

International psychiatry

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Principled mental health law?

Tony Zigmond

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A set of principles which might underpin mental health law across the world is discussed, and one particular difficulty is highlighted.

There is, unfortunately, a long, ignoble history, across the world, of using mental health services to rid a family, community or state of people who are embarrassing, inconvenient or dissident. In an attempt to stop such practices and to uphold human rights for patients suffering from mental disorder, many countries have introduced mental health legislation. The provisions vary. Is it possible to agree on a set of principles which should underpin all mental health legislation?

Both mental disorder and physical illness can have serious, even fatal, consequences. Having different grounds for the non-consensual treatment of the two types of disorder is illogical. In England, risk is the basis for intervention in relation to mental disorder (under the Mental Health Act 1983), while lack of capacity is applicable for physical illnesses (under the Mental Capacity Act 2005). Thus, a person who suffers from depression and cancer, but who retains decision-making capacity in relation to both, is entitled to refuse treatment for the cancer but not for the depression. A patient with schizophrenia and a potentially fatal gangrenous leg was forcibly treated for the former but legally permitted to refuse recommended treatment for the latter (and did so) (*Re C (Adult refusal of medical treatment)* [1994]).

Is the risk to others presented by some people with a mental disorder a good reason for having laws based on different principles from those that apply to the rest of the population? There are circumstances in which people with physical conditions may present serious risks to others (e.g. a person with epilepsy or diabetes who neglects to take medication or to monitor blood sugar but continues to drive). They would be dealt with through the criminal justice system.

Mental health law is not just about making it lawful to deprive patients of their liberty or to give them treatment without consent. It also includes safeguards for their protection against abuse or overzealous intervention. Again, one must ask, are patients with mental disorders necessarily more at risk from medical staff or institutions than are people who have a physical infirmity?

Should patients ever be detained in hospital solely for the protection of other people, that is, without the patients themselves gaining any health benefit? In England and Wales the law regarding the non-consensual treatment of people with a mental disorder changed in 2007, with an amendment to the Mental Health Act, so that the criterion

that 'treatment is likely to alleviate or prevent a deterioration of the condition' was removed and replaced with 'treatment which is for the purpose of alleviating, or preventing a worsening of, a mental disorder or one or more of its symptoms or manifestations'. Is 'purpose' good enough, or should a patient be detained in hospital, or forced to accept medical treatment, only if there is a real prospect of health benefit? The law for those with physical illnesses requires such benefit for the patient.

If there is to be just one law, what should be its basis – risk or capacity? It might be argued that intervention without consent should be permitted on the basis of incapacity with regard to self-harm but that risk should be the basis when the potential harm is to other people.

Principles of mental health law

- 1 Every country should have a clear legal process, in accord with accepted international standards, regulating the detention and medical treatment of patients in the absence of their consent.
- 2 Criteria for detention and treatment must conform to internationally accepted values and be confirmed by examination of the patient by appropriately qualified medical practitioners.
- 3 All patients subject to detention or compulsory treatment should have a legal hearing within a reasonable period.
- 4 The least restrictive alternative should be preferred.
- 5 Detention and treatment should be permitted only when likely to be of therapeutic benefit for the patient and given for that purpose.
- 6 When patients are deprived of their liberty for the purpose of receiving a particular medical treatment, then they must be provided with that treatment. If they are put in a position where they cannot fend for themselves, then they must be provided with food, shelter and protection.
- 7 The person must suffer from a mental disorder.
- 8 Patient autonomy must be respected.
- 9 The law must be equitable. Everyone should be equal under the law and the law should apply equally to all citizens regardless of race, gender, age or disability.

Young people, under the age of 18, may in part require different principles. This article does not address the requirements for minors.

Principles 1–6 should not be contentious, although details require discussion. For example, should application of principle 2 be the preserve

solely of suitably qualified professionals, after gathering information and taking advice from a variety of sources, or should relatives have some formal authority? How long is 'reasonable' in relation to principle 3? Should detention have judicial authority from the start (other than in an emergency) or is 'clinical' authority, with judicial review, sufficient? The European Convention on Human Rights requires that someone accused of committing a criminal offence must *have* a hearing, while a person with a mental disorder who is detained has only a *right* to a hearing. Is the 'right' to a hearing sufficient, given that many severely ill patients may not understand their 'rights' and so never apply?

Rather more complex issues arise in relation to the three remaining principles.

Principle 7 (the presence of mental disorder) may seem to be a necessary prerequisite for the application of a mental health act. However, some countries include personality disorders as grounds for detention and compulsory treatment (e.g. England), while others specifically exclude such disorders (e.g. Ireland). Furthermore, many countries are so concerned that their legislation should not be used for social or political detention that their laws specifically exclude detention of particular groups on such grounds (e.g. sexual orientation, substance misuse or a person's political or religious beliefs).

Principle 8, respect for autonomy, is not compatible with a 'mental disorder' requirement as a principle. No one would be forced to accept medical intervention against their capacitous wishes. If principle 9 is accepted, then the basis for medical treatment without the patient's consent, whether deprived of liberty or not, is solely that the patient lacks the mental capacity to make the necessary decisions. In many countries this is the basis for the non-consensual medical treatment of patients deemed to have a 'physical' illness but not for those with a 'mental' disorder.

Principle 9 is also not compatible with most mental health legislation. The United Nations High Commissioner for Human Rights has said in relation to the UN Convention on the Rights of Persons with Disabilities (2006):

Legislation authorizing the institutionalization of persons with disabilities on the grounds of their disability without their free and informed consent must be abolished.... This should not be interpreted to say that persons with disabilities cannot be lawfully subject to detention for care and treatment or to preventive detention, but that the legal grounds upon which restriction of liberty is determined must be de-linked from the disability and neutrally defined so as to apply to all persons on an equal basis. (United Nations High Commissioner for Human Rights, 2009)

As Dawson & Szmukler said as long ago as 2006:

a single legislative scheme governing nonconsensual treatment of both 'physical' and 'mental' illnesses ... would reduce unjustified legal discrimination against mentally disordered persons and apply consistent ethical principles across medical law. (Dawson & Szmukler, 2006)

Should 'disability' be added to race, gender and age (other than children) as grounds which must not be used for legal discrimination? Should 'mental illness or disorder' be removed as a requirement for mental health legislation and replaced with 'lack of capacity to make the necessary healthcare decision'?

Principle 9, if accepted, might result in respect for autonomy and lack of decision-making capacity as the only basis for non-consensual medical treatment. However, respect for autonomy (principle 8) would not be necessary in order to uphold principle 9 if a state decided that preservation of life and health should override personal wishes no matter what the patient's disorder: no one, whether suffering from schizophrenia or cancer, would be entitled to refuse medical treatment deemed necessary by a doctor. This would be equitable. Indeed, principle 9 would not be breached by having two laws, one in relation to risks to the patient and another for risks to other people, so long as they were indeed based on risk, not nature of the disability. Abiding by principle 9 would stop people with mental disorders being lesser citizens and might lead to a clearer debate as to the relationship society wishes to have for its citizens between respect for autonomy on the one hand and life and health on the other.

The central questions

Assuming there is agreement that people should be protected by law from unwarranted detention or compulsory treatment, an international framework could be agreed. There remains, however, a fundamental question. Should countries have one law to regulate the care and treatment of patients, or two? Is it principled, assuming proper legal safeguards for all, to have a capacity-based law for the non-consensual treatment of patients with a diagnosis of a physical illness and a risk-based law if the diagnosis is of a mental disorder? And if the law is to be the same for all patients, should it be based on capacity or risk?

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Mental health and conflict in the Middle East

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For the past decade, overt unrest and danger have typified daily life for many families in Iraq and Afghanistan, while in Egypt under the former regime a superficial appearance of political stability lay over a sense of deep discontentment. What impact does living in those circumstances have on mental health? We asked psychiatrists with personal knowledge of events in three countries that have recently been riven by war and revolution to discuss their experiences. Because so few objective data are available on the impact of stress in any of the three regions reviewed, the authors have inevitably relied in large part upon anecdote and upon news reports from the internet.

Afghanistan did not possess any dedicated mental health services until recently, as Drs Rahimi and Azimi describe in their historical review. Within the past 30 years much progress has been made, but the impact of the Soviet invasion, the period of Taliban rule and the subsequent attempts by Western powers to create stability led to a roller-coaster ride. It is telling that there are still no community mental health teams functioning in the country.

In Iraq, Drs Al-Uzri, Abed and Abbas describe continuing problems, with a high level of violence and trauma, with major mental health consequences. We should not forget that the international sanctions preceding the overthrow of Saddam Hussein devastated the ability of doctors in Iraq to provide adequate medical care, but it seems there has been some improvement in the past 5 years. Following the US-led invasion, and the breakdown of law and order throughout the country, many doctors emigrated for their own safety. It is heartening to learn they are beginning to return.

Finally, we have seen dramatic changes in Egypt since the 'Arab spring' last year. Early hopes of an orderly change to democratic rule are still not certain to be met, but the outcome of the presidential election is encouraging. Since the overthrow of Mubarak, a failure of coherent government has resulted in reduced safety for ordinary citizens, with many terrorist incidents and a surge of criminal activity throughout the country. Dr Nagy gives us a personal account of the difficulties faced by her patients at the present time. While Egypt formerly provided good mental healthcare for many of its citizens, the future is far from predictable.

MENTAL HEALTH AND CONFLICT IN THE MIDDLE EAST

War and the crisis of mental health in Afghanistan

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Mental health and psychiatric services in Afghanistan have gone through various stages of development and crisis but the long-term impact of recent wars and conflict on the country's mental health services has not been evaluated. What is obvious is the shortage of trained mental health professionals in the country.

Mental health services in Afghanistan have suffered from the continuous crisis in its recent history, and a few times were hit so badly as to stop functioning altogether. At their inception, psychiatric services started as a custodial in-patient care unit at Ali Abad Hospital in 1933. The main purpose of this unit was to provide teaching for students of the newly established medical school in Kabul as well as psychiatric services for the entire country. This

unit trained many renowned neuropsychiatrists in the country over the years and has continued teaching medical students at Kabul Medical University. At the same time, the unit attracted stigma and among the public there was a general fear that patients in this hospital were dangerous and therefore that people, especially children, should be kept away from this place. Patients were kept on a couple of locked wards and behind bars, with minimal facilities. The most catastrophic event occurred when one in-patient who had escaped from the hospital to the town jumped in front of a car which turned out to be carrying the Prime Minister of Afghanistan at the time. Angry, he ordered the removal of these patients from the city. A large number of patients from the hospital and the city were taken to a suburb of Kabul, Qala-e Zaman Khan, and buried alive. The rest were transferred to a 'secure' place in Jalal-Abad city, capital of Nangahar Province, where most of them were kept in chains for decades (Burna-Asefi, 1988).

Introduction of modern mental health services

With the return in 1985 of Dr Burna-Asefi (after 27 years of working in the UK), a psychiatrist who had trained in the UK, the Department of Mental Health was opened in the Ministry of Public Health, which replaced what was previously known as the Mental Hygiene and Rehabilitation Department. Kabul Psychiatric Hospital, with an open-door policy, was opened and community psychiatric services were introduced.

Despite the unwillingness of the regime at the time, mental health services developed to a high standard in a short period, mostly due to Burna-Asefi's efforts and the team he created of committed colleagues who devoted themselves to this work. Other services and initiatives such as supportive out-patient psychotherapy groups, 'day hospital' services that exist even now, the first national mental health programme, a mental health act, a detoxification centre and the recruitment of non-medical staff (e.g. psychologists, social workers and occupational therapists) in mental health facilities were introduced for the first time in the country and a close, cooperative relationship was built with the World Health Organization (WHO). However, the new psychiatric hospital was housed in a small dilapidated building that had previously belonged to an electronics factory, with no metal bars on windows or locks on the doors. Although the open-door policy was seen as frightening at the time and resisted by some people initially, it was finally accepted as a new method of patient care. A large number of medical and non-medical staff were sent to neighbouring countries as well as eastern Europe for short-term training while intensive 'in-service training' courses were introduced in the capital and major cities in Afghanistan. The first mental health outreach service was opened in Dasht-e Barchi, west of Kabul, in the 1980s, but was terminated after the mujahideen took Kabul. Mental health services were beginning to integrate

with primary healthcare and a few beds were opened in general hospitals both in Kabul and in a few other provinces. Despite continuous fighting between the mujahideen, the Soviet army and the then Soviet-backed government in Kabul from 1975 to 1992, mental health teams and facilities continued to function in Kabul and some major cities, but were by no means sufficient to meet the needs of the country.

Time of crisis

Mental health services had experienced great difficulties before the 1980s but with the April revolution in 1979 and occupation of the country by the Soviet Union the problems deepened. However, a major crisis took place with the defeat of the Soviet-backed government in 1992, from which services did not recover until the fall of the Taliban. What had been developed over the years (especially from 1985 to 1992) collapsed suddenly when the mujahideen took control of Kabul. Government was then in the hands of different factions of the mujahideen; lawless armed groups also became active and a full-blown civil war and criminal activities erupted in Kabul. Nearly all health facilities – including the mental health hospital, central office and four community centres – were looted, occupied by armed groups and ruined during the internal fighting. Patients who could escape left the hospital; the few patients with chronic conditions such as intellectual disabilities who remained in Marastoon, the long-stay sheltered accommodation facility, were subjected to atrocities, including the rape of female patients (Anderson, 1993). The first and the only detoxification centre, which had been opened in a rented building in Qala-e Jawad, was initially taken over by the owner but was later closed.

Most mental health staff, particularly senior staff, left Kabul to take refuge in safer provinces or left the country altogether. The brain drain was the biggest loss in a country that at best had only one trained psychiatrist and few core members of the mental health team who had developed leadership and management skills by being in the business for a long time. Some locally trained doctors working in the psychiatric hospital left to work for non-governmental organisations (NGOs) and international organisations in non-medical capacities. Those who stayed in the profession to keep nominal services going had to cope with financial difficulties and multiple traumas experienced directly by themselves or by their family members. The situation worsened during the Taliban era, when nearly all health services, including mental health services, were reduced to a minimum or became non-existent, although the Mental Health Act was revised in 1997, with the omission of only a few sentences.

Current situation

Since the fall of the Taliban, mental health services have slowly started to take shape again. In 2005 the Mental Health Department reopened at

the Ministry of Public Health but now under the Department of Preventive Medicine, that is, at a lower level than previously. Although the numbers of doctors working in psychiatry and of allied mental health professionals as well as the number of NGOs providing mental healthcare have increased over the past decade compared with the 1980s, the need for mental health and substance misuse services has also increased, to the extent that both government and private sectors, with the help of international donors, are still unable to meet the mental health needs of the public. The absence of mental health services for children and women remains one of the chief challenges.

Currently, there are around 60 locally trained psychiatrists working in the country but no trained psychiatric nurses; nor are there postgraduate courses for allied mental health professionals. All nurses in the mental health facilities are general nurses who are self-taught and gained their experience working in the facilities, until last year, when a UK-trained nurse took up the challenge of training the 17 nurses at Kabul Psychiatric Hospital.

There are around 30 drug detoxification centres in the country, each with a capacity of around 10–20 beds, mostly supported by international donors and run by the Ministry of Health and NGOs. The treatment offered in drug detoxification centres is usually symptomatic, with no community follow-up or psychosocial rehabilitation services. The relapse rates of drug misuse and psychiatric disorders must therefore be high, although there are no reliable statistics. Although the national Basic Package of Health Services has included a mental health component with a strong emphasis on bio-psychosocial counselling, there are still no community mental health teams functioning in the country.

Despite all the improvements, vast challenges still remain, including:

- the high prevalence of psychiatric disorders, particularly post-traumatic stress disorder and unrecognised depression
- the ready availability of narcotics, which has led to a sudden rise in drug addiction in the country
- the shortage of qualified mental health workers.

Until recently, heroin addicts gathered in large numbers under the bridges of Kabul city, which caused a public outcry. A government campaign to remove them as well as a very cold winter last year and a high volume of rain this spring helped to disperse them. No methadone replacement therapy exists for heroin users in the country except for a small pilot project run by Medicine de Monde.

Kabul Psychiatric Hospital is currently receiving financial and technical support from a project funded by the European Union (EU) but it is still in need of qualified staff.

Psychiatric education

Neuropsychiatry is taught at undergraduate level to medical students in years 4 and 5 and behavioural science is taught in the first year. A 3- to 5-year postgraduate training programme was introduced in all medical branches, including psychiatry, by the Ministry of Public Health, which is currently running in the psychiatric hospitals in Kabul and in the psychiatric wards of some regional/provincial hospitals. However, the country is in dire need of qualified psychiatrists and other mental health professionals to support these programmes.

Legislation and government strategy

Although a Mental Health Act was drafted in the 1980s it still has not been translated into practice. Patients are treated and kept in hospital mostly at the request of their relatives, who have to stay with them to stop them from leaving hospital. There is no legal protection for either staff or patients.

The Ministry of Health has developed a national mental health strategy at an estimated cost of \$40 million over 5 years, which needs to be raised by the ministry, and this represents yet another challenge.

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International Links: Faculty of Psychiatry of Intellectual Disabilities

Members of the College's Faculty of Psychiatry of Intellectual Disabilities are involved in sharing their skills and expertise in projects in low- and middle-income (LaMI) countries that work with people with intellectual disabilities. International Links is a subgroup of the Faculty that facilitates coordination within the College through its links with the International Affairs Committee. It is in the process of capturing the wealth of work that members are engaged in.

The group conducted a survey of Faculty members in 2012 that revealed their involvement in projects in 24 countries. As would be expected, the countries reflect the backgrounds and interests of the members of the Faculty, with many working in India and Pakistan. From the survey we know that the members have good links with non-governmental organisations (NGOs) and academic departments in African countries. Contact with central and eastern European countries is an emerging interest of some members. The level of involvement in projects ranges from direct clinical care to project development.

International Links plans to consolidate its contacts within the College and with colleagues and services in LaMI countries. It intends to offer routes to new members to assist them in joining current projects and in developing new ones. Members will share their clinical, leadership and managerial skills to advance projects by assisting in funding applications, to apply new perspectives to current projects and to ensure the perpetuation of existing work. The group will host a one-day conference of members in October 2012 to consult on the factors important in consolidating the work of International Links.

Ken Courtenay



MENTAL HEALTH AND CONFLICT IN THE MIDDLE EAST

Rebuilding mental health services in Iraq

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Since 2003 Iraq has experienced significant challenges in reforming and rebuilding its health services. A national mental health survey reported a high level of mental health problems consistent with a country that has experienced widespread violence and trauma. The survey also highlighted limited access to services. This paper outlines developments in and plans for mental health services in Iraq.

Iraq had strong health and higher education sectors in the second half of the last century; however, due to three decades of wars, international sanctions and civil strife these sectors experienced severe decline (Abed, 2003). Iraq went through phases of suffering and trauma. During Saddam's regime (1979–2003) Iraq witnessed 8 years of war with Iran, the invasion of Kuwait, the Gulf War in 1991, 13 years of economic sanctions, and invasion and regime change in 2003. For decades, human rights organisations have documented government-approved executions, acts of torture and rape. Mass graves containing thousands of bodies have been found in different parts of Iraq. Following 2003, Iraq went through another difficult phase which had a devastating impact on the social fabric of Iraqi society and which had all kinds of conflict-related consequences. The sectarian violence peaked in 2006 and 2007, with political instability, a rise in ethnic and sectarian identities at the expense of national identity, threats to the cohesion of Iraqi society, and division of the population along ethnic and sectarian lines. It is not surprising that the Iraq Mental Health Survey found that half of the participants reported experiencing at least one traumatic incident (Al-Hasnawi *et al*, 2009). As a consequence of the violence and instability, a large part of the population suffered from internal displacement and migration, which led to the flight out of the country of many skilled people, including doctors. However, the restructuring of mental

health services (Sadik & Al-Jadiry, 2006), followed by an improvement in the security situation and the appointment of ministers of health sympathetic to the cause of rebuilding mental health services, have set services on a tentative road to recovery.

Iraq Mental Health Survey

This survey was conducted by the Iraqi Ministry of Health (MoH) in collaboration with the World Health Organization (WHO). Data were collected by Iraqi mental health workers. The survey reported a lifetime prevalence rate of any disorder (excluding psychotic disorders) of 18.8% (Al-Hasnawi *et al*, 2009). This is comparable to levels of psychiatric disorder in Lebanon, which has also recently suffered from wars and violence. A notable although not unexpected finding was the very low level of access to mental health services by people with mental health problems. Only 10.8% of patients with a diagnosable mental disorder received treatment (Al-Hasnawi *et al*, 2009). This shows that families and carers are carrying the burden of mental health problems with little professional support. It also highlights the limited role that existing mental health services can provide, faced with such a magnitude of need.

Development of mental health services

Following the drop in the number of practising psychiatrists in the country during the period of civil violence, the Iraqi Ministry of Health and the Ministry of Higher Education made a concerted effort to increase the numbers of trainees and thus increase the numbers of qualified psychiatric specialists within mental health services. As a result, the number of psychiatrists doubled, according to official figures (Ministry of Health, 2010). There has also been an increase in the number of psychiatric units and facilities (Table 1). Although this remains quite low by comparison to high- or even middle-income countries, it represents an improvement compared with the low point reached in 2006.

Integration of mental health into primary care

It was recognised that secondary mental health services would not be able to deal with the magnitude of mental health needs and hence measures were taken to improve the capacity of primary care to respond. As a result, around 350 primary care workers (mostly doctors) were offered a short training course on mental health using a recognised training toolkit (Ministry of Health, 2010). This initiative was led by the MoH with support

Table 1

Workforce and mental health facilities in Iraq, 2006 and 2010

	Sadik & Al-Jadiry (2006)	Ministry of Health (2010)
Psychiatric hospitals	2	3
Psychiatric units	12	23
Psychiatrists and other medical doctors working in psychiatric settings	98	206
Nurses	145	335
Psychologists	16	47
Social workers	25	33

from the International Medical Corps in 2009/10. The programme has been shown to be effective in improving knowledge and skills of health workers and in improving the detection of mental disorder in primary care (Sadik *et al*, 2011).

International collaboration

The MoH benefited from collaboration with a number of governmental and non-governmental organisations (NGOs) to develop mental health services. A number of action planning conferences on mental health in Iraq were conducted with support from the Substance Abuse and Mental Health Services Administration (SAMHSA), as well as from the WHO, the UK Department of Health, the World Bank, the Royal College of Psychiatrists and others. The first conference was held in 2005 in Amman (Jordan), the second in 2006 in Cairo (Egypt) and the third in Baghdad in 2008, at which a 5-year strategy for mental health in Iraq was adopted.

SAMHSA

The partnership with SAMHSA helped establish an international action planning group that supported mental health service development in Iraq (Mitchell & Sadik, 2011). It introduced a unique model of inviting multidisciplinary teams from Iraq to propose service developments. The successful teams would receive training in the USA and would be supported on their return by the MoH to implement those initiatives. Those initiatives covered a wide range of mental health services and all parts of Iraq.

The Iraq Subcommittee of the Royal College

In 2005, the Royal College of Psychiatrists sanctioned the formation of the Iraq Subcommittee (ISC). The ISC was composed predominantly but not exclusively of British psychiatrists of Iraqi origin who organised themselves in the Iraqi Mental Health Forum in 2003. Following a fact-finding visit to Iraqi Kurdistan in 2007, a number of areas were identified that the College could help with (Abed *et al*, 2008). The ISC has participated in a number of training and service improvement projects:

- More than a dozen training events have been held in the region since 2007. These have included the Middle East Division Conference of the Royal College of Psychiatrists, held in Baghdad for the first time in 2009.
- The ISC has collaborated closely with a number of NGOs that are interested in assisting Iraqi mental health. A particularly strong partnership was formed with the Heartland Alliance (HA) to protect the rights of people with mental illness. This partnership, in collaboration with the MoH, helped in organising and leading five 'service improvement' events as part of a 'standards and quality' project which targeted in-patient psychiatric care in Iraq. One notable outcome of this work has been the reform of

practice regarding the use of electroconvulsive therapy across Iraq.

- An email group was established in 2008, the Iraqi Mental Health Network (IMHN). This includes most psychiatrists within Iraq as well as some outside Iraq and has become the main information conduit used by Iraqi psychiatrists.
- The ISC has contributed to the development of a new curriculum for the Iraqi Board of Psychiatry through training events in Iraq as well as in the UK and at the College. This has brought radical change, including the introduction of mandatory training in cognitive-behavioural therapy (CBT), which has led to the development of a CBT department under the supervision of a visiting psychiatrist from the UK.

Work with NGOs

Before 2003, Iraq was a closed country with limited access to the outside world. However, after 2003 it became more accessible and a large number of international organisations established bases and programmes in Iraq. These organisations provided assistance in the form of training for medical and other staff as well as some material aid to help improve Iraq's crumbling infrastructure. In particular there was a focus on trauma victims and, as a result, trauma centres were established across the country, from Kurdistan to Basra. One of the major challenges was the lack of qualified and skilled staff in psychological therapies in Iraq. In view of the language and the security challenges, it was difficult for foreign personnel to deliver training within the country, hence much of the training of Iraqi staff took place in neighbouring countries or further afield.

Child mental health was an important area of development as there were few services. A child mental health training centre in Duhok (Iraqi Kurdistan) was set up in collaboration with Uppsala University in Sweden (Ahmed, 2009). A number of psychiatrists in mental health services received re-training in child mental health and they went on to establish two units in Baghdad for child mental health, in addition to the main children's mental health centre at the Department of Child Mental Health, College of Medicine, University of Dohuk.

Iraq has also seen an escalation of the problem of substance misuse since 2003. This has prompted the Iraqi authorities to focus attention on this area and there are plans to establish a centre for the treatment of addictions. In addition, work is under way to produce new mental health and substance misuse legislation.

Conclusion

The evidence and experience from Iraq highlight the high level of mental health needs associated with a country going through long periods of trauma and violence. Poor access to services is to be expected where the need is great and the provision is limited. The experience also provides a useful model of improving services and standards

in collaboration with national and international organisations, including expatriate professionals. There is evidence that the quality of mental healthcare provided in Iraq is improving; however, the need remains vastly disproportionate to the available capacity within healthcare services.

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MENTAL HEALTH AND CONFLICT IN THE MIDDLE EAST

The Egyptian revolution seen through the eyes of a psychiatrist

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The 2011–12 Egyptian revolution (*thawret 25 yanāyir*, revolution of 25 January) took place following a popular uprising that began on Tuesday 25 January 2011 and is still continuing. The uprising was mainly a campaign of non-violent civil resistance. In this revolution the participants have proved that if resistance begins with sincerity and unity, it may yet achieve victory.

In the Egyptian revolution, millions of protesters from a variety of socioeconomic and religious backgrounds were united in their demands. They wanted to overthrow the regime of President Hosni Mubarak. Despite being predominantly peaceful in nature, the revolution was not without violent clashes between security forces and protesters, with at least 846 people killed and 6,000 injured (BBC, 2011). The grievances of the Egyptian protesters were focused on legal and political issues. These included the persistence of state emergency laws (first enacted in 1958 and which have remained in effect since 1967), the lack of free elections and freedom of speech, high unemployment, food price inflation, and low minimum wages (New Age, 2011).

During the period of protest, police from Egypt's central security forces were gradually replaced by largely restrained military troops, who protected the protesters, and people's belongings, from the police and Mubarak supporters.

In response to the protests from inside the country and to international pressure, on 11 February 2011 Vice President Omar Suleiman announced that Mubarak would be stepping down as President and turning power over to the Supreme

Council of the Armed Forces. On 24 May 2011, Mubarak was ordered to stand trial on charges of premeditated murder of peaceful protesters (Reuters, 2011).

Social media

The usage of social media during the protest was extensive, despite attempts to censor and restrict access to the internet in Egypt and elsewhere. As one Egyptian activist succinctly Tweeted during the protests there, 'We use Facebook to schedule the protests, Twitter to coordinate them, and YouTube to tell the world' (*Independent*, 2011).

Wael Ghonimis is credited as one of the primary sources of influence on the use of social media in this period of protest. He created a Facebook page dedicated to Khaled Saeed entitled 'We are all Khaled Saeed' (see http://en.wikipedia.org/wiki/Wael_Ghonim). Saeed was an Egyptian businessman. He was beaten to death by police in June 2010. It is believed that this was in retaliation to a video he posted online showing Egyptian police sharing the spoils of a drug bust (interestingly, this video appears to have been taken offline subsequently). The Facebook page dedicated to his death attracted over 400,000 followers, and thereby created an online arena where protesters and those discontented with the government could gather, vent their frustrations and organise themselves. The Facebook site called for protests on 25 January 2011, a day that later became known as the Day of Wrath. Hundreds of thousands of protesters flooded the streets to show their disgust at both the murder (and the delays that ensued when attempts were made to bring to justice the policemen responsible) and the corruption within their country.

Another major contributor to the protest was Asmaa Mahfouz, an Egyptian activist and member of the April 6 2011 Youth Movement. A week before the first protest, she posted a video urging the Egyptian people to meet her at Tahrir Square, to rise up against the government and to demand democracy. In the video, she also speaks of four protesters who had set themselves on fire in protest against the poverty and degradation they had to live in under the Mubarak regime. On 24 January, she again posted a video chronicling the efforts that people had made to support the protest, from printing posters to creating flyers. The videos were first posted to Facebook, then to YouTube, where they went viral in Egypt within a matter of days. The day after her last log posting, hundreds of thousands of Egyptians poured into the streets in protest (*World Politics Review*, 2011).

Political and military response

Since the revolution, Islamist parties such as the Muslim Brotherhood and Salfi groups have shown unprecedented strength in the new, more democratic landscape, taking leading roles in bringing about constitutional changes, voter mobilisation and protests. In parliamentary elections held in September 2011, the Liberty and Justice party (the new-born Muslim Brotherhood party) gained 48.5% of valid votes. Islamists and secularists have both been faced with new opportunities for dialogue, on matters such as the role of Islam and Sharia in society, freedom of speech and opportunities offered by communication using modern technology (*Guardian*, 2011).

On 9 March 2011, military police violently dispersed a sit-in in Tahrir Square and detained a number of protesters who were later moved to the Egyptian Museum and tortured. Seven female protesters were subjected by force to virginity tests. Also, on repeated occasions in the autumn of that year, military police attacked Coptic Christian protesters in Tahrir Square, in the Maspero building (which houses a media centre) and in the Abbassia district, where protesters stayed for several days. The military are reported to have crushed protesters under the wheels of armed personnel carriers, and shot live ammunition at the demonstration, leading to many people being seriously injured, of whom a number lost their eyesight (*Guardian*, 2011).

Mental health aspects

The 25 January revolution seems to have exacerbated certain symptoms among Egypt's population; feelings of worry and anxiety have spread since the early days of the revolution, leading to feelings of confusion about the future, and these problems are coming to the attention of psychiatrists.

One case concerns a 34-year-old young man who was effectively imprisoned on 28 January 2012 together with his elderly parents in their flat, where they were under threat of being set on fire by thieves, for 12 hours. They were saved by the military forces but had to move to a relative's house

and lost all their belongings. He has since suffered from symptoms ranging from severe anxiety, acute insomnia, loss of appetite and distressing flashback memories. His anxiety increases when he has to leave his parents for work. Since this incident, he has had a herpes simplex eruption due to reduced immunity and he reports a sense of insecurity that he had never felt before.

Another case concerns a formerly active woman who now spends most of her time watching the television news and commentaries. She suffers from a sense of fear when she thinks about having to leave the house or attempting to regain her social life. Continuing strikes and demonstrations plus the increasing incidence of crime affect her willingness to send her children to school or to attend outdoor activities. Sometimes she cannot go to work. Sometimes she feels compelled to buy extra food to stockpile. It is difficult for her to use her car because she is frightened that it will be stolen. She says, 'I felt very happy and optimistic when the 25 January revolution broke out, but now I feel that things are collapsing, and it breaks my heart'.

In my university department, the students go every now and then to participate in demonstrations. Two of my students were killed while trying to save injured protesters. Resident doctors work under exceptionally hard conditions because hospitals are frequently exposed to attacks, due to the escalation of crime and inadequate police protection. In my teaching classes, there are increasing numbers of Muslim students, including boys with long beards and girls in burkas. They try to redirect interactive medical discussions about psychiatric problems along religious pathways, especially when those discussions are about conditions such as obsessive-compulsive disorder, depressive disorders and suicide.

The many people who gathered in Tahrir Square said they had gone there to bring about change, and as time went on they gained in confidence. They were seeking autonomy for the present and future Egyptian generations. They hoped that, once the old regime had been removed, people in their home or work environments would start to think in different ways, that they would acquire different values and that they would eventually feel confident to express their ideas without fear. However, the proliferation of satellite television news channels, and the fierce debates and commentaries aired and repeated on them, seem to have accentuated feelings of anxiety among viewers. Even if the slightest accident happens in a remote alley, you see it covered on television as though it were a national catastrophe. People fear the breakdown of law and order since the revolution.

The Egyptian Mental Health Act of 2009 enacted important human rights legislation, including psychiatric patients' rights. These included the right to have an independent assessment of your mental state. It set the criteria for legal compulsory admissions. Following the Egyptian revolution,

many specialist psychiatrists and professors of psychiatry raised the issue that there could be abuse of the legislation, with attempts by the regime to admit people accused of political crimes, especially those from religious groups, into psychiatric hospitals. A young female psychiatrist working in El Abbassia Hospital (a major psychiatric mental hospital in the centre of Cairo) refused to write a medical report after she was asked to assess the mental condition of one of the leading protesters, Alaa Abdel Fattah, who was subsequently imprisoned by the regime (en.wikipedia.org/wiki/Alaa_Abd_El-Fattah).

Conclusion

The Egyptian revolution, which was enacted on the basis of non-violent resistance, provides a model for how peaceful protest, with people expressing their hopes through the internet and other media channels, can lead to change.

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MENTAL HEALTH LAW PROFILES

Mental health law profiles

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Just mental health law is a vital priority in an era of increasing international economic hardship, social inequalities and authoritarianism in some countries and neglect in others. It is essential for human rights but also for psychiatric professionalism and reputation. In this issue *International Psychiatry* begins publication of a regular series on mental health law across the world. In the first two articles, Ogunlesi and

Ogunwale and, separately, Loza and El Nawawi report on the history and evolving legislation in two key countries, Nigeria and Egypt. They report some progress but also the considerable distance from a fair outcome for people with psychiatric disorder and those who care for them. In the guest editorial in this issue, Tony Zigmond crucially highlights issues of principle that necessarily form the foundation of law.

MENTAL HEALTH LAW PROFILE

Mental health legislation in Nigeria: current leanings and future yearnings

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Nigeria's current mental health legislation stems from a lunacy ordinance enacted in 1916 that assumed the status of a law in 1958. The most recent attempt to reform the law was with an unsuccessful Mental Health Bill in 2003. Currently, though, efforts are being made to represent it as an executive Bill sponsored by the Federal Ministry of Health. The present paper reviews this Bill, in particular in light of the World Health Organization's recommendations on mental health legislation.

Nigeria, the most populous country in Africa, has a multi-ethnic and poly-religious population totalling about 167 million. Recent data suggest that, of this population, about 20 million have suffered from mental health problems in their lifetime, although few current sufferers have any form of effective treatment (Gureje *et al.*, 2006). Despite the large population and the significant social burden of mental disorders, resources for mental health remain scarce and overconcentrated in urban areas. Indeed, there appears to be roughly

1 psychiatrist per million citizens in Nigeria, a situation that mirrors the state of things in many African countries (Ogunlesi *et al*, 2012).

Apart from the obvious low priority accorded to mental health in terms of policy, funding and personnel, the legal framework for the provision of mental healthcare in Nigeria remains a major concern to psychiatrists as well as other stakeholders. The World Health Organization (WHO) has estimated that only 50% of countries in the African region have mental health policies, while about 79.5% (compared with 91.8% in Europe) have mental health legislation (WHO, 2003). Only about 30% of these laws were enacted after 1990, with some dating back to the colonial era of the early 1900s (Morakinyo, 1977; WHO, 2003; Ogunlesi *et al*, 2012).

Evolution of existing legislation

Historically, the lunacy ordinance enacted in 1916 (see *Laws of Nigeria*, 1948) was drafted about four and a half decades before Nigeria's independence from British rule. The colonial influences in its terminology and expectations are thus quite obvious. Enacted two years after the amalgamation of the northern and southern protectorates into a single entity in 1914, it became the source of regional laws that appeared as the country evolved into regions thereafter. It assumed the status of a law rather than an ordinance in 1958. It is the current legislation in the country and has been etched into state laws within the Federation. The latest versions of these laws have some minor alterations in terms of language and certain stipulations (e.g. size of fine), in order to reflect current realities, but the principles of the ordinance have remained unchanged (*Laws of Ogun State*, 2006). While the existing mental health legislation, derisively called the 'lunacy law', has been able to address certain basic issues relating to mental healthcare, its age (at almost a century) clearly suggests that it must suffer from some anachronism and indeed it does so, in four principal areas:

- the altered political and social climate
- antiquated definitions and terminologies
- non-application of later developments in psychopharmacology, which clearly provided alternatives to custodial care
- non-incorporation of certain human rights charters (United Nations, 1948, 1991).

A more fundamental issue that is clearly related to the foregoing is the recent WHO document on recommendations for drafting acceptable and effective mental health legislation (WHO, 2005). The areas of deficiency in the existing law include its failure to define 'mental disorder' or 'mental disability' and its overwhelming emphasis on custodial care without adequate provision for treatment in the community. Its use of highly derogatory terms such as 'asylum', 'lunatic', 'idiot' and 'unsound mind' demonstrates its antiquity. The law does not accord specific recognition to the

human rights of persons with mental disorders as recommended by the WHO. It also has no provisions for vulnerable groups who may fall within its ambit.

In spite of these shortcomings, it has managed to ensure some degree of compliance with the WHO recommendations in the areas of provisions for emergency and involuntary admissions (although not separate from treatment), general reference to the level of competence required for the determination of mental disorder, provision of oversight and review mechanisms (by way of 'visiting committees') as well as a section dealing with offences committed by asylum officials and the appropriate sanctions.

An aborted attempt at revision – the Mental Health Bill (2003)

The most recent attempt to reform the lunacy law was undertaken in the democratic dispensation of the 4th republic (1999–2003). During that republic, the Mental Health Bill was sponsored as a legislative bill in the Nigerian Senate. This task was undertaken by two serving senators who were also medical practitioners and of whom one was a psychiatrist (now deceased). Happily enough, the bill passed its first reading on the floor of the Senate. In Nigeria, bills for new laws or amendments must pass through three readings and obtain presidential assent before they become law. Unfortunately, in the interval between the first and second reading, the bill suffered a setback with the expiration of the life of that Senate and the death of the lead sponsor. Currently, efforts are on stream to re-present it as an executive bill sponsored by the Federal Ministry of Health.

Notwithstanding this, it is equally necessary to assess the level of compliance of this proposed bill with the recommendations of the WHO (2005) (although these were made 2 years after this proposed law was drafted). It must be understood that while these recommendations are not inviolable, they represent adaptable schema upon which contemporary draft legislation can be based. Broadly speaking, the current proposal seems to contain fairly satisfactory provisions in the following areas of the WHO Checklist on Mental Health Legislation (WHO, 2005): definitions of mental disorders, with proper coverage of dissociative personality disorder and substance use disorders; rights of families or other carers of patients; mental capacity issues (although there is in fact no clear definition of capacity in the draft Nigerian legislation); voluntary admission and treatment; involuntary admission (not clearly separated from treatment); proxy consent for treatment; emergency situations; specification of competence required for determination of mental disorders; oversight and review mechanisms (mental health tribunals, judicial review at the level of a state high court); some mention of police responsibilities; provisions for minors within the mental health and justice systems; and a description of offences under the act with appropriate sanctions outlined.

However, it is worrisome to note that the proposed bill falls short in some vital areas. It failed to provide a clear statement on the promotion of fundamental rights of people who are mentally ill and does not specifically guarantee the rights of users of mental health services in relation to issues like confidentiality. It is silent on provisions regarding 'non-protesting' patients and involuntary treatment in community settings. The proposed law does not regulate special treatments such as electroconvulsive therapy (ECT), the use of seclusion and restraint, issues related to clinical and experimental research (consent in particular), and socio-political issues such as discrimination, housing, employment, social security, civil issues (e.g. voting rights, parental rights) as well as protection of other vulnerable groups, like women and ethnic minorities. When all these areas are further distilled into component parts, the overall level of compliance with WHO recommendations may be far lower than is superficially suggested by this overview.

In spite of the foregoing, the prospects for a successful revision of the existing law are brightened by a variety of local factors. Currently, the Association of Psychiatrists in Nigeria (APN), a major stakeholder in mental healthcare, is at the vanguard of the mental health law reform and mental health advocacy is gaining momentum. In recent times, a desk officer for mental health had been appointed at the Federal Ministry of Health, partly with a mandate to work with stakeholders towards collating inputs for the bill to be sponsored as an executive bill. Furthermore, the National Human Rights Commission subscribes to existing charters that strengthen human rights and thus constitutes a potential ally and stakeholder in the current effort to revise the existing legislation.

The WHO recommendations of developing country-specific mental health legislation that is needs-based, driven by human rights, collaborative in orientation and culturally sensitive offer practical guidelines for the construction of a new law. Coupled with these are the abundant legislation-related resources which the WHO has made widely available and which afford the opportunity to learn from more recent legislation in

other countries. Furthermore, current epidemiological data with which to identify mental health needs are available (Gureje *et al*, 2006) and provide a basis for the needs-based approach of the WHO.

In addition, the recommended technical competence required to draft new legislation is obtainable in the country. In line with the WHO recommendation, major stakeholders (including the medical directors of existing federal psychiatric hospitals in the country) are currently brainstorming and engaging the Federal Ministry of Health with a view to accelerating the passage of the bill.

Conclusion

It is important to state that to achieve the desired target of the passage of the proposed legislation, advocacy driven by all stakeholders must be given serious attention. This certainly will bring pressure to bear on the government and ensure speedy enactment of a new law that will meet contemporary benchmarks, improve mental healthcare delivery and provide a better basis for later legislative revisions that must come with time.

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Mental health legislation in Egypt

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This paper first briefly reviews the history of psychiatric services in Egypt. It then details the legislation in place during the last years of the Mubarak regime and goes on to set out recent developments, in particular the Code of Practice introduced for the Mental Health Act of 2009.

Historical background

The earliest reference to the care in specialised institutions of people with a mental illness dates back to Fatimid Egypt and the establishment of the Bimaristan in the 13th century, which still stands today in central Cairo. Throughout the Islamic

era in Egyptian history, care of people with a mental illness appears to have been community based, while institutional care for those suffering from mental health problems was within general hospitals. The building of asylums away from residential areas, to separate those with mental illness from their communities, began only in the late 19th century. This followed a visit by Urquhart and Tuke from the Royal Medico-Psychological Association in 1879 (see Tuke & Urquhart, 1879).

The beginning of the British protectorate in Egypt led to the modern practice of asylum care. The Department of Mental Health at the Medical School of Cairo University was closed in 1880 and psychiatrists were directed towards the newly built asylums, where training for their profession was more vocational than academic. It was at this point that regulations organising the involuntary admission of a person with a mental illness were needed. With only one asylum in Egypt, however, the regulations were internally set by the superintendent.

The first reference to a draft of a proposed lunacy law appears in the 1921 annual report from the lunacy division of the Egyptian Ministry of the Interior (Government Press Cairo, 1922). Dr John Warnock, superintendent at El Abbassia Hospital, appears to have modelled this draft on Britain's 1890 Lunacy Act. Asylums in Egypt were regulated by the Central Administration for Lunatics, which granted licences, organised visits and reviewed petitions from the families of detained lunatics.

The Egyptian parliament ratified the first Mental Health Act in 1944. This legislation addressed the involuntary detention of psychotic patients, second opinions, consent to treatment and appeals. The law formed the basis of hospital practice of psychiatry for about 30 years. Nonetheless, by the 1980s psychiatric hospitals were detaining numerous patients who did not suffer from psychotic disorders (largely because of loopholes in the legislation), but rather had addictions or behavioural disorders; in fact, the involuntary detention of patients on moral grounds became common practice (Zaki, 2009).

The recent past

By 2006, Egypt had 8000 in-patient beds for people presenting with mental illness, all on locked wards, and many of these patients stayed for decades. The Mental Health Act was not applied; instead, almost all patients were claimed to be voluntarily admitted as, nationally, only four were detained under the Act.

In 2006, a group of mental health professionals at the Ministry of Health, with the support of the World Health Organization (WHO) and funding from donors, including the Foreign Ministry of Finland, drafted a new Mental Health Bill. This was ratified in parliament in May 2009.

The Mental Health Act of 2009 (Law 71, published in the *Official Gazette*, issue 20, 14 May 2009) brought basic conceptual changes to the care of people with a mental illness in Egyptian

institutions. This, like its predecessor, focused on the rights of those with a mental illness, independent second opinions from psychiatrists and patients' right to consent to treatment. The real change in the environment of mental hospitals followed the policy of opening the gates to visitors, the press and international professional organisations, such as the Royal College of Psychiatrists, the Arab Board of Psychiatry, the Institute of Psychiatry in London and the World Federation for Mental Health, which all offered to support the work. In parallel to this, another important step was to campaign and raise awareness regarding the rights of people with a mental illness to live in the community. A media campaign was launched using television, billboards and educational material in schools.

Initially, this started with the Ministry of Health's effort and funding; then the work gradually took off on its own, with non-governmental organisations (NGOs), human rights organisations and consumer representatives taking the lead.

By May 2009, the law was applied to all mental institutions in Egypt, and a Code of Practice (2010 – ministerial decree number 128) was completed. Training workshops were conducted throughout Egypt. The application of the new Act appeared to be well accepted by most hospital-based professionals but not fully supported by psychiatrists, who had practised without the implementation of the 1944 Mental Health Act for decades. Indeed, a body of resistance built up among clinicians, who felt that the new Act, by empowering patients, represented a threat to clinicians' judgement. In a culture that is essentially patriarchal, in a society that lived under a dictatorship, it is not surprising that doctors would want to retain their powers.

On the brink of change

In January 2011, young Egyptian activists went out on to the streets to demonstrate against police brutality and eventually demanded a change of political system. The Mubarak regime was replaced by the Supreme Council of Armed Forces and parliamentary elections took place in November 2011 (with an overwhelming majority of religious parties). A number of liberal attitudes perceived as being Western ideologies came into question in the new Egypt, including laws addressing women's rights, the protection of children and rights pertaining to sexual orientation. With an increased level of street violence, accompanied by a prevailing mixed culture of military and religious ideologies, the current government is unlikely to uphold these values.

The Code of Practice of the Mental Health Act was redrafted in 2011 (ministerial decree number 210) by a working group, which chose to relax the requirements for patients' informed consent to treatment, from a written signed form to a written entry in the patient's notes stating that the patient has verbally consented. The new Code allows the compulsory use of psychotropic medication to facilitate bringing people to hospital from their

private homes without prior permission from the district attorney. Involuntary electroconvulsive therapy (ECT) without second opinion for up to three initial sessions became legitimate. The role of patients' rights committees was diminished.

Violations of the human rights of people who are mentally ill are recognised globally (Drew *et al*, 2011). The Egyptian experience underlines the importance of public education and community participation in the drafting of new legislation. Ideally, laws are ratified to fulfil society's need for regulation. Bringing in new ideas of human rights and empowerment of service users becomes a challenge when the predominant culture does not fully acknowledge the rights of people with a mental illness.

Nevertheless, the process of drafting the Act – with repeated conferences and workshops, lengthy parliamentary debates in the upper and lower

houses, and substantial media coverage – has had an effect on the wider community's perception of people who are mentally ill, their place in society and their role. Patients are their own best advocates. Bringing a long-stay patient to meet with MPs in the Egyptian parliament was probably the loudest call that led to Egypt's Mental Health Act 2009.

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The 'revolving door': a profile of acute admissions at a South African psychiatric hospital

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This paper reports admission rates within the acute service at a major South African tertiary psychiatric facility, Lentegeur Psychiatric Hospital (LPH) in Cape Town.

The acute service in South African psychiatric hospitals is a challenging environment in which clinicians are faced with a multitude of factors that impinge on the efficacy of their interventions. This environment is characterised by lengthy and constantly growing waiting lists, an ever-present pressure to vacate hospital beds for incoming patients and a noticeable increase in the clinical presentation of severe Axis I diagnoses (Strebel *et al*, 1999). Moreover, the social context from which these patients emerge compounds the burden on services and should be considered in planning treatment. There is widespread poverty, the vast majority reside in informal housing on the outskirts of the urban cities, there is mass unemployment, some of the highest rates of substance misuse in the world, and an increasing prevalence of HIV and other communicable diseases. This is an important consideration, given that there is emerging evidence from low- and middle-income countries that mental ill-health is strongly associated with poverty and aspects of social deprivation

(Patel & Kleinman, 2003). These external psychosocial factors in turn contribute to poor discharge planning, the premature discharge of patients who clinically would require a lengthier hospital stay and, ultimately, speedy readmission following discharge. This phenomenon is most often captured by the term 'revolving door', coined to describe patients who are admitted at least three times during their lifetime (Webb *et al*, 2007). Findings in the UK suggest that readmission rates among patients with severe psychiatric disorders are high: approximately 50% of patients admitted have had previous psychiatric admissions, and about 40% of patients require rehospitalisation within 1 year of discharge (Sweetman & Davies, 2004).

There are a number of factors that appear to predict readmission. The majority of studies suggest that the number of previous psychiatric admissions is a good predictor of the risk of re-admission (e.g. Webb *et al*, 2007; Bowersox, 2009). This is often the most reliable indicator. Of those readmitted, between one-half and two-thirds are readmitted within 12 months of discharge, suggesting that this is a high-risk period. The most critical point is 1 month after discharge. Higher rates of readmission are associated with a diagnosis of schizophrenia and other psychosis. A diagnosis of substance misuse or dependence is also associated

Table 1
Sample characteristics (n = 666)

Variables	Frequency (%)
<i>Age (years)</i>	
18–24	122 (18.2)
25–34	206 (30.9)
35–49	238 (35.7)
50–59	85 (12.7)
60+	15 (2.2)
<i>Differential diagnosis</i>	
Schizophrenia spectrum	177 (26.5)
Affective spectrum	246 (36.9)
Substance-induced spectrum	27 (4.1)
Brief-episode spectrum	150 (22.5)
Secondary to a general medical condition	63 (9.5)
Other	3 (0.5)
<i>Catchment area</i>	
Urban	552 (82.7)
Rural	86 (12.9)
Not part of catchment area	28 (4.2)
<i>Type of admission</i>	
First	359 (53.9)
Repeat	307 (46.1)

with more frequent admissions, as are chronic psychiatric disorders with an affective component. Sweetman & Davies (2004) found that patients with a dual diagnosis have twice as many admissions per year as those with a single diagnosis. Furthermore, research indicates that individuals who are compliant with their psychotropic medication have a lower rate of readmission. Studies have indicated that more detailed planning at discharge can be a protective factor against future readmission. Age also appears to be a factor that affects readmission, with younger individuals being more likely to be readmitted early (Fontanella, 2008). Nonetheless, McGurk & Mueser (2008) found that older patients with severe mental illness were more cognitively impaired and thus less responsive to cognitively based interventions. This is a factor which could result in readmission.

Method

The present study is archival and reports retrospective data from March 2009 to February 2011 for all 666 patients admitted to the acute service at Lentegeur Psychiatric Hospital (LPH) during this period. All patients are examined by a medical officer and assessed using the Maudsley psychiatric interview; a provisional diagnosis is assigned upon admission. The following patient characteristics were recorded: age, household location and provisional diagnosis. Then the number of admissions for each patient within the 2-year time frame was counted and the periods between each episode calculated.

Results and discussion

The 'revolving door' refers to the expectation that patients will present frequently for readmission over a short period of time. However, in stark

Table 2
Readmission data (n = 666)

	Frequency (%)
Number of admissions	
1	359 (53.9)
2	111 (16.7)
3	36 (5.4)
4	11 (1.7)
5	7 (1.1)
Previous admission prior to March 2009	142 (21.3)
<i>One relapse</i>	
Within 1 week	1
Within 1 month	7
Within 6 months	16
Within 1 year	21
More than 1 year	19
<i>Two relapses</i>	
Within 1 week	0
Within 1 month	0
Within 6 months	10
Within 1 year	3
More than 1 year	1
<i>Three relapses</i>	
Within 1 week	0
Within 1 month	0
Within 6 months	2
Within 1 year	0
More than 1 year	0
<i>Four relapses</i>	
Within 1 week	0
Within 1 month	0
Within 6 months	1
Within 1 year	0
More than 1 year	0

contradiction to this expectation, the current retrospective study reveals a lower than anticipated readmission rate, with similar rates of first admissions (54%) and readmissions (46%) (Tables 1 and 2). Furthermore, when patients were re-admitted for a second (or later) episode, this was often after a period exceeding 2 years. It seems that a large proportion of patients who do indeed relapse do so long after discharge, certainly well after 2 years (beyond the period examined here).

Patients presented with a minimum of one (16.7%) to a maximum of five relapse episodes (1.1%). Most patients who presented for readmission did so only once and within 1 year of discharge. A similar trend is evident for the other groups who presented more often. This is an interesting finding given that the literature strongly suggests that frequent admissions over a short period of time should be expected, certainly in Western samples (Sweetman & Davies, 2004). Why might this be different in South Africa?

- The ethos common to the indigenous African culture – encompassing a sense of community, and social, decentralised care by families and larger community structures – may reduce the burden on formal mental health services. It also assists patient compliance with post-discharge treatment.

- The Health Professionals Council of South Africa has introduced a compulsory system of continuing professional development to encourage mental health staff to improve their clinical knowledge and skills, especially with regard to ethical, evidence-based services. Education and implementation of powerful evidence-based interventions whose efficacy is empirically validated ensure that patients receive the best management possible, potentially contributing to favourable patient outcomes.
- The inception of the Mental Health Care Act 2000 and a recent move towards deinstitutionalisation have had an impact on the pathways of care and consequently the nature of presentations to tertiary-level psychiatric facilities such as LPH. Patients in the catchment area of this hospital now have access to psychiatric care (usually by a registrar) and are subject to a compulsory 72-hour observation period at a district-level facility. It is only when patients become unmanageable or symptoms persist for longer than 72 hours that they are transferred to a tertiary facility. As a result, the smaller than expected readmission rate observed here may suggest that a larger than anticipated proportion of patients remit during those first few days and do not require further admission to acute care. Moreover, the low incidence of substance-induced disorders (SIDs) – at 4% – in this sample is contrary to that expected, given the widespread prevalence of substance misuse in this catchment area. It is plausible that most SIDs dissipate within a short period of time (while patients are at district facilities) and therefore most may never require tertiary care.
- Despite the commonly held belief that South Africa suffers from an underresourced public health service and clinicians feel unable to render optimal care due to the pressure of contextual challenges, it seems that adequate treatment is nevertheless being provided at this particular hospital and patients seem to derive a sense of benefit from the interventions received, potentially resulting in longer periods of remission.

Our results concur with previous findings regarding the high prevalence of affective disorders in psychiatric samples (36.9%; Loveland-Cook *et al*, 2010), the tendency for younger patients to present with more severe symptoms and a greater likelihood of readmittance (22.9%; Fontanella, 2008) and the relatively high incidence of readmissions in the older age category, where it has been suggested that patients may be unable to adequately utilise the psychotherapeutic services offered to them (McGurk & Mueser, 2008).

The data indicate that the periods between episodes increase progressively over time, suggesting that patients remain well for longer periods over the course of their illness. We cannot with any certainty conclude why this may be so. However, it may be the result of the natural psychological process of coming to terms with the psychiatric diagnosis, accompanied by acceptance of the prescribed treatment. Furthermore, having received comprehensive multidisciplinary input, including evidence-based interventions over an extended period of time, as well the fact that patients may be more amenable to accepting and acting upon the input received, may result in extended positive outcomes. Researchers studying reasons for attrition have found that there were few differences for patients who remain compliant and those who drop out. One difference was that patients who were satisfied with their level of treatment did not drop out of the study (Primm *et al*, 2000).

It is important to bear in mind that these results pertain to one hospital in a particular catchment area situated reasonably close to a major city centre. This may not reflect what happens in hospitals elsewhere in South Africa, which may not be as well resourced. Patients at LPH are able to access the services of a complete multidisciplinary team and a bio-psychosocial approach to treatment which includes psychiatric and medical input, psychological services (e.g. psychotherapy groups, individual psychotherapy, family psycho-education), occupational therapy, physiotherapy, nutrition/dietetics and social work, as part of a complete package of care.

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An evaluation of training in brief cognitive-behavioural therapy in a non-English-speaking region: experience from India

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The authors wanted to learn whether it was possible to deliver cognitive-behavioural therapy (CBT) in a low-income country where English is neither the first nor the preferred spoken language and to evaluate the effectiveness of the training in terms of skills acquisition. Twenty participants attended a 3-day workshop on the technique. All had experience of communicating in Hindi with patients, although their medical training was in English. There is no manual for CBT in Hindi. Role-plays focused on basic CBT skills such as Socratic dialogue, the 'five area' approach, the use of the 'downward arrow', developing an automatic negative thought record and devising behavioural experiments, in Hindi. The findings suggested that it is feasible to train mental health professionals in CBT where English is not the first language.

Background

Growing evidence for the efficacy of cognitive-behavioural therapy (CBT) in the treatment of mental illnesses (Williams & Garland, 2002) has stimulated the interest of psychiatrists in India. Over the course of 3 years, a series of 3-day workshops was organised by the first author at the Department of Psychiatry, Chhatrapati Sahuji Maharaja Medical University (CSMMU), previously known as King George's Medical College, Lucknow, India. This article focuses on outcome data from the fourth of these workshops. The first two workshops were at an introductory level, while the third focused on the use of behavioural experiments within a CBT context. (The results of these initial workshops have been presented at annual conferences of the British Association for Behavioural and Cognitive Psychotherapies and the Indian Psychiatry Society's Central Zone.)

The authors wanted to learn whether it was possible to deliver CBT in a low-income country where English is neither the first nor the preferred spoken language and to evaluate the effectiveness of the training in terms of skills acquisition.

How delivering CBT training was different in India

A commonly encountered barrier to initiating psychological therapies in non-English-speaking

countries is the focus on biological/medical models of treatment on the part of both medical professionals and their patients. Training doctors in approaches that are new to them and their patients can be difficult. We distributed a report of a randomised controlled trial of CBT (King, 2002) to suggest to our psychiatric colleagues that CBT is an appropriate treatment for common mental health problems. An initial comment from one influential member of the local faculty was that CBT is appropriate for Western culture but may not work with Indian patients. This comment was turned into a question for the training programme and was presented as a behavioural experiment. The presumption was that if trainees are able to learn CBT skills, to use these with their patients and to get some good results in the first instance, it will be worthwhile developing a randomised controlled trial at a later stage for gathering strong scientific evidence in favour of the efficacy of CBT delivered to Indian patients in the local language.

Another barrier we faced was the hierarchical professional system within medicine in India (as is the case in many other low-income countries). When the workshop started, we noticed that there were four distinct groups: consultants, junior doctors, psychologists and medical students. We addressed this issue by ensuring a good mix of skills in each group when dividing them into smaller groups for skill practice, in order to give everyone a chance to participate fully in the training and to work as a team. There was naturally some apprehension among participants about this approach as it is difficult to break with tradition. But doing so helped the group to understand the concept of a collaborative approach.

The teaching environment and equipment were of a poorer standard than one would have in the UK and this necessitated a certain amount of improvisation. A 40-inch flat-screen television was attached to laptop via S-video cable and a home cinema surround-sound system was used for the audio output. We also utilised more role-plays in order to compensate for the lack of good presentation equipment. Role-plays focused on the demonstration of basic CBT skills by the first author, such as Socratic dialogue, discussing the 'five area' approach with the patient, the use of the 'downward arrow', developing an automatic negative thought record, devising behavioural experiments and so on, in Hindi.

In order to help trainees consolidate and continue to practise skills learnt, some clinical supervision sessions were provided after the 3-day workshop, via telephone. Video-chat and email were also used, using the principles of distance learning. Trainees submitted therapy notes and case summaries for review. The supervision suggested that the trainees had been able to utilise CBT skills learnt during the workshop.

All participants had previous experience of communicating in Hindi with patients, although their medical training was in English. The first author worked with the participants during the workshop to agree Hindi equivalents (in the local dialect of the region) of common Socratic dialogue questions used in CBT, as there is no manual for CBT in Hindi. Unfortunately, the participants could not use rating scales when monitoring the results of CBT as there is a lack of standardised scales in Hindi.

The workshop

Twenty participants attended the course. The agenda for all three training days was agreed at the beginning of each session based on the learning objectives of the participants. Eight participants had attended previous workshops (in 2008 and 2009) and rest were new to the training (denoted 'repeat' and 'fresh', below). The fresh participants received introductory lectures from CSMMU faculty members beforehand, based on two books covering the basic principles of CBT (Hawton *et al.*, 1998; Simmons & Griffiths, 2009).

On day 1, the participants were asked to highlight their learning needs, which included understanding the 'five areas' model, assessment of patient suitability for CBT, the art of Socratic questioning and eliciting negative automatic thoughts. One of the participants volunteered to bring therapy notes (with the patient anonymous)

to facilitate a discussion of the practical difficulties. The same participant was asked to role-play the patient, while the trainer (the first author) role-played the therapist and demonstrated the technique of Socratic dialogue to elicit negative automatic thought. A thought record was completed, based on the 'seven columns' technique as used by Greenberger & Padesky (1995). The criteria used for the selection of patients for therapy were discussed (Blenkiron, 1999).

Day 2 started with a recap of day 1. Based on feedback, an agenda for the day was agreed, which was to develop the skills of explaining the CBT model to patients and the rationale behind the behavioural experiments. A simple method was developed of explaining the CBT model to the patients in Hindi using an interactive vignette and Socratic dialogue.

Day 3 started with a recap of days 1 and 2. An agenda was agreed to discuss supervision for trainee therapists and the practical aspects of behavioural experiments. Possible modifications to behavioural experiments based on cultural norms were also discussed and an experiment was devised based on a vignette brought by a trainee. The participants practised devising behavioural experiments in groups of three or four and the first author supervised the skill practice.

Assessment

The baseline knowledge of all the participants was assessed before the workshop, using a questionnaire designed for participants to self-rate their core CBT skills. It covered seven areas: activity scheduling; the use of the positive data log; Socratic dialogue; core belief; negative automatic thought; formulation; and all-or-nothing thinking.

Participants were asked to complete the questionnaire again after the workshop. There was no formal measure of competency following the

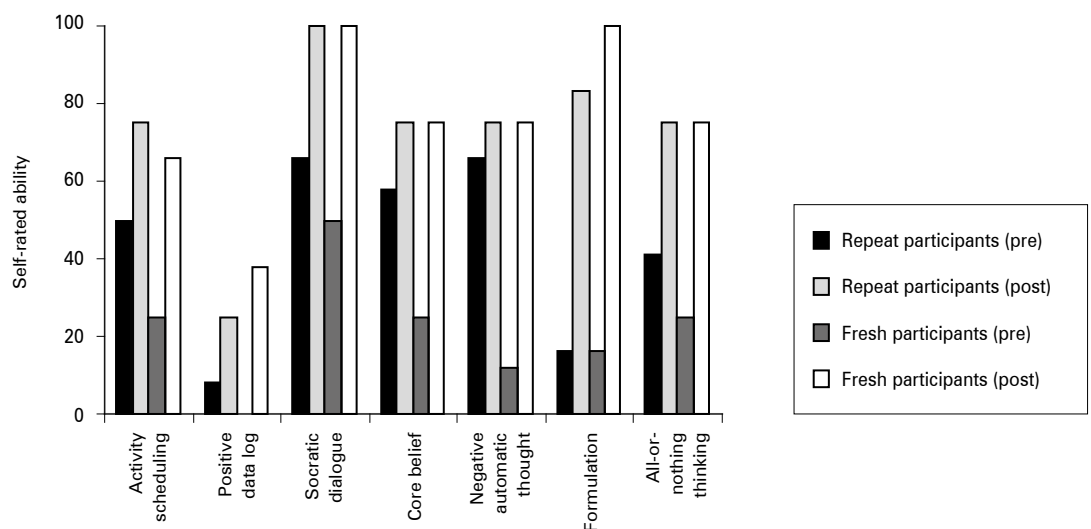


Fig. 1 Comparison of the self-evaluated skill ratings of the fresh and repeat participants before and after the workshop.

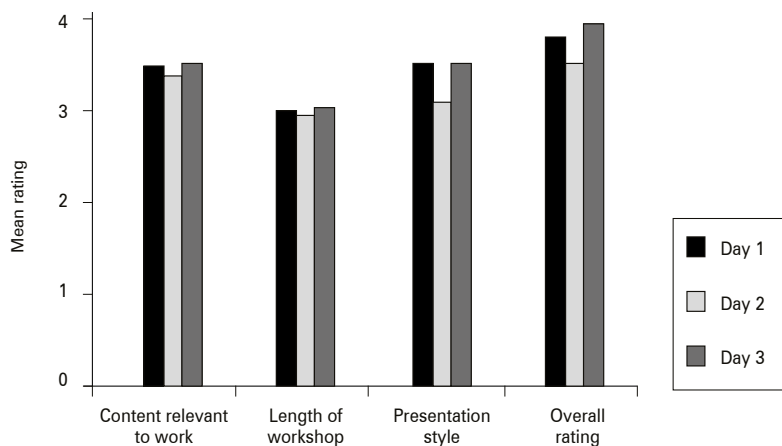


Fig. 2
Feedback on each of the 3 days of the workshop

course owing to a lack of facilities such as video-equipment and difficulty in gaining consent from patients because of issues of stigma.

All the trainees were asked to provide feedback at the end of each day on four different aspects of the workshop: content relevant to work, length of workshop, presentation style and overall rating. These were scored on a scale of 0–4: 0, poor; 1, fair; 2, good; 3, very good; 4, excellent.

All the data collected were analysed using SPSS. Means and standard errors (s.e.) were calculated and significance was determined using paired *t*-tests.

Results and discussion

We found that all participants (both repeat and fresh) improved after training (mean score on the self-assessment questionnaire 75.29, s.e. = 5.95) compared with baseline (mean 32.71, s.e. = 5.92) ($t(13) = -6.899, P < 0.001, r = 0.886$) (see Fig. 1).

In the fresh participants group a skill level of 100% was noted for Socratic dialogue and formulation. There was no difference observed in either cohort of trainees in their understanding of core belief and negative automatic thoughts, which reached satisfactory levels (around 70%). Skills like activity scheduling, core belief, negative automatic thoughts and all-or-nothing thinking showed some improvement (to around 75%). There was poor understanding of the use of the positive data log (25%) among all the trainees and this area needs to be addressed in future workshops.

The trainees' feedback is summarised in Fig. 2.

Areas for improvement/limitations of the study

- There is a lack of standardised rating scales in Hindi for the measurement of mental illness.

The first author has started work on one such measure.

- The questionnaire we used was from an unpublished small-scale research project and so its validity is questionable. Also, it is based on self-evaluation and lacks objective assessment.
- Accuracy of measurement of skills development would have been improved if formal assessment measures were used and this needs further consideration for future training.
- The lack of suitable teaching aids such as audio- and video-equipment needs to be addressed.
- As the participants had different levels of theoretical knowledge at the beginning of training it was difficult to compare the groups to measure the outcome of training.
- Future work is now focusing on the development of rating scales in Hindi, video-recording of therapy sessions, the use of formal assessment measures and the development of randomised controlled trials for evaluating the efficacy of CBT in an Indian population.

Conclusion

This initial study would suggest that it is feasible to train mental health professionals in CBT in India and possibly other countries where English is not the first language. As this was a small project with a number of methodological constraints, the evidence cannot be seen as conclusive. In the context of training mental health professionals, the central indicator of an effective training programme would be an improvement in client care and clinical outcomes (Kirkpatrick, 1979). There is therefore a need to carry out more robust work in recruiting more patients and carrying out systematised research.

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Self-burning in Iraqi Kurdistan: proportion and risk factors in a burns unit

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To determine the rate of self-burning among all burns patients admitted to the Burns and Plastic Surgery Centre at Sulaimani University in Iraqi Kurdistan and to identify the risk factors and motives, all burns patients, aged 8 years and over, admitted between 1 September 2009 and 30 April 2010 were surveyed. Of the 200 patients interviewed, 54 (27%) reported self-burns and 146 (73%) reported accidental burns. The risk factors for self-burning included mental illness, female gender and younger age. Almost two-thirds of those who reported self-burns (32, 60.4%) had intended to kill themselves. The most commonly cited reasons for the act were family problems (24, 44%) and marital problems (13, 24%). Burns in the self-burning group were more severe and were associated with a higher mortality rate (34, 63%) than in the accidental burns group (29, 20%).

Self-burning is a violent method of suicide which is associated with high mortality (Laloe, 2004). It is more common in Asia and the Middle East (Laloe, 2004). A number of studies have investigated the phenomenon in this region (e.g. Mabrouk *et al.*, 1999; Panjeshahin *et al.*, 2001; Ahuja & Bhattacharya, 2002; Zarghami & Khalilian, 2002). It has been reported that the majority of these patients are young women (Laloe, 2004). Laloe (2004) reported that self-burns are associated with psychiatric and inter-personal problems and with political motives for the act of self-immolation.

Self-burning among young females in Iraqi Kurdistan has generated concern on the part of non-governmental organisations (NGOs) and has been publicised in the local and international media (e.g. Peraino, 2007). Two published studies were partly related to this condition (Carini *et al.*, 2005; Hanna & Ahmad, 2009). This study aimed to investigate the rate of self-burning, as well as causal factors, in a burns unit in Iraqi Kurdistan (the Burns and Plastic Surgery Centre of Sulaimani).

Method

Settings and study period

The population of Iraq, in mid-2010, was 32.7 million (Haub & Kaneda, 2011). The city of Sulaimani is situated in north-east Iraq. It is administered

by the Iraqi Kurdistan Regional Government (KRG). The study was conducted between 1 September 2009 and 30 April 2010.

Sample and data collection

Data were collected by one researcher (N.R.) who visited the centre three times a week. Depending on the availability of the researcher and the clinical state of the patients, all patients aged 8 years and above were approached (8 is the youngest age at which the act has been performed, according to media reports). Verbal consent was obtained from patients, or their parents for those aged 15 years or less. Those who did consent were interviewed once or more as soon as possible after their admission, but data on the interval between admission and interview were not recorded.

A data-collection form (available on request) was specially developed for the study. It covered demographic and clinical variables and motives. It was administered by the researcher (N.R.), in the patients' native language. Participants were given the choice of either answering directly or selecting from a number of options and their responses were further clarified. Data, including history of mental illness, were based on patients' self-reports rather than structured instruments. The degree of burns and total body surface area (TBSA) burnt (as a percentage of overall body surface area) were collected from case-notes and the mortality data were obtained from the hospital records.

The sample size was determined on the basis of two risk factors: female gender and younger age (Laloe, 2004; Carini *et al.*, 2005; Hanna & Ahmad, 2009). Based on previous research, we estimated that 47% of controls (patients with accidental burns) (Carini *et al.*, 2005) and 76% of cases (patients who had deliberately burned themselves) (Hanna & Ahmad, 2009) would be female. For a 5% significance level, 80% power and three controls per case, the necessary sample size was calculated to be 29 cases and 87 controls. In relation to the second risk factor, on the basis of previous studies we estimated that 30% of the control group (Carini *et al.*, 2005) and 75% of the cases (Hanna & Ahmad, 2009) would be aged 15–30 years. This age group was chosen because it covered age groups found to be risk factors in previous studies (Carini *et al.*, 2005; Hanna & Ahmad, 2009). Using the same parameters, the sample size came out to be 12 cases and 36 controls. To adjust for confounding variables, a

Table 1

Characteristics of the 'self-burning' and 'accidental burning' groups

Variable		Self-burning (n = 54)		Accidental (n = 146)		P
		n	%	n	%	
Female gender	Female	44	81.5	89	61.0	0.006 ^a
Age group	15–30 years	40	74.1	72	49.3	0.002 ^a
	Other	14	25.9	74	50.7	
Marital status	Single	22	40.7	51	35.2	0.574 ^a
	Married	29	53.7	87	60.0	
	Separated/divorced	2	3.7	2	1.4	
	Widowed	1	1.9	5	3.4	
	Husband married to another woman	4	14.3	7	11.5	0.736 ^b
Have children		23	71.9	78	83.9	0.137 ^a
Ethnicity	Kurdish	44	81.5	109	74.7	0.624 ^a
	Turkmen	0	0	2	1.4	
	Arab	10	18.5	34	23.3	
	Other	0	0	1	7	
Residency	City	37	68.5	95	65.1	0.674 ^a
	District	11	20.4	38	26.0	
	Village	6	11.1	13	8.9	
Religious attitude	Atheist	0	0	1	7.0	0.403 ^a
	Believer, not practising	18	33.3	36	24.7	
	Believer, practising	36	66.7	109	74.7	
Religion	Muslim	54	100	144	98.6	1 ^b
	Kakaiy	0	0	2	1.4	
Education	Illiterate	17	31.5	39	26.7	0.48 ^a
	Primary school	25	46.3	58	39.7	
	Secondary school	8	14.8	35	24.0	
	University or technical institute	4	7.4	14	9.6	
Occupation	Employed	6	11.1	44	30.1	0.006 ^a
	Unemployed	48	88.9	102	69.9	
Financial status	Poor/very poor	26	48.1	42	28.8	0.03 ^a
	Intermediate	22	40.7	86	58.9	
	Good/very good	6	11.1	18	12.3	
Alcohol use		1	1.9	3	2.1	1 ^b
Substance misuse		0	0	0	0	
Mental illness		14	25.9	8	5.5	<0.001 ^a
Diagnosis	Depression	4	7.4	3	2.0	0.028 ^a
	Schizophrenia	3	5.5	0	0	
	Bipolar disorder	1	1.8	0	0	
	Other	0	0	4	2.7	
	Unknown	6	11.1	1	0.6	
Family history	Of mental illness	5	9.3	6	4.1	0.156 ^a
	Of suicide	5	9.3	2	1.4	0.01 ^b
Method of burning	Kerosene	50	92.6	76	52.4	<0.001 ^a
	Petroleum	4	7.4	12	8.3	
	Other	0	0	57	39.3	
Degree of burn	Second degree	5	9.3	31	21.4	0.04 ^a
	Third degree	49	90.7	114	78.6	
Fatal outcome		34	63.0	29	19.9	<0.00 ^a

^a Chi-square test, ^b Fisher's exact test.

sample size of 50 cases and 150 controls was used. The study was approved by the Research Ethics Committee of the University of Sulaimani.

Data analysis

The dependent variable was burns status (self-burning or accidental burning). Categorical variables in the two groups were compared using the chi-squared test and Fisher's exact test, while continuous, normally distributed variables were compared using the *t*-test.

Multivariate conditional logistic regression was used to identify risk factors independently associated with self-burning. The odds ratio (OR) and 95% confidence interval (CI) are reported. The following hypothetical risk factors were entered in the initial models: age group (with two categories: age 15–30 and other age), gender, marital status, residency, ethnicity, religion, financial status, occupation, history of mental illness, family history of mental illness and family history of suicide. The specific diagnoses were not included because of the small numbers. Forward and backward logistic regression models were used. If the same variables remained in the final model, this was taken as a confirmation of the findings. Analysis was performed using SPSS version 15.

Results

During the study period, 642 patients were admitted to the unit, of whom 462 were aged 8 years and over. Two hundred of these patients were interviewed. Patients were not interviewed if they were clinically unfit to be interviewed or if they refused to give consent; some patients were discharged from hospital and some died before they could be interviewed. Burns were categorised as accidental (139, 70%), self-induced (54, 27%) or caused by others (7, 4%). Patients whose burns were caused by others were combined with those with accidental burns to form the control group (all those for whom the burns were not self-inflicted).

The mean age of patients in the self-burning group was 27 years (s.d. = 12.6) compared with 30.6 (s.d. = 16.7) in the control group ($t = 1.671$, $P = 0.09$). Demographic and clinical characteristics are shown in Table 1. The burns in the self-burning group were more extensive (mean TBSA burnt 52.4%, s.d. = 26.2%) than in the accidental burns group (mean TBSA 28.7%, s.d. = 20.2%) ($t = -6.01$, $P < 0.001$).

The reasons cited by the patients for the self-burning were family problems (24, 45%), marital problems (13, 24%), psychiatric illness (9, 17%), financial problems (3, 6%), physical health

Table 2

Multivariate logistic regression

Variable	Self-burning (n = 54)		Accidental (n = 146)		Crude OR			Multivariate OR		
	n	%	n	%	OR	95% CI	P	OR	95% CI	P
Gender (female)	44	81.5	89	61.0	2.81	1.31–6	0.08	2.6	1.1–6.2	0.03
Age group 15–30 years	40	74.1	72	49.3	2.2	1.3–3.8	0.002	3.3	1.4–7.6	0.004
Mental illness	14	25.9	8	5.5	6.0	2.3–15.4	<0.001	10	3.3–29.8	<0.001

problems (2, 4%) and fear of loss of reputation (1, 2%). Family and marital problems were more common in females (33, 80%) than in males (4, 40%) ($P = 0.009$). Thirty-two (60%) patients reported that the aim of their act was to kill themselves. Other aims were: to make others feel guilty (6, 11%), to put pressure on others (8, 15%), to solicit affection (3, 6%) and other aims (4, 7%). Patients with suicidal intent had a higher mean TBSA burnt (58%) than those who had other motives (42%) ($P = 0.02$). Subsequently, their mortality rate was far higher (26, 81.3%) than in the control group (7, 33%) ($P = 0.001$).

In the self-burning group, 8 patients (15%) had a history of self-harming, 4 (7%) had asked for help before the act and 8 (15%) had informed others before the act. The majority (50, 94%) said that it was their own idea and 40 (74%) said that they regretted it; however, 11 (20%) said that they would burn themselves again if they had the chance.

Multivariate logistic regression

Three variables showed a statistically significant association with self-burning: mental illness, female gender and age 15–30 years (Table 2). Separate multivariate logistic regressions were carried out for males and females. It showed that the association between mental illness and self-burning was stronger in males (OR = 40, 95% CI = 6–274, $P < 0.001$) than in females (OR = 4.1, 95% CI = 1.2–14, $P = 0.02$). The young age group (15–30 years) was a statistically significant risk factor only for females (OR = 3.6, 95% CI = 1.5–8.7, $P = 0.005$).

Discussion

This study showed that the rate of self-burning among burns cases is high in a burns unit in Iraqi Kurdistan. We found only one study in this region (Iran) which reported a higher rate, of 36.6% (Saadat, 2005). Burns in the self-burning group were more severe and were associated with a higher mortality rate, which is consistent with previous studies (Laloe, 2004). The majority of self-burning patients in our study were young women, in line with studies from Asia and the Middle East (Laloe, 2004). Explanations might include the new responsibilities young women face when they become of marriageable age (Soni Raleigh & Balarajan, 1992) together with the status of being female in a traditional society. This might be supported by the predominance of family and marital problems in our female sample. In the absence of official data about suicide in Kurdistan and Iraq, it is unclear whether the predominance of young females is restricted to this method or extends to suicide in general.

A history of mental illness was found to be a risk factor for self-burning, with depression being the most common diagnosis, followed by schizophrenia, which is consistent with Laloe's review (2004). The low rates of mental illness in the self-burning group could be due to our use of patients' reports rather than a structured instrument, which

might have led to underestimation. A history of mental illness was less prominent in females, suggesting that factors associated with female gender itself are more important risk factors in this group.

The question as to why this violent method is used is difficult to answer and requires further exploration. The ready availability of kerosene in Iraq might be one reason (it is used in virtually every house, mainly by women, for cooking and heating).

Limitations

This study was conducted in one burns unit in Iraqi Kurdistan, which could limit the generalisation of its findings, even to other parts of Iraq. Some of the accidental burns could have been in fact self-inflicted, and in some cases 'self-burning' could in fact have been inflicted by other people. Patients' own reports of their mental illness could have led to underestimation. This study did not explore motives in depth.

Implications

Self-burning is a significant public health issue in Iraqi Kurdistan, occurring mainly in young females with social problems. Psychiatric assessment should be done in all cases. Follow-up is necessary, as a significant number of patients stated that they would repeat the act given the opportunity. A register of all cases of suicide is urgently needed.

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New directions in psychiatry – defining the way

Sir: Psychiatry as a discipline will undergo major changes over the next few years. Although such changes can be stimulating and challenging from intellectual, scientific and social viewpoints, the new generations of psychiatrists must be prepared for them.

Paradigms which have represented the foundations of psychiatry in the last century are now in need of major revision. In particular, young psychiatrists feel the need: (1) to rediscover psychopathology in order to improve their diagnostic skills; (2) to adopt a preventive approach to psychiatry, intervening in the early stages of psychiatric disorders; (3) to improve their skills in conducting research and writing scientific papers; (4) to refine their knowledge of the biological and social determinants of mental illness.

All this was debated at the congress 'New Directions in Psychiatry', organised by the Early Career Psychiatrists Committee of the European Psychiatric Association (EPA) at Sorrento (Naples) on 21–23 May 2012 and dedicated to the needs of European early-career psychiatrists. More than 400 young colleagues from almost all European countries attended the congress, at which prominent European scientists gave their views on the future of mental healthcare.

The scientific track was organised as five thematic areas. The first session dealt with the future of psychiatry and mental health, and contributors were three past or future Presidents of the World Psychiatric Association, namely Professors Maj, Sartorius and Bhugra. The second session was dedicated to preventive psychiatry, in particular to early intervention in psychoses, prevention of suicide and management of perinatal depression. Speakers were Professors Birchwood, Wasserman and Bassi, respectively. The third session was dedicated to early-career psychiatrists' needs in the area of psychiatric diagnosis and classification, with contributions from Professor Sass on the role of psychopathology, Professor Galderisi on the role of the neurosciences and Professor Kastrup on the role of culture. The fourth session was dedicated to research in mental health. Professors Goldberg, Boyer and Gorwood provided practical tips and basic knowledge on the whole process of research and publication. The last session was dedicated to expectations for the future in biological and social psychiatry, with two of the most renowned European experts in the fields, namely Professors Kasper and Priebe.

Besides the plenary sessions, workshops, sponsored symposia, courses in continuing medical education (CME) and poster sessions were also organised. The two workshops dealt with the role of biomarkers in diagnosis and treatment, and with the relevance of psychopathology for clinical practice. During the sponsored symposia, new directions in the management and treatment of the three major mental disorders (schizophrenia, bipolar disorder and major depression) were

discussed with several experts and speakers. Also, three CME courses were organised in collaboration with the Committee on Education of the European Psychiatric Association.

Finally, an interactive poster session was organised with 114 accepted posters. The three best posters received an award from the organising committee.

The congress was highly appreciated by both young and senior participants, and represented the basis for a fruitful discussion on how to improve psychiatric practice and training for the new generations in psychiatry.

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A challenge of the 21st century: brain migration in psychiatry

Sir: There is an ongoing debate on the migration of healthcare professionals from lower-income to higher-income countries. These movements involve the loss and gain of health resources and the modification of the capacity of the health systems to deliver healthcare, and thus the achievement of the Millennium Development Goals (Global Health Workforce Alliance, 2008).

The concern over migration, as a challenge of the 21st century, has moved to the forefront of agendas and raises many questions. Changes such as globalisation, increased mobility, population ageing, the financial crisis and social networking are forcing us to test old views and adapt to new realities: honour or endurance, identity or governance, quantity or quality, innovation or stability, rights or duties, facts or judgements. These interrogations reflect differences of perception created by the great velocity and intensity of change, along with an unprecedented degree of interconnectivity and a lowering of international barriers (Spencer, 2011).

Defining migration is controversial, since it involves both space and time, which currently are continuously in evolution. Although the terminology has been criticised for its ambiguity, it is worth looking for actual and future migration in the new global context, even though it is a difficult task, by recognising the *push* factors that pressure people to leave the *donor* country, and the *pull* factors that make the *recipient* country seem attractive (Gureje *et al.*, 2009), while confirming *patterns* and *duration* of migration. Connecting such data with the *burden* of illness and relating them to perceived stigma and experiences of discrimination might act as an input to influence healthcare policy stakeholders to support the planning processes according to current needs and the present use of treatment and services (Prince *et al.*, 2007).

Is it a brain gain or a brain drain? In addition to the health dimension, brain migration has a cultural, economic, educational, financial and

social impact, and affects the world as a whole: low-, middle- and high-income countries. The effects arising are both benefits and burdens in the country of destination or origin (Jenkins *et al*, 2010). Thus, it can be assumed that this migration will affect health services and care in some countries, especially if there is no support for the people who do migrate.

Unfortunately, there is lack of data on migration flows, as significant highly skilled migration has been within the European Union and, additionally, there is a particular scarcity of data in psychiatry (Gureje *et al*, 2009). Therefore, as an attempt to explore the extent of migration among psychiatry trainees, the European Federation of Psychiatry Trainees (EFPT) Research Group is doing a survey on brain migration to assess opinions on and experiences of international migration. The data will permit further comparison with other groups, such as physicians in general and psychiatric consultants.

Migration within psychiatry will probably continue. It is therefore essential to enhance support for those who do migrate and influence the mental healthcare provided internationally.

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Forthcoming international events

17–21 October 2012

WPA International Congress 2012

Prague Congress Centre (PCC), Czech Republic
Organiser: World Psychiatric Association
Website: <http://www.wpaic2012.org/en/welcome>

18–20 October 2012

Consultation–Liaison Psychiatry and Psychosomatics

Ev. Krankenhaus Königin Elisabeth Herzberge (KEH), Berlin, Germany
Organiser: KEH and European Psychiatric Association
Email: psychiatrie.abteilungssekretariat@kehberlin.de

7–9 November 2012

12th International Forum on Mood and Anxiety Disorders

Barcelona, Spain
Website: <http://www.ifmad.org/2012>
Email: ifmad@publiccreations.com

8–11 November 2012

International Conference on Clinical Practice in Alzheimer Disease (CPAD)

Budapest, Hungary
Organiser: Paragon-Conventions
Website: <http://www.cpadconference.com/>

10–12 November 2012

3rd Global Conference: Making Sense of Suicide

Salzburg, Austria
Website: <http://www.inter-disciplinary.net/probing-the-boundaries/making-sense-of/suicide/call-for-papers/>

6–9 March 2013

Crises and Disasters: Psychosocial Consequences

Athens, Greece
Organiser: World Federation for Mental Health in collaboration with the Hellenic Psychiatric Association and the Society of Preventive Psychiatry
Website: <http://psychcongress2013.gr/en/index.html>
Email: info@era.gr

6–9 April 2013

EPA 2013: 21st European Congress of Psychiatry

Nice, France
The 2013 Congress will bring psychiatrists and other discipline-related professionals together to address the complex theme of 'Europe challenges the burden on mental disorders'. The programme will tackle research and clinical/therapeutic aspects. In addition the meeting will again feature the highly successful EPA early-career psychiatrists programme.
Organiser: European Psychiatric Association
Website: <http://www.epa-congress.org/>
Email: reg_epa2013@kenes.com

18–21 April 2013

9th International Congress on Mental Disorders and Other Non-Motor Features in Parkinson's Disease and Related Disorders

Seoul, South Korea
Website: <http://www2.kenes.com/mdpd>

30 May–2 June 2013

3rd International Congress on Neurobiology, Psychopharmacology and Treatment Guidance

Thessaloniki, Greece
Organiser: European Psychiatric Association, World Psychiatric Association and School of Medicine, Aristotle University of Thessaloniki
Website: <http://www.psychiatry.gr/>

5–8 June 2013

14th International Congress of the International Federation of Psychiatric Epidemiology: The Uses of Psychiatric Epidemiology in Improving Population Mental Health

Leipzig, Germany
Organiser: International Federation of Psychiatric Epidemiology
Website: <http://ifpe2013.org/>
Email: sjansen@eventlab.org

29 June–3 July 2013

XXI World Congress of Social Psychiatry. The Bio-Psycho-Social Model: The Future of Psychiatry

Lisbon, Portugal
Website: <http://www.wasp2013.com>

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