

International Psychiatry

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International Psychiatry is published four times a year.

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Annual subscription rates for 2011 (four issues, post free) are £28.00 (US\$50.00).
Single issues are £8.00 (US\$14.40), post free.

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

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

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

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

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

Manuscripts for publication must be submitted electronically to the Editor (hghodse@sghms.ac.uk), with a copy sent to the Secretariat (ip@rcpsych.ac.uk). The

maximum length for papers is 1500 words; correspondence should not be longer than 500 words. The Harvard system of referencing should be used.

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

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Mission of *International Psychiatry*

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

Subthreshold psychiatry

Ahmed Okasha

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Are we in need of including in our diagnostic systems a new category of subthreshold psychiatry? Studies have shown that we are faced in our daily clinical practice with many patients who do not fulfil the criteria of either ICD-10 or DSM-IV (at best they may be included under 'atypical', 'unspecified' or 'not elsewhere classified'). Subthreshold cases or prodromal psychotic or non-psychotic clinical cases are encountered frequently in clinical practice, especially primary care (Knappe *et al*, 2008), but because of some ethical and nosological issues their needs are unmet. Pharmacological interventions for such conditions are denied in some countries, especially with managed care, where maximisation of profit and minimisation of cost are often the main objectives. It has been reported that the early treatment of many disorders ensures a better outcome and better assimilation in society and reduces residual manifestations of disease. Recent data suggest that the impairment and disability caused by subsyndromal disorders are almost equal to those caused by syndromal ones. We need more scientific data and research studies to evaluate the course, outcome and value of treating such disorders.

Early identification of the prodromal phase of a psychotic illness can lead to earlier treatment and perhaps prevention of a first psychotic episode. Up to 35% of 12- to 30-year-old individuals with a family history of psychosis plus a recent deterioration in functioning or new subsyndromal psychotic symptoms become psychotic within 2–3 years, which suggests that these factors have important diagnostic implications (Cadenhead *et al*, 2010). It was found in the ABC Schizophrenia Study that in three-quarters of the cases initial psychotic symptoms were preceded by a prodromal phase of several years' standing, which began with non-specific signs such as negative and depressive symptoms (subthreshold) (Häfner *et al*, 1998). These had had adverse effects (including social disabilities) on those who subsequently developed schizophrenia (Löffler & Häfner, 2000). To adhere only to criteria specifying a number of symptoms or their duration could be misleading and we should take into consideration the level of disability and impairment.

Morbidity and prevalence

In post-traumatic stress disorder (PTSD), no significant differences were found between patients with full PTSD and those with subthreshold PTSD regarding their degree of impairment. In fact, though, it is rather difficult to identify clinical criteria that delineate between full-blown PTSD and subthreshold PTSD (Zlotnik *et al*, 2002).

Subthreshold symptoms in bipolar disorder impair functioning and diminish quality of life. In one study, a re-assessment of bipolar-spectrum disorders with the inclusion of patients with subthreshold symptoms revealed a prevalence at least fivefold greater than found with traditionally defined syndromal diagnostic criteria (Berk *et al*, 2008). The authors said that appropriate therapeutic interventions for the subthreshold manifestations should be considered even when threshold-level symptoms are absent.

In a 20-year follow-up study, patients with type I and type II bipolar disorder were found to experience subthreshold affective symptoms for half their lives (Judd *et al*, 2005). Many healthy people report depressive and hypomanic symptoms and many are identifiable as manifesting depressive, hypomanic and cyclothymic temperaments, which appear to predispose to the respective affective disorders and personality disorders. Only about 15% of the population report no such symptoms over their lifetime and are 'super-normal', with very low scores for vegetative lability and neuroticism (Merikangas *et al*, 2007).

Studies have demonstrated that depressive symptoms in various combinations, including subthreshold conditions, are present in as much as 24% of the population. This suggests that subthreshold and full syndromic disorders can be considered as falling along a spectrum, with subthreshold disorders being viewed as quantitatively milder than, but qualitatively similar to, full syndromic disorders (Shankman *et al*, 2008).

Karsten *et al* (2010) suggested that subthreshold depression based on functional impairment is better defined by symptom severity than by number of DSM-IV symptoms.

Types of subthreshold disorder

The only specific subthreshold diagnosis in either ICD-10 or DSM-IV is 'mixed anxiety depression disorder' (MADD), presented in ICD-10 under F41.2, 'Other anxiety disorders'. Data from the National Psychiatric Morbidity Survey suggest that MADD may account for half of all cases of common mental disorders in Britain. Of those with MADD, 12% reported a lifetime suicide attempt and 20% of all disability days in Britain occurred in people with MADD, accounting for around half of all the disability days occurring in people with common mental disorders (Das-Munshi *et al*, 2008).

There is a growing literature on subthreshold anxiety disorders, substance use disorders, conduct disorder, antisocial personality disorder and eating disorder. A family study of a variety of subthreshold disorders (MADD, bipolar disorder, anxiety disorders, alcohol use disorders, drug use disorders,

and conduct disorder/antisocial personality disorder) in a large community sample of young adults found that a subthreshold disorder may be associated with multiple full syndromic disorders and *vice versa*. Just as there is high comorbidity between full syndromic disorders, there is also high comorbidity between subthreshold conditions. A study on social anxiety disorder (SAD) above and below the diagnostic threshold found that the 12-month prevalence rate for above-threshold SAD was 2%, while it was 3% for subthreshold and symptomatic social anxiety (Lewinsohn *et al*, 2004).

Subthreshold eating disorders have been frequently observed in transcultural studies. In a study of 371 Egyptian adolescent girls (age range 13–18 years; 4.4% of the target population), only two cases met the ICD-10 research criteria for atypical anorexia nervosa (0.5% of the sample), while 26 cases met the criteria for atypical bulimia nervosa (7.0%) and 32 cases the criteria for unspecified eating disorders (8.6%). The author suggested that a culture-sensitive nosology for eating disorders was needed (Mahmoud, 1997).

Subthreshold personality disorder

Perhaps the most challenging field of research on cultural issues beyond the questions of boundaries between normality and abnormality is in personality functions. Cultural factors can contribute to the debate on whether personality disorders should or should not be considered autonomous mental disorders, or whether some of them are best considered as variants of Axis I disorders (e.g. schizotypal personality disorder as a variant of schizophrenia and borderline personality disorder as a variant of bipolar disorder).

The reliability and validity of the current diagnostic criteria of personality disorders in both ICD-10 and DSM-IV are low when applied in the Arab and North African regions. The schizoid, obsessive and avoidant personality disorders can have religious connotations, for example, and may even be desirable traits. It may be particularly problematic cross-culturally to apply categorical criteria developed in one culture to members of other cultures, for whom relevant categorical thresholds may differ. Again, religious perspectives in traditional societies may offer alternative interpretations of personality disorders: schizotypal features could connote closeness to God, schizoid features a kind person, paranoid features carefulness; similarly, avoidant behaviour may be praised by some religious conservatives who believe that mixing the sexes is unacceptable and who cherish shyness and avoidance, and anankastic traits may be perceived as meticulousness in following religious rituals. Culture thus affects the perception of mental symptoms – of what is a mental disorder and what is an accepted social trait (e.g. in traditional and religious societies negative symptoms may connote deeper contemplation of God, while positive symptoms may be attributed as a gift from God for extraordinary perception).

Need for dimensional measures

The addition of continuous, 'dimensional' measures to the various diagnostic domains might help to resolve some of the critical taxonomic issues currently facing the field of mental health. Regier *et al* (2009) recognised that categorical

and dimensional approaches to diagnosis are important both for clinical work and for research, and that the ideal taxonomy would offer both. To avoid diagnostic chaos, the dimensional scale must reflect the categorical definition and the two must have an obvious relationship to one another.

It is clear that the inclusion of subthreshold or sub-syndromal psychiatric disorder should have a place in our current nosology. The suffering, morbidity and functional impairment are almost equal to those of full syndromal disorders. The inclusion of those disorders not accommodated in the current nosology, whether ICD-10 or DSM-IV-TR, should be attempted in the proposed categorical dimensional system in ICD-11 and DSM-V so that we can ameliorate the suffering of people with these neglected mental disorders (Okasha, 2008).

There are, though, four ethical questions to be answered:

- Should we treat people who do not have a disorder by the current criteria of international classifications?
- Should we take 'quality of life' and 'disability' more into consideration in our diagnostic system?
- Should we include subthreshold disorders as part of the dimensional spectrum, rather than adding them as separate disorders?
- If we expand the scope for intervention, how can we address the risk of inappropriate medicalisation and iatrogenic harm from overdiagnosis and balance this against amelioration of suffering and disability caused by subthreshold disorders?

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THEMATIC PAPERS – INTRODUCTION

Children caught up in conflict

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We present our theme in this issue with an emphasis on the Middle East. Unrest between Israel and Palestine has a long history. Even when there is no overt aggression by either side, decades of conflict may have engendered cognitive distortions and emotional vulnerability.

Danny Brom and colleagues emphasise that there is evidence that even infants and pre-school children in Israel have suffered the consequences of trauma, or anticipated trauma. Their reactions look very much like the post-traumatic stress disorder (PTSD) we see after exposure to a variety of abusive experiences. Up to one-third of children who have been living in areas that are subject to missile attacks in Israel show some symptoms of PTSD. It seems that the duration of exposure to threats of potential violence is a particularly important variable. Similar patterns of disturbance have been observed in older children and adolescents. Interventions based within schools, from early childhood through to adolescence, have been shown to have measurable benefits.

In the Palestinian territory of Gaza, Abdel Aziz Thabet and colleagues describe the evidence for psychiatric disorders following exposure to war during middle childhood and adolescence. The Gaza territory has suffered major structural damage to domestic property in recent years as a

consequence of Israeli incursions. The authors were particularly interested in the possibility that components of attention-deficit hyperactivity disorder (as well as PTSD) could be related to exposure to such events. Using a variety of standardised instruments, the team surveyed a representative sample of children from cities, villages and refugee camps. Over a third were found to have experienced at least some PTSD symptoms.

In the third of our thematic papers on the longer-term impact of conflict on children, we revisit the Rwandan genocide. Ian Palmer and Nsanzumuhire Firmin describe the outcomes for children who had been caught up in the terrible events of 1994. They are now in early adulthood. The nature and scale of the depraved behaviour that occurred throughout Rwandan society was probably without precedent in modern times, in terms of both the proportion of the population affected and the involvement of children themselves as perpetrators as well as victims of the violence. Attempts at restorative justice have seemingly not proved very effective in this, Africa's most densely populated country. Half the population was born after the conflict; many children were the product of rape. Many more have HIV/AIDS. Attempts are being made to establish an effective mental health service in Rwanda, but progress is slow.

President's Medals

During its 2011 International Congress, the College celebrated the achievements and contributions to mental health from people in all walks of life by presenting them with President's Medals. There were nine medal winners this year:

- Dr Martin Deahl
- Dr Andrew McCulloch
- Ms Trisha Goddard
- Dr Peter Hughes
- Dr E. S. Krishnamoorthy
- Norman Lamb MP
- Emma Thompson
- Dr Peter Carter
- HE Kjell Magne Bondevik

Further information about these medal winners is available on the College website (<http://www.rcpsych.ac.uk>).

The influence of war and terrorism on post-traumatic distress among Israeli children

Danny Brom PhD,^{1,2} Ruth Pat-Horenczyk PhD^{1,2} and Naomi L. Baum PhD¹

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The Middle East has been in conflict for many decades and wars have become the 'normative reality' of children residing in the area. Questions have been raised about children's vulnerability to the stresses that come with living in a war area. Are children more resilient because they are more flexible in their ways of coping? Or are children more vulnerable because their psychological development is influenced by the environment?

The impact of war and terrorism on children has been the focus of a growing number of studies in Israel (Solomon & Lavi, 2005; Pat-Horenczyk *et al*, 2007). Related studies have investigated the effectiveness of school-based interventions designed to build resilience in the face of such trauma (Berger *et al*, 2007). In this brief report we focus on the impact of political violence in Israel on children, with a special emphasis on these children's post-traumatic distress. Although there is a parallel literature on Palestinian children, our focus is on the Israeli side. And, although we have extensively studied the effectiveness of protective factors that may help to shield certain children, reporting on that line of research is outside the scope of this paper.

Early childhood

The prevailing opinion is that:

- even infants appear to have the ability to perceive and remember traumatic events and, consequently, develop symptoms of post-traumatic distress that are similar to those exhibited by older children and adults
- the developmental skills of infants affect the phenomenology of their post-traumatic distress (Scheeringa *et al*, 2003).

Reactions akin to those exhibited by persons diagnosed with post-traumatic stress disorder (PTSD) have been reported among infants and pre-school children following traumatic events such as a car accident, witnessing a parent being murdered, experiencing physical or sexual abuse and being exposed to terrorist attacks or natural disasters.

Laor and colleagues conducted several studies with 3- to 5-year-old Israeli children and their mothers during three different time periods: 6 months, 30 months and 5 years after the Gulf War (see Laor *et al*, 2001). The results showed a clear relationship between the mothers' post-traumatic symptoms and the intensity of post-traumatic distress in their children, regardless of the amount of time elapsed after the war. On the other hand, by 30 months and 5 years after the war the post-traumatic symptoms had significantly improved, irrespective of age or gender.

Wang *et al* (2006) have reported that, based on maternal reports of their children's behaviour, young children's exposure to terrorism significantly increased their risk of post-traumatic distress. Another study (Pat-Horenczyk *et al*, 2011a) examined 255 toddlers and their mothers at risk of missile attacks. The assessment included interviews measuring maternal post-traumatic and depressive symptoms as well as evaluations of their children's behavioural, developmental and post-traumatic symptoms. There was a high prevalence of PTSD in both the young children (33%) and their mothers (28%). The most prevalent behavioural symptoms among the young children were low tolerance of frustration (52%), demanding immediate attention (51%) and sleep disorder (44%).

In an as yet unpublished study, Pat-Horenczyk *et al* compared the level of post-traumatic distress in young children growing up in Sderot, an area exposed to continual missile attacks for over 7 years, with the distress of children in two Israeli cities exposed to fire during the 2006 Lebanon War (further details available on request). The children exposed to the ongoing but often harmless missile attacks manifested much higher post-traumatic distress (37%) than the children exposed to war (approximately 12%). Regardless of the site, there also was a strong association between maternal post-traumatic symptoms and children's distress.

Mid-childhood

Because of differences in developmental level, one might expect that the reactions of older children and adolescents to war and terrorism would be different from those of young children. Solomon & Lavi (2005) conducted a study in middle schools and found that approximately 12% of Israeli children living in the Jerusalem area reported moderate to very severe levels of post-traumatic symptoms during the Second Intifada, when bus bombings and suicide bombers were an everyday reality. The percentage was significantly higher (27.6%) among Israeli youths living in settlements within the occupied territories, where exposure to terrorism was even greater.

Adolescence

The prevalence of PTSD in adolescents exposed to terrorism was investigated by Pat-Horenczyk *et al* (2007), who found that, during the Second Intifada, 5–10% of Israeli adolescents reported severe post-traumatic symptoms and an additional 8–10% reported partial PTSD.

In a large comparative study of Palestinian and Israeli youths, Pat-Horenczyk *et al* (2009) reported that greater exposure to conflict-related violence was associated with more post-traumatic distress and more somatic complaints, with girls reporting more distress than boys. A total of 6.8% of the Israeli students and 37.2% of the Palestinian students met criteria for PTSD.

A study carried out in Israel after the Second Lebanon War (Brom *et al*, 2007) based on more than 3985 youths (1761 Jewish and 2224 Arab) found that 7.2% of the Jewish students and 15.2% of the Arab students exhibited symptoms of PTSD.

Taken together, these studies indicate that both Palestinian and Israeli youths have been affected by the violence that has raged in the Middle East for many years, but particularly since the beginning of the Second Intifada.

School-based interventions

Israel, like other areas where there is ongoing conflict, has tried to deal with the relatively large groups of children who show signs of post-traumatic distress. Models of intervention have been developed that integrate community outreach, prevention and clinical approaches. Most of these models focus on educational settings and train teachers to become agents of change (Baum *et al*, 2009). Teachers are well placed to teach children resilience skills and to create an atmosphere of trust in the classroom. Focusing on educational environments as centres of rehabilitative activity allows students to return to a sense of normalcy while surrounded by peers and educators who can offer support. School-based interventions have an additional advantage, in that they can be delivered on a city-wide or regional scale, creating the greatest impact on the community at large. One example is the Building Resilience Intervention (BRI) model (Baum *et al*, 2009). It focuses on helping teachers with their own coping strategies; they can then bring into the classroom the resilience skills that they have learnt, to the benefit of their students.

Programmes have been delivered via the Israeli educational system from early childhood through to adolescence. The goals of these interventions include:

- empowerment of institutions that deal with children to become trauma-informed agents of change, strengthening resilience and children's mental health
- strengthening the resilience of teachers, parents and children
- monitoring the mental health responses of children
- delivering non-stigmatising and easily accessible treatment for children who manifest severe responses to trauma.

Such intervention programmes have been shown to be effective. In one study, teachers received 4 hours of intensive training and then administered eight classroom intervention sessions to their students to teach them post-trauma coping skills. Students' PTSD symptoms improved and no new symptoms developed (Berger *et al*, 2007).

Conclusions

The Israeli experience has shown that political violence affects the well-being and mental health of children. Younger

children seem to be more vulnerable than older children. The symptoms of distress change along the developmental axis. In the aftermath of trauma and disaster, schools can be a major force in protecting the well-being of children. Teachers can be trained in resilience techniques aimed at increasing awareness and developing coping skills both for themselves and for their students. A promising approach is a city-wide implementation of the school-based intervention method, with the involvement of teachers, parents and community leaders (Pat-Horenczyk *et al*, 2011b). Particular effort should be made to adapt the model for vulnerable populations, such as minorities, immigrants and other special-needs groups. The comprehensive model for post-trauma intervention developed in Israel is applicable to many other contexts in which entire communities are affected. It should include immediate intervention, followed by a screening process designed to assess post-traumatic distress, provision of targeted interventions for teachers, parents and students, and longer-term treatment services for those with persisting needs. Clearly, the impact of trauma on children goes beyond psychopathology. Further research is needed to elucidate the complex influence of trauma on the development, behaviour and attitudes of children growing up in a war zone or in any other type of traumatised community.

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Post-traumatic stress disorder and attention-deficit hyperactivity disorder in Palestinian children affected by the war on Gaza

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The Gaza Strip has been badly affected by war and conflict over the past four decades. Palestinians are exposed to repeated incursions of the border areas, with many resulting casualties. At the end of December 2008, more than 230 Palestinians were killed and at least 770 were injured, including 100 in critical condition, after an Israeli airstrike. This was followed by a military operation that continued for 23 days, in which 1420 Palestinians, including 446 children, were killed. At least 4000 houses were totally destroyed and 16000 partially damaged (Palestinian Red Crescent, 2008).

Previous studies have reported on the impact of trauma on child and adult mental health following this conflict (Thabet *et al*, 2008). Indeed, there is a growing literature on the prevalence of emotional disorders, predominantly post-traumatic stress disorder (PTSD) and depression, in similar circumstances. Some studies have focused on the different pathways and mechanisms between these disorders, while others have examined their comorbidity. Less research has been done on the comorbidity between PTSD and externalising conditions such as attention-deficit hyperactivity disorder (ADHD). This would be particularly important for diagnostic and treatment purposes, because of the potential similarities between symptoms such as hyperarousal and hypervigilance (Ford *et al*, 2000). For example, an early study of maltreated children found that 35% met criteria for PTSD, of whom 37% were also diagnosed with ADHD (Famularo *et al*, 1996). The rationale of the present study was to examine this interesting type of comorbidity in children at high risk of developing PTSD because of their exposure to war trauma.

Method

The sample was randomly selected from the population census in five areas of the Gaza Strip. Each area was divided into blocks; from each block one street was chosen; and from each street every tenth family home was approached. All selected families provided informed consent. The resulting sample consisted of 410 Palestinian children, aged 8–18 years (mean 12.9, s.d. 3.9): 224 boys (54.6%) and 186 girls. The fieldwork was conducted between May and June 2009 by five mental health professionals trained in research.

The following measures were completed:

- War on Gaza Traumatic Events Checklist for Children (Thabet *et al*, 2008). The earlier version was adapted for the nature of traumatic events occurring during the recent conflict. It consisted of 25 items, rated 'no/yes' (0/1), and a total score was calculated (Cronbach's $\alpha = 0.80$, split half = 0.68).
- UCLA PTSD Index for DSM-IV for Children (Pynoos *et al*, 1998). This comprises 22 self-report items rated 0–4. A total score was calculated and a categorical prevalence estimated. The reliability of the Arabic version used in this study was ascertained (Cronbach's $\alpha = 0.83$, split half = 0.81).
- Structured Clinical Interview for DSM-IV Diagnosis of ADHD – Parents' form – Arabic version (Thabet *et al*, 2006). This consists of 18 items, with children scoring positive on six or more 'inattentive' items considered inattentive and those positive on six or more 'hyperactivity-impulsivity' items considered hyperactive-impulsive. The 'combined' category (inattentive-impulsive) is based on summing both inattentive and hyperactive-impulsive scores. The Arabic version was used, following translation and back-translation by a panel of five experts (Cronbach's $\alpha = 0.89$, split half = 0.760).

Results

Families lived in cities (43.5%), villages (12.5%) and refugee camps (44.0%). Their size was large, as 13.6% had fewer than four children, 61.4% had five to seven children and 25.0% eight or more children. The majority (60.9%) had a monthly income of less than US\$350, 30.4% earned US\$351–700 and only 8.7% earned more than US\$700.

Palestinian children reported a range of traumatic experiences: 95% had heard sonic sounds of jetfighters, 92% had heard shelling by artillery, 92% had seen mutilated bodies on television, 80% had been deprived of water or electricity during the war and 51% had left their home for a safer place. The mean number of reported traumatic events was 8.5 (s.d. 3.9), without significant gender differences ($t = 1.18$, $P = 0.23$).

The total number of traumatic events (as recorded on the Traumatic Events Checklist) was significantly associated with scores on the UCLA PTSD Index (Pearson correlation $r = 0.29$, $P = 0.001$). There was no significant difference between

boys and girls in PTSD scores ($t=0.53$, $P=0.56$). Overall, 39.3% of children reported reactions that fulfilled the DSM-IV criteria for partial PTSD, while a further 9.8% met the criteria for full PTSD. According to parents' reports on the Structured Clinical Interview for DSM-IV Diagnosis of ADHD, 31.3% of children reported clinically significant attention-deficit symptoms, 36.3% reported impulsivity-hyperactivity symptoms and 29.0% reported a combination of the two (inattentive-impulsive). Twenty-one children (5.1%) had significant comorbid PTSD and attention-deficit symptoms, 18 (4.4%) had comorbid PTSD and impulsivity-hyperactivity symptoms and 18 children (4.4%) had comorbid PTSD and inattentive-impulsive symptoms.

Discussion

This study was conducted 6 months after the participants had been exposed to a wide range of traumatic events during the war on Gaza. Most of the children still remembered traumatic events and over half had had to leave their home for a place of safety. This is consistent with our previous studies (Thabet *et al*, 2008).

In the present study, 39.3% of children reported partial PTSD and 9.8% reported full PTSD, which is also consistent with earlier findings. Pat-Horenczyk *et al* (2009) assessed the effects of ongoing violence on the mental health of Palestinian and Israeli youths. They found that 37.2% of Palestinian students in the West Bank reported symptoms meeting the criteria for full PTSD and an additional 12.1% reported symptoms meeting the criteria for partial PTSD. Abdeen *et al* (2008), in a study of Palestinian students from both the West Bank and Gaza, similarly found that 36% of West Bank and 35% of Gaza participants reported symptoms meeting criteria for full PTSD according to DSM-IV-TR, while 12% and 11% respectively reported symptoms meeting criteria for partial PTSD.

The focus of the present study was, however, the overlap or comorbidity between post-traumatic stress and attention-deficit hyperactivity, which ranged between 4.4% and 5.1% for the ADHD symptom categories recorded on the Structured Clinical Interview for DSM-IV Diagnosis of ADHD. The overlap of ADHD and PTSD often involves the following symptoms: irritability, excessive motor activity, concentration difficulties, impulsive behaviour and exaggerated startle responses (American Psychiatric Association, 1994). Both conditions may be characterised by difficulty in concentrating, restlessness or irritability and impulsivity. Some authors (e.g. Famularo *et al*, 1996) have argued that because several symptoms in the diagnosis of ADHD also arise in the context of the maltreated child syndrome (or attachment disorders), they may indicate PTSD and anxiety rather than developmental disorder. Alternatively, physical overactivity in children with PTSD could be a result of increased muscular tension because of anxiety. According to DSM-IV-TR (American Psychiatric Association, 2000), the symptoms of ADHD and PTSD in growing children have certain similarities. In both ADHD and PTSD there is difficulty in sustaining attention, an incapacity to listen, failure to complete duties, difficulty in organisation, avoidance of mental tasks, memory dysfunction, irritability and restlessness.

Children repeatedly exposed to traumatic events seem to have a high risk of displaying both sets of symptoms and

diagnoses. The finding of PTSD-related and ADHD-related symptoms appearing together in the same child might be looked on as comorbidity. Nevertheless, true comorbidity might not apply because the symptoms manifested in the two disorders are so similar. Children may have PTSD-related symptoms and, because of their anxious state, show hyperactivity, attention problems and impulsivity. This could be conceptualised as ADHD by the clinician.

The diagnostic implications would benefit from further research with children exposed to different types of trauma, especially longitudinal studies that might disentangle the phenomenology and outcome of the two disorders (including their comorbid presentation). Whatever the underlying issues and mechanisms, the findings highlight the importance of psychiatric training in detecting both the effects of trauma and neurodevelopmental disorders, across different conflict situations and cultural groups. Only accurate diagnosis can formulate appropriate treatment for children with ADHD, as opposed to psycho-educational and other universal and targeted interventions for PTSD.

It is important to acknowledge a number of limitations in this study, such as: the use of structured interviews in the community that were originally designed to measure childhood ADHD in clinical settings; the lack of multi-informant and consistent corroboration of both PTSD and ADHD symptoms; and the lack of measurement at different points.

Acknowledgements

We are grateful to all children and families who participated in the study, and to the five mental health practitioners who completed the fieldwork.

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Mental health in post-genocide Rwanda

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The children who experienced the genocide against the Tutsi in Rwanda are now in their mid to late 20s. It is almost impossible to comprehend the scale of the terror and destruction of Rwanda's societal infrastructure between 6 April and 16 July 1994. While the world remained inactive, Rwanda, a small impoverished central African state, experienced the murder of about 1 million of its citizens; it also saw the terrorising, humiliation and rape of countless thousands. Although women and children were directly targeted, some actively engaged in atrocities. About 300 000 children were murdered, a significant number at the hands of other children. The level of terror differed across the country and escape was frequently by luck alone. A UNICEF (2004) study of 3000 children revealed that 80% had experienced death in the family, 70% had witnessed a killing or injury, 35% saw other children killing or injuring other children, 61% were threatened with being killed and 90% believed they would die (Human Rights Watch, 2003). Of the 250 000 women raped, 30% were between 13 and 35 years of age, 67% developed HIV/AIDS and 20 000 births resulted (Donovan, 2002).

Rwanda is Africa's most densely populated country. Forty-three per cent of the population are 14 years of age or under, the median age is 18.7 years and life expectancy at birth is 58 (CIA, 2011). The frames of reference in relation to children's developing identity within families and communities were disrupted for the thousands of children who suffered at the hands of family members or neighbours during the genocide. Such a legacy colours all contemplations of mental health in Rwanda today. While justice, trust and safety have improved immeasurably over the past 17 years, individuals can find themselves isolated from their collective past and current social and political realities. About 95 000 were orphaned in 1994 and subsequently through violence, infectious diseases, HIV/AIDS or imprisonment of parents. Women and girls were raped and some genitally mutilated; some remain open to sexual exploitation and abuse. Children as young as 7 were recruited, manipulated, incited or forced into perpetrating atrocities and some were combatants. Many have since become heads of household and now care for ill, injured or disabled relatives; most will have had their education severely disrupted (UNICEF, 2004).

Justice

Rwanda's National Policy of Reconciliation has the object of recovery and reconciliation for individuals and the nation, and justice is paramount in this process. The problems of

providing justice are uniquely difficult. In 1994 Rwanda had to create a new criminal justice system and legislation to address the situation but the involvement of the international community in this could have undermined Rwanda's own progress (Unvin, 2001).

There are three levels of justice:

- the International Court of Justice
- the usual judicial process
- local *gacaca* restorative justice courts.

At an individual level, involvement in the justice system can be deeply distressing and even dangerous. How successful it will be remains to be seen, especially as survivors and perpetrators continue to live together and some perpetrators show no remorse and do not seek forgiveness.

Education

The Rwandan government has utilised education to aid reconciliation and healing. In 1994 the educational infrastructure was destroyed and many teachers killed. Since this time a university and 13 institutes of higher education have been created, as well as schools. Nine years of free education is provided for all. Through the FARG (Fond d'Assistance pour les Rescapes du Genocide), the government funds fourth-, fifth- and sixth-form fees and 4 years of higher-education fees for survivors' children unable to pay. For homeless children collective accommodation is provided, for example in orphanages (as part of the *imidugudu* housing policy), sometimes with the inclusion of vocational training. The government has encouraged the population to abandon ethnic affiliation and to see themselves as Rwandans and in 1994 the National Unity and Reconciliation Commission established the Ingando programme to educate all Rwandans about the causes of the genocide and to promote messages of peace and unity, through seminars and workshops. One non-governmental organisation (Radio La Benevolencija) uses the media to present educational material through radio plays, documentaries and local workshops.

Commemoration

Every April there is a week of national mourning in which the collective memory is revisited across the country. The Rwanda Ministry of Health (through its hospitals) provides ambulances, medicines and mental health professionals for medico-psychosocial interventions at the sites of commemoration across the country as numerous survivors

become agitated, anxious, fearful and very distressed, particularly those with flashbacks who relive the events of 1994. Some require hospitalisation but not all seek help.

Mental health services

Ninety per cent of mental health service costs are met by community-based health insurance (the figure is 100% for those on the lowest incomes). Those who are better off financially have access to other types of health insurance. A stepped-care approach is provided, from health centres in rural areas, to district hospitals and the central referral facility in Kigali (Ndera Neuropsychiatric Hospital). The Ministry of Health has created the Psychosocial Consultation Service (Service de Consultation Psycho-Social; SCPS), based in Kigali, for all Rwandans. There are now five psychiatrists in Rwanda. Specialised nursing staff and psychologists work in district hospitals and are trained at the Kigali Health Institute and the National University of Rwanda, and the Institute of Agriculture, Technology and Education (INATEK), respectively; they provide pharmacological, psychological and social support. Attempts are made to provide outreach and home-visiting programmes and classic out-patient clinics remain in district hospitals. Other than the Comité Technique Belge (CTB), which continues to collaborate with the Ministry of Health's programme of mental health, there are few non-governmental organisations involved with mental health issues (their endeavours are more related to infectious diseases).

Although there are some problems with the epidemiological studies (Rodin & Van Ommeren, 2009), post-traumatic symptoms were common soon after the genocide and in one study done 10 years on the prevalence rate was 44% (Schaal & Elbert, 2006). Those children caught up in the holocaust are now adults and in 2009 depression and substance misuse were common in the 29% of the general population who were found to have post-traumatic stress disorder (PTSD) (Munyandamutsa & Mahoro Nkubamugisha, 2009). There is no similar national experience to draw from nor consensus as to how to proceed (Staub *et al*, 2005; Gupta & Zimmer, 2008) but traumatic exposure and post-traumatic symptoms are among the factors associated with attitudes towards justice and reconciliation (Pham *et al*, 2004) and need to be addressed.

In the district hospital in Ngarama, as well as post-traumatic symptoms, common mental health conditions are managed; these include depression, anxiety, brief psychosis, drug (mainly cannabis) and alcohol misuse, and somatoform disorders. Sadly, despite continuing fears of being killed and emotional and dissociative re-experiencing phenomena that plague many, delayed presentation seems common. As yet there is no specific service for children and adolescents, among whom substance misuse is increasingly problematic, as are ongoing family and community adjustments to the genocide and frequent sexually transmitted infections,

including HIV/AIDS. The mental health needs of women are important, especially as 34% are heads of household. The most powerful nationwide women's group is Avega Agahozo, founded in 1995 by the widows of genocide. Women who were raped have been particularly stigmatised (Newbury & Baldwin, 2002) and children affected by HIV/AIDS have complex needs. Children may be infected or have to care for affected relatives, with all the attendant issues of poverty, stigma and loss (Cluver & Gardner, 2007).

Conclusion

A functioning mental health service is a small yet important part of recovery from the social and moral consequences of war. As with the Rwandan criminal justice system, the task for mental health services is unique. We can only support and learn from Rwanda as the country seeks to find a distinctive cultural solution to a unique problem.

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Mental health in the Plurinational State of Bolivia

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Bolivia is a multicultural country located in the heart of South America. Neighbouring countries include Brazil, Peru, Argentina, Paraguay and Chile. It is a large nation, with an area of nearly 1 100 000 km², although most of its territory was lost in wars. A particularly damaging loss was the sea coast, which was lost to Chile in the late 1800s. According to the constitution, Sucre is the capital city but La Paz is the seat of government and is often referred to as the capital.

As with most Latin American countries, Bolivia was subject to Spanish colonisation in the 1500s. It became an independent republic in 1825. According to the National Institute of Statistics (<http://www.ine.gob.bo>), Bolivia has a population of 10 million and the largest proportion of native people in Latin America. In fact, in the 2001 census, 62% of the population over 15 years of age self-identified as native. Bolivia is a multicultural country. The ethnicities most represented are: Quechua (30%), Aymara (25%), Chiquitano (2.2%), Guarani (1.5%) and Mojeno (0.85%), with 36 groups having been identified in all. The main languages spoken in Bolivia include Spanish, Aymara, Quechua and Guarani. In 2009, following the implementation of the new constitution, Bolivia officially became a secular state. However, Roman Catholicism remains, at least nominally, the religion of most of the population.

Bolivia is considered one of the poorest countries in South America, despite recent improvements in financial, social and health areas brought by the first native president, Evo Morales, elected in 2005 and re-elected in 2009. These included, for example, the 'Bono Juana Azurduy de Padilla', which provides free antenatal care for expectant mothers, as well as postnatal care up to the age of 2 years, with a view to reducing mortality rates in infants. Overall, the proportion of the population living on less than US\$2 a day was 30.4% in 2005 and 21.9% in 2007 (United Nations Development Programme, 2010). As a result of Bolivia's slight reduction in inequality in recent years, it is no longer considered the most unequal country in Latin America.

The major export industries include gas and soya. There is a long history of mining, dating back to colonial times. Large amounts of lithium, used in many modern batteries, have been found in the south-west. Bolivia is also the third largest producer of coca leaves in the world.

Health

Life expectancy is currently 66.3 years (United Nations Development Programme, 2010). In the decade 2000–09, there were on average 120 doctors per 100 000 people; in

2008, the under-5 mortality rate was 54 per 1000 live births and the proportion of births attended by trained health professionals was 65.8% (United Nations Development Programme, 2010).

Overall, health has improved in the past 20 years, with illnesses such as malaria and polio being now much better controlled (Rivera, 2008a). However, access to healthcare is still uneven across the population and is especially difficult in rural and highland areas. A health service reform process started in 2004 but resources for mental health remain scarce (Rivera, 2008a,b).

Traditional/alternative medical practice is common in Bolivia, with *curanderos* being known as *Kallawayas* (Becht, 1998). Most healers use natural herbs and remedies, as well as general counselling, which involves lengthy discussions with the patient. It is estimated that, when ill, some 40% of Bolivians typically use traditional medicine only.

Mental health services

The first psychiatric hospital was opened in 1933, in Sucre, as an independent hospital, but in 1964 the psychiatric services became part of the national health service, Caja Nacional de Seguridad Social (Rivera, 2008a,b).

Mental health legislation was formulated in 1978 and revised in 2001. It focuses on promotion, prevention and human rights, and it regulates mental health services. Alongside the mental health strategy, there is a national mental health programme in place, initially put forward in 1972 and revised in 2001. Its objectives include the integration of mental health services in primary care and the development of specialised services. So far, only 10–25% of the programme has been implemented. The specialist programmes in place are directed at children and elderly populations (Rocha, 2008; World Health Organization, 2008).

At present, there are 9 psychiatric hospitals across the country, offering 9.2 beds per 100 000 inhabitants and 29 mental health units for out-patient psychiatric care (World Health Organization, 2008). For every 100 000 inhabitants, working in mental health there are 0.22 general doctors (not trained in mental health), 0.34 nurses, 5 psychologists, 0.25 social workers, 0.20 occupational therapists and 1.43 other professionals, including medical assistants and counsellors (Rivera, 2008a; World Health Organization, 2011). The total number of psychiatrists in the country is 95 (Rocha, 2008).

Access to services and adequate management of psychiatric conditions are unfortunately suboptimal, due to financial constraints. Only 0.2% of the national budget is

ring-fenced for mental health services. Typically, most resources are provided to the psychiatric hospitals and out-patient units to cover the costs of medication and staff and so on. Extra funding may, however, come from both non-governmental organisations and charities supported by the Church.

Professional training

Formal academic training involves 5 years of general medicine plus 3 years of specialisation in psychiatry. This involves placements in city-based hospitals as well as in more rural areas of the country. The first stage of training is awarded by the university in which the training was completed; further specialist psychiatric training is awarded by the Sociedad Boliviana de Psiquiatria (see <http://www.psiquiatriabolivia.org>).

Prevalence of psychiatric conditions

The principal conditions for which patients are admitted to specialised psychiatric centres in Bolivia (Rivera, 2008a) include: schizophrenia/schizotypal disorders (28.0% of admissions); substance misuse (28.0%); organic mental disorders (including somatic disorders) (17.5%); mood disorders (13.5%); neurotic disorders secondary to stress

(6.9%); personality disorders (2.9%); intellectual disability (1.7%); and anorexia nervosa (0.2%). Substance misuse involves alcohol in 88% of cases and drugs (mainly cocaine and marijuana) in 7%; the remaining 5% involves polydrug misuse. Overall, the tenth commonest reason for any doctor's consultation in Bolivia is depression.

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COUNTRY PROFILE

Mental health in Somalia

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Somalia, in the Horn of Africa, suffers violence, political instability and high mortality rates. The recent major drought in Somalia led to what was termed the worst humanitarian disaster in the world. In July 2011 it was reported that nearly 60 000 people had entered into Kenya from Somalia already that year, including 1300 new arrivals every day to the Dadaab refugee camp, described as 'the largest, most congested and one of the most remote refugee camps in the world' (see <http://www.unhcr.org/4e204b1e9.html>). The drought along with mass migration into such poor conditions are likely to have

significant short- and long-term mental health consequences for the populations involved.

Somalia comprises Somaliland, Puntland and South Central Somalia (Somalia-SC). Somaliland, in the north, declared independence from Somalia in 1991, with resulting relative peace, stability and development, but is yet to be internationally recognised. The Puntland State of Somalia, in the centre (including the Horn itself) was established in 1998 by traditional and political leaders (Ministry of Planning and Statistics, 2003). Most of the violence is now concentrated in Somalia-SC, where there is considerable destruction of the infrastructure.

The population of Somalia is estimated to be around 9.3 million, of whom 65% are nomadic (United Nations Department of Economic and Social Affairs, 2010). Some 1.5–2.2 million are in Puntland (Ministry of Planning and Statistics, 2003; Puntland Development Research Center, 2004) and 2–3.5 million are in Somaliland (Jarabi, 2007), with the remainder in Somalia-SC. There are 139 000 internally displaced persons in Puntland, 67 000 in Somaliland and 1 259 000 in Somalia-SC (see <http://www.unhcr.org/refworld/docid/4d3574d42.html>). The vast majority of Somalis are Sunni Muslim. Gross domestic product (GDP) per capita was US\$298 in 2008.

There are not yet any national epidemiological studies of mental illness in Somalia. However, in a community study in Hargeisa, Somaliland, in which 4854 randomly selected persons were screened, the rate of severe disability due to mental disorders was 8.4% among adult males. Exposure to conflict and heavy *khat* use were correlated with psychotic symptoms (Odenwald *et al*, 2005). High rates of female genital mutilation (98%) (Gulaid, 2008) as well as suspected high rates of domestic and gender-based violence may prove potent risk factors for mental illness in women.

Mental health legislation and policy

There is no overarching mental health policy or legislation in Somalia. In Somalia-SC national mental health 'focal points' (health service providers nominated by the Ministry of Health) are authorised to provide mental health services (World Health Organization, 2009a) and psychotropic medicines are included on the essential medicines list. In Somaliland mental health is included in the 1999 National Health Policy (a precursor to mental health legislation) and in the essential package of health services (EPHS) at tertiary (referral hospital) level. The Puntland Agency for Social Welfare (PASWE), an autonomous semi-governmental agency, was created to 'develop and promote policies and standards toward protecting and assisting the most vulnerable people' in Puntland (see <http://paswe.org>).

Health funding

There has been a fivefold increase in external funding for the health sector in Somalia over the past decade (Capobianco & Naidu, 2001) but the performance of the health sector remains poor and less than half the population has access to adequate healthcare (United Nations Development Programme, 2001). In Somalia-SC there is no public budget and no public financial management or accountability: most health-related activities are run by private or public institutions or through the unofficial out-of-pocket system (World Health Organization, 2009a). The health budget in Somaliland is only \$750 000. In Puntland, the education, health and water sectors combined receive less than 5% of the government budget. According to government officials, 'resources available to the Ministry are limited and its role has been primarily to coordinate the activities of international agencies and NGOs' (Ministry of Planning and Statistics, 2003).

Mental health services

The civil war destroyed much of Somalia's healthcare infrastructure, which, in addition to the migration or death of health personnel, means that access to healthcare is greatly compromised (Leather *et al*, 2006).

Traditional and religious healers (mostly herbalists and faith healers) are the mainstay of the general population's access to mental healthcare. There are no data available on their numbers or training, or on patient outcomes, and there is concern that some practices are harmful. Families often feel they have no option other than to restrain people with severe mental illness in homes or local jails (which can occur without a court hearing).

The mental health of patients has often severely deteriorated by the time they are brought to hospital. For example, the onset of mental illness among patients of the Bosaso Mental Health Department (MHD) in Puntland is on average 3.5 years before their first visit. At the time of their first clinic visit, some 85% of patients have been visited at least once by a Koranic healer or by a traditional healer. During the first year of opening of the MHD almost 30% of patients were brought in physically chained (according to the MHD database). Psychotropic drugs are unregulated and family members often rely on the purchase of drugs directly from pharmacies.

Somaliland

There are no psychiatric staff available in general primary or secondary healthcare services, and limited psychotropic medication is available in only two of the general health facilities. Until recently there were only two public psychiatric units in Somaliland, a ward in Hargeisa Group Hospital (HGH) (110 beds) and Berbera Mental Hospital (42 beds), both staffed by auxiliary nurses. The unit at HGH has input from a post-intern doctor and is supported by an Italian non-governmental organisation (NGO), Gruppo per le Relazioni Transculturali (GRT), and a local NGO, the General Assistance and Volunteer Organisation (GAVO), which provide salary support, medication, supervision and training. The unit in Berbera is supported by GAVO and has access to a general doctor (Syed Sheriff *et al*, 2010).

The newly opened out-patient unit in Boroma is supported by Amoud University and run by one of the former KTSP mental health representatives (see below), and an out-patient clinic and day clinic in Burao for children with intellectual disability is supported by a local NGO.

There is a growing number of privately owned, unregulated mental health service providers which have in-patient and out-patient facilities with pharmacies in Somaliland (World Health Organization, 2009b).

Puntland

A ten-bed mental health facility was opened in 2003 in Bosaso. GRT has supported the training of eight staff, including one doctor, the provision of free mental healthcare to in-patients and out-patients, home visits and free medication. In Garowe there is a facility run by a local organisation for 39 male patients that has some nursing staff and sporadic visits from a doctor. There is also a psychological out-patient department run by PASWE. PASWE also runs a 22-bed facility for women staffed by four nurses in Galkayo.

Somalia-SC

There are five public facilities with mental health services in Somalia-SC, two in Mogadishu (53 beds and 170 beds), one in Jalalaqsi (15 beds and an out-patient department), one in Merka providing basic mental health services from the general hospital, and one in Baidoa (35 beds), all staffed by nurses and volunteers with *ad hoc* mental health training by the World Health Organization (2009a).

Psychiatric training

The Somaliland health sector is largely unregulated and health professionals unlicensed. With the exception of the newly qualified, most doctors in Somaliland work exclusively in the private sector and have not received continuing professional development (Syed Sheriff *et al*, 2010).

In 2000 and 2005, two medical schools opened in Somaliland, in Boroma and Hargeisa respectively, and over 50 students have graduated. A link between King's College Hospital, THET (the Tropical Health and Education Trust) and partners in Somaliland, known as KTSP (King's THET Somaliland Partnership), set up a mental health group in 2007, described elsewhere (Syed Sheriff *et al*, 2010), which has enabled mental health to be incorporated into undergraduate and postgraduate training. For the past 4 years mental health has been taught to final-year medical students by visiting UK psychiatrists in collaboration with the educational institutions and GAVO. The website Medicine Africa delivers distance tutorials to final-year students (see Finlayson *et al*, 2010). There is a project partnering medical students in Somaliland with those in the UK. Since 2009 psychiatry has been examined in medical finals, assisted by external examiners from the UK.

A 2-year internship programme provides a structured training environment for junior doctors in Somaliland. Mental health has been part of internship since late 2009, and in 2010 a continuing professional development course in psychiatry was provided by KTSP for 28 interns in Hargeisa and Boroma. Currently, regular supervision for Somaliland interns and post-interns is provided from matched UK staff via Medicine Africa. A KTSP mental health representative has been regularly selected competitively from among Somaliland interns to advocate for mental health locally, build local faculty and medical leadership, and increase the sustainability of the work of KTSP. GRT also provides periodic training by a consultant psychiatrist to the post-intern former KTSP representative working in Hargeisa Group Hospital.

In Somalia-SC the first 20 medical students since 1991 graduated in 2008 (see <http://www.somalianinfo.com/somalian-physicians.html>), although less encouraging was the brutal suicide bombing attack during the diploma ceremony 1 year later.

There is no medical school in Puntland.

Research

There is no academic faculty for mental health. Limited research in mental health has been conducted by academic institutions elsewhere in the world, sometimes in collaboration with local NGOs (Odenwald *et al*, 2005; Reggi, 2011). A

patient database was created by GRT in 2004 in the Mental Health Department, Bosaso, Puntland.

Acknowledgements

The authors acknowledge the work of Abdulkadir AbdiKalif Ali, Fatuma Hashi Farah, Maryam Hassan Dahir, Sakin Jirdeh, Deria I. Ereg, Sacad A. Walhad, Andrew Leather and the work of THET.

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New Honorary Fellows

On 30 June 2011 the College inaugurated five new Honorary Fellows:

- Professor James Louis John Appleby CBE FRCPsych
- Stuart Bell CBE
- Professor Michael Gelder FRCPsych
- Dr Pedro Ruiz
- Dr Nada Stotland MD MPH

Honorary Fellowship is one of the highest awards the Royal College of Psychiatrists can bestow on an individual. The individuals to whom Honorary Fellowship is awarded are highly distinguished and have all made tremendous contributions either to psychiatry or to mental health services in the UK and worldwide during their careers. Further information about these outstanding candidates is available on the College website (<http://www.rcpsych.ac.uk>).

The representation of low- and middle-income countries in the psychiatric research literature

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Despite the growing importance of mental health in international and national policies, the contribution to the psychiatric evidence base from non-Western countries is sparse. Such a gap in research output between high- and low-income countries constrains improvements in public health and mental health policy and practice in developing countries, where there is perhaps the greatest unmet need. If research is to inform local mental health policy and practice, it must reflect the diverse realities of local health systems and cultural factors.

The World Health Organization (WHO) warns that inequalities in health outcomes and access to care between the world's richest and poorest countries are much greater today than they were in 1978 (World Health Organization, 2008). Another useful reminder is the 'nine to one' rule, according to which 90% of health resources are consumed by 10% of the richest countries. Therefore, it is not surprising to note similarly high inequity in health research. This applies to dissemination outputs in leading psychiatric journals. Despite a plethora of declarations, funding for mental health research in low- and middle-income (LAMI) countries remains hard to obtain. Lack of an evidence base consequently has an adverse impact on service planning and delivery (Gonzalez-Block, 2004).

Geographical disparities have been recorded and commented upon in mental health research. A review of the period 1996–98 showed that only 3.2% of research contributions came from less affluent countries (Patel & Sumathipala, 2001); a similarly low proportion from LAMI countries was found again a few years later (2002–04), despite the fact that these countries account for 90% of the global population (Patel & Kim, 2007). This was aptly labelled 'Western medical journals and the 10/90 problem' (Saxena *et al.*, 2006). In the light of these findings by previous reviews and advances in technology, it would be interesting to explore whether the publication trends have changed in recent years. This was the rationale for this study.

Method

The aims of this study were: (1) to determine the overall contribution of LAMI countries to high-impact general psychiatric journals between 2005 and 2009; and (2) to contrast our findings with earlier reviews. In order to draw comparable findings, we based our method on that of Patel &

Kim (2007). We thus liaised with the authors, who kindly advised on their adopted criteria.

A retrospective review of all issues in 2005–09 was conducted of the following high-impact journals: *Archives of General Psychiatry*, *American Journal of Psychiatry*, *Journal of Clinical Psychiatry*, *British Journal of Psychiatry*, *Acta Psychiatrica Scandinavica* and *Psychological Medicine*. Three journals were published in North America and three in Western Europe. Only research articles (i.e. not case reports or reviews) were included. We searched all research articles and identified those containing original data collected from one or more LAMI countries, as defined by World Bank (2003) criteria. For example, countries like Taiwan and Hong Kong were not included. Multinational studies were counted if at least one LAMI country was involved or where there was clear evidence that at least some data were collected from a LAMI country.

Results

Our search identified 3791 research articles. The total number of articles from LAMI countries was 259 (6.8%). The breakdown of publications and the proportion of LAMI publications per journal was: *Archives of General Psychiatry* (16/349; 4.6%); *American Journal of Psychiatry* (28/736; 3.8%); *Journal of Clinical Psychiatry* (72/914; 7.9%); *British Journal of Psychiatry* (67/764; 8.8%); *Acta Psychiatrica Scandinavica* (34/355; 9.6%); *Psychological Medicine* (42/673; 6.2%). Thus the European journals published more articles from LAMI countries. When contrasted with the findings of earlier surveys (Patel & Sumathipala, 2001; Patel & Kim, 2007), the overall trend seems to be towards an increased proportion of articles from LAMI countries (Fig. 1), although the number of contributions remains low. The first author for half of all research articles published from LAMI countries was based in a high-income country. The five leading LAMI countries were India, Turkey, Brazil, China and South Africa. The majority of LAMI countries had no articles published in these journals.

Discussion

This survey of the six leading international psychiatric journals shows that less than 7% of all literature published is derived

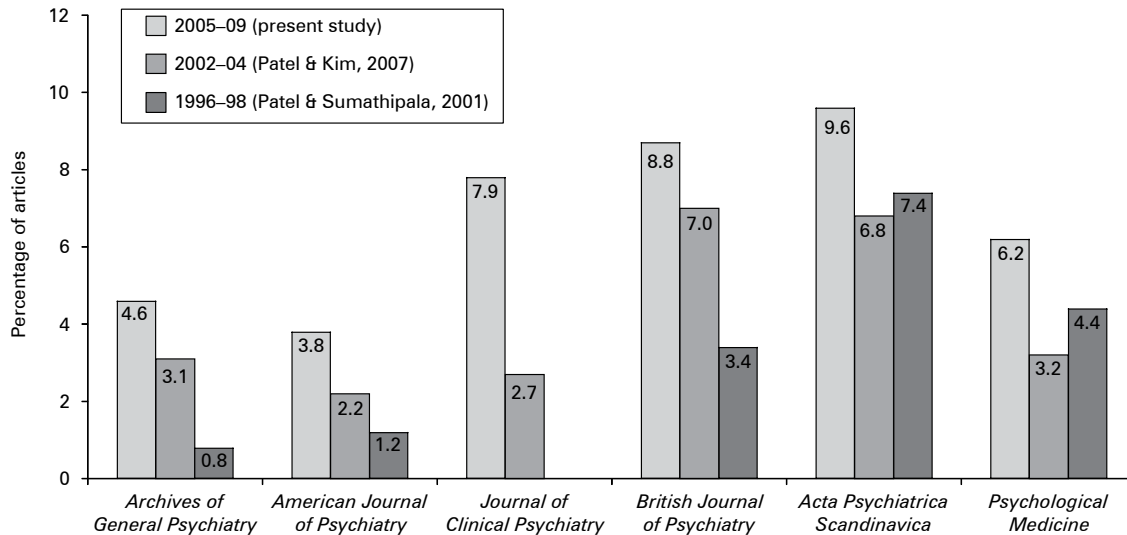


Fig. 1 Percentage of articles from low- and middle-income countries published during different periods

from LAMI countries, which account for 90% of the global population. The findings are similar to a review of all ISI journals over a 10-year period, which reported that 6% of the articles were from LAMI countries (Saxena *et al*, 2006). However, it was also found that all journals showed an increase in the proportion of articles from LAMI countries compared with earlier reviews.

It is evident that the majority of articles in major psychiatric journals originate from high-income countries; and despite the efforts of the WHO in promoting research from LAMI countries (World Health Organization & Joint Editors, 2004), their international representation in high-impact psychiatric journals remains low.

We can only speculate about the reasons underpinning these disparities. It is possible that the overall proportion of submissions is low, which can be attributed to various issues. The authors from these countries might be submitting to national journals. More importantly, there appears to be a shortage of trained researchers as well as limited opportunities for training and supervision in LAMI countries. Furthermore, previous research suggests that WHO programmes promoting mental health research (Eisenberg *et al*, 1999) in low-income countries did not always have the level of impact that might have been expected.

Submitted papers might be of low presentational quality, including writing style and difficulties for authors from countries where English is not their first or academic language (Ehrlich *et al*, 2007), along with poor research design and methodology, which are themselves due to restricted availability of research infrastructure and funds. It is estimated that only 5% of global health research funds are devoted to health conditions in low-income countries (Mari *et al*, 1997) and this disproportion appears even greater for mental health research.

It is also important to consider editorial policy on and peer review of articles from LAMI countries (Tyrer, 2005; Osrin *et al*, 2009). Editors and reviewers may reject these papers on the grounds that they are less relevant to their national readerships, although this will increasingly be counterbalanced by marketing strategies to access new and larger reading markets. More than half of the research published

from LAMI countries is led by authors from high-income countries. This may highlight potential benefits of international collaboration, while remaining mindful that the high-income origins of Western researchers do not result *per se* in papers being accepted from LAMI countries. It could also be a matter of concern that the already small research capacity of LAMI countries could be diverted towards the research agenda of high-income countries and organisations, particularly through industry-sponsored research, rather than led by national and local needs.

Previous researchers (Patel & Kim, 2007) proposed several actions which, although not measured by this study, are important to consider in explaining the findings: some high-impact journals have indeed broadened their remit to address an international readership and this is beginning to be reflected by editorial board membership; there have been more explicitly international journals; and more national journals are being indexed. Certain limitations of this study need to be acknowledged, such as not controlling for the number of LAMI countries included in multinational studies, which may have upwardly biased longitudinal comparisons; and only including six journals, thus potentially missing broader publication changes, like a greater proportion of articles from LAMI countries in the lower-impact or explicitly international journals or a decrease in other high-impact health journals, which would have compensated for the proportionate increase in this sample.

Overall, the tentative increase in the range of international research dissemination, despite the awareness of its importance, suggests the need to raise skills and capacity for research in diverse regions. The WHO and international research institutions can play an influential role in this process. Low- and middle-income countries with good research output should play a leading role in increasing the infrastructure and quality of future mental health research skills. In addition to previous recommendations, journals should be proactive in attracting and supporting submissions from LAMI countries. Publishers should provide help in improving presentation and language if they wish to increase worldwide readership, considering the wider electronic access to libraries and different formats of dissemination.

Such robust steps in the near future to break barriers and to reduce research under-representation from LAMI countries will improve the evidence base at international level, and thus the quality of service provision and the further development of truly international psychiatry.

Acknowledgements

We would like to thank Professor Ricardo Araya for his advice on the inception of the study, and Professor Vikram Patel and Youl-Ri Kim for their permission to replicate their selection criteria in the method.

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ORIGINAL PAPER

Audit of ICD-10 diagnosis use at admission assessments and in discharge summaries by psychiatric trainees

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Article 14 of the General and Specialist Medical Practice Order 2003 for specialties in psychiatry describes the specific conditions that a doctor must meet in order to be eligible as a specialist for the purposes of inclusion on the Specialist Register. The conditions as published by the Royal College of Psychiatrists (2003) include, among other requirements, that the psychiatrist shall demonstrate working knowledge of the epidemiology, aetiology, psychopathology, clinical features and natural history of the major psychiatric disorders in ICD-10 (World Health Organization, 1992), including age, gender and socio-cultural considerations, based upon the scientific literature. Familiarity with ICD-10 diagnostic criteria is therefore an important part of psychiatric training.

Clinical audit serves the goals of improving communication among colleagues and other professional groups, improving patient care and administration, and increasing professional satisfaction (Johnston et al, 2000). A clinical audit therefore is a valuable tool. The use of ICD-10 diagnosis at admission assessment can be beneficial in formulating the management plan. In this study, we present an audit of the use of ICD-10 diagnosis among psychiatric trainees, at

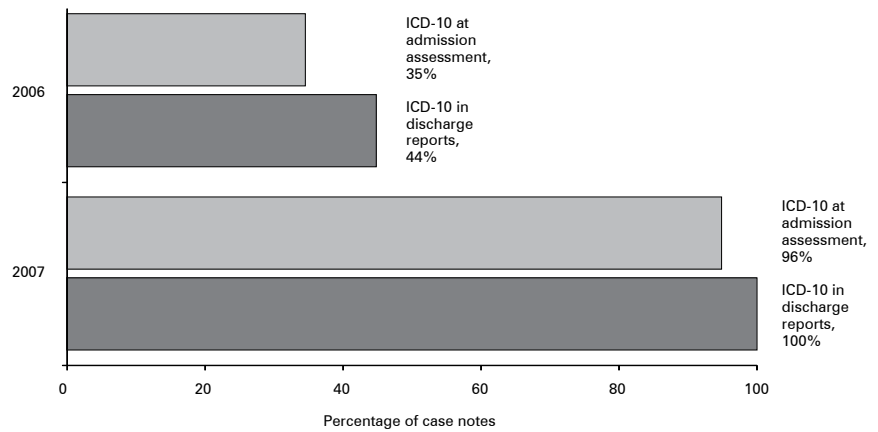
admission assessments and in discharge summaries provided for general practitioners; it was conducted with a view to improving the quality of clinical practice of these trainees.

Method

This audit was undertaken in a 49-bed acute psychiatric unit (25 beds for women, 24 for men) located in the south-eastern part of Ireland.

A period was chosen in the calendar year of the psychiatric training scheme that was generally deemed to be a fair representation of a time when trainees were expected to have gained at least a fair working knowledge of common psychiatric disorders, including ICD-10 diagnoses. These trainees were at various stages of psychiatric training. The period chosen was the 2 months at the end of the calendar year (i.e. November–December), because new intakes come into the psychiatric rotation scheme twice a year, first in January and then in July of every year, meaning that the least experience at the end of any year is about 6 months in psychiatry (i.e. intake in July).

Fig. 1 The results of the clinical audits before and after implementing agreed departmental standards



Admission records from the computerised database on the unit were examined to identify patients who had been admitted and discharged between 1 November and 31 December of the year 2006. Using the hospital numbers of each admission, the files were manually retrieved from the filing office, and each file individually checked for recording of ICD-10 diagnosis in assessment notes at admission and in discharge summaries. The audit was based on the files that could be retrieved, as some were not found (for various reasons, including misfiling and misplacement). The exclusion criteria were patients admitted between 1 November and 31 December 2006 but not discharged during this period and patients discharged but not admitted during this period.

First stage of the audit – baseline

Entries in the files that correctly used ICD-10 diagnostic terminologies were counted. For example, a diagnosis of 'depression' was not counted but 'moderate depressive episode with somatic syndrome' was accepted. Similarly, a mere entry of 'recurrent depression' was not accepted but 'recurrent depressive disorder', with a further stipulation of current episode moderate with or without somatic syndrome, or current episode severe with or without psychotic symptoms, was accepted. The entries at admission assessments and in discharge letters to the general practitioners were manually counted and collated.

The findings were presented and discussed during one of the weekly departmental clinical meetings.

Second stage of the audit – interventions

A departmental standard of 70% compliance with ICD-10 diagnosis use was set. This was designed to improve the quality of clinical practice of trainees. The following interventions were agreed (see Crossan *et al*, 2004).

- Copies of the ICD-10 codebook were made available on the ward and in the admission office.
- Use of ICD-10 diagnostic criteria/terminology was encouraged and discussed at ward rounds and case presentations.

- Trainees received tuition on writing discharge summaries.
- Discharge summaries were checked by consultant psychiatrists for appropriate use of ICD-10 diagnosis, and feedback was given to trainees.

Third stage of the audit

The clinical audit was then repeated over the same period 1 year later (in 2007) without the knowledge of the trainees and consultants, and the results compared.

Results

Seventy-two admissions were identified from the computerised database on the unit at the first stage of the clinical audit. Five of these patients remained on admission during the 2-month audit period. Of the remaining 67 patients who were discharged (and who therefore qualified for inclusion in the study) only 54 cases (81%) were studied because 13 sets of case notes could not be found.

In the admission assessment notes of the 54 cases studied, only 19 (35%) complied with ICD-10 diagnosis. When the discharge summaries provided for the general practitioner were examined, only 24 (44%) used an ICD-10 diagnosis.

When the audit was repeated 12 months later, there were a total of 85 admissions. Thirty-five of these patients remained on admission during the 2-month period. Files were recovered for all 50 of the discharged patients. Of the 50 sets of admission assessment notes, 48 (96%) recorded the ICD-10 diagnosis. When the discharge summaries were examined, all 50 (100%) had an ICD-10 diagnosis recorded (Fig. 1).

Discussion

Specific interventions – provision of education and tuition in the use of ICD-10, provision and easy availability of ICD-10 codebooks and encouraging trainees to use the ICD-10

Treatment of Bahraini health workers

Many health associations across the globe have expressed their concerns at the sentencing of 20 health workers in Bahrain who offered medical assistance to protestors during the time of civil unrest in Bahrain in February 2011.

In a letter to the UK Foreign Secretary, the President of the Royal College of Psychiatrists wrote that it condemned "the sentencing of doctors and nursing staff for treating patients according to their medical need, and according to every code of practice of doctors and nurses". The British Medical Association has called on the Bahrain Government to recognise international standards of human rights and medical ethics and continues to campaign for the human rights of the Bahraini health workers. The *British Medical Journal* has stopped all dealings with the Bahraini Government since the uprising in February.

criteria and terminologies in clinical communication – improved trainees' use of ICD-10 diagnoses. This type of audit, to the best of our knowledge, has not been previously performed.

Despite the small number of cases in this study, the issue of trainees' familiarity with standard diagnostic classification systems, especially ICD, is important because it is expected that all trainees, irrespective of location, are taught how to assess patients and communicate with colleagues. Familiarity with ICD criteria is also vital in the preparation for the membership examinations of the Royal College of Psychiatrists, in which it is often tested. Our study findings and recommendations have broad relevance in this regard.

Limitations

It is not always possible at the point of admission to know the exact ICD-10 code, as the diagnosis may still be unclear, but a good working diagnosis at this stage will inform appropriate intervention. The small sample size of this study is also an issue. It is uncertain how far the results of this local audit may be generalised. This audit was based on ICD-10 and this is expected to be soon superseded by ICD-11 and DSM-V.

Conclusion

Use of ICD-10 diagnoses is an important part of psychiatric training. It enhances good clinical practice and is often tested in College examinations. Emphasis on ICD-10 diagnostic criteria and terminologies during ward rounds, and in every form of clinical communication, should be encouraged at every stage of training. Psychiatric trainees should be taught their use in order to bring their clinical practice up to the College standard.

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Being monolingual, bilingual or multilingual: pros and cons in patients with dementia

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This article looks at the advantages and disadvantages of being monolingual or multilingual, with particular reference to dementia patients who belong to ethnic minorities. There has been some progress in understanding the field of cultural diversity and the variations between different ethnic groups in relation to their specific difficulties when suffering from dementia (Hendrie et al, 2001). However, research has largely been targeted towards cultural variations and dementia, while the language aspects have not been properly researched.

The National Dementia Strategy was launched in the UK in 2009. It highlights the needs of dementia patients who belong to ethnic minorities and tries to predict what problems may arise if services are not appropriately geared to managing this particular group.

There is an increasing need to understand the linguistic changes faced by multilingual patients from ethnic minorities who suffer from dementia. A more comprehensive

understanding of this group of patients could be achieved if professionals were aware of some of the implications of multilingualism for their patients.

Language has been described as comprising symbols that convey meaning and also the rules for combining those symbols. By definition 'monolingual' means the ability to speak only one language, 'bilingual' two languages and 'multilingual' several languages.

D'Acerno (1990) describes the acquisition of a first language as an intrinsic component of a child's overall social and cognitive development, whereas the learning of a second language need not be so. D'Acerno also noted three types of bilingualism: compound bilingualism, coordinate bilingualism and sub-coordinate bilingualism. Individuals who learn two languages in the same environment so that they acquire one notion with two verbal expressions are compound bilinguals. A coordinate bilingual person acquires the two languages in different contexts, say in home and

in school, so that the words of two languages belong to separate and independent systems. In sub-coordinate bilingualism, one language dominates.

Findings in aphasic multilinguals or polyglots

In aphasic multilingual patients, recovery in one language is usually accompanied by recovery in another, but non-parallel recovery is also seen (Mendez *et al*, 1999). The language first recovered may be the one acquired earliest, the predominant one or the one spoken in the patient's environment.

In dementia, new information is retained the least well and older information is preserved for longer; this is similar to what is observed in multilingual patients who revert to their mother tongue (i.e. the earliest acquired language) (Mendez *et al*, 1999). This phenomenon was highlighted in a survey of bilingual aphasic patients who had suffered from asymmetrical language impairment, with preservation of their first acquired language (Paradis, 1997).

There are differences in the physiological brain function of early and late bilinguals, for example in the left inferior frontal gyrus, which modulates syntactic processing, word generation and sentence generation. Further differences have been observed in the grey-matter density of the posterior parietal cortex, as well as in right-hemisphere involvement (Wattendorf & Festman, 2008).

Perani *et al* (1998) studied individuals who had learnt their second language either early or late, and who had varying degrees of proficiency in their second language, using a sample of individuals who spoke Italian and English or Spanish and Catalan. They found that the degree of proficiency was more important than age of acquisition of the second language as a determinant of cortical representation.

Findings in relation to dementia in monolingual versus multilingual patients

Language 'separation' as dementia progresses has been studied by Hyltensam & Obler (1989). Multilingual dementia patients regress to their original language as a result of an exacerbation of their cross-language difficulties, and this process advances with age. But bilinguals have also been observed not to deactivate either of their languages, which results in interference of their second language by their first (dominant) language (Hyltensam & Obler, 1989).

Mendez *et al* (1999) studied 51 patients of varying fluency in both English and another language who were having progressive memory or cognitive problems. In this study most patients communicated in their native language with family or friends and English was used only in a rudimentary form and only outside the home. Despite these patients' differences in educational level, the age at acquisition of English, the frequency of use and their baseline fluency in English, all their caregivers reported that these patients had a preference for their original, primary language. When talking in English, the caregivers reported that words from their mother tongue intruded into the patient's conversation.

The advantages of being multilingual in relation to dementia

Bialystok *et al* (2006) examined the role of a lifelong bilingual status in maintaining cognitive functioning and delaying the onset of symptoms of dementia in old age. A cohort of 228 patients (of whom 51% were bilingual) with varying degrees of cognitive impairment was followed up in a memory clinic. The bilinguals presented with symptoms of dementia 4 years later than monolinguals. All the other components of their cognitive assessments were similar.

The mother tongue or primary language appears to be maintained longer because it is stored using implicit strategies, whereas the second language is stored using explicit strategies (Fabbro, 2002). Language is used not only in social relationships but also to control cognitive processes. These findings suggest that there are significant differences between bilinguals and monolinguals in relation to age-associated cognitive decline during both normal and abnormal ageing, as indicated by Ardila & Ramos (2010). Their research review suggests that normal ageing is associated with increased interference between two languages and that reverting to the primary language can be considered a predictor of dementia; it has also been found that bilinguals are usually faster in performing attention tasks and more efficient at carrying out tests that require executive control than monolinguals (Ardila & Ramos, 2010).

A study was conducted by Howard (2010) in Montreal (Canada) on patients suffering from Alzheimer's dementia who were multilingual immigrants in Canada or bilingual non-immigrants who had grown up speaking both Canadian languages – French and English. The study reported a small but significant protective effect in relation to both the diagnosis and the age of symptom onset of Alzheimer's dementia in those who spoke more than two languages; they did not find a similar significant benefit in the bilinguals. In relation to the immigrant group they found that speaking two or more languages delayed the onset of dementia for 5 years on average, which was similar to the findings of Bialystok *et al* (2006).

To illustrate this phenomenon, we can look at the case of a 61-year-old bilingual Spaniard who suffered from Alzheimer's dementia and spoke both Italian and Spanish. Neuropsychological assessments were performed and an individualised integral cognitive stimulation programme was given to him that lasted 3 years. His progress was followed up by a series of cognitive tests in both languages. As the illness progressed the patient had increasing difficulty in separating the two languages and had frequent intrusions of either language. In this patient the first language, which was Italian, remained intact for a longer period, as suggested in the studies referred to above. Italian intrusions of his mother tongue were found during his test sessions in Spanish (his second language) and *vice versa*. Gradually, this patient started to respond mainly in Italian, even though the tests and questions were given in Spanish (Diaz & Peraita, 2008). In patients suffering from dementia, both comprehension and the ability to speak in the primary language are preserved longer than comprehension and the ability to speak in both the second and third language.

Conclusion

There does seem to be sufficient evidence to conclude that as dementia advances with age, patients who speak two or more languages have a tendency to revert to their primary language. It does also appear that bilingual and multilingual immigrants from various geographical backgrounds appear to be protected from the onset of dementia for about 4 years. In terms of the National Dementia Strategy referred to above, these linguistic issues are important in the treatment of aphasic bilingual or multilingual patients. If we are to provide information and make people aware of the implications of their illness, further research is necessary which could lead to improved communication and care for these patients suffering from dementia who belong to ethnic minorities.

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SPECIAL PAPER

Psychiatrists are stakeholders in improving access to controlled medicines

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Medicines made from substances that are controlled under the international drug control treaties ('controlled medicines') are out of reach for the majority of patients around the world. Seya et al (2011) demonstrated that 5.5 billion people (83% of the world's population) live in countries with little or no access to opioid analgesics, 250 million (4%) have moderate access and only 460 million people (7%) have adequate access. Insufficient data are available for 430 million (7%). If the need for treatment of moderate to severe pain were to be satisfied adequately, the global consumption of strong opioid

analgesics would go up from 231 tonnes of morphine-equivalents to 1292 tonnes.

Controlled medicines belong to a number of therapeutic classes. The World Health Organization (WHO) has produced a Model List of Essential Medicines and a Model List of Essential Medicines for Children. Among the controlled medicines on these lists are: opioid analgesics; long-acting opioids for the treatment of opioid dependence; medicines for emergency obstetrics; benzodiazepines both for mental disorders and against epilepsy; and phenobarbital, also an anti-epileptic. Ketamine is listed as an

anaesthetic and, although not controlled under the international treaties, many countries now control it under their national responsibility. Ketamine is often the only possibility for anaesthesia in resource-poor, often rural settings in low- and middle-income countries. Various other medicines not listed on the WHO Model Lists of Essential Medicines are controlled, including stimulants for the treatment of attention-deficit hyperactivity disorder (ADHD) and similar syndromes.

For classes other than opioid analgesics, we have limited data on their availability. However, it is certain that many do not have access to opioids for the treatment of opioid dependence. Furthermore, it has been reported that in low- and middle-income countries many patients with epilepsy are not treated and are thus needlessly disabled. In Africa, 80% of the population affected by epilepsy have no access to essential anti-epileptic medicines (World Health Organization, 2008). With benzodiazepines we estimate that under- and over-treatment occur simultaneously, but whether over- or under-treatment dominates depends very much on the country situation.

During the past century the world has developed an international system of drugs control that has gradually become more stringent. The current treaties date back to 1961 (amended by a protocol in 1972) and 1971. After stating that the parties are 'concerned with the health and welfare of mankind', the treaties define the objectives of the prevention of 'abuse' and dependence, and of keeping the controlled medicines available for medical and scientific purposes. However, the focus over time has been on the prevention of misuse and dependence, so much so that the accessibility and availability of the medicines containing the substances have declined.

Legislation in many countries does not allow for the medical use of these medicines; even where it is allowed, procedures are complex and in practice patients often do not have access. Also, many physicians do not have adequate knowledge of how to use these substances and many are biased against their use because they believe patients will become very easily dependent on these medicines when prescribed, or even will be killed by their medicines. Patients and their families often hold similar attitudes and hence many refuse potentially beneficial treatments. Moreover, procurement can be difficult because of the bureaucracy involved and low turn-over expectations may hamper enterprises seeking market access for these medicines.

WHO action towards better patient access

Since 1986, the International Narcotics Control Board (INCB) has requested that countries improve access to controlled medicines. For instance, in its 2009 annual report, it once again declared that:

One of the fundamental objectives of the international drug control treaties is to ensure the availability of narcotic drugs and psychotropic substances for medical and scientific purposes and to promote access to and rational use of narcotic drugs and psychotropic substances. (United Nations, 2010)

Over the last few years, attention to the problem of low accessibility has increased, as shown by resolutions adopted by the World Health Assembly (World Health Organization, 2005), the United Nations Economic and Social Council (United Nations, 2005) and the Commission on Narcotic Drugs (2010). As a result of the former two resolutions, the INCB and WHO developed the Access to Controlled Medications Programme in 2007, operated by the WHO. Many other organisations have developed activities to improve access to these medicines. Human Rights Watch (2009) and the Open Society Institute (2008) have published on the topic.

The WHO's *Ensuring Balance in National Policies on Controlled Substances* provides guidance on how to develop policy and legislation that will improve access to these medicines (World Health Organization, 2011). It includes 21 guidelines based on the principle of balance, i.e. that policies should aim to optimise public health outcomes by maximising access to controlled medicines for medical and scientific purposes while minimising misuse and dependence. The guidance, which includes a Country Assessment Checklist for operationalising its recommendations, can be used by governments and others to review policies and legislation.

Over the years, the WHO Access to Controlled Medications Programme experienced a tendency to focus on pain patients and even on cancer pain patients only. However, the WHO estimates that there are, in addition to the 5.5 million cancer pain patients untreated for pain every year, tens of millions other pain patients who are not treated for their moderate or severe pain. Moreover, it is estimated that 1 million HIV infections could be prevented every year if methadone and/or buprenorphine were available for the treatment of dependence and annually 75 000 cases of maternal death from post-partum haemorrhage could be prevented if ergometrine (which is also a precursor for LSD) or oxytocin (not under international control) were readily available (World Health Organization, 2009). Benzodiazepines, although they may be over-prescribed in some countries, may be insufficiently available in other countries. Causes of the unavailability of controlled medicines may be similar for all these classes of medicine and therefore it is important that any action taken to improve access to and the availability of controlled medicines aims at *all* of these medicines.

Prescription medicines

A new threat to patients' access to these medicines is the misuse of prescription medicines. Often little distinction is made between prescription and prescribed medicines, between medicines legally distributed through pharmacies and medicines sold illicitly through the internet, counterfeit medicines or medicines obtained from crime. Many research publications on this topic do not define their sample population well, but a review that did so demonstrated very low figures for misuse of (0.25%) and dependence on (0.05%) opioids prescribed for pain treatment (Noble *et al*, 2008).

Misuse of prescription medicines is a problem in some countries, but more detailed information on the source of the medicines and the mechanisms behind their diversion is urgently needed. This is crucial in order to avoid the implementation of ineffective measures that only deny patient access to these essential medicines.

Conclusion

Psychiatrists all around the world have various stakes in controlled medicines. They have an urgent need to be able to prescribe methadone or buprenorphine for the evidence-based treatment of dependence and to use benzodiazepines for various other mental disorders. In collaboration with organisations of other medical specialists, their national associations should advocate improved access to these medicines. Furthermore, they can play a role in monitoring misuse of and dependence on these medicines when prescribing them and in collecting information on the mechanisms behind the diversion and misuse of prescription medicines.

These associations can, together with those of other medical specialties and patients' organisations, assess the situation with regard to controlled medicines in their country by using the recent WHO policy guidelines and the checklist mentioned above. Together they can call on governments to implement policies and legislation aimed at solving any problems identified and can promote attitudes and practices among their members that will help to overcome such problems.

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NEWS AND NOTES

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

College position statement: recommendations for psychiatrists on spirituality and religion

Evidence suggests that the relationship between spirituality/religion and mental health is a positive one, and there may be benefits associated with considering spiritual and religious factors within treatment planning. The Royal College of Psychiatrists' position statement recommends that psychiatrists consider a tactful and sensitive exploration of patients' religious beliefs and spirituality during consultations – but that psychiatrists should also ensure that a patient's lack of religious or spiritual beliefs is equally respected. The statement can be viewed on the College's website (<http://www.rcpsych.ac.uk/publications/collegereports/positionstatements.aspx>).

Inayat Khan

The World Health Organization has highlighted on its website the achievements of a former member of staff, Dr Inayat Khan, who is also a Fellow of the College (see http://www.who.int/archives/fonds_collections/special/former_staff_history_khan/en/index.html).

Obituary – Professor Tolani Asuni

The College is saddened to announce the death of Professor Tolani Asuni on 21 June 2011 at age 86 in Lagos. Professor Asuni was a Foundation Fellow of the Royal College of Psychiatrists and had a long, illustrious professional career in Nigeria at Obufemi Awolowo in Lagos, Ibadan University and the Federal Neuropsychiatric Hospital Abeokuta. He was one of the founders, and the first President, of the Association

of Psychiatrists in Africa. Professor Asuni was Director of the United Nations Social Defence Research Institute in Rome in the 1980s. He had a lifelong interest in the mental health of homeless people, as well as many other interests. He had an invaluable impact on improving mental health in Nigeria. *The Psychiatrist* will feature a full obituary of Professor Asuni.

International Narcotics Control Board

On 19 September 2011 in New York at the United Nations General Assembly High-Level Meeting on the Prevention and Control of Non-communicable Diseases, the President of the International Narcotics Control Board (INCB), Professor Hamid Ghodse, emphasised that millions of people around the world are afflicted by mental illnesses, which are non-communicable diseases and which include substance use disorders. Substance misuse requires prevention and treatment and is a contributing factor to some other non-communicable diseases.

Addressing the Roundtable on strengthening national capacities and policies, Professor Ghodse highlighted the importance of the availability of internationally controlled drugs in the treatment of non-communicable diseases and for the relief of associated pain. He stressed that appropriate medical use of controlled medicines can improve the quality of life of patients, with opioids being essential in the palliative care of cancer patients and psychotropic substances being a key component in the treatment of mental illness. However, there are considerable disparities in the availability of controlled substances. Ninety per cent of global consumption of analgesics is accounted for by a number of high-income countries, and overconsumption in some countries is increasingly of concern. In contrast, 80% of the world's population has no or limited access to these essential medicines.

Professor Ghodse reminded member states of the right of all people to be free from the pain and suffering caused by non-communicable diseases and said that prevention should be the primary means of achieving this. Well-functioning regulatory systems within each country are essential in

ensuring the availability of controlled medicines, including for non-communicable diseases, and in preventing the diversion of drugs to illicit uses. The President of the Board indicated that many countries do not have a functioning drug control regulatory system in place and that the first steps to reverse this include the development of national drug policy and national capacity.

UN political declaration on the prevention and control of non-communicable diseases

The United Nations General Assembly gathered in New York in September 2011 for a summit to shape the international agenda on non-communicable diseases (NCDs). Thanks to the work and lobbying by non-governmental organisations and senior mental health experts, the burden of mental ill-health was acknowledged as being a contributor to the burden of NCDs and the inclusion of mental health in the political declaration of the High-Level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. This declaration can be found on the United Nations' website (<http://www.un.org/en>).

World Psychiatric Association – new officers

The General Assembly of the World Psychiatric Association took place on 21 September 2011 in Buenos Aires. Elections for new Officers of the WPA took place during the Assembly:

- President Elect, D Bhugra
- Secretary of Education, E Belfort
- Secretary of Publications, M Riba
- Secretary of Sections, M A Javed.

Elections for zonal representatives also took place and details of all the elected officers can be found on the WPA website (<http://www.wpanet.org>).

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Phenothiazines and community care

Sir: I felt I could not let go unchallenged the statement in the May issue of *International Psychiatry* (p. 36) that the movement towards community care in the UK started with the advent of phenothiazines (Banks *et al*, 2011). There is an alternative view (e.g. Odergard, 1964; Warner, 1985) – that the reduction in numbers of in-patients in psychiatric hospitals began after the Second World War and before the introduction of phenothiazines, which had relatively little effect on the

rate of emptying of the old asylums. This has been related to, among other things, the postwar labour shortage and the need to draw on the reservoir of labour available at that time from a number of sources, including the mental hospitals. It was also a view held at the time that the move in the 1980s to community care was about saving money and was made despite warnings that proper care in the community would be more expensive than hospital care. Some would say this was why the Care Programme Approach was introduced, as poor funding led to embarrassing examples of poor outcomes for those with mental illness in the community.

I was a trainee in the 1980s and remember the debate at the time as well as the anecdotes of my consultant trainer about the men from the Labour Exchange visiting the hospital in earlier decades!

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Psychiatric training in Europe: the opinions of early-career psychiatrists

Sir: In the past decades, scientific advances as well as changes in society and in mental health delivery have led to the need to redefine the structure and content of postgraduate training in psychiatry. An important step in this process is the assessment of psychiatric trainees' views on training programmes and on psychiatric care in general (World Psychiatric Association, 2002; Union of European Medical Specialists (UEMS) Board of Psychiatry, 2003). However, studies evaluating residents' opinions on psychiatric training have been carried out only in national contexts and with very different methodological approaches (Herzberg *et al*, 1999; Giacco *et al*, 2010).

The European Psychiatric Association's Early Career Psychiatrists Committee (EPA–ECPC) has recently developed the self-rated Psychiatric Training Questionnaire (PTQ), which covers three areas:

- satisfaction with the training obtained and self-confidence in clinical psychiatry, pharmacotherapy, psychopathology, psychotherapy, emergency psychiatry, consultation–liaison psychiatry, old age psychiatry, substance use disorders, child and adolescent psychiatry, psychiatric rehabilitation and forensic psychiatry
- participation in research activities
- compatibility with European standards, assessing the use of log-books and participation in exchange programmes.

The questionnaire, which is freely available on the EPA–ECPC website (<http://www.europsy.net/what-we-do/early-career-psychiatrists>), is used as an online survey, and aims to assess, in collaboration with the European Federation of Psychiatric Trainees, the opinions of European early-career psychiatrists from different sociocultural and mental health system backgrounds.

The survey, still ongoing, has so far included 132 early-career psychiatrists from 29 European countries. Respondents are predominantly male (59%), with a mean (s.d.) age of 32 (2.5) years; half of them are residents and half of them are psychiatrists within the first 5 years of their professional career. Most respondents (86%) are completely or partially satisfied with the training obtained and feel more confident in clinical psychiatry, pharmacotherapy and

emergency psychiatry; on the other hand, low levels of self-confidence in psychotherapy, forensic psychiatry and child and adolescent psychiatry (CAP) have been reported. Only 39% of respondents received psychotherapeutic supervision during training, and three out of four had to attend external training programmes in psychotherapy at their own expense.

Seventy per cent of respondents are or have been involved in research activities, mainly consisting of data collection and reference updates.

The use of a log-book (recommended by the UEMS) is not yet widespread: it has been adopted by 45% of European early-career psychiatrists. During psychiatric training, 23% of respondents participated in exchange programmes, which were predominantly organised through informal agreements between professors. Those who participated in exchange programmes found them very useful for their professional career.

The preliminary results show that European early-career psychiatrists are, overall, satisfied with their training. However, some aspects of psychiatric training could still be improved. Forensic psychiatry and CAP, which are reported as core elements of psychiatric training curricula (World Psychiatric Association, 2002; Union of European Medical Specialists Board of Psychiatry, 2003), are often neglected. Moreover, strategies to enhance psychotherapeutic training and supervision are needed. Finally, participation in exchange programmes and the use of a log-book are still unsatisfactory and not in line with standards set by the Union of European Medical Specialists Board of Psychiatry (2003).

Early-career psychiatrists from all WHO European countries are warmly invited to participate in this survey. The final results will serve as a basis for improving and harmonising psychiatric training in Europe.

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The uneasy price of a nation's 'stability'

Sir: In Egypt, Hosni Mubarak spearheaded a regime that lasted 30 years. During the recent unrest, ambivalence ruled the country, dichotomising the public into pro- and anti-government parties. A new environment

of emotional lability came to prevail, as one would hear about the victims of police aggression and then shortly after about thugs attacking people, and the following day perhaps listen to a sentimental speech by Mubarak appealing to the masses, as a war hero who deserved to be glorified.

During the revolution, the numbers of admissions to accident and emergency departments skyrocketed, as did the numbers of psychiatric admissions with diagnoses like 'acute stress disorder', 'acute polymorphic psychosis' and anxiety disorders, the last related to fear of chaos, fear of supply shortages, violence and loss of work and income, particularly for those in business and in the tourism industry. There were also numerous relapses of psychiatric patients, despite their compliance with treatment.

After Mubarak stepped down, disbelief dominated the streets, along with elation and a momentary state of power. Non-governmental organisations have been providing

psychological support for the victims of the revolution, some of whom have lost their sight, a limb, or both limbs. Families of the victims have been traumatised, feeling helpless and hopeless and abandoned by the 'new' government, not receiving any form of funding for their treatment.

The post-revolution 'honeymoon' phase has now come to an end, paving the way to more confusion and suspicion. People are left with optimism yet uncertainty about the future during this transitional phase in the nation's history. Which direction the country will take will depend largely on the outcome of the anticipated presidential and parliamentary elections. Until then, the people will have to cope with ambiguity and uncertainty, and mental health workers will have to cope with people's resultant insecurities.

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The Arab Journal of Psychiatry is published by the Arab Federation of Psychiatrists in May and November electronically and as hard copy.
PO Box 541212, Postal Code 11937, Amman, Jordan.
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Website: www.arabjpsychiat.com

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

Forthcoming international events

15–17 November 2011

ISAD 2012: Affective Disorder – Mind, Body and Society
London, UK
Organiser: International Society for Affective Disorders
Website: <https://www.isad.org.uk/conference.asp>

19–20 November 2011

Base Course: Phenomenological Psychopathology as the Foundation of Diagnosis, Understanding and Therapy of Mental Disorders
Florence, Italy
Organiser: School of Psychotherapy and Clinical Phenomenology SRL
Website: <http://www.psicopatologiafenomenologica.it>

23–27 November 2011

4th International Congress on Psychopharmacology
Antalya, Turkey
Organiser: Turkish Association for Psychopharmacology
Website: <http://www.psychopharmacology2011.org>

24–25 November 2011

5th Annual New Savoy Partnership Conference: Psychological Therapies 2011
London, UK
Organiser: New Savoy Partnership
Website: <http://www.newsavoypartnership.org/2011conference.htm>

24–27 November 2011

2nd International Congress on Neurobiology, Psychopharmacology and Treatment Guidance
Thessaloniki, Greece
Organiser: International Society on Neurobiology and Psychopharmacology
Website: <http://www.psychiatry.gr/>

5–8 December 2011

Australasian Society for Psychiatric Research 2011 Conference
Dunedin, New Zealand
Organiser: International Conferences and Events (ICE) Australia
Website: <http://www.iceaustralia.com/aspr2011/>

8–11 December 2011

AAAP 22nd Annual Meeting and Symposium
Scottsdale, Arizona, USA
Organiser: American Academy of Addiction Psychiatry
Website: <http://www2.aaap.org/announcements/aaap-22nd-annual-meeting-and-symposium.org>

9–10 December 2011

Anxiety Disorders: Children/Adolescents/Adults
Massachusetts, Boston, USA
Organiser: Harvard Medical School
Website: <http://cme.med.harvard.edu/index.asp?SECTION=CLASSES&ID=00311505&SO=N>

9–12 December 2011

Australasian Cognitive Neurosciences Conference 2011
Sydney, Australia
Organiser: Australasian Society for Psychophysiology
Website: <http://www.ccd.edu.au/events/conferences/2011/acnc2011/index.html>

13–14 December 2011

Cognitive Remediation Training for Anorexia Nervosa
London, UK
Organiser: Institute of Psychiatry, King's College London
Website: <http://www.iop.kcl.ac.uk/events/?id=315>

8–11 February 2011

WPA Thematic Conference (Zone 8): Mental Health and Family Medicine Working Together
Granada, Spain
Organiser: World Psychiatric Association, Spanish Association of Neuropsychiatry
Website: <http://www.thematicconferencegranada2012.com>

9–10 February 2011

14th National Conference: Dementias 2012
London, UK
Organiser: Institute of Engineering and Technology
Website: http://www.mahealthcarevents.co.uk/cgi-bin/go.pl/conferences/detail.html?conference_uid=275

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