

International Psychiatry

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Stigma: winners and losers

John Bowis

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Four Oscars went to the 2001 film *A Beautiful Mind* about John Nash. It was a rare and beautifully observed drama about the experience of schizophrenia. It took us into that world and helped us understand both the experience and the reaction of others to it. Successful but a rarity. In straitened economic times such counters to stigma may not be top of the agenda. The stigma of mental illness is a prevalent global issue, perhaps more so in some countries and cultures than in others; therefore, the Royal College of Psychiatrists in the UK, national mental health associations and international organisations with mandates for mental health, such as the World Health Organization and the World Psychiatric Association, have an important role, if not duty, to keep up their programmes of anti-stigma activities.

We know that, in the UK, neuropsychiatric disorders are responsible for a third of disabilities, 15% of in-patient costs, nearly a quarter of drug costs, half the case-load of our social workers and over 90 million days lost at work a year. One in three people going to their general practitioner has mental health problems, and one in six is diagnosed with a mental disorder. That does not mean that two in three of us will have good mental health; it means we may not need, or we may not seek, or we may not be offered, treatment or care, or even advice.

Stigma may cause us to be given inappropriate treatment, with drugs and therapies and institutions and laws that at best may do no harm and at worst may lead to physical and psychological damage. It almost certainly means that we are labelled, patronised, despised, feared and, to a greater or lesser extent, segregated – in society, within our family, at work, at play and even within our health and social services.

When I first encountered mental health policy as a member of a Community Health Council, mental healthcare still featured locks, bolts, restraint garments and isolation rooms. In reality, mental health services were on the move, with more humane surroundings, treatments and therapies, and patients were on the move too – to community housing or back to their own homes. The public did not always like that. No longer 'out of sight, out of mind', it became 'out of his or her mind and living next door to me and my children'. Doctors and nurses were on the move too – with community health work, sharing patients with social workers or housing officers. Many did not much like the change either. It can be lonely for a young mental health nurse to be called out at night to a disturbed patient on an estate of tower blocks and you miss the team support of working in a hospital. Nor were all doctors happy to share knowledge of a patient with a social worker or housing officer, and vice versa.

If modern humane mental health policy is to work, it must offer a spectrum of care, from secure units to home support, and it must have the range of health and

social services, housing, training, transport and benefits services working in partnership; it must have trust between professionals, patients and families and it needs government resources. All this requires political awareness, public consent and professional support. A service that does not gain professional, public and political support fails to treat and care adequately and prompts a downward spiral of public confidence, thus reinforcing stigma.

In the countries of the European Union we like to think we have moved on from the human rights abuses of patients with a mental illness. We still, though, have debates about compulsory treatment; discharge or sectioning decisions are sometimes unsound; patient abuse is from time to time exposed in a residential home; arguments abound on the vexed and conflicting rights of patients, families and communities. But, by and large, we do have fewer locks and bolts, more patient choice and consent, and legal checks and balances to see the patient's civil rights are not abused. We have not had the use of psychiatry for political purposes, as happened under the Soviet system; we do not acknowledge politically convenient diagnoses such as 'sluggish schizophrenia'; we do not pump healthy people full of drugs and turn them into zombies because of their criminal, antisocial or political behaviour.

Yet stigma is rampant in all our countries and it is a human rights abuse – unintentional, born of fear and ignorance, but just as damaging to the individual as any other form of abuse. We all contribute to the stigmatisation of people who, if they had a physical problem, would receive our sympathy and support. Yet with mental illness we so often turn away with a shiver of rejection and hope someone else will cope. Living with mental illness is tough enough, without having added to the burden of illness the pain of rejection and stigma.

To tackle it, we must confront stigma for what it is. It is prejudice. Prejudice literally means pre-judging. It uses neither logic nor facts; it is ignorance mixed with assumption and emotion. So we could start by listening to and learning from service users. They should be partners and not just patients. Then we could admit our role in stigma, in ourselves and in society. Just as we have acknowledged the concept of institutionalised racism, so we should admit to its health cousin, 'institutionalised stigma', in our political, social and health systems. We have laws on the former. We have legislated on discrimination against people with physical disabilities. Perhaps we need to explore whether such laws could apply effectively, or more effectively, to people with mental illness.

But laws will not cure prejudice: they can only try to prevent prejudiced actions. We need to educate and inform so that we can break the vicious chain of prejudice and ignorance that links public, media, patient and government.

When I was a Health Minister in the 1990s we 'benefited' from the publicity surrounding one man jumping into the lions' den at London Zoo and another stabbing a stranger to death on the London Underground. We benefited because the shock-horror media stories led to public, Parliament and press demanding action. Indeed, each case of violence had a triple impact. The media gave dramatic coverage first to the event, then 6 months later to the trial and then another 6 months on to the inquiry report in the purple prose of Louis Blom-Cooper and others. So the public thought the number of cases was multiplying and turned against care in the community. The result was more money from finance ministers for better health and care services, but at a price – the terrible stigmatising price of lost public confidence and a demand to reverse the policy of community treatment and care.

Mental health suffers a quadruple whammy

There is constant public, professional and media pressure on government and health service managers to do more, spend more, achieve more. Unlike with heart disease or AIDS or cancer, though, with mental health problems there is little political, press or public understanding of what can be done to treat, cure and rehabilitate. There is even less understanding of what can be done to prevent mental illness and promote mental health. And there are few outcome measurements that health departments and managers, much less public and politicians, can understand. There is little point in campaigning to put mental health up the political and budgeting agenda if the minister cannot convincingly argue to his colleagues that €x million invested will lead to a y% improvement in problem z.

If you accept that stigma was there in and around the old institutionalised regimens but that it is multiplied 100 times when you move to treatment and care in the community and attempt to integrate people with community, working and leisure life, then it becomes 100 times more important to convince people that the policy can work. If you place people neatly into a hospital ward, politicians, press and public feel you have dealt with a health problem and will not enquire too closely what you are achieving behind the hospital gates. If people are visible, then so is the nature of their health problem and questions are asked as to whether the policy is working, how much is being spent and what it is achieving.

So services need to be as visible as patients; their regimens need to be as well understood as are the illnesses; and the safety net needs to be accessible and to build confidence for patient and community alike. An effective and comprehensive spectrum of services; outcome measurements that are more easily understood by lay people; visible and responsive local services; rehabilitation and retraining services that bring people back, at a pace appropriate to each, to active and involved life, so that their friends, family and neighbours can see the progress – all will aid the defeat of stigma.

But the twin peaks are to convince the public to believe and to convince governments to spend. And they are interdependent. If the public believe, they will put pressure on the government to spend. If the government spends, it will make public belief possible.

Further reading

Ramsey, R., Page, A., Goodman, T., *et al* (eds) (2002) *Changing Minds: Our Lives and Mental Illness*. Royal College of Psychiatrists.

The College anti-stigma campaign has compiled a good online list of sources at <http://www.rcpsych.ac.uk/campaigns/changingminds/>

THEMATIC PAPERS – INTRODUCTION

Empowering people with intellectual disability

David Skuse

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Services for people with intellectual disabilities are not necessarily a high priority even in the high-income countries. We look in this issue at the way in which approaches to support are provided in three contrasting regions, with different cultures and histories. We begin with an account of intellectual disability in India, where Dr Satish Chandra Girimaji discusses past and present frameworks for care and education. It is a cultural norm within the subcontinent that families are expected to look after relatives with disabilities, both in childhood and in adulthood; it seems that this long-standing

tradition continues. On the other hand, rapid industrialisation and urbanisation mean that it is ever more difficult for families to cope with disability, because of other pressures, without externally provided support services. The tension between tradition and economic development is palpable.

In our second paper, by Dr Meera Roy and Sivasankaran Balaratnasingam, the plight of Australian Aborigines is discussed sympathetically. Here we have a culture that is little understood it seems, even in Australia, and the closest many readers will have come to appreciating the complexity of Aboriginal culture is through books like Bruce Chatwin's *Songlines*. The

authors discuss the apparent excess of intellectual disability among Aborigines, which may be exacerbated by their cultural dislocation and consequent loss of their traditional relationship to the land and nature. Their history of appalling treatment by settlers from Europe has resulted in a cultural limbo, with high rates of drug and alcohol misuse, which fosters developmental disorders in the children of users. There are no culturally appropriate ways of measuring 'intelligence' in a people for whom the Western way of relating to the world is completely alien. This is a very thought-provoking essay on an important and neglected subject.

Finally, Dr Allen-Leigh and colleagues from Mexico present a qualitative account of the way in which adults with intellectual disability are benefiting from recently developed services that are designed to encourage their sense of independence and self-efficacy. This has come about in part through changes in societal attitudes and in part because of new legislation. Their conclusion, that it is particularly important to combine practical training with services to support greater social inclusion for people with intellectual disabilities, is applicable to all regions represented by these articles.

THEMATIC PAPER – EMPOWERING PEOPLE WITH INTELLECTUAL DISABILITY

Intellectual disability in India: the evolving patterns of care

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Intellectual disability was recognised in ancient Indian literature, but organised services have a history of just five decades. India shares many features of low- and middle-income (LAMI) countries regarding intellectual disability. There is a low level of awareness about its nature, causes and interventions. One can come across many superstitions, myths and misconceptions about intellectual disability. In general, services are inadequate, being concentrated in big cities and urban areas. There is generally limited access to support services and few government benefits, and these, in any case, are often of little value (World Health Organization, 2007). Locally and nationally, there are few relevant and reliable epidemiological data on the prevalence of intellectual disability. However, there have been some positive developments within the past three decades, and they are the focus of this paper.

The limited epidemiological data in India on intellectual disability suggest a prevalence of around 2–2.5% in the general population. An excess prevalence in males, rural areas and low-income groups is reported. Acquired causes account for about 30% of cases. It is estimated that at least 25% of intellectual disability is preventable in India (Srinath & Girimaji, 1999).

Legislation

The first attempt by the central government to provide legislation for people with disability resulted in the Persons with Disabilities Act 1995, an Act that emphasised equality of opportunity and non-discrimination, together with the range of services that needed to be developed, such as prevention, early intervention, education, training and social benefits. This Act is currently undergoing revision to bring it in line

with the United Nations Convention on the Rights of Persons with Disabilities. Both central and state governments have introduced many social justice measures such as disability pensions, family pensions, travel concessions, income tax exemption and health insurance, but, as noted above, limited access to the benefits and the extent of utilisation are causes for concern.

Later legislation that specifically addressed those with intellectual disability included the National Trust Act 1999 for persons with 'mental retardation', cerebral palsy, autism and multiple disabilities. This Act was intended to empower persons who could not speak for themselves, as well as their families. It was envisaged that it would permit greater participation of parents' associations (see below) and non-governmental organisations (NGOs) in service development. Subsequent Acts, policies and issues, including progress in research and in human resources, have been reviewed elsewhere (Girimaji & Srinath, 2010). One notable development has been a remarkable growth in the number of professionals trained in special education (Narayan, 2007).

Services

India has many prevention and promotion programmes that concern intellectual disability. These include integrated child development services as well as reproductive and child health services. Their main focus is on health education, health promotion during pregnancy, optimum perinatal care, childhood nutrition, immunisation and, to some extent, early detection and intervention.

A recent and widely acclaimed programme is the National Rural Health Mission. Of great interest is the role of 'accredited social health activists'. These are women from the local

community who are paid to educate rural folk and bring them into contact with services. Their roles include booking clinic appointments for pregnant women, bringing them for periodic checkups, ensuring hospital-based delivery and bringing sick children to hospital for care.

Clinical services for intellectual disability are inadequate and unevenly distributed. They include: clinical evaluation, physical and psychological testing, parent counselling, treatment of comorbid physical and mental disorders, and genetic counselling. Mental hospitals, general hospital psychiatric units, paediatric clinics and a handful of child guidance clinics and intellectual disability clinics provide some mental health services. There are a few referral centres that provide good-quality care; they also undertake some professional training and research.

Families and family-focused intervention

The closely knit kinship systems in India have always cared for their members with intellectual disability. Institutionalisation, unlike in the West, has never been a major movement in India and a very small proportion of the population with intellectual disability lives away from home. Families generally take care of their needy relatives with compassion, because of a sense of duty. This does not mean that they do not suffer; studies have demonstrated that families experience high levels of stress because of the care burden upon family members, especially mothers (Girimaji *et al*, 1999). There may be a negative impact on the family's quality of life, as well as that of the affected individuals, because of the lack of adequate support services. Recent social changes in terms of globalisation, urbanisation and Westernisation may have, to some extent, eroded the capacity of families to cope in these circumstances.

In the 1980s and 1990s, professionals working with intellectual disability started exploring the possibility of involving families in management. They were successful in training parents to use behaviour modification techniques and in teaching self-help skills. The approach has now found widespread application, albeit with wide variations in goals and approaches (Russell *et al*, 1999; Girimaji, 2003), affirming the strength of parent-professional partnerships. A National Trust Act grant now funds training programmes for informal caregivers.

Community-based rehabilitation initiatives in India

One can trace three or four decades of community orientation in the organisation of services for people with intellectual disability in India. This developed initially from outreach services, satellite clinics and camps run by centres that were already providing some support to that population, but which felt the need to extend their involvement, driven by the philosophy of 'reaching the unreached'. Those centres also engaged in the training of workers at the grass-roots level.

The initial focus of community-based rehabilitation (CBR) was on highly 'visible' impairments such as locomotor disability, blindness and deafness. However, within the past

two decades intellectual disability has been included on the CBR agenda, an extension initiated by NGOs with strong community links and, later, by governmental agencies. One example is the establishment of district disability rehabilitation centres (DDRCs). An interesting feature of DDRCs is that at least one grass-roots worker must be a person with a disability, called *vikalang bandhu*.

Typical activities in CBR programmes include: improving community awareness and attitudes; reducing social isolation and enhancing community participation; helping individuals and their families to access services and benefits; transferring skills to families for home-based training programmes; and improving school enrolment.

There is no doubt that the CBR approach holds promise, with the participation of a trained grass-roots worker as the key professional. By way of example, a 10-year-old boy with severe intellectual disability was never taken out of the house, as his mother feared he would have a recurrence of his seizure on exposure to the wind, but also because she felt ashamed of having a handicapped child. A CBR worker visited her at home, counselled her and initiated the child's socialisation by convincing the mother to take him to the village temple. This visit succeeded because the CBR worker accompanied her. The outing provided a turning point in the boy's and family's life, and reduced the social consequences of his disability.

Parents' associations

The parental self-help movement has its origins in 1981, with a workshop held in Bangalore (sponsored by the World Health Organization and the Indian National Institute of Mental Health and Neuro Science) and it has seen remarkable growth. Currently, there are more than 180 parents' associations and the number is growing. These associations have formed an umbrella organisation, Parivaar (a Sanskrit word meaning 'extended family'). They play an increasing role in advocacy, awareness, the organisation of services, participation in legislative initiatives and policy-making, and the implementation of relevant policies and programmes (see www.parivaarnfpa.org).

Education and training

Special schools for children with intellectual disability were first organised in India over five decades ago. They are mostly run by NGOs, with or without the support of public funds. They started in large metropolitan areas, but later spread to smaller cities and towns. Their number has seen a phenomenal growth in the past decade and there are now more than 1200 such schools all over India.

The government of India recently endorsed the philosophy of inclusive education and has started the 'Education for all 6- to 14-year-olds' programme ('Sarva Shiksha Abhiyan'). This follows a zero-rejection policy, which means that all children – regardless of any type or degree of disability – should receive appropriate education, preferably within regular schools or through education at home from specially trained teachers. This programme has witnessed considerable growth in recent years. A further development has been the enactment of the new Right to Education Act.

Services for adults with intellectual disability are still relatively undeveloped. Vocational training and job placement services are hard to find, even in metropolitan areas. There is some potential for the employment of people with intellectual disability in rural, agriculturally based economic activities, but this arrangement needs further exploration and consolidation.

Conclusions

Currently in India, there is a mosaic of services for people with intellectual disability. Within recent years innovative approaches for the better management of these conditions in childhood have emerged, including parents' associations, family-focused interventions and CBR programmes. Families continue to be a major source of care, but they are in need of many additional services and support. Landmark legislation to recognise and address the problem has been passed but it still requires full implementation. We anticipate a stronger, rights-based approach to service development in the years to come.

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THEMATIC PAPER – EMPOWERING PEOPLE WITH INTELLECTUAL DISABILITY

Intellectual disability and Aboriginal Australians – training needs for psychiatrists

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Aboriginal Australians have relatively high rates of intellectual disability, a situation that is probably due mainly to poor health and social disadvantage. Populations with high rates of intellectual disability are more at risk of developmental disorders and mental ill health. We explore the training needs for psychiatrists working with indigenous people and how they can be met.

Aboriginal Australians are the original inhabitants of the Australian continent and nearby islands. Together with the Torres Strait Islanders, they form 2.7% of the population. Aboriginal communities are diverse, with different languages and cultural practices. Historically, they were a semi-nomadic hunter-gatherer people. Each clan possessed specific territory, defined by geographical features such as rivers and mountains. They shared an intimate understanding of and relationship with the land, and that relationship was

underpinned by 'dreamtime' stories, a set of beliefs that is fundamental to their well-being. An Aboriginal person attains status by acquisition of knowledge (especially about the land) rather than by acquiring material possessions. Traditional Aboriginal society is structured by social and family systems, which organise all aspects of life and perception.

The British colonisation of Australia was a catastrophic event for the Aboriginal people. Disease, displacement and direct violence from the settlers reduced the Aboriginal population by 90% between 1788 and 1900. The settlers also introduced alcohol, and alcohol misuse played a major role in further destroying Aboriginal social structures. Between 1869 and 1969 Aboriginal children were removed from their parents by federal and state agencies and church organisations, and brought up within a 'white' culture, on such disparate grounds as child protection and maintenance of

racial purity. These children constituted the 'stolen generation' and their institutional upbringing further destroyed historical Aboriginal social structures.

Aboriginal people's health-related beliefs are interconnected with aspects of their life such as the land, kinship obligations and religion. Well-being is contingent on the effective discharge of a person's obligations to society and the land itself (Morgan *et al*, 1997). Supernatural agents are regarded as an important cause of illness and to many Aboriginal peoples they provide an explanatory model of illness.

Mental ill health

Aboriginal people have significantly worse health outcomes than other Australians and their life expectancy is, on average, 17 years shorter. They continue to experience greater poverty. In the Aboriginal population, indices of social deprivation are higher – such as overcrowding, illiteracy, representation in prisons and substantiated child protection notifications – as are reports of being victims of crime (Swan & Raphael, 1995; Cohen, 1999; Australian Health Ministers' Advisory Council, 2006). Mental ill health is also a major issue. Aboriginal rates of depression, suicide and self-harm, trauma and grief, domestic violence and substance misuse are relatively high (Swan & Raphael, 1995; Parker, 2010). The 2004–05 National Aboriginal and Torres Strait Islander Health Survey (Australian Bureau of Statistics, 2006) found substantial psychological distress, especially among Aboriginal young people. The latter suffer more emotional and behavioural problems but are less likely than other Australians of their age to access mental health services (Zubrick *et al*, 2005).

The prevalence of mental illness and suicide in the Aboriginal population reflects the severe disruption of their society since European immigration. It reflects a context of emotional and social deprivation, characterised by trauma, loss and grief, the separation of families from their children, and the loss of their land, culture and identity. It is exacerbated by the impact of social inequity, stigma and racism in the post-colonial period (Parker, 2010).

Intellectual disability among Aboriginal people

The construct of intellectual disability is determined by what is seen as competent behaviour in a particular culture. In a Western culture, for example, small children may be considered intelligent if they are able to count up to ten or if they have a large vocabulary. In contrast, an indigenous child from a particular desert community in Australia may be expected to know directions, space and place or to demonstrate independence to be considered intelligent (Dingwall & Cairney, 2010). In some Aboriginal cultures, people with intellectual disability were considered to have a specific impairment or 'sickness' that prevented them doing certain tasks, but they were still involved in the kinship system, with roles and responsibilities. Aboriginal families considered themselves to be accepting and supportive of family members who had a disability (Stopher & D'Antoine, 2008).

The 2002 National Aboriginal and Torres Strait Islander Social Survey (Australian Bureau of Statistics, 2004) showed

that 7% of the Aboriginal population aged over 15 years had an intellectual disability, compared with 1–2% of all Australians (Wen, 1997). As this figure was obtained by questioning family members, it is likely to be indicative of what is seen as intellectual disability by the Aboriginal community rather than being equivalent to disability measured by Western standards. Although Aboriginal people comprise just 3.5% of the population of Western Australia, they represent 7.4% of all people registered with intellectual disability services (Glasson *et al*, 2005). It is important to note that tests used in the assessment of general intelligence are rarely culture-free. Accordingly, test bias could have contributed to the over-representation of indigenous Australians among those considered to have intellectual disability. Dingwall & Cairney (2010) comment that the Queensland Test, which was developed in the 1960s and adapted for the purpose of evaluating the intelligence of indigenous peoples, is probably neither culture free nor an adequate measure of general intellectual ability. There are, though, currently no alternative tests that possess greater validity.

Potential causes of increased levels of intellectual disability among the Aboriginal population include intrauterine exposure to toxins such as alcohol, tobacco and cannabis, which could adversely affect fetal brain development. A lack of adequate antenatal and perinatal care is an issue in some remote communities. Prematurity, particularly when associated with poor intrauterine growth, often leads to delayed development. Postnatal factors such as trauma and infections also increase vulnerability to the later development of intellectual disability. In summary, the interplay of prenatal and environmental factors is likely to contribute to high rates of intellectual disability in the Aboriginal communities, although much work needs to be done to delineate the specific mechanisms further.

Implications for psychiatric training

The training of psychiatrists who will be working with Aboriginal people requires a multifaceted approach. Their education and training need to focus strongly on cultural awareness. They have to understand the prejudice that leads to discrimination, reflected by the interface of Aboriginality and disability. Such prejudice can militate against Aboriginal people receiving appropriate psychiatric diagnosis, treatment and care. Psychiatrists need to be aware of the important cultural differences between themselves and an Aboriginal person and the need for respect, adaptation and self-reflection.

In working with Aboriginal communities, psychiatrists need to take a culturally sensitive perspective on human development, and to understand that the presentation of disability and cultural responses to disability may be different. Assessment should be systemic, taking into consideration individual, family and community factors. It is necessary for family and respected community members to be consulted, in order to determine whether the symptoms an individual is experiencing are explicable within a cultural context. The assessment should be undertaken in collaboration with Aboriginal mental health workers or cultural consultants.

It is important for psychiatrists working with Aboriginal peoples to have received training in developmental psychiatry.

There is a high prevalence of conditions such as autism-spectrum disorders and people with intellectual disability are strongly represented (Bhaumik *et al*, 2008). Training should incorporate a culturally appropriate interpretation of the mental state examination. For instance, lack of direct eye contact or social reciprocity in an Aboriginal setting is not necessarily evidence of impaired social functioning.

The establishment and retention of a specialised workforce in intellectual disability also needs to be urgently undertaken. For example, the Kimberley region of Western Australia, which spans 500 000 km² and has almost 25% of the state's Aboriginal population, has just two adult psychiatrists. Neither has subspecialty training in intellectual disability. Although the Royal Australian and New Zealand College of Psychiatrists provides a 12-month training fellowship in intellectual disability and mental health, the programme does not specifically address Aboriginal intellectual disability. Forming links with groups of psychiatrists such as the Psychiatry of Learning Disability Faculty of the Royal College of Psychiatrists could help with gaining skills to meet the needs of indigenous people with intellectual disability.

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THEMATIC PAPER – EMPOWERING PEOPLE WITH INTELLECTUAL DISABILITY

Services for adults with intellectual disability in Mexico: opinions and experiences of service users

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We have conducted a qualitative study to collect information about services for adults and older adolescents with intellectual disability in Mexico, as part of ongoing research on intellectual disability from a public health and rights-oriented perspective. Our focus is on existing services and outstanding needs. One of our main goals is to provide an opportunity for people with intellectual disability to convey their experiences and express their opinions about the additional services they require. Three types of service are included: those supporting autonomy or independence (personal and economic);

those enhancing community inclusion; and those providing vocational opportunities.

Method

We interviewed a convenience sample of 17 young adults and older adolescents (9 women and 8 men, age range 16–41 years, median age 25 years) with moderate to mild intellectual disability, in central Mexico. Most of the people interviewed worked ($n = 14$) and most had used both public

and private vocational, medical and social services ($n = 13$). Interviewees lived with their families, in an institution or with other people with intellectual disability (independently but with some supervision). Interviews were conducted at the workplace of the participants, or at the institution where they lived; they lasted 20–45 minutes and were recorded.

Results

Personal autonomy

As independence is both a human right and a central element of the quality of life, we asked interviewees about the training they had received to help them live independently. The following responses describe some of their experiences within public services or with a private not-for-profit training centre, *Capacitación y Desarrollo Integral (CADI; Integral Training and Development)*, which provides training and support for community inclusion:

Yes, I feel like I am self-sufficient. Before, in the public home, I didn't know what to do out on the street. But now that I am at CADI, I go out more and, well, I am learning a little more to be independent, more, um, learning many things, to be outside, and I don't know, cross the street, to be out on the street. Yes, I feel like I am self-sufficient. (Amelia, age 29)

At CADI, they show us how to make breakfast, by ourselves. Once a week, each one of us. Then other flat-mates do [clean] the bedroom. Another, the dining room. Another, the bathroom. Another, the kitchen. (Javier, age 41)

They even teach you how to cross the street, what to take, what bus to take, so we are independent. Up to now we go with a teacher to see if we do it right or if there is still some mistake we make. (Ana, age 19)

Economic autonomy

Economic autonomy is an important element of quality of life, is linked to other areas of autonomy and contributes to social and community inclusion. Interviewees with intellectual disability emphasised the importance of economic autonomy, stating, for example:

I work to value money and to be independent. (Fernando, age 29)

Well yes, I work to live my life independently. (Ana, age 19)

Others spoke of the educational services they had received that had helped them acquire the skills they needed for economic autonomy:

Here they have a programme that they carry out. This programme, if you, you need toiletries, cleaning [supplies] you buy it with your own money. If you need clothes, if you need, if you want something for yourself, for yourself, you also buy it with [your money]. Now that you are earning money, well, now you are going to do what you want. Now you are going to buy it with your effort. But there is a programme, because you are not going to spend your whole salary in a week. Really, they make a budget for you. There is a budget for spending. Because each month you buy cleaning supplies, each week you buy toiletries. Then, but if you want something, something else, you need to buy

a Discman, mobile phone, that is another thing. (Alejandro, age 34)

Also, also they put, they teach us how to spend it. Right now we are only spending it on our toiletries, things we use like lip gloss, or if we want to get a present for someone. Like they help us to manage it so we don't spend it all in an instant. On the needs we have, we spend it. Or on clothes. (Ana, age 19)

Community inclusion

While there is a trend towards the greater social inclusion of people with intellectual disability in Mexico, the focus is mainly on educational inclusion. Policies and services supporting community inclusion are extremely limited, although some training initiatives do exist. Interviewees who lived at CADI described some services that they were currently using in this area:

One Wednesday we go to the movies and one Wednesday we go out for dinner. So that is when we are with other people more. (Liliana, age 25)

Mondays we go shopping, Wednesdays movies or dinner. Saturdays we have field trips, to the park. Sundays we train [for the Special Olympics]... During the week I am no longer going to be able to [train] because we are working. My work hours are from 7.30 in the morning to 5.00 in the evening ... you're tired when you get here [home]. (Alejandro, age 34)

Saturdays and Sundays we have field trips. Saturdays we go to museums and that sort of thing, Sundays we have sports. Actually, I work here [at a special education centre] Monday to Thursday and then when we get home we don't have time or we're tired. Fridays are for remembering the rules, the structure and everything [of independent living training] and then Saturdays and Sundays are like free time and everything. (Ana, age 19)

Vocational experiences and services

Inclusion in employment is also a human right and forms part of community inclusion, as well as making important contributions to social inclusion. Working and earning a salary are important if people with intellectual disability are to feel productive, be more independent and achieve economic autonomy. Some interviewees said that their motivation to work was economic:

I work to earn money. (Saul, age 33)

I work because I have to, sometimes for money, sometimes to help. (Liliana, age 25)

Other reasons for wanting to work were also mentioned. The following two examples are from men who worked in a factory:

I like to work to meet people, spend time with other people. Be in a different place and I have fun packing toys. (Fernando, age 29)

To learn, to know, to be part of society, to get to know more people, to feel how it is to work in a factory. (Alejandro, age 34)

Two women and a man who worked with children as special education aids said of their motivation to work:

I work because I very much like to be here. (Julia, age 17)

I like to be with the children, um, play with them, um, talk to them so they are happy that, that I am working with them ... I work because I like to, I like this type of work, working with special children. (Amelia, age 29)

I like to be close to the children. Also, um, what I like the most is to help the children do well. To be useful and to click with them, so I can say, 'I did it'. (Javier, age 41)

In Mexico, both public and private vocational training programmes exist for people with intellectual disabilities, providing skills and sometimes work placements. Vocational training and experience acquired from public services in Mexico were described as follows by interviewees who had used them:

I come from the National Family Development [public] system. They put me in the company ... they teach you the basics first, the basics but they teach you, they practise some things with you. Then later they place you in a company or a place. But I also took courses in carpentry, upholstery, wood

carving, leather embossing ... I got into the public system and worked in industry. (Alejandro, age 34).

I was in a school ... there were a lot [of things] to study, whatever you wanted. There was cooking, carpentry and bakery. I chose bakery and I graduated. (Andrea, age 41)

At the public home, well, that is, there when you went to school, you learned, and like they taught me carpentry and that, and also they taught us to take care of the little ones. So I was catching on to what they told us. What I do here at the clinic [special education centre] and everything. (Ana, age 19)

Conclusions

This study supports the idea that it is important to combine training in basic, practical skills for independent living with services to support social inclusion as well as vocational training and job placement services for people with intellectual disability. Our findings also suggest the need for public policy to support community and employment inclusion and the importance of public campaigns to facilitate it.

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

COUNTRY PROFILE

Psychiatry in the UK: an overview

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The National Health Service (NHS) serves the UK through four devolved organisations for England, Scotland, Wales and Northern Ireland. It is one of the largest public healthcare systems in the world, universal and free at the point of delivery. Its key challenge is to maintain this approach within tight financial constraints, while embracing new technologies, treatments and styles of service delivery, as well as meeting the health needs of an ageing population.

The population of the UK was 61 792 000 in mid-2009. Children aged under 16 represented approximately one in five of the total population, around the same proportion as those of retirement age (over 65). In mid-2009 the average age of the population was 39.5 years, up from 37.3 in 1999. Population growth is greatest in the over-85s, who currently number around 1.4 million, a figure which is estimated to reach 3.5 million by 2034, which will represent 5% of the population.

Mental health in the UK

Mental illness contributes 22.8% of the total burden of disability-adjusted life years (DALYs) in the UK (World Health

Organization, 2008). One in six adults has a mental health problem at any one time (World Health Organization, 2004).

Half of those with a long-term mental illness have it by the age of 14 (Kim-Cohen *et al*, 2003) and three-quarters by their mid-20s (Kessler & Wang, 2007). The most deprived communities in the UK have the poorest mental health and physical health (McManus *et al*, 2009). People with severe mental illness die on average 20 years earlier than the general population. Mental health problems cost England approximately £105 billion each year, including costs of lost productivity and the wider impacts on well-being (Centre for Mental Health, 2010), and represent the largest single cost to the NHS, accounting for 11% of the secondary care budget (Department of Health, 2009).

Further key statistics are presented in Box 1.

Mental health service policy development and delivery

When it was created in 1948, the NHS took over a large number of old mental asylums. The movement towards

Box 1 Mental illness in England: some illustrative figures

- 10% of children and young people have a mental disorder. Of 5- to 16-year-olds, 6% have conduct disorder (Green *et al*, 2005), 4% an emotional disorder (Green *et al*, 2005) and 18% subthreshold conduct disorder (Colman *et al*, 2009)
- 17.6% of adults in England have at least one common mental disorder and a similar proportion have symptoms which do not fulfil full diagnostic criteria for common mental disorder (McManus *et al*, 2009)
- Postnatal depression affects 13% of women following childbirth (O'Hara & Swain, 1996)
- In any one year, 0.4% of the population suffer from a psychosis (McManus *et al*, 2009) and a further 5% from subthreshold psychosis (Van Os *et al*, 2009)
- 5.4% of men and 3.4% of women have a personality disorder (Singleton *et al*, 2001); 0.3% of adults have antisocial personality disorder (McManus *et al*, 2009)
- 24% of adults have hazardous patterns of drinking, 6% have alcohol dependence (Singleton *et al*, 2001), 21% tobacco dependence (McManus *et al*, 2009) and 3% dependence on illegal drugs (Singleton *et al*, 2001)
- 25% of older people have depressive symptoms which require intervention: 11% have mild depression and 2% severe depression (Godfrey *et al*, 2005); the risk increases with age – 40% of over-85s are affected
- 20–25% of people with dementia have major depression, whereas 20–30% have minor or subthreshold depression (Amore *et al*, 2007)
- Dementia affects 5% of people aged over 65 and 20% of those aged over 80 (Knapp & Prince, 2007)
- In care homes, 40% of residents have depression, 50–80% dementia and 30% anxiety (Godfrey *et al*, 2005)
- A third of people who care for an older person with dementia have depression (Milne *et al*, 2001).

community care for people with severe mental illness started in the 1950s with the advent of phenothiazines and the exploration of rehabilitation methods in community settings. The movement received government policy endorsement in the 1970s. Research from the 1960s through to the 1980s demonstrated the damaging effects of institutionalisation and the improved health and social outcomes which accompanied deinstitutionalisation. A major Department of Health drive to close the large asylums started in the 1980s, accompanied by expansion of district community teams and the development of comprehensive local care systems. The Care Programme Approach (CPA) was introduced in 1990 to ensure systematic assessment of needs, individual tailored care plans, regular review and assignment of a key worker. Mental health was prioritised in the 1992 white paper *The Health of the Nation*, which set outcome targets to reduce morbidity from mental illness and suicide. This was followed by frameworks for intersectoral working (*Building Bridges*, 1995) and for local comprehensive care (*The Spectrum of Care*, 1996). A national psychiatric morbidity survey programme was started in 1993 (see <http://www.mentalhealthsurveys.co.uk>).

The Mental Health National Service Framework (NSF) was established in 1999; it sets standards of care for suicide

prevention, access to services, mental health promotion, and carer support and involvement, with prescribed models of service delivery in both primary and secondary care. In 2000, the NHS Plan aimed to strengthen community care and reduce the use of acute in-patient beds; this was followed by major investment, which led to an additional 700 mental health teams, 1300 consultant psychiatrists, 2700 clinical psychologists and 10000 mental health nurses, who were deployed in highly specialised teams (community mental health teams, crisis resolution and home treatment teams, assertive outreach teams and early intervention teams); these were able to reduce admissions, but their operation was often rather fragmented.

The past few years have seen more highly structured care delivery, using care pathways. Consultant psychiatrists use their expertise at the beginning of the care pathways, assess complex cases, review those in crisis and advise team members and primary care staff (Royal College of Psychiatrists, 2010a). Psychological treatments have been expanded with a tiered programme of brief psychotherapeutic interventions (particularly cognitive-behavioural therapy) provided by the Improving Access to Psychological Therapies (IAPT) programme (Department of Health, 2008).

Service users and their carers have been increasingly involved in service development, supported by a number of voluntary organisations. An important focus has been the 'personalisation' of care, which has been led by a new national body, Health Watch, which has pilot projects already established in a number of services.

Both public and private mental health services are regularly inspected, most recently by the Care Quality Commission (CQC) (see <http://www.cqc.org.uk>), which also monitors the use of the Mental Health Act, and protects the rights and interests of detained patients.

A recent national patient satisfaction survey showed that 77% of community patients rate their care as good, very good or excellent. The suicide rate in England has fallen steadily since 1990, alongside implementation of a national suicide prevention strategy (National Mental Health Development Unit, 2009) and the World Health Organization has declared that England has the best services in Europe (see Appleby, 2007).

The past few decades have seen continuous organisational change in the NHS, ranging from the separation of the purchase and provision of services in the late 1980s to several moves to achieve greater autonomy for local health providers. The 2010 white paper *Equity and Excellence: Liberating the NHS* sets out plans to form new purchasing organisations run by family physicians ('GP consortia'), while the new mental health strategy, 'No Health Without Mental Health' (with a supporting paper, *Delivering Better Mental Health Outcomes*; HM Government, 2011a,b), adopts a life course approach, as advocated by the 'Foresight' report on mental capital and well-being (Cooper *et al*, 2008), and aims to create parity of esteem between physical and mental health. These have been followed by a statement on public mental health from the Royal College of Psychiatrists (2010b).

Many of the developments described above relate to England but similar challenges face the devolved administrations in the other countries of the UK, which are evolving their own tailored responses.

Mental health legislation

There have been a number of recent changes in mental health legislation. The essential principles of the Mental Health Act 1983 remain unchanged, but the Mental Health Act 2007 (England and Wales) introduced community treatment orders (CTOs), changes in professional roles and additional safeguards for patients receiving electroconvulsive therapy.

The Mental Capacity Act 2005, followed by Deprivation of Liberty Safeguards 2007 (DoLS), provides a legal framework for those who lack capacity, with key principles, procedures and safeguards in line with human rights legislation.

There is a similar Mental Health (Care and Treatment) (Scotland) Act 2003 and new legislation for Northern Ireland covering capacity and mental health is due in 2011.

Undergraduate training

In the UK there are 31 undergraduate medical schools which train doctors on behalf of the NHS (50% of these undergraduates will go on to become family physicians). Medicine is usually a first degree course, that is, entered directly from school, although some medical schools offer graduate entry and some offer an intercalated second degree. Training is guided by the UK General Medical Council (GMC) (see GMC, 2003). Learning has become both more learner led and more research based (including problem-based learning), with clinical experience earlier in training.

Psychiatry undergraduate training lasts 6–12 weeks but, in order to achieve parity with physical health, this should be increased to reflect the prevalence of mental health problems in the community.

Postgraduate training in psychiatry

Training in psychiatry follows a 6-year programme: 3 years in core training; then, after passing their professional examinations, trainees re-apply for higher training and a further 3 years as a (sub)specialty trainee. Successful completion leads to the Certificate of Completion of Training (CCT) in psychiatry. Recruitment into psychiatry is at a low level, with many unfilled posts in core training across the UK.

The education of the trainee is actively managed within a structured framework of competencies, which are continuously assessed through workplace-based assessments (WPBAs) – which are now web based. Progress through training is managed by an annual review of competency progression (ARCP), which is informed by an electronic portfolio of experience, hosted by the Royal College of Psychiatrists. Core trainees must pass the MRCPsych examination (which comprises three written papers and a clinical examination) to progress to advanced training. The curricula for the new training programmes are approved and quality assured by the GMC, which recently took over responsibility for post-graduate education.

There are 21 deaneries responsible for the delivery of post-graduate medical education in England, Scotland, Northern Ireland and Wales. In 2006–07, deaneries introduced

'specialty schools', which, together with the Royal College of Psychiatrists, lead national recruitment and training, maintain standards and support innovation and diversity in psychiatry education, and work closely with the College's Psychiatric Trainees' Committee.

Research and academic psychiatry

Research in mental health is undertaken by universities, NHS trusts and charities. There has been a growing trend to involve users and carers in research design and conduct, and all research with human participants has to receive prior ethical approval. There are a variety of UK funding sources, including the Department of Health, the Medical Research Council, the Economic and Social Research Council, the Wellcome Trust, and smaller foundations, as well as international sources such as the European Union. Many UK researchers have strong links to researchers in other countries, and participate in international studies. Universities run master's degree courses and PhD training programmes, and some funders offer PhD scholarships. A number of high-impact mental health research journals are based in the UK. The UK Department of Health also funds the regular production of 'good practice' guidelines by the National Institute for Health and Clinical Excellence, based on systematic reviews of the research evidence.

Conclusions

In the UK the delivery of mental healthcare is under constant change, against a backdrop of regular reform of the NHS. Recent changes in legislation and organisation offer opportunities to improve the mental health of the UK. To deliver these changes strong consultant leadership, increased recruitment to psychiatry, and a drive for equity for physical and mental healthcare in the UK are needed.

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COUNTRY PROFILE

Psychiatry in paradise – the Solomon Islands

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The Solomon Islands is situated in the South Pacific Ocean and is a low-income country. It comprises nearly 1000 islands with a total land area of 304 000 km² spread over a sea area of about 1 500 000 km², making communications, travel and service delivery difficult and creating inequities in access. The population of the Solomon Islands was estimated to be just over 580 000 in 2008, and is young, with 42% aged under 15 years (Solomon Islands Ministry of Health, 2006). The majority of the people are Melanesian (93%) and 98% of the population belong to a Christian church. The population is, though, extremely diverse, with 91 indigenous languages and dialects being spoken, in addition to the Solomon Islands pijin (the most common language) and English (the official national language). Over 83% of the population live in rural areas, where subsistence agriculture, fishing and food gathering are the main sources of income. There is no substantial tourist industry. The gross domestic product (GDP) is US\$1.5 billion and annual per capita income is approximately US\$2800 (International Monetary Fund, 2009). Total expenditure on health represented 5.6% of GDP but only 1% of the total health budget is allocated to mental health (World Health Organization, 2005).

Mental health policy and legislation

Mental health has been attracting increasing attention in the Solomon Islands, with growing support for the adoption of a broad national mental health policy. Following agreement between the Ministry of Health and medical services, and the World Health Organization, a short-term consultant was mobilised from October 2008 to January 2009 to assist with the development of this policy. As part of the intensive consultation process, over 120 individuals were interviewed, including senior national and provincial staff of the Ministry of Health, non-governmental organisations, church leaders and relatives and carers for people with mental disorders. The feedback from a workshop and the consultation process was then incorporated into the national mental health policy.

Mental health legislation

The Mental Treatment Act 1970 consolidated the law relating to people of unsound mind and makes better provision for the care of persons suffering from mental disorders

and for their custody, as well as governing the management and control of mental hospitals. There is now an attempt to include community and primary care facilities within the remit of the Act. The Act was amended in 1995 by two external consultants and attempts are now being made for its revision and passage through Parliament. The country's sole consultant psychiatrist (the second author) is responsible for the assessment of persons suffering from mental disorder under the Act.

Mental health services

Formal mental health services in the Solomon Islands date back to 1950, when an asylum was established in Honiara, the capital. It was principally a place for custody of anyone considered a danger to society or unable to care for themselves. In 1977, the government built a new 15-bed mental hospital on the grounds of Kilu'ufi Hospital in Auki, Malaita Province. In 1984, 12 new beds were added to accommodate female patients. Like its predecessor, the facility lacked qualified mental health staff and adequate resources.

The current mental health service has both national and provincial arms and has been built up around a small core of trained psychiatric nurses and one psychiatrist.

The national arm

The national arm includes the 20-bed National Psychiatric Unit in Auki and a 4-bed acute care unit at the National Referral Hospital in Honiara. Both facilities also provide out-patient services, but there is little community mental health activity other than general community awareness, although it is acknowledged that families need to be informed and supported if they are to provide continuing care and rehabilitation for patients after discharge.

Recently, a fully functioning community mental health and rehabilitation team was established with the help of the first author, a volunteer under the auspices of the World Health Organization and the Royal College of Psychiatrists (Singh, 2010). The main role of the volunteer was to improve the clinical skills of the local psychiatrist and senior nurses in terms of diagnosis, prescribing, psychosocial rehabilitation and psychoeducation with patients and families. Further aims were:

- to improve their management skills by holding and chairing regular meetings
- to develop the World Health Organization's model for community mental health services
- to establish individual care plans
- to reduce relapse and readmission rates
- to improve mental health services to local prisons.

The volunteer was able to understand the local language most of the time and only on a few occasions did nursing staff have to be used as interpreters.

The provincial arm

The provincial arm is represented by identified mental health nurses (psychiatric coordinators) in six of the country's nine provinces: Choiseul, Guadalcanal, Ysabel, Makira, Temotu and Western. Acute treatment of severe mental disorder is not available at the primary care level; however, there is a basic continuum of service from acute care at the out-patient

clinics to outreach services. The relapse and readmission rates are high, for various reasons, such as non-adherence to medication, intolerable side-effects and lack of aftercare in the community.

Pharmacological interventions

A national therapeutic drug policy/essential list of drugs operates. Only first-generation antipsychotics are available; fluphenazine decanoate depot injection is commonly used. The tricyclic antidepressants are available and sodium valproate is used as a mood stabiliser. The nurses give depot injections to patients in rural areas. All medications are provided free of charge to every patient. A discussion is ongoing over whether to include newer drugs on the essential list of drugs.

Other service providers

A discussion is ongoing over ways in which community resources could link with mental health services. Two important resources supplement the formal services: the churches and traditional healers.

Churches

The churches deliver a range of welfare services and psychosocial interventions to women, youths and families, including counselling and community development. Although the churches do link with specialist mental health services, these links are generally poor. The churches have a number of roles and church leaders are also role models. The churches run a trauma support programme that offers assistance to individuals, families and communities suffering from stress and trauma. This programme was further developed following a tsunami in 2007. The churches also try to engage young people, and keep them busy (through youth groups, sports and community programmes such as visiting old people) and away from trouble and antisocial activities such as substance misuse. None of the churches (or indeed other non-government organisations) focuses on providing core mental health services.

Traditional healers

Traditional healing practices vary across the country. They include song and dance, as well as the provision of food and medicine. In many places, such practices are the principal means of mental healthcare, being regarded as essential for cultural and spiritual well-being, while mental health services are the last resort.

Training

There are few personnel with mental health qualifications within the governmental mental health services. This has come about through limited opportunities for employment and an absence of a specialist tertiary course in the mental health field in the Solomon Islands. Since 1995, 11 psychiatric nurses and one psychiatrist (the current consultant psychiatrist) have been sent overseas for training. Another doctor is currently undergoing postgraduate training in psychiatry in Papua New Guinea. There are no psychiatric subspecialties in the country, so the sole psychiatrist looks after all patients.

Workforce

As indicated above, there is an acute shortage of trained psychiatrists (with just one consultant) and mental health nurses. There are no medical schools in the Solomon Islands and there is no local postgraduate training in psychiatric nursing. Students are sent overseas, mostly to Cuba, to do their medical training and most of the nurses are sent to either Papua New Guinea or Fiji. Recently, the sole clinical psychologist resigned and the post was still vacant at the time of writing. The total number of posts in the mental health services is 55; there are seven vacancies at various grades. There is no central record of the number of health workers who have been trained, or when, to guide future education and training in mental health for primary care workers.

Prevalence of mental disorder

Epidemiological data on the prevalence and distribution of mental disorder, alcohol and drug use, and suicide and self-harm are lacking in the Solomon Islands. However, according to the 2006 national disability survey of the 14 403 people with disabilities, 5.3% had a general intellectual disability, 3.5% had dementia, 2.8% had a psychiatric disorder and 3.9% had epilepsy.

Self-harm is a new but growing problem (Finau & Losalo, 1985). In 2004 intentional self-poisoning was one of the ten leading causes of death recorded at the National Referral Hospital, Honiara. A review of the accident and emergency department's records from February to October 2008 revealed 77 recorded cases of self-harm and one suicide. From January 2009 to December 2009 there were 142 psychiatric consultations (see Table 1).

There are no culture-bound disorders specific to the Solomon Islands. More widely, in the South Pacific direct expression of dissatisfaction with an elder is constrained and is indirectly expressed in a person becoming *musu* (socially withdrawn); in extreme form the person may become clinically depressed and suicidal.

Publications and research

The Solomon Islands does not have a psychiatric journal and most research work is being done by donor organisations. This research has been on psychosocial aspects of mental problems, in particular in relation to youth, substance misuse, violence and HIV/AIDS. Australian researchers (Blignault *et al*, 2009) are looking into the community perception of mental health needs in the Solomon Islands.

Conclusion

In the Solomon Islands, mental health services have come a long way in recent years, but the harsh social economic

Table 1 Numbers of out-patient psychiatric consultations at the National Referral Hospital, January–December 2009

	Number of patients
Male (age range 10–76 years, mean 31 years)	83
Female (age range 13–80 years, mean 30 years)	59
Generalised anxiety disorder/panic/ anxiety/somatiform disorder	45
Stress/adjustment disorder	8
Dementia	3
Schizophrenia	41
Depression	24
Bipolar disorder	2
Self-harm	3
Substance misuse	4
Malaria	1
Domestic violence	1
Sexual abuse	1
Epilepsy	5
Intellectual disability	1
Other	3
Total	142

environment is now slowing their development. There is a need to modernise the Mental Treatment Act, to invest more in the recruitment, retention and training of medical staff and to extend mental healthcare beyond cities and urban areas to the villages, where most people live, and to integrate mental health into primary care.

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Working conditions and job satisfaction of Argentinian psychiatrists: initial results of a comprehensive survey

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Working in psychiatry is generally rewarding. However, it can also lack job satisfaction and be detrimental to personal life. Research findings indicate high rates of burnout (Kumar *et al*, 2007), impaired health status of practitioners (Korkeila *et al*, 2003), negative effects of violence in the workplace (Inoue *et al*, 2006) and lack of job satisfaction (Fischer *et al*, 2007; Bressi *et al*, 2009).

This article presents the initial results of a survey performed by the Association of Argentinian Psychiatrists (APSA in Spanish) at its 25th annual meeting in 2009. The survey was planned in a series of discussions and workshops on working conditions and professional burnout (Wolfberg, 2003). These discussions followed the economic crisis of 2001, when Argentina's financial and economic system collapsed. It was then that the APSA's executive committee commissioned a comprehensive survey of psychiatrists' working conditions, health status and related topics. Its objectives were to collect initial data from psychiatrists, with the aim of delineating areas for future research.

We report in this article the results obtained on working conditions, job satisfaction and doctors' perceptions of the support available to them in their workplace.

Methods

Sample

A structured interview was offered to all doctors attending the 25th annual meeting of the APSA, held 21–24 April 2009, at Mar del Plata, Argentina. Participants' consent was obtained before the interview, including their agreement to disseminate the results on the Association's website and in publications. The survey had ethical approval from the APSA.

Data collection and analysis

The questionnaire for the interview was designed by members of APSA's Faculty of Prevention in Psychiatry. The Faculty is chaired by the first author of this paper (EW). The interviews were carried out by ten psychology students previously trained by EW.

The questionnaire was designed to obtain the information in a user-friendly and culturally sensitive manner. It included several domains:

- work location and conditions
- total income (often combined earnings from more than one source)

- job satisfaction
- supervision at work (most psychiatrists in Argentina, including senior professionals, work with a psychotherapeutic orientation and supervision is embedded into the job)
- sources of recognition at work
- violence at work
- health status
- work–life balance.

Results

The sample consisted of 722 participants (55.4% female, 44.6% male). The participation rate was 82%. The mean age of participants was 47. For some of the data analysis, the sample was divided into three age groups, as follows:

- those under 30 years ($n = 89$, 12.3% of the sample)
- those between 30 and 50 years ($n = 337$, 46.7%)
- those older than 50 ($n = 296$, 41.0%).

The mean time since qualification in the total sample was 19.5 years. Most (84.9%) were qualified specialists; the remainder (15.1%) were trainees. Marital status was as follows: 51.0% married, 8.3% cohabiting, 2.5% widowed, 20.1% single and 18.1% divorced.

Income was divided into three bands (in Argentine pesos):

- low, for those who reported earnings less than ARS3000
 - middle, for those earning ARS3000–7000
 - high, for those earning more than ARS7000.
- Only 2.2% of young doctors (aged 30 or under) reported having an income within the high band, while 63.0% were within the low band. Of doctors in the middle age group (30–50 years), 50.2% reported having an income within the middle band and 29.1% in the high band. Even among doctors aged more than 50, 8.8% were still within the low-income band and 53.7% reported their income within the middle band. However, income was reported as being sufficient to meet doctors' needs by 67.4% of young doctors, by 76.3% of doctors in the middle age group and by 79.7% of those aged more than 50.

More than half of the doctors surveyed reported working 31–50 hours weekly in each of the age groups. However, a substantial number of doctors worked more than 50 hours: 14.6% of young doctors, 29.3% of doctors in the middle age group and 24.6% of those aged more than 50. Data for working hours did not include the on-call shifts for those who were in hospital practice.

Table 1 Select survey results, by age group (% of respondents)

	< 30 years (n = 89)	30–50 years (n = 337)	> 50 years (n = 296)
Satisfaction with job	90	91	92
Satisfaction with time for patients	47	67	80
Satisfaction with time for supervision	67	45	32
Exposure to violence at work	86	81	69
Perceived recognition in the workplace			
from patients	73.6	75.0	68.1
from colleagues	47.2	46.9	52.4
from medical directors	21.3	29.4	29.7
no recognition	5.6	5.9	6.1
not reported	19.1	13.1	11.8
Employment, by sector			
private practice only	21.3	28.5	40.6
public sector only	36.0	13.1	6.1
public and private combined	13.5	24.6	19.9
HMO only	10.0	7.1	8.4
HMO and private and public practice	4.5	9.2	6.4
HMO and public practice	7.9	2.7	1.4
HMO and private practice	6.7	14.8	17.2

HMO, health maintenance organisation.

Doctors in Argentina usually work in several settings: public sector hospitals, private practice and health maintenance organisations (HMOs), which deliver insurance-based healthcare. More than a quarter of doctors in the middle and older age groups reported working in private practice only.

Table 1 shows data on perceived job satisfaction, including satisfaction with supervision at work, and the results regarding perceived recognition in the workplace.

Discussion

The survey was the first ever performed in Argentina about working conditions for psychiatrists. Despite the presence of a psychiatric system in the country since the beginning of the 20th century, both political upheavals and the lack of organisation of the medical profession delayed the establishment of an inclusive psychiatric association until the restoration of democracy in 1983. The APSA is the first society to represent members in Argentina and those Argentinians living and working abroad.

A persistent lack of funds has hindered the development of approaches more consistent with systematic research and evidence-based psychiatry. In this context, we think this survey constitutes a first attempt to gather data; the results should illuminate areas for further research.

One remarkable finding of this survey is that perceived satisfaction with work remains high for all age groups of professionals surveyed, with more than 90% of doctors declaring satisfaction with their jobs. Studies on the subject in Latin America more widely are few. One article reported a similar survey to ours in Colombia; it found a rate of job satisfaction of 71% among those surveyed (Gomez–Restrepo *et al*, 2003). In the present survey, satisfaction with time available for patients seemed to correlate with age, with young doctors declaring less satisfaction in this respect. Conversely, more young doctors declared their satisfaction with the arrangements for supervision.

At present, many doctors in Argentina hold several jobs within the private and public sectors, and work long hours to achieve a reasonable standard of living. More than a

quarter of doctors surveyed worked in private practice. The percentage of those working exclusively in private practice increased with age (Table 1). Still, about a third of doctors worked for several employers, in a combination of various sectors (public, HMOs and private practice). Although jobs in the public sector are poorly paid, if not unpaid, they do constitute the main route to the acquisition of specialist qualifications; it is therefore not entirely surprising that the only way to make financial progress is to move from the public to the private sector. For those who do progress, earnings nonetheless remain low when compared with those in high-income countries. A conversion of the local currency (ARS) to British pounds should really account for the instability of the Argentine currency, due to persistent inflation. However, if taking a mean value of £1 = ARS6, incomes will be equivalent to up to £500 monthly for the low-income group, £500–1170 monthly for the middle-income group, and more than £1170 monthly for the high-income group. These figures are objectively low for Argentina, a country undergoing a process of globalisation, which leads to, among other things, a constant sharp increase in the prices of basic commodities. Nevertheless, about three-quarters of doctors surveyed declared their incomes to be sufficient to meet their needs. Again, more rigorous investigation is required, including a more accurate operational definition of needs.

In this context, it is remarkable that 90% or more of those surveyed declared a subjective sense of satisfaction with the profession. To our knowledge, the only survey done in 19 Latin American countries (including Argentina) reported similar rates of job satisfaction (86.4%), but there was a lower rate of satisfaction with incomes (only 64.7%) (Cordoba *et al*, 2009).

This survey has several domains that merit future research. It will be interesting to develop a more sophisticated approach to assess job satisfaction. It could be assessed on several domains of the clinical work. Variable rates were reported across the three age groups on satisfaction with time for supervision. The presence and quality of supervision have been found by others to be significantly associated with job satisfaction for both trainees (Ellencweig *et al*, 2009) and specialists (Kazantzis *et al*, 2010).

Doctors reported patients and colleagues to be their main sources of recognition in the workplace. We hypothesise that perceived recognition increases self-esteem and provides emotional support, which may, in turn, compensate for the low financial recognition. Psychiatry has historically been a prestigious specialty in Argentina. It will be interesting to test formally the hypothesis whether its prestige is related to the subjective satisfaction of practitioners.

A study evaluating job burnout in a European Union country used several structured assessments. It found that a low level of job satisfaction was the variable that most predicted burnout (Bressi *et al*, 2009). Our group is currently researching to what extent burnout is predicted by emotional exhaustion, as opposed to lack of job satisfaction (Wolfberg *et al*, 2005).

In summary, this study was the first to have addressed in Argentina questions about psychiatrists' job satisfaction and related aspects of their working lives. It surveyed a large sample, and provided data to advance research, in a country rich in human resources, and a system that needs a more rigorous research policy.

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SPECIAL PAPER

Training on the management of depression in primary care in Azerbaijan

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In 2006, the Azerbaijan Ministry of Health and the World Bank launched the 6-year Health Sector Reform Project (HSRP). The principal goal of the Project is to prepare and implement a fundamental and comprehensive reform of the health system in Azerbaijan, including a major emphasis on strengthening the primary care system (Ministry of Health Project Implementation Unit, 2007). The project envisions the development of a new optimised system of services, with the integration of mental health into general healthcare. In the line of this process, the Public Health and Reform Centre (PHRC) of the Ministry of Health has developed evidence-based clinical practice guidelines on depression, for implementation within primary care (Ministry of Health, 2009). At the same time, representatives from the PHRC and the Departments of Psychiatry and Family Medicine of Azerbaijan Medical University, as well as

the State Institute for Advanced Training of Physicians (in cooperation with the World Health Organization Country Office), formed a task force to carry out a survey to assess the need for education in mental health for primary care doctors. A total of 308 primary care doctors (see Table 1) working in 14 settings in different regions of the country were randomly selected and interviewed by the research team.

All participants of the survey were asked to fill in a specially designed semi-structured questionnaire consisting of 34 items. Along with items covering personal information and professional responsibilities, the questionnaire included a set of questions about the recognition and treatment of depression in primary care. In addition, it queried the respondents' opinions and expectations regarding improvements in care provision for patients with depression.

Table 1 Demographic data of the survey respondents (*n* = 308)

	Number (%) of participants
Setting location	
urban area	186 (60.4)
rural area	122 (39.6)
Gender ^a	
male	138 (45.1)
female	168 (54.9)
Age (years)	
up to 30	15 (4.9)
31–40	39 (12.7)
41–50	89 (28.8)
51–60	122 (39.6)
61 and over	43 (14.0)
Years in practice	
less than 6	25 (8.1)
6–10	16 (5.2)
11–20	78 (25.3)
21–30	116 (37.7)
over 30	73 (23.7)

^aData not recorded in two instances.

Recognition of depression in primary care

According to international studies, the median prevalence rate for depression around the world is more than 10% in primary care settings (Üstün & Sartorius, 1995). The data obtained from the survey revealed that less than 3% of the population presenting to primary care were recognised as suffering from depression. Although detection rates of depression varied between the different primary care settings, it may be proposed that the vast majority of sufferers are not being identified at the primary care level. In fact, primary care physicians have the difficult task of detecting depression among persons who are applying for services other than psychiatric treatment. Furthermore, patients with depression often present to primary care physicians with somatic symptoms such as poor appetite, weight loss, sleeplessness, fatigue and pain, which may be confused with physical illness. In addition, primary care physicians are highly likely to have patients with dual diagnoses – somatic illness and comorbid depressive disorder – which, in turn, may significantly extend the disability in these patients. In such cases, physicians often attribute the ‘presenting’ depression to the physical illness; thus they consider them as psychological responses secondary to a wide variety of underlying health conditions. Both patients and their doctors tend to ‘normalise’ depressive symptoms as variations of normal mood swings, and thus the prevalence of depression is underestimated (Ismayilov, 2004).

Even when recognised, the type and severity of depressive episodes are not always identified in accordance with the ICD-10 diagnostic criteria. In the present survey, 68% of primary care physicians could identify patients suffering from severe depression, but mild or moderate depressive episodes, as well as depression with atypical features, would generally remain undetected. Furthermore, 54% of primary care physicians were unaware of bipolar depression and they never asked patients about a history of manic episodes.

Similarly, approximately only 15% of primary care physicians confirmed that they routinely assessed risk of suicide in patients recognised as having depression.

The treatment of depression in primary care

Despite the availability of clinical practice guidelines on the diagnosis and treatment of depression, primary care doctors have often treated them as academic reference materials, and have been slow to implement their recommendations. Although many patients receive treatment from primary care physicians, there is a lack of evidence that treatment is provided in effective doses and for adequate periods of time.

In the survey, 30% of primary care physicians reported prescribing antidepressants in their practice. Most of these tended to treat their patients with older classes of drugs, such as tricyclic antidepressants, and only 18.5% prescribed the newer selective serotonin reuptake inhibitors (SSRIs) and serotonin–noradrenaline reuptake inhibitors (SNRIs), which have been shown to be better tolerated than older classes of drug. In general, physicians demonstrated insufficient awareness of safety profile, side-effects and drug–drug interactions of the psychotropic medicines they prescribed. Therefore, many primary care doctors tend to administer very low (i.e. ineffective) doses of antidepressants. They have misconceptions about dosage regimens and rarely focus on adherence issues. Although the guidelines on depression stipulate at least 6 months of maintenance treatment, this period often does not exceed 2 months in primary care, as medication is discontinued after any initial improvement in depressive symptoms.

In some primary care settings the majority of physicians prescribe tranquillisers (benzodiazepines) rather than antidepressants as the first-line treatment for depression. Moreover, 21.9% of physicians who treat depression reported treating it with other medications (e.g. neuroleptics, nootropics and herbal medications) that are not indicated for depression. At the same time, psychological interventions that are effective for depression, such as counselling, cognitive–behavioural therapy, family therapy and interpersonal therapy, are not familiar to most physicians and are not used at primary care level.

In addition, currently in Azerbaijan there is no system in place to monitor or supervise the psychopharmacological or other mental health treatment approaches of primary care physicians.

Training primary care doctors in the management of depression

The problems in the recognition and treatment of depression are caused by inadequate training of primary care physicians, which is often limited to information obtained at the undergraduate level. Moreover, their training in mental health is based within psychiatric institutions and focuses on severe and complicated mental disorders, rather than on the mental health problems commonly encountered in primary care settings. The postgraduate programme for general

practitioners that follows graduation from medical university does not include a mental health rotation. In our survey, only 2.3% of primary care physicians had had any postgraduate training in mental health.

In order to prepare primary care practitioners to provide services for patients with depression, ten master trainers from regional primary healthcare settings have been selected and educated to teach primary care doctors. The training is supervised by mental health professionals employed by Health Sector Reform Project Implementation Unit and is based on the Educational Programme on Depressive Disorders of the World Psychiatric Association (Maj *et al*, 2009), which has four modules:

- overview and fundamental aspects of depression
- physical illness and depression
- depression in specific population groups
- methods of training and education about depression.

The trainees learn general information about depression (epidemiology, clinical features, natural course and outcomes), application of the bio-psychosocial approach to depression, and contemporary classification of depressive disorders. Practical skills in the management of depressive disorders include their recognition, diagnosing depression with the Patient Health Questionnaire (PHQ-9), suicide risk assessment, developing a treatment plan, administering non-pharmacological interventions and antidepressant medications, and referral to specialist care. An emphasis was placed on addressing specific needs of patients (pregnancy, developmental aspects, ageing and comorbid physical illness). Doctors in training should develop proper attitudes

towards interpersonal functioning, suicidal ideation and adherence to treatment on the part of patients with depression. An important aspect of the training are the methods of teaching primary care doctors, which include case presentations, role-play, small-group discussions and evaluation of knowledge, skills and attitudes.

Along with this short-term training for already employed primary care doctors, the Department of Psychiatry, Azerbaijan Medical University, in cooperation with the World Health Organization Country Office, has introduced a training programme on the management of depression for graduates in primary care. It is expected that training of primary care doctors on the management of depression will result in the development of whole-person care, reduce the stigma accompanying mental illness and improve access to care for the most vulnerable population groups.

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SPECIAL PAPER

Global child mental health: what can we learn from countries with limited financial resources?

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In 1977 the World Health Organization recommended that every country throughout the world should have a national plan for child mental health. The United Nations Convention on the Rights of the Child has been another important stimulus for child mental health policies and services in many countries. Adopted unanimously by the United Nations General Assembly in 1989 and instituted as international law in 1990, the Convention is an agreement on the basic protections that should be accorded to children. Adopted in 1961, the European Social Charter is

the major European treaty that secures children's rights. In 1996 the Charter was revised and expanded to include a list of core obligations of the contracting parties relating to the recognition of social, legal and economic rights for children and young persons.

These three international initiatives stimulated governments worldwide to develop national child and adolescent mental health policies and legislation. The presence of informed, effective policy is critically important for the mental health of children. Without guidance on the development of child

and adolescent mental health policies and plans there is the danger that systems of care will be fragmented, ineffective, expensive and inaccessible (Belfer, 2008).

Obviously, it is not enough just to have a good policy: it is has to be properly implemented. Although an increasing number of countries have developed child mental health policies (World Health Organization, 2005), in the current climate of economic recession, implementation of these programmes poses a real challenge, as many governments are being forced to make stringent reductions in public sector expenditure. Child mental health services are under constant threat or have already suffered significant financial cuts in many countries.

Thus one of the most important questions these days is how to deliver adequate child and adolescent mental services with limited resources. The aim of this paper is not simply to present a literature review but also to point out that it has been a big challenge in recent times to implement child and adolescent mental health policies and to consider alternative approaches to improve child and adolescent mental health services.

Method

Relevant studies were identified by searching the PubMed, PsycINFO, EMBASE, Science Direct and Ovid online databases from inception through to October 2010. The search was confined to English-language articles. Selected articles, as a criterion for inclusion, had to describe an original study that provided alternative approaches to the improvement of child and adolescent mental health services in a low- or middle-income country.

Results

Higher-income countries even in the current financial crisis are spending more money on child mental health than the majority of low- and middle-income countries were before the crisis. Of course, the quality of and demand for such services in most cases are incomparable between rich and poor nations. However, there are a few countries which, with limited resources, were able to develop and implement progressive child mental health policies. That said, we have to admit that reports from low- and middle-income countries are not as thorough as those from high-income countries, and crucial data such as outcomes (including partial recovery, relapses and critical events) are not always recorded comprehensively. Moreover, resources and challenges in the former group of countries differ widely and uniform recommendations are difficult to make; however, positive tendencies, especially in so-called emerging economies, cannot be ignored.

South America

Successful child mental health policies have been implemented in a few South American countries, notably those which followed the World Health Organization's proposal to develop community mental health services through the integration of mental health into the existing primary care system

and the mobilisation of community resources. Integration is particularly useful when resources are limited and there is strong stigma around mental ill health.

A sophisticated child mental health programme based on a comprehensive primary care model exists in Chile. Experience from Chile indicates that the use of robust scientific evidence, combined with persistent public advocacy, civic education and media pressure, can facilitate the uptake of research into practical child and adolescent psychiatry (Pemjean, 2010). Today, one or more general practitioners with mental health training participate in mental health teams within every urban primary health centre. They work jointly with psychologists and social workers, receive referrals from other professionals at the same centre, and act as a first level of screening, making preliminary diagnostic and treatment decisions. There are over 60 community mental health centres, which work closely with the primary care centres, a system that has been evolving over the past 15 years. Staff in the two types of institution in many cases cooperate in the overall planning for mental healthcare and they are in frequent contact. This policy has meant that mental healthcare is a key aspect of the identity of primary care in Chile, and such services now serve more than 80% of the 500 000 people who receive mental healthcare in the whole of the public health system (Pemjean, 2010).

Strong advocacy programmes with government support at the highest levels exist in Brazil. Brazil's primary care system involves the deployment of family health teams (FHTs), who are responsible for primary and community-based healthcare in a defined geographical area. This includes the diagnosis and treatment of most diseases, together with promotion and prevention activities. Mental healthcare is now integral to the work of FHTs. Other mental health resources at community level include centres for psychosocial care (CAPS), which have been established in both urban and rural areas (although with some inequity between different regions of the country). These centres offer specialised mental health out-patient and, in some cases, day and limited in-patient care, as well as first-line emergency care. The CAPS, together with FHTs and mental health units in general hospitals, make up a comprehensive mental health network. This example demonstrates the value of a number of interlocking strategies: a strong system of family-centred primary care (particularly appropriate for mental healthcare), together with specialist mental health support delivered through collaborative care and a network of supporting mental health resources, including both hospital and community care (World Health Organization & World Organization of Family Doctors, 2008).

Africa

The integration of mental health into primary care has been a policy objective in Kenya for two or three decades, but there was no specific allocation of resources to implement this, and there was no continuing professional education on mental health for primary care staff. A few years ago, hundreds of front-line health workers were trained in a 5-day interactive course in mental health, using relatively small-scale funds, local trainers and a project management system embedded in a local training system, to achieve effective outcomes (Jenkins *et al*, 2010). Of course, the effectiveness of such a project needs to be carefully monitored.

Europe and Asia

Historical accidents may stimulate the development of child and adolescent mental health services. In Turkey, severe earthquakes in 1997 led to increased recognition, both inside and outside the country, of the need to increase services and to coordinate them better (Munir *et al*, 2004). For example, the mental health component of the Marmara Earthquake Emergency Reconstruction Project identified the need to develop community-based mental health services – including trauma-related interventions related to the earthquakes – initially in the north-west where the earthquakes occurred, and later across the remainder of Turkey, thereby ensuring that the country would be better prepared for similar disasters (Munir *et al*, 2004). In India, natural and human-made disasters have been followed by enhancement of emergency relief and mental health services; progress in rehabilitation and rebuilding has been slower (Rao, 2006).

In the past decade, Serbia has been exposed to many stressors, such as civil war, United Nations sanctions, several waves of refugees and internally displaced persons, always with a high percentage of children and youths (Lecic Tosevski *et al*, 2007). The Serbian national action plan for the development of mental healthcare and youth development was created to address some of these problems, by, among other things (Lecic Tosevski *et al*, 2007):

- expanding the preventive and therapeutic potential of primary healthcare services
- facilitating cooperation between youth health services, youth mental health services and tertiary psychiatric institutions
- supporting the programmes and projects of non-governmental organisations for the psychological care of youths
- training young people and developing peer support.

Incorporation of child mental health programmes into other programmes

Additional funding for child mental health programmes can be secured when child mental health issues are included in programmes dedicated to other important disorders. For example, in many parts of the world AIDS is now pandemic and special attention should be given to the consequences of AIDS on children and young people, including their mental health needs. There is a concern that the effects of AIDS on children and young people, including dementia, depression and other disorders, may go largely untreated. Moreover, the lack of recognition of depression, dementia and other mental illness in the context of HIV infection may contribute to the continuing spread of the epidemic. There is an interdependence and ‘vicious circularity’ between mental health and

HIV/AIDS. Mental health programmes are needed because of the vulnerability of people with mental disorders and substance misuse to contracting HIV, because mental ill health is an important health outcome of being infected with HIV and because mental health status affects the course of the disease in various ways. Access to mental health services has been shown to decrease AIDS progression and mortality.

Conclusions

The integration of child and adolescent mental health services into the primary care system can help to reduce the costs of services but also minimises stigma; however, convincing evidence of the effectiveness of such a combination in various socioeconomic and cultural settings still needs to be produced.

Rather than creating child and adolescent mental health policies and services after a disaster, it is likely to be cheaper and more convenient to develop and maintain them in advance. Such a strategy, and such arguments, could be used to secure funding for child and adolescent mental health services or at least to avoid cuts in funding.

Additional funding for child mental health programmes could be secured when child mental health issues are included in programmes dedicated to other important disorders, such as AIDS.

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College International Divisions: chairs and email addresses

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Pan-American Division
South Asian Division
Western Pacific Division

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Professor Sue Bailey elected College President

Congratulations to Professor Sue Bailey OBE, who was elected President of the Royal College of Psychiatrists. Professor Bailey will take office from Thursday 30 June 2011, at the College's International Congress in Brighton. Professor Bailey has previously been Registrar of the Royal College of Psychiatrists (2005–10) and since 1983 has been a Consultant Child and Adolescent Forensic Psychiatrist and Professor of Child Mental Health Policy at the University of Central Lancashire. Professor Bailey's priorities as President will be to ensure that the College helps its Members to be inspirational leaders for clinical teams and to be respected across medicine. Among Professor Bailey's priorities for the International Divisions is to enable them to develop their own programmes.

International Psychiatry Editorial Board

The Editorial Board of *International Psychiatry* is recruiting new members with a view to enhancing its pool of expertise. Editorial Board members will be required to contribute ideas for the development of the journal, to introduce new contacts, to assist with peer review and to submit papers for publication. They are also required to participate, either in person or by teleconference, in Editorial Board meetings, which take place four times a year.

To be considered for one of these positions, please submit a curriculum vitae and covering letter to ip@rcpsych.ac.uk. Please outline in the covering letter any relevant experience and your reasons for applying. The deadline for receipt of applications is 17 May 2011. Please refer to 'The role of the board member' (available at http://www.rcpsych.ac.uk/pdf/IP_EditBoard_terms.pdf) before submitting your application.

Eurobarometer special report on mental health

Eurobarometer, the European Commission's public analysis department, has published a special report on mental health. The main themes addressed in the report are:

- the state of mental well-being – how well people feel mentally and physically
- level of comfort at work – how secure people feel in their current jobs, whether they feel their skills match their current role and whether they feel they receive adequate recognition/respect for what they do
- care and treatment – what help and treatment people have sought to ameliorate any mental health conditions they have experienced

- perceptions of people with mental illness – how comfortable people feel about interacting with those with a mental health problem.

The full report can be found at http://ec.europa.eu/public_opinion/archives/ebs/ebs_345_en.pdf

Bursary from the Faculty of the Psychiatry of Old Age

The College's Faculty of the Psychiatry of Old Age has established an annual bursary to enable a psychiatrist from a low- or middle-income country to attend the 2012 Faculty Annual Residential Meeting (usually held in March) in order to give an oral or poster presentation, or deliver a workshop.

The bursary is intended to cover the cost of economy-class travel, accommodation, free registration and attendance at the conference dinner, up to a maximum of £1500. Informal mentors will be identified for the bursary holder, to enhance their introduction to Faculty members and their enjoyment of the meeting. Requests for more information and details of how to apply should be sent to ip@rcpsych.ac.uk

Pilot mental health outreach programme in Sindh

The Psychiatry Department at Shaheed Mohtarma Benazir Bhutto Medical University in Pakistan, in association with Singh Doctors Association UK, the British Pakistani Psychiatrists Association and the Royal College of Psychiatrists, has launched a schizophrenia outreach programme in Larkano Sindh, Pakistan (the SOUL Project). This project addresses the stigma attached to long-term mental healthcare, both for the patient and for the family. The SOUL project aims to:

- recognise, treat and manage identified patients with schizophrenia through a stepped-care approach, starting with home-based outreach treatment and with symptom resolution, stepping down to out-patient treatment
- aid recovery of the patients by facilitating their absorption into the local employment/labour market, through collaboration with local chambers of commerce and industry
- provide psychoeducation and awareness about schizophrenia to the family and local community
- generate clinical, functional and economic evaluation outcomes.

Obituary: Charles Schuster

It is with great sadness that we inform you of the recent death of Dr Charles Schuster. Dr Schuster contributed to the work of the World Health Organization through its

Expert Advisory Panel on Drug Dependence and Alcohol Problems from 1977 to 1998 and as a member of the Expert Advisory Panel on Drug Dependence (Dependence Liability) since 1998. He served on several Expert Committees, including the 33rd and 34th Expert Committees on Drug Dependence. Dr Schuster also founded the University of Chicago's Drug Abuse Research Center. From 1986 to 1992, he served as the Director of the National Institute on Drug Abuse, a position from which he oversaw the development of grant and contract programmes to fund research into

the aetiology, prevention and treatment of drug misuse, and its medical and social consequences. In 2000, he became Director of the Addiction Research Institute at Wayne State University, a position he held until his premature death. Dr Schuster made an outstanding international contribution to the field of addictions and international drug policy. He was a visionary leader with great personal charm, charisma and empathy for people in distress, whether through addictions or other mental illness. Deepest condolences go to his family and friends.

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NHS reforms – a threat to mental health services?

Sir: As a psychiatrist and general practitioner (GP) who moved to the UK to train in the National Health Service (NHS), we are concerned that controversial proposals for wide-sweeping reform may damage mental healthcare provision. According to a Department of Health spokesman (as widely reported in the news media, 11 March 2011), the UK government proposes to 'cut bureaucracy and give doctors the power and freedom to make the service more responsive to patient needs'. General practitioners are to be handed budgets to commission specialist services, including mental health services, with an emphasis on competition, not collaboration. We are concerned that these reforms are another step towards the privatisation of the NHS. Experience in countries with private, competitive healthcare systems is that mental health service users may be at a disadvantage and the quality of care variable. Recent US healthcare reforms towards a more inclusive model, based on social care and supporting the more vulnerable in society, reinforce this view.

The evidence for the need for transformation has been on the basis of poorer health outcomes in the UK compared with countries with similar levels of spending on health. This evidence has been contested robustly (Appleby, 2011; Goldacre, 2011). Moreover, the British Medical Association has stated that the reforms are 'potentially damaging' (as reported on 1 October 2010), particularly where competition as opposed to collaboration risks fragmentation of services.

The implications for mental health services are unclear. However, a number of UK mental health groups have expressed disquiet at the potential effects of these proposals. A survey by the charity Rethink (2010) found that most GPs did not feel equipped to commission mental health services. The mental health charity Mind (2011) has called on the UK government to ensure that any changes to NHS commissioning do not jeopardise the continuity and quality of care currently received by people with mental health problems. It emphasised the difficulties people already face in a relatively

well provisioned NHS mental health service. Mind (2011) also raised the spectre of GP 'doorstep lobbying', which may mean that mental health loses out in the battle for resources. A study by the Institute for Public Policy Resource Research (2011) suggested that the quality of dementia care would suffer under the reforms. The Institute reported that just 31% of GPs in London feel that they have received sufficient training to diagnose dementia. Furthermore, productivity improvements could be put at risk by the reforms, as could joint working, according to a report by the King's Fund and the Centre for Mental Health, with input from the Royal College of Psychiatrists and other stakeholders (see King's Fund, 2010). Substantial long-term financial savings can be made by integrating mental health and social care services according to the King's Fund study.

It is difficult to see how the proposals in their current form might promote integration and collaboration when their focus is on competition and fragmentation. Collaborative working across and between services, and optimal care pathways, are a cornerstone of successful mental health service provision. Countries undergoing healthcare reform might wish to follow both developments and mental health outcomes in the UK over the next few years.

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Elective on PTSD and mental health in Gulu, northern Uganda, December 2008–January 2009

Sir: I chose a psychiatry elective because of my interest in Uganda. There is a high rate of post-traumatic stress disorder (PTSD) among the Acholi people in the north, following the 1986–2006 guerrilla war between the Ugandan government and the rebel Lord's Resistance Army (LRA).

The LRA is infamous for using child soldiers (during the conflict, 30 000–60 000 children were abducted, making up over 90% of LRA troops) and committing atrocities against civilians. Villages were attacked, their inhabitants killed, beaten and raped; crops and stores were stolen and roads made impassable. In an attempt to gain control, the Ugandan government moved over 90% of the population of the north into camps for internally displaced persons; by 2005 these contained 2 million people. Unable to farm, the Acholi became dependent on the World Food Programme.

PTSD is found both in former child soldiers and civilian victims. Gulu town, once at the centre of the conflict, is now at the heart of regeneration. I worked with three organisations there:

- Gulu Regional Referral Hospital Mental Health Unit, the main psychiatric centre in the north, which runs outreach and daily out-patient clinics
- The Peter C. Alderman Foundation, an American non-governmental organisation (NGO) which specialises in rehabilitating victims of trauma, and which works closely with Gulu Hospital
- the African Centre for Treatment and Rehabilitation of Trauma Victims (ACTV), staff from which spend up to 4 days at a time in the field addressing all aspects of victims' lives.

Psychiatry is very paternalistic in Uganda, but PTSD management seems an exception, focusing on talking therapies, involving the patient in treatment. Medication is used in most cases, primarily antidepressants (usually amitriptyline), often with an antipsychotic (haloperidol). Almost universally, patients I spoke to had seen a benefit from therapy, especially meeting others who shared their experiences. But the further people are from Gulu town, the harder it is for them to access help.

The ACTV works effectively using a multidisciplinary approach. It has discussions led by social workers and drama projects which recall and deal with the trauma of the past. A clinical officer manages medication and a staff physiotherapist deals with stress-related musculoskeletal pain. Lawyers and social workers offer advice on everything from domestic violence to the land wrangles which resulted when families returned from camps to find strangers occupying their land. All aspects of patients' problems are covered.

Although there were fewer hands-on opportunities for me than there might have been in a medical elective, all the teams involved me fully. I found my psychiatry elective an excellent way to develop the brief grounding I had as a student – and by visiting a low-income country I learned a way of practising using limited resources. The 'Western' way of treating patients simply is not possible (for instance following guidelines produced by the National Institute for Health and Clinical Excellence).

A place as traumatised as northern Uganda will not heal overnight; but hope remains as long as victims of trauma have someone to talk to – even though, as one ACTV social worker told me – 'sometimes the best you can do is listen to their stories and say "I'm sorry"'.

Emily Sherley

Student Associate of the RCPsych

'Legal highs' – a health warning that does not appear on the wrapper

Sir: There are an increasing number of substances appearing on the recreational drug scenes in Europe, North America, Oceania and Japan (International Narcotics Control Board, 2011). In 2009 for example, 24 new psychoactive substances were notified in Europe, compared with 13 in 2008, including synthetic cannabinoids, tryptamines, phenethylamines and synthetic cathinones, according to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA & Europol, 2009).

Many are synthesised by chemists who modify the structure of existing psychoactive substances controlled by United Nations conventions so that they remain legal. These new generations of 'designer drugs' are marketed as 'legal highs', and sold in 'head shops' and increasingly over the internet as 'research chemicals'. Purity levels are very high; they are laboratory manufactured and sold, for example, as 'synthetic cocaine'. Thus, the products appear to potential consumers as both legal and safe.

Such assumptions are dangerous. If sold under a 'brand name', the contents and active ingredients are not listed; consumers do not know what they are taking. Even if a substance is advertised using its chemical name, is extremely pure and is chemically related to drugs with known desired psychoactive properties, there is no guarantee that it does not have potential adverse or even toxic effects. Adverse effects reported by users in recent years include psychiatric conditions such as psychoses, depression, anxiety, paranoia and suicidal ideation. Physiological effects similar to those experienced by overdosing on amphetamines, cocaine and ecstasy have been reported by attendees at emergency departments. Sometimes, these complications have resulted in fatalities (Ghodse *et al*, 2010).

Such occurrences led to risk assessments being conducted at national level in many countries, resulting in substances being controlled. For example, the Council of Europe on 2 December 2010, following a formal risk assessment (EMCDDA, 2010), adopted a Decision submitting mephedrone to control measures (Council of Europe, 2010). Following new controls, some chemists further manipulated the molecules of these chemicals so that they complied with the law.

New psychoactive substances are appearing at an increasingly faster rate than hitherto. Users are exposed to all types of unknown risks, as research and analyses have not been undertaken. Branded products may contain different active ingredients than when first marketed. For instance, initially,

'Ivory Wave' contained mephedrone, methylenedioxypropylvalerone (MDPV) and other cathinones but, following their control, desoxypropylvalerone was substituted. Imports of this latter chemical were restricted, but retailers released older stocks containing MDPV.

One beneficial effect of the control of mephedrone in the UK and media coverage of the adverse mental and physical properties of the substance was a fall in the number of suspected and confirmed fatalities involving its use.

Health professionals should be aware of the ever-changing nature of recreational drug use and the potential mental and physical health problems that may be caused by the consumption of new psychoactive molecules. Patients should be asked about their use of 'legal highs', as well as other substances misused.

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International Congress of the Royal College of Psychiatrists

28 June - 1 July 2011, Hilton Metropole, Brighton, UK

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Forthcoming international events

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Athens, Greece
Organiser: Association of Psychology & Psychiatry for Adults & Children
Email: congress@appac.gr
Website: <http://www.appac.gr/>

26–29 May 2011

3rd International Congress on ADHD

Berlin, Germany
Organiser: World Federation of ADHD
Website: <http://www.adhd-congress.org/>

29 May–2 June 2011

Royal Australian and New Zealand College of Psychiatrists 2011 Congress

Northern Territory, Australia
Organiser: Robert Parker
Website: <http://www.ranzcp2011.com>

29 May–2 June 2011

World Federation of Societies of Biological Psychiatry Congress 2011

Prague, Czech Republic
Website: <http://www.wfsbp-congress.org/>

7–12 June 2011

American Psychoanalytic Association 100th Annual Meeting

San Francisco, USA
Contact: Jake Lynn
Website: <http://www.apsa.org/>

9–12 June 2011

World Psychiatric Association Thematic Conference: 'Rethinking Quality in Psychiatry: Education, Research, Prevention, Diagnosis, Treatment'

Istanbul, Turkey
Contact: Ayse Askin Erten
Website: <http://wpaist2011.org/>

11–15 June 2011

14th International Congress of ESCAP (European Society for Child and Adolescent Psychiatry)

Helsinki, Finland
Email: escap2011@congress.fi
Website: <http://www.escap2011.fi/>

15–18 June 2001

51st International Neuropsychiatric Pula Congress (INPC)

Pula, Croatia
Email: info@pula-cong.com
Website: <http://www.pula-cong.com/>

28 June–1 July 2011

International Congress of the Royal College of Psychiatrists 2011

Brighton, UK
Email: conference@rcpsych.ac.uk
Website: <http://www.rcpsych.ac.uk/events/internationalcongress2011.aspx>

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://iafmhs.org/iafmhs.asp>

11–12 July 2011

6th International Conference on Child and Adolescent Psychopathology

London, UK
Organiser: Centre for Applied Research and Assessment in Child and Adolescent Wellbeing
Website: <http://www.roehampton.ac.uk/childandadolescentpsychopathology/index.html>

5–7 August 2011

1st Global Conference on Music and Mental Health

St Louis, Missouri, USA
Organiser: Global Research Studies
Website: <http://www.globalresearchstudies.com>

17–21 October 2011

World Federation for Mental Health 2011 World Congress

Cape Town, South Africa
Email: info@wmhc2011.com
Website: <http://www.wmhc2011.com>

19–22 October 2011

7th European Congress on Violence in Clinical Psychiatry – Challenges for Care and Treatment

Prague, Czech Republic
Email: conference.management@freeler.nl
Website: http://www.oudconsultancy.nl/prague_cfa/ecvcp/Invitation.html

15–17 November 2011

2nd Bergen Conference on the Treatment of Psychopathy

Bergen, Norway
Contact: Steffen Stamnes
Website: <http://www.bctp.no>

18–20 April 2012

ISAD 2012: Affective Disorders – Mind, Body and Society

London, UK
Organiser: International Society for Affective Disorders
Website: <https://www.isad.org.uk/conference.asp>

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