commonly identified factor (Table 1). Gender differences were observed, with more girls perceiving use of alcohol by friends as a significant predisposing factor than boys (*P* < 0.001). Curiosity and academic stress were the most commonly reported reasons for students taking up alcohol; religion and moral unacceptability were identified as protective factors (Table 1).

Ten per cent of respondents said that alcohol improved academic performance by improving mood and concentration, while 38% felt it helped to alleviate stress. Males were more likely to believe in a positive association between use of alcohol and improvement in academic performance (*P* < 0.001).

About half of the respondents resided in hostels – residential complexes managed by medical colleges in the vicinity of teaching hospitals for their students and doctors (in particular those from remote areas), and a large majority of respondents felt that students living in hostels were predisposed to using alcohol, the top reasons being lack of parental influence (55%), easier access to alcohol (40%), greater stress (23%) and greater peer pressure (18%).

Counselling (48%), more recreational facilities on campus (42%), frequent checks by security staff in hostels (35%) and rehabilitation programmes (26%) were the leading suggestions to reduce the problem of alcohol use on campus.

Table 1 Factors related to alcohol misuse by medical students

	Respondents answering in affirmative, n (%)	
<i>Predisposing factors</i>		
Consumption of alcohol by friends	1096	(84.4)
Consumption of alcohol by family	281	(21.7)
Tobacco smoking	289	(22.3)
<i>Reasons for students taking alcohol</i>		
Curiosity (experimentation)	619	(47.7)
Academic stress	589	(45.4)
Peer pressure	388	(29.9)
To feel good (get high)	301	(23.2)
To help with sleep	190	(14.7)
Other	48	(3.8)
<i>Protective factors</i>		
Religion	569	(57.1)
Moral unacceptability	554	(55.6)
Side-effects/risks	352	(35.3)
Fear of being caught	274	(27.5)
Other	50	(3.9)
<i>Perceived adverse effects</i>		
Addiction	813	(63.0)
Threats to one's own and others' lives	545	(42.0)
Socially inappropriate behaviour	476	(36.7)
Psychological complications	452	(34.8)
Physical complications	366	(28.2)
Decreased academic performance	305	(23.5)

Comparisons of the perceptions of the medical students at the public and private institutions (using the chi-squared test) did not reveal any statistically significant results.

Seventeen per cent of respondents (222) admitted to ever experimenting with cigarettes, alcohol or drugs, with 3.6% admitting to use of one or more of these substances at the time of the study. Among these 222 students, alcohol use was reported by 58 students (26.2%), second only to cigarettes (175; 78.9%). Students belonging to the private medical college were more likely to have experimented with alcohol ($P < 0.001$).

Discussion

Our study provides further evidence of gaps in the knowledge of alcohol among medical students in Pakistan. This is a matter of concern because medical students, as future physicians, will be treating patients with alcohol-related problems. Many were unaware of potential adverse effects of alcohol misuse and on the contrary considered alcohol to be helpful in stress alleviation. In Pakistan, alcohol and drugs are not discussed openly, for societal, cultural and religious reasons. Medical school can therefore be considered critical in providing future physicians with a sound knowledge of the adverse effects of alcohol misuse. Unfortunately, the undergraduate curriculum in addiction medicine in Pakistan is inadequate in this respect. It may be because of the perception that the Muslim medical community is immune to problems of alcohol and drug misuse, due to religious factors. This may be coupled with the mistaken belief that medical students are already fully aware of the harmful effects of these substances.

Factors commonly identified by our respondents as predisposing medical students to use alcohol – such as peer involvement and living away from home – have been well established by previous research (Naskar & Bhattacharya,

1999; Gjeruldsen *et al*, 2003). The most frequently endorsed reasons for students misusing alcohol were curiosity (47.7%), academic stress (45.4%) and peer pressure (29.9%). Previous studies done in Pakistan and Nigeria have cited peer pressure, curiosity, academic stress, euphoria, family conflicts and mental health problems as common reasons for students misusing alcohol and drugs (Gjeruldsen *et al*, 2003; Shafiq *et al*, 2006). These factors include the pressure felt by students to excel in their studies, the expectations of families and the wish to join in peer groups and associated activities, even when considered harmful. A conscious effort needs to be made to alleviate such pressures.

Another interesting finding was that students believed that using alcohol is a way to look cool and fashionable. This, together with curiosity about new and adventurous pursuits, may lead students to experiment with alcohol and other illicit drugs.

Given the sensitivity of the issue, students' own behaviour regarding substance use was not explored in detail. However, the frequency and pattern of psychoactive substance misuse among our respondents is in line with the social acceptability of cigarette smoking in Pakistani society, especially among young people. However, the significant number of respondents who had experimented with alcohol negates the perception of alcohol not being a major problem among Pakistani medical students.

Our study's strengths include large sample size and good response rate. Limitations include the restricted generalisability of the results and possible differences between students' actual perceptions and how they answered the questionnaire.

We conclude that undergraduate medical students in Pakistan are inadequately aware of the potential hazards of alcohol misuse. The relevant risk factors as well as protective factors for alcohol use in medical students need to be identified in nationwide studies. Our study also underscores the need for integration of addiction medicine in the undergraduate curriculum. Efforts should be made at the secondary school and college level to increase awareness of the dangers of substance misuse and to make students realise that experimental use of drugs may lead to misuse and dependence.

References

- Akvadar, Y., Demiral, Y., Ergor, G., *et al* (2004) Substance use among medical students and physicians in a medical school in Turkey. *Social Psychiatry and Psychiatric Epidemiology*, **39**, 502–506.
- Gjeruldsen, S., Myrvang, B. & Opjordsmoen, S. (2003) Risk factors for drug addiction and its outcome. A follow-up study over 25 years. *Nordic Journal of Psychiatry*, **57**, 373–376.
- Kumar, P. & Basu, D. (2000) Substance abuse by medical students and doctors. *Journal of the Indian Medical Association*, **98**, 447–452.
- Kuo, M., Adlaf, E. M., Lee, H., *et al* (2002) More Canadian students drink but American students drink more: comparing college alcohol use in two countries. *Addiction*, **97**, 1583–1592.
- Naskar, N. N. & Bhattacharya, S. K. (1999) A study on drug abuse among the undergraduate medical students in Calcutta. *Journal of the Indian Medical Association*, **97**, 20–21.
- Shafiq, M., Shah, Z., Saleem, A., *et al* (2006) Perceptions of Pakistani medical students about drugs and alcohol. *Substance Abuse Treatment, Prevention and Policy*, **1**, 31.
- Webb, E., Ashton, C. H., Kelly, P., *et al* (1996) Alcohol and drug use in UK university students. *Lancet*, **48**, 922–925.

Problem drinking among young people in Ireland

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Alcohol is widely consumed in many societies. It is estimated to be responsible for 4% of the global disease burden, and is third only to tobacco and hypertension as a leading cause of death in high-income countries. Ireland has one of the highest levels of alcohol use per capita in the world. According to Barnardos (a children's charity) there was a 48% increase in alcohol consumption per capita in Ireland between 1986 and 2006 (Barnardos, 2008). The Irish government endorsed the European Charter on Alcohol in 1995 but, in spite of this, the negative health consequences of alcohol consumption have increased (Mongan *et al*, 2002). About 28% of all injuries presenting to emergency departments in Ireland are alcohol related (Hope, 2008) and the number of hospital discharges related to alcohol increased by 92% between 1995 and 2002 (Mongan *et al*, 2002). Hope (2008) found that alcohol was implicated in 36.5% of road traffic fatalities in 2003 in Ireland, and was also a contributory factor in several cases of house fires and domestic abuse.

The average age of drink initiation in Ireland is 13 and continues to fall (Palmer & O'Reilly, 2008). The European School Survey Project on Alcohol and Other Drugs (ESPAD) revealed that Irish 16-year-olds are among the highest misusers of alcohol in Europe in terms of binge drinking and drunkenness (Hibell *et al*, 2004). Irish adolescents spend approximately €145 million annually on alcohol (Office of Tobacco Control, 2006), with 25% of Irish schoolchildren surveyed admitting to getting drunk regularly. This was double the rate reported by Polish children and five times that of French children (Hibell *et al*, 2004).

In this paper, we examine the factors that may influence the attitudes of young people in Ireland to problem drinking.

Overview of youth-oriented alcohol-related policies in Ireland

A National Alcohol Policy (NAP) was adopted by the government in 1996 to address the widespread problem of alcohol misuse in Ireland. In 2002 the Strategic Task Force on Alcohol (STFA) took particular interest in the effects on young people of excessive drinking. It made recommendations aimed at lessening the impact of alcohol advertising. It advocated monitoring of the content, placement and timing of advertisements to ensure that they do not appeal to or target children. It also called for a ban on the drinks industry from sponsoring children's activities. The Commission on Liquor Licensing, established in 2003, further recommended

the promotion of school-based educational measures as a means of decreasing alcohol-related problems. Other policy measures that were adopted by the state included setting the legal age for purchasing alcohol at 18 years, introduction of a national identity card system as proof of age for purchasing alcohol and random breath testing of drivers, with particular emphasis on young people.

Young people and their attitudes to alcohol use in Ireland

In 2007, the Office of the Minister for Children (OMC) organised a youth-led and youth-friendly consultation process aimed at providing a safe atmosphere in which young people could freely express their opinions regarding alcohol misuse among youths, and give their views on more effective ways of dealing with this problem. About 257 youths aged 12–18 years attended these forums in five locations across the country. The problem of excessive teenage drinking was acknowledged by all groups. Participants were of the view that scare-mongering educational tactics to persuade young people not to drink at all are unrealistic, and preferred an emphasis on 'reasonable drinking'. They also believed that young people who drink reasonably should be used as role models for younger people, rather than using only those who never drink. The top five solutions proffered by the youths for curbing the effects of under-age drinking were:

- lowering the legal age of drinking alcohol to 16
- providing alternative, alcohol-free facilities for young people
- promoting and supporting the role of parents
- developing age-appropriate and specialist-delivered educational programmes
- updating and enforcing the national identity card system and other related laws for the purchase of alcohol.

Participants also identified the roles of the police, media, peer pressure and peer mentoring as important. These 'solutions' are likely to reflect the factors that greatly influence the attitudes of Irish youths to alcohol misuse.

It has been suggested that, in the UK, young people drink alcohol for different reasons, related to their ages (Newburn & Shiner, 2001): 12- to 13-year-olds experiment with alcohol from a desire to attain adult status; 14- to 15-year-olds drink to get drunk, with the aim of testing their limits and having fun; while 16- to 17-year-olds see drinking as a sign of maturity and experience. It is likely that this is similarly the case with Irish teenagers.

Factors contributing to problem drinking among Irish youths

Cost of alcohol

The cost of alcohol is inversely linked with consumption rates and related problems among youths (Chaloupka *et al*, 2002). In Ireland, alcoholic drinks have become more affordable for youths, a situation which may have been worsened by a reduction in the excise duty on alcohol in the December 2009 budget.

Regulation of advertising

Studies have consistently demonstrated a positive correlation between exposure to alcohol advertising and the level of alcohol use (Smith & Foxcroft, 2007); this link has also been demonstrated in children (Dring & Hope, 2001). The voluntary code for alcohol advertising as currently practised in Ireland does not maximise the potential to reduce consumption.

Legal age for purchasing alcohol

The legal age for purchasing alcohol in Ireland is 18. In the USA it is 21. This difference may explain, at least in part, why only 7% of American teenagers get drunk regularly, compared with 25% of teenagers in Ireland. Although a national identity card was introduced in Ireland in 1999 to serve as proof of age for alcohol purchase, inadequate enforcement means this has had little effect on the procurement of alcohol by under-age drinkers.

Normalisation of unhealthy drinking practices and attitudes

The concept of modelling is central to social learning theory. Unhealthy drinking patterns and behaviours and their attendant consequences enjoy high tolerance in Irish culture, to the point of normalisation (Mongan *et al*, 2002). Social influences (e.g. parents and peers) are among the strongest correlates of adolescent substance misuse (Hawkins *et al*, 1992). Attitudes of Irish youths to alcohol are likely to be formed through these social influences (Abrams & Niaura, 1987).

Stakeholders and their roles

Government

The government has a role in providing the political will necessary to address the problems of youth drinking. Alcohol policies in Ireland, when benchmarked against those of other members of the European Union (EU), are rather casual (Anderson & Baumberg, 2006). The recent postponement of the lowering of the legal blood alcohol concentration limits for driving (from 80 mg to 50 mg of alcohol per 100 ml of blood, in line with most EU countries) following opposition from vested interest groups illustrates this casual approach.

The alcohol industry

Teenagers who drink regularly are more likely to become heavy-drinking adults (Grant *et al*, 2006). Early brand loyalty is established through brand awareness and exposure. According to Smyth *et al* (2008), the industry has lobbied against the introduction of stricter advertising guidelines with this in mind. In June 2009, the director of the Alcohol

Beverage Federation of Ireland rejected calls for new legislation to govern drinks advertising on television.

Media organisations

Alcohol advertising generated about €69 million in 2007, a 31% increase from 2006 figures (Smyth *et al*, 2008). It is likely that editorial policies are influenced by such profits.

Conclusion

Binge drinking and drunkenness among young people in Ireland are common and place a burden on society. The attitude of young people to alcohol use is influenced by government policies (which determine accessibility and affordability) as well as social and cultural factors. The governmental and other stakeholders therefore have a role in ensuring that the appropriate policies are enacted and properly enforced, and that sociocultural mediators are modified to promote a positive change in the attitude of young people to alcohol.

References

- Abrams, D. B. & Niaura, R. S. (1987) Social learning theory. In *Psychological Theories of Drinking and Alcoholism* (eds H. T. Blane & K. E. Leonard), pp. 131–178. Guilford Press.
- Anderson, P. & Baumberg, B. (2006) *Alcohol in Europe: A Public Health Perspective*. Institute of Alcohol Studies.
- Barnardos (2008) Submission to the Alcohol Advisory Group, http://www.barnardos.ie/assets/files/pdfs/submission_to_the_Advisory_Group.pdf (accessed 23 August 2010).
- Chaloupka, F. J., Grossman, M. & Saffer, H. (2002) The effects of price on alcohol consumption and alcohol-related problems. *Alcohol Research and Health*, **26**, 22–34.
- Dring, C. & Hope, A. (2001) *The Impact of Alcohol Advertising on Teenagers in Ireland*. Health Promotion Unit, Department of Health and Children.
- Grant, J. D., Scherrer, J. F., Lynskey, M. T., *et al* (2006) Adolescent alcohol use is a risk factor for adult alcohol and drug dependence: evidence from a twin design. *Psychological Medicine*, **36**, 109–188.
- Hawkins, J., Gtalanio, R. & Miller, J. (1992) Risk and protective factors for alcohol and other drug problems in adolescence and early childhood: implications for substance abuse prevention. *Psychological Bulletin*, **112**, 64–105.
- Hibell, B., Anderson, B., Bjarnason, T., *et al* (2004) *The ESPAD Report, 2003*. Swedish Council for Information on Alcohol and Other Drugs and Pomidou Group at the Council of Europe.
- Hope, A. (2008) *Alcohol Related Harm in Ireland*. Health Services Executive, Alcohol Implementation Group.
- Mongan, D., Reynolds, S., Fanagan, S., *et al* (2002) *Health Related Consequences of Problem Alcohol Use. Overview 6*. Health Research Board.
- Newburn & Shiner (2001) Cited in Alcohol Concern Factsheet. *Young People's Drinking*. March 2004. Available at http://www.alcoholconcern.org.uk/servlets/wrapper/knowledgebase.jsp?topic_id=5&theme_id=84 (accessed August 2010).
- Office of Tobacco Control (2006) *Children, Youth and Tobacco: Behaviour, Perceptions and Public Attitudes*. Office of Tobacco Control.
- Palmer, D. & O'Reilly, G. (2008) *Strategic Task Force on Alcohol: Second Report*. Health Promotion Unit, Department of Health and Children.
- Smith, L. & Foxcroft, D. (2007) *The Effect of Alcohol Advertising and Marketing on Drinking Behaviour in Young People: A Systematic Review*. Alcohol Education and Research Council.
- Smyth, B., Keenan, E., Flannery, W., *et al* (2008) *Calling Time on Alcohol Advertising and Sponsorship in Ireland: Supporting a Ban on Alcohol Advertising in Ireland. Protecting Children and Adolescents*. Policy paper by the Faculty of Addiction Psychiatry, Irish College of Psychiatrists.

A collaborative community approach to adolescent substance misuse in Iceland

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Substance use has become a major threat to health and human development in many European countries. In 23 out of 28 countries participating in the European School Survey Project on Alcohol and Other Drugs (ESPAD), there was a constant and substantial increase in substance use among secondary-school students between the years 1995 and 2003 (Hibell *et al*, 2003). Iceland experienced a similar upward trend in substance use (Sigfusdottir *et al*, 2008). Throughout the 1990s, the use of alcohol, tobacco and other drugs increased steadily among 15- and 16-year-olds. In 1998, approximately 17% of 16-year-olds had tried hashish, which was the highest frequency to be measured in Iceland, and over 80% reported that they had used alcohol once or more in their lives (Thorlindsson *et al*, 1998).

In spite of prevention efforts being employed at the time, which mainly focused on educating adolescents about the negative health effects of substance use and was mostly carried out within schools, use of substances was increasing. At this point, we decided to try a new approach to prevention: a collaborative method that focused on youth behaviour. For the past decade, an interdisciplinary group of social scientists, policy makers and practitioners interested in youth development has made an effort to understand what predicts adolescent behaviour. We work closely with various governmental and non-governmental organisations and, with their support, a number of comprehensive studies have been done, focusing on the health and well-being of adolescents, their lifestyle, behaviour and delinquency. Based on the findings, an evidence-based policy has been devised and developed to reduce known risk factors and strengthen a broad range of community-level protective factors.

The earlier approach

For decades, adolescent substance use prevention in Iceland focused on educating adolescents about the negative consequences of substance use. Most of these educational programmes were carried out and evaluated within separate community spheres and thus failed to foster the necessary collaboration between schools and other community stakeholders that might have led to a common set of understandings about the multilevel aetiology of substance use. Schools and youth organisations, working in isolation, failed to produce the kind of shared conceptual framework that characterises transdisciplinary approaches (Rosenfield, 1992),

from which local authorities might have more successfully addressed the potentially modifiable factors underlying substance use. Finally, prevention efforts were not grounded in social science theory, nor had they used empirical research and the available evidence base on substance use prevention (Saxe *et al*, 2006).

The current approach

Our current work has been guided by key theories from social science, including Durkheim's work on social integration and regulation (Durkheim, 1897). Although Durkheim focused on suicide and social deviance, his theoretical perspective on human behaviour and social problems has a broad and enduring conceptual scope. It covers critical variables related to the family, the school and other social institutions that are readily applicable to many contemporary social problems, including substance use. Durkheim emphasised that weak social integration can lead to social problems and reduced individual well-being. Thus, individuals experiencing insufficient social control and social support are more likely than well-integrated individuals to engage in delinquent acts. In line with Durkheim's theory, as well as Hirchi's (1969) control theory, our annual surveys (see below) of all adolescents in secondary schools in Iceland have shown that those who are better attached to their parents are likely to experience greater social control over their behaviour than those who are poorly attached. Further, individuals with weak attachment bonds experience fewer social controls over their behaviour, thus enabling them to engage in delinquent behaviour such as substance use. These theories, along with Coleman's (1998) theory on social capital, provide the theoretical foundation on which Iceland's adolescent substance use prevention policy and practice have been based for over a decade.

Consistent with systems-based public health (Yarnell, 2007), Iceland's approach to adolescent substance use is primary prevention. We seek to curtail the initiation of substance use before any signs of experimentation are evident.

Surveys and intervention

Figure 1 shows the substance use rate among two age cohorts, one born in 1984 and another born in 1991. It reveals different trends for the two. Adolescents in a cohort who reported above-average use of any substance at the age of 13 maintained its high use through to the next 2 years and used substances heavily at the age of 15. However,

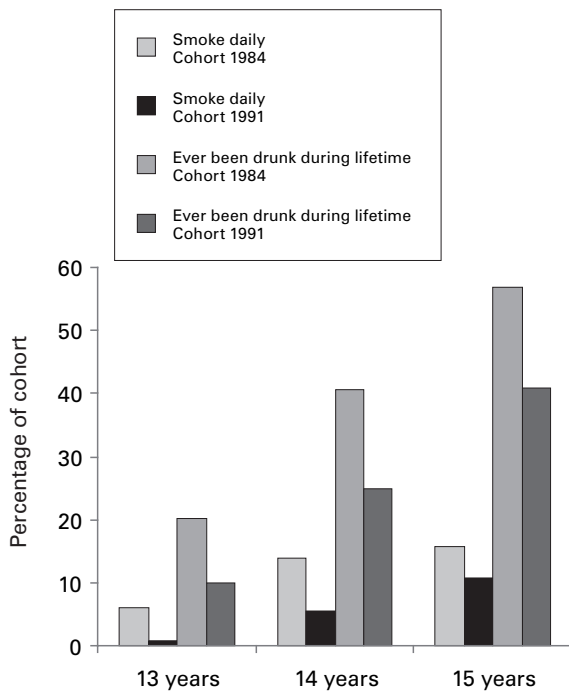


Fig. 1 Percentages of community respondents who reported ever being drunk (in lifetime) and daily smoking: cohorts born in 1984 and 1991, at ages 13, 14 and 15 years.

13-year-olds who reported little substance use continued to engage in relatively low use through the next 2 years.

In line with these findings, we tried to identify and reach adolescents early in their formative school years, as well as the parents of younger adolescents, in order to intervene at the developmentally critical stage before substance use is adopted. Thus, understanding the major peer and social influences in the lives of adolescents is essential to strengthening those protective factors and decreasing those risk factors that become the priority for intervention.

The intervention uses the concepts and processes suggested by traditional planning models. First, our annual survey data provide iterative cycles of evidence that are necessary to monitor annual changes in both risk and protective factors, as well as in alcohol, tobacco and cannabis use in each community. This permits us to compare changes over time within the Icelandic community in general and with other countries. Second, our presentations of these data to the community provide local stakeholders with an opportunity to reflect on what the data say about youth behaviour in their community. Finally, the community-level input about the practical means by which any given community may contribute to the work of prevention has enabled us to recommend actions that are likely to be owned, implemented and sustained by local communities. Informed by the data, we are able to propose and facilitate action across multiple sites and at multiple levels. As new data from our surveys emerge and are periodically reviewed by participants to assess process and outcome dimensions of the intervention, local authorities work with us to make adjustments in programming to ensure the continued relevance of the approach.

By studying the findings from our annual surveys and comparing them with those of studies carried out in other countries, we have achieved good results.

Results

Substance use declined

The proportion of tenth-graders who reported becoming drunk during the past 30 days decreased from 42% in 1998 to 20% in 2007. Also, the proportion of tenth-graders who reported smoking cigarettes daily was 23% in 1998 but fell to 10% in 2007. Furthermore, the proportion of adolescents who had ever used hashish in their lives decreased from 17% in 1998 to an all-time low of 7% in 2007.

Trends in risk and protective factors changed

Changes in many risk and protective factors for adolescent substance use have been clear and consistent. For example, the proportion of adolescents reporting that their parents monitored with whom they were spending time in the evenings was 49% in 1997, compared with 67% in 2006.

Binge drinking and incidents related to drinking decreased in ranking across Europe

When findings from the ESPAD studies in 1995 and 2003 are compared, Icelandic tenth-graders moved in the ranking of adolescents' binge drinking and serious incidents related to drinking from being among the highest to well down into the middle (Hibell *et al*, 2003).

Community comparison

Although substance use among Icelandic adolescents in general decreased over the period, the decrease was significantly larger in those local communities that used our methods than in other communities (Kristjansson *et al*, 2010).

Discussion

Adolescents spend their lives predominantly within the domains of parents and family, the school, the peer group, and in leisure activities, as well as within the larger social milieu of their local communities. It is in these social circumstances that adolescent substance use occurs (Thorlindsson *et al*, 1998). Although the onset of substance use usually emerges in the peer group, risk and protective factors can be found in all domains of adolescent lives. Furthermore, these domains intersect and influence each other in complex ways that place young people at risk for health-compromising behaviours.

Our primary prevention approach focuses on adolescent health promotion in both the school and broader (community-wide) settings (Sigfusdottir *et al*, 2009). Moreover, our approach is based on social science theory, which links community-level mobilisation to individual behaviour, coupled with an institutionalised capacity for collecting population-based data; this has yielded a rich, dynamic and nuanced picture of the potentially modifiable risk and protective factors at the individual, family, community and societal levels.

The core elements of the approach include:

- utilising evidence-based understanding of the risk and community-level protective factors to inform intervention
- an intervention approach designed to be community-based and responsive to these two sets of factors
- an emphasis on building collaboration between researchers, policy makers and practitioners at the community level.

References

- Coleman, J. (1998) Social capital in the creation of human capital. *American Journal of Sociology*, **94** (suppl.), 95–120.
- Durkheim, E. (1897) *Suicide*. Free Press (1951).
- Hibell, B., Barbro, A., Bjarnason, T., et al (2003) *The ESPAD Report 2003. Alcohol and Other Drug Use Among Students in 26 European Countries*. Swedish Council for Information on Alcohol and Other Drugs (CAN) and the Pompidou Group at the Council of Europe.
- Hirchi, T. (1969) *Causes of Delinquency*. University of California Press.
- Kristjansson, A. L., James, J. E., Allegrante, J. P., et al (2010) Adolescent substance use, parental monitoring, and leisure-time activities: 12-year outcomes of primary prevention in Iceland. *Preventive Medicine*, **51**, 168–171.
- Rosenfield, P. L. (1992) The potential of transdisciplinary research for sustaining and extending linkages between the health and social sciences. *Social Science and Medicine*, **35**, 1343–1357.
- Saxe, L., Kadushin, C., Tighe, E., et al (2006) Community-based prevention programs in the war on drugs: findings from the 'Fighting back' demonstration. *Journal of Drug Issues*, **36**, 263–293.
- Sigfusdottir, I. D., Kristjansson, A. L., Thorlindsson, T., et al (2008) Trends in prevalence of substance use among Icelandic adolescents, 1995–2006. *Substance Abuse Treatment Prevention and Policy*, **3**, 12.
- Sigfusdottir, I. D., Thorlindsson, T., Kristjansson, A. L., et al (2009) Substance use prevention for adolescents: the Icelandic model. *Health Promotion International*, **24**, 16–25.
- Thorlindsson, T., Sigfusdottir, I. D., Bernburg, J. G., et al (1998) *Vímuefnaneysla ungs fólks: Umhverfi og aðstæður* [Substance Use Among Young People.] Rannsóknarstofnun uppeldis-og menntamála.
- Yarnell, J. W. G. (2007) *Epidemiology and Prevention: A System-Based Approach*. Oxford University Press.

COUNTRY PROFILE

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Mental healthcare in the Slovak Republic: current situation and future challenges

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The Slovak Republic is a landlocked country in central Europe with a population of over 5 million. The Czech Republic and Austria lie to the west, Poland to the north, Ukraine to the east and Hungary to the south. The largest city is the capital, Bratislava; the second largest city is Košice. Slovakia is a member of the European Union, the United Nations, the Organisation for Economic Cooperation and Development (OECD) and the World Trade Organization, among other international organisations. The majority of the inhabitants of Slovakia are ethnically Slovak (85.8%). Hungarians are the largest ethnic minority (9.5%). With a gross domestic product (GDP) of €63.3 billion in 2009, Slovakia is classified as a middle-income country. In that year total health expenditure represented 6.7% of GDP (Pažitný, 2008), 34% of which went on pharmaceuticals, the highest share among all OECD countries (World Health Organization, 2010).

Prevalence of mental disorders

Two epidemiological studies have recently been conducted to assess the prevalence of depressive and anxiety disorders in Slovakia – the EPID (Heretik et al, 2003) and EPIA (Novotný et al, 2006) surveys. According to the EPID survey, the 6-month prevalence rate of depression is 41% (13% major depression, 5% minor depression and 23% depressive symptoms only); and according to the EPIA survey, the 6-month prevalence of generalised anxiety disorder is 4%.

The overall rates for first lifetime contact with mental health out-patient services for all mental disorders has been reported to be 1724.4 per 100 000 inhabitants (NCZI, 2009). Almost 27% of treated mental disorders were classified as neurotic disorders; organic disorders were the second most commonly treated conditions in the out-patient setting (20.5%), followed by affective disorders (17.5%) and substance use disorders (12.7%) in 2008 (NCZI, 2009).

Policy and legislation

Slovakia has no laws specific to mental healthcare and there is no monitoring of the quality of care. Several independent bodies monitor human rights in general and some non-governmental organisations address the human rights of those with mental illness (Bražinová et al, 2008).

Slovakia ratified the main human rights instruments in 1992, shortly before the division of Czechoslovakia and the establishment of the Slovak Republic. Mental healthcare falls under the general system of healthcare and is regulated by general healthcare legislation, which reflects much of the international thinking about human rights. An anti-discrimination act, adopted in 2004, bans discrimination on the grounds of health status. The government adopted the Charter of Patients' Rights in 2001 and this has since been promoted through various non-governmental activities. The Charter defines all the rights and entitlements of patients within healthcare delivery as they are stipulated in other

legally binding documents. The Slovak Public Defender of Rights, for instance, monitors the legality of official decisions that affect individuals and the Slovak National Centre for Human Rights is an independent human rights monitoring centre that provides information and assistance.

The act on healthcare specifies forms of out-patient and in-patient care (Bražinová *et al*, 2008). It has improved the protocols for informed consent, the right to information, choice of provider, access to documentation, right to dignity, confidentiality and refusal of care. The Healthcare Surveillance Authority was established in 2005; it supervises public health insurance and the overall delivery of healthcare services.

Personnel

The professionals involved in mental healthcare may be classified as follows:

- medical doctors – psychiatrists, child and adolescent psychiatrists
- nurses – general nurses with secondary education, nurses with a bachelor's degree and nurses with a specialisation ('nursing in psychiatry')
- other health professionals with a degree – psychologists, social workers, physiotherapists, 'pedagogues' in health establishments, etc.
- health workers without a degree.

In 2004 the Slovak Republic had 32 psychiatric nurses, 10 psychiatrists, 3 psychologists and 1 social worker per 100 000 inhabitants (UZIS, 2006). The shortage of nurses, social workers and case managers sometimes results in patients having no one to coordinate comprehensive care packages for them.

Service delivery

Nationally, there are 26 psychiatric wards in general hospitals (including the psychiatric departments in university hospitals), with a total of 1744 beds. These beds are used for short-term acute hospitalisations. The length of stay is limited by the health insurance companies to around 21 days (NCZI, 2009). The comparatively large number of beds can be explained by the tradition of in-patient care in central Europe and because hospital psychiatric services sometimes have to compensate for the lack of social care and community services. Community-based services, such as case management, rehabilitation centres, sheltered housing and employment schemes, are few in number (Table 1) and in fact only one region (Michalovce) has a system of community-based mental healthcare (Nawka *et al*, 2008).

Training in psychiatry and in allied professions

On the basis that well-trained mental healthcare personnel are at the foundation of quality care, the Slovak Republic has made important reforms in the post-communist period (Vevera *et al*, 2008). The structure of the system where most psychiatric patients are treated in general hospitals is, however, mirrored in the training requirements.

Table 1 Mental health services in Slovakia (2006) (population 5.44 million)

Facility/service	<i>n</i>
Psychiatric out-patient clinics	201
Psychology out-patient clinics	179
Day clinics	14
Case management services	1
Rehabilitation centres	60 places
Sheltered workshops	12 places
Sheltered living services	1 (8 beds total)
Psychiatric departments in general hospitals	26 (1744 beds total)
Psychiatric hospitals	5 (1392 beds total)
Mental hospitals	4 (630 beds total)

Slovakia has three medical faculties that provide comprehensive courses in psychiatry: the Faculty of Medicine, Comenius University, in Bratislava; the Jesenius Faculty of Medicine, Comenius University, in Martin; and the Faculty of Medicine, University of P. J. Šafárik, in Košice. Postgraduate training is directed by the Ministry of Health and executed mainly by the Slovak Medical University and other accredited institutions. The postgraduate curriculum is in accordance with the Charter of the Union Européenne des Médecins Spécialistes (UEMS; European Union of Medical Specialists) for training in psychiatry; it includes a variety of psychiatric in-patient and out-patient services. There are also 2-year certified courses for specialisation in geriatric psychiatry, psychiatric sexology and substance misuse. Two of three existing medical faculties, in Bratislava and Košice, are able to grant PhDs in psychiatry.

Psychology as an independent bachelor and masters degree programme is delivered by faculties of philosophy. There are also three public faculties and one private faculty for health-care and nursing and one medical university focusing mainly on training, as well as 24 secondary medical schools.

Research and publications

Research in Slovakia is mostly carried out at universities and institutions attached to the Academy of Sciences. The most important are psychiatric departments within medical schools (Bratislava, Košice and Martin) and the Slovak Medical University. Unfortunately, mental health research in Slovakia is fragmented and largely *ad hoc* in nature, financed from different resources (Veselý & Ocvár, 2008). Most scientific research is in biological psychiatry (e.g. electrophysiology in schizophrenia and addiction), epidemiology (depressive and anxiety disorders, suicide), quality of life and psychopathology.

There are only two professional Slovak mental health journals in which researchers can publish their results, and neither is indexed in the ISI Web of Knowledge. Research findings are often published in conference brochures.

Plans for future

In recent years, Slovakia has achieved important results in the organisation of its mental health services, but there is still a lot to do in order to achieve sustainability. Developments will focus on the following areas (Nawka *et al*, 2008).

Prevention

Primary, secondary and especially tertiary prevention had been largely neglected. There is now, though, promotion of social integration and employment of individuals with mental illness in their community. Special focus should be placed on the mental health needs of children, adolescents and the elderly.

Adequate resources

A system with adequate resources must be created to support better quality of care and more consumer-driven services. This should actually reduce overall spending on mental health.

Community-based care

Most chronic beds in psychiatric hospitals should be eliminated or transformed to social health beds. Specialised secure departments for the compulsory long-term treatment of non-voluntary patients are planned in psychiatric hospitals.

Integration

Mental healthcare is due to be better integrated into general health and social services, as care shifts away from psychiatric hospitals to psychiatric departments in general hospitals.

Local participation

Local government must be involved in health promotion, and in the treatment, rehabilitation and integration of patients into the community and labour market.

Training

New curricula will be needed for the transformation to community mental healthcare, which will require both traditional and new categories of personnel: social workers, case managers, primary care physicians, self-help group workers, patient advocates and advocacy experts.

References

- Bražinová, A., Baudiš, P., Háva, P., *et al* (2008) Mental health policies and legislation. In *Mental Health Care Reform in the Czech and Slovak Republics, 1989 to the Present* (eds R. M. Scheffler & M. Potucek), pp. 81–112. Charles University Press.
- Heretik, A., Sr, Heretik, A., Jr, Novotný, V., *et al* (2003) *EPID – Epidemiológia depresí na Slovensku*. [Epidemiology of Depression in Slovakia.] Psychoprof.
- Nawka, P., Dragomirecká, E., Džúrová, D., *et al* (2008) Organizational structures. In *Mental Health Care Reform in the Czech and Slovak Republics, 1989 to the Present* (eds R. M. Scheffler & M. Potucek), pp. 113–141. Charles University Press.
- NCZI (Národné Centrum Zdravotníckych Informácií; National Health Information Centre) (2009) *Zdravotnícka Rocenka Za Rok 2008*. [Health Yearbook Year 2008.] NCZI.
- Novotný, V., Heretik, A., Sr, Heretik, A., Jr, *et al* (2006) *EPIA – Epidemiológia Vybraných Uzkostných Porúch na Slovensku*. [Epidemiology of Selected Anxiety Disorders in Slovakia.] Psychoprof.
- Pažitný, P. (2008) *Stanovisko HPI k Rozpočtu Zdravotníctva na Roky 2009–2011*. [Health System Budget 2009–2011 from the Standpoint of the Health Policy Institute.] Available at <http://www.hpi.sk/hpi/sk/view/2213/stanovisko-hpi-k-rozpoctu-zdravotnictva-na-roky-2009-2011.html> (accessed August 2010).
- UZIS (Ústav Zdravotníckych Informácií a Statistiky; Institute of Health Information and Statistics) (2006) *Trendy Vývoje Zdravotníckych Dat v SR a CR v Letech 1994–2004*. [Trends in Evolution of Health Data in the SR and CR, 1994–2004.] UZIS.
- Veselý, A. & Ocvár, L. (2008) Research and evaluation. In *Mental Health Care Reform in the Czech and Slovak Republics, 1989 to the Present* (eds R. M. Scheffler & M. Potucek), pp. 225–250. Charles University Press.
- Vevera, J., Bražinová, A., Nemeč, J., *et al* (2008) Human resources and training. In *Mental Health Care Reform in the Czech and Slovak Republics, 1989 to the Present* (eds R. M. Scheffler & M. Potucek), pp. 197–223. Charles University Press.
- World Health Organization (2010) Slovakia. Country cooperation strategy at a glance. Available at http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_svk_en.pdf

COUNTRY PROFILE

Psychiatry in the USA: an overview

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The USA has the world's largest economy and the highest per capita spending on healthcare, but it lags behind other countries on a number of key health measures. It ranks 23rd in healthy life expectancy and 32nd in infant mortality (World Health Organization, 2009). In 2000, the World Health Organization ranked the US healthcare system as 1st in responsiveness, 37th in overall performance, and 72nd by overall level of health (among 191 member nations in the study).

Mental health in the USA

Approximately 25% of US adults have a diagnosable mental disorder in a given year and approximately 6% have a serious mental illness. Mental disorders are the leading cause of disability for people aged 15–44 years (National Institute of Mental Health, 2010).

About 11% of adults experience serious psychological distress, such as anxiety and mood disorders, that result in

functional impairment that impedes one or more major life activities. Rates of mental illness are highest for adults aged 18–25 years and lowest for those over 50; rates for women are significantly higher than for men. The most common mental illnesses are anxiety and mood disorders (Substance Abuse and Mental Health Services Administration, 2009).

Some 17% of inmates entering jails and prisons have a serious mental illness (which is nearly three times the rate in the general population) (Steadman *et al*, 2009). As many as 70% of those in the juvenile justice system have a diagnosable mental disorder and one in five has a mental disorder significant enough to impair functioning (Skowrya & Cocozza, 2006).

Unfortunately, the high rate of mental illness does not correlate with adequate treatment. Fewer than half of adults with a diagnosable mental disorder receive treatment in a given year (Kessler *et al*, 2005). The number of Americans under care for mental illnesses nearly doubled between 1996 and 2006 (from 19 to 36 million) (Agency for Healthcare Research and Quality, 2009). Among those with serious mental illnesses, adults aged over 50 were more likely to use mental health services (71%) than adults aged 18–25 (40%) (Substance Abuse and Mental Health Services Administration, 2009).

A variety of social, financial and systemic barriers contribute to the lack of psychiatric treatment. Although society's perception of individuals with mental illness has improved, stigma is still significant. A negative attitude to mental illness, which can be expressed as distrust, stereotyping, fear, embarrassment, anger and avoidance, often inhibits people from seeking treatment.

Service delivery

A range of services and treatments to help people with mental disorders is provided by a variety of caregivers working in public and private settings. There are four major components to these services:

- specialty mental health professionals (psychiatrists, psychologists, psychiatric nurses, psychiatric social workers, etc.)
- general medical practitioners
- social services providers (e.g. school-based counselling, vocational rehabilitation)
- informal volunteers (e.g. self-help groups).

Approximately 15% of adults and 21% of children and adolescents in the USA use these services each year (Surgeon General, 2001). Most care is provided in out-patient settings (public or private clinics or offices). Acute hospital care is usually provided in psychiatric units of general hospitals rather than in free-standing psychiatric hospitals.

Patients frequently seek care exclusively from primary care physicians and clinicians. For example, more than 50% of patients with depression see only primary care physicians or clinicians (Kessler *et al*, 2003).

The roles of consumer self-help, consumer-operated, consumer advocacy, family support and peer support services are expanding. There are also increasing efforts to coordinate not only medical and mental health services, but also other services for those recovering from mental illness, such as education, housing and employment. However, these are generally fragmented and dispersed among a number of organisations, both private and government-based.

A history of deinstitutionalisation

In 1955 there was one psychiatric bed for every 300 Americans; today there is one for every 3000 (Torrey *et al*, 2010). Beginning in the mid-20th century, large psychiatric hospitals began to close so that care could be provided to patients in less isolated, more inclusive community mental health services – a process referred to as deinstitutionalisation. Although this was successful for some people, community resources have not been available or have been inadequate for many others. People with mental disorders have all too often ended up homeless or as inmates in the criminal justice system.

New laws providing greater access and coverage

Recently enacted laws are expected to go a long way to improve access to care for those with mental illness. The 2010 Patient Protection and Affordable Care Act will have far-reaching effects on patients, as well as on psychiatrists and other physicians. It will provide comprehensive health insurance coverage, including for the treatment of mental illness and substance misuse, to an estimated 30 million Americans who are currently uninsured.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 specifically expands federal requirements for mental health coverage. Private insurers who cover mental health must provide coverage at least equivalent to that for other medical illnesses. Furthermore, co-payments for mental health services cannot exceed those for general health services, and insurers may not impose special limitations on the number of mental healthcare visits.

Workforce and resources

There are more than 40 000 psychiatrists in the USA. Approximately 137 psychiatry residency programmes accredited by the Accreditation Council of Graduate Medical Education (ACGME) train some 6000 residents each year. There are nearly 9000 advanced practice psychiatric nurses who provide mental health services, including prescribing (under varying state regulations), and more than 90 000 psychologists who provide services, generally not including prescribing.

Clinicians providing mental health services do not reflect the ethnic diversity of the US population. Members of the major ethnic/racial minorities in the USA make up about 33% of the population, but only about 25% of physicians, 19% of psychiatrists, 10% of psychologists and 15% of social workers. There is even greater disparity among specific racial/ethnic groups. For example, African Americans make up approximately 13% of the population, but only 3% of psychiatrists and 2% of psychologists, and Latinos make up about 14% of the population but only 5% of psychiatrists and 3% of psychologists (Sribney *et al*, 2010).

More resources are available in some parts of the country than in others. There are over 3500 'health professional shortage areas' for mental health in the USA, affecting more than 84 million people, 65% of them in non-metropolitan

areas. Although the total number of psychiatrists per 100 000 population has been relatively stable over the past 20 years, the average age of psychiatrists (half are over 55) has raised concerns that there will soon be too few to meet future demands (Skully & Wilk, 2003).

Key factors in the future are likely to include the changing scope of practice and roles of non-psychiatrists; growth and ageing of the population; mainstreaming of psychotropic drugs; increasing insurance coverage; and changing utilisation patterns in subpopulations (e.g. Latinos) (Vernon *et al*, 2009).

Financing mental healthcare

In terms of healthcare expenditure, mental disorders are among the five most costly types of health conditions in the USA (along with cancer, heart disease, asthma and trauma-related disorders) (Agency for Healthcare Research and Quality, 2009). Mental healthcare in the USA is paid for from a combination of public and private sources, including public funding (Medicaid, 18%; Medicare, 22%), private insurance (28%) and out-of-pocket individual/self-pay (25%) (Agency for Healthcare Research and Quality, 2006).

Other sources of federal funding include the Veterans Administration and Department of Defense (through service delivery), the Substance Abuse and Mental Health Services Administration (through block and discretionary grants), and the Health Resources and Service Administration (via federal community health centres).

States have traditionally served as the safety net for people unable to access mental health services and have carried much of the responsibility for low-income individuals with serious mental illness. The recent economic downturn has forced many states to scale back this funding.

Critical issues

Several critical issues currently affect mental healthcare and will continue to do so in the near future. Access to care is limited by problems in rural areas (travel distance for patients, a scarcity of providers) and also by stigma and too few culturally competent and linguistically diverse providers. Another challenge is the lack of coordination of care – of public and private services, of various specialty services, of general medical and mental health services, and of social services and other institutions (housing, criminal justice, education). Also at issue is growing public concern over the influence of pharmaceutical companies on how physicians practise. The transition to the use of electronic health records is another major adjustment.

Although psychiatry remains an important and fulfilling career in the USA, there will be many challenges for patients and mental healthcare workers for many years to come. However, there will also be many new opportunities to provide better mental health services for all those who need them.

References

- Agency for Healthcare Research and Quality (2006) *Medical Expenditure Panel Survey* (Table 4: Total Expenses and Percent Distribution for Selected Conditions by Source of Payment: United States, 2006). AHRQ.
- Agency for Healthcare Research and Quality (2009) *The Five Most Costly Conditions, 1996 and 2006: Estimates for the U.S. Civilian Non-institutionalized Population*. Statistical Brief No. 248. AHRQ. Available at http://www.meps.ahrq.gov/mepsweb/data_files/publications/st248/stat248.pdf (accessed July 2010).
- Kessler, R. C., Berglund, P., Demler, O., *et al* (2003) The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication (NCS-R). *JAMA*, **289**, 3095–3105.
- Kessler, R. C., Demler, O., Frank, R. G., *et al* (2005) Prevalence and treatment of mental disorders, 1990 to 2003. *New England Journal of Medicine*, **352**, 2515–2523.
- National Institute of Mental Health (2010) *The Numbers Count: Mental Disorders in America*. NIMH. Available at <http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america.shtml> (accessed July 2010).
- Skowyrza, K. R. & Cocozza, J. J. (2006) *Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System*. National Center for Mental Health and Juvenile Justice, Policy Research Associates, Inc. Available at <http://www.ncmhjj.com/Blueprint/pdfs/Blueprint.pdf> (accessed July 2010).
- Skully, J. H. & Wilk, J. E. (2003) Selected characteristics and data of psychiatrists in the United States, 2001–2002. *Academic Psychiatry*, **27**, 247–251.
- Sribney, W., Elliott, K., Aguilar-Gaxiola, S., *et al* (2010) The role of non-medical human services and alternative medicine. In *Disparities in Psychiatric Care* (eds P. Ruiz & A. Primm), pp. 274–289. Lippincott, Williams & Wilkins.
- Steadman, H. J., Osher, F. C., Robbins, P. C., *et al* (2009) Prevalence of serious mental illness among jail inmates. *Psychiatric Services*, **60**, 761–765.
- Substance Abuse and Mental Health Services Administration (2009) *National Survey on Drug Use and Health, 2008*. SAMHSA. Available at <http://www.oas.samhsa.gov/NSDUHlatest.htm> (accessed July 2010).
- Surgeon General (2001) *Mental Health: Culture, Race, and Ethnicity*. US Department of Health and Human Services. Available at <http://www.surgeongeneral.gov/library/mentalhealth/cre/> (accessed July 2010).
- Torrey, E. F., Kennard, A. D., Eslinger, D., *et al* (2010) *More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States*. Treatment Advocacy Center (TAC) and National Sheriffs Association (NSA). Available at http://www.treatmentadvocacycenter.org/storage/tac/documents/final_jails_v_hospitals_study.pdf (accessed July 2010).
- Vernon, D. J., Salsberg, E., Erikson, C., *et al* (2009) Planning the future mental health workforce: with progress on coverage, what role will psychiatrists play? *Academic Psychiatry*, **33**, 187–192.
- World Health Organization (2009) *World Health Statistics 2009*. WHO. Available at <http://www.who.int/whosis/whostat/2009/en/index.html> (accessed July 2010).

Bursary from the Faculty of the Psychiatry of Old Age

The Faculty has established an annual bursary to enable a psychiatrist from a low- or middle-income country to attend its annual residential meeting (the next will be 17–18 March 2011, in Stratford-upon-Avon) in order to give an oral or poster presentation, or deliver a workshop. The bursary is intended to cover the cost of economy-class travel, accommodation, free registration and attendance at the conference dinner, up to a maximum of £1500. Informal mentors will be identified for the bursary-holder. For details of regulations please visit the Faculty website at <http://www.rcpsych.ac.uk/specialties/faculties/oldage.aspx>. The closing date this year is 31 October 2010 and submissions should be sent to the Faculty Academic Secretary (email kkottasz@rcpsych.ac.uk).

Mental health in Zimbabwe

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Zimbabwe is a landlocked country which has recently emerged from some marked political and socio-economic challenges. Against this background, mental health has fallen down the priority list, as matters such as food shortages and the AIDS scourge have taken precedence. Zimbabwe is in southern Africa; Zambia and Botswana lie to the north, Namibia to the west, South Africa to the south and Mozambique to the east. Its population is 11.4 million. The capital city is Harare, which has a population of 1.6 million.

Recent health service history

Zimbabwe had centralised health services prior to 1980. In 1984 a project was set up to decentralise health services by upgrading the infrastructure. Each of the country's nine provinces had a provincial hospital built or refurbished. The provinces are subdivided into districts, and district hospitals were also built or refurbished. In each district there are smaller hospitals, called health centres. In the community, local clinics were built within a radius of 10 km of all households. A referral system was put in place where patients accessed treatment at clinics and were referred via the different levels of services up to the central hospitals. Unfortunately, there was pressure to reduce public spending and the projects had to be abandoned before completion. Each of the provincial hospitals was supposed to have a psychiatric unit and the district hospitals psychiatric beds. The project was abandoned before this could be achieved. The problem was made worse with the political and socio-economic crisis which began in 2000. Psychiatric nurses began to emigrate in large numbers and health services gradually became centralised again. Mental health services were once free for all but this became unsustainable as the country's economy contracted. Social workers were then used to determine who had the means to pay hospital fees and who would be given permission to access free mental health services. The country's economy is now showing signs of stability and the process of decentralisation is being re-implemented. Mental health services are free again in all government facilities.

Mental health services

There are six public institutions with psychiatric beds: Harare Hospital Psychiatric Unit, Parirenyatwa Hospital Annexe, Ingutsheni Hospital, Mpilo Hospital Psychiatric Unit,

Ngomahuru Hospital and Mutare Hospital Sakubva Unit. In addition, three facilities provide forensic psychiatry services: Mlondolozhi Special Institution, Harare Central Prison and Chikurubi Special Institution. The facilities available are not suitable for children or the elderly. Parirenyatwa Hospital Annexe and Harare Hospital Psychiatric Unit are the only institutions with a psychiatrist.

The staff of Zimbabwe's mental health services comprise: a deputy director, a mental health manager and nine provincial mental health coordinators, plus seven psychiatrists – one working for the government, two for the medical school and the others in private practice. They all work in Harare. The country welcomes any foreign English-speaking psychiatrists on condition they are registered and licensed with the Zimbabwe Medical and Dental Council. The only challenge is the low remuneration. Foreign psychiatrists can assist the university by identifying a project sponsored by a donor or research project.

The country has one child psychiatrist, who is in the private sector. All the psychiatrists belong to the Zimbabwe College of Psychiatrists, which discusses issues related to mental health in the country and administers continuing medical education (CME) for psychiatrists and other medical practitioners. The College has no formal links with other psychiatric associations in the region or further abroad, but works with the Zimbabwe Therapist Association, whose membership comprises psychologists and counsellors.

The primary healthcare clinics serve psychiatric patients. They screen psychiatric patients, refer them to the psychiatric hospitals and are involved in follow-up (mainly resupply of medication).

In addition, some non-governmental organisations (NGOs) offer mental health services. The main one is the Zimbabwe National Association for Mental Health (ZIMNAMH), which represents the interests of people with mental illness. It was founded in 1981 and has been the main vehicle for advocacy for mental health services. The Association has been involved in rehabilitation; its main project is based at Tirivanhu Farm. Amani Trust is an organisation which helps torture victims and promotes human rights. There are also organisations that look at the psychosocial issues of HIV/AIDS.

In the informal sector, the Zimbabwe National Traditional Healers Association (ZINATHA) has a big role in the management of psychosomatic and anxiety disorders. ZINATHA has attempted to educate its members in the referral of patients with mental health problems to the formal sector. Unfortunately, there has not been much collaboration between the formal and informal sectors. Psychiatrists could do more in the training of traditional healers.

Training

There is one medical school, at the University of Zimbabwe. The Department of Psychiatry teaches undergraduate medical students and offers a 1-year tertiary diploma in mental health and a 3-year masters degree in psychiatry. Normally, the diploma has four students and the masters degree has up to two candidates in each year (currently there is one student in the first year, none in the second year and two in the third year). Psychiatry is the least popular of the medical specialties because the remunerations in private practice are the lowest. Psychiatric nurses are trained at Ingutsheni Hospital. The programme is 18 months and normally has approximately 12 students.

Mental health disorders

In Zimbabwe in-patients typically present with schizophrenia, substance-induced psychosis, bipolar affective disorder (mania), epilepsy or the psychiatric complications of HIV. In the psychiatric out-patient clinics and private practice, depression, substance dependency and anxiety disorders are also typical. Eating disorders and personality disorders are diagnoses rarely made among the Black population. The reason for this might be a poor detection rate by health personnel. Research on the prevalence of personality disorder would be an area of interest.

Mental health policy

Zimbabwe's mental health policy was introduced in 1999 and has attempted to decentralise services. Coordinators have now been established in each province. The economic downturn has slowed the establishment of community mental health centres. An important emphasis of the policy is to incorporate mental health within the national HIV/AIDS programme.

Mental health legislation

The Mental Health Act of 1976 was repealed in 1996. The country now uses the Mental Health Act 1996 No. 15, which safeguards the rights of a patient but still emphasises

institutionalisation of those who are mentally ill. An extensive mental health training programme focusing on the rights of offenders with mental disorders was provided for officers of the courts between 2006 and 2008. This led to a substantial decline in the incarceration of people who are mentally ill when brought before the courts for minor offences.

Publications and research

The country does not have a psychiatric journal. Most research work is being done into the psychosocial aspects of HIV and depression. Earlier research has, however, led to the development of indigenous screening tools for common mental disorders. There is currently a move to incorporate use of the validated Edinburgh Postnatal Depression Scale into the routine 6-week postnatal visit at primary postnatal clinics. At primary city health clinics, lay health workers since 2006 have screened for common mental disorders using the Shona Symptom Questionnaire (SSQ-14), an indigenous screening tool. The lay health workers then provide structured problem-solving therapy. There is a need to carry out a randomised controlled trial of this intervention delivered by lay health workers.

Conclusion

In Zimbabwe, mental health services have come a long way. The harsh socioeconomic environment slowed the process of decentralisation which was embarked on when the Mental Health Act and policies were reviewed. The central structures are now in place and services are being brought to the people. As socioeconomic conditions improve, the country can increasingly focus on the setting up of community mental health services; it also needs to encourage more medical and nursing students to train in mental health and to arouse greater interest in mental health research.

Sources

World Health Organization (2009) See <http://www.afro.who.int/en/zimbabwe/who-country-office-zimbabwe.html> (accessed July 2010).
Zimbabwe Ministry of Health and Child Welfare (2009) See <http://www.mohcw.gov.zw> (accessed July 2010).

Help for Pakistani flood victims

More than 20 million people have been affected by the floods in Pakistan, in particular in the Khyber Pukhtoonkhwa Province (formerly known as North West Frontier Province). More than 3.5 million children are in immediate physical and mental health danger. More than 5 million people require emergency relief. Urgent rescue and healthcare needs are the top priorities.

The Horizon agency, chaired by a College Fellow, has stepped in to help with relief efforts. An emergency medical relief centre has been established at Ibadat Hospital in Peshawar City, with a two-pronged service-delivery mechanism:

- attending to patients who require mild to moderate medical cover, such as for skin infections, chest infections, mild cuts and abrasions
- sending people who are acutely and severely physically ill (and pregnant women) to secondary or tertiary hospitals.

Those presenting with mental health problems to the Ibadat Hospital emergency centre will be referred by a qualified and experienced team of psychiatrists and psychologists under my own supervision. These professionals are highly skilled in disaster and first-aid mental health management. In addition, the immediate social needs of the victims will be met as far as possible.

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Personality profiles of patients with alcohol and drug misuse in a Nigerian treatment facility

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Drug dependence treatment in Nigeria is at an early stage of development. The first 'stand alone' drug dependence treatment in-patient unit in Nigeria, the Drug Addiction Treatment Education and Research (DATER) unit, Aro, Abeokuta, Nigeria, was established in 1983. Prior to this, patients with drug dependence received care along with other patients in psychiatric wards and traditional healing homes (United Nations International Drug Control Programme, 1998). Currently, there is no national body in Nigeria actively involved in regulating or facilitating good practice in drug dependence treatment.

Personality may be viewed as the characteristic pattern of feelings, thinking, perception and behaviours that defines the interaction of an individual with the environment. Several studies have shown associations between substance use and personality, the latter influencing both the aetiology and the course of the former (Verheul, 2001). The DATER unit, in an effort to improve treatment outcomes, commenced the routine personality assessment of all its patients in 2004, as part of the admission procedure. The present study set out to identify common personality attributes of the patients treated over a 5-year period in the DATER unit.

Method

This cross-sectional study involved all consecutive patients admitted to the DATER unit of the Neuropsychiatric Hospital, Abeokuta, between 2004 and 2008. The unit is a 26-bed 'stand alone' drug dependence treatment ward. A detailed description of the unit has been given by Makanjuola (1986). The treatment programme is eclectic, incorporating detoxification, relapse prevention and treatment approaches based on the therapeutic community model and the Alcoholics Anonymous programme. Patients were admitted for 6–9 months.

All patients admitted to the unit had a clinical psychiatric interview and diagnoses were made according to ICD-10 criteria (World Health Organization, 1992). Those with current comorbid mental disorders were treated in the general psychiatric wards of the hospital before admission to the DATER unit. Integral to the admission procedure, all patients signed a contract agreement and gave informed consent for treatment and various laboratory and psychological investigations, including the Minnesota Multiphasic Personality Inventory (version 2, MMPI-2; Graham, 1993).

The patients received the MMPI-2 within the first 2 weeks of admission. None withdrew consent during the study period.

The MMPI-2 is the most widely used and researched personality assessment instrument; it was originally intended to assign psychiatric diagnoses to patients. However, it describes personality *profiles* rather than personality disorders (Graham, 1993). Eight of its ten clinical scales were based on patients with specific psychiatric diagnoses; however, studies showed that the clinical scales were not the pure measures of symptom syndromes suggested by the scale names. To prevent the erroneous interpretation of the scales on account of their titles, numbers were assigned to the scales instead (Graham, 1993).

Each scale has several items, which generate a raw score, which for purposes of percentile comparability and interpretation is mathematically converted to a uniform *T* score. The uniform *T* score has a mean of 50 and a standard deviation of 10; however, because of the positively skewed nature of the *T* score distribution, scores of 65 and 70 have percentile equivalences of 92 and 96 respectively (Butcher *et al*, 2001). A high *T* score (> 65) on a clinical scale suggests psychopathology but not necessarily a psychiatric diagnosis. It also suggests a personality profile, both for individuals with and for those without a psychiatric diagnosis (Butcher *et al*, 2001). Since interpretation based on more than one clinical scale gives a better personality description (Graham, 1993), a two-point MMPI-2 code type was used for the interpretations in this study. This code type denotes the two clinical scales (i.e. excluding scales 0 and 5) with the highest scores (not necessarily over 65). Each two-point code type has research-based descriptors highlighting the personality profiles of the individual (Graham, 1993).

Results

Sociodemographic and clinical variables

Ninety-one consecutive patients participated in the study. Their ages ranged between 18 and 57 years; their mean (SD) age was 32.0 (9.9) years. As shown in Table 1, most were male (92%), single (76%) and unemployed (71%); 59 (65%) had completed secondary school education. More than half the participants had comorbid mental disorders, the most prevalent diagnosis being schizophrenia (45%). The most common main drug of misuse was marijuana (55%), followed by alcohol (26%).

Table 1 Sociodemographic and clinical variables (n = 91)

Variable	n	%
<i>Gender</i>		
Male	84	92
Female	7	8
<i>Marital status</i>		
Single	69	76
Married	13	14
Divorced/separated	9	10
<i>Education level completed</i>		
Primary	4	4
Secondary school	59	65
Tertiary	28	31
<i>Psychiatric disorder</i>		
None	35	38
Schizophrenia	41	45
Bipolar affective disorder	10	11
Psychoses not otherwise specified	5	5
<i>Main drug of misuse</i>		
Marijuana	50	55
Alcohol	24	26
Cocaine	15	16
Opiates	2	2

Table 2 The common personality descriptors (n = 91)

Personality descriptors	n	%
Perception of insecurity/poor self-esteem/ poor self-concept	51	56
Distrustful of others and/or avoidance of deep emotional ties	48	53
Impulsiveness/poor control of gratification	32	35
Disregard for social standards and authority figures	32	35
<i>Two-point MMPI-2 code types (commonly associated personality problems)</i>		
4-8/8-4 (antisocial, schizoid or paranoid)	13	14
6-8/8-6 (paranoid, schizoid)	10	11
8-9/9-8 (emotional lability)	10	11
2-4/4-2 (antisocial)	9	10
2-8/8-2 (anxious, dependent traits)	6	7
4-6/6-4 (passive-aggressive traits)	6	7
4-7/7-4 (passive-aggressive traits)	5	5
1-4/4-1 (anxious)	4	4
4-9/9-4 (antisocial)	4	4
Others	24	26

Two-point MMPI-2 code types and personality descriptors

The 91 patients yielded 24 different two-point MMPI-2 personality code types, nine of which occurred at least four (4%) times. Table 2 shows the nine most common code types and the commonly associated personality problems. The code types have overlapping descriptors; for example, perception of insecurity/poor self-esteem (56% of the patients) occurs in individuals with code types 4-8/8-4, 2-4/4-2, 6-8/8-6, 8-9/9-8, 4-7/7-4 and 4-9/9-4. Distrust of others and/or avoidance of deep emotional ties also occurred in more than half the participants (53%). Other common descriptors and their frequencies are shown in Table 2.

Discussion

The predominance of cannabis (55%) over other drugs in this study is in keeping with the report by Adamson *et al* (2010)

of a change in the pattern of drugs used by patients admitted to the DATER unit between 2002 and 2007 compared with between 1992 and 1997. They reported that the rate of cannabis use by admitted patients increased from 26.6% to 53.3%, while the use of cocaine and opiates decreased from 44.0% and 22.0% to 17.1% and 8.6% respectively. They also reported significantly greater odds of presenting with comorbid mental disorders with the use of cannabis as against the use of other drugs. It appears from their report that the development of mental disorders is a key factor which makes an individual with cannabis use disorder present for treatment at the DATER unit. A majority of the patients admitted to the unit originally presented for treatment of mental disorders at the general wards of the hospital.

The two-point MMPI-2 code types in this study are similar to those reported by others. Craig (1984) reported code types 4-9/9-4, 4-2/2-4 and 4-8/8-4 as the most common among drug-dependent patients. These code types reflect high scores on the pairs of psychopathic deviate and hypomania, psychopathic deviate and depression, and psychopathic deviate and schizophrenia respectively. The code types are not synonymous with personality disorders, although certain personality disorders are commonly associated with some code types; for example, code type 4-8/8-4, the most common in this study, is often associated with antisocial, schizoid and paranoid personality disorders (Graham, 1993). To *diagnose* a personality disorder, however, an appropriate instrument such as the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II) would need to be administered.

The personality descriptor of poor self-esteem/concept was obtained in about half the patients. This is of clinical significance, as poor self-esteem has been associated with drug dependence, being a precursor or sequela of drug dependence and contributing to poor prognosis. In the 'self-esteem' theory of drug misuse, Steffenhagen (1980) opined that every 'behaviour is mediated by the individual's attempt to protect the "self" within the social milieu' and that 'the preservation of the concept of "self" is the most important variable in understanding the initiation, continuation and cessation of drug use, and further explains why the rehabilitation process frequently results in relapse'. However, self-esteem is not the only important variable in the predisposition to and perpetuation of drug dependence, which partly explains why some of the patients with drug dependence in this study did not have poor self-esteem as a descriptor. Other variables, such as impulsivity and distrust, have also been reported (Ball, 1998), lending credence to one of the fundamental principles of drug dependence treatment, highlighted by the US National Institute on Drug Abuse (1999): 'Effective treatment attends to multiple needs of the individual, not just his or her drug use'.

Limitations of the study

Since there was no control group, the personality descriptors cannot be associated with the drug misuse. Moreover, the study at best suggests the *possibility* of personality disorders occurring in the patients. To determine the *occurrence* of the disorders, an instrument such as the SCID-II would have to be used. In addition to determining the personality of the patients, there is a need to evaluate their self-concept/esteem using a standardised instrument.

Conclusions

Whereas many studies have revealed the association of personality disorders with substance misuse, this study has highlighted the co-occurrence of specific maladaptive personality schemas with substance misuse. To improve the overall prognosis, these schemas can be addressed through specific cognitive-behavioural therapies such as the manualised treatment approach of dual-focus schema therapy (Ball, 1998).

References

- Adamson, T. A., Onifade, P. O. & Ogunwale, A. (2010) Trends in socio-demographic and drug abuse variables in patients with alcohol and drug use disorders in a Nigerian treatment facility. *West African Journal of Medicine*, *29*, 12–18.
- Ball, S. A. (1998) Manualised treatment for substance abusers with personality disorders: dual focus schema therapy. *Addictive Behaviors*, *23*, 883–891.
- Butcher, J. N., Graham, J. R., Ben-Porath, Y. S., et al (2001) *MMPI-2 Manual for Administration, Scoring and Interpretation*. University of Minnesota Press.
- Craig, R. J. (1984) A comparison of MMPI profiles of heroin addicts based on multiple methods of classification. *Journal of Personality Assessment*, *48*, 115–120.
- Graham, R. J. (1993) *MMPI-2: Assessing Personality and Psychopathology* (2nd edn). Oxford University Press.
- Makanjuola, J. D. A. (1986) The Aro drug addiction research and treatment centre: a first report. *British Journal of Addiction*, *81*, 809–814.
- National Institute on Drug Abuse (1999) *Principles of Drug Addiction Treatment: A Research-Based Guide* (2nd edn). NIH Publication No. 99-4180. Available at <http://www.drugabuse.gov/PDF/PODAT/PODAT.pdf> (accessed May 2010).
- Steffenhagen, R. A. (1980) Self-esteem theory of drug abuse. In *Theories on Drug Abuse: Selected Contemporary Perspectives* (eds D. J. Lettieri, M. Sayers & H. W. Pearson), pp. 96–95. National Institute on Drug Abuse. Available at <http://archives.drugabuse.gov/pdf/monographs/30.pdf> (accessed May 2010).
- United Nations International Drug Control Programme (1998) *Report of the Rapid Situation Assessment of Drug Abuse in Nigeria*. UNDCP.
- Verheul, R. (2001) Co-morbidity of personality disorders in individuals with substance use disorders. *European Psychiatry*, *16*, 274–282.
- World Health Organization (1992) *International Classification of Diseases* (10th revision) (ICD-10). WHO.

ORIGINAL PAPER

Public mental health services in Mumbai

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Mumbai, India's largest city, also has the distinction of being the most populous city in the world. The association between urbanisation and mental illness has been widely documented (Harpham & Blue, 1995, especially pp. 41–60). Mumbai is characterised by dense slums housing large migrant populations facing stressful lives. The state of publicly funded mental health facilities in Mumbai has special significance in this context, since they are the only resource available to a large economically vulnerable section of the population. The objective of the present study was to evaluate the public mental health services in Mumbai and to identify areas for improvement.

Mental disorders account for 8.5% of the national burden of disease in India (Peters *et al*, 2001). Statistics specific to Mumbai are not readily available but, given that 54% of the city's population of approximately 13 million live in slums, one can assume that this burden would be substantial.

Public healthcare in Mumbai

The Municipal Corporation of Greater Mumbai (MCGM) and the Maharashtra state government are the two independent bodies responsible for healthcare in Mumbai. The MCGM administers primary care through 185 municipal dispensaries and 176 health posts for out-patient services and public health activities, secondary care through 16 'peripheral' municipal general hospitals and 26 maternity homes in the suburbs, and

tertiary care at three teaching hospitals. The state government runs one teaching hospital, three general hospitals and two health units (Dilip & Duggal, 2004). Only ten of these hospitals have general hospital psychiatric units (GHPUs), which constitute the public mental health facilities for the city.

Method

The present study assessed nine of these ten GHPUs using the World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) version 2.2 (World Health Organization, 2005). This is a tool for collecting information on the mental health system of a country or region in order to identify weaknesses and make changes. Of the tool's six domains, numbers 2 (mental health services) and 4 (human resources) were adapted (based on a pilot study) for the current study by focusing on questions relevant to GHPUs.

Permission to conduct the study was obtained from the executive health officer of the MCGM. As aggregate data regarding mental health services are not maintained by the municipal public health department, data (hospital records, doctors' records and interviews with doctors) were obtained directly from nine of the GHPUs (one GHPU did not grant permission). Some of the data in the study were taken from doctors' records as opposed to official hospital records and there may be minor inconsistencies between the two, which do not, however, affect the overall trends presented here.

Table 1 Number of psychiatric beds, patient load in out-patient department and human resources

	G1	G2	T1	T2	T3	P1	P2	P3	P4
Number of beds	30	30	60	90	30	33	NA	25	NA
Number of patients per day in department	150	30	120	175	145	168	38	37	32
Number of doctors	5	1	4	5	3	6	2	3	0
Number of residents	6	2	4	8	8	0	0	4	2
Clinical psychologists	0	0	3	2	1	1	0	1	0
Social workers	1	0	2	3	2	1	1	1	1
Catchment area (ward population)						2 501 000	1 875 377	2 905 047	1 242 000

G, state government hospitals; T, teaching hospitals; P, peripheral hospitals. NA, not applicable.

Results

Psychiatric in-patient units existed in only seven of the ten GHPUs. A total of 298 beds were recorded in these seven GHPUs, which was consistent with previous findings (Joshi, 2005) (see Table 1 for data from individual hospitals). In most cases, a family member was required to stay with in-patients to guard against suicide attempts as well as to prevent abandonment of the patient at the hospital by the family.

All ten hospitals had an out-patient department (OPD). The average total number of patients seen per day ranged from 30 to 175, with the number of new patients ranging from 4 to 25, the remainder being follow-up cases (Table 1). These numbers are consistent with a previous report (Joshi, 2005). The hospitals do not have formal catchment areas; however, the city is divided into wards (administrative zones) and people in all probability decide to go to the nearest peripheral hospital, hence we have reported in Table 1 the population of the ward where the hospital was located combined with that of neighbouring wards without hospitals.

Approximately 60% of the patients came to the GHPU without a referral from a general practitioner.

Four of the ten hospitals had a separate day on which children were seen in the OPD. One of the teaching hospitals had a special section for children, which included a centre for intellectual disabilities and a school for children with autism.

The teaching hospitals were relatively well staffed, with four doctors and six residents on average. Overall, the government and peripheral hospitals had fewer doctors, 2.2 on average, as well as fewer residents (1.5) (Table 1). The number of patients per doctor varied from 12 to 38 per day. Scanning facilities (magnetic resonance imaging or computerised tomography) were available in only five of the GHPUs.

Drugs were found to be the first line of treatment in all hospitals. Those listed in the National Therapeutic Drug policy, which include older-generation antipsychotics, mood stabilisers and anti-epileptics, are provided free to all patients, but patients are expected to buy drugs not on this list. Electroconvulsive therapy (ECT) was used in all the in-patient units but rarely in the OPD. In most cases, it was used only for suicidal ideation and schizophrenia. The Indian Psychiatric Society (IPS) considers ECT with anaesthesia a reasonable therapeutic modality (Addlakha, 2008, pp. 300–302).

Only four of the nine hospitals used some form of psychotherapy; cognitive-behavioural therapy was the most common, while others included behaviour therapy with relaxation, rational emotive therapy, couples and family therapy, biofeedback techniques for phobias and play therapy for children. In a fifth hospital a form of meditation (*Vipashna*) was used. However, in-patients were largely the

recipients of therapy rather than out-patients and therapy sessions were always conducted by psychiatrists.

Interviews with 19 doctors revealed two major areas of concern: excessive patient loads, and additional administrative and organisational responsibilities. Areas for improvement suggested by doctors included the availability of both medicines (seven doctors) and digital electroencephalography (four doctors) and more psychologists and nursing staff (four doctors).

Discussion

The entire Mumbai mental health system is overburdened, partly because of the large numbers accessing mental health-care without first consulting a primary care provider. The teaching hospitals were superior in terms of services offered, human resources and infrastructure, and were better funded than peripheral hospitals, by a factor of 10 (Verma, 2006). The peripheral hospitals in comparison with the teaching hospitals were lacking in terms of having a children's OPD (three of the four peripheral hospitals did not have one), clinical psychologists (two did not have one), scanning facilities (three did not have any) and the availability of medicines. These four peripheral hospitals together serve a population of around 8.5 million (Table 1).

It seems clear that upgrading the existing infrastructure of peripheral hospitals would lead to dramatic improvements in services provided, in terms of quality as well as accessibility. For the teaching and government hospitals it would not be possible to estimate the population served, for in addition to the population of the whole city they also serve the nearby districts, as well the state and the country in a nominal sense.

Around 60% of the patients came without a referral from primary care. This underscores the need to link mental healthcare to primary healthcare and develop a protocol for referrals at the primary care level. Since common mental disorders (CMDs) account for a large share of the disorders observed (as also confirmed by the current findings), it would be useful to train doctors at the primary level to manage CMDs in coordination with psychiatrists at the GHPUs (Sriram *et al*, 1990). The incidence of postpartum depression and its costs (Patel *et al*, 2004) is another urgent reason to link mental healthcare to primary care.

Psychotherapy was available to only a small group of patients and was under-utilised by the system. We feel its value needs to be systematically explored within the Mumbai mental health system, although this was not echoed by the doctors. Psychological counselling and therapy were reported as being the most well-received services after a restructuring

of the health system in Shanghai (Yan, 1998). In Mumbai, it would be useful to document the role of psychotherapy for anxiety disorders (Roffman *et al*, 2005) and group psychotherapy for depression (Siskind *et al*, 2008), especially with reference to their cost-effectiveness. Developing a standardised psychotherapeutic model that has been adapted to the cultural milieu may help to make therapy more accessible to both patients and doctors. Another issue, also mentioned by Patel & Kleinman (2003), is the difficult life circumstances faced by people on low incomes and the need for social interventions. Supportive counselling provided by psychologists and social workers for patients and family members also needs to be considered.

At a broader level, the absence of a detailed mental health plan (such as the Mental Health National Services Framework in the UK) and an executive body (such as the Division of Mental Hygiene Services in New York, USA) makes it impossible to plan for the city's mental health needs or to implement city-wide mental health education/awareness programmes. In this context, it would be useful if epidemiological data for mental health were maintained in a centralised manner, as this would facilitate research.

Finally, given the large numbers served by the system, even a partial implementation of these suggestions may result in significant improvements for a very large patient population. Given the extenuating life circumstances of patients, access to some treatment may allow people to live productive and relatively happy lives.

Acknowledgements

We would like to acknowledge the Executive Health Officer of the Municipal Corporation of Greater Mumbai and Dr Nilesh Shah.

References

- Addlakha, R. (2008) *Deconstructing Mental Illness – An Ethnography of Psychiatry, Women and the Family*. Zubaan.
- Dilip, T. R. & Duggal, R. (2004) Unmet need for public healthcare services in Mumbai, India. *Asia-Pacific Population Journal*, **19**, 27–39.
- Harpham, T. & Blue, I. (eds) (1995) *Urbanisation and Mental Health in Developing Countries*. Ashgate.
- Joshi, A. (2005) Mental health in India: review of current trends and directions for the future. In *Review of Health Care in India* (eds L. V. Gangolli, R. Duggal & A. Shukla), pp. 127–136. CEHAT.
- Patel, V. & Kleinman, A. (2003). Poverty and common mental disorders in developing countries. *Bulletin of the World Health Organization*, **81**, 609–615.
- Patel, V., Rahman, A., Jacob, K. S., *et al* (2004) Effect of maternal mental health on infant growth in low income countries: new evidence from South Asia. *BMJ*, **328**, 820–823.
- Peters, D., Yazbeck, A., Ramana, G., *et al* (2001) *Raising the Sights: Better Health Systems for India's Poor*. World Bank.
- Roffman, J. L., Marci, C. D., Glick, D. M., *et al* (2005) Neuroimaging and the functional neuroanatomy of psychotherapy. *Psychological Medicine*, **35**, 1385–1398.
- Siskind, D., Baingana, F. & Kim, J. (2008) Cost-effectiveness of treatments for depression in Uganda. *Journal of Mental Health Policy and Economics*, **11**, 127–133.
- Sriram, T. G., Moily, S. & Kumar, G. S. (1990) The training of primary health care medical officers in mental health care: errors in clinical judgement before and after training. *General Hospital Psychiatry*, **12**, 384–389.
- Verma, M. (2006) *Recommended Policy Guidelines for Public Health*. Draft dated 1st May, 2006 for discussion. A Report to the MCGM and the NGO Council. Available at <http://www.karmayog.com/publichealth/publichealthindex.htm> (accessed 26 November 2009).
- World Health Organization (2005) WHO–AIMS. World Health Organization Assessment Instrument for Mental Health Systems, version 2.2. Available at http://www.who.int/mental_health/evidence/AIMS_WHO_2_2.pdf (accessed August 2010).
- Yan, H. Q. (1998) New challenges of psychiatry: the development of mental health services in Shanghai. *Psychiatry and Clinical Neurosciences*, **52**, 357–358.

UK devolution and the international perspective of the College

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Some principles of psychiatric practice are applicable across all healthcare settings and epochs, whereas other issues are more specific to one healthcare model and/or time. The increasing divergence of service models and underlying policies in the four UK devolved jurisdictions (England, Northern Ireland, Scotland and Wales) means that this distinction between general and specific issues has increasing relevance to the College. There are many benefits in identifying, and being strong advocates for, the generic principles of excellent psychiatric care, which are transferable across settings and relatively stable over time. These are also, of course, the principles that will have the most relevance in a broad international perspective that goes far beyond the UK.

The role of the psychiatrist in healthcare inevitably varies over time and place, according to the specific service model, statutory legal framework, needs of the population served and the number and skill mix of other professionals. It is unrealistic (and probably undesirable) to think there should or could ever be a 'one size fits all' service model for how psychiatrists use their skills optimally to benefit patients. This applies at all levels of service variation. Perhaps most obviously, major differences occur between different areas of the world, as geographical and cultural context (e.g. Sorketti *et al*, 2010) as well as economic constraints (e.g. Muijen, 2010) exert profound influences. However, although the variations may be within a much more moderated range, there are increasingly important differences within the UK. The four

political jurisdictions have increasingly divergent approaches to service model, budget and strategic priorities. Further, even within a particular jurisdiction (in the UK or elsewhere) there are often substantial regional or local variations in funding, clinical priorities and context, which may mean that psychiatrists work in very different ways in different locations.

Recent major changes in organisation and strategic vision of mental health services in the UK (Craddock *et al*, 2008), as in other high-income countries (e.g. Madianos & Christodoulou, 2007; Muijen, 2010), have meant the traditional role of the psychiatrist has been changing, even to the extent that the very future of psychiatry as a specialty has been questioned (Katschnig, 2010). Whatever the developments, it is essential that role changes are not purely driven by legislation, politics or ideology (Craddock *et al*, 2008). Rather, changes should make use of psychiatrists' core expertise, and the special expertise of other professionals, in a way that enhances patient care and ensures the quality and safety of services (Craddock & Craddock, 2010).

The readership of *International Psychiatry* will be fully aware that there are many parts of the world in which psychiatrists and mental health services are non-existent, sparse or rudimentary. Where and when it is available, psychiatric expertise is a very valuable resource for a healthcare service and it is important that this resource is used as effectively as possible. The core skills of the psychiatrist should be matched to the professional role in a way that maximises benefits to both individual patients and to the service as a whole (Craddock *et al*, 2010). Such matching and clarity may also enhance psychiatric professional identity, encourage recruitment and increase morale and job satisfaction.

Implications for the Royal College of Psychiatrists

The Royal College of Psychiatrists is a major international professional organisation with a membership from a wide range of geographical and cultural backgrounds and active international structures, including the International Divisions and, of course, this journal. Many members have experience of working in widely differing service settings (Ghodse, 2003), for example moving between one or more UK jurisdictions and even between services on different continents. The College is, therefore, ideally placed (perhaps uniquely among organisations that provide training and accreditation) to be able to take a 'big picture' perspective that has relevance and

influence beyond any local political, ideological, economic or cultural imperatives (Kulhara & Avasthi, 2007; Mullick, 2007) and is capable of offering some degree of temporal and situational stability. The richness and breadth of experience of the College's members can usefully inform the principles used in all service developments: in other words, the general features of psychiatric excellence (perhaps they might be called the 'psychiatric basics'?).

This will help to ensure that, two centuries after J. C. Reil, the eminent German physician, first described the specialty of psychiatry (Reil & Hoffbauer, 1808; Marneros, 2008), patients can continue to benefit from the particular expertise and training of medical practitioners who specialise in psychiatric illness and who use their broad medical and biological expertise and diagnostic skills effectively within the context of an appreciation of psychosocial factors and the full range of available treatment modalities (Craddock, 2010).

References

- Craddock, N. (2010) A psychiatrist is... – in 100 words. *British Journal of Psychiatry*, **196**, 473.
- Craddock, N. & Craddock, B. (2010) Patients must be able to derive maximum benefit from a psychiatrist's medical skills and broad training. *World Psychiatry*, **9**, 30–31.
- Craddock, N., Antebi, D., Attenburrow, M. J., *et al* (2008) Wake-up call for British psychiatry. *British Journal of Psychiatry*, **193**, 6–9.
- Craddock, N., Kerr, M. & Thapar, A. (2010) Core expertise of the psychiatrist. *The Psychiatrist* (in press).
- Ghodse, H. (2003) International psychiatry – the way forward. *International Psychiatry*, **1**, 1.
- Katschnig, H. (2010) Are psychiatrists an endangered species? Observations on internal and external challenges to the profession. *World Psychiatry*, **9**, 21–28.
- Kulhara, P. & Avasthi, A. (2007) Teaching and training in psychiatry in India: potential benefits of links with the Royal College of Psychiatrists. *International Psychiatry*, **4**, 31–33.
- Madianos, M. G. & Christodoulou, G. N. (2007) Reform of the mental healthcare system in Greece, 1984–2006. *International Psychiatry*, **4**, 16–19.
- Marneros, A. (2008) Psychiatry's 200th birthday. *British Journal of Psychiatry*, **193**, 1–3.
- Muijen, M. (2010) Challenging times for mental health services. *International Psychiatry*, **7**, 1–2.
- Mullick, M. S. I. (2007) Teaching and training in psychiatry and the need for a new generation of psychiatrists in Bangladesh: role of the Royal College of Psychiatrists. *International Psychiatry*, **4**, 29–31.
- Reil, J. & Hoffbauer, J. (1808) *Beyträge zur Beförderung einer Kurmethode auf psychischem Wege*. Curtsche Buchhandlung.
- Sorketti, E. A., Zuraida, N. Z. & Habil, M. H. (2010) Collaboration between traditional healers and psychiatrists in Sudan. *International Psychiatry*, **7**, 71–73.

NEWS AND NOTES

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

College Eating Disorders Section

During the Eating Disorders Awareness Week in February, psychiatrists of the 'damaging portrayal' of eating disorders in the media and called for a new editorial code to be drawn up to encourage the media to stop promoting unhealthy body images and 'glamorising' eating disorders.

Instead, the media should be encouraged to use images of people with more diverse body shapes, and help people feel more positive about their own bodies.

Members of the College Eating Disorders Section are increasingly concerned about the harmful influence of the media on people's body image and self-esteem, and called for a new forum to tackle the issue. The forum should include

representatives from the media and advertising agencies, regulatory bodies, eating disorder experts, eating disorder organisations and politicians. The psychiatrists are being backed in their call by the eating disorders charity, Beat.

UK International Health Links Funding Scheme (IHLFS)

IHLFS is a 3-year scheme that supports 'Health Links' between health institutions in low- and middle-income countries and the UK. Funded by the UK Department for International Development and the Department of Health, and jointly managed by THET (Tropical Health and Education Trust)

and the British Council, IHLFS (Round 2) is now open for applications. The scheme aims to strengthen the capacity of health services in low- and middle-income countries by providing £1.25 million each year to support the work of Health Links – formalised partnerships between a health institution in a low- or middle-income country and a counterpart in the UK. The purpose of a Link is to strengthen health systems and improve health service delivery by allowing for a reciprocal transfer of skills and knowledge between people working in the healthcare sector. Round 2 has funding available for start-up grants of up to £3000 and project grants of up to £15000 a year for 1 year or 22 months. Further details can be obtained at <http://www.britishcouncil.org/learning-healthlinks.htm>.

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Edinburgh in retrospect: the 2010 College Congress

Sir: Great cities evoke memories and invoke visions. The June 2010 College International Congress held in Edinburgh did both for this correspondent. The reminiscence is of a place for the bridging of art and science, and for recalling the value of mentors such as Henry Walton, Bob Kendell and Norman Kreitman, who had encouraged my international journeyings. The vision was of a Royal College as a truly international organisation – a prospect first glimpsed at the Edinburgh annual meeting in 2000, and when the College had co-hosted a meeting with the Association of European Psychiatrists (AEP) in 1996.

We later celebrated, with the World Psychiatric Association (WPA), the millennium in a 2001 'Mind Odyssey of Psychiatry and the Arts' at the Queen Elizabeth Conference Centre in Westminster – a costly but apt venue. The international arts certainly flourished on that occasion. Guy Woolfenden's commissioned music *Paeon* was performed by vocalists and a brass ensemble at the opening ceremony, actors approached delegates in the coffee breaks, Ismond Rosen's fine sculptures were displayed, and the College music society held its first meeting. The scientific programme was also invigorating. Dr Gro Brundtland, Director General of the World Health Organization (WHO), received the Honorary Fellowship.

Yet at most such major international congresses there are conflicts of loyalties, as well as conflicts of interests, to be considered. These occasions, including the recent Congress in Edinburgh, were no exceptions. There was learning to be done. I would respectfully suggest, therefore, that several international issues might be reconsidered by the organising committee, and by College officers, when reviewing the venues and the content of future annual meetings.

- Specifically, to welcome and, when appropriate, subsidise international delegates.
- Devise new ways of encouraging more Honorary Fellows to attend. They can, and should in my opinion, be able

to contribute more actively to College affairs. The College needs to retain their brains as well as their resources.

- Establish an inclusive high-profile international reception – an excellent time to give international guests a chance to meet each other, and to converse with past and present College officers.
- Consider a strategy for enhancing the profile of the International Divisions and of the International Advisory Committee – the successor to the International Board.
- Continue to publicise formal business meetings with WPA officers.
- Review the strategy, and the protocol, for working within the WPA, and for welcoming its President. It is the only world organisation for all psychiatrists that can guard, through its Review Committee, the rights of patients and psychiatrists, and can provide academic and clinical support for isolated colleagues.
- Consider the timing and content of the Annual General Business Meeting. It is the only formal occasion when any member of the College, including its international members, can raise with due notice matters of importance and listen to pre-circulated reports from College officers.

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Hikikomori in Japan

Sir: *Hikikomori* is the name given to a major problem in Japan: extreme social withdrawal (the term is a compound of *hiki*, withdraw, and *komoru*, hide). The condition is reminiscent of social phobia – an apparent fear of exposure to and embarrassment within social situations, driving avoidant behaviour. In *hikikomori*, the isolation is frequently extreme; people with the condition have been known to lock themselves in their bedroom for several years. The age range of those affected is rather narrow: they are generally young adults. The sustained isolation is in part

to blame for a paucity of direct information regarding the psychological characteristics of *hikikomori* sufferers. The numbers of people with *hikikomori* appears to be increasing and this is a worrying trend. The cause of this mass expression, however, remains a mystery. One epidemiological survey in Japan estimated that around 200 000–400 000 households support an individual with *hikikomori* (Koyama *et al*, 2010). This survey suggested only 55% of people with *hikikomori* have (over their lifetime) any definable psychiatric diagnosis. In these, *hikikomori* is linked to anxiety disorder, mood disorder, substance-related disorder or intermittent explosive disorder.

There is evidence for a cohort effect. The average age of people with *hikikomori* is around 32 years and is increasing (Sakai *et al*, 2008), which suggests the condition is related to factors that have affected one particular generation. This mirrors other 'social illnesses' within Japan. The fathers of *hikikomori* sufferers are (or were) vulnerable to *karoushi* ('death from overwork'), encapsulating the inflated male work ethic of the modernising Japanese society. The link between *karoushi* and *hikikomori* is argued as follows. The (work-related) absence of the father affects family dynamics such that the mother (housewife) compensates by strengthening emotional bonds with her (co-dependent) child and ultimately suppresses the child's psychological independence.

International comment has highlighted the intense educational pressure on young people in Japan: school refusal, more common in *hikikomori* individuals, has markedly increased among Japanese teenagers over the past 10 years. The technological revolution of the past 20 years (which has led to the dominance of an internet/gaming/media culture), with Japan at the vanguard, may also have fuelled the emergence of *hikikomori*, which overlaps with internet addiction. It is speculated that long hours spent playing computer games deprives children of opportunities to develop and refine adaptive social skills.

Superficially, *hikikomori* appears bound by the specific cultural and economic background of Japanese society, but cases resembling *hikikomori* are increasingly recognised outside Japan (García-Campayo *et al*, 2007). Global socio-economic conditions and (technology-driven) shifts in behaviour may have similar effects on people's mental health across the world: over a decade ago Japan experienced severe economic depression. In parallel, new patterns of behaviour, such as computer gaming, were established earlier in Japan and neighbouring Asian countries. The present global economic depression and rapid embracing of technology in Western countries may see *hikikomori*, already epidemic within Japan, becoming more common in other societies.

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García-Campayo, J., Alda, M., Sobradie, N., *et al* (2007) A case report of *hikikomori* in Spain. *Medicine Clinica*, **129**, 318–319.

Koyama, A., Miyake, Y., Kawakami, N., *et al* (2010) Lifetime prevalence, psychiatric comorbidity and demographic correlates of 'hikikomori' in a community population in Japan. *Psychiatry Research*, **176**, 69–74

Sakai, M., Ueda, K., Nakamura, M., *et al* (2008) 'Hikikomori' no jittai ni kannuru choushoukokusho (6) – Zennokoku Hikikomori KHJ oyanokai niokeru jittai. [Report on the state of 'hikikomori' (6) – Information from the National Hikikomori KHJ Parents Society.] *Tokushimadaigaku, Sougoukagaku* – Sakai kennkyushitsu, *Soukousu*, **87**.

Undergraduate electives

Sir: The elective period has been a feature of the undergraduate medical curriculum for many years. Medical schools recognise that undertaking the elective overseas can have a profound impact on students (*Lancet*, 1993); the elective can broaden horizons, develop skills and enhance cultural understanding. This was certainly the case for me. I spent my elective period doing psychiatry at Tygerberg and Stikland Hospitals in the vibrant metropolis that is Cape Town, South Africa. I was able to participate in clinical activities in in-patient and out-patient settings, gaining experience of a range of illnesses and clinical presentations that I would not have seen at home. Moreover, working in such an ethnically diverse setting gave me an insight into the cultural influences which shape mental illness and its management in different societies. The placement was facilitated by excellent guidance and teaching from the Cape Town psychiatrists I worked with.

Considering the current problems in recruiting psychiatrists in the UK, it is all the more important that those undergraduates who show an interest have the opportunity to undertake electives in the specialty. It is well known that positive undergraduate experiences, as I had during my elective, can shape future medical careers, especially when the medical student is practically involved during clinical attachments (Mihalynuk *et al*, 2006).

For the past year I have been a Student Associate representative on the Psychiatric Trainees' Committee of the Royal College of Psychiatrists. As part of the College's strategy for recruitment into psychiatry, we would like to expand the number of overseas psychiatry elective placements available. We are developing a database of the College's international members who are willing to provide elective periods of 4–8 weeks for UK medical students in their clinical years. To this end, we would very much welcome any offers from international readers who can provide international psychiatry experience to a UK student with an interest in the specialty. This would have an appreciable impact on the development of the student as well as allowing readers to establish links with UK facilities. If any reader is able to offer this opportunity, please email Ms C. Cox on ccox@rcpsych.ac.uk for further details.

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Lancet (1993) The overseas elective: purpose or picnic? *Lancet*, **342**, 753–754.

Mihalynuk, T., Leung, G., Fraser, J., *et al* (2006) Free choice and career choice: clerkship electives in medical education. *Medical Education*, **40**, 1065–1071.

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

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

Deskilling of trainee psychiatrists

Sir: The medical profession has traditionally been the domain of doctors who acquired their position and prestige through a long and arduous apprenticeship. Not very long ago they worked without any intervening bureaucratic structure. This situation has changed substantially over the years. Healthcare is heading in the same direction as other industries, with the fragmentation and standardisation of doctors' work, as well as the construction of a managerial superstructure. In addition, the past two decades have seen a proliferation of new clinical roles for nurses in the UK. Nurses are extending their repertoire of skills to include those that were once the domain of junior doctors. The proliferation of specialist nurses and prescriber nurses and so on is pushing doctors away and is deskilling them in areas previously seen as a core part of their role.

Woodall *et al* (2006) reported that junior doctors are being prevented from actively participating in patient management or handling emergencies because of the introduction of nurse liaison assessment services. This they believe may reduce trainee psychiatrists' experience of performing self-harm assessments, if they are left with just routine ward work, while nurses become skilled at emergency psychiatric assessment. Junior doctors feel very displeased over their lack of exposure and inadequate training, which are not only deskilling them but also making it harder for them to pass their professional examinations (Zafar & Sadiq, 2007). Sadiq & Sehgal (2007) feel that the introduction of rotas compliant with the European Working Time Directive (EWTD) means that the emergency work which was earlier seen by junior doctors is now shared by crisis resolution home treatment services, as well as liaison and self-harm nurses; this has reduced the opportunity trainee psychiatrists have to gain experience. This opinion is shared by many others who agree that nurses are crossing boundaries that should not be crossed and getting distracted from their real job.

This marginalisation and deskilling of doctors endangers the values that medicine traditionally espoused: service, moral responsibility, and placing the patient's interests first. Where is all this leading and what lies ahead for junior doctors? There is a need to think seriously about the impact of this 'industrialisation' of healthcare and deskilling of junior doctors. In the name of improvement and money saving, the deskilling and downgrading of junior doctors should not be allowed to continue. Doctors will likely find their work less valued over time if they are increasingly replaced by non-doctor clinicians. Changes intended to help junior doctors have gone beyond their original objectives. In the light of these developments, it appears necessary to redefine the role, duties, status and even title of junior doctors.

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Sadiq, K. T. & Sehgal, C. (2007) Training opportunities still exist. *Psychiatrist Online*, 18 December.

Woodall, A. A., Roberts, S., Slegg, G. P., *et al* (2006) Emergency psychiatric assessments: implications for senior house officer training. *Psychiatric Bulletin*, **30**, 220–222.

Zafar, R. & Sadiq, K. T. (2007) Deskilling of junior doctors. *Psychiatric Bulletin*, **31**, 467.

Psychosis in Malta

Sir: Camilleri *et al* (2010) are to be congratulated on their study of the incidence of psychosis in Malta. They have been able to replicate the findings of the AESOP study (Kirkbride *et al*, 2006), that the incidence of psychosis does vary across small areas and that the variance depends on more than one factor – not simply population density but also other social factors, such as available housing; hence the incidence of psychosis in the Southern Harbour Area of Malta, where the housing is arguably poorer, is higher than that in the Northern Harbour Area, despite a higher population density in the latter. Similar data, linking a higher incidence of psychosis in areas of increased social deprivation in Luton, England, have been published by our team (Agius & Ward, 2009). Such data must be of great importance in allocating resources in community psychiatric services.

Another important finding reported by Camilleri *et al* was the markedly increased incidence of psychosis in the population of irregular immigrants. It needs to be noted that this population largely comprises persons from sub-Saharan Africa who have undertaken an extremely arduous journey first to the southern Mediterranean African shore and then by boat in often dangerously unseaworthy craft across the Mediterranean to Europe. Often these persons have had to be rescued from shipwreck. Many come from war zones in Africa. Hence these immigrants may very well have been subject to multiple traumatic experiences, in their homeland, in their journey across Africa, and then across the sea.

A link between post-traumatic stress disorder (PTSD) and the subsequent development of psychotic illness in a subgroup of patients with PTSD was reported from Croatia during the Balkan Wars (Ivezic *et al*, 1999, 2000) and our team have suggested that the development of psychotic illness in patients with PTSD may be related to exposure to repeated traumatic episodes (Pepper & Agius, 2009). Others have made similar suggestions. Hence these 'irregular immigrants' or 'boat people' appear to be a group at particularly high risk of developing psychotic illness, as demonstrated by Camilleri *et al*, and public policy to deal with this group of individuals should bear this in mind.

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Agius, M. & Ward, C. (2009) The epidemiology of psychosis in Luton. *Psychiatria Danubina*, **21**, 508–513.

Camilleri, N., Grech, A. & Taylor East, R. (2010) Socio-economic status and population density risk factors for psychosis: prospective incidence study in the Maltese Islands. *International Psychiatry*, **7**, 69–71.

Ivezic, S., Oruc, L. & Bell, P. (1999) Psychotic symptoms in post-traumatic stress disorder. *Military Medicine*, **164**, 73–75.

Ivezic, S., Bagaric, A., Oruc, L., *et al* (2000) Psychotic symptoms and comorbid psychiatric disorders in Croatian combat-related post-traumatic stress disorder patients. *Croatian Medical Journal*, **41**, 179–183.

Kirkbride, J. B., Fearon, P., Morgan, C., *et al* (2006) Heterogeneity in incidence rates of schizophrenia and other psychotic syndromes. *Archives of General Psychiatry*, **63**, 250–258.

Pepper, H. & Agius, M. (2009) Phenomenology of PTSD and psychotic symptoms. *Psychiatria Danubina*, **21**, 82–84.

Forthcoming international events

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>

28–30 October 2010

7th World Congress on Men's Health 'Men's health: how to overcome the challenges?'
Nice, France
Organiser: ISMH International Society for Men's Health
Contact: Astrid Lederer
Email: office@ismh.org
Website: <http://www.wcmh.info>

28–30 October 2010

14th Pacific Rim College of Psychiatrists Scientific Meeting
Brisbane, Queensland, Australia
Organiser: Pacific Rim College of Psychiatrists
Contact: Sarah Hoekater
Email: conference@anzmh.asn.au
Website: <http://www.anzmh.asn.au/PRCP10/>

5–7 November 2010

1st Global Conference – Making Sense Of: Suicide
Prague, Czech Republic
Organiser: Inter-Disciplinary.net
Contact: Dr Rob Fisher
Website: <http://www.inter-disciplinary.net/probing-the-boundaries/making-sense-of/suicide/call-for-papers/>

11–13 November 2010

Intercultural Aspects of Mental Disorders
Heidelberg, Germany
Contact: Folke Boysen, Ania Conradi, Johannes Zimmermann
Website: <http://chgdp.org/conference>

17–19 November 2010

Sixth World Conference on the Promotion of Mental Health and Prevention of Mental and Behavioral Disorders
Washington, DC, USA
Organiser: WFMH, EDC, Clifford Beers Foundation, Carter Center
Contact: Elena Berger, WFMH
Website: <http://wmhconf2010.hhd.org>

5–8 December 2010

Australasian Society for Psychiatric Research (ASPR) 2010 Conference
Sydney, NSW, Australia
Organiser: International Conferences & Events
Email: aspr2010@iceaustralia.com
Website: <http://www.iceaustralia.com/aspr2010>

11–13 December 2010

Brain, Behaviour and Mind 2010
2nd Joint International Conference of the Hong Kong College of Psychiatrists and the Royal College of Psychiatrists
Hong Kong, China
Email: bbm10@hkam.org.hk
Website: <http://www.psychconference.org.hk>

25–28 January 2011

37th PPA Convention 6th APAP Congress Mirroring the Asian Way of Psychotherapy
Cebu, Philippines
Contact: Chery Candava, Conference Secretariat
Website: <http://www.apaphil.org>

2–4 February 2011

Faculty of Forensic Psychiatry Annual Meeting
Berlin, Germany
Contact: Dela Goka
Email: dgoka@rcpsych.ac.uk
Website: <http://www.rcpsych.ac.uk/events/collegediary.aspx>

12–15 March 2011

19th EPA Congress – 'Translating Research Into Care'
Vienna, Austria
Organiser: European Psychiatric Association
Website: <http://www.kenes.com/epa>

27–29 April 2011

Controversies in Psychiatric Practice – The 7th International Conference on Psychiatry
Jeddah, Saudi Arabia
Contact: Dr Mohamed Khaled
Website: <http://www.sghgroup.com/sghg-Events-en-Jeddah-55.html>

9–12 June 2011

World Psychiatric Association Thematic Conference: 'Re-thinking Quality in Psychiatry: Education, Research, Prevention, Diagnosis, Treatment'
Istanbul, Turkey
Contact: Ayse Askin Erten
Website: <http://www.wpaist2011.org>

29 June–1 July 2011

11th Annual Conference of the International Association of Forensic Mental Health Services: 'Towards Integrated Prevention'
Barcelona, Spain
Organiser: IAFMHS
Email: tmoropito@iafmhs.org
Website: <http://www.iafmhs.org/iafmhs.asp?pg=conference>

17–21 October 2011

World Federation for Mental Health 2011 World Congress
Cape Town, South Africa
Email: info@wmhc2011.com
Website: <http://www.wmhc2011.com>

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