International psychiatry

Volume 10
Number 1
February 2013
ISSN 1749-3676

Journals affiliated to *International Psychiatry*:
African Journal of Psychiatry
Arab Journal of Psychiatry

Guest editorial

1 **Liaison psychiatry and the interface between mental and physical health – perspectives from England**
Hugh Griffiths

Thematic papers – Economic crises and mental health

3 **Introduction**
David Skuse

3 **The financial crisis and the future of mental health in Greece**
Nikos G. Christodoulou and Dimitris C. Anagnostopoulos

6 **Impact of recent economic problems on mental health in Ireland**
Brendan D. Kelly and Anne M. Doherty

8 **Mental health impact of the economic crisis in Spain**
Luis Salvador-Carulla and Miquel Roca

Mental health law profiles

11 **Introduction**
George Ikkos

11 **The new mental health law in Argentina**
Daniel Moldavsky and Hugo Cohen

13 **Mental health law in Brazil**
José G. V. Taborda

Research paper

15 **School-based survey of psychiatric disorders among Pakistani children: a feasibility study**
Sajida Abdul Hussein, John Bankart and Panos Vostanis

Special papers

18 **Clinical psychology in a medical setting in Sri Lanka**
Piyanjali de Zoysa

20 **Euthanasia and physician-assisted suicide: historical and religious perspective in the Middle East**
Mona Y. Rakhawy, George Tadros, Farooq Khan and Ahmed Mahmoud El Houssini

21 News and notes

22 Correspondence

25 Forthcoming international events

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

International psychiatry

Volume 10
Number 1
February 2013
ISSN 1749-3676

Journals affiliated to *International Psychiatry*:
African Journal of Psychiatry
Arab Journal of Psychiatry

Mission of *International Psychiatry*

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

Founding Editor

Hamid Ghodse

Deputy Editor
David Skuse (Section Editor – Theme)

Associate Editors
Walid Sarhan
(Editor, *Arab Journal of Psychiatry*)

Christopher Szabo
(Editor, *African Journal of Psychiatry*)

Administrative support
Joanna Carroll
Elen Cook
Chris Naughton
Andrew Morris

Hamid Ghodse, CBE, 1938–2012

With great sadness, we announce the sudden death of Professor Hamid Ghodse, who was Professor of Psychiatry and of International Drug Policy at the University of London. He held many other official positions on the national and international stage, and had been Editor of *International Psychiatry* since its inception. We will miss his wise counsel in the editing of this journal, which represents a legacy that will inspire future generations of psychiatrists.

David Skuse

Editorial board

Michel Botbol
France

Nick Bouras
UK (Section Editor – Special papers)

Katy Briffa
UK

Jorge Calderon
Chile

Rakesh Chadda
India

Santosh Chaturvedi
India

George Christodoulou
Greece

John Cox
UK (Assistant Editor)

Anna Datta
Ireland

Oluwole Famuyiwa
UK

Peter Hughes
UK (Section Editor – News and notes)

George Ikkos
UK (Section Editor – Guest editorials; Mental health law profiles)

Rachel Jenkins
UK (Section Editor – Research papers)

Stephen Kisely
Australia

Marinos Kyriakopoulos
UK

Nasser Loza
Egypt (Assistant Editor)

M. Akmal Makhdum
UK

Amit Malik
UK (Section Editor – Correspondence)

Donald Milliken
Canada

Gholam Reza Mir-Sepassi
Iran

R. N. Mohan
UK

Hellme Najim
UK

David Ndetei
Kenya

Sean O'Domhnaill
Ireland

Olufemi Olugbile
Nigeria

Eleni Palazidou
UK

Vikram Patel
India

Sundararajan Rajagopal
India

Mohamed Omar Salem
United Arab Emirates

Shekhar Saxena
Switzerland (Assistant Editor)

Fabrizio Schifano
UK (Section Editor – Country profiles)

Emma Stanton
USA

Samuel Stein
UK

Allan Tasman
USA

John Tsiantis
Greece

Xin Yu
China

Subscriptions

International Psychiatry is published four times a year.

For subscriptions non-members of the College should contact:

Publications Subscriptions Department, Maney Publishing, Suite 1C, Joseph's Well, Hanover Walk, Leeds LS3 1AB, UK tel. +44 (0)113 243 2800; fax +44 (0)113 386 8178; email subscriptions@maney.co.uk

For subscriptions in North America please contact: Maney Publishing North America, 875 Massachusetts Avenue, 7th Floor, Cambridge, MA 02139, USA tel. 866 297 5154 (toll free); fax 617 354 6875; email maney@maneyusa.com

Annual subscription rates for 2013 (four issues, post free) are £28.00 (US$50.00). Single issues are £8.00 (US$14.40), post free.

Design © The Royal College of Psychiatrists 2013.

For copyright enquiries, please contact the Director of Publications and Website, Royal College of Psychiatrists.

All rights reserved. No part of this publication may be reprinted or reproduced or utilised in any form or by any electronic, mechanical or other means, now known or hereafter invented, including photocopying and recording, or in any information storage or retrieval system, without permission in writing from the publishers.

The views presented in this publication do not necessarily reflect those of the Royal College of Psychiatrists, and the publishers are not responsible for any error of omission or fact.

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

International Psychiatry was originally published as (and subtitled) the *Bulletin of the Board of International Affairs* of the Royal College of Psychiatrists. Printed in the UK by Henry Ling Limited at the Dorset Press, Dorchester DT1 1HD.

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

Notice to contributors

International Psychiatry publishes original research, country profiles, mental health law profiles and thematic overviews, dealing with mental health policy, promotion and legislation, the administration and management of mental health services, and training in psychiatry around the world. Correspondence as well as items for the news and notes column will also be considered for publication. The journal aims to be a platform for work that is generally underrepresented in the literature, especially psychiatry research and opinion from low- and middle-income countries.

Manuscripts for publication must be submitted electronically to the Editor (ip@sghms.ac.uk).

Research papers and special articles printed in the journal may be no longer than 1500 words; at the Editor's discretion, longer versions of papers that have been successfully peer reviewed may be linked to the online version of the journal in manuscript form. Correspondence should be no longer than 500 words. The Harvard system of referencing should be used.

Manuscripts accepted for publication are copy-edited to improve readability and to ensure conformity with house style. Authors whose first language is not English are encouraged to contribute; our copy-editor will make any necessary corrections, in consultation with the authors.

Contributions are accepted for publication on the condition that their substance has not been published or submitted elsewhere. Once a paper is accepted for publication, all its authors are required to disclose any potential conflict of interest. Completion of the form developed by the International Committee of Medical Journal Editors for this purpose (http://www.icmje.org/coi_disclosure.pdf) is mandatory.

About our peer-review process
All articles submitted will be peer-reviewed to ensure that their content, length and structure are appropriate for the journal. Research papers and special papers are reviewed by a minimum of two peers. Not all papers will be accepted for publication, but our peer-review process is intended to assist our authors in producing articles for worldwide dissemination. Wherever possible, our expert panel of assessors will help authors to improve their papers to maximise their impact when published.

GUEST EDITORIAL

Liaison psychiatry and the interface between mental and physical health – perspectives from England

Hugh Griffiths

Consultant Psychiatrist, Northumberland, Tyne and Wear NHS Foundation Trust; and National Clinical Director for Mental Health, Department of Health, email Hugh.Griffiths@dh.gsi.gov.uk

The views of Dr Griffiths expressed here are given in a clinical capacity and as a national expert in the field. They do not impose any mandatory requirements on NHS organisations.

There has been increasing policy interest in the interface between mental and physical health in recent years. One of the key objectives of the current Cross-Government Mental Health Strategy (for England) is to improve the physical health of those who suffer from mental illness. In parallel, people who suffer from long-term physical conditions have very high rates of comorbid mental ill-health, which are associated with worse outcomes, can delay recovery and can lead to longer hospital stays. Therefore there are opportunities for liaison psychiatry to do its part in helping our healthcare systems to deliver better outcomes in an economically challenging environment.

In England, there has been increasing policy interest in the interface between mental and physical health in recent years, exemplified by the clear priority given to it in the current Cross-Government Mental Health Outcomes Strategy, 'No Health Without Mental Health' (HM Government, 2011). One of the key objectives of this strategy is to improve the physical health of those who suffer from mental illness, who have a high rate of comorbid health problems and who also have shortened life expectancy. For example, having conditions such as schizophrenia or bipolar disorder can lead to mortality somewhere between 16 and 25 years too early (Parks *et al*, 2006) and recent evidence suggests that those who suffer from more common mental health problems also suffer poor physical health and premature mortality (Lewis, 2012). Clearly, it is unacceptable that such significant health inequalities persist and so it follows that any mental health policy should seek to address them.

But there are other important dimensions to this interface. People who suffer from long-term physical conditions have very high rates of comorbid mental ill-health, which is associated with worse outcomes, can delay recovery and can lead to longer hospital stays. Furthermore, in acute hospitals up to 50% of sequential new out-patients are reported to have 'medically unexplained symptoms' (Nimnuan *et al*, 2001). For many of these patients, psychological interventions can be effective (Speckens *et al*, 1995).

So there are very good reasons for the current interest in this area and there are opportunities for liaison psychiatry (providing mental health services to patients in general hospital settings) to do its part in helping healthcare systems to deliver better outcomes in an economically challenging environment. For example, people with conditions such as diabetes, heart disease and chronic obstructive pulmonary disease have high rates of mental health problems (estimated at about 30%), which increase risk and delay recovery (Cimpean & Drake, 2011). The risk of mortality for those with myocardial infarction is increased threefold if they suffer from comorbid depression (Frasure-Smith *et al*, 1999). Those who have a long-term physical condition are two to three times more likely to have depression, and people with three or more long-term conditions are seven times more likely to have depression (National Institute for Health and Clinical Excellence, 2009). Furthermore, the prevalence of comorbid conditions is increasing, and adults with both mental and physical health problems are much less likely to be in employment.

Mental ill-health is common among acute hospital in-patients, occurring in around 60% of those over 65 years of age, and they have higher levels of physical morbidity and longer lengths of stay. In addition, self-harm is among the five most prominent reasons for emergency admission to hospital for medical treatment, with around 170 000 admissions per year in the UK, of which some 80% are for self-poisoning through overdose (Royal College of Psychiatrists, 2005).

The point is that this is an area which is crucial, both clinically and economically, and it has arguably received too little attention thus far. Liaison psychiatry has evolved in response to these problems and to the organisational separation between mental and physical health services. With their work predominantly in acute hospitals, liaison teams provide advice (and often training) to healthcare staff, undertake assessments for people with a very broad range of mental and physical health problems, prescribe and recommend treatment and act as a key link to other specialist mental health services. However, as highlighted in the report from the Academy of Medical Royal Colleges in 2008, the provision of liaison teams across the country is 'extremely variable'. The document goes further, describing the position as 'unacceptable' and, in describing the consensus on what good services should look like, it says 'the situation must be addressed as it is not in the best interests of an NHS [National Health Service] ambitious to be more effective and efficient'. Its recommen-

dations include a plea that 'patients with mental health problems should receive the same priority as patients with physical problems', a statement which clearly resonates with the current government's determination to achieve 'parity of esteem' for mental health (HM Government, 2011).

But despite all this, provision remains patchy and the question has to be asked, could the NHS, with its need to achieve £20 billion efficiency savings by 2015 (by focusing on quality, innovation, productivity and prevention) achieve some of its key objectives by investing in liaison services? There is little doubt that such services, properly constructed, offer significant clinical benefits and are also generally well appreciated by acute hospital staff. However, until recently there has been scant evidence with regard to their cost–benefit profile.

In 2009, a new liaison service (developed from an existing one) was established within Birmingham City Hospital, with the aim of making comprehensive mental health assessment, treatment and care available 24 hours a day, 7 days a week to all patients over the age of 16 (including older adults), regardless of presenting complaint or severity. Rapid response is central to what the service does, with a target time of assessing all people referred from the accident and emergency department (A&E) within a maximum of 1 hour, whatever the time of day or night. An internal evaluation after a year appeared to show significant economic (as well as clinical) benefits, so an independent economic evaluation was undertaken by the Centre for Mental Health together with a team from the London School of Economics (Parsonage & Fossey, 2011).

The resulting report states that the service, in its first year of operation, demonstrated incremental savings in the order of £3.55 million (as a result of a reduction in occupied-bed-days of 14 500) for an incremental cost of £0.8 million. The benefit:cost ratio was therefore in excess of 4:1 – in other words, it saved £4 for every £1 invested. The point is that, even if it were cost neutral, it would be worth it. The fact that it has the potential to save such large amounts of money begs another question – can the NHS afford not to commission similarly enhanced liaison services everywhere?

The answer, in my view, is no. Given everything we know about comorbidities, self-harm, the need for rapid access to proper mental health expertise (wherever patients may present) and the clear economic need for the NHS to rely less on acute hospital beds in the future, this is just the sort of development which should be adopted to improve quality and save money at the same time. That is why it is mentioned in the NHS Operating Framework for 2012 (Department of Health, 2011) and why there is increasing interest in investing in similar services around the country. So, can liaison psychiatry save the NHS? Well, maybe not on its own, but it can make a major contribution and help improve quality and outcomes, especially at a time of economic hardship.

There is one final note of caution though. Working in acute hospital settings can be difficult and challenging, particularly for those professionals who may not have worked in them before. There are differences in language and culture, and understanding the fascinating but complex interface between mental and physical health requires training, time and experience. Not everyone is suited to it and, for teams to be successful they need to be staffed by people who have the aptitude, interest and knowledge. For many, this may take quite some time to build. So we need to be wary of a frantic hurry to develop new services and deliver savings. For it to work, it needs to be done properly. To rush it may be to plan for failure; thoughtful planning based on assessed local need and careful development could deliver much for patients and the wider health and social care system.

References

Academy of Medical Royal Colleges (2008) *Managing Urgent Mental Health Needs in the Acute Trust: A Guide by Practitioners, for Managers and Commissioners in England and Wales*. AoMRC. Available at http://www.aomrc.org.uk/publications/statements/doc_view/55-managing-urgent-mental-needs-in-the-acute-trust-background-report.html (accessed December 2012).

Cimpean, D. & Drake, R. E. (2011) Treating co-morbid medical conditions and anxiety/depression. *Epidemiology and Psychiatric Sciences*, **20**, 141–150.

Department of Health (2011) *The Operating Framework for the NHS in England 2012/2013*. DH. Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131360 (accessed December 2012).

Frasure-Smith, N., Lesperance, F., Jumeau, M., *et al* (1999) Gender, depression and one-year prognosis after myocardial infarction. *Psychosomatic Medicine*, **61**, 26–37.

HM Government (2011) *No Health Without Mental Health – A Cross-Government Mental Health Outcomes Strategy for People of All Ages*. Department of Health.

Lewis, G. (2012) Psychological distress and death from cardiovascular disease (editorial). *BMJ*, **345**, e5177.

National Institute for Health and Clinical Excellence (2009) *Depression in Adults with Chronic Physical Health Problems: Treatment and Management* (Clinical Guideline 91). NICE. Available at http://www.nice.org.uk/nicemedia/pdf/CG91NICEGuideline.pdf (accessed December 2012).

Nimnuan, C., Hotopf, M. & Wessely, S. (2001) Medically unexplained symptoms: an epidemiological study in seven specialities. *Journal of Psychosomatic Research*, **51**, 361–367.

Parks, J., Svendsen, D., Singer, P., *et al* (2006) *Morbidity and Mortality in People with Serious Mental Illness* (13th technical report). National Association of State Mental Health Program Directors.

Parsonage, M. & Fossey, M. (2011) *Economic Evaluation of a Liaison Psychiatry Service*. Centre for Mental Health. Available at http://www.centreformentalhealth.org.uk/pdfs/economic_evaluation.pdf (accessed December 2012).

Royal College of Psychiatrists (2005) *Who Cares Wins. Improving the Outcome for Older People Admitted to the General Hospital: Guidelines for the Development of Liaison Mental Health Services for Older People*. RCPsych. Available at http://www.rcpsych.ac.uk/pdf/WhoCaresWins.pdf (accessed December 2012).

Speckens, A. E. M., van Hemert, A. M., Spinhoven, P., *et al* (1995) Cognitive behavioural therapy for medically unexplained physical symptoms: a randomised controlled trial. *BMJ*, **311**, 1328–1332.

THEMATIC PAPERS

Economic crises and mental health: unhappy bedfellows

David Skuse

Behavioural and Brain Sciences Unit, Institute of Child Health, London, UK, email d.skuse@ucl.ac.uk

The world economic crisis has had an immediate and a longer-term effect on mental health. In the UK, there has been a rise in suicides (Barr *et al*, 2012) and in the USA a similar picture is emerging (Reeves *et al*, 2012), but the main impact recorded thus far has been in countries hit hardest by the economic cut-backs necessitated by excessive national debt repayment. We present articles from three European countries that have suffered especially serious repercussions from the debt crisis. In Greece, suicides have risen by 60% since 2007. Nikos Christodoulou and Dimitris Anagnostopoulos review the future of mental health services in Greece, in the face of what they describe as a 'catastrophe'. They point out that Greek society has traditionally depended upon an informal approach to care in the community, provided by the family and the Church, but with increasing fragmentation (characterised as the 'Western' way of life), this is proving hard to sustain.

Ireland was one of the first countries to recognise its economic vulnerability, and to take radical steps to rectify the problem even though this meant a reduction in living standards for many. Perhaps unsurprisingly, the long-standing self-appraisal by the Irish as a particularly happy nation has been adversely affected by the economic crisis, and the correlation of happiness with income has strengthened in recent years. Brendan Kelly and Anne Doherty provide a valuable perspective on the impact of the downturn in the Irish economy on mental health and well-being, noting the rather surprising observation that prescriptions of antidepressants north of the border in Ulster still far exceed those in the Republic.

Finally, Luis Salvador-Carulla and Miquel Roca discuss the burgeoning unemployment rate in Spain, especially among the young. This now stands at over 50%, rather worse than the situation in Greece, and it is particularly acute among those with limited education. Younger adults are more likely than not to live with their parents, and to some extent families have buffered the impact of the economic crisis on threats to mental health. Also, the Spanish government initially acted to support healthcare at the expense of the wider economy, increasing national debt substantially as a consequence. Such measures cannot be sustained, and the future appears increasingly bleak, especially for young people without specific skills and training.

References

Barr, B., Taylor-Robinson, D., Scott-Samuel, A., *et al* (2012) Suicides associated with the 2008–10 economic recession in England: time trend analysis. *BMJ*, **345**, e5142.

Reeves, A., Stuckler, D., McKee, M., *et al* (2012) Increase in state suicide rates in the USA during economic recession. *Lancet*, **380**, 1813–1814.

THEMATIC PAPER

ECONOMIC CRISES AND MENTAL HEALTH

The financial crisis and the future of mental health in Greece

Nikos G. Christodoulou[1] and Dimitris C. Anagnostopoulos[2]

[1]Clinical Lecturer in Psychiatry, University of Nottingham, UK, email Nikos.Christodoulou@nottingham.ac.uk

[2]Associate Professor of Child Psychiatry, University of Athens, Greece

The recent financial crisis in Greece has affected the mental health of the population as well as mental health service provision and planning. These new adverse circumstances call for the profession's swift response. In this paper we make evidence-based suggestions for urgent, as well as longer-term, mental health reform. We consider psychiatric prevention and mental health promotion to be the central principles to abide by in the long term. We also offer suggestions for important current issues, including the devolution and coordination of decision-making, the further development of community psychiatry and the implementation of sectorisation, support for service user involvement, the reform of psychiatric education and the creative integration of mental health service provision with Greek culture. We conclude that enhanced participation of the profession in decision-making and service planning can result in cost-effective, evidence-based reform.

In recent years Greece has been experiencing a financial catastrophe, which has already affected mental health service provision and the mental health of the population. The financial crisis has

primarily affected the most vulnerable members of Greek society, people with mental illness being among those worst hit (Christodoulou & Christodoulou, 2013). Studies show an association between income reduction and out-patient visits, acute psychiatric referrals, suicide rates, homicide rates, divorce rates and death rates (Giotakos *et al*, 2011; Kentikelenis *et al*, 2011).

The current state of the Greek mental health system

There is an ongoing mental health reform in Greece, for which credit is due; deinstitutionalisation and the development of community services have progressed (Christodoulou *et al*, 2011). In addition, attitudes have changed; mental health promotion, anti-stigma and a person-centred approach have been promoted and incorporated in the ethos of mental health service provision (Christodoulou *et al*, 2010; Thornicroft *et al*, 2011).

However, there are still important challenges in the development and management of mental health services. Underfunding has been a threat to reformed services since before the recent financial downturn, and effective reinstitutionalisation beckons. Similarly, sectorisation and the development of mental health trusts have not been implemented adequately, rendering the reform incomplete (Christodoulou *et al*, 2012). Additionally, there are deficits in service coordination and planning, equitable resource allocation, clinical governance and quality assurance. There is also sparse epidemiological evidence to guide evidence-based service development (Thornicroft *et al*, 2011).

Suggestions on the management of mental health in Greece in view of the financial crisis

Urgent priorities

Urgent priorities for mental health at the moment include raising awareness of crisis-associated psychiatric morbidity factors. For instance, in view of the alarming increase in unemployment – which reached 25.4% in August 2012 (and 32.9% for those aged 24–35) (Hellenic Statistical Authority, http://www.statistics.gr) – policy-makers need to be made aware of the potential link between unemployment and suicide (Stuckler *et al*, 2009). Also, the effect of the rapid dissolution of the social matrix on the mental health of the population needs to be stressed (e.g. the increase in borderline behaviours observed in young people).

Importantly, we need to avoid the *de facto* reinstitutionalisation of chronic patients, and ensure basic care (medications and service access) for community patients. The rash removal of the autonomy of mental health services needs to be challenged.

Meaningful reform, not just cuts

There is a real need for further mental health reform in Greece and cost improvements are a pragmatic necessity. The profession's duty is to ensure that there is cooperation between the profession and policy-makers and that rational, evidence-based policies are implemented. We also need to safeguard a political commitment to mental health and to ensure savings are reinvested in mental health rather than used elsewhere (e.g. for debt servicing).

Advocacy and representation

People with mental illness who cannot voice their concerns or defend their rights are easy targets for austerity policies. Our profession has to facilitate effective advocacy for them. The suggested development (Thornicroft *et al*, 2011) of relevant psychiatric subspecialties (e.g. intellectual disabilities, old age psychiatry) should sustain representation for these groups in the future. The involvement of persons with mental illness and their families in mental health service governance can be supported by the Hellenic Psychiatric Association.

Devolution and coordination

A recent evaluation report on psychiatric reform in Greece yielded two useful findings: firstly, it confirmed that mental health workers in Greece have good leadership skills; secondly, it ascertained that central coordination is deficient (Thornicroft *et al*, 2011). These two facts suggest that administrative devolution from central government to local mental health authorities may have several benefits, including the introduction of an effective accountability framework, quality assurance and locally relevant service development. Crucially, cost-effective resource allocation and equitable budgeting can start taking place. It needs to be stressed that the success of future service development depends on its disentanglement from political confounders.

The organisational and coordinating role of the Hellenic Psychiatric Association needs to be reinforced at this critical conjuncture. In addition to educational responsibilities, it needs to enhance its role as the government's scientific advisor and increase its leverage on reform decision-making and planning.

Taking advantage of Greece's culture

Greek society has traditionally depended on local communities and the family institution for mental healthcare in the community. Supporting this model of community mental healthcare has many advantages: carer empowerment and increased advocacy, cost-effectiveness and stigma reduction are just a few. Nevertheless, there are significant barriers to its implementation. Firstly, the family institution is itself in crisis at the moment due to an increasingly 'Western' way of life. Secondly, the family is a dynamic part of society and is therefore also affected by the current crisis (Anagnostopoulos & Soumaki, 2011). Lastly, moral support is not enough; considerable financial investment in this model is required.

Another traditional institution of Greek society, the Church, caters for niche populations and

is often the first port of call when mental illness emerges. Priests have developed their own pastoral therapeutic approach when dealing with mental illness, but need the contribution of informed mental health professionals in order to ensure the delivery of safe and holistic care.

Prevention of mental illness and promotion of mental health (preventive psychiatry)

Probably the most important mental health principle for Greece to commit to at this critical conjuncture is that of preventive psychiatry. In recent years it has become clear not only that preventive psychiatry is imperative from an ethical point of view, but also that it has a robust evidence base to support its effectiveness. It is our profession's duty to persuade policy-makers that the prevention of mental illness and promotion of mental health are not just important, but *necessary*, even if their results may not be immediately tangible. Using humanitarian arguments, for example the transgenerational effects of the crisis on the mental health of children, is probably not enough to persuade policy-makers. Thankfully, we can now speak the policy-makers' language in doing so, as preventive psychiatry has been shown to be cost-effective and has already been endorsed by the World Health Organization (2004) and the European Parliament (2009).

Preventive psychiatry is sometimes difficult to advocate, given that preventive policies are broad and may often lie outside the remit of mental health. For instance, if we assume that the inequality gap is a causal factor in mental illness (Pickett & Wilkinson, 2010), then tackling the gap would be a valid preventive strategy; but is it the role of psychiatry to promote social justice and socialist ideas? Or, similarly, if we assume that a society's maladies are a causal factor, then would it be our duty as a profession to promote a change of political culture? Professional humility demands further debate on these roles.

From a service development point of view, primary care mental health services would be the best platform for preventive psychiatry in Greece, particularly for younger people (Anagnostopoulos & Soumaki, 2011).

Education, specialisation, revalidation

The reform of psychiatric training is long overdue in Greece. Responsibility for quality assurance for the professional development of psychiatrists should lie with the scientific advisor of the government (i.e. the Hellenic Psychiatric Association). Quality assurance should begin with meritocratic recruitment for specialist training, extend to certification of specialist training and expand longitudinally beyond that to professional revalidation. Such a reform would be cost-effective and ultimately benefit service users.

A final word on optimism

The Chinese term for crisis (*Wai Chi*) means 'danger and opportunity'. On the other hand, 'crisis' is etymologically a Greek word meaning 'judgement' (hence the uses of 'critical' in English). The Sino-Hellenic confluence yields an optimistic message: with good judgement, crisis can be turned into opportunity.

It is our profession's duty to exercise leadership and prudence (Aristotelian phronesis) in delivering this good judgement, by suggesting evidence-based, rational change. There is no doubt that change is needed in mental health in Greece, and this may be the best time to make it happen.

References

Anagnostopoulos, D. & Soumaki, E. (2011) The impact of socio-economic crisis on mental health of children and adolescents (editorial.) *Psychiatriki*, **23**, 15–16.

Christodoulou, G. N., Ploumpidis, D., Christodoulou, N. G., *et al* (2010) Mental health profile of Greece. *International Psychiatry*, **7**, 64–67.

Christodoulou, G. N., Jenkins, R., Tsipas, V., *et al* (2011) Mental health promotion: a conceptual review and guidance. *European Psychiatric Review*, **4**, 9–13.

Christodoulou, G. N., Ploumpidis, D. N., Christodoulou, N. G., *et al* (2012) The state of psychiatry in Greece. *International Review of Psychiatry*, **24**, 301–306.

Christodoulou, N. G. & Christodoulou, G. N. (2013) Management of the psychosocial effects of economic crises. *World Psychiatry*, in press.

European Parliament (2009) Resolution of 19 February 2009 on Mental Health. Available at http://www.europarl.europa.eu/ (accessed 4 November 2012).

Giotakos, O., Karabelas, D. & Kafkas, A. (2011) Financial crisis and mental health in Greece. *Psychiatriki*, **22**, 109–119.

Kentikelenis, A., Karanikolos, N., Papanikolas, I., *et al* (2011) Health effects of financial crisis: omens of a Greek tragedy. *Lancet*, **378**, 1457–1458.

Pickett, K. & Wilkinson, R. (2010) Inequality: an under-acknowledged source of mental illness and distress. *British Journal of Psychiatry*, **197**, 426–428.

Stuckler, D., Basu, S., Suhroke, M., *et al* (2009) The public health effect of economic crises and alternative policy responses in Europe: an empirical analysis. *Lancet*, **374**, 315–323.

Thornicroft, G., Craig, T., Power, T., *et al* (2011) *Evaluation Report of the Implementation of the Psychiatric Reform for the Period 2000–2009*. Ministry of Health and Social Solidarity.

World Health Organization (2004) *Prevention of Mental Disorders: Effective Interventions and Policy Options*. WHO. Available at http://www.who.int/mental_health/ (accessed 4 November 2012).

Overseas volunteering by health professionals as a mechanism to improve global health is increasingly on the agenda. For further details on how to join the Royal College of Psychiatrists' Volunteer Scheme and make a real difference to people in low- and medium-income countries, please contact Ellen Cook at the College:

Email: ECook@rcpsych.ac.uk. Tel: +44 (0)20 7235 2351, extension 6136

ECONOMIC CRISES AND MENTAL HEALTH

Impact of recent economic problems on mental health in Ireland

Brendan D. Kelly[1] MD PhD DGov FRCPsych FRCPI
and Anne M. Doherty[2] MB BCh MRCPsych MMedSc

[1]Senior Lecturer in Psychiatry and Consultant Psychiatrist, Department of Adult Psychiatry, University College Dublin and Mater Misericordiae University Hospital, Dublin, Ireland, email brendankelly35@gmail.com

[2]Consultant Liaison Psychiatrist (Locum), 3DFD: 3 Dimensions of Care For Diabetes, King's College Hospital, London, UK

This paper uses data from the European Social Survey (ESS), an academically driven social survey designed to chart and explain the interaction between Europe's changing institutions and the attitudes, beliefs and behaviour patterns of its diverse populations. It is funded via the European Commission's 5th and 6th Framework Programmes, the European Science Foundation and national funding bodies in each country. The project is directed by a Central Coordinating Team led by Roger Jowell at the Centre for Comparative Social Surveys, City University, London.

The effect, if any, of recent economic problems on mental health in the Republic of Ireland is not fully clear. Rates of suicide increased slightly between 2006 and 2011, and there was a notable increase in 2011 itself. Rates of psychiatric admission continued to fall, however, in line with national mental health policy. Use of sedative and tranquilliser medications (but not antidepressants) increased, although use in the Republic of Ireland remains substantially lower than in Northern Ireland. Mean self-rated happiness in Ireland declined steadily and significantly between 2005 and 2012. In 2009, as economic problems deepened, satisfaction with income replaced satisfaction with health as the strongest correlate of happiness in Ireland. By 2011/12, however, none of the traditional correlates of happiness retained an independent association with happiness. Overall, these trends suggest that suicide prevention strategies will be increasingly important for Ireland in future years. Active labour-market programmes to address unemployment may also play an important role in suicide prevention. Rates of mental illness and medication usage in the community merit further study. The solution to declining happiness levels may elude purposive description but this trend is likely to reverse as Ireland's economic prospects improve.

Over the past decade, the Republic of Ireland experienced a dramatic economic boom followed by equally dramatic economic problems (Doherty & Kelly, 2013). In 2003, Ireland's unemployment rate was 4% but by 2011 it had risen to 14%, as a result of a collapse in Irish property prices and problems in the world economy. In 2007, Ireland's gross domestic product (GDP) stood at €189 billion but by 2009 it had fallen to €159 billion. In 2010, Ireland had to accept economic assistance from the International Monetary Fund, the European Union and the European Central Bank. In addition, Ireland became subject to relentless scrutiny by international media, most of it highly critical (Lewis, 2011).

Have these events affected mental health in Ireland? It is difficult to answer this question definitively, owing to a paucity of research. Nonetheless, some data are available in relation to specific indices of mental health, including rates of suicide, rates of admission to in-patient psychiatric care and medication usage, and studies of population happiness. Notwithstanding their limitations, these data can help identify emergent trends and indicate key needs to be addressed in future years.

Suicide in Ireland

In 2011, there were 525 suicides in Ireland, which yields a rate of 11.4 suicides per 100 000 population per year (Central Statistics Office, 2012). This is slightly higher than the rate of 10.8 per year reported in 2006, before Ireland's recent economic problems became apparent. The rate of suicide may, however, be changing quite rapidly: the 525 suicides recorded in 2011 represent an increase of 7% on the previous year, suggesting that Ireland's economic problems may have a delayed effect on suicide rates.

Ireland's rate of unemployment is especially relevant to the rate of suicide. Unemployment increased from 4% in 2006 to 14% in 2011. At European level, there is strong evidence that every 1% increase in unemployment is associated with a 0.79% rise in suicides among those aged under 65 years (Stuckler *et al*, 2009). Data from Ireland confirm that, prior to recent economic problems, unemployment was associated with a two- to threefold increased risk of male suicide and undetermined death, and a four- to sixfold increase in risk in females (Corcoran & Arensman, 2011). Against this backdrop, it is logical to hypothesise that the recent increase in unemployment in Ireland may be associated with an increase in suicide.

Ireland already has a National Office for Suicide Prevention, which, in 2011, allocated an additional €1 million to 22 new projects aimed at suicide prevention (National Office for Suicide Prevention, 2012). Over 3500 people received training in applied suicide intervention skills and nearly 5000 underwent suicide alertness training. If current trends in unemployment and suicide continue, these kinds of initiative are likely to be of increasing importance in years to come.

Admission to psychiatric care and medication usage

More information on trends in mental illness can be derived from national data on admissions to in-patient psychiatric care. In recent decades, Ireland's mental health services have moved towards community-based models of care, in line with *A Vision for Change*, Ireland's national mental health

policy (Expert Group on Mental Health Policy, 2006). Consistent with this, the rate of admission to in-patient psychiatric care has declined by 20% over the past decade: in 2002 there were 23 677 admissions to in-patient psychiatric care and by 2011 this had fallen to 18 992 (Daly & Walsh, 2012). This trend remains strong, despite Ireland's economic problems: in 2010 the rate of psychiatric admission was 462.7 per 100 000 population; in 2011 this fell to 413.9.

Rates of admission, however, reflect just one parameter of mental healthcare. It is possible that increased rates of mental illness, if they exist, are not reflected in admission rates, owing to the move towards community services. Rates of medication use may provide insights into rates of mental illness in the broader community. Data here present a mixed picture: in 2010/11, 6.5% of Irish adults said they had used sedatives and tranquillisers over the previous year, compared with 4.7% in 2006/07; this was a statistically significant increase (National Advisory Committee on Drugs & Public Health Information and Research Branch, 2012). Rates of antidepressant use, however, remained steady, at 4.4% in 2006/07 and 4.8% in 2010/11.

Interestingly, in Northern Ireland (which is part of the UK) the rate of antidepressant use over the previous year is almost three times that in the Republic of Ireland (12.0%, compared with 4.8%) and the rate of sedative and tranquilliser use is almost double (11.0%, compared with 6.5%). These contrasts both require further study.

Happiness

Recent years have seen increased interest in the study of happiness as an index of national well-being. In Ireland, we have traditionally rated ourselves as very happy: in 1998, our self-rated happiness was the highest among 28 countries surveyed worldwide, with 44% self-rating as 'very happy', compared with 18% in West Germany (Dorn *et al*, 2007).

In order to investigate the effects of Ireland's recent economic problems on happiness, we used data from the European Social Survey (ESS), collected between 2003 and 2009 (Doherty & Kelly, 2013). The ESS measures individual happiness based on the question 'Taking all things together, how happy would you say you are?' (Jowell & Central Coordinating Team, 2007) (see http://www.europeansocialsurvey.org). Respondents rate their own happiness between 0 (extremely unhappy) and 10 (extremely happy).

We found that, as Ireland's economic problems became apparent, mean self-rated happiness decreased slightly but steadily, from 7.9 in 2005 ($n = 2274$) to 7.7 in 2007 ($n = 1794$; $P < 0.001$) and 7.5 in 2009 ($n = 1764$; $P < 0.001$) (Fig. 1). For the present paper, we went on to analyse the most recent ESS data-set, collected between September 2011 and January 2012 ($n = 2570$), and found that mean happiness in Ireland has continued to fall, and now stands at 6.8, a further significant reduction on previous years ($P < 0.001$).

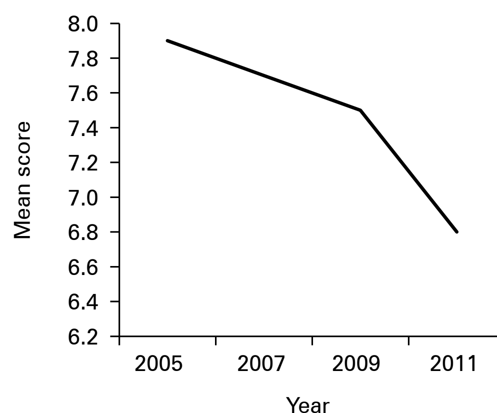


Fig. 1
Self-rated happiness in Ireland, 2005–11. Data are derived from the European Social Survey, 2005–11/12 (Jowell & Central Coordinating Team, 2007) (http://www.europeansocialsurvey.org). Respondents rated their happiness between 0 (extremely unhappy) and 10 (extremely happy) in response to the question 'Taking all things together, how happy would you say you are?' The figure is based in part on Doherty & Kelly (2013).

There has also been a substantial shift in the key correlates of happiness over this period. We studied relationships between happiness and age, gender, employment, community trust, religiosity, satisfaction with income, satisfaction with health and satisfaction with democracy (Doherty & Kelly, 2013). In 2005, satisfaction with health was the strongest correlate of happiness in Ireland but by 2009, as economic problems deepened, satisfaction with income became the strongest correlate.

The most recent data demonstrate further change in this pattern: multi-variable modelling reveals that in 2011/12 *none* of the previous predictors of happiness predicted it any longer, after controlling for the others ($P > 0.05$ for all potential correlates examined). Therefore, while happiness in Ireland has fallen steadily since 2005, the key correlates or predictors of happiness have also undergone substantial change, resulting in substantially altered levels *and* correlates of happiness in Ireland.

Conclusions

Both the international and Irish literatures draw clear links between unemployment and suicide. In light of the increase in Ireland's unemployment rate (from 4% in 2006 to 14% in 2011) and the 7% increase in suicides between 2010 and 2011, initiatives to prevent suicide should now take on an added urgency. Active labour market programmes to address unemployment may also play an important role in suicide prevention (Stuckler *et al*, 2009).

While Ireland's economic problems did not see increased rates of admission to in-patient psychiatric care, this does not mean that the economic crisis has not affected mental health. There is a paucity of data on rates of presentation to out-patient and primary care. Moreover, use of sedatives and tranquillisers, although not

antidepressants, has increased. This area merits further study, not least because the apparent increase in suicide following Ireland's economic problems emerged only in 2011, some years after Ireland's economic problems commenced. Extrapolating from this trend, there may well be similar increases in presentations with depression and anxiety disorders in primary care in future years (McElwee, 2009).

Finally, self-rated happiness in Ireland has declined significantly. The increasingly close association between happiness and income, as opposed to health, between 2005 and 2009 likely reflected the effects of Ireland's economic problems on employment rates and income. The more recent finding that happiness no longer demonstrates independent relationships with *any* of its traditional predictors may reflect the transitional situation in which Ireland finds itself, as the economy stabilises and Ireland finds its feet in a new and altered economic world.

Alternatively, the absence of any robust, independent predictors of happiness at this time may simply reflect the idea that happiness, in the end, can be neither fully explained nor purposively sought. Perhaps, in words commonly attributed to American philosopher Henry David Thoreau (1817–62), 'happiness is like a butterfly: the more you chase it, the more it will elude you, but if you turn your attention to other things, it will come and sit softly on your shoulder'.

References

Central Statistics Office (2012) *Vital Statistics: Fourth Quarter and Yearly Summary, 2011*. The Stationery Office.

Corcoran, P. & Arensman, E. (2011) Suicide and employment during Ireland's Celtic Tiger economy. *European Journal of Public Health*, **21**, 209–214.

Daly, A. & Walsh, D. (2012) *HRB Statistics Series 18: Activities of Irish Psychiatric Units and Hospitals 2011*. Health Research Board.

Doherty, A. M. & Kelly, B. D. (2013) When Irish eyes are smiling: income and happiness in Ireland, 2003–2009. *Irish Journal of Medical Science*, **182**, 113–119.

Dorn, D., Fischer, J. A. V., Kirchgassner, G., *et al* (2007) Is it culture or democracy? The impact of democracy and culture on happiness. *Social Indicators Research*, **82**, 505–526.

Expert Group on Mental Health Policy (2006) *A Vision for Change*. The Stationery Office.

Jowell, R. & Central Coordinating Team (2007) *European Social Survey 2006/2007: Technical Report*. City University.

Lewis, M. (2011) When Irish eyes are crying. *Vanity Fair*, March.

McElwee, O. (2009) Depression and stress due to economic hardship. *Forum*, **26**, 25–28.

National Advisory Committee on Drugs & Public Health Information and Research Branch (2012) *Drug Use in Ireland and Northern Ireland: First Results from the 2010/2011 Drug Prevalence Survey*. National Advisory Committee on Drugs & Public Health Information and Research Branch.

National Office for Suicide Prevention (2012) *Annual Report 2011*. Health Service Executive.

Stuckler, D., Basu, S., Suhrcke, M., *et al* (2009) The public health effect of economic crises and alternative policy responses in Europe: an empirical analysis. *Lancet*, **374**, 315–323.

ECONOMIC CRISES AND MENTAL HEALTH

Mental health impact of the economic crisis in Spain

Luis Salvador-Carulla[1] MD PhD and Miquel Roca[2] MD PhD

[1]Professor of Mental Health and Disability, University of Sydney, Australia, email luis.salvador-carulla@sydney.edu.au

[2]Professor of Psychiatry, Institut Universitari d'Investigacio´ en Ciencies de la Salut (IUNICS), University of Balearic Islands, Palma de Mallorca, Spain

Both authors prepared the paper as part of their work for the Red de Actividades Preventivas y de Promocion de la Salud (REDIAPP)

According to preliminary data, by 2010 the economic crisis in Spain had already led to an increase in the prevalence of anxiety, mood disorders and alcohol misuse, identified in primary care settings, but there had not been an impact on suicide rates. Since then, several indicators suggest that the full impact of the economic crisis on mental health was delayed, until at least the second half of 2011 and even later, to 2012. There is increasing evidence that budget cuts had a particular impact on mental healthcare during this latter period.

After a decade of high growth, the Spanish economy was beginning to contract by the end of 2007. Spanish debt grew from 12% of gross domestic product (GDP) in 2009 to over 90% of GDP in 2012, while government revenues plummeted. With increasing unemployment, the social security system lost nearly 3 million contributors after 2008 and this had caused a €6.5 billion deficit in the pension system by 2012, according to data from the website of the Instituto Nacional de Estadistica (INE; http://www.ine.es). The Spanish government did not institute any intervention strategies to deal with the financial crisis until mid-2011. The main impact of the financial crisis on Spanish citizens was therefore delayed until late 2011, partly because of the buffer effect of a highly developed social support network, and partly because of a contentious government strategy which allowed the national debt to increase in order to support welfare benefits and social protection, as well as to allow the provision of aid to local governments, companies and others. Hence,

comprehensive data on the period 2011–13 will be necessary in order fully to understand the impact of the financial crisis on mental health in Spain.

Social and demographic characteristics

The national unemployment rate increased from 8.6% in 2006 to 25% in October 2012. Spanish youth unemployment is now over 51% and it is particularly high for those who have not completed full-time education; as many as one in three students do not complete upper secondary education in Spain, according to the United Nations Educational, Scientific and Cultural Organization (2012, p. 17). The impact on mental health is attributable not only to the precariousness of employment and to unemployment, but extends far beyond the actual loss of one's job (e.g. anticipation of unemployment and insecurity among family members and in the broader social network) (Vives *et al*, 2011; Gili *et al*, 2012).

In 2010, the proportion of people living in conditions of extreme poverty was 5.3%, and by 2012 evictions had increased by 134% (126 426 cases). The number of registered homeless persons who have used any social service nearly doubled between 2008 (11 844 persons) and 2012 (22 938). Of these homeless people, 32% had lost their homes during the previous year (INE website).

Up until 2012, families were a major buffer that limited the impact of social deprivation, mainly by providing financial support and shelter. By November 2012, 300 000 households depended exclusively on the retirement pension received by one member of the family. Over half (52.8%) of people aged between 18 and 34 years lived with their parents. Unfortunately, this buffer effect cannot be sustained, because of the persistence of the crisis. By the end of 2012, the number of families with all members unemployed was over 1.73 million; and 4.46 million of the 17 million Spanish households did not have an economically active member in October 2012 (INE website).

Impact of the economic crisis on psychiatric morbidity and mortality

The 2011 report on National Health System Key Indicators from the Ministerio de Sanidad, Servicios Sociales e Igualdad (Ministry of Health, Social Policy and Equality) (MHSPE, 2012) and the European Study of the Epidemiology of Mental Disorders (ESEMeD study) (Alonso *et al*, 2004) indicate prevalence rates of mental disorders in Spain that are similar to those found in Italy but lower than those seen in northern European countries. A recent survey on the prevalence of mental disorders treated in primary care during 2006–07 and 2010–11 revealed substantial increases in the proportion of patients with major depression and other mood disorders, generalised anxiety disorder, panic disorder, somatoform and alcohol-related disorders. The authors observed a particularly high risk of major depression associated with mortgage repayment difficulties and evictions. These events accounted for about one-third of the overall risk in the consulting population's attendance with mental health disorders. Mortgage payment difficulties accounted for an additional 11.0% of the overall population risk of depression among primary care attendees (Gili *et al*, 2012).

Rates of suicide showed a slight increase during the recessions that occurred between 1980 and 1996 (Tapia Granados, 2005) and then remained constant from 1996 until 2007 (Gotsens *et al*, 2012). In 2009 Spain had the third lowest European rate of suicide in men, after Greece and Italy. In 2010 registered suicides were actually lower than in 2008 (3145 *v.* 3421 cases). The age-adjusted mortality rate due to suicide and self-injury (per 100 000 population) was 6.3 in Spain in 2009, and became slightly lower in 2010 (INE website). The reduction in the suicide rate in Spain between 2007 and 2010 is in contrast to the increasing suicide rate reported from other European countries, apparently related to the financial crisis (Barr *et al*, 2012). There does not seem to be a direct relationship between unemployment and suicide in Spain. However, data from the period 2011 to 2013 may provide a different picture, because there could be a delayed impact of the financial crisis.

Impact on the general healthcare system and health financing

Total health spending accounted for 9.6% of GDP in Spain in 2009, which is slightly higher than the average for the Organisation for Economic Co-operation and Development (OECD). There was an increase in the proportion of government expenditure on health during the period 2009 to 2011, although this figure is misleading. There was a sharp reduction in Spanish GDP after 2008, while health expenditure was kept at the previous level (€100 billion in 2009) until 2012 (OECD, 2012). Sustaining health expenditure in the face of decreasing GDP was achieved by increasing the structural financial debt of the National Health Service (NHS), which tripled from 2005 (€5 billion) to 2011 (€16 billion). The government approved health reform measures in April 2012 in order to deal with a pending crisis in the national health system. These reforms included introducing co-payment for pharmaceuticals and certain health products, a reduction in the overall health budget of €7 billion, repayment of debts totalling €12 billion to healthcare providers and a series of cost-containment measures that were addressed to non-resident users of the Spanish NHS.

The financial crisis has had impacts of different intensity on the 17 regional health systems in Spain. Regions have developed different strategies to deal with the problem. In Catalonia, there was a decrease in the use of out-patient care in the community mental health centres in 2011 and again in 2012. This reduction may be related to budget cuts in the provision of specialised mental healthcare. In 2012 there was a 2% reduction in the tariffs for mental healthcare, a 5% reduction of the activity of specialised mental healthcare and a 10% cut in the

budget of community mental health centres. Care delivery contracts were reduced by 7% and specific mental care programmes by 8%; for example, a support programme to provide independent living for persons with severe mental illness living alone was discontinued in 2012 (Catalan Association of Families and Users with Mental Illness, 2012).

Cuts in government healthcare expenditure were greatest in pharmaceuticals and staff costs. In 2010, 18.9% of total health expenditure in Spain was on pharmaceuticals (OECD, 2012). The cost of drugs as a proportion of total direct expenditure on health was higher for mental disorders than for other conditions (e.g. accounting for 65% of direct costs of depression in Catalonia) (Salvador-Carulla *et al*, 2011). In July 2012 a new patient co-payment system was introduced. The degree of co-payment was means tested and depended on the patient's income, with some exceptions. A reduction in the NHS listing of approved pharmaceuticals was introduced a month later. These two measures have had a major impact, leading to a reduction in expenditure on pharmaceutical products: a 17.8% reduction in the annual expenditure on pharmaceuticals was achieved by October 2012, and the figure is above 22% since the introduction of co-payment. The total saving on drug expenditure in 2012 was over €1.2 billion (€931 million in the last 5 months of 2012) while prescriptions decreased 13.6% in November 2012. Prior to these new measures, consumption of antidepressants and anxiolytics had grown by 12.6% between 2007 and 2011.

Social care

The 2012 budget cuts have had a significant impact on provisions made by the social care system for people with disabilities, particularly in severe cases of functional dependency, the costs of which are covered by the regional agencies. Royal Decree 20/2012, dated 13 July 2012, aimed to bring about a reduction in the social care budget of €1.59 billion, which would have a major effect on the functional dependency care subsystem. New regulations have restricted eligibility to severe cases. Provisions for those with moderate functional dependency (which includes most severe mental illness) have been delayed until 2015; benefits for families providing care have been reduced by 15%. Deductions for employers already providing contracts to persons with disabilities have been reduced from 70% to 50% and new contracts to support such employment have been discontinued (Catalan Association of Families and Users with Mental Illness, 2012).

Conclusions

The abrupt collapse of the Spanish economy has created conditions of economic hardship for many people. There has been an increase in taxation, associated with a sharp fall in tax revenue and investment, and rising national debt. This situation poses a huge challenge to the Spanish welfare system and especially to the health and social care sectors. Uncertainties about continuing employment prospects, increasing unemployment and widespread mortgage payment difficulties have had a cumulative deleterious impact on mental health, especially on rates of affective disorders and alcohol misuse (Gili *et al*, 2012). In addition, Spain is particularly vulnerable to other risk determinants of poor mental health, such as the high proportion of students who do not complete secondary education. These issues may prolong the long-term consequences of the crisis.

In summary, the economic crisis in Spain may have a significant but delayed impact on mental health. Already, the provision of mental healthcare has decreased sharply during the past 2 years. Both national and regional action plans should incorporate measures to reduce the short-term and the long-term consequences of the economic crisis. Recommendations suggested by experts from other European countries (Wahlbeck & McDaid, 2012) may contribute to the appropriate design of action plans to mitigate the impact of the crisis.

References

Alonso, J., Angermeyer, M. C., Bernert, S., *et al* (2004) Prevalence of mental disorders in Europe: results from the European Study of the Epidemiology of Mental Disorders (ESEMeD) project. *Acta Psychiatrica Scandinavica*, suppl. 420, 21–27.

Barr, B., Taylor-Robinson, D., Scott-Samuel, A., *et al* (2012) Suicides associated with the 2008–10 economic recession in England: time trend analysis. *BMJ*, 345, e5142.

Catalan Association of Families and Users with Mental Illness (Federació catalana d'associacions de familiars i persones amb problemes de salut mental; FECAFAMM) (2012) *Impacto de la Crisis en la Salud Mental en Cataluña* [*Impact of the Crisis on Mental Health in Catalonia*]. FECAFAMM.

Gili, M., Roca, M., Basu, S., *et al* (2012) The mental health risks of economic crisis in Spain: evidence from primary care centres, 2006 and 2010. *European Journal of Public Health* [Epub ahead of print, doi: 10.1093/eurpub/cks035].

Gotsens, M., Marí-Dell'olmo, M., Pérez, K., *et al* (2012) Trends in socio-economic inequalities in injury mortality among men in small areas of 26 Spanish cities, 1996–2007. *Accident; Analysis and Prevention*, 51C, 120–128.

MHSPE (2012) *Informe anual del Sistema Nacional de Salud 2010* [*2010 Annual Report of the Spanish National Health System*]. Ministry of Health, Social Policy and Equality.

OECD (2012) *OECD Health Data 2012. How Does Spain Compare?* Organisation for Economic Co-operation and Development. At http://www.oecd.org/spain/publicationsdocum (accessed December 2012).

Salvador-Carulla, L., Bendeck, M., Fernández, A., *et al* (2011) Costs of depression in Catalonia (Spain). *Journal of Affective Disorders*, 132, 130–138.

Tapia Granados, J. A. (2005) Recessions and mortality in Spain, 1980–1997. *European Journal of Population*, 21, 393–422.

United Nations Educational, Scientific and Cultural Organization (2012) *EFA Global Monitoring Report: 2012. Youth and Skills: Putting Education to Work*. UNESCO.

Vives, A., Vanroelen, C., Amable, M., *et al* (2011) Employment precariousness in Spain: prevalence, social distribution, and population-attributable risk percent of poor mental health. *International Journal of Health Services*, 41, 625–646.

Wahlbeck, K. & McDaid, D. (2012) Actions to alleviate the mental health impact of the economic crisis. *World Psychiatry*, 11, 139–145.

MENTAL HEALTH LAW PROFILES

Mental health law profiles

George Ikkos

Consultant Psychiatrist in Liaison Psychiatry, Royal National Orthopaedic Hospital, London, UK, email ikkos@doctors.org.uk

Argentina and Brazil are two countries which have yet to recover fully from the crushing legacy of imperialism, dictatorship and inequality in their history. In this context, the rights of patients with mental illness have suffered, along with those of others. Since the restoration of democracy there has been a clearly expressed intention in law to redress this legacy, as the authors of this issue's Mental Health Law Profiles report. Regrettably, they also highlight that the reality on the ground, in terms of service delivery, lags well behind the intention of the law, which perhaps is not surprising in light of the persistent inequalities in both countries.

MENTAL HEALTH LAW PROFILE

The new mental health law in Argentina

Daniel Moldavsky[1] MD DipPsych (Israel) and Hugo Cohen[2] MD

[1]Specialist in Psychiatry (Argentina), Consultant Psychiatrist, Nottinghamshire Healthcare NHS Trust, UK, email daniel.moldavsky@nottshc.nhs.uk

[2]Specialist in Psychiatry (Argentina), MPH (Spain), World Health Organization and Pan-American Health Organization Adviser for Mental Health, South America

The Argentinean Congreso de la Nacion (National Congress, or Parliament) approved in November 2010 a new Mental Health Law (MHL) (Law 26657, 'Salud Publica. Derecho a la Proteccion de la Salud Mental' [Public Health. The Right to Protect Mental Health]). Although it is not the first law concerning mental health – as several of the provinces and the autonomous city of Buenos Aires (Argentina's capital) have enacted their own – the MHL establishes principles for human rights and the protection of patients, and aims to develop approaches in mental health that are compatible with the most advanced views and legislation from high-income countries. In this paper we report on the most important aspects of the MHL. We highlight areas that represent a change for Argentina, such as the new arrangements for both informal and compulsory admission to hospital.

We have published in *International Psychiatry* a paper outlining the main aspects of mental healthcare in Argentina, to which we refer the reader who wishes to understand more about the context for the law (Moldavsky *et al*, 2011).

The MHL is divided into 12 sections (or chapters), each section comprising several articles.

Section 1. The rights of people with mental disorders

The MHL is explicitly grounded on principles from the United Nations, the World Health Organization (1996) and the Pan-American Health Organization. It is also based on some existing Argentinean legislation from several provinces for people with mental illnesses, particularly those laws that stress treatment in the community (in Rio Negro, 'Promocion Sanitaria y Social de las Personas que Padecen Sufrimiento Mental' [Health and Social Advance for People with Mental Suffering], 1991; in Buenos Aires, 'Ley de Salud Mental de la Ciudad de Buenos Aires' [Law for Mental Health of the Autonomous City of Buenos Aires], 2000).

Section 2. Definition

The MHL defines mental health as a multifactorial outcome of several processes, in line with a robust social orientation that is developed further in several of its articles.

The Law establishes the presumption of capacity (i.e. a patient has capacity unless this is proven otherwise).

It sets up also diagnostic exclusions (e.g. sociopolitical affiliation, sexual orientation and other personal and lifestyle matters) and inclusions (particularly the addictions as illnesses that require treatment).

Section 3. Domain of the Law

The MHL applies to all health providers, from the public, private and social security sectors.

Section 4. Human rights

The MHL acknowledges cultural diversity and the protection of personal and collective identity. The latter is particularly relevant for the recognition of the rights of indigenous people in a multicultural country where the rights of the native populations have been historically neglected. The MHL prohibits discrimination on any grounds.

Other principles here include using the least restrictive environment, the need for informed

consent and the need for monetary compensation if the patient is in protected employment within the mental health system.

Section 5. Professional approaches

In this section the Law promotes the creation of multidisciplinary teams (MDT), which include all the professions involved in delivering mental healthcare. It is remarkable that the MHL encourages the prescription of psychotropic medications as an outcome of the MDT discussion. All these approaches are considered substantial pathways to community-based treatments that promote social inclusion.

Section 6. Equality among mental health professionals

In the spirit of supporting values of equality and democracy, this section explicitly upholds the equality of all mental health professionals and enables non-medical professionals to become programme directors and team leaders.

Section 7. Hospital admissions

This is the longest section of the MHL, containing 16 articles. We shall consider its main points.

- For an admission to be considered as a therapeutic option, it should bring more benefit than a community-based intervention. Equally, it has to be of the shortest possible duration. It should aim at the reintegration of the patient within the family and community. The state bears responsibility for providing social resources (notably housing) that may prolong admissions if they are otherwise nonexistent. The decision to admit should be made by the MDT.
- A new government organisation, the Review and Regulatory Body (RRB), will control both voluntary and compulsory admissions.
- Voluntary admissions should be notified to the justice system if they last more than 60 days. The justice system must respond within 5 days if a problem is encountered and eventually suggest alternatives.
- Compulsory admissions must be reported to the justice system and the RRB within 10 hours. Immediate risk and the impossibility of community-based approaches are necessary conditions to initiate the compulsory admission. This is done by two professionals, who need to be from a different discipline, but one must be either a psychiatrist or a psychologist.
- Once the justice system receives the information, the judge must reply within 3 days. The justice system can authorise the continuation of a compulsory admission, reject it and order a discharge (or convert the admission to informal status), demand further evidence, or ask for an independent evaluation by professionals appointed by the justice system. However, if the justice system authorises the continuation of the admission as compulsory, it will request periodic assessments every 30 days, and if the admission will last longer than 90 days the justice system will appoint an MDT to review the case.
- Patients have a right to appoint a solicitor and in the case of a patient under compulsory admission the state has the duty to provide one.
- A key topic of this section is a prohibition on new psychiatric hospitals (asylums) in either the public or the private sector. The asylums already existing must adapt themselves to the regulations of the MHL. The Law aims to promote the admission of psychiatric patients to psychiatric units within general hospitals.

Sections 8–12

Section 8 stipulates that any treatment must take place where the patient has local connections, to promote the aforementioned approaches based on community integration and social inclusion.

Section 9 establishes several principles for implementation. The MHL states that within a 3-year period there must be an increase in the budget allocations for mental health, to 10% of the total health budget. It also demands from the Ministry of Health a National Plan for Mental Health. A further remarkable feature is the inclusion within the ambit of the MHL of health maintenance organisations (which provide insurance-based and private medical services).

Section 10 governs the composition and goals of the RRB, focusing on the protection of the human rights of service users and families.

Section 11 states the need to promote agreements between federal policies and those of the provincial governments.

Section 12 deals with modifications to the Argentinean Civil Code of Legislation that will need to be done as an outcome of some of the changes proposed by the MHL.

Principal issues in the Mental Health Law

Considering the historical and social contexts in Argentina, we think the present Law has many progressive aspects.

The MHL encourages approaches that are socially oriented and endorses the rehabilitation and recovery model for those with mental disorders. It aims to create MDTs for the present and future mental health system. In this respect, bearing in mind that the medical profession has been traditionally dominant in Argentina, proposals promoting the equality of all mental health professionals and the expansion of a multidisciplinary approach for assessment and treatment are necessary and welcome.

The judicial supervision of admissions to hospital, both informal and formal, is progressive as well. The aim is to consolidate the rule of law and principles of citizenship and good governance. These matters have already been welcomed by organisations of patients and carers.

The MHL ventures also into issues of general policies for mental health. It determines that

the model for in-patient treatment should be the general hospital, and rules out opening new asylums. Together with the proposed establishment of MDTs this is another enlightened step forward.

Despite these advances, there are some potential conflictive features. The Argentinean health system is fragmented. Different and sometimes contrasting sectors coexist side by side, with poor central regulation. With a historically debilitated public sector, poor regulation and supervision in other sectors within health and social care, and a private sector that has significantly expanded over the past decades, it is challenging to see how the practical principles of the MHL might be enforced (for example, introducing the concept of the MDT as the unit for assessment and treatment). Mental health organisations have welcomed the MHL in general terms, but have been mindful of various areas of tension and dispute.

Other important challenges for future consideration include:

- regulating the private sector
- promoting the teaching of mental health in general hospitals (following recommendations from the World Health Organization and the Pan-American Health Organization at Caracas in 1990)
- the inclusion of public health in the training of psychiatrists and psychologists
- relocating budgets from the psychiatric hospital-based facilities to the community.

The absence of a robust and prolonged democratic tradition is another obstacle to the subordination of conflicting sectors of the health system to the principles of the MHL.

Will the MHL be sufficient as an instrument to change existing realities? What other structures need to be created? These and further questions arise. Nevertheless, the MHL is a very good starting point. The sovereignty of the rule of law, the parliamentary discussions that originated the law, and its focus on the protection of human rights of patients make the MHL a progressive hallmark of a system that aims to improve conditions for patients, families and professionals. It is now the responsibility of the state's executive structures, together with health and social care organisations, to design comprehensive mental health plans and policies that will render the MHL a living reality.

References

Moldavsky, D., Savage, C., Stein, E., *et al* (2011) Mental health in Argentina. *International Psychiatry*, 8, 64–66.

World Health Organization (1996) *Guidelines for the Promotion of Human Rights of Persons with Mental Disorders.* WHO.

Mental health law in Brazil

José G. V. Taborda

Forensic Psychiatrist, Associate Professor of Psychiatry, Department of Clinical Medicine, Federal University of Health Sciences of Porto Alegre, Porto Alegre, RS, Brazil, email jose@taborda.med.br

Brazil is a Federal Union which comprises 27 member states, one Federal District, and about 5000 municipalities. According to the Federal Constitution (Constituição da República Federativa do Brasil; *Diário Oficial da União*, 05/out/1988), the competence to rule over health issues is shared by all of them. So, in each part of the country three levels of legislation apply: federal, state and local law. However, as an inferior level of law must not conflict with a superior one, there is a relative uniformity throughout the country, at least in theory. Regarding actual mental healthcare delivery, there are many differences across the Brazilian regions, mostly due to socioeconomic variation.

Historical issues

In Brazil, reform of mental healthcare (derogatorily called 'psychiatric reform' by anti-psychiatry activists) has two main themes: changing the model from hospital-based to community-based care; and the regulation of involuntary psychiatric in-patient treatment. Changing the model of psychiatric care had actually begun in some states (the more developed and richer ones) in the 1960s. However, by the end of the 1980s most of the states still had large psychiatric hospitals, whose main functions were to 'feed and shelter' patients with enduring mental health problems, instead of treating acute psychiatric in-patients. The grounds for involuntary in-patient psychiatric treatment have been specified in law since 1934 (Decreto 24.559/34, Dispõe sobre a profilaxia mental, a assistência e proteção à pessoa e aos bens dos psicopatas, a fiscalização dos serviços psiquiátricos e dá outras providências [Provisions for mental prophylaxis, assistance and the protection of the person and property of psychopaths, supervision of psychiatric services and other matters]; *Diário Oficial da União*, 03/jul/1934). However, there was no specification of the due legal process for depriving patients of their freedom: involuntary hospitalisation was simply agreed between the physician and the patient's relatives.

In 1989 a federal bill on mental healthcare, authored by a member of the House of Representatives of the Partido dos Trabalhadores (Labour Party), was proposed to the Brazilian Parliament. In that decade Brazil was emerging from a military regime which had lasted 20 years. The same

had happened in other Latin American countries. A new Federal Constitution was promulgated in 1988. So, the political atmosphere was intense and a general clamour for freedom had spread all over the country. In the health field, the most obvious target for political struggle was psychiatry and mental healthcare. An anti-psychiatry activist stated that 'The struggle for the insane is part of society's overall strategy of struggle for the woman, the indian, the negro, the homosexual and other minorities' (Amarante, 1998).

Thus, it is not surprising that the bill had a bias against psychiatry and psychiatric care, among them the determination to close all psychiatric hospitals in the country, not taking into consideration the quality of care. This bill was so radical that it provoked a reaction. Finally, 12 years later, in 2001, it was rejected and substituted by a bill without anti-psychiatric tenets. That bill became Federal Law 10.216/01, of 2001 (Dispõe sobre a proteção e os direitos das pessoas portadoras de transtornos mentais e redireciona o modelo assistencial em saúde mental [Provisions for the protection and rights of people with mental disorders and reform of the mental healthcare model]; *Diário Oficial da União*, 09/abr/2001).

Federal Law 10.216/01

Law 10.216 does not define mental illness but instead relates to 'people with mental disorders'. However, as Brazil has adopted ICD-10 (World Health Organization, 1992) as its official classification of diseases, the psychiatric disorders must fit ICD-10 criteria.

Psychiatric hospitalisation

Law 10.216 recognises three kinds of psychiatric hospitalisation: *voluntary*, *involuntary* and *compulsory*. All require *medical certification* that the patient needs in-patient treatment. Voluntary hospitalisation takes place when a competent patient gives informed consent; involuntary hospitalisation requires consent by proxy; compulsory hospitalisation is effected under a judicial order. The *grounds* for involuntary hospitalisation are not specified in Law 10.216. Thus, the old 1934 Law provides them: risk of aggression against the self, risk of aggression against others, risk of 'moral exposure' (social/moral risk in financial, sexual or behavioural areas) and serious incapacity in terms of self-care. The discharge of the patient is a decision for the treating physician. Under voluntary hospitalisation the patient can apply for discharge at any time; under involuntary hospitalisation the right of application rests with the patient's representative. There is no time limit to involuntary hospitalisation, nor is a need for renewal specified by law.

When a patient is involuntarily hospitalised, the medical director of the hospital must inform the Public Prosecutor within 72 hours. The Public Prosecutor has the power to make an inquiry and must protect the rights of people who are mentally ill. However, in most cases this is limited to a bureaucratic role. Only when a complaint is received (usually from a patient's relative or friend) does an inquiry take place. This investigation basically consists of sending a psychiatrist from the office of the Public Prosecutor to the hospital. This psychiatrist must contact the treating physician, evaluate the patient, review the medical records and determine whether the patient is receiving appropriate treatment. Finally, this psychiatrist must write a report about the patient's clinical condition and confirm whether or not there is a need for continued hospitalisation for the patient's protection and that of third parties.

Changing of the model of psychiatric care

Law 10.216 rules that it is a right of people with mental disorders 'to be, preferentially, cared for in mental health community services', that 'in-patient treatment will be allowed when the out-patient resources have been exhausted' and that 'psychiatric treatment must target the patient's social reintegration into his/her original environment'. These provisions are general guidelines to direct public policies on mental health. There is no provision forbidding the establishment of psychiatric hospitals or psychiatric units in general hospitals, nor ordering the closure of those already in existence.

Involuntary treatment

Law 10.216 does not rule on involuntary treatment, only on 'involuntary hospitalisation'. The implication is that the latter includes the former and that an involuntary in-patient has no right to refuse treatment. However, for potentially riskier treatments (such as electroconvulsive therapy) consent from the patient's representative is required, except where there is 'imminent risk to life' and there is no time to contact the representative. In Brazil there are no involuntary out-patient or community treatment orders, except for those that apply to offenders with a mental disorder and other forensic patients.

When defendants are found not guilty by reason of insanity, they must receive a criminal commitment called a 'safety measure'. The safety measure could consist of in-patient psychiatric treatment in a forensic mental hospital or of out-patient psychiatric treatment. Regarding the latter, if the patient does not comply with the medical treatment plan the safety measure can be transformed into in-patient treatment.

Civil competence

Law 10.216 does not rule on civil competence. This is an issue governed by the civil law. According to the 2002 Brazilian Civil Code (Código Civil, Law 10.406/02; *Diário Oficial da União*, 11/jan/2002), people can be declared incompetent and be put under guardianship if, in addition to a mental disorder, they manifest impaired judgement due to that mental disorder. So, mental disorder itself is not sufficient grounds for guardianship. Unless a judicial decision explicitly declares incompetence, a person with a mental disorder is presumed competent.

Final remarks

Brazilian healthcare reform has not been a success. 'Minor legislation' (such as decrees) enacted at the national level by the Ministry of Health, or at the state or local-government level, has been used to subvert Law 10.216, by closing psychiatric beds and psychiatric hospitals before sufficient community services have been established, while the opening of psychiatric beds in general hospitals is discouraged by the legislation. Sadly, those with mental disorder who do not have access to adequate mental health services remain at home in an impoverished state, wander the streets, are locked in prisons or present at general emergency rooms.

References

Amarante, P. (1998) *Loucos Pela Vida: A Trajetória da Reforma Psiquiátrica no Brasil* [*Crazies for Life: Psychiatric Reform in Brazil*] (2nd edn). FIOCRUZ.

World Health Organization (1992) *The ICD-10 Classification of Mental and Behavioural Disorders* (10th revision) (ICD-10). WHO.

School-based survey of psychiatric disorders among Pakistani children: a feasibility study

Sajida Abdul Hussein,[1] John Bankart[2] and Panos Vostanis[3]

[1]Research Fellow and Clinical Psychologist, University of Leicester, Greenwood Institute of Child Health, Leicester, UK, email sa27@leicester.ac.uk

[2]Senior Lecturer in Biostatistics, Department of Primary Care and Health Sciences, Keele University, UK

[3]Professor of Child and Adolescent Psychiatry, University of Leicester, Greenwood Institute of Child Health, Leicester, UK

The study reported here was completed by the Learning Support Unit (LSU) of the Sindh Education Foundation (SEF) in Karachi, Pakistan. We graciously render our deepest gratitude to all the parents and teachers who kindly participated in the study and to the entire research team. Special thanks to Professor Howard Meltzer, one of the leading researchers in child psychiatric epidemiology, Dr Susan Purdon from the National Centre for Social Research (NatCen), who checked that the survey weights were correctly calculated, and Professor Ambrosini, for his advice on the K-SADS. We are grateful to the Rawji Educational Trust Belgium for providing funds for the study.

A cross-sectional survey of children aged 5–11 years attending 22 primary schools was carried out in Karachi, Pakistan. In the first (screening) phase, broad morbidity rates were measured using the Strengths and Difficulties Questionnaire (SDQ). A total of 968 parents and 793 teachers participated. In the second phase, 100 children were selected for a diagnostic interview using the Kiddie Schedule of Affective Disorders & Schizophrenia for School-Age Children. A weighted rate of 17% (95% CI 6.2–28.3%) was found for common child psychiatric disorders, with a preponderance of behavioural disorders, followed by anxiety and mood disorders. The feasibility study established methods and preliminary rates of child psychiatric disorders, which appear higher than in other countries. School surveys could be an important source of data in low-income countries and form the basis for interventions in the absence of specialist services.

A review of non-clinic-based epidemiological studies from 51 Asian countries found that the prevalence of child psychiatric disorders ranged from 10% to 20% (Srinath *et al,* 2010). Most such studies from low-income countries have reported higher prevalence rates than studies conducted in high-income countries, which have, overall, estimated the prevalence at approximately 10% (Green *et al,* 2005).

In Pakistan, the scarcity of child mental health services mirrors the limitation of evidence-based studies on children's needs and how these should be met (Jawaid & Rehman, 2007). A survey conducted two decades ago produced an estimate of 9% for the prevalence of behavioural and emotional problems among children (Javad *et al,* 1992).

The increasing public concern over child mental health in Pakistan has highlighted the need for more accurate and up-to-date knowledge on prevalence rates (Syed *et al,* 2007). This was the rationale for the present two-stage preliminary study, which aimed to develop and test methods, and to establish the rates of common psychiatric disorders among children at primary school in Karachi. The long-term objective is to apply these methods in a later definitive epidemiological study.

Method

Setting and sampling strategy

The study was conducted in Karachi primary schools (for children aged 5–11 years). The educational system in Pakistan comprises public or government schools, community schools (typically run by non-governmental organisations) and private schools. In order to maximise the representativeness of the sample, schools of all three types were invited to participate. Table 1 provides the demographic profile of the study sample. Central Karachi has a total of 1380 primary schools. Twenty-seven schools were randomly selected and 22 agreed to participate – seven private, seven government and eight community schools. The five schools (two private and three community schools) that declined to take part in the study asserted that the topic might upset parents or was irrelevant to their pupils. After schools had consented to participate, the researcher (SAH) identified the sample of children using a pseudo-random technique, based on alternating odd–even serial numbers on the attendance register; school authorities selected this technique for pragmatic reasons. A sample of 2188 children aged 5–11 years was selected. The parents of 1003 of these children agreed to participate, and in the first screening stage data were collected from 968 parents and 793 teachers.

Table 1

Sociodemographic characteristics of the sample ($n = 968$)

	n (%)
Gender	
Male	515 (53.2)
Female	453 (46.8)
School type	
Private school	272 (28.1)
Community school	368 (38.0)
Government school	328 (33.9)
Mother's education	
Not educated	591 (61.1)
<10 years of schooling	125 (12.9)
10–12 years of schooling	176 (18.2)
Graduate degree/higher	76 (7.9)
Father's education	
Not educated	340 (35.1)
<10 years of schooling	264 (27.3)
10–12 years of schooling	207 (21.4)
Graduate degree/higher	157 (16.2)
Father's occupation	
Unemployed	258 (26.7)
Business	131 (13.5)
Government	139 (14.4)
Skilled labour	176 (18.2)
Private employment	264 (27.3)
Mother's occupation	
Unemployed	725 (74.9)
Business	1 (0.1)
Government	45 (4.6)
Skilled labour	154 (15.9)
Private employment	43 (4.4)

Measures

Screening phase

The first phase was conducted using the Urdu version of the Strengths and Difficulties Questionnaire (SDQ; Goodman, 2001), completed by parents and teachers. The SDQ has acceptable reliability and validity and has been previously used in Pakistan (Samad *et al,* 2005).

Interview phase

Recruitment for the second phase depended on the SDQ results of the screening phase. Because of lack of resources and time constraints, it was not possible to interview all the children that the SDQ recorded as 'cases'. Therefore, a sample of 100 children was randomly selected (via computer randomisation), comprising 50 SDQ high scorers (scoring 17 or more; screen positive) and 50 SDQ low scorers (scoring < 17; screen negative). This sample was further assessed by the researcher using the Kiddie Schedule of Affective Disorders and Schizophrenia for School-Age Children (6–18 years) (K-SADS-P-IV-R; Ambrosini & Dixon, 1996). The in-depth assessment interview was carried out at the school or home as per parents' choice. All parents invited to take part in this phase agreed to do so. The interview was conducted with mothers, because of their availability and proximity to the child. All interviews were conducted by the researcher (SAH), who maintained regular communication with Professor Ambrosini for advice and support for the effective use of the instrument. Details of the translation and adaptation procedure have been published separately (Hussein & Vostanis, 2008).

Children's Global Assessment Scale (C-GAS)

The Children's Global Assessment Scale (C-GAS) (Shaffer *et al,* 1983) was used by the researcher (who had been trained in its use) to assimilate and synthesise knowledge about the child's psychosocial functioning, and to condense it into a single index.

Statistical analysis

Descriptive statistics were computed for sociodemographic characteristics. To calculate likely prevalence rates in this study, the data were weighted at two stages: first, to take into account disproportionate sampling from within gender and school groups; and subsequently, in the calculation of weights to take into account disproportionate sampling of SDQ scores within the gender/school group strata. To analyse the sample survey data, the SURVEYFREQ procedure in SAS 9.1 was used, which incorporated the sample design into the analysis. Descriptive statistics were generated using SPSS version 14.5.

Results

Weighted DSM-IV rates of common child psychiatric disorders

Of the 100 children interviewed at stage 2, 26 had at least one DSM-IV diagnosis (16 boys and 10 girls), giving a prevalence rate of 17.3% for Karachi as a whole (95% CI 6.2–28.3%), after adjusting for the oversampling of SDQ high scores and school type, and weighting them back to the general population (Table 2). All but one child diagnosed as a clinical 'case' had been 'screen positive' on the SDQ. Of the broad diagnostic categories, behavioural disorders were the most common (10.2%), followed by anxiety (4.2%) and mood disorders (2.9%).

Rates according to gender and school type

Since the second-stage sample consisted of 100 children, there was limited power to conduct statistical tests for comparison of prevalence rates according to school type and gender. Descriptive analysis suggested that, overall, the prevalence was

Table 2

DSM-IV rates of child psychiatric disorders using the K-SADS diagnostic interview, with C-GAS impairment

Disorders	Prevalence rate (%)	95% CI (%)
Any disorder	17.3	6.2–28.3
Anxiety disorders	4.2	0.0–8.7
Generalised	3.5	1.0–5.3
Avoidant	0.2	0.1–0.4
Separation	0.1	0.0–0.2
Phobia	0.1	0.0–0.2
Overanxious	0.3	0.0–0.6
Behavioural disorders	10.2	6.3–15.4
Attention-deficit hyperactivity disorder	5.5	0.3–10.7
Oppositional defiant disorder	4.7	0.0–9.5
Mood disorders	2.9	0.0–7.0

slightly higher in girls (17.6%; 95% CI 3.6–31.6%) than in boys (16.9%; 95% CI 0.0–33.8%). The prevalence of behavioural disorders, including oppositional defiant disorder (ODD) and attention-deficit hyperactivity disorder (ADHD), appeared to be higher in boys than in girls, while the prevalence of anxiety and mood disorders appeared to be higher in girls. Children attending government schools had the highest prevalence of any disorder (21.2%; 95% CI 6.5–35.9%), followed by community (19.1%; 95% CI 5.9–32.4%) and private schools (13.9%; 95% CI 0.0–29.3%). Among children attending private schools, ADHD (6.1%; 95% CI 0.1–14.7%) was the most common diagnosis, followed by anxiety (4.6%; 95% CI 0.0–11.7) and ODD (3.1%; 95% CI 0.0–8.5%).

Discussion

There is little information on child mental health problems in Pakistan. This is the first study of its kind conducted in Karachi on school children. It found that around 17% of Pakistani children aged 5–11 years have emotional and behavioural problems that are severe enough to result in significant distress or social impairment, thereby warranting a clinical assessment and possible intervention. A review of non-clinic-based epidemiological studies from 51 Asian countries showed that the prevalence of mental health problems/disorders is in the range 10–20% (Srinath *et al*, 2010). Thus, our estimate of 17%, although at the high end, falls within the range of results from previous studies conducted in low-income countries.

Consistent with previous studies in Pakistan, behavioural disorder was the most frequent diagnosis. However, clinical studies in Pakistan have shown that, although most referred children have behavioural problems, substantial proportions are not diagnosed with disruptive disorders. This seems to indicate that mental health or developmental problems may have been masked by behaviour that was misinterpreted as oppositional (Syed *et al*, 2007). This study found higher rates of emotional disorders, including both anxiety and mood disorders, than have studies conducted in other countries. In their review, Mirza & Jenkins (2004) reported that socioeconomic adversity and relationship problems were major risk factors for anxiety and depressive disorders among Pakistani adults. It is essential that these risk and protective factors are investigated among Pakistani children.

The findings of the present feasibility study have implications for policy and service development. The differences in the rates of child psychiatric disorders between the three main school types highlight the importance of providing flexible interventions and services for different educational institutions, in particular in areas of socioeconomic deprivation. There is an urgent need to train teachers to be able to identify child mental health problems, apply school-based management techniques and make appropriate and timely referrals of children with complex disorders to the sparse specialist services (Tareen *et al*, 2009).

Brief training sessions can improve accuracy in the identification of children and young people with mental health problems, on the part of both teachers and general practitioners. Teachers who attend a brief course on child mental health have been shown to be better able to identify behavioural difficulties and to manage them in the classroom. The effectiveness of such interventions indicates that it is possible to conduct school-based interventions using limited resources. These findings are particularly relevant to low-income countries.

Children with mental ill-health have an adverse effect on a country's productivity and economic stability. Further studies will enhance our understanding of the patterns of comorbidity, perceived treatment needs and psychosocial correlates. A comprehensive cross-sectional study is needed in Pakistan with a more sound methodology, a wider sample and some exploration of culture-specific aspects of behaviour indicating difficulty or distress. A qualitative study focusing on parental attitudes to and perceptions of mental health problems in children and adolescents would provide the information needed to design an appropriate longitudinal study to investigate the prevalence of and risk factors for child mental health problems in Pakistan. These future studies will help policy-makers to develop services and interventions.

References

Ambrosini, P. & Dixon, J. (1996) *Schedule for Affective Disorders and Schizophrenia for School-Age Children – Version IVR* (K-SADS-IVR). Medical College of Pennsylvania, Eastern Pennsylvania Psychiatric Institute.

Goodman, R. (2001) Psychometric properties of the Strengths and Difficulties Questionnaire. *Journal of the American Academy of Child and Adolescent Psychiatry*, **40**, 1337–1345.

Green, H., Mc Ginnity, A., Meltzer, H., et al (2005) *Mental Health of Children and Young People in Great Britain*. Office for National Statistics.

Hussein, S. A. & Vostanis, P. (2008) Urdu translation and cultural adaptation of the Schedule for Affective Disorders & Schizophrenia for School Age Children (6–18 yrs) K–SADS–IV R. *Journal of Pakistan Psychiatric Society*, **5**, 81–85.

Javad, A. M., Kundi, M. Z. & Khan, A. P. (1992) Emotional and behavioural problems among school children in Pakistan. *Journal of Pakistan Medical Association*, **42**, 181–184.

Jawaid, A. & Rehman, T. (2007) Paediatric mental health in Pakistan: a neglected avenue. *Journal of Pakistan Medical Association*, **57**, 50–51.

Mirza, I. & Jenkins, R. (2004) Risk factors, prevalence, and treatment of anxiety and depressive disorders in Pakistan: systematic review. *BMJ*, **328**, 794.

Samad, L., Hollis, C., Prince, M., *et al* (2005) Child and adolescent psychopathology in a developing country: testing the validity of the Strengths and Difficulties Questionnaire (Urdu version). *International Journal of Methods in Psychiatric Research*, **14**, 158–166.

Shaffer, D., Gould, M. S., Brasic, J., *et al* (1983) Children's Global Assessment Scale (CGAS). *Archives of General Psychiatry*, **40**, 1228–1231.

Srinath, S., Kandasamy, P. & Golhar, T. S. (2010) Epidemiology of child and adolescent mental health disorders in Asia. *Current Opinion in Psychiatry*, **23**, 330–336.

Syed, E. U., Hussein, S. A. & Yousafzai, W. (2007) Developing services with limited resources: establishing a CAMHS in Pakistan. *Child and Adolescent Mental Health*, **12**, 121–124.

Tareen, A., Mirza, I., Minhas, A., *et al* (2009) Developing child and adolescent mental health services in a low-income country: a global partnership model. *Psychiatric Bulletin*, **33**, 181–183.

SPECIAL PAPER

Clinical psychology in a medical setting in Sri Lanka

Piyanjali de Zoysa

Senior Lecturer in Clinical Psychology, Department of Psychological Medicine, Faculty of Medicine, University of Colombo, Sri Lanka, email ptdz@sltnet.lk

It is my observation that Sri Lankan clinical psychologists, contrary to international standards, can, at times, be prevented from independent practice by psychiatric colleagues. This paper suggests reasons for the sometimes strained relations between clinical psychology and psychiatry and discusses the future of the profession in Sri Lanka. An important step would be the establishment of separate departments of clinical psychology in the health system, rather than psychologists being situated within departments of psychiatry.

Sri Lanka (formerly known as Ceylon) is an island lying off the south-eastern tip of India. Its capital is Colombo. The two principal ethnic groups in the country are the Sinhalese and the Tamils. Sinhala is the official language but Tamil is also a national language. English is spoken by about 10% of the population and is commonly used for official purposes. The majority of the population (68%) is Buddhist but substantial minorities are Hindu (15%), Christian (8%) and Muslim (8%).

Sri Lanka's mental health needs

Sri Lanka has varied mental health needs. The prolonged ethnic conflict, which ended in 2009, affected people physically, psychologically and socioeconomically. In recent times, Sri Lanka has also experienced several natural disasters, the worst of which was the 2004 tsunami, which exposed thousands to trauma, and in addition there have been floods and landslides. Disaster studies indicate serious mental health problems for the survivors of such events and this has been so in Sri Lanka (Wickrama & Wickrama, 2008).

Other than the impact of the ethnic conflict and disasters, Sri Lanka also has other mental health issues. For instance, depression and anxiety are common, with prevalence rates of 2.1% for major depression, 7.1% for other depressive disorders and 0.9% for anxiety-related disorders (Institute of Research and Development, 2007). Further, tobacco, substance and alcohol use and misuse have increased in Sri Lanka and the country has one of the world's highest suicide rates among adolescents, young adults and those over 70 years (World Health Organization, 2008).

Psychology education in Sri Lanka

Unlike in most Asian countries, psychology education has had a chequered history in Sri Lanka. Only three government universities offer specialised psychology degrees, the first of which was started in the 1990s. A few private institutions, mainly in collaboration with overseas universities, also offer psychology degrees. There are some diploma courses in psychology, which mainly admit non-psychologists; these give a grounding in psychology that students may apply in their own professions. There is only one postgraduate degree in clinical psychology, a Master of Philosophy in Clinical Psychology, which was started in 2008.

Issues in the work setting

A handful of clinical psychologists have been working sporadically in the country since the 1970s. Most of them have been in academic positions, particularly in departments of psychiatry, and at present there are three such psychologists; in lieu of clinical posts, these psychologists practise in teaching hospitals. Other than these posts, the national health system has not, as yet, employed clinical psychologists, although the National Mental Health Policy (Mental Health Directorate, 2005) recommends their provision. Hence, in the government health sector, there are only three clinical psychologists catering for the entire population of the country – some 20 million. Because of the dearth of government employment opportunities, most clinical psychologists are in private work, providing independent out-patient services at non-government hospitals.

In Sri Lanka, the clinical psychologists in the private sector and almost all of those in the government sector practise autonomously. This is in an out-patient context, where direct self-referrals and referrals from psychiatrists and non-psychiatric specialists are taken, for assessment and treatment. Clinical psychologists also provide psychometric services (such as intelligence testing) and forensic psychological services (e.g. evaluations relating to child abuse).

This autonomous practice of most Sri Lankan clinical psychologists in independently assessing, diagnosing and treating patients is in keeping with international practice (Eckleberry-Hunt *et al*, 2009). However, this has not been without some difficulty. In my experience, although a majority of my psychiatry colleagues have been consistent with these international practices, a minority have resisted, preferring instead to relate in a supervisory mode to clinical psychologists. They appear to be of the view that all patients seeking mental healthcare need a psychiatric and a medical screening and only then can be considered for a clinical psychology referral. If and when a patient is referred to the clinical psychologist, these psychiatrists wish to 'supervise' the psychologist's work, for example psychotherapy or psychometric testing. Some of these psychiatrists have worked in

a high-income country as part of their postgraduate training, often in the UK or Australia, but they appear to resist a multidisciplinary approach once they return to Sri Lanka – and work instead in a regressive way.

With so few clinical psychologists per head of population, this mental health profession should be carefully used. Its over-use, misuse *and* under-use should be curtailed. Such 'supervision' of clinical psychologists by psychiatrists runs contrary to international practice and is disrespectful to the profession. It is also a misuse of scarce resources – if these patients wish to consult a clinical psychologist they have no choice but to be seen by a psychiatrist instead – burdening an already overworked system. Further, it erodes goodwill between the two professions. Fortunately, relatively few psychiatrists are of this view: the majority accept clinical psychology as an equal partner in mental health delivery.

Initiating change in medical settings tends to be a slow and, at times, a painful process (Eckleberry-Hunt *et al*, 2009). This is due in part to the complexity of competing interests. This is seen not only in Sri Lanka but also in countries such as the USA, where the relationship between clinical psychology and psychiatry has often been and continues to be a struggle. General economic trends, along with expansions in the extent of practice by professional psychologists, have and will increase competition and conflict between the two professions (McGrath *et al*, 2004).

Regulation of clinical psychology

At present, it is the Sri Lanka Medical Council (SLMC) that licenses clinical psychologists. There are about 15 so registered, while a smaller number are not registered, largely because they are not clinically active. I have observed that most Sri Lankan clinical psychologists would prefer to be regulated by a psychology body rather than the SLMC, as is the case in many other countries. The reason for this is that in the SLMC procedure there is no clinical psychologist on the committee that assesses the qualifications of an individual requesting a clinical psychology licence. In fact, until 2000, most clinical psychologists were unaware that they were regulated by the SLMC, until a newspaper article proclaimed the fact. Indeed, internationally, it is unusual for clinical psychology to be regulated by a medical body, because, although it is closely associated with medicine, it is a distinct discipline. Nonetheless, in the absence of a psychology body regulating clinical psychology, the SLMC has done a service in licensing clinical psychologists and preserving the integrity of the profession. However, once a Sri Lankan psychology body is formed, it will naturally take over from the SLMC the governance of its own discipline.

The future of clinical psychology in Sri Lanka

In most parts of the world, clinical psychologists are routinely granted a broad range of hospital privileges (Dörken *et al*, 1982) and the historic systemic barriers, particularly from psychiatry, that had prevented clinical psychologists from practising independently, fully consistent with their postgraduate level of education and clinical training, appear to have been surmounted. Clinical psychologists have emerged as active players in the healthcare arena, broadening the range of populations they serve, from their earlier exclusive mental health focus. Worldwide, they practise in nearly all hospital departments. In fact, in the USA, even in the 1940s, clinical psychologists worked not only with psychiatrists but also with other medical specialists, who directly called upon their expertise for assistance with the management of medical and even surgical patients. Thereafter, liaison psychology services fast gained momentum.

In Sri Lanka, too, I envisage such a trend. Although, at present, academic psychologists are attached to departments of psychiatry within teaching hospitals, it is important that clinical psychologists expand their horizons by working alongside other medical specialties too. In fact, clinical psychologists should be placed in a separate department of clinical psychology rather than within psychiatry (Goodman, 2000). In order to pave the way for a separate department, clinical psychologists should first form collaborative relationships with non-psychiatric specialists, as they are likely to be supportive. Such collaborations, although in their infancy, are not uncommon in Sri Lanka. A significant barrier for expediting such separate departments is the country's dearth of psychologists to staff these units. Hence, the country first needs to establish more postgraduate degree courses to train clinical psychologists.

Clinical psychology in Sri Lanka needs to see an improvement in the profile of the profession and this could be best achieved through the establishment of a national psychology association. Such an association would additionally provide continuing professional development for its members. Forming such an association is an urgent need, not only for the specialty of clinical psychology but also for other specialties, such as organisational and forensic psychology.

References

Dörken, H., Webb, J. T. & Zaro, J. S. (1982) Hospital practice of psychology resurveyed. *Professional Psychology*, **13**, 814–829.

Eckleberry-Hunt, J., Van Dyke, A., Stucky, K., *et al* (2009) Attaining medical staff membership and privileges for psychologists: a case study. *Professional Psychology: Research and Practice*, **40**, 579–585.

Goodman, T. (2000) Three decades of professional psychology. Reflections and future challenges. *Canadian Psychology*, **41**, 25–33.

Institute of Research and Development (2007) *National Mental Health Survey*. IRD.

McGrath, R. E., Wiggins, J. G., Sammons, M. T., *et al* (2004) Professional issues in pharmacotherapy for psychologists. *Professional Psychology: Research and Practice*, **35**, 158–163.

Mental Health Directorate (2005) *National Mental Health Policy*. Ministry of Healthcare and Nutrition.

Wickrama, K. & Wickrama, T. (2008) Family context of mental health risk in tsunami affected mothers: findings from a pilot study in Sri Lanka. *Social Science and Medicine*, **66**, 994–1007.

World Health Organization (2008) *Mental Health Update*. WHO.

SPECIAL PAPER

Euthanasia and physician-assisted suicide: historical and religious perspective in the Middle East

Mona Y. Rakhawy,[1] George Tadros,[2] Farooq Khan[3] and Ahmed Mahmoud El Houssini[4]

[1]Associate Professor of Psychiatry, Cairo University, Egypt

[2]Professor in Ageing and Mental Health, Centre for Ageing and Mental Health, Staffordshire University, Stafford, UK

[3]Honorary Lecturer, Centre for Ageing and Mental Health, Staffordshire University; Consultant Psychiatrist, Birmingham and Solihull Mental Health NHS Foundation Trust, UK, email farooqkhan@nhs.net

[4]Psychiatric Resident, Dar El Mokattam Mental Health Hospital, Cairo, Egypt

Euthanasia and physician-assisted suicide have provoked controversy. The ethical and legal issues have been debated but more emphasis on the cultural and religious aspects is needed.

Cultural differences could account for some inequalities related to physician-assisted suicide (PAS), especially as clinical decisions are necessarily influenced by the structure of society at large and the context in which they are made (Clark *et al*, 1991). Sociological influences on clinical decision-making include the social characteristics of patients and physicians, the patterns of social interaction and authority in clinical settings, and the structure of healthcare organisations. In the UK and other European countries, there are sizeable minorities who originate from the Middle East and similar cultures who come into contact with the health sector as patients or clinicians. Euthanasia and PAS are legally prohibited in all Middle Eastern countries and this review, though not exhaustive, explores these topical issues from historical and religious perspectives.

Historical perspective

A historical approach makes it possible to understand what meaning suicide and assisted suicide have for people from different cultural backgrounds and from different generations. The history of suicide from the perspective of Western society has been described by a number of writers, including Alvarez (1990) and Retterstol (1993).

In Athens, hemlock was supplied by the authorities to people who wanted to die by suicide after giving their reasons to the magistrates. They also had to plead their case before the senate in order to gain official permission (Alvarez, 1990), which has parallels with PAS laws in the Netherlands and Switzerland. It was believed that suicide was an act worthy of respect in the following conditions: when a service is done for others by the act of suicide; when suicide is to avoid being forced to perform unlawful or immoral acts; and when poverty, chronic disease or mental illness makes death more attractive than life (Alvarez, 1990; Retterstol, 1993).

In the Roman Empire soldiers were not allowed to perform acts of suicide because this would weaken the Empire, and citizens facing a trial faced a similar prohibition; their estates would be forfeited if they did so.

A contemporary Middle Eastern perspective

The strong legal, cultural and religious restrictions on euthanasia prevent the expression of opposing views. This is reflected in the paucity of research and data in this area (Askar *et al*, 2000). There is a dearth of literature on PAS in the Middle East, although a study in Kuwait examined the attitude of physicians working in government hospitals; it found that about 92% of all the respondents did not support the provision of the means for suicide to terminally ill patients, while 8% did (Askar *et al*, 2000). Studies on euthanasia are much more common and elaborate in high-income countries than elsewhere.

Another study of attitudes to PAS in Kuwait (Ahmed *et al*, 2010) found that 44% of university students felt that PAS was unacceptable at all times, whereas 23% felt that it was unacceptable unless the patient was old or requested it repeatedly.

Religious perspective

In the Middle East, the usual practice of allowing only limited disclosure of medical information to the terminally ill patient, and sometimes to the family, complicates matters and especially so with end-of-life decisions. Almost all ethical decisions in the Middle East are ultimately grounded upon, and inseparable from, some set of religious beliefs. The three main Middle Eastern religions, Judaism, Christianity and Islam, share a belief in the existence of God, an afterlife and the immortality of the soul; this is strongly reflected in opinions on euthanasia (Benjamin, 1981). The Judaeo-Christian Bible and the doctrine of ‘the divine ownership’ (1 Corinthians 10:26) stresses the dignity of the human being as a person. St Augustine, an early Church father, who opposed euthanasia, commented in 413 that the sixth commandment applies to suicide and euthanasia as well as to homicide (Bettenson, 1972). St Aquinas in 1271 adopted the view of the Jewish scholar Maimonides that killing an innocent person, whether healthy or about to die from natural causes, is absolutely prohibited. The Roman Catholic catechism teaches that euthanasia is a sin against the greatest commandment about loving God, oneself and one’s neighbour (Matthew 22:38–40) and against God’s specific plan for each person (Ephesians 2:10).

The Qur’an stresses that God is the ‘owner’ and the ‘giver’ of life (Qur’an 3:145; 16:61) and that

God is the most merciful (Qur'an 4:29). Life is a 'trust' that we should keep and so the deliberate termination of one's life or the life of another is not permitted unless it is in 'the course of justice' (Qur'an 6:151). Euthanasia is thus forbidden in Islam, particularly in the Prophet Mohammed's teachings. Jundub narrated that the Prophet Mohammed said: 'A man was inflicted with wounds and committed suicide; so Allah said: My slave has caused death on himself hurriedly, so I forbid paradise for him' (Khan, 1995). Van den Branden & Broeckaert (2011) similarly concluded that euthanasia is forbidden in Islam when they studied 32 English sunni e-fatwas (Islamic religious rulings or scholarly opinions). Abu Hurairah narrated that the Prophet Mohammed said: 'Whoever kills himself by a certain means, will keep on being tortured by such means in hell' (Sabiq, 1983).

Another important issue, as discussed by Babji (2009), is that of end-of-life care and the differences between Islamic and more secular cultures regarding ownership of life and advance directives concerning personal wishes at the end of life, although there are similarities between these two systems, including the preservation of life, protection of individuals' rights and a ban on assisted suicide (with some exceptions) (Babji, 2009).

Conclusions

The Middle East has a unique position in history. People from the region have collectively developed their cultures through years of interaction with different eras of history, cultures and religions. There are sizeable minorities in the USA, Australia, the UK and mainland Europe who emigrated from or have links with the Middle East. Also, there are millions of Muslims who currently live in Western countries. Therefore, it is essential for doctors practising in those countries to understand the historical, spiritual and cultural perspective of those who have their cultural roots in the Middle East. We also need to understand who the physician is, the relationship between professional and patient, and the impact of societal structures on that relationship. Only if professionals understand the cultural and religious needs of diverse groups of our patients can we offer them appropriate suggestions and advise on end-of-life decisions.

References

Ahmed, R. A., Sorum, P. C. & Mullet, E. (2010) Young Kuwaitis' views of the acceptability of physician-assisted suicide. *Journal of Medical Ethics*, **36**, 671–676.

Alvarez, A. (1990) *The Savage God: A Study of Suicide*. Norton.

Askar, A. H. G., Ben Nakhi, M., Al-Rashidi, K., *et al* (2000) Religion, spirituality and medicine: history, research and applications. *Medical Principles and Practice*, **9**, 268–281.

Babji, A. (2009) Legal issues in end-of-life care: perspectives from Saudi Arabia and the United States. *American Journal of Hospice and Palliative Medicine*, **26**, 119–127.

Benjamin, M. (1981) *Ethics and Religion: Ethical Decisions in Medicine*. Little, Brown.

Bettenson, H. (1972) *St Augustine. City of God*. Penguin Books.

Clark, J. A., Potter, D. A. & McKinlay, J. B. (1991) Bringing social structure back into clinical decision making. *Social Science and Medicine*, **32**, 853–866.

Khan, M. M. (1995) *Sahih Al-Bukhari* [Prophetic Traditions]. Egyptian Press of Mustafa Al-Babi Al-Halabi.

Sabiq, S. (1983) *Fiqh Al Sunnah*. Dar Shoaaa.

Retterstol, N. (1993) *Suicide: A European Perspective*. Cambridge University Press.

Van den Branden, S. & Broeckaert, S. (2011) Living in the hands of God: English Sunni e-fatwas on (non-)voluntary euthanasia and assisted suicide. *Medical Health Care Philosophy*, **14**, 29–41.

Contributions to the 'News and notes' column should be sent to ip@rcpsych.ac.uk

Hamid Ghodse, CBE, 1938–2012

Among many other tributes, Professor Sue Bailey wrote on 3 January to inform the College membership:

My sadness is at the news of the untimely death of Professor Hamid Ghodse, just after Christmas. Many of you will have known Hamid in his work in the field of addictions, and in his role at St George's Hospital. His hugely important work with the United Nations, advising on addictions policy, has had an enormous influence on global mental health. He has been a senior member of the College, to whom I and many past-Presidents have often turned for advice.

Hamid steered the College's International Affairs Committee, and edited our journal *International Psychiatry*. We presented him with the Lifetime Achievement Award at the RCPsych Awards in 2011. In Hamid I, and countless colleagues, have lost a good friend and one of the wisest, most humane people I have ever met. Hamid was blessed with a loving family, and family was always utmost in his mind. I therefore hope we can hold in mind his family, and all the families of College members who have died in 2012.

Sue Bailey
President, Royal College of Psychiatrists

Volunteering and International Psychiatry Special Interest Group

On 2 November 2012, the College's Volunteering and International Psychiatry Special Interest Group held its first annual conference. There was a full house at the College. It was an opportunity to celebrate the volunteering and international activities of members and non-members. There was a talk by former President Sheila Hollins on the international aspects of the College, and presentations from Uganda, Somaliland, Haiti and Ghana. The day ended with a debate on the role of diaspora organisations in international work. Workshops were held to develop future strategies.

West Pacific Division

The West Pacific Division of the College, chaired by Dr M. Parameshvara Deva, has been involved in

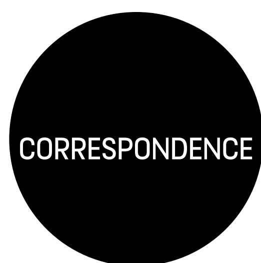
helping to establish a Labasa Stress Management Day Centre in Venua Levu, Fiji. The centre is a place to promote recovery for those experiencing mental illness or emotional distress. It will aim to promote meaningful experiences in a social, supported and welcoming environment. It has been shown to serve as an acute treatment centre for those not needing in-patient psychiatric care and is better than out-patient care alone. It is also an opportunity for family members to participate in activities and understand the many aspects of stress and its management. Sessions can be run from the day centre for those recovering from mental illness, emotional distress or stress. The day centre focuses on the following areas to support clients and their families: community engagement and activities; personal recovery goals and strategies to cope with stress; well-being and a healthy lifestyle; ensuring medication compliance and reducing side-effects.

RCPsych Awards 2012

The Royal College of Psychiatrists Awards are currently in their fourth year and recognise and reward the most talented psychiatric trainees, the most innovative teams and the most dedicated psychiatrists. Some of the 2012 winners were:

- Lifetime Achievement Award – Professor Eve Johnstone
- Psychiatrist of the Year – Dr Geraldine Strathdee
- Psychiatric Team of the Year – Adult Cognitive Assessment and Intervention Team, Cheshire and Wirral Partnership NHS Foundation Trust
- Service User Contributor of the Year (jointly awarded to two winners) – Maurice Arbuthnott and Graham Morgan

Nominations for the RCPsych Awards 2013 opened in January 2013.



Correspondence should be sent to ip@rcpsych.ac.uk

Into the dragon's belly: the experience of a psychotherapist among the victims of the 2012 Emilia earthquake

Sir: On 30 May 2012, I received a call from a psychologist living in the Emilia region of Italy, after two major earthquakes that month. My colleague had gone here to put together a group of experts on emergencies, who met near a school; the roof of the building had caved in and the health workers were on the lawn nearby to provide help.

My house, too, had swung frightfully – I live on the eighth floor; cracks had appeared on the walls, but it had held. 'Let's go into the belly of the dragon', I told myself. Of this I was sure: I definitely preferred to be of some help than stay at home, waiting for the next shake. But as I was putting together an emergency bag, I wondered about what tools I could bring within myself, and whether I would be able to exploit my professional skills and experience in such an exceptional situation.

I have been working for three years within a collaborative project addressing the mental health of political refugees and torture victims. Under the supervision of Marco Mazzetti, we studied how to deal with torture, war and violence (Mazzetti, 2010), as we felt that our standard training in psychiatry was insufficient in this regard. The earthquake, I told myself, may be a little like that: like a dragon, an external enemy, violent and unpredictable. In those few hours, before I reached the meeting point, my experience with refugees allowed me to pack my bags more appropriately.

In people affected by torture, as well as by earthquakes, an external action produces objective psychological reactions than cannot be interpreted in terms of individual, intrapsychic conflict. This external action undermines one's own foundations of being: victims no longer feel at home with their own thoughts. What is left is a human being bared of complexity and affectivity, at the mercy of ancient traumas awaken by the shock. Their experience, as I collected it in small-talk on the grass around the ruins, was that of being attacked, violently attacked in their physical and psychic identity.

So I worked to return to people their integrity and sense of self-determination, to differentiate the parts within them that had become powerless from those that were still functioning, to let them expel the invading and destructive presence of the earthquake, as if it were a torturer. I had to act quickly, to 'go into the belly of the dragon', right inside, to stop the colonising process of fear within the territories of free self-determination. By picturing the earthquake as a torturer, I found the right attitude to get in touch with both the injured and the resilient portions of self of those who needed my help. Just as with torture, we can speak of the earthquake as a living scar of something that is no longer here.

That journey, those 40 kilometres, were like a round trip through a time portal into another dimension, one which felt even more real than reality itself.

Eleonora Bertacchini (with Licia Masoni and Silvia Ferrari)

Department of Psychiatry, University of Modena and Reggio Emilia, Modena, Italy, email silvia.ferrari@unimore.it

Mazzetti, M. (2010) Eric Berne and cultural script. *Transactional Analysis Journal*, **40**, 187–195.

Substance misuse and mental health in Guernsey, Channel Islands

Sir: Since moving from London to take up my first substantive consultant position in one of the Channel Islands, I have been reflecting on the challenges and opportunities that working in such a setting provides. Guernsey is a small island

about 55 km (35 miles) from the Normandy coast, which is legally and financially independent from the UK and the European Union but is a British Crown Protectorate. Its total area is 65 km^2 and its population 62 000.

Working within a small service in a discrete, largely coastal community has allowed me to see and manage a far wider range of psychiatric and addictive conditions than I would working in inner-city psychiatry and to work more closely with multidisciplinary colleagues. Often we hear early on about a patient's relapse, which allows for early intervention. However, a community grapevine poses challenges for clinical confidentiality and may also entrench stigmatised attitudes to mental illness and addiction. Working as a consultant with a specialist interest in drugs and alcohol, I was interested to find there is little heroin available on the island, largely due to a highly effective border agency, and that, as a result, people dependent on drugs tend to misuse mostly prescription medication (either diverted or imported). A 2011 audit revealed that 96% of Guernsey drugs clients in treatment reported misuse of prescription-only medication (POM), compared with about 16% in the UK. Compared with inner-city heroin users, it can be clinically challenging, for example, to estimate total opiate intake when patients report use of up to five or six types of opiate over 2–3 days, depending on availability. There was a surge in the use of 'legal highs' (emerging drugs of concern, or EDOC), with an increase in admissions for drug-induced psychosis, until these were made illegal in 2008. Because these substances come in an ever-changing variety of chemical formulations, it is challenging to keep abreast of their neuropsychiatric manifestations, and to test for their use in routine drug screening. For the first time in Guernsey, a joint strategic needs assessment is being undertaken with expert UK partners, which will allow for an independent review of current drug treatment services and service gaps.

These challenges represent opportunities for a creative psychiatrist. There is immense potential for both service development and research within a stable, relatively homogeneous population, often with multiple family generations available. Discrete populations may offer improved follow-up and novel research approaches. One example is the piloting of a primary care psychological service embedded within general practice, which appears to have reduced inappropriate referrals to secondary care and has possibly reduced high levels of antidepressant and benzodiazepine prescribing.

To address the risks of professional isolation, Guernsey is working actively to build clinical, academic and professional relationships with National Health Service trusts in the south of England. On a personal level, I have been privileged to join a peer group for the purposes of continuing professional development, based in Bristol. In addition to ensuring that I keep my skills and knowledge up to date, the group provides a useful reflective and comparative space. Guernsey is refreshing its local psychiatric academic programme and I would welcome contact from potential guest speakers or partners worldwide.

Dr Greg Lydall

Consultant psychiatrist, Castel Hospital, Guernsey, email greglza@yahoo.co.uk

Discovering new horizons

Sir: The third meeting of the Young Psychiatrists (YPs) Network of the European Federation of Psychiatric Trainees (EFPT), 'Stigma from the YPs' perspective: hopes and challenges', took place in Minsk at the end of September 2012. It gathered 74 early-career psychiatrists from 21 countries, ranging from Portugal and the UK in the west to Armenia and India in the east. The meeting was set to tackle one of the most challenging problems of modern healthcare – the stigma attached to psychiatry, its patients and professionals. The programme included not only lectures by senior psychiatrists but also workshops, run mainly by young specialists themselves. They provided a forum for discussions about stigma and other relevant topics. A much-appreciated part of the programme in previous meetings was the discussion of 'tricky cases'. This session allowed participants to compare diagnostic and treatment approaches between countries and to gain valuable insight from world-renowned experts. Another attractive feature of the programme was the opportunity to deliver a presentation on any interesting topic during the participant-generated session called Barcamp. Patients contributed to the conference with an exhibition of paintings and a musical concert which took place during a study visit to the local hospital.

The YPs Network started in 2010 in Vilnius with its first meeting supported by the Swedish Eastern Europe Committee (SEEC). The second meeting took place in Riga in 2011 with the support of the World Psychiatric Association and the SEEC. In 2012 the meeting was arranged in cooperation with the EFPT in line with its goals of improving psychiatric training in Europe (Kuzman *et al*, 2012) and was supported by the Ministry of Health of the Republic of Belarus, the Belarusian Medical Academy of Postgraduate Education (BelMAPGE) and the Belarusian Psychiatric Association (BPA).

Every year this unique event attracts more attendants. The main aims of the meetings are to exchange experience of practising psychiatry in different parts of Europe, to allow early-career doctors to develop an international peer-support network, and to inspire collaboration and the development of joint projects (Bendix *et al*, 2011).

At the end of the conference anonymous evaluation surveys were distributed and 52 were returned. The meeting was evaluated positively by all. Large majorities of the respondents anticipated future positive influence of the meeting on their professional (81%) and personal (88%) career.

Participants and organisers wish to continue with future meetings and are happy to welcome

other early-career psychiatrists to the Network, who can join at any time. Stronger cooperation will enrich both the Network and the programme.

Further information is available at http://ypsnet.org

Olga Paravaya,[1] Dmitry Krupchanka,[2] Nikita Bezborodovs,[3] Marisa Casanova Dias,[4] Maria Navadvorskaya,[2] Marie Bendix[5] and Agnieszka Butwicka[6]

[1]Republican Research and Practice Centre of Mental Health, Minsk, Belarus, email olgaparavaya@gmail.com; [2]Belarusian Medical Academy of Postgraduate Education, Minsk, Belarus; [3]Riga Stradins University, Riga Centre of Psychiatry and Addiction Disorders, Latvia; [4]Department of Mental Health Sciences, University College London, UK; [5]Karolinska University Hospital, Huddinge, Stockholm, Sweden; [6]Department of Child Psychiatry, Medical University of Warsaw, Poland

Bendix, M., Paravaya, O., Kochetkov, Y., *et al* (2011) Young psychiatrists' meetings in Eastern Europe – networking for the development of psychiatric training, education and service. *World Psychiatry*, 10, 239.

Kuzman, M. R., Giacco, D., Simmons, M., *et al* (2012) Psychiatry training in Europe: views from the trenches. *Medical Teacher*, 34, e708–717.

Africa and the World Health Organization

Sir: It was disappointing to see that Africa was missing from the summaries of the mental health activities of the World Health Organization (WHO) in the thematic papers in *International Psychiatry*'s November 2012 edition, as this does not reflect the tremendous work that is being done on the continent by the WHO, governments and other groups.

Africa, which in WHO Regions mainly refers to sub-Saharan Africa, is estimated to have a mental health treatment gap of 85%, which of course constitutes a major barrier to the fight against poverty. It is therefore appropriate that during the development of the WHO's Mental Health Gap Action Plan (mhGAP), significant attention was paid to ensuring the practical translation of the evidence on which it was based, so that it would be appropriate to the typical African context. This has started to bear fruit, with several large-scale mhGAP-based programmes taking root, for example in Ethiopia, Sierra Leone and Nigeria, and its use as an advocacy and teaching resource following local contextualisation. Africa also provided a strong voice in the campaign to include mental health in the United Nations High-Level Meeting on Non-Communicable Diseases, discussed by Vijay Ganju in Guest Editorial in the same issue (pp. 79–80).

There has also been a recent strengthening in research, which has become increasingly focused on the particular needs of Africa. The *African Journal of Psychiatry*, *International Psychiatry's* sister publication, has provided an important platform for dissemination. This is essential, given the scarcity of research focused on African needs, and has contributed to an increase in resources for advocacy, for example to increase government prioritisation of mental health and its mainstreaming into other sectors. The PRIME programme, for instance, is starting to produce excellent policy briefs that help to make research evidence available for advocates (see http://www.prime.uct.ac.za).

Of course, there is much to do, but there is no doubt that Africa has taken significant steps to address its mental health treatment gap and made an important contribution to global mental health in recent years, and this should be acknowledged.

Julian Eaton

CBM Mental Health Advisor, Lomé, Togo

Contents of the *Arab Journal of Psychiatry*

(affiliated journal)
Volume 23 Number 2 November 2012

Autism

87 **Concept, diagnostic criteria and classification of autistic disorders: a proposed new model**
Khalid A. Mansour

108 **Prenatal and perinatal risk factors in autistic disorders**
Ilham Khattab Al-Jammas, Rabei M.Y. AL-Dobooni

Schizophrenia

115 **Antipsychotic polypharmacy among Arab patients with schizophrenia**
Mostafa Amr, Tarek Tawfik Amin, Dahoud Al-Raddad, Ahmed El-Mogy, GianlucaTrifirò

122 **Quality of life for people with schizophrenia: a literature review**
Amira Alshowkan, Janette Curtis, Yvonne White

Original papers

132 **Psychiatric aspects of polygamy in Jordan**
Walid Sarhan

138 **The prevalence of mental health symptoms among outpatients in the United Arab Emirates**
Jane Lawton, Sabrina J. Schulte

Psychology

148 **Cross-sibling attachment styles and marital satisfaction among married Lebanese**
Souha Bawab and Shahé S. Kazarian

159 **Validation of the Arabic translation of the Multidimensional Scale of Perceived Social Support (Arabic-MSPSS) in a Lebanese community sample**
Rana Merhi and Shahe S. Kazarian

169 **Socio-demographic factors predicting perceived parenting styles: implications for counselors**
Abdul-Kareem M. Jaradat

Case report

175 **Asneezia – a medically unexplained symptom and abnormal illness behavior: review of literature and a case report**
Santosh K. Chaturvedi, Geetha Desai, Manoj K. Sharma

World report

178 **The World Federation for Mental Health: Building its constituency in the East Mediterranean Region for improving care and the lives of the mentally ill and their families**
Mohammed T. Abou-Saleh

History

185 **Avicenna's no health without mental health**
Abdi Sanati, Mohammed T. Abou-Saleh

Forthcoming international events

4–7 March 2013
5th World Congress on Women's Mental Health
Lima, Peru
Organiser: International Association for Women´s Mental Health
Website: http://www.iawmh2013.com

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

14 March 2013
Mental Health: From Strategy to Reality
Manchester Conference Centre, UK
Website: http://www.publicserviceevents.co.uk/programme/241/mental-health

21–23 March 2013
22nd Annual Conference of the International Association for Forensic Psychotherapy (IAFP)
Konstanz, Germany
Website: http://www.forensicpsychotherapy.com

26–27 March 2013
RSM Global Health – The World in Denial: Global Mental Health Matters
London, UK
Organiser: Royal Society of Medicine
Website: http://www.rsm.ac.uk/globalhealth/society.php

6–9 April 2013
EPA 2013: 21st European Congress of Psychiatry
Nice, France
Organiser: European Psychiatric Association
Website: http://www.epa-congress.org
Email: reg_epa2013@kenes.com

18–21 April 2013
9th International Congress on Mental Dysfunction and Other Non-Motor Features in Parkinson's Disease and Related Disorders
Seoul, South Korea
Website: http://www2.kenes.com/mdpd

24 April 2013
Dementia: A National Crisis
Harrogate, UK
Website: http://www.publicserviceevents.co.uk/programme/244/dementia

16–18 May 2013
57th Annual Meeting. Psychodynamics: Essential to the Issue of Suicide and Other Challenges to Modern Day Psychiatry
San Francisco, USA
Organiser: American Academy of Psychoanalysis and Dynamic Psychiatry
Website: http://aapdp.org/index.php/new-meetings

18–22 May 2013
American Psychiatric Association Annual Meeting
San Francisco, USA
Organiser: American Psychiatric Association
Website: http://www.psych.org/annualmeeting

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
21st World Congress for Social Psychiatry. The Bio-Psycho-Social Model: The Future of Psychiatry
Lisbon, Portugal
Website: http://www.wasp2013.com

2–5 July 2013
Royal College of Psychiatrists International Congress 2013
Edinburgh, UK
Organiser: Royal College of Psychiatrists
Website: http://www.rcpsych.ac.uk/traininpsychiatry/eventsandcourses/internationalcongress2013.aspx

Contents of the *African Journal of Psychiatry* (affiliated journal)

Volume 15 Number 6 November 2012

Guest editorial

370 **A milestone for mental health in South Africa**
G. Ramokgopa

Articles

402 **Mental health services in South Africa: taking stock**
C. Lund, I. Petersen, S. Kleintjes, A. Bhana

407 **The Mental Health Care Act No 17 – South Africa. Trials and triumphs: 2002–2012**
S. Ramlall

417 **Developing the philosophy of recovery in South African mental health services**
J. S. Parker

420 **Integrating mental health into general health care: lessons from HIV**
J. A. Joska, K. R. Sorsdahl

424 **Addressing psychosocial problems among persons living with HIV**
A. Kagee

427 **Psychiatry and mental health research in South Africa: national priorities in a low and middle income context**
D. J. Stein

432 **Research in lower middle income countries – recommendations for a national mental health research agenda in South Africa**
J. Chipps, S. Ramlall

436 **Suicide prevention: a proposed national strategy for South Africa**
L. Schlebusch