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encouraged.

A revised mental health classification for use in general medical settings: the ICD11–PHC

David Goldberg

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The World Health Organization (WHO) was aware that many hospital doctors and general practitioners did not use the detailed ICD–10 classification of mental and behavioural disorders (WHO, 1993), which had been produced for mental health professionals, and so it commissioned a specially modified version suitable for general medical settings. The new system was required to have modified – but not exact – equivalence to the main classification, and to consist of clinical descriptions rather than operational criteria for each of the proposed categories. The system would describe typical presenting complaints for each category in this setting, as well as the diagnostic features and the differential diagnosis for each disorder. An important new feature of the system was that it included the information that should be given to the patient and family, described the effective psychological and drug treatments and gave indications for specialist referral.

The 26 conditions recommended by a group consisting of psychiatrists and general practitioners (GPs) is given in Box 1, together with the corresponding F (or Z) number for the main classification (Ustun *et al*, 1995; WHO, 1996):

Experience with the ICD10–PHC

A study by Upton *et al* (1999) with established GPs showed that the guidelines had no impact on the overall detection of mental disorders, the accuracy of diagnosis or the prescription of antidepressants, but there was a significant increase in the number of patients diagnosed with depression or unexplained somatic symptoms, and the GPs also made increased use of psychological interventions. A well-conducted randomised controlled trial by Croudace *et al* (2003) with established GPs similarly failed to show that the guidelines had any impact either on detection or on patient outcomes. However, the ICD10–PHC has had a major impact in low- and middle-income countries, and is used in the training of nurses and multi-purpose health workers, as well as medical officers (Jenkins *et al*, 2002).

However, some of the ICD10–PHC disorders were equivalent to existing categories in the parent classification, and did not take into account developments in diagnostic thinking. An interesting example of this concerns ‘medically unexplained symptoms’, which appear to have fallen out of favour with our GP colleagues, who have taken the view that even some medically explained symptoms can be abnormally prolonged and accentuated. Psychiatrists have taken a similar view: the new concept of ‘complex somatic symptom disorder’ being field tested for DSM–V also draws attention not to whether somatic symptoms can be *explained*, but

Box 1 The 26 conditions included in ICD10–PHC

F00	Dementia
F05	Delirium
F10	Alcohol use disorder
F11	Drug use disorder
F17.1	Tobacco use disorder
F20	Chronic psychosis
F23	Acute psychosis
F31	Bipolar disorder
F32	Depression
F40	Phobic disorders*
F41	Panic disorder
F41.1	Generalised anxiety
F42.2	Mixed anxiety and depression*
F43	Adjustment disorder*
F44	Dissociative disorder
F45	Unexplained somatic complaints*
F48	Neurasthenia*
F50	Eating disorders
F51	Sleep problems
F52	Sexual disorders (male and female)
F70	Mental retardation
F90	Hyperkinetic disorder
F91	Conduct disorders
F98	Enuresis
Z63	Bereavement*

*Not to be included in ICD11–PHC.

to the cognitive components that may accompany them, whether they are part of a known physical disease or not.

‘Mixed anxiety depression disorder’ (MADD) was introduced in ICD–10 in order to take account of the fact that patients may just miss the diagnostic threshold for either generalised anxiety or depressive episode, but if they have symptoms of both disorders they are often distressed and disabled by them. However, it is an unsatisfactory concept because there is an unbroken continuum between such ‘sub-threshold’ patients and others who are above the threshold for both, and are at present (confusingly) described as being ‘comorbid’ for two quite separate disorders. This is because mood disorders and anxiety disorders are in two different chapters of the parent ICD. A revised classification needs to take account of these patients with a combination of symptoms, who give the most common presentation of psychological distress in general medical practice, as well as often being severely disabled by their symptoms.

A fresh look at the problem

The ICD11–PHC is currently under development; the process is advised by a group consisting of approximately equal numbers from high-income, and low- and middle-income

countries, of primary care physicians and psychiatrists who actually teach mental health skills to trainees in primary care, and of men and women. The deputy chairman is Dr Michael Klinkman, a GP who represents WONCA (the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians), and another member, Dr Marianne Rosendal, is the European representative on WONCA where classification is concerned.

In our early discussions, many of the disorders in ICD10–PHC are recommended to be retained – often with suitable amendments – but there have been several interesting new disorders suggested, as well as several disorders proposed for removal. Perhaps the most radical proposal is to abandon the distinction between anxiety disorders and mood disorders, and to gather them all under the single umbrella of ‘dysphoric disorders’. Within this important group, two innovations are proposed. First, some simple operational criteria will be tested in field trials to assess whether clinicians in the field find them useful; if they do not, we could return to diagnosis by descriptions of clinical prototypes. Even if they do like the operational criteria, we will need to recalibrate the point on the scale equivalent to what was previously described as MADD. The simple scales will allow a clinician to diagnose depression and anxiety on their own, or the combination of both – to be called ‘anxious depression’. Second, where any of these three disorders achieve the severity required for a ‘case’, any somatic symptoms not part of a known physical disorder will be assumed to be related to the dysphoric disorder. Those whose symptoms fall short of the requirements for any of these three diagnoses, but who are distressed and disabled by their current symptoms (whether dysphoric or somatic), are to be given the residual diagnosis of ‘distress disorder’. Distress disorder replaces a motley collection of minor disorders, including neurasthenia (or chronic fatigue) and adjustment disorder.

The concept of anxiety disorder will not be exactly equivalent to generalised anxiety disorder (GAD), which by definition has to last at least 6 months. Clinicians in general medical practice need to know what is wrong with the patient now, rather than forming a lifetime concept of the patient’s psychological health. Current anxiety is very much more common than GAD, and needs to be recognised if the patient is to receive appropriate reassurance and support.

A new category called bodily distress disorders will include conversion disorder (fairly common in some lower-income countries), health preoccupation (a new disorder similar to hypochondriasis) and the less severe ‘bodily distress syndrome’. In the syndrome, the patient is both distressed and concerned and has three or more somatic symptoms in one bodily system. This is diagnosed only if the patient does not have one of the three dysphoric disorders.

Post-traumatic stress disorder and panic/agoraphobia are other new adult disorders. In addition, the GPs on the group wish to have a single category of personality disorder, equivalent to borderline personality. These patients are well known to GPs, and we will try the concept out in a field trial.

Bereavement has been deemed to be surplus to requirements because it is not the only transition that is followed by a psychological disturbance.

Tobacco use disorder has been retained because of its public health importance, and the fact that patients may ask GPs for advice on how to reduce their use of tobacco.

Box 2 The 28 disorders to be field tested for ICD11–PHC

Childhood disorders

- 1 Intellectual development disorder (was mental retardation)
- 2 Autism spectrum disorder (new)
- 3 Specific learning disability (new)
- 4 Attention-deficit hyperactivity disorder (ADHD)
- 5 Conduct disorder
- 6 Enuresis, encopresis

Psychotic disorders

- 7 Acute psychosis
- 8 Chronic psychosis
- 9 Bipolar disorder

Dysphoric disorders

- 10 Anxious depression (new)
- 11 Depressive disorder
- 12 Anxiety disorder
- 13 Distress disorder (replaces F42.2, F43, F48)
- 14 Post-traumatic stress disorder (PTSD) (new)
- 15 Panic/agoraphobia (was panic disorder)

Body distress disorders

- 16 Bodily distress syndrome (new – was unexplained somatic complaints)
- 17 Health preoccupation (new)
- 18 Conversion disorder (was dissociative disorder)

Bodily function disorders

- 19 Sexual function disorder, male
- 20 Sexual function disorder, female
- 21 Sleep disorder
- 22 Eating disorder

Substance use disorders

- 23 Alcohol use disorders
- 24 Drug use disorders
- 25 Tobacco use disorders

Personality disorder

- 26 Borderline personality (new)

Acquired neurocognitive disorders

- 27 Dementia
- 28 Delirium

Two new childhood disorders are autism spectrum and specific learning disabilities, as it is thought important that GPs recognise them. They are part of the list of childhood disorders being drawn up by the Childhood Disorders Group at the WHO, and they will be field tested with all the other categories to see whether GPs recognise them and find them useful. The 28 disorders to be field tested have been arranged in eight rough groups, shown as Box 2.

These proposals are radical indeed, and by no means all of the proposed disorders will survive the field tests. Each proposed category will be commented upon by experts who are not part of the group, as well as by the main advisory group responsible for ICD–11. Final amendments will be made by the primary care group before the revised classification is released for field tests. The field tests are likely to be quite extensive, and to involve studies in both high-income and low- and middle-income countries. A second set of revisions will be made after the field tests. Disorders that survive the field tests must have an equivalent disorder in the main classification – a requirement which may cause a problem with the new concept of anxious depression, since

it requires some modification to the meta-structure of diagnoses used in the main classification.

The field tests will at first be confined to the diagnostic classification to be used in primary care; discussion about optimal management has been deferred to a later stage, but is likely to use the forms of management recommended by the mhGAP study (WHO, 2008), with possible additional headings.

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THEMATIC PAPERS – INTRODUCTION

Policy on mental health

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Our theme this month concerns nascent psychiatric services in countries that are still developing their mental health provisions, but which face specific and diverse challenges. The most dramatic example of this is Iraq, where there continues to be far more conflict, corruption and instability than is ever reported in the Western media. Over 85% of non-governmental organisations have stopped operating in Iraq in recent years, and the future is uncertain for those that remain. Dr AlObaidi writes about the impact of the recent conflict on the mental health of children living in this traumatised country. There are concerns about the chances of creating a stable country in the future, when the current generation of children become adult, unless something is done to address their needs now. There are no formally trained child and adolescent psychiatrists, and it is not clear how the author's plea for a comprehensive and culturally sensitive child and adolescent mental health service could be answered in the near future without financial and professional assistance from outside Iraq itself.

Dr Araya and colleagues discuss a different challenge, in Chile. The aim was to find a way of providing good-quality mental healthcare within the primary care sector. Chile is one of those countries in South America with a burgeoning economy. Its growth rate, in terms of gross domestic product, was 4.3% in 2010, on a par with Mexico. There is an enthusiasm for innovation, and funding is available to make it happen. Over the past 20 years several studies within Chile have examined the prevalence of psychiatric disorder

in the general population. Interestingly, it seems that the impact of these 'home-grown' investigations, supported by the Ministry of Finance, has been far greater than that of innovations derived from studies in countries with a stronger scientific infrastructure. The authors describe clearly the steps taken to implement and evaluate the intervention, which provides a paradigm for countries aiming to establish novel psychiatric services that do not simply imitate the European/US out-patient model.

Finally, Dr Osei and colleagues discuss the issue of mental health legislation in Ghana, a country that has fewer active psychiatrists now than in 2003. Existing services follow a traditional format, with their foundations set in large psychiatric hospitals. They have a relatively high ratio of admission to attendance. As in most other African countries, Ghana's mental health legislation is outdated and outmoded in both its scope and its application. Fortunately, a new mental health act has been drafted. One of the key aims will be, as in Chile, to move resources into the community and away from centralised in-patient care. We have previously, within *International Psychiatry* (vol. 4, no. 4, October 2007), discussed the important role of traditional healers in Africa and the need for psychiatric services to establish a dialogue with them. It has been estimated that there are no fewer than 45 000 such healers in Ghana, and monitoring of their activities will be subsumed under the new legislation. Unfortunately, for a variety of reasons the authors discuss, bringing the act into force has proved more problematic than they had anticipated.

Iraq: children's and adolescents' mental health under conditions of continuous turmoil

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Children and adolescents constitute half of Iraq's population of over 30 million. Mental health problems experienced by Iraqi children and adolescents are a hidden problem. Many factors contribute to the mental health problems of young Iraqis, including being victims and witnesses to violence, seeing family members become victims, being displaced from their homes, and experiencing the instability that still plagues their nation. Iraqis have experienced severe deprivation caused by many years of war, economic embargoes and civil unrest. Violence, poverty and the failure of the education and health systems have severely undermined the well-being of Iraqis, especially children (AlObaidi *et al*, 2009).

Child and adolescent mental health is a major concern, especially as it is increasingly recognised as a key influence on and predictor of problems in adulthood. Current events in Iraq have raised concerns about the consequences of trauma and stress on the mental health of the country's youth. Addressing the mental health needs of children and adolescents is critical to the success of relief efforts and requires effective, coordinated interventions.

Shortage of resources

Interest in the mental health of children in Iraq is a relatively recent development. Biomedical care for adults with mental illnesses began about 60 years ago with the formation of separate psychiatric hospitals in the capital city (Baghdad), and became part of general hospital care across Iraq just three decades ago.

In Iraq, child and adolescent mental health services (CAMHS) are commonly provided in out-patient mental healthcare facilities for the general population. Psychotropic medications are virtually the exclusive mode of therapeutic treatment. A small CAMHS clinic with very limited resources was launched at the Central Child Hospital in Baghdad in 2003. In addition, a number of institutes for children with special needs and residential homes for orphans are run by governmental and non-governmental agencies. However, a lack of resources and staff training may undermine the provision of services by these institutions.

Multidisciplinary work and behavioural, play and other forms of psychotherapy are not part of standard practice. School-based CAMHS are not available. A small team of psychologists and social workers serve in the Iraqi juvenile justice

system, but they have no specialist training in the treatment and rehabilitation of youth offenders.

The current instability and violence prevalent in Iraq limit the work of national and international non-governmental organisations (INGOs); many of the latter have in fact left Iraq because of the danger to their staff. However, a few INGOs have made CAMHS a priority, for example the work of Diaconia in the north, and the assistance offered by the International Medical Corps in a rehabilitation programme for orphanages and the provision of mental health training for primary care doctors, mostly in central Iraq (AlObaidi *et al*, 2010a). The United Nations Children's Fund (UNICEF) has provided support to Iraqi children since 1952 in the areas of nutrition and immunisation, child protection and education and local training of primary care workers. Civil unrest and more specific threats to UNICEF staff have sometimes interrupted these efforts. Save the Children, partnered with Mercy Corps, has returned and since the end of 2008 has supported the psychosocial care of children in the Kurdistan northern part of Iraq.

Another challenge facing the delivery of CAMHS in Iraq is the shortage of human resources. None of the 100 or so psychiatrists in Iraq has formal training in child and adolescent mental health. According to the World Health Organization (2009), the only other mental health human resources include, nationally: 7 general practitioners practising mental health; 145 psychiatric nurses; 16 psychologists; and 25 social workers. In the majority of low- and middle-income countries, mental health awareness is lacking and low priority is given to mental health within general health planning (Murthy, 2008). In Iraq, the picture is even bleaker, as there are few CAMHS available in spite of the additional needs arising from the prolonged conflict and violence. With decreased awareness, the stigma associated with mental health problems is an obstacle compounded by widespread unconcern and a lack of scientific knowledge about mental health.

Mental healthcare in Iraq was a neglected area even before the 2003 war (Abed, 2003). The recent armed conflict has had a profound impact on children's physical and mental health. The problems facing Iraqi children have their roots in the decades immediately before 2003. For example, access to health services for children aged under 5 years is severely limited, especially in rural areas, and the mortality rate among those under 5 in Iraq is one of the highest in the Middle East (Awqati *et al*, 2009). There were no formal CAMHS before

2003; however, some progress has occurred since then, including the implementation by the Iraqi Ministry of Health of a general mental health policy with an integrated CAMHS component. The current instability and shortage of resources are hindering these efforts. It is hard to compare the CAMHS between the two periods due to the lack of comparable data.

Legislation and human rights

The old Iraqi laws, proclaimed in the 1980s, continue to be valid but are difficult to navigate and are not in complete agreement with the United Nations Convention on the Rights of the Child and other international standards. A special commission has been charged with creating child protection policies, coordinating and monitoring the various projects under way in this area, and the adoption of legal resolutions related to child welfare. Child-care facilities, including juvenile welfare institutions, orphanages and centres for the care of mothers, children and people with disabilities were to be supervised and funded by the state. Establishing a separate child protection act may help to fill the gaps (AlObaidi *et al*, 2009).

Needs assessment

Major national surveys of child and adolescent mental health are lacking in Iraq. Resources for service monitoring and outcome effectiveness research are needed, as the present lack of statistical data and research findings makes it difficult to plan CAMHS. Nonetheless, several smaller studies have demonstrated increased rates of mental health problems among Iraqi children and adolescents, including post-traumatic stress disorder (PTSD) and attention-deficit hyperactivity disorder (ADHD) in the cities of Baghdad, Mosul and Nassiriya. One study in Mosul, for example, showed that 37% of children who were patients at a primary health facility complained of a mental disorder (Al-Jawadi & Abdul-Rhman, 2007). PTSD was reported among 14% of children living in Baghdad and among 30% of those living in Mosul (Razoki *et al*, 2006); 20% of children were estimated to have PTSD among Iraqi Kurds in the north (Ahmad *et al*, 1998). In a clinical sample study conducted in Baghdad during 2005, anxiety disorders were diagnosed in 22% and behavioural problems in 18% (AlObaidi *et al*, 2010b). In 2006 at Nassiriya, a city in southern Iraq, ADHD was found among 15% of schoolchildren (Sadik *et al*, 2008), and in Baghdad the prevalence of the disorder was estimated to be 5.9% during 1999 (AlObaidi & Ali, 2009).

National professional population surveys of the mental health of children and adolescents that are culturally sensitive are needed to form a secure base for the establishment of child and adolescent mental health policy.

Baselines for CAMHS in Iraq

Much remains to be done to meet the mental health needs of children and adolescents in Iraq. A system of low-cost service delivery staffed by well-trained health professionals is required that focuses on child, family, school-based and

community mental health. It is necessary to build a well trained workforce of health professionals within the primary health setting who have fundamental CAMHS skills and who are able to track progress the development of CAMHS and early-intervention services. Comprehensive, culturally sensitive CAMHS grounded in the existing local infrastructure should be developed by local professionals and evaluated for the effectiveness of their outcomes.

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New College report

College report CR163, *Psychiatric Services for Children and Adolescents with Intellectual Disabilities*, deals with those people falling between child and adolescent psychiatry and intellectual disability psychiatry services. It reviews the resources required for a psychiatric service for young people (under 18 years) and their families. Starting with an overview of the changing approaches to the psychiatric needs of this population, the nature of its disorders and the variety of interventions, it sets out the characteristics of a model service dealing with its structure, location, personnel and resources. The report is aimed at anyone involved in planning or helping to develop a psychiatric service for children and adolescents with intellectual disabilities. This report replaces CR123 (and formerly CR70).

Depression in primary care: Chile's Programme for Screening, Diagnosis and Comprehensive Treatment of Depression

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In 2001, an initiative to provide effective treatment for people with depressive disorders in primary care clinics was introduced in Chile, the Programme for Screening, Diagnosis and Comprehensive Treatment of Depression (PSDCTD) (Ministerio de Salud, 2001). It was extended to all primary care clinics in the country 4 years later.

The PSDCTD works as follows. The detection of depressive cases is done by any health professional in the clinic during regular consultations. Identified potential cases are referred to a physician within the clinic, who confirms the clinical diagnosis (using ICD-10 criteria). If the depression is severe (defined by the presence of marked suicidality, bipolar disorder or psychosis), the patient is referred to a specialist clinic for evaluation by a psychiatrist. Patients retained for treatment in primary care enter a depression management programme based on clinical guidelines, which stipulate checks every 2 weeks, antidepressant medication (fluoxetine, sertraline or venlafaxine), and individual or group psychotherapy. If there is little improvement with this regimen, a joint assessment with a consultant psychiatrist is arranged and, if necessary, the person may be referred to a specialist clinic for further treatment (about 14% of cases). For those who respond well, monitoring in primary care is maintained for not less than 6 months (Ministerio de Salud, 2001).

During 2001, a total of 18224 persons used this service; the annual total had increased to 125425 in 2005 and approximately 200000 each year thereafter (Ministerio de Salud, 2009). The public expense for this programme grew from US\$893460 in 2002 to US\$33642991 in 2008, more than a 30-fold increase in 6 years!

Programme's development

At the early stages of the introduction of this policy, scientific research, especially that done within Chile, played an important role, together with a strong and dynamic leadership,

which helped to amalgamate the technical and political will to make the PSDCTD a success.

Scientific research had a major influence, because the results not only indicated the magnitude of the problem within the country (Ministerio de Salud, 1996; Araya *et al*, 2001; Vicente *et al*, 2004), but also provided strong evidence that it was possible to introduce cost-effective interventions within primary care (Araya *et al*, 2003; Gilbody *et al*, 2003). This provided a strong basis for the introduction of the policy. While studies conducted in other parts of the world reported good results from initiatives seeking to improve the effectiveness of treatments for depression (Gilbody *et al*, 2003), having information from studies in Chile was a key factor in persuading political authorities to make a commitment to the programme.

In the 1990s, two studies of the prevalence of mental disorders were conducted, and both showed a high prevalence of depressive disorders. One of these, conducted in Santiago ($n = 3870$) in 1998, found a point prevalence of common mental disorders of 25%, and of 5.5% for depressive episodes only (meeting ICD-10 criteria) (Araya *et al*, 2001). The other was conducted in four cities in Chile ($n = 2978$) and reported a 6-month prevalence of 19.7% for all mental disorders studied and 4.7% for major depressive disorder according to DSM-III-R criteria (Vicente *et al*, 2004). Though these two studies used different methodologies, they came to similar results, adding further credibility to their estimates.

Also in the 1990s, a study of disease burden estimated the impact of different diseases through premature mortality and disability. Mental disorders were among the leading causes of lost years of healthy life in Chile, and depressive episodes were the leading specific cause among adult women (Ministerio de Salud, 1996). This study was coupled with a cost-effectiveness study which showed that the out-patient treatment of depression was the third most cost-effective intervention examined (after treatment of tuberculosis and cervical cancer).

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Later, between 1999 and 2001, a controlled trial in primary care clinics evaluated the effectiveness of a comprehensive multi-component treatment programme for depression, which included: participation in structured group psycho-education (led by social workers and nurses); systematic monitoring of clinical progress; and drug treatment for the most severe cases (performed by general practitioners). This programme was much more effective and slightly more expensive than usual care (Araya *et al*, 2003, 2006). People receiving this 'improved care' programme obtained a recovery rate of 70%, compared with 30% in the 'usual treatment' group.

Programme's effectiveness

Once the PSDCTD had been launched, an evaluation of its effectiveness was undertaken, based on monitoring a cohort of patients. This cohort showed a significant decrease in the intensity of depressive symptoms at 3 months, in comparison with those who abandoned the treatment (Alvarado *et al*, 2005a). Factors reducing the effectiveness of treatment included comorbidity and psychosocial complications. There was a drop-out rate of 19.5% from the programme within the first 3 months (Alvarado *et al*, 2005b). These results were known by the Ministry of Finance during the budget negotiations of 2004; nonetheless, a further increase in resources was agreed to extend the activities of the programme throughout Chile. Successful experiences with other health programmes (maternal and child health, chronic diseases, and so on) helped to convince policy makers to support the programme, and this was facilitated by the coincidental introduction of a National Mental Health Plan. There were five activities that were critical to the success of the PSDCTD:

- the definition of evidence-based activities that were feasible to be implemented in primary care clinics
- ongoing training of primary care teams, through short courses and ongoing joint consultations (mental health professionals reviewed clinical cases with primary care teams)
- additional resources for the recruitment of mental health professionals and purchase of medication
- better coordination between primary and specialist care (ensuring continuity of care)
- training and ongoing support for local and regional mental health managers (regional and municipal).

A multidisciplinary team at the Ministry of Health led this initiative, advocating for more resources with authorities at the Ministries of Health and Finance, supporting local management teams, as well as negotiating with various

actors involved in implementing the PSDCTD. This team gradually institutionalised the programme (incorporating depression among the country's top health priorities and ensuring the continuous flow of resources), something crucial for the sustainability of this policy.

Conclusion

The PSDCTD has been active for 8 years and is seen as an example of a successful policy in terms of coverage, effectiveness and sustainability. Chile is one of the few middle-income countries that has implemented a national programme for the treatment of depression in primary care with good results and we believe this experience could be emulated by other countries.

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Time is very slow for those who wait,
Very fast for those who are scared,
Very long for those who lament,
Very short for those who celebrate,
But, for those who love,
Time is eternity.

William Shakespeare

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

John Schaar

The new Ghana mental health bill

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In Ghana, the main burden of ill-health, as in many sub-Saharan countries, consists of communicable disease, illnesses due to inadequate nutrition and poor reproductive health. As these conditions are tackled, other diseases, such as mental disorders and substance misuse, are also becoming the focus of development efforts. In Ghana, it has been estimated that there are 2 166 000 individuals experiencing a mild to moderate mental disorder, with a further 650 000 suffering from a severe mental disorder, out of a population of 21.6 million (World Health Organization, 2007). In 2003, the country's mental health workforce consisted of 9 psychiatrists (only 4 of whom worked in mental health services), 451 nurses and 160 community psychiatric nurses (World Health Organization, 2003). Currently there are just 5 consultant psychiatrists in active service in the public sector and 11 retired psychiatrists. As just under 33 000 individuals are seen each year in Ghana by mental health services, there is an estimated treatment gap of 98% (World Health Organization, 2007). Most mental healthcare is undertaken at the three large psychiatric hospitals, in the south of the country. This is reflected in the ratio of out-patient attendance to admission, which is 4.64 for mental health, compared with 14.6 for all health conditions (Ghana Health Service, 2005).

Current state of mental health legislation in Africa

Across Africa, 11 countries (20% of the continent's total) are known currently to have no mental health law. Of those that do have legislation, 18 (33%) have mental health acts that date from before 1961. A further 8 (15%) have laws from the decades 1962–71 and 1972–81, while only 16 (30%) have legislation dating from 1991 to the present (World Health Organization, 2005). There has been variable development of mental health law in western sub-Saharan countries. As might be expected, low-income countries such as Niger and Benin, which come near the bottom in ranking on the Human Development Index (United Nations, 2008), have legislation dating from the first half of the last century. In some cases, however, there is a marked disparity between a nation's 'development' and its provision of mental health law. Nigeria, which ranks 154th out of 179 in terms of its Human Development Index, has mental health law dating from the 1940s, while Burkina Faso, which ranks 173rd, has

legislation dating from just over 10 years ago. Ghana, like other countries in the region, such as Senegal, currently has outdated legislation from 1972.

Mental health legislation in Ghana

Mental health legislation began in Ghana in 1888, when a Lunatic Asylum Ordinance was passed. This empowered the authorities to arrest and detain as special prisoners vagrant people with a mental illness, which in turn led to the building of Accra Asylum in 1906 (the Asylum has since become Accra Psychiatric Hospital). There was no revision of the legislation until 1972, when a Mental Health Decree (known as the NRC 30) was passed. This was a more progressive piece of legislation, in that it recognised that those with mental illness should not be prisoners but patients who require treatment. Even so, the NRC 30, which recognised as mentally ill only persons residing in psychiatric hospitals, made no mention of human rights and required no oversight of treatment. The Decree did prescribe the establishment of a Mental Health Tribunal; however, this was never actually done. Therefore patients do not currently have any independent organisation from which to seek redress if they are involuntarily detained. At present, patients, if they feel aggrieved (and have the means), report to the Commission for Human Rights and Administrative Justice (CHRAJ) or to the office of the President. In both cases the response of the hospital authorities is usually enough to resolve the case (usually with detention being upheld). The visiting committees called for by the Decree have similarly never been established.

Although some efforts have been made by bodies such as the CHRAJ to monitor in-patient standards periodically, in reality facilities are currently not monitored and those involved have no accountability for the care they provide to individuals with mental disorder under current legislation.

In Ghana, prayer camps and traditional healers see far more cases of mental illness than the three psychiatric hospitals. Individuals held involuntarily in these settings are not afforded any protection under current legislation.

The 1972 Decree defines the conditions for involuntary detention of forensic cases; however, in reality even unwilling and aggressive individuals are admitted as 'voluntary' patients as long as there is the consent of relatives. Once admitted, it is often difficult for forensic patients to leave the hospital system. Even those who have recovered and are fit

to plead in court have remained in hospital for as long as 20 years because the courts do not recall them and there is no mechanism for automatic release into the community.

The new Ghana mental health bill

The new bill will have two main effects: first, it provides a legal framework for the safe management of patients; and second, it establishes an authority to govern mental health services. Under the 1972 legislation, people with a mental illness were defined as those residing in psychiatric hospitals. The new Ghana mental health bill changes this to include the majority of those in the community who are mentally ill. The new bill emphasises community rather than institutional care. This is important because in Ghana, as in many low-income countries, most funding is spent on institutional care (Hyman *et al*, 2006), and by moving care into the community the new act will allow resources to be redirected. It is hoped that this redistribution will allow more individuals to access care, and start to reduce the mental health treatment gap.

The new bill establishes a mental health tribunal to adjudicate on alleged cases of abuse, in order to protect both service users and mental health staff. It will cover traditional and faith-based settings as well as psychiatric facilities. The bill criminalises human rights abuses such as flogging, forced fasting and discrimination. Visiting committees will be established with the primary function of protecting the rights of people with mental disorder. Yearly inspections of facilities will be mandatory.

The bill clearly spells out for the first time the rights of people who are mentally ill, explicitly highlighting their right to marriage, employment, accommodation and vote. The principle of non-discrimination is core to the legislation, with protection for vulnerable groups in Ghanaian society such as women, children and the elderly. Individuals with intellectual disability or incapacity are safeguarded through guardianship.

The legislation establishes minimum standards of care and makes specific funding available for this. It is hoped that these measures, and the influence of the new Mental Health Board, will help ease the problems of inadequate drug supply and lack of recruitment and retention of mental health workers. The establishment of the Board to oversee mental health services is an internal mechanism which will ensure the bill is implemented. Specifically, it will ensure that the administrative structures like mental health tribunals and visiting committees are established and function in practice.

Challenges in bringing the new act into effect

Just after the millennium, the World Health Organization (2001) commenced a programme to strengthen mental health legislation in low- and middle-income countries. In

response to this, in early 2004 a technical drafting committee was formed by the Minister of Health in Ghana, supported by a team from the World Health Organization. A wide range of stakeholders, including mental health and general health workers, legal experts, traditional and faith healers and teachers, were consulted during the initial drafting of the new act. It went through 19 drafts before proving acceptable to all parties. Since January 2006 the new mental health act has been waiting to progress through parliament. During 2009, the Ministry of Health made two significant retreats to resolve all outstanding issues concerning the mental health bill and other legislation, and has now decided to present the bill as part of a more general health service bill.

Conclusions

We would encourage countries with outdated mental health legislation to redress the rights of those with mental illness in their locality. Change is by no means easy. Producing new legislation is arduous: it requires patience and diplomacy. Any new legislation has to be considered in the widest context, with care taken to examine the impact and interrelationships with other legislation and systems. There will always be the need to manage the expectations of service users and health professionals while the drafting and implementation of new legislation take place. Advocacy work is needed to keep the rights of those with mental illness high on the political agenda. Various agencies, including non-governmental organisations and the media, are of help in this task. International publications can also help to raise awareness.

The developments we have described in Ghana provide hope and optimism. Ghana has taken positive steps to support and protect those who have mental illness. In Ghana today the majority of this hard work has been done, a document has been drafted and is ready to pass into law.

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Mental health in Uzbekistan

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Uzbekistan is a landlocked central Asian country with an area of 447 400 km². It borders Kazakhstan in the north, Kyrgyzstan and Tajikistan in the east, Turkmenistan in the west and Afghanistan in the south. Uzbekistan has 14 regions (provinces). In 1991 it emerged as a sovereign country after more than a century of Russian rule – first as part of the Russian empire and then as a component of the Soviet Union.

The population is 27 767 100, which represents half the region's total population. A third of the population is younger than 14, and just 4.7% are over 65; 64% of the population is rural. Uzbeks comprise a majority (80%) of the total population. Other ethnic groups include Russians, Koreans, Tajiks, Kazakhs, Karakalpaks and Tatars. The largest religious group are Muslims (Central Intelligence Agency, 2010). The literacy rate is 97% (United Nations Children's Fund, 2008). The life expectancy at birth is 64.5 years for males and 70.9 for females (United Nations, 2009).

The country is a low-income group country based on World Bank criteria. The health budget represents 3.1% of the country's gross domestic product. The per capita total expenditure on health is US\$91, and the per capita government expenditure on health is \$68. Overall, 2.3% of the government's healthcare expenditure is directed towards mental health (World Health Organization, 2007).

Mental health policy and legislation

Psychiatric care in Uzbekistan is provided only by the public sector. Mental health was declared a public health priority area by a presidential decree (no. UP-2107) in November 1998 (World Health Organization, 2007). Benefits for people with mental disorders were defined by a Decree of the Cabinet of Ministers of Uzbekistan in March 1997. In August 2000 the Uzbek parliament adopted comprehensive mental health legislation, under the title 'On Psychiatric Care for the Population'. Later it issued a supplement entitled 'Compulsory Hospitalisation in Psychiatric Establishments', which was aimed at protecting the legal rights and interests of patients with mental illness (Cooper *et al*, 2008). A national suicide prevention strategy (2010–20) was adopted by the government in December 2009.

Mental health services are regulated by the Department of Mental Health in the Ministry of Health. The department

employs a number of specialists, including a chief psychiatrist, a chief child psychiatrist, a chief forensic psychiatrist and a suicide specialist. Also, each region of Uzbekistan has a chief psychiatrist responsible for the mental health services.

Mental health issues and planning are regularly discussed at annual conferences that involve all stakeholders.

All patients with mental disorders have a right to essential psychotropic medicines either free of charge or subject to at least an 80% subsidy. Additional mental health patient benefits include free nursing care and treatment in psychiatric hospitals, as well as free provision of special drugs for out-patients.

Mental health service delivery

After independence in 1991, Uzbekistan inherited a centralised and hierarchically organised model of healthcare from the Soviet Union. There was over-provision of hospital beds, which contributed to an imbalance in the overall structure of the healthcare system. On the whole, the Soviet system tended to neglect primary care and placed too much emphasis on specialist and hospital care. During the first years of independence, health policy focused on improving primary care facilities (poly-clinics in cities and rural primary medical practices) and cutting the cost of in-patient facilities (Ahmedov *et al*, 2007).

With a view of achieving deinstitutionalisation of psychiatric services, the number of psychiatric beds was reduced by a factor of 1.6, to 7831. The funds gained through deinstitutionalisation were supposed to be transferred from hospital to out-patient (and primary care) mental health facilities. Unfortunately, a majority of these funds were transferred from the mental health system to other fields of healthcare.

Out-patient psychiatric care is provided by 22 neuro-psychiatric out-patient clinics (dispensaries), 17 of which offer 24-hour care. There are also 3-day treatment clinics in the psychiatric hospitals. There are 446 poly-clinics that offer psychiatric care, including 226 in adult psychiatry, 156 in child psychiatry and 27 in adolescent psychiatry. Ten of the 14 regions of Uzbekistan provide day treatment facilities for persons with mental disorders; these offer a level of service that falls between out-patient and in-patient care and give opportunities for occupational therapy and rehabilitation.

There are 13 psychiatric hospitals with a total of 29.2 beds per 100 000 population. All of these establishments are

Table 1 The number of psychiatrists by subspecialty, 2009

Psychiatric subspecialty	Numbers in 2009
Adult psychiatrists	674
Child psychiatrists	170
Adolescent psychiatrists	57
Forensic psychiatrists	14
Psychotherapists	21
Suicidologists	1

organisationally integrated with mental health out-patient facilities. Eleven hospitals have emergency psychiatric care teams, which can assess and review at-risk patients at home. Nine per cent of the beds in mental hospitals are reserved for children and adolescents. Furthermore, nine psychiatric hospitals have special adolescent departments (240 beds).

There are, in addition, 12 in-patient drug and alcohol services, with a total number of 325 beds, and 890 beds are for the treatment of people with mental disorders in forensic in-patient units.

There are 3178 primary rural medical practices. General practitioners can provide emergency care to patients with mental disorders and refer them to a psychiatrist. Assessment and treatment guidelines for key mental health conditions in non-physician-based primary care are not available.

The suicide rate in Uzbekistan during 1984–90 was reported to be 11.8 per 100 000 (World Health Organization, 2005). This might not reflect the real picture, as misclassifications could occur in cases where there was a wish to conceal a murder. Negative attitudes towards suicide, especially in Muslim regions, where suicide is taboo, might also have contributed to under-reporting of suicide (Wasserman & Varnik, 1998). From 2005 to 2009, 8286 people attempted suicide. There is a specialist centre for suicide prevention which analyses the suicide rate and supports people with a risk of suicide. Every region has a crisis unit for people who have attempted suicide, located in emergency medicine centres. In addition, regional telephone helpline services have been created and are staffed with trained professionals who give advice and information to anyone in distress. In 2009 the helpline served 10 090 people, including 333 with suicidal intentions.

Psychiatric training, subspecialties and allied professionals

Medical undergraduate training lasts 7 years and is offered by seven medical schools. All seven and the Tashkent Institute of Postgraduate Medical Education also offer postgraduate psychiatric training. In 2009 there were 52 doctors in training: 26 residents and 26 masters. In addition, 184 doctors attended refresher training courses run by the Tashkent Institute of Postgraduate Medical Education.

At the end of 2009 there were 937 psychiatrists working in Uzbekistan. Their distribution by subspecialty is presented in Table 1. In the same year, 2442 psychiatric nurses participated in the treatment of people with mental illness in Uzbekistan. All of them had a general medicine background before entering psychiatry. Whereas the World Health Organization recommends a psychiatric doctor:nurse ratio of

1:4, in Uzbekistan it is 1:2.9. The number of healthcare assistants working in psychiatry was 3196 in 2009.

There are no social workers or occupational therapists. Because of a lack of trained professionals, 150 places for clinical psychologists remain vacant and in all mental health facilities there is total of only 23 psychologists.

Research

Research in Uzbekistan is focused on community epidemiological studies, clinical psychiatry, pharmacological, psychosocial and psychotherapeutic interventions and surgical and electroconvulsive treatment. From 2005 to 2010 there were 234 publications on health from Uzbekistan identified in PubMed, of which 16 (6.8%) were on mental health.

Obstacles and areas for development

Despite some positive changes in mental health policy and legislation over the past two decades, insufficient funding has led to a deterioration of mental health services. A reduction in the number of psychiatric beds and day treatment clinics as well as difficulties with drug supply are the main problems. The overall number of mental health professionals is continuing to decline and as a consequence a major treatment gap can be expected for the increasing number of patients who need specialist help. Furthermore, many specialists are approaching retirement age and an annual output from medical training colleges of 52 doctors will not be enough to cover future service needs.

To overcome these problems, it would be desirable, first, to decentralise mental health services and create mental health units within general hospitals. Second, despite initial efforts to integrate mental health services into primary care through the training of general practitioners, there is still a need for better integration and a more comprehensive approach to increasing the accessibility of care for patients with mental health problems at primary care level.

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Mental health in the Dominican Republic

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The Dominican Republic is located in the Caribbean Sea and comprises three-quarters of the island Hispaniola, which it shares with Haiti. According to the 2002 census, approximately 8.5 million people live in the Republic, with 64% residing in urban areas (Oficina Nacional Estadística, n.d.). During 1990 and 2000, the Dominican Republic was a leader in economic development for Latin America and the Caribbean; however, this was not reflected in the areas of human and social development (Pan American Health Organization & World Health Organization, 2007). Less than 1% of the health budget administered by the Ministry of Public Health and Social Assistance (MISPAS) is allocated to mental health and the public system is generally underfunded (Pan American Health Organization & World Health Organization, 2008). However, there is an array of mental health services within the country when privately funded facilities are taken into account.

In the Dominican Republic, it is estimated that the most common mental disorders are mood disorders, substance misuse, schizophrenia, intellectual disability and epilepsy. Depression has a prevalence of 1.9% for males and 3.7% for females, with 5.8% of men and 9.8% of women experiencing a depressive episode at least once yearly (Sánchez-Martínez, 2006). Approximately 80 000 Dominicans carry the diagnosis of schizophrenia and half of them receive inadequate follow-up and treatment (Sánchez-Martínez, 2006). Psychosocial factors that play a role in the mental health of Dominicans include poverty, violence, physical abuse, sexual abuse, exploitation of minors and the sequelae of substance misuse.

Mental health policy and legislation

In recent decades, the Dominican Republic has undergone enormous economic and social transformation, driven by global changes and national trends. In the health sector, one major change was the approval of the General Health Law (no. 42-01), enacted in 2001, and the Law Establishing the Dominican Social Security System (no. 87-01), of 1987. These laws were followed by the integration of the National Mental Health System into the National Health System and the Dominican social security system (Ministerio de Salud Pública y Asistencia Social, 2004). The General Health Law regulates all activities that make it possible for the state to ensure the right to health, while the Law Establishing the Dominican Social Security System laid the groundwork for

the development of a social protection system with universal coverage, promoting the growth of insurance coverage via social contributions by employers, employees and the government (Alarcon, 2003).

The regulation of mental healthcare within a framework of rights of persons with such disabilities was established by the Minister of Health through enactment of the Mental Health Law in February 2006. It stated the basic rights and freedoms of people who are mentally ill and established that the 'objective is to regulate the right to the best care available in mental health of all persons under the provisions of the General Health Law'. Chapter II, article 10, provides that there are 'basic rights and fundamental freedoms of persons with a mental illness' (Ministerio de Salud Pública y Asistencia Social, 2006). The current mental health policy is consistent with the Mental Health Law and is overseen by a national authority in MISPAS.

The Dominican government has a 10-year health plan (2006–15). Its mental health component aims to improve mental health service delivery within primary care and to reform the main public hospital, the Padre Billini Psychiatric Hospital. Progress is ongoing (Pan American Health Organization & World Health Organization, 2008).

Mental health service delivery

Mental health services are primarily located in urban areas, as are medical professionals more generally. There is one major public psychiatric hospital, Padre Billini Psychiatric Hospital, located near the capital, Santo Domingo. It provides in-patient and out-patient services to patients aged 16–65 years and plays a very important role in the delivery of mental healthcare in the Dominican Republic. Approximately 50% of national public mental health funding goes to the Padre Billini Hospital. The in-patient service has approximately 130 beds, 60 of which are occupied by patients who have no options for discharge and therefore reside permanently in the hospital (World Health Organization, 2005).

The current plan is to decentralise mental health services by closing this facility, opening new psychiatric in-patient units in medical hospitals, optimising the current in-patient units, updating the mental health community centres, and creating a supervised residence for people with chronic mental illness. This decentralisation has been ongoing since 1997 and aims to reduce the number of in-patient beds while increasing out-patient services and integrating mental health with primary care (World Health Organization, 2005).

The Ministry of Health has 256 psychiatric beds available nationally, with the capacity to serve approximately 9000 patients. Of these beds, 65% are located in the Padre Billini Psychiatric Hospital and 35% in the 47 psychiatric units distributed throughout hospitals in Santo Domingo, Santiago, San Francisco de Macoris, Barahona and other cities. Most of these units provide out-patient services.

There are a few privately funded in-patient acute and long-term treatment facilities in the major cities. Privately funded in-patient substance rehabilitation centres are also available.

There are no in-patient psychiatric units for children. Only 4% of out-patient services are focused on treating children.

Costs associated with mental healthcare are shared by the public system, some private insurance and by families. Disability benefits exist for people with mental disorders. Those outside the public system incur significant out-of-pocket expenses for in-patient services and medications at the private hospitals.

One policy used by certain public in-patient units is to admit patients with a family member. This family member serves to advocate for the patient, maintains patient comfort, and ensures a timely discharge plan. This reduces prolonged hospital stays and allows the unit to admit new, acutely ill patients.

The government-sponsored services have a limited list of essential medications, including antidepressants, anti-psychotics, mood stabilisers and anxiolytics, consistent with the World Health Organization's recommended medications. In the private sector, there is a broader range of medications, available in part due to marketing from local and international pharmaceutical companies. Electroconvulsive therapy remains a commonly used treatment, as it is considered safe and effective for mood and psychotic disorders.

Undergraduate and postgraduate psychiatric training

There has been a robust programme of psychiatry training in the Dominican Republic since 1977. The current programme lasts 4 years, with the first year exclusively for internal medicine rotations. All psychiatry residents complete undergraduate and medical school requirements. Training in psychiatry is primarily conducted at the Padre Billini Psychiatric Hospital. Residents get experience in in-patient and out-patient psychiatry. They are trained in mood disorders, psychosis, substance misuse disorders, child psychiatry, human sexuality, epidemiology and neuro-radiology. As a requirement for graduation, each resident has to complete a thesis. Residents have the opportunity to do international electives in Costa Rica, Panama, Spain or the USA. There are currently 18 psychiatry residents at the Padre Billini Hospital. Another residency programme, located in the city of Santo Domingo at the Salvador Gautier Hospital, has four psychiatry residents. Both residency programmes have an affiliation with the Universidad Autónoma de Santo Domingo (UASD).

Workforce issues and resources

There are approximately 210 psychiatrists in the Dominican Republic, but there are insufficient mental health nurses,

social workers and occupational therapists. There are no fellowship training programmes for these disciplines. There is, though, a large and increasing number of psychologists, as well as a small number of child psychiatrists and substance misuse specialists, some trained in fellowships abroad.

There are national associations for psychiatrists, specifically the Association of Psychiatrists from Dominican Residency Programs (ASPERDO), Colegio Dominicano de Neuropsicofarmacología and the Dominican Society of Psychiatry. The last was founded in 1968 and is a subsidiary of the Dominican Medical College, the World Psychiatric Association, the Latin American Psychiatric Association and the Central American Psychiatric Association.

Regionally, human mental health resources in Latin America are scarce. The estimated figures of 1.6 psychiatrists, 2.7 psychiatric nurses, 2.8 psychologists, and 1.9 social workers per 100000 are far below those of Europe or the USA (Alarcon, 2003). Their training takes place in facilities that have limited teaching staff, not enough equipment and limited monitoring by academic centres or governmental agencies. In spite of some slight growth in the absolute numbers of psychiatrists, this threatens to be lost through the emigration of trainees. The Dominican Republic is no exception to this regional situation.

Main areas of research

There is some research ongoing in the Dominican Republic under the umbrella of universities (see for example the websites of the Colegio Dominicano de Neuropsicofarmacología, www.cdn.org.do, and of the Instituto de Sexualidad Humana, www.institutodesexualidadhumana.org). A PubMed search for articles on mental health in the Dominican Republic yielded no articles. More support for research and training in research is needed. A centralised system of data collection exists with some limitations and over time will allow for more systematic data collection, which will yield important statistics about the effect of psychiatric disorders on Dominicans.

Human rights issues

The Dominican Republic has human rights training for employees working in certain in-patient psychiatric units and community residential facilities (Pan American Health Organization & World Health Organization, 2008).

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ORIGINAL PAPER

Perceived coercion and need for hospital admission among psychiatric in-patients: figures from a Pakistani tertiary care hospital

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In Pakistan, an increasing proportion of psychiatric patients present to community health services as crisis admissions, with their relatives as the main decision makers. Patients are bound to perceive this process as coercive. Farnham & James (2000) report that elements of coercion are found even in voluntary hospital admission, in the form of verbal persuasion, physical force and threats of commitment. Few patients consider hospitalisation justified and most view the process of admission negatively (Swartz *et al*, 2003; Katsakou & Priebe, 2006; Priebe *et al*, 2009).

Perceptions of coercion depend on context and are subject to cultural differences. Unfortunately, there is no study from Pakistan, a low-income country with unregulated mental health services, where sections of Mental Health Act 2001 are loosely followed at best (Gilani *et al*, 2005). Most mental health facilities define 'involuntary admission' as the situation where the family brings a patient against his or her will and a physician takes a decision after assessment without due legal procedures or recourse to appeal.

We explored perceptions of coercion and hospitalisation among patients admitted to a psychiatric unit in Karachi. The unit accepts compulsory admissions advised by courts for assessment (this is uncommon). The Mental Health Act 2001 is not used formally. We looked for associated patient characteristics.

Method

Patients admitted to the psychiatric in-patient unit (a 16-bed adult unit) of Aga Khan University Hospital were sampled. Patients 18 years or older, admitted with any psychiatric diagnosis, were enrolled. Younger patients and those with intellectual disability, cognitive impairment or acute psychotic symptoms were excluded. Patient characteristics were recorded: gender, age, marital status, language, occupation and education, clinical diagnosis, admission type (first *v.* repeat) and nature (voluntary *v.* involuntary).

Each patient was administered the MacArthur Admission Experience Survey (AES; Nicholson *et al*, 1996), which comprises 15 items in a true/false format. This scale was translated into Urdu by bilingual translators and administered to 20 patients before the study. Difficulties were resolved by consensus. The AES has good internal reliability (Gardner *et al*, 1993). It contains four subscales with yes/no responses: the Perceived Coercion Scale (PCS, 5 items), which has an equivalent consistency and test–retest reliability, the Negative Pressures Scale (NPS, 6 items), the Voice/Process Exclusion Scale (PES, 3 items) and the Affective Reactions to Hospitalisation Scale (1 item). Scoring involved summing over the whole scale (except items 9 and 15) as well as the first three subscales, as has been done in other studies (Gardner *et al*, 1993). A cut-off score of 2 on the PCS was used to split

Table 1 Sample characteristics ($n = 87$)

Variables	Frequency (%)
<i>Gender</i>	
Male	46 (53)
Female	41 (47)
<i>Age (years)</i>	
Less than 30	37 (43)
31–50	34 (39)
More than 50	16 (18)
<i>Marital status</i>	
Single	41 (47)
Married	46 (53)
<i>Education</i>	
Illiterate	9 (10)
Undergraduate	42 (48)
Graduate and above	36 (41)
<i>Occupation</i>	
Student	14 (16)
Professional	12 (14)
Retired	7 (8)
Unemployed/housewife	11 (13)
Business	27 (31)
Unskilled or skilled worker	16 (18)
<i>Ethnicity</i>	
Urdu-speaking	41 (47)
Pathan	16 (18)
Sindhi	15 (17)
Punjabi	9 (10)
Balochi	2 (2)
Other	4 (5)
<i>Diagnosis</i>	
Substance misuse	14 (16)
Mood disorders	38 (44)
Anxiety and stress-related disorders	9 (10)
Schizophrenia and other psychotic disorders	26 (30)
<i>Type of admission</i>	
First	57 (66)
Repeat	30 (34)
<i>Nature of admission</i>	
Voluntary	53 (61)
Involuntary	34 (39)

the sample into 'high coercion' and 'low coercion' groups, as in a previous study (Iversen *et al*, 2007). For the NPS and PES, scores above the mean value were considered 'high' and those below 'low'.

Written informed consent was taken. The study was approved by the hospital's ethics committee. An interviewer experienced in psychiatric interviewing was hired to administer the questionnaire within first 24 hours of admission.

Data were analysed using the Statistical Package of Social Sciences (version 16.0). Frequency distributions were determined and data dispersion for each subscale of the AES examined. Chi-square tests of association and regression analysis looked for differences between those scoring high and low on the PCS.

Results

In total, 101 patients were approached; 14 patients declined to participate, giving an 86% response rate. Table 1 details the sample characteristics.

On the PCS, the mean (s.d.) score was 3.06 (2.09). Overall, 70% of the sample had a 'high' PCS score (2 or

Table 2 Comparison of characteristics of patients with low and high coercion scores

Variables	Frequency (%)		P-value
	Low score	High score	
<i>Gender</i>			
Male	18 (39.1)	28 (60.9)	0.807
Female	15 (36.6)	26 (63.4)	
<i>Age (years)</i>			
Less than 30	20 (54.1)	17 (45.9)	0.012*
31–50	11 (32.4)	23 (67.6)	
More than 50	2 (12.5)	14 (87.5)	
<i>Marital status</i>			
Single	22 (53.7)	19 (46.3)	0.004*
Married	11 (23.9)	35 (76.1)	
<i>Education</i>			
Illiterate	3 (33.3)	6 (66.7)	0.953
Undergraduate	16 (38.1)	26 (61.9)	
Graduate and above	14 (38.9)	22 (61.1)	
<i>Diagnosis</i>			
Substance misuse	1 (7.1)	13 (92.9)	0.008*
Mood disorders	12 (31.6)	26 (68.4)	
Anxiety and stress-related disorders	5 (55.6)	4 (44.4)	
Schizophrenia and other psychotic disorders	15 (57.7)	11 (42.3)	
<i>Type of admission</i>			
First	20 (35.1)	37 (64.9)	0.451
Repeat	13 (43.3)	17 (56.7)	
<i>Nature of admission</i>			
Voluntary	6 (11.3)	47 (88.7)	<0.001*
Involuntary	27 (79.4)	7 (20.6)	

*P value significant.

Low coercion score = 0 or 1 on the PCS; high coercion scores = 2 or more on PCS (Perceived Coercion Scale of the MacArthur Admission Experience Survey).

more); strikingly, only 21% involuntary patients scored 'high' on this subscale, compared with 89% of voluntary admissions. All patients with a diagnosis of substance misuse or mood disorder who were voluntarily admitted perceived high coercion.

Table 2 shows the differences between the high and low PCS groups. Participants older than 30 years were twice as likely to report high PCS scores. Similarly, having a diagnosis of substance misuse or mood disorder increased the likelihood seven-fold ($P = 0.014$) and four-fold ($P = 0.04$), respectively, while a diagnosis of psychotic disorder reduced the likelihood by six times ($P = 0.013$). Voluntary admission predicted a high PCS score even after controlling for demographic and clinical characteristics ($P < 0.001$).

The mean (s.d.) score on the NPS was 2.07 (1.03); 41% of involuntary and 21% of voluntary admissions scored 'high'. The mean (s.d.) score on the PES was 1.75 (0.53); 44% of involuntary and 41% of voluntary patients scored 'high'. Both differences were statistically significant.

The affective reactions to hospitalisation reported were as follows: one-third were angry and frightened, whereas 63% were sad; another 46% were confused; only 30% were pleased with the process of hospitalisation; a further 52% felt relieved. These reactions were not significantly different between voluntary and involuntary admissions but, overall, those with high PCS scores were more likely to be angry and relieved than those with a low score.

Discussion

Our sample was from a private tertiary care hospital in Karachi, one of the major cities of Pakistan. The demographic characteristics of the participants were similar to the patient profile of all attenders at the hospital. The majority were experiencing hospitalisation for the first time. Nearly half had a diagnosis of mood disorder; psychotic disorders were the next most common category.

A high proportion reported feeling coerced in the hospitalisation process. A qualitative study from Switzerland (Bonsack & Borgeat, 2005) and another that used the AES on a Norwegian sample (Iversen *et al*, 2007) have reported similar findings. Surprisingly, a greater proportion of voluntary admissions compared with involuntary ones perceived coercion. This was a counter-intuitive finding which could be the result of a small sample size or either sample being atypical, as it was not specific to any diagnosis. It needs to be replicated. Negative pressures were, though, felt more in involuntary admissions and in nearly half of voluntary and involuntary admission patients felt they were excluded from the hospitalisation process. These findings support previous observations (Fu *et al*, 2008), although the present figure is much higher. Most of the voluntary admissions were patients with mood disorder; stigma related to hospitalisation as well as illness perception could have contributed to feelings of coercion. A diagnosis of substance misuse was also associated with higher coercion. Disapproval of any form of substance misuse in the local culture often results in families bringing patients in a pre-contemplative stage. External pressures, especially marital (from spouse or in-laws) and parental, are common. Moreover, many of these patients could have an underlying personality disorder, which might have contributed to this perception.

Having a psychotic illness was not associated with high coercion scores, though this has been reported by others (Hiday *et al*, 1997; Fu *et al*, 2008), but there was a small number of such patients in the present sample.

Being married was associated with higher coercion, similar to previous studies (Bonsack & Borgeat, 2005; Katsakou & Priebe, 2006). Marital pressures in the local culture may have caused this. Participants older than 30 years felt a higher degree of coercion; this may reflect diagnosis, however, since patients with substance misuse or mood disorder usually present at that age. There was no association of gender, education or type of admission (first v. repeat) with feelings of coercion. Hiday *et al* (1997) found an association with female gender and education in 331 individuals; our negative finding could have resulted from our much smaller sample size.

Those with higher coercion scores were also more likely to be both angry and relieved. This suggests that the perception of coercion is independent of the need for hospitalisation. Our study confirms an observation by Bonsack & Borgeat (2005) that this distinction does not depend on duration of hospital stay; our patients showed it within 24 hours of admission.

Limitations of the study include the fact that the sample was not representative of patients across Pakistan, and so, for example, no general comment can be made on the need for mental health legislation. Also, a comparison of participants with those who declined could not be made; this may have introduced selection bias. The MacArthur questionnaire was not validated against the English version or other objective measures of coercion. The yes/no response style of the question is restrictive. Lastly, the source of coercion was not explored.

Conclusions and recommendations

A significant proportion of patients admitted on even a voluntary basis perceived a high degree of coercion in the process of hospitalisation. Patients with a diagnosis of substance misuse or mood disorder perceived significantly more coercion. There is need for larger surveys as well as improved planning and communication between patient, family and hospital staff during hospitalisation. Mental health legislation needs to be revisited with these conclusions in mind and mental health practices across the country need to be standardised.

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A working visit to Chad's refugee camps for the people of Western Darfur

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In 2004 at least 200 000 people from Darfur in Western Sudan are thought to have died in a wave of what has been alleged to have been ethnic cleansing (Flint & De Waal, 2008). And in April 2008 it was reported that a total of over 300 000 people might have died in the (then) 5-year Darfur conflict. During the period of the alleged genocide, nearly a quarter of a million refugees (Central Intelligence Agency, 2009) crossed the nearby border into Chad, where they remain in a dozen or so camps looked after by the United Nations and international aid organisations. These camps are strung along the frontier, in remote semi-desert locations that are sustainable only with United Nations support. Many of the camps no longer take new refugees, and are in effect transplanted communities from nearby Darfur, their social and leadership structures mirroring those of the communities that were torn apart by war. Even place names have been transplanted, to suggest a kind of normality.

The health system in the camps

The case example of Abdaman is presented in Box 1 to illustrate the nature of the health system in the camps. Each camp is home to around 16 000 refugees and has about 40 community health workers, who are locally trained refugees familiar with the dialects and customs of the camp population. Every health worker has a community patch and also spends time in the central health centre. This centre, usually operating from a group of simple tents or buildings at the edge of the camp, provides basic medical, maternity, and in some cases psychosocial care, together with immunisation and child nutrition clinics.

In those camps with a psychosocial programme (at present about half of them), two community health workers are selected and given training in the detection and management of people who have serious mental health problems. It was one of these more specialised health workers who engaged with Abdaman's family after being alerted by the local community health worker.

The psychiatric team for a camp consists of two psychosocial community health workers, supervised by a Chadian

Box 1 Abdaman's story

Abdaman was recruited into a local rebel army as a teenager, and had witnessed bad things. At 19 he returned to the family compound in Sudan's Western Darfur apparently traumatised. His mother took him to traditional healers, but his night terrors, paranoid ideas and disturbed behaviour persisted. In early 2005 his family crossed the nearby border into Chad, escaping the organised slaughter of their people by the Janjaweed militia. Abdaman's father and two brothers were never seen again.

In Chad, the family was taken to one of the international refugee camps, in a zone with other families from their part of Darfur. Their new community included a familiar local leader, as well as fellow farmers and traders who had survived the violence. Further expensive visits to traditional healers failed to help Abdaman, who for much of the time was in chains. His mother had taken the decision to confine him to the small mud compound that was now the family home to stop him disappearing into the desert. In mid-2009, one of the refugee community health workers covering the zone in which the family lived got to hear about Abdaman, and spoke to the community leader. A visit from a more specialised psychosocial community health worker (also a refugee) was arranged. He thought that Abdaman was suffering from a post-traumatic state and sought the advice of his supervisor, a Chadian-trained psychiatric nurse. A joint home visit by the nurse and a visiting psychiatrist confirmed a diagnosis of paranoid schizophrenia, perhaps triggered by exposure to trauma. Depot medication was started, and after a month the mother felt able to unlock her son's chains. It is hoped that Abdaman will benefit from attending an activity programme for vulnerable young men.

psychiatric nurse and, when available, a visiting psychiatrist. Psychiatrists are hard to recruit, so, as in most sub-Saharan countries, nurses routinely assess and provide the care, supported where needed by general medical officers. As well as running twice-weekly clinics and doing home visits, the team also runs groups for mothers and for children, and plans further groups for vulnerable young men and for carers.

Whom does the psychiatric team see?

The clinical activity figures for one of the typical camps during the most recent year are summarised in Table 1. As can be seen, despite being a clinic for refugees, a large number of local Chadian villagers were assessed, among them a high proportion of people with epilepsy. These were mainly children, often brought on long journeys by their parents.

In late 2009 Dr Nick Rose worked as a consultant for the International Medical Corps (IMC) in Eastern Chad. Since February 2010 he has been working for IMC based in Port-au-Prince, Haiti. The views expressed are those of the author, and do not necessarily represent those of IMC. Dr Lynne Jones of IMC instigated the original mental health programme in Chad.

Table 1 Numbers of new cases presenting at a typical refugee camp, January 2008 to January 2009

Diagnosis	Refugees in the camp (n = 60)	Chadian villagers (n = 103)
Dementia	0	3
Epilepsy	13	55
Intellectual disability	1	1
Bipolar disorder	9	8
Schizophrenia	3	10
Substance misuse	0	4
Depression	8	12
Somatoform disorder	7	4
Post-traumatic stress disorder	8	1
Anxiety	11	5

Camp population approximately 16000. Village population hard to estimate but probably in excess of 20000.

Table 2 All cases seen in September 2009, Guereda camp

Diagnosis	New cases (n = 21)	Follow-up cases (n = 335)
Dementia	0	8
Epilepsy	10	197
Attention-deficit hyperactivity disorder	0	8
Bipolar disorder	5	4
Schizophrenia	5	60
Substance misuse	0	0
Depression	0	56
Somatoform disorder	1	0
Post-traumatic stress disorder	0	2
Anxiety	0	0

Camp population approximately 16000.

The relatively high numbers may in part reflect poor obstetric care in the more remote communities, where there also seemed to be high levels of maternal and infant mortality, probably caused by poor nutrition and lack of antenatal care. The higher levels of post-traumatic stress disorder among the refugee population reflect the violent circumstances that resulted in the exodus from Darfur. In addition, 30 cases of sexual and gender-based violence were seen during the year, almost all involving female refugees.

Table 2 lists all cases seen in a typical 'snapshot' month at another camp, where over 90% of follow-up consultations were for patients who had epilepsy, schizophrenia or depression.

What were the dilemmas faced in Chad?

Abdaman's case posed some tricky dilemmas for aid workers. Perhaps the most challenging was whether it was right to keep him in chains. But with virtually no resources or legal framework to draw on, was there a sufficiently safe alternative? In this case the family took responsibility for the care of their son, and worked with the team to make sure that medication was taken regularly, and that he was humanely looked after. They also cooperated with regular reviews of

his progress, with the aim of minimising the time he spent in chains – a pragmatic approach that, given Abdaman's lack of capacity, traded his right to liberty with his need to be kept safe and receive medical help.

In these resource-poor circumstances, medical aid organisations have to work in ways that are consistent with universal human rights yet do not undermine local resourcefulness. This is particularly important since aid organisations are usually unable to provide safe alternatives to family care. So in practice, it is important to identify people with mental illness cared for in chains as early as possible, and then to have an agreed approach for working with the families and community members concerned. The focus is on urgent treatment provision, regular monitoring, making sure that the patient's living circumstances are as minimally restrictive as possible, and checking that abuse is not occurring. Public education and the sensitisation of local leaders are also important.

A further dilemma arises from the fact that impoverished as the refugees like Abdaman are, local Chadian villagers are often worse off. This is borne out by the particularly high levels of maternal mortality and childhood malnutrition among villagers. The dilemma for the medical aid organisation, of course, is whether to treat refugees only, for whose care funding was raised, or to treat everyone, including the region's non-refugee population. Ethically, the only answer is to treat everyone equitably. And so villagers travel for up to 2 days across the desert to receive treatment. In one particular camp clinic, for example, 63% of attendees over a 1-year period were villagers (see Table 1).

What seemed to work well?

Employing and training refugees as health workers seemed to benefit everyone. Patients had helpers who spoke their dialect, understood their beliefs and customs, and lived nearby. The employed refugees had a job and a greater sense of empowerment. And the aid organisation could maximise the effect of the relatively small number of skilled outside staff it employed. This is particularly important in a country with few mental health staff (see below). Another effective way of reaching people in need of services was to train community and religious leaders, teachers and general health workers in mental health awareness, a strategy now well established in post-trauma situations (Danvers *et al*, 2006; Makhdam & Javed, 2006).

In terms of developing the skills of mental health workers, what seemed to work best was to train people in their workplace as much as possible, usually by giving them feedback on directly observed clinical, liaison and public health work. This is expensive in terms of the skilled workforce, but was achieved across a span of five large refugee camps by one psychiatrist providing on-the-job training in each camp at least once every 2 weeks, with access to telephone advice at any time. The long-term plan is to replace the international psychiatrist with a local one, but this is unlikely to happen in the foreseeable future because of the shortage of Chadian psychiatrists, combined with the challenges of working in remote, resource-poor settings. So for the moment, the psychiatrist is provided on a long-term basis by an international medical aid organisation.

Can this model be scaled up?

The model described above depends on one supervising psychiatrist covering up to six refugee camps together with the surrounding villages, equivalent to a general population of about 100 000. Each camp has clinics and basic therapeutic activities run by a specialist community mental health nurse supported by trained volunteers and other health workers. But the important question in relation to sustainability is whether, without international input, such a model can be replicated across all refugee camps in Chad, or be scaled up to run nationally. Sadly, the answer is probably not, mainly because of the lack of available local psychiatrists, although specialist mental health nurses are also in short supply. The *Mental Health Atlas* published by the World Health Organization (2005) describes Chad as having no mental health policy, and 0.01 psychiatrists per 100 000 people. The country has a population of 10.3 million. A more recent estimate of psychiatrists in a number of other African counties (Jenkins *et al*, 2010) estimates an average of 0.33 per 100 000 people, but does not include Chad. It is hard to know how accurate these figures are, but they confirm my impression that, compared with many other African countries, Chad is particularly short of trained mental health staff. So, without the prospect of local recruitment, the existing programme is dependent on international aid for psychiatrist input and, given the demands on donors elsewhere, this is unlikely to be scaled up in the future, and may indeed be phased out at some point.

In the long term, therefore, true sustainability of the existing programme, and further development of services across the country, could be achieved only through big institutional infrastructure projects such as supporting the Chadian government to design a funded mental health policy and strategy, and by developing national training programmes for mental health professionals.

Lasting memories

Imprinted most lastingly on my memory is the dignity with which those who have lost everything conduct themselves. This was apparent in the way families presented at clinic, squeezed on to rough benches, patiently and gracefully waiting their turn, often dressed in colours and tribal designs that echoed their rich heritage as descendants of a powerful 19th-century North African kingdom. And patients almost always attended with their family. So the strategy of keeping families and local communities together after the chaotic mass exodus from Darfur appears to have worked, thereby protecting the all-important social capital and natural resilience associated with relationships that is so crucial for mental well-being in the aftermath of trauma (Pfefferbaum, 2008).

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SPECIAL PAPER

Getting your paper published

Patricia Casey

Editor, *The Psychiatrist*, and Professor of Psychiatry, Mater Misericordiae University Hospital, Dublin, Ireland, email apsych@mater.ie

Embarking on a research project is always exciting, although a large number are not completed. One study of pharmacotherapy projects submitted to a research ethics committee found that after 5 years more than a quarter had not been completed and almost a sixth were considered unpublishable (Winther & Hole, 1997).

Achieving publication is the aim of most doctors. The primary motivation for this varies from a wish to enhance job prospects to boosting one's ego and a desire to see one's name in print. The most noble, of course, is a desire

to spread knowledge and contribute to the science of our specialty.

The proportion of submitted papers that ultimately succeed in achieving publication varies greatly; journals with a high impact factor have the lowest yield. For *The Psychiatrist*, the proportion of submitted papers that are published is around 50%, well above the 16.6% identified in one study of eight high-impact English-language journals (although only five replied to the study questionnaire) (Singh, 2006), a figure that fell to only 4.4% when papers from low- and

middle-income countries were examined. This finding of underrepresentation of published output from those outside Europe, Australia and North America has been replicated by others (Patel & Sumathipala, 2001).

What is a quality paper?

There is an assumption that once a research project has been completed, it will be worthy of publication in a scientific journal. This is misguided; it is often forgotten that nobody has a 'right' to have their work published. Quality always supersedes ego. Quality refers to the methodology and relevance of the research project itself and also to the way in which a paper is written and presented. The latter is within the control of the writer, since the style of writing and the focus of the paper come from the researcher. It is also an attribute that can be developed as the preparation of the paper progresses. On the other hand, for beginners, the quality of the research project itself is more dependent on the advice and supervision of senior colleagues. These are factors that are often outside the control of the investigator, since they depend on having access to supervisors who understand research methods and who are willing to give their time to trainees.

Choosing the project

Selecting an area to study and developing a research proposal around this is arguably the most vital aspect of the work to achieve publication. If the methods are not sound or if the study design will not answer the question you want to ask, then publication will be next to impossible.

The primary rule is that if you decide to carry out an original piece of research, you must be properly supervised from the beginning. Where there are difficulties obtaining guidance and supervision locally, the assistance of the nearest academic department will be necessary.

You must prepare a written proposal detailing the background to the study, the aim or hypothesis and the methods. This will keep you focused on the specific question you are asking. You need to obtain ethical approval, since most journals require a statement that this approval has been granted before they will consider your paper for review.

The type of study or paper you want to write

There are papers and studies about which novice researchers are enthusiastic but which hold little appeal for many journal editors. These include:

- case reports
- incomplete audit cycles
- retrospective case-note studies
- descriptive papers without any statistical analysis (e.g. describing the development of services or case series)
- reports of studies with small sample sizes
- narrative reviews
- reports of qualitative studies
- reports of pilot studies.

Nonetheless, some journals will accept these papers, especially journals that are new to the market. Others will accept them under certain exceptional circumstances. And there are some established journals dedicated to these topics, such as the *Journal of Medical Case Reports*.

Studies that are described as 'qualitative' often do not adhere to the methods required of such investigations and are nothing more than descriptions of conversations with a small sample of people whose comments are extracted and presented in an unstructured style. Before carrying out a qualitative study, you should check with an expert in the field to ensure appropriate methods are used and that this approach is appropriate to your investigation.

Choosing the journal

In your quest for publication it is worth spending some time identifying a suitable journal where your paper may find a home. Journal databases in libraries are a useful source of this information, as are medical librarians. Ultimately, you may have to search the PubMed journal database yourself or even use search engines such as Google. Reading the reference lists at the end of scientific papers in your field is also a useful way of finding new and obscure journals.

In selecting a journal there should be a match between it and your paper, both in the subject matter and in the quality. For example, a paper on eating disorders has a better chance of publication in a journal dealing with that topic than in a general journal. On the other hand, if the methodological quality of your study is questionable, there is little point in seeking publication in a high-impact international journal. Reading papers from your chosen journal will assist in deciding if your paper stands a chance of being considered by the particular journal.

A further consideration is whether there are any other restrictions on what is accepted by the journal. For instance, some do not accept case reports, whereas others do not accept narrative reviews and some journals accept mainly, or only, commissioned reviews.

Writing your paper

Careful attention should be paid to the house style of the journal, such as the style of referencing, the number of tables and figures allowed and the length required.

The title should be short and to the point. If possible, avoid mentioning a local town or city in the title, since this immediately restricts the likely interest and gives the impression of parochialism. The abstract should contain only basic data and should be an accurate summary of the content of your paper.

The length of the section dealing with the background to the study varies from journal to journal and you should check this by reading other recent papers in your chosen publication. This section should conclude with the aims or hypotheses being tested.

When presenting the results, avoid duplicating what is in the tables with detailed descriptions of these in the text also. Simply point out the key findings of the tables in the text. Many editors now prefer confidence intervals to *P* values and

it is important to ascertain, in consultation with your statistician, that the correct statistics have been used.

The discussion should not repeat the results. Instead, the focus should be on dealing with the implications of your findings as well as on possible explanations of the discrepancies between the results of your study and those of others. Always mention the limitations of your study.

Comprehensibility

The ease with which the paper can be understood is highly important. Even with powerful data, if it is difficult to read or to understand the report, then reviewers are likely to be critical. Faced with a turgid and dense style a reviewer may simply reject a paper or recommend a complete rewrite. To assess the comprehensibility of your paper it is advisable to ask colleagues to read it and to feed back to you honestly. If the language of your chosen journal is not your mother tongue, the opinion of a person fluent in the spoken and grammatical aspects of that language should be sought.

One reason for difficulties understanding papers is that too much information is presented. Simply because a statistical test has been carried out does not mean that it needs to be included in the paper. Use only the data that are relevant to testing your specific hypothesis.

Relevance

There is an understandable tendency among novice researchers to carry out studies in single services, owing to the convenience of the sample. This may limit the generalisability of the findings. On the other hand, it may be of immense local interest, so consideration should be then given to publishing it in a local journal rather than an international one.

Scientific merits

The most important aspect with regard to achieving publication is the quality of the study itself. Ask yourself whether

the sample size was large enough, and whether a specific hypothesis was identified and tested. Were the correct statistics applied and were the interpretations of these accurate? Some papers may be descriptive only and not use any statistics, but these are less favoured by most journals.

If you write a narrative review it must be of exceptionally high quality to achieve publication. It must contain information that is not accessible in major textbooks and must show a depth of knowledge that only an expert can have. Few journals, except those that commission them, now accept narrative reviews, opting instead for systematic reviews.

Conclusion

Getting published in a peer-reviewed journal is difficult and requires a significant amount of time and effort, labour that begins the day you conceive of your study. Publication is not inevitable but it is immensely rewarding when it comes to fruition. It also carries with it the possibility that you will be invited to review papers written by that journal. The key to success lies in planning your project carefully at the outset and relentlessly focusing on the quality of your work at each stage of this long process. From the day you decide to begin your study until you receive the letter confirming the acceptance of your paper you may be 4 years older but the wait will have been worth it.

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I made an agreement of peaceful coexistence with time:
Neither he pursues me, nor I run from him, one day we will
find each other.

Mario Lago

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*

International Psychiatry Editorial Board

The Editorial Board of *International Psychiatry* seeks to expand its membership with the view to enhancing its pool of expertise and managing a wider variety of submission topics. Any informal expressions of interest should be sent to ip@rcpsych.ac.uk. Formal vacancies on the Editorial Board will be advertised in the College e-Newsletter.

RCPsych Awards 2010

The winners of the second annual RCPsych Awards were announced on 16 November 2010 at a ceremony at the Royal Society of Medicine, hosted by journalist and broadcaster Libby Purves. The awards mark the highest level of achievement within psychiatry, and are designed to recognise and reward excellent practice in the field of mental health.

The winners of the RCPsych Awards 2010 were:

- Lifetime Achievement Award – Professor Sir Michael Rutter
- Psychiatrist of the Year – Dr Michele Hampson
- Psychiatric Academic of the Year – Professor John Geddes
- Core Psychiatric Trainee of the Year – Dr Amanda Deren-Jones
- Advanced Psychiatric Trainee of the Year – Dr Sharon Smith
- Public Educator of the Year – Dr Max Pemberton
- Specialist Child and Adolescent Mental Health Services Provider of the Year – Flintshire Early Intervention & Prevention Team and Flintshire Child & Adolescent Team
- Mental Health Services Provider of the Year – South Staffordshire & Shropshire Healthcare NHS Foundation Trust
- Psychiatric Team of the Year – Intensive Home Treatment Team, NHS Lothian
- Medical Manager/Leader of the Year – Dr John Simpson.

Professor Dinesh Bhugra, President of the Royal College of Psychiatrists, said:

Through the RCPsych Awards, we bring national recognition to those individuals and services who are delivering the highest-quality care for service users and carers, and who are advancing our understanding of mental illness through research and public education. Once again we were overwhelmed by the quality of entries, and our judging panels had an extremely tough job. On behalf of the College, I offer my heartfelt congratulations to the overall winners as well as the outstanding individuals and brilliant teams who were short-listed for each category.

Professor Bhugra paid a special tribute to Professor Sir Michael Rutter, who was presented with the 2010 RCPsych Lifetime Achievement Award. Professor Bhugra said:

Sir Michael has quite simply been one of the most influential psychiatric scientists of his generation. After qualifying in medicine, he embarked on a programme of research and

clinical development that transformed child and adolescent psychiatry and, in 1973, became the country's first ever professor of child and adolescent psychiatry. Sir Michael is a richly deserving winner of the RCPsych Lifetime Achievement Award 2010.

Nominations for the RCPsych Awards 2011 opened in January. For further details please visit the College website, <http://www.rcpsych.ac.uk/events/rcpsychawards2011.aspx>

Congratulations to Sheila Hollins

The House of Lords Appointments Commission announced on 5 October that Professor Sheila Hollins was recommended to be a new non-party-political peer to sit on the cross-benches at the House of Lords. Non-party-political peerages are granted to people of distinction to bring authority and expertise to the House of Lords. The Commission recommends individuals on merit and their ability to contribute effectively to the work of the House. Sheila Hollins is Professor in Psychiatry of Disability at St George's, University of London. Her research has focused on clinical and social aspects of the mental and physical health of people with intellectual disabilities. Since 2008 she has served as the Chair of the World Health Organization's Steering Group to develop a declaration and action plan on the health of children and young people with intellectual disabilities. She has served on a number of national advisory boards, including as a member of the Independent Inquiry into Access to Healthcare for People with Learning Disabilities (2007–08). Professor Hollins was the President of the Royal College of Psychiatrists 2005–08.

Enhancements to the College website

The contents of the 'College' area of the website have been redistributed. This is part of a wider project to improve overall site navigation and build on the College's reputation for online mental health information. The following areas can now be found in the 'Members' area:

- Public members list
- Divisions
- Special interest groups (SIGs)
- Sections
- Join a SIG or Section
- Library and information services
- College archives
- Media advice

The following College information pages have been moved to the 'About us' section:

- What we do
- Contact us
- Vacancies

- Directions to Belgrave Square
- College Officers
- Council structure
- College structure
- Equality and diversity
- Legacies and donations
- Interesting RCPsych facts

A new tab called 'Specialties' (<http://www.rcpsych.ac.uk/specialties/faculties.aspx>) has been created for Faculties.

New WHO report on mental health and development

A new report from the World Health Organization (WHO), *Mental Health and Development: Targeting People with Mental Health Conditions as a Vulnerable Group* (available from http://www.who.int/mental_health/policy/mhtargeting/en/index.html), calls on all development stakeholders – governments, civil society, multilateral agencies, bilateral agencies, global partnerships, private foundations, academic and research institutions – to focus their attention on mental health. The report presents compelling evidence that persons with mental and psychosocial disabilities are a vulnerable group but continue to be marginalised in terms of development aid and government attention. It makes the case for reaching out to this group through the design and implementation of appropriate policies and programmes and through the inclusion of mental health interventions within broader poverty-reduction and development strategies. The report also describes a number of key interventions which can provide a starting point for these efforts. By investing in persons with mental and psychosocial disabilities, development outcomes can be improved.

Obituary: Haroon Rashid Chaudhry

It is with great sadness that we inform you of the recent death of Professor Haroon Rashid Chaudhry, Head of the Department of Psychiatry at Fatima Jinnah Medical College, Honorary Executive Director of Fountain House, President of the Pakistan Psychiatric Society, Fellow of the Royal College of Psychiatrists and a member of the International Advisory Board of *International Psychiatry*. Professor Chaudhry died in Lahore on 5 October 2010, aged 55. A pioneer in bringing psychiatry to general hospitals in Pakistan in the 1960s and an early supporter of rehabilitation programmes in the community, he will be remembered for his contribution to psychiatry and mental health in Pakistan and wider Asia. Deepest condolences go to his family and friends.

Child and adolescent psychiatry training course in Ibadan

A 1-week intensive course in child and adolescent psychiatry was held in Ibadan, Nigeria, from 11 to 16 October 2010. The course was a collaboration between the West African College of Physicians and the Royal College of Psychiatrists under the memorandum of understanding signed between the two organisations in 2007. The course brought together expertise from both West Africa and the UK and it is hoped will have a significant impact on the child and adolescent mental health services, which are under-resourced in West Africa. It is hoped that this innovative way of delivering joint educational activities will be replicated to provide opportunities for further collaboration between the two organisations.

CORRESPONDENCE

Correspondence should be sent to:
Amit Malik MRCPsych, Consultant Psychiatrist, Hampshire Partnership NHS Trust, UK, email ip@rcpsych.ac.uk

Loss of the psychiatrist's professional identity

Sir: We read Professor Ikkos's editorial in the October 2010 issue with keen interest. The loss of the psychiatrist's professional identity among patients and colleagues is set to worsen the recruitment crisis facing psychiatry internationally.

The World Psychiatric Association (WPA) has made improving the image of psychiatry and enhancing the quality of psychiatric education its top priorities (Maj, 2008) and, in relation to this, awarded us, at the Royal College of Psychiatrists, a competitive grant to study the aetiology and factors associated with the global recruitment crisis facing psychiatry.

A systematic review of the literature has been undertaken to evaluate pre-medical, undergraduate and postgraduate (including societal) factors that affect doctors' career choices in relation to psychiatry. Informed by this review and other expert discussions, an evaluation is now under way in over 20 countries across the world. The study is using a quantitative cross-sectional design, with triangulation of data from questionnaires administered to final-year medical students, together with institutional and national data on selection policy, working conditions, demographics, and recruitment rates. A secondary analysis is of the influence of country, medical school and individual factors upon choosing psychiatry as a career. A full report will be presented to the WPA by July 2011 and the findings will be presented at the World Congress of Psychiatry in Buenos Aires in September 2011.

We believe that lessons learnt will help national and international psychiatric societies and institutions to develop locally relevant action plans to improve both the image of and recruitment into psychiatry. Any such strategies, however, will have to be an integral part of a wider plan to meet the greater challenges facing psychiatry, as outlined in the editorial (Ikkos, 2010).

Amit Malik,¹ Kitty Seed² and Gregory Lydall³

¹Clinical Service Director, Hampshire Partnership NHS Foundation Trust, Hampshire; ²Specialist Registrar, South London and Maudsley NHS Foundation Trust, London; ³Consultant Psychiatrist, Castel Hospital, Guernsey

Ikkos, G. (2010) Futures of psychiatrists 2020: external and internal challenges. *International Psychiatry*, 7, 79–81.

Maj, M. (2008) *The WPA Action Plan 2008–2011*. WPA. Available at <http://www.wpanet.org> (accessed January 2010).

The psychiatrist of the new millennium: training needs, clinical skills, professional risks

Sir: On 13–16 October 2010, Italian early-career psychiatrists met at their first national conference, held in Riccione, to address training, and clinical and professional issues relevant to psychiatrists of the new millennium.

Recent social changes and reforms to mental health legislation have occurred in most European countries, together with continuous technological advances and the development of research in all the domains of psychiatry; these have modified the role of mental health professionals, with consequent changes to the training needs of early-career psychiatrists.

The clinical knowledge and skills expected of young psychiatrists today differ from those expected in the past. For instance, in relation to diagnosis, young psychiatrists tend to emphasise the use of diagnostic tools and statistical manuals, at the expense of thorough clinical and psychopathological assessments. Moreover, the first-generation psychotropic drugs, such as lithium, haloperidol and tricyclic antidepressants, whose efficacy is now well documented, have largely been replaced by drugs which are easier to use and safer, but whose efficacy is not as well established.

Furthermore, today's psychiatrists are increasingly challenged to search for a balance between the typical acts of clinical daily work and professional responsibility. In fact, the increasing awareness of patients and their families of the therapeutic options and possibility to recover from mental illnesses has led to several legal controversies with physicians.

During the conference, organised by the Italian Young Psychiatrists' Association, 12 plenary lectures, given by international and national experts, were held to open up the discussion of these issues. Professor Sartorius delivered a lecture on the possible future scenarios of psychiatry, and Professor Munk-Jørgensen on the academic responsibility of being a psychiatrist today. The roles of psychopathology, social psychiatry and biological psychiatry in the training and practice of young psychiatrists were addressed by Professors Sass, Priebe and Moeller, respectively. Professor Burns' lecture highlighted the importance of research findings for psychiatric practice.

The conference was attended by almost 800 European and Italian trainees and young psychiatrists (aged below 40 or less than 5 years from completion of postgraduate training), who had the chance to improve their psychiatric education, to exchange and discuss their experiences with leaders, and to present the results of their own research and clinical activities.

The scientific programme was conceived as an ideal path, which moved from the 12 plenary lectures of opinion leaders to the everyday practice of young psychiatrists discussed in the 30 symposia, 20 forums and 10 courses for continuing medical education (CME). Moreover, three workshops were organised, on how to carry out research (Professors Barbui and Cipriani), how to write scientific papers (Professor Munk-Jørgensen) and how to approach treatment-resistant depression (Dr Joubert). Finally, a symposium on opportunities to work and practise in Europe, with the participation of young colleagues from the UK (A. Malik and J. Beezhold), Germany (I. Calliess) and Croatia (N. Jovanovic), was highly appreciated by Italian young psychiatrists.

The positive feedback received from this event suggests the importance of such meetings, which could be very useful for all European early-career psychiatrists if implemented at national and international levels.

Andrea Fiorillo, Domenico Giacco and Mario Luciano

Department of Psychiatry, University of Naples SUN

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

Amit Malik MRCPsych, Consultant Psychiatrist, Hampshire Partnership NHS Trust, UK, email ip@rcpsych.ac.uk

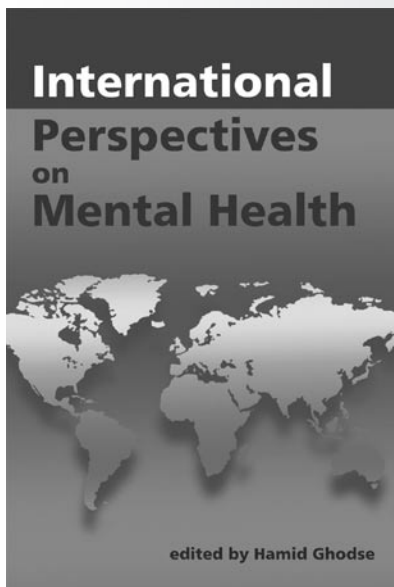
Readers are invited to send in quotations for use within the pages of *International Psychiatry*. Please email suggestions to ip@rcpsych.ac.uk

COMING SOON FROM RCPSYCH PUBLICATIONS

International Perspectives on Mental Health

Edited by Hamid Ghodse

International Perspectives on Mental Health is a unique collection of authoritative briefings from over 85 countries around the world. Each chapter covers demographics, mental health resources, undergraduate education, postgraduate training in psychiatry, research activities, mental health legislation, policy and development strategies within the chosen country.



Each chapter is written by experienced senior practitioners who have intimate knowledge of all aspects of psychiatry, including workforce, policy and delivery models. They offer a wealth of information as well as critical examination and evaluation of service development. The chapters were originally commissioned, reviewed and edited prior to publication in *International Psychiatry*.

There is a growing recognition of the cultural aspects of psychiatric practice in different regions, and in today's globalised society many health professionals have interests that cross geographical boundaries. This is the first book of its kind that will meet the needs of this diverse group of readers.

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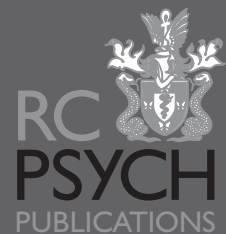
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Forthcoming international events

16–19 March 2011

4th World Congress on Women's Mental Health – Biological, Psychological and Socio-cultural Aspects of Women's Mental Health
Madrid, Spain

Organiser: International Association for Women's Mental Health (IAWMH)
Contact: Debra Tucker
Email: debra@iawmh.org
Website: www.iawmh.org

17–19 March 2011

ESDaP 2011 – 14th European Society for Dermatology & Psychiatry Congress
Zaragoza, Spain

Organiser: European Society for Dermatology & Psychiatry Congress
Email: info@bocectium.com
Website: <http://www.bocectium.com>

20–22 March 2011

1st Global Conference Spirituality in the 21st Century: At the Interface of Theory, Practice and Pedagogy
Prague, Czech Republic

Contact: Dr Rob Fisher
Email: s21@inter-disciplinary.net
Website: <http://www.inter-disciplinary.net/critical-issues/ethos/spirituality-in-the-21st-century/call-for-papers/>

21–25 March 2011

16th World Congress of the World Association for Dynamic Psychiatry and XXIX International Symposium of the German Academy of Psychoanalysis
Munich, Germany

Organiser: World Association for Dynamic Psychiatry
Email: wadp@psychoanalysebayern.de
Website: <http://www.wadp-congress.de/con-2009-frame.html>

29 March–2 April 2011

International Society of Psychiatric–Mental Health Nurses 13th Annual Conference
Tucson, Arizona, USA

Organiser: International Society of Psychiatric–Mental Health Nurses
Contact: Carla J Groh
Email: info@ispn-psych.org
Website: <http://www.ispn-psych.org>

7–8 April 2011

XVIII International Symposium on Current Issues and Controversies in Psychiatry
Barcelona, Spain

Email: controversias@geyseco.es
Website: <http://www.geyseco.es/controversias/index.php?go=inicio>

18–20 April 2011

International Society of Critical Health Psychology (ISCHP) 7th Biennial Conference
Adelaide, Australia

Email: ischp2011@adelaide.edu.au
Website: <http://www.adelaide.edu.au/ischp>

19–20 April 2011

First International Conference on Attachment, Neuroscience, Mentalization Based Treatment and Emotionally Focused Therapy. Creating Connections
Tilburg, Netherlands

Contact: Jaap Kool and Berry Aarnoudse
Email: creatingconnectionsconference@gmail.com
Website: <http://www.creatingconnections.nl>

26–28 April 2011

II International Symposium on Disorders of Consciousness
Santiago de Cuba, Cuba

Contact: Dr Calixto Machado. Instituto de Neurología y Neurocirugía
Email: braind@infomed.sld.cu
Website: <http://www.engraciacal.com/>

27–29 April 2011

Controversies in Psychiatric Practice – The 7th International Conference on Psychiatry
Jeddah, Saudi Arabia

Organiser: Saudi German Hospital (SGH)-Jeddah, Al-Amal Hospital – Jeddah, Saudi Psychiatric Ass. (SPA), Egyptian Psy. Ass., Motmaenna Psychiatric centre
Contact: Dr Mohamed Khaled
Email: webmaster@sghgroup.com
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>

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