

International psychiatry

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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.

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Using the lever of parity of esteem between mental and physical health to close the mental health gap – a call for action

Sue Bailey,¹ Lucy Thorpe² and Greg Smith³

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This paper provides a six-point definition of what parity of esteem for mental health means in practice. It highlights examples of the current disparity between mental and physical health and the importance of redressing this. The significance of securing a legislative basis for parity in England is discussed. The authors make a call for action, and pose six questions for international readers to consider and respond to.

A Man's body and his mind, with the utmost reverence to both I speak it, are exactly like a jerkin, and a jerkin's lining; –rumple the one – you rumple the other. (Laurence Sterne, *The Life and Opinions of Tristram Shandy, Gentleman*, 1761)

'The overarching principle of the parity movement is equality – in access to care, in improving the quality of care, and in the way resources are allocated' (Fritz & Kennedy, 2012). In practice, parity between mental and physical health means (Bailey *et al*, 2013):

- equal access to effective, safe care
- equal efforts to improve the quality of care
- the allocation of resources on a basis commensurate with need
- equal status within healthcare education and practice
- equally high aspirations for service users; and
- equal status being given to the measurement of health outcomes.

Since the mid-20th century, most nations have signed many accords establishing that the provision of health is a fundamental human right. Health for all should be not only an aspirational target but also an essential framework for the United Nations system (Garrett *et al*, 2009).

We are potentially at the cusp of a new era in mental health. (Ganju, 2012)

There can be no health – and no public health – without mental health. The reported annual prevalence rate of mental health problems is as high as 38% (Wittchen *et al*, 2011), with mental disorders making up 13% of the disease burden and with a treatment gap of anything up to 80%.

So why doesn't mental health receive the attention it deserves? Mental health problems affect every part of every country, rich and poor, across

the lifespan, children, parents and grandparents, those who work and those who cannot, people with physical disabilities and those with none. It undermines the welfare of any nation and is an economic challenge, holding back prosperity. Quality of life is even more important in hard economic times, yet mental illness still remains a taboo across and within cultures. It is instinctively avoided at home, in the workplace and out in the community. When we are young, teachers and parents are unlikely to talk to us about mental illness. We all fear the unknown.

We, as mental health professionals, must shoulder some of the responsibility for failing to speak with one voice to policy makers about the potential of 'mental health global' to improve the health, well-being and resilience of populations.

What happened in England – using the power of legislation

In England mental illness represents 22.8% of the disease burden (in terms of disability-adjusted life-years, or DALYs) and accounted for 11.1% of the 2010/11 budget of the National Health Service (NHS). By way of comparison, diabetes represents 1.8% of the disease burden but accounted for 1.5% of the 2010/11 NHS budget (World Health Organization, 2004; Department of Health, 2011). Common mental disorders have 24% treated prevalence, diabetes 94% treated prevalence (Ormel *et al*, 2008; McManus *et al*, 2009). Stigma and discrimination significantly contribute to the treatment gap (Thorncroft, 2008). Among people with a diagnosis of depression, 8 out of 10 report discrimination in at least one area of their lives (Lasalvia *et al*, 2013). A review of the 2004/05 research portfolios of the largest UK funders of health research indicates that mental health research received 6.5% of total funding, compared with 25% for cancer, 15% for neurological diseases and 9% for cardiovascular diseases (UK Clinical Research Collaboration, 2006).

Health professionals, including psychiatrists, were in the main opposed to the recent reform of the NHS in England. However, we used this reform as a lever to start to bring about parity, through laying bare the facts, lobbying and working with other key stakeholders and patients and carers. In consequence, included in the Health and Social Care Act 2012 (available at <http://www.legislation.gov.uk>) is the statement:

the Secretary of State must continue the promotion in England of a comprehensive health service designed to secure improvement –

- (a) in the physical and mental health of the people of England, and
- (b) in the prevention, diagnosis and treatment of physical and mental illness.

Securing a legislative requirement for mental health to have parity with physical health offered us the opportunity we needed to drive changes in professional training and practice, attitudes and priorities in order to address the continuing inequities in healthcare provision experienced by those with mental illness.

A call for action

We need to promote a prevention paradigm mind shift. A review of research shows that half of all lifetime cases of diagnosable mental illness, other than dementia, have begun by the age of 14 (Kessler *et al*, 2007; Shiers & Kendall, 2012). There is evidence that improved availability of early-intervention services for children and for young people could prevent up to 50% of mental illness (Kim-Cohen *et al*, 2003).

We need to prevent people from dying prematurely when they have mental illness.

We need to enhance the quality of life of people with long-term conditions across psychiatry, neurology and geriatric medicine.

We need to help people to recover from episodes of ill health and to ensure that people have a positive experience of the health services provided in any country.

We need to treat and care for people in a safe environment and to protect them from harm.

We need to play our part as professionals to promote innovative ways to integrate care, and to engage with patients and their families.

Specific challenges and emerging solutions

Many of the causes of the premature mortality and excess morbidity associated with mental illness – for example smoking and obesity, which, for a combination of reasons, are both common among people with mental illness – are avoidable (Thorncroft, 2011). Why are people with mental illness less likely to be offered smoking cessation interventions, despite being more likely to smoke than people without mental illness and being just as motivated to quit (Phelan *et al*, 2001; Siru *et al*, 2009; McManus *et al*, 2010)? We can bring about change, for example by improving the cardiovascular health of young people with severe mental illness, thereby addressing an epidemic within an epidemic (Bailey *et al*, 2012).

Psychiatrists as leaders for change

Psychiatrists as doctors should lead in enabling zero tolerance of discrimination, comprehensive mental health training for all healthcare staff, the promotion of direct contact with service users which destigmatises mental illness, and the adoption of an approach based on human rights

(Pettigrew & Tropp, 2006), with a focus on equality, dignity and respect (Curtice & Exworthy, 2010). This can also improve clinical outcomes. Systemic underrepresentation should be measured by comparing actual service usage with population incidence and demography; also, a recovery ethos should be adopted in all the work we undertake.

In conclusion

The long-standing and continuing lack of parity between mental and physical health remains inequitable and socially unjust. It breaches the fundamental human right of people with mental health problems to the highest attainable standard of health. The poorer outcomes that result are considered by many, both within and outside mental healthcare, to be all that can be expected. To tackle this we need to move beyond the field of mental health legislation and look for opportunities across all legislation as it relates to education, social care, employment, justice and minority rights.

For example, the United Nations Committee on Economic, Social and Cultural Rights in its most recent report on the UK's adherence to the Convention on Economic, Social and Cultural Rights states that, in relation to article 12 – the commitment to recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health – people with mental health problems experienced 'significantly poorer health conditions' than those without (United Nations, 2009, p. 9).

At a global level, the recent 65th World Health Assembly highlighted the global scale of mental health problems and the need for a comprehensive, coordinated response from health and social care sectors at the country level. That response was to include 'equitable access to affordable, quality and comprehensive health services that integrate mental health into all levels of the health-care system' (World Health Assembly, 2012).

A rallying call for a worldwide parity approach can deliver healthier nations with improved well-being but, more importantly, those with physical and mental health problems will be able to sustain and maintain resilience to cope with whatever adversity life throws at them. This is achievable through interventions that can save money, in both the short and the longer term, and this should be music to the ears of ministers of finance, health, justice, education, and employment (Knapp *et al*, 2011).

To progress this work, we are asking all readers to respond to the following questions, in relation to your country and area of expertise:

- What is your view of the main challenges involved in achieving parity between mental and physical health? (These might include a lack of understanding of the concepts, direct opposition to the concepts, stigma, cultural issues and patients' and carers' experiences of physical health specialists.)
- Could you provide us with real examples of good parity initiatives from your country,

including but not confined to vulnerable groups of patients, or within the population?

- Have you experienced any particular legislative barriers or enablers in relation to parity, beyond health legislation? (Examples might include welfare reform, the criminal justice system, education, immigration and asylum.)
- From your perspective, what does 'good' look like? (For example, people with mental health disorders would have the same physical health outcomes as people without them.)
- What are the organisational barriers and enablers, whether in local government or in your part of the healthcare system?
- What, in your view, are the financial, cultural, structural, educational (undergraduate/post-graduate/continuing professional development, etc.) and technological implications of delivering parity of esteem for mental health?

Please address your responses to Greg Smith (gsmith@rcpsych.ac.uk). Together we can make a difference.

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THEMATIC
PAPERS

Conflict and mental health in North Africa and the Middle East

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Conflict in the Middle East and in North Africa has consistently made headlines over the past 2 years for one reason or another. Yet despite the extensive coverage of slaughter and mayhem, little has been said about the destruction of the infrastructure

supporting medical services, and even less about the psychiatric consequences of conflict. There is growing evidence of deteriorating mental health of the general population in affected countries, among both those who stay and the burgeoning

refugee diaspora. Even worse, in some ways, is the abandonment (or even the targeting) of psychiatric patients, whose hospitals have been destroyed and whose carers have long since fled. In this issue we review the crisis in three countries affected by civil war: Libya, Syria and the Sudan.

Libya went through a convulsive, although relatively brief, civil war that began in February 2011 and ended in October of that year. As Dr Abuazza writes, decades of neglect had left the mental health system in that country in bad shape. There are now just two functioning psychiatric hospitals. The impact of the civil war was to drive many doctors out of the country and few mental health professionals remained to cope with patients. Although matters are beginning to turn around for the better, those seeking help have not only overwhelmed services in those hospitals but they have spilled over into neighbouring countries too, such as Egypt.

Drs Abou-Saleh and Mobayed report on the conflict in Syria, a situation that has persisted now since March 2011 and shows no sign of abating.

General medical care has suffered terribly. The authors report that children in particular are affected, because armed groups (especially government forces) have specifically targeted them. Post-traumatic stress disorder (PTSD) could be a problem for up to 60% of adults and an even higher proportion of children. Active destruction of psychiatric facilities has been witnessed.

Finally, Drs Ali, Saeed and Sultan give us an account of the outcome of 22 years or more of conflict in Sudan, where the effects of civil war have been compounded by famine. The proportion of the population affected by PTSD is similar to that in Syria, studies suggest, but in other respects the situation differs from that in Middle Eastern states, perhaps especially in the south. There is a cultural reluctance to acknowledge the extent of mental health problems, because of the stigma. Spiritual healers still play a major role. Yet, as in Libya and Syria, there is a growing call for help from the international community to provide mental health management, both to those within the country and to the refugee populations across borders.

CONFLICT AND MENTAL HEALTH IN NORTH AFRICA AND THE MIDDLE EAST

The Arab Spring movement: a catalyst for reform at the psychiatric hospital in Tripoli, Libya

Adel Abuazza



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The assistance of Dr Fahmy Bahjat, mental health consultant to the World Health Organization mission in Libya, in the preparation of this paper is gratefully acknowledged.

Decades of neglect have left the mental health system in Libya in bad shape. Services for the entire population are scarce, highly centralised and provided only through two psychiatric hospitals in the two biggest cities of the country. There are virtually no other mental health services anywhere else in Libya. Even the most basic of services, such as the availability of psychotropic medication for people with severe mental illness, are scarce outside Tripoli and Benghazi. This paper reviews the state of the country's mental health services since the civil war of 2011 and highlights a new fourfold approach taken by the management of the psychiatric hospital in Tripoli.

A major problem faced in Libya in relation to the country's mental health services is that the two main psychiatric hospitals, in Tripoli and Benghazi,

have their own limitations, especially a shortage of doctors. This shortage has arisen largely because, during their medical training, students in Libya no longer receive education in psychiatry as part of their curriculum; there are various reasons for this situation in different universities across the country. Also, there is no postgraduate training scheme for psychiatry as a specialty. This lack of an infrastructure for psychiatry as a specialty discourages graduates from working in the field as trainees or consultants. Unfortunately, psychiatric nurses, psychologists and social workers are in no better position. There are no specialist training programmes and they receive no clinical training as part of their education. All these limitations have contributed to a situation in which there are very limited human resources and service provision in mental health.

The lack of psychiatric care was a challenge even before the liberation of Tripoli in 2011. During the

internal conflict the weaknesses of the system were exposed by traumatic events; moreover, there was a flood of people with experience of significant psychological and social suffering. The civil war led to a substantial increase in the numbers of new patients as well as a relapse in the condition of former patients whose condition had been stabilised before the fall of the Gaddafi regime.

The Benghazi and Tripoli psychiatric hospitals represent the cornerstone of the country's specialist mental healthcare. They were opened about three decades ago, with approximately 200 beds each. They were established with a view to treating and caring for all people with various mental health disorders across the whole country. There are no other public mental health services, apart from a few satellite clinics (reportedly totalling four); there is questionable availability of mental health professionals and psychotropic medications outside of the psychiatric hospitals. There are no private psychiatric hospitals.

The buildings and the grounds at the Al Razi psychiatric hospital in Tripoli have not been well maintained. The furniture and equipment are in an unacceptable condition. Most of it has not been repaired or replaced for many years. This situation is not supportive of the proper care and rehabilitation of patients. Patients attending Al Razi hospital represent 60–70% of all mental health service users in Libya. Many other patients attend services in neighbouring countries (principally Egypt and Tunisia).

No rehabilitation programmes exist at either psychiatric hospital for patients on the wards; there are few if any activities to fill the patients' days. There is limited communication with staff, and little contact with the outside world. Management of patients relies mainly, and at most of the times of the day, on the use of medication and maintenance regimes. Where patients remain in hospital over many years they should be encouraged to participate in activities of daily living and self-care, as such rehabilitation regimes are essential to avoid institutionalisation and the loss of hope they might have that eventually they will be able to live a proper and useful life outside the hospital. Even the hospital staff are demoralised.

Innovation in response to crisis

During 2011 there was a flow of hundreds of people with war-related psychological symptoms to the limited mental health facilities. There were many reports across the country that service providers were not able to cope with the urgent needs because of deficient human resources and the lack of a suitable care system. Due to the overwhelming situation, which was unique in many ways, the management at the psychiatric hospital in Tripoli instituted major reforms in the first 6 months following the liberation of Tripoli in August 2011, against all the odds.

They took a fourfold approach: improving the basic services at the hospital: initiating a capacity-building programme; introducing a rights-based

approach to mental health practice; and establishing a community-based approach to services.

Improving the basic services at the hospital

The management at Al Razi hospital established a new department for patient care. The main task for this department was to create hospital policies, procedures and guidelines, and to implement a new system for documentation, including medical records. It also implemented critical incident review and analysis.

A new department for hospital renovation and development was established. This was tasked with providing rapid renovation of the hospital and with taking the appropriate measures to ensure staff and patients adapted to these changes, while making sure that service interruption was avoided whenever possible.

An information technology department was introduced. This was something the hospital had been deprived of for decades. The amount of work accomplished by this department was extensive. One of its major achievements was the installation of closed-circuit television (CCTV) cameras in all the hospital departments to reduce the impact of low staffing; it also helped the nursing staff to observe the patients. Previously, the layout of the buildings prevented patients being visible to the staff. This surveillance system has minimised the number of in-patient critical incidents. A photo identification system was established for all hospital staff, which can be used to access doors, the internal intranet and the telephone network. Also, a pager system was introduced to facilitate staff communication. These achievements had a beneficial impact upon the care of both out-patients and in-patients.

A new multidisciplinary team approach to patient management was introduced, in which medical staff were divided into three units, each led by a consultant psychiatrist.

A new out-patient department was opened with large waiting areas for patients and several interview rooms. The task of renovating and running the out-patient department was given to a group of motivated nursing staff. Patient feedback reflected great satisfaction with these changes.

An additional temporary acute admissions unit with 20 beds was opened to cope with the large number of patients with acute presentations requiring admission. This unit was closed after the crisis had been dealt with.

A new rehabilitation unit was opened, with 40 beds, attached to a new occupational therapy department. The rehabilitation unit supports the transfer of long-stay patients from the acute admissions unit.

A subacute unit of 16 beds was opened, with a gym and physiotherapy unit; it was designed to facilitate the rehabilitation of patients into the community following an acute admission.

The 40-bed acute admissions unit was renovated and seclusion rooms were constructed according to

international standards, to replace the malpractice of restraining patients who had become aggressive.

The establishment of several new departments has solved some of the problems of service provision but has also created pressure because of the need to staff these units. The problem was partially addressed through the employment of 50 new nursing staff and more than 50 new care assistants.

The capacity-building programme

The hospital recruited 23 new doctors, who signed contracts and started working as trainees in psychiatry. Five have gone on to pass the first part of the Arab Board examination in psychiatry.

An agreement was made to link to regional excellence centres for capacity-building programmes, which support study tours in neighbouring countries. A programme of twinning Libyan hospitals with other psychiatric hospitals in the region has now been running for over 6 months.

Visiting professors and trainers were invited back to the country, including expatriate Libyan mental health professionals. The World Health Organization has supported training within the hospitals. Short courses have been established both for general doctors and for the team working at the hospital, to bridge the gap in human resources.

In order to get psychiatrists from all over the country together, the hospital has supported the establishment of a professional organisation, the Libyan Psychiatric Association; previously psychiatrists came under the Libyan Neurology Association. Furthermore, the Libyan Board for Psychiatry Training is now in the process of establishment and official training in psychiatry is expected to begin in 2014.

Introducing a rights-based approach to mental health practice

The malpractice of administering electroconvulsive therapy (ECT) without anaesthesia was

stopped and it is given now only with general anaesthesia. Guidelines on the use of seclusion and restraint have been drawn up. Seclusion rooms have been introduced, based on international standards, to replace physical restraints.

Patient complaints are now collected and reviewed by dedicated staff.

A community-based approach to services

Teams at the hospital supported the launch of the first psychiatric out-patient department at the Tripoli central hospital. Outreach services have been started to support local prisons, as well as centres for people with intellectual disabilities and a nursing home for elderly people.

In order to open up the hospitals to the community, a day care unit has been established. This is designed to provide services for in-patients; here, they can learn new skills away from the hospital culture. Other service users from the community together with family members will become involved too, thus bridging the former gulf between the community and the hospital.

Conclusion

All these reforms at the hospital are associated with a larger and more ambitious reform process in the national mental health system in Libya, which is supported by the World Health Organization in partnership with the Libyan Centres for Disease Control and Ministry of Health. This process was initiated in late 2011, and includes the introduction of capacity-building programmes for multidisciplinary professionals, initiating community mental health services, supporting mental health and launching advocacy and awareness programmes for mental health such as ongoing training for general practitioners, psychologists and social workers.



CONFLICT AND MENTAL HEALTH IN NORTH AFRICA AND THE MIDDLE EAST

Mental health in Syria

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This paper begins by outlining the nature of the present conflict in Syria. It goes on to describe the psychological consequences of this conflict and the present state of the mental health services in the country.

The Syrian conflict

Syria has been in a state of conflict for over 2 years. What started as a civil protest against decades of oppression and human rights violations by the Syrian regime rapidly escalated into a humanitarian and

public health catastrophe. The brutal actions of the Syrian regime have continued since March 2011, with the United Nations (UN) reporting in January 2013 that there had been over 60 000 people killed (including 4084 children, 3986 women, 1405 protesters killed under torture, plus an unknown number of soldiers) (Price *et al*, 2013a; updated as Price *et al*, 2013b, with an estimate of over 90 000 people killed). There are more than 60 000 people who are missing, over 200 000 who have been arrested and over 137 000 who have been critically injured or disabled. Two million people have been displaced, both within but especially outside the country, to camps in Jordan, Lebanon and Turkey, with little prospect of returning soon.

A delegation to Syria from the UN Office for the Coordination of Humanitarian Affairs found that 35% of hospitals, 10% of health centres and 40% of the country's ambulances had been severely damaged (Amos, 2013). In major cities such as Aleppo, Hama and Homs, the public health systems have collapsed: disease registration and vaccination programmes have stopped and many qualified doctors have fled the country. Only very basic health services exist in the refugee camps of Lebanon, Jordan and southern Turkey, and some camps have no health services at all. Journalists have reported children dying from exposure to cold and a lack of medical care for physical injuries caused by armed conflict (Coutts *et al*, 2013).

A crisis report from the United Nations Children's Fund (UNICEF), *Syria's Children: A Lost Generation?*, indicated that of the 4 million affected people inside Syria, almost 2 million are children, and of the 2 million who have been displaced outside the country, 800 000 are children (UNICEF, 2013). Children have been exposed to grave human rights violations, including killing and maiming, sexual violence, torture, arbitrary detention, recruitment and use by armed forces and groups, and exposure to the explosive remnants of war. Basic infrastructure and public services are being systematically destroyed. Families are struggling to survive in increasingly desperate conditions. One in every five schools in Syria has been destroyed, damaged or converted into shelters for displaced families – disrupting schooling for hundreds of thousands of children (UNICEF, 2013).

There has been a tremendous amount of destruction; reports say that some towns and villages have been completely demolished, and the economic cost of the conflict has been estimated at hundreds of millions of dollars.

The psychological consequences of the conflict

There are no published studies on the impact of the conflict on mental health in Syria. A study by one of the authors (Mobayed, in preparation) of a random sample of 228 Syrian men and women aged between 18 and 65 years, selected from two camps, who had been exposed to the conflict, reported prevalence rates of post-traumatic stress disorder (PTSD) across the camps from 36.3% to

61.9%. Exposure to fighting and hostility and a history of trauma before the current conflict were the main predictors of current symptoms of PTSD.

The study also involved 129 Syrian children aged 10–16 years from two camps. The number of traumatic experiences related to conflict was positively correlated with PTSD symptoms, and the prevalence of PTSD among the children was higher than among adults, at 41.3–76.4%.

A survey of 300 Syrian refugees in four camps in southern Turkey reported the prevalence rate of PTSD to be 61%, morbid anxiety 53% and morbid depression 54% (Marwa, 2012). These results are similar to the findings of studies of the mental health consequences of conflict in Palestine and Lebanon. For instance, a Lebanon study reported that, 20 years after the war, PTSD-related chronic diseases and physical symptoms were associated with a greater engagement in risk behaviours (Saab *et al*, 2003).

It was distressing to learn that the main psychiatric hospital of Ibn Khaldun in the suburb of Nayrab in the city of Aleppo was bombed on 25 December 2012; patients fled and were abandoned to their fate. Some were subsequently killed by snipers, according to local reports (see http://www.youtube.com/watch?v=_ynVqQ2vhuU). The Dar al-Ajaza psychiatric hospital in the Old City has also been bombed but remains in operation because of the dedication of its staff. The ancient mental hospital Bimaristan Argun dating to the 14th century AD, has also been damaged (see <http://archaeolife.blogspot.com/2012/10/destruction-of-bimaristan-argun-of.html>).

Mental health services in Syria

Syria is considered to be a lower middle-income country. It has predominantly residential mental health services, comprising two mental hospitals in Damascus and Aleppo (1200 beds in total). In addition, there is an addiction treatment centre in Damascus (30 beds), mental health departments in two military general hospitals and a psychiatric ward (with 12 beds) at Damascus University Hospital. Syria has two small private hospitals (Assalman *et al*, 2008). Community mental health services are rudimentary, comprising clinics in major cities, with the majority being private clinics. The number of mental health professionals is low (1 per 100 000 population), with very few specialists in child and adolescent mental health and other subspecialties.

Because there have been both massive destruction of health service infrastructure, including mental health services, and an increase in the prevalence of mental health problems as a result of the conflict, it is expected that mental health conditions will overwhelm services. In the future, most Syrians with mental health problems can expect no treatment or care.

Discussion and conclusion

The conflict in Syria, which is now in its third year, is almost unprecedented in the magnitude of

humanitarian and public health catastrophe. The *Lancet* stated in an editorial:

As if the direct effects of military force on Syrians were not enough, there has also been a full-scale assault on the health infrastructure. Even if Syrians are able to reach health facilities, which they often cannot because of ground fighting and erratic and unsafe transport, government forces have targeted health-care facilities, health workers, and patients intentionally, as described by independent observers such as Physicians for Human Rights, Amnesty International, and Médecins Sans Frontières. (Coutts *et al*, 2013)

It is very disturbing that the world has been witness to these atrocities but it has done so little to intervene. The *Lancet* rightly also stated:

A disturbing feature of modern conflicts and, indeed, the Arab uprisings, has been the flagrant disregard for the Geneva Conventions, including targeting of civilians, persecution of health workers, and attacks on hospitals, alongside the failure of the UN system to prevent these violations. The medical community may feel hopelessness in the face of these seemingly intractable situations. But there is much that it can do to monitor, report, and prevent the impact of conflict on the health of populations, as well as condemning attacks on civilians and breaches of medical neutrality. (Coutts *et al*, 2013)

The World Health Organization (WHO), as well as professional and humanitarian organisations, including non-governmental organisations (NGOs), has called attention to these challenges. The World Federation for Mental Health (WFMH), a global NGO, issued a statement in March 2013 on the mental health consequences of the complex emergency in Syria and made a call for action. Of major concern to the WFMH is that combatants on both sides of the conflict are generally ignoring the mental health consequences of the hardship and trauma created by violence and disruption. The WFMH called urgently for all parties involved, including the Syrian government and those contributing aid to support the conflict, to respond specifically to these issues and to consider the serious immediate and long-term mental health consequences of continuing armed conflict. Major humanitarian organisations that traditionally have not prioritised mental health should provide the means to support established organisations like the WFMH to expand training and services according to the *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* produced by the Inter-Agency Standing Committee (2007).

The overriding priority for mental health in Syria now is to determine the mental health burden and consequent service response needs

in relation to the conflict. A recent study in post-conflict Libya estimated the number of cases of severe PTSD and depression and related health-service requirements from the 2011 conflict there, and recommended mental health service targets (Charlson *et al*, 2012). When the conflict in Syria ends, what remains of the mental health services will be grossly insufficient to meet the predicted care needs. We call on national regional and international organisations to address these needs as part of the reconstruction of health services and to assist in providing skilled human resources for the suffering people of Syria.

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CONFLICT AND MENTAL HEALTH IN NORTH AFRICA AND THE MIDDLE EAST

Mental health and the civil conflicts in Sudan

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Sudan has endured the longest civil war in the history of Africa. The conflict between the northern (mainly Arab) and southern (mainly sub-Saharan African) populations started in 1983, and in its first phase continued for 22 years. The combination of civil war and famine has taken the lives of nearly 2 million people and displaced an estimated 4 million people from their villages and homes. This paper presents some data on the prevalence of mental disorder and the mental health service response to the situation.

Since July 2011, Sudan has been divided into two states, Sudan and South Sudan, following a peace agreement signed in 2005. However, since this separation, conflict has begun between the two countries for control of the town of Abyei, which sits within a disputed region, rich with oil, on the border between the two. A conflict had already started in the region of Darfur, lying in the far west of northern Sudan, in 2003, and has continued to this date. According to the United Nations (2007), over 2.5 million civilians have been displaced from Darfur and the death toll is variously estimated to lie between 200 000 and 400 000, including many women and children. Not only that, but other parts of Sudan have also been affected by the long and exhausting civil conflicts, with shortages of water and food, and ultimately widespread famine. Thousands of people have become refugees. The extended civil conflict and war have undoubtedly had a negative impact on the country's economy and consequently on the health services, including mental health services.

Prevalence of mental disorder

Studies have shown that the incidence rates of certain psychiatric conditions, notably depression and post-traumatic stress disorder (PTSD), substantially increased as a consequence of the civil conflicts in Sudan. For example, Roberts *et al* (2009) carried out a cross-sectional survey of a random sample of the general population in Juba city, the capital of South Sudan, with a sample of 1242 adults. Levels of exposure to traumatic events and the prevalence of PTSD were measured using the Harvard Trauma Questionnaire and the presence of depressive illness was measured using the Hopkins Symptom Checklist. Over a third (36.2%)

of respondents met the criteria for PTSD and more than half (58.7%) the criteria for depression.

A study of the impact of trauma on the Ngok-Dinka, the native people of South Sudan living in the town of Abyei, was conducted by Kush Inc. (Campbell, 2012). This survey reported that within the population displaced by the conflict, 38% overall, and 51% of women, met criteria for PTSD. We do not have any statistics about the prevalence of PTSD or of depression in the general population of Sudan before the conflict, but in the UK, by way of comparison, the lifetime prevalence of PTSD is just 1–9%, and that of depression 5.8%.

All people displaced as a consequence of conflict are affected by mental health problems to some degree, but women and children are more seriously affected. Kim *et al* (2007) carried out a study in January 2005 among six camps for displaced persons in Nyala District, Darfur. They used systematic random sampling to select 1253 women and asked them about their mental health and general health status as well as their opinions on women's rights. The investigators found that the prevalence of major depression was 31%. Women expressed concerns about their limited rights arising out of the constraints of marriage, lack of freedom of movement and limited access to healthcare. The study also found that 98% of women meeting criteria for depressive illness felt that counselling provided by international agencies would be the most helpful form of treatment. These findings confirm that the prevalence of mental illnesses such as depression increases as the result of civil conflict. They also stress the importance of counselling as a potentially useful treatment option.

Services

The mental health services in Sudan, before and during these conflicts, were lacking human and other resources to handle the high demand, and to date that position remains unchanged. Mental health services are not a priority for government, and their availability varies considerably from one region to another. In the capital Khartoum, in the east of Sudan, the situation is better than in other regions, because there are established psychiatric hospitals and mental health professionals in the capital.

In a report by the Sudanese Psychiatrists Association (2006), the following problems were highlighted:

- The prevalence, incidence, pattern and trends of mental illnesses are not adequately known due to limited sources of information.
- Mental health services coverage is low. Outside of Khartoum State, the service is limited to nine urban areas and services are almost absent at provincial and district levels; there is no coordination across centres.
- Mental illness still carries a social stigma and help-seeking tends to happen only at late stages of illness.
- Patients with psychiatric disorders consult spiritual healers first. Psychotropic drugs are not available at an affordable price. Children with psychiatric disorders are often taken to see paediatricians and general practitioners.
- Long-standing conflicts and political instability causing large-scale population displacement have resulted in an increase in immediate and future health hazards, particularly in populations who are living in temporary settlements.
- Some 150–200 qualified Sudanese psychiatrists have moved abroad, and this brain drain is a persistent and continuing problem.

What is needed now

In order to ensure there is sufficient and effective provision of mental health services to the population affected by the civil conflicts in all parts of Sudan, community surveys should be carried out, to determine the prevalence of different mental disorders and specific service needs. A holistic approach needs to be adopted to ensure delivery of efficient care packages to all affected individuals. Such care packages should take into consideration the basic needs of individuals, such as suitable accommodation, clean water, electricity and good ventilation. The physical health needs of the population must also be addressed adequately in order

to improve their mental health. Other needs, such as education, finance and a sense of security must be met to ensure a good response to any psychological help that can be offered. One suggestion has been to introduce mobile community mental health units to refugees in camps, to assess and address any mental health needs. Mental health professionals – psychiatrists, psychologists, social workers and nurses – should be present in each unit, with all the necessary resources to provide a community-based service. A local in-patient unit should be available for patients who need to be hospitalised.

Although various international organisations have been working hard to provide services for displaced persons and refugee populations in Sudan, there is still a significant gap between the services provided and actual demand. The situation is likely to deteriorate further following the outbreak of civil war in South Kordufan (in Sudan but close to the border with South Sudan) and the Upper Blue Nile regions (in South Sudan) in addition to the ongoing conflict in Darfur.

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Mental health law profiles

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Empires come and go. Both Hungary and Serbia were part of the Austro-Hungarian and Communist empires. Although these empires have gone, on the evidence of the reviews published in this issue, their legacy, in terms of culture, law and institutions, remains. The authors highlight that, on the negative side, this legacy includes stigma and the neglect of people with mental illness, although these are hardly exclusive to these countries.

Effective protection in law, including guaranteed access to mental health services, is an essential component of ensuring parity between physical

and mental illness. The contributions to this issue on mental health law profiles differ in focus, with Kurimay and Vizi focusing on such provision in law as exists at present and advocating change for the future, while Lecic Tosevski *et al* demonstrate the complexities of attempting to change the law, something that must always happen in political contexts and with political processes. In this context, the 'Enhancing social cohesion through strengthening community care' project as part of the Stability Pact for South Eastern Europe appears noteworthy.

Mental health law in Hungary

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There is no separate mental health act in Hungary and there has never been one. This paper gives some historical background and then summarises the legislation that relates to mental health.

History

In Hungary, Act XIV of 1876 on the restructuring of public health first addressed the issue of psychiatric patient care as a health and social services issue. This act stipulated that persons with mental disorders had to be placed in government-run asylums for the insane for medical treatment and care if they posed a public threat. The care of persons with incurable mental conditions who did not pose a threat to the public and had no personal wealth had to be financed by any relatives responsible for their care. If they had no such relatives, the relevant residential communities were required by law to provide social care for those patients.

Subsequently, the care given to psychiatric patients was regulated by decree-law 12 of 1966 on the medical treatment and care of persons with mental disorders, as well as decree 5 of the same year (X.1) of the Ministry of Health, which implemented statutory rule 12 of 1966 on the medical treatment and care of persons with mental disorders.

Separate rules applied to 'alcoholics', for example decree-law 41 of 1982 on the compulsory institutional treatment of alcoholics. In fact, regulations pertaining to alcoholics were significantly more extensive than the regulations pertaining to psychiatric patients. Similarly, psychiatric patients who committed criminal acts were the subject of more extensive regulation than non-forensic patients.

Act II of 1972 was the first act on healthcare under the socialist regime. Pursuant to this act, a medical board made a decision regarding compulsory treatment, the lawfulness of which was reviewed by a court. However, the head of the psychiatric department was entitled to place persons with mental disorders with a family who provided care for the patient and, if it became necessary, to transfer the patient back from the family to an institution. The 1972 act was replaced by the Healthcare Act of 1997, which is considerably more modern in its approach.

Mental health in current health law

The medical care of psychiatric patients is discussed only in chapter X of Act CLIV (on healthcare) of 1997 (Healthcare Act), but even it devotes merely 12 articles, 192 lines, to the issue. Chapter X sets

out special rules (*lex specialis*) in respect of psychiatric patients and institutions. Consequently, the provisions described in the other chapters of the act apply also to the medical care of psychiatric patients, as general rules, while, in the specified circumstances, the provisions of chapter X on psychiatry must be applied. The majority of these special provisions relate to medical treatment in a psychiatric facility, restrictive measures, certain patient rights and the judicial review of admittance to an institution (Vizi, 2011). Only one implementing regulation, decree (VII.6) of the Ministry of Health, Welfare and Family, was issued in relation to the act. This concerns the rules for the admission of psychiatric patients to an institution and the restrictions that may apply to care.

Act III of 1993, on social governance and social welfare, regulates the social assistance given to psychiatric patients, and decree 1/2000 (I.7) of the Ministry of Health, Welfare and Family on the professional tasks and the conditions of operation of social welfare institutions that provide personal care stipulates detailed rules. In Hungary, in addition to the service provided by transitional institutions (legally defined bodies such as nursing homes and shelters for homeless people, as well as accommodation for people with drug problems and psychiatric patients), community psychiatric care is also considered a social welfare service (Vizi & Ilku, 2005). The core issues in Hungarian community psychiatric care include the lack of sufficiently detailed regulations and the lack of sufficient links between medical and social care (Maj & Kurimay, 2010).

How mental disorder is defined by law

The Healthcare Act defines a psychiatric patient as someone who is diagnosed as having a mental or behavioural disorder (F00–F99) or who is at risk of self-harm (X60–X84), as set out in ICD-10. This definition, however, applies only within healthcare legislation. In other legal areas, including the Criminal Code and the Civil Code, the legislation uses outmoded phrases, some of which stigmatise patients, such as 'imbecility' and 'mental degradation'. These phrases are not defined in legislation.

Grounds for compulsion

Pursuant to the Healthcare Act, the rights of psychiatric patients – with respect to the healthcare services they receive – may be restricted only in cases where they exhibit 'dangerous or immediately dangerous behaviour to his own or others' life, physical well-being, or health'. In this respect, intoxicated psychiatric patients (persons under the influence of drugs or alcohol) present a growing

problem because their behaviour (conduct) under the effect of a chemical substance often poses a risk. If the police find more than a 'negligible' quantity of drugs, as specified in the Criminal Code, on a person, the possession of the drug is considered a criminal act. The new Criminal Code (due to take effect in 2014) will make the possession of even a negligible quantity of drugs a criminal offence.

In respect of patients who are presumed to be responsible for their actions (i.e. who have mental capacity), the general rules of the Healthcare Act apply to the right to refuse psychiatric treatment, with the provision that only those treatments may be used without the patient's consent that serve to prevent conduct that poses a threat. Normally, the general rules of the Healthcare Act also apply to the rights of psychiatric care providers. They have special rights only in respect of the prevention of conduct that poses a threat, access to healthcare records and preventing patients who are treated against their will from leaving the facility (Vizi & Ilku, 2005; Vizi, 2011).

Protecting the public and protecting the human rights of people with mental disorder

If compulsory measures are enforced against a patient, the guardian of the patient (generally a family member) or a relative if the patient is not under guardianship or a person designated by the relative must be immediately notified, in addition to the patients' rights representative. If patients cannot assume complete responsibility for their actions, the guardian and/or the surrogate decision makers – usually relatives – will be entitled to appeal under the law (Vizi & Ilku, 2005).

If the court review determines that the admission of the patient was not lawful or the treatment in a facility was not justified, it orders the release of the patient. The patient – if he or she does not wish to receive voluntary treatment – must be discharged from the facility if continued institutional treatment is no longer justified. The patient's doctor will make this decision.

A complaint may be filed with the head of the institution, the patient's rights representative, the National Public Health and Medical Officers' Service, the ethics committees of the Medical Chamber and the court. There are also other procedures that are applied less frequently.

There is no time limit for the detention. A court review takes place every 30 days.

Currently, there is no effective legal framework for out-patient and compulsory treatment in the community. However, Hungarian law acknowledges the concept of so-called detention ('re-routing'/diversion) in the case of patients who are addicted to drugs and who commit a drug-related minor criminal act punishable by less than 2 years' imprisonment. However, drug-related

activity without addiction (e.g. drug trafficking) does not qualify (opinion 57/2007 of the Criminal Board of the Supreme Court – *Court Resolutions*, 2008).

In terms of patient rights, Hungary follows international norms and directives from the European Union (EU). The few legal violations in general arise as a consequence of inadequate resources, namely the low numbers of nurses and therapists (Kurimay, 2010).

The treatment of high-risk and violent patients, their legal regulation and forensic management remain problematic. Hungary has no so-called high-security hospitals or secure units, nor does it have forensic services outside of the penal system. The profession has proposed concrete plans for the introduction of both types of institution, but as yet no decision has been taken (Kurimay, 2010; Vizi, 2010).

Discussion

In our view, the current Healthcare Act, which regulates the rights of the public and the rights of people with mental disorders, has several gaps which in practice lead to legal uncertainty, primarily in respect of the admission and the treatment of patients without their consent. We believe that it is necessary to draft a dedicated Mental Health Act (Bitter & Kurimay, 2012).

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Mental health law in Serbia – an important step towards destigmatisation

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Serbia has, along with other countries in the region, begun reform of its mental healthcare services. The delivery of mental healthcare was hitherto only partially regulated by law. Hence the National Committee for Mental Healthcare in Serbia has prepared a draft Mental Health Law within the context of a multicentre project entitled ‘Enhancing social cohesion through strengthening community care’ as part of the Stability Pact for South Eastern Europe. It is expected that new mental health legislation will soon be approved by Parliament and lead to the implementation of changes concerning mental healthcare. It should contribute to the destigmatisation of patients, mental health professionals and psychiatry as a discipline.

Stigma and social exclusion

Mental disorders constitute a large group of heterogeneous disorders affecting over 25% of the population at different stages of their lives, regardless of their gender, age, educational or social status and background (World Health Organization, 2003a). According to estimates, mental disorders are the cause of 12.3% of years lost due to diseases and injuries, and 30.8% of years lived with disability, and represent 3 of the 20 leading causes of death throughout the world (World Health Organization, 2003b). The prevalence of mental disorders in Serbia increased by 13.5% between 1999 and 2001, to become the second largest public health problem in the country (Lecic Tosevski *et al*, 2010).

Patients with mental health problems are stigmatised by lay persons, the media – which are prone to reporting sensationalist news – and even medical professionals. Along with their patients, psychiatrists, mental health workers and the specialty of psychiatry itself are also stigmatised.

Individuals suffering from mental health problems are subject to breaches of their human rights, especially those in the large psychiatric hospitals, where patients sometimes remain for many years, often due to the lack of social support systems. Involuntary treatments have often included physical restraint without adequate supervision or control. More generally, patients are excluded from any decision-making in their own treatment process. These practices have taken place in the context of discrimination and the isolation of the patient from the work setting, from the family and from

the community, which fosters the general image of psychiatric patients as being out of control and dangerous to society.

Regional cooperation

In Serbia, mental health practice is currently only partially regulated by law and the rights of persons with a mental illness are only partially protected. The legislation does not address issues such as informed consent and involuntary treatment – matters elsewhere regulated by international declarations and conventions on human rights. Serbia started the reform of mental healthcare in 2002 by joining the project ‘Enhancing social cohesion through strengthening community care’ as part of the Stability Pact for South Eastern Europe. Nine countries were involved in the project: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Former Yugoslav Republic of Macedonia, Moldova, Montenegro, Romania and Serbia. The project had three basic goals (Lecic Tosevski *et al*, 2007, 2008):

- the harmonisation of mental healthcare in the region
- the preparation of mental health laws
- the development of community mental healthcare.

It led to the *National Strategy for Development of Mental Healthcare*, a document prepared by the National Committee for Mental Healthcare of the Republic of Serbia, which was approved by the government in January 2007 (Ministry of Health, 2007). One of the goals of that strategy was the improvement of legislation related to the rights of persons with a mental illness.

Mental health law – a long way from draft to expected approval

The first draft of the mental health law was prepared by the National Committee for Mental Healthcare in October 2003. It was presented at many meetings of mental health experts, representatives of social institutions and local authorities in different towns in Serbia. Professional associations as well as non-governmental organisations were consulted on the draft legislation and made a number of constructive suggestions. The draft law was reviewed by: Julio Arboleda-Florez, Professor of Forensic Psychiatry, Queen’s University, Canada; Svetlana Poluminskaya, Institute of

Law, Russian Academy of Sciences, Moscow; Paolo Serra, Caritas, Italy; Robert van Voren, Geneva Initiative on Psychiatry, the Netherlands; and Richard J. Bonnie, attorney at the Geneva Initiative on Psychiatry, and Professor of Law, University of Virginia, USA.

Close cooperation was established with regional experts, through continuous discussions and consultations at official technical seminars of the 'Enhancing social cohesion' project, or at other international meetings. Of invaluable help was the material within the 'Mental Health Policy and Service Guidance Package', prepared by a group of experts from the World Health Organization, and particularly the *Manual on Legislation and Human Rights* (World Health Organization, 2003c). In the course of drafting the law, a long list of international charters, regulations and standards was referred to. They are listed in the Appendix of the draft document.

The draft law was submitted to the Ministry of Health in December 2004. The long process that followed resulted in the Mental Health Law being provisionally approved in 2005, with three other versions reaching the next stages of approval in 2009, 2010 and 2011. The need to harmonise a number of other laws with European legislation was a priority for the Serbian Parliament and resulted in the postponement of the final approval of mental health legislation. It is quite possible that the marginalisation of mental illness was an additional reason for the delay.

The proposed Mental Health Law deals with the basic principles, organisation and implementation of mental healthcare, as well as matters directly related to patients' experiences. It addresses the full affirmation of the rights of persons with mental disorders, including prevention, mental health promotion, treatment and psychosocial rehabilitation in the community, as well as the recovery of persons with mental disorder and their integration in family, professional and social settings. Research should require the informed consent of participants or proxy consent. Associations of persons with mental disorders should be established, to help patients exercise their rights, to provide help and to promote self-help, and to have an influence on health policy planning and implementation, partially through the involvement of family members, legal representatives, other interested parties and the community in general. These objectives as well as the control and supervision of the work of institutions and professionals treating persons with mental disorders represent some of the main principles underlying the legislation, along with non-discrimination, protection of dignity, non-abuse and protection of specific groups (minors, women and minorities).

The Mental Health Law also regulates treatment, ensuring that care is individualised and person-centred (Lecic Tosevski, 2009). Principles underlying involuntary admission and in-patient treatment are adumbrated by reference to published research (Jovanovic *et al.*, 2009). The law

covers the rights and obligations of persons with mental disorders and addresses issues of confidentiality. Procedures such as discharge from a psychiatric institution, the proper application of physical restraint and seclusion, and special treatments (electroconvulsive therapy, biomedical research) are also covered.

Current and future developments

The Ministry of Health established a working group in 2010 with the aim of revising the most recent draft of these provisions and aligning mental health legislation to already existing and approved legislation from related areas. Consultations were held at several conferences in the drafting of the Mental Health Law, and suggestions and comments were incorporated. The Ministries of Justice and of Social Welfare were also included in the process. The final draft has been forwarded to the government for approval.

We hope that the implementation of the Mental Health Law in Serbia will lead to the integration of several important areas of activity concerning mental healthcare, including deinstitutionalisation (without trans-institutionalisation); the social inclusion of persons with a mental illness; person-centred treatment; and the humanisation of the doctor-patient relationship. The implementation of this new legislation will represent a historic moment for both the country and the profession, and should contribute to the destigmatisation of both patients and mental healthcare.

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Note added in proof

The Mental Health Law was approved by Parliament in May 2013, after this paper was submitted.

The Addiction Severity Index (ASI) and the attitudes of staff to the use of care outcome measurement in Saudi Arabia

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Thanks to all the clinicians who participated in this survey. Special thanks to Dr Ahmed Mansour, Consultant Psychiatrist, and Dr Abdurrahman Alamri, Clinical Psychologist, Al Amal Hospital, Riyadh, Kingdom of Saudi Arabia.

Several years ago, Al Amal Hospital began to use the Addiction Severity Index (ASI) for the assessment and measurement of the outcome of care provided for persons with addiction problems. Clinical staff have been sceptical about the usefulness of this tool in clinical practice. We conducted a survey of staff to record their opinions of the ASI and other outcome measurement tools. Participants highlighted factors that would encourage the use of such tools in daily practice. In order to achieve the desired goals, an outcome measurement tool should be concise, adapted to culture and suitable for use in treatment planning and follow-up by clinicians.

Outcome measurement has recently received considerable attention as part of the effort to improve the quality and effectiveness of healthcare (Duncan & Murray, 2012). The economic challenges currently faced by many countries around the world have resulted in the imposition of restrictions on health services. Clinicians are required to show the impact of their interventions. Other reasons for promoting the use of outcome measurements in daily practice include: improving quality of care, conducting effective treatment planning, assessing the cost-effectiveness of care (Holcomb *et al*, 1997), increasing the efficiency of services, communicating progress to patients and carers, and eliminating variations in clinical practice (Battaglia, 2001; Gilbody *et al*, 2002a,b; Holloway, 2002).

Outcomes mean different things to different individuals, depending on whether they are a care provider, a care receiver, a policy maker or a researcher. Clinicians are generally interested in clinical results (Battaglia, 2001); nevertheless, several studies have shown little evidence of routine outcome measurement in mental health practice. Other studies have found considerable ambivalence towards outcome measurement among psychiatrists and allied health professionals (Smith *et al*, 1997; Gilbody *et al*, 2002a,b; Duncan & Murray, 2012).

This study explored the opinions of clinical staff at Al Amal Hospital regarding the use of treatment outcome measures in addiction services. The study aimed to find out, from front-line staff, which factors facilitate the use of such tools in clinical settings. We thought the experience clinical staff have had with the ASI would be valuable in predicting their attitude towards the future use of outcome measurement in this hospital.

Method

A qualitative design was used to study the experience of clinical staff in the drug dependency unit at Al Amal Hospital in Riyadh. The inclusion criteria were: being a member of one of the treatment teams on the unit, plus having taken the role of care coordinator. All care coordinators were included in this survey, which took place in February 2013. Care coordinators are responsible for completing the ASI; most of them have received training on its use. We used a questionnaire to explore the views of the target group of their experience with the ASI and to record their opinions on the measurement of outcome of care in addiction services.

The study was approved by the hospital's research committee. Tables were used to summarise and code data. Key themes were derived from care coordinators and then compared and contrasted. Transcripts were rated by two independent researchers, as were the data derived for coding, and consensus was reached.

Results

The questionnaire was completed by 24 of the 31 clinicians who fulfilled the inclusion criteria for this study (Table 1), a 77% response rate.

Table 1

Questionnaire responses

Profession	Number	Responded
Consultants	3	2
Specialists	7	6
Residents	8	8
Social workers	5	3
Clinical psychologists	8	5
Total	31	24 (77%)

Experience with the ASI

The clinicians could be placed in two groups regarding their opinions on the use of the ASI. One group described the ASI as a tool that is useful for collecting comprehensive information about patients, but nevertheless thought it did not have an impact on the quality of patient care. The other group expressed a very negative view of the ASI, citing the complexity of the scale and, consequently, the increase in workload.

Strengths of the ASI

There was agreement among the participants that the greatest strength of the ASI is its ability to allow the collection of detailed information about

patients' drug problems as well as medical, psychological and social history. In addition, specialist and resident doctors believed that, if used properly, the ASI is useful in developing a person-centred treatment plan that includes relapse prevention. Few thought the ASI would be useful for research, however.

Limitations of the ASI

The excessive length and the time-consuming nature of the ASI were its main drawbacks, as identified by almost all clinicians. Other concerns included lack of sensitivity to cultural differences; respondents believed the questions had not been properly adapted to Saudi culture. Moreover, they believed that, as the ASI was not used in follow-up, there was no proper measurement of the outcome of treatment. Inadequate training sufficed to throw into doubt the usefulness of this scale in the way it was used.

General use of outcome measurements in psychiatric and addiction services

Some clinicians did not believe that the use of an outcome measurement scale would add value to patient care, but others did believe such a scale would be valuable in treatment planning and follow-up.

Desirable characteristics of an outcome measurement scale

The clinicians indicated that an outcome measurement scale should be concise, require only a short time to complete and be easy to use. They believed these characteristics would encourage its use in daily practice. Adaptation of the scale to the local culture, sensitivity to change in patient presentation and ease of interpretation were other desirable characteristics identified by the group.

Discussion

This work helps to clarify why the use of the ASI has not achieved the goals intended, mainly measuring the outcome of care, at this Saudi hospital. In addition, it proposes methods that can be used to render an outcome measurement scale more useful within clinical settings. This is important, especially with the current drive for using outcome measurement tools in Saudi hospitals.

The achievement of better treatment outcomes and the provision of high-quality care that produces a measurable improvement in the patient's clinical state were clearly desirable to all the members of staff surveyed. Medical and non-medical staff believed that the use of care outcome measurement tools would improve the quality of care. The findings also highlighted the desirable characteristics of an outcome measurement tool, from the view point of staff.

The study showed that the experience with the ASI had not been as successful as anticipated, for several reasons. These included the length of the tool and its impact on workload. Further, the information obtained from the ASI was not used

properly in establishing management plans and neither in follow-up nor research. This seems to have led to a loss of the enthusiasm with which the ASI was first met. Insufficient training probably affected the reliability of this tool. There is a belief that the translation of the ASI did not take into consideration cultural differences, which would potentially reduce the validity and relevance of information obtained from Saudi patients.

Although the findings support the use of outcome measurement tools at this Saudi hospital, they nevertheless raise concerns that a new outcome measurement tool might be used inconsistently by staff unless the hospital addresses the issues raised in the survey. These issues are consistent with the available evidence on what is considered necessary to render an outcome measurement tool suitable for use in daily practice (Slade *et al*, 1999; Battaglia, 2001; Zimmerman *et al*, 2008; Duncan & Murray, 2012).

Conclusions

Despite being available for several years, the ASI has not been properly used in this hospital. There has been no research into this or the impact on staff workload and patient care. We found evidence from staff that the introduction of the ASI had not provided significant benefits to patients or clinicians. Careful consideration should be taken of the views expressed by clinical staff if the use of an outcome measurement tool is to achieve the desired goals. A locally developed tool that takes into consideration cultural factors would be more useful in determining future policies and impacts.

Limitations

This was a qualitative, not a quantitative study. As such, rich and detailed accounts were acquired from participants, but the group declining to participate might have had different opinions.

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Persistent negative symptoms in schizophrenia: survey of Canadian psychiatrists

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A sample of 206 Canadian psychiatrists who routinely treat patients with psychotic disorders were randomly surveyed regarding their knowledge and practice in relation to persistent negative symptoms of schizophrenia. Large majorities reported observing a high prevalence of persistent negative symptoms that do not respond to available treatments (83%), have a profound impact on functional outcomes (96.5%) and contribute to family burden. Almost half the sample (43%) recognised the importance of formally assessing persistent symptoms and nearly a third (30%) indicated that this was a part of their usual practice. These survey results correspond with recent consensus and highlight the importance and challenge of treating persistent negative symptoms in schizophrenia.

Negative symptoms, a distinct domain of schizophrenia, represent a fundamental challenge to treatment protocols (Kirkpatrick *et al*, 2006). This cluster of symptoms, comprising affective flattening, poverty of thought, anhedonia/asociality, avolition and poor motivation (Andreasen & Olsen, 1982), is conceptualised as either primary deficits (core deficits of schizophrenia) or secondary deficits – resulting either as medication side-effects or from other symptoms such as depression (Möller, 2003). These symptoms are present in a majority of patients during their first episode of psychosis (Malla *et al*, 2002). A smaller proportion (20–30%) have sustained primary negative symptoms that are defined as persistent negative symptoms (Buchanan, 2007). The importance of treating negative symptoms is highlighted by their strong association with quality of life (Bow-Thomas *et al*, 1999), social functioning (Corcoran *et al*, 2011), interpersonal relationships, work performance and overall functional outcomes (Milev *et al*, 2005); they are also of great importance to carers and contribute to community burden (Perlick *et al*, 2006).

Despite the serious implications of negative symptoms, few effective pharmacological treatments are available for primary negative symptoms, which, therefore, tend to persist (Malla *et al*, 2002). According to expert consensus, clinical recognition and understanding of negative symptoms is the first step in improving functional outcomes (Malla *et al*, 2002). However, the often insidious and relatively complex nature of negative symptoms

(Kirkpatrick *et al*, 2006), lack of adequate pharmacological treatment (Malla *et al*, 2002), possible benefit from psychosocial interventions (Barnes & Paton, 2011) and the potential for new treatment discoveries highlight the importance of current physician perspectives, knowledge and practices. The aim of this pilot study was to explore broadly how Canadian psychiatrists who regularly treat patients with psychotic disorders conceptualise, evaluate and treat persistent negative symptoms in schizophrenia in the light of recent developments in this field. No *a priori* hypothesis was considered.

Method

Psychiatrists listed in the Canadian Medical Directory, including those from the Canadian Psychiatric Association and Association des Médecins de Psychiatrie du Québec (which have a combined total of 3500 registered members), were contacted to ask for their participation in a survey on negative symptoms if they routinely treated patients with a psychosis. They were given the option of participation via a secure website or by post (with a paper copy). Two hundred and six agreed to participate: 127 (62%) by post and 79 online (38%).

Ethical approval for the study was obtained from the Douglas Mental Health University Institute.

The questionnaire for the study was designed by the investigators to obtain psychiatrists' perspectives on persistent symptoms in schizophrenia as seen in their clinical practice. There were 13 questions regarding knowledge of negative symptoms and several items relating to persistent positive symptoms (the latter are not included here, given the scope of this report). The questions concerned: negative symptoms and potential confounds such as extrapyramidal symptoms and depression; level of awareness; the efficacy of treatment options; the relevance of such symptoms for functional outcomes; and their effect on carers. Each item was scored on a five-point Likert scale. Details of the survey instrument are available upon request from the authors.

Simple frequencies were computed for physician demographics and responses using Statistical Package for the Social Sciences (SPSS, version 18).

Results

Respondents came from a range of settings and indicated an average of 21 years in practice (s.d. 12.64, $n = 179$). More than half of all respondents were male (60%, $n = 124$). Their mean age was 53 (s.d. 12.75, $n = 188$).

Frequency and visibility of symptoms

Comparatively large proportions of psychiatrists reported observing asociality ($n = 92$, 46%), avolition ($n = 91$, 45%) and flat affect ($n = 71$, 36%) 'very frequently' (i.e. in 50–74% of patients) in patients with psychotic disorders in their clinical practice. Anhedonia and alogia were rated as being seen 'frequently' (25–49% of patients) by 89 (44%) and 72 (36%), respectively. Specifically in first-episode psychosis (FEP), the prevalence of negative symptoms was rated at 25–49% of patients by 93 psychiatrists (46%). Respondents largely 'agreed' or 'strongly agreed' that they could distinguish between negative symptoms and overlapping symptoms (e.g. extrapyramidal symptoms and depression) ($n = 150$, 76%) (for complete responses, see Table 1).

The impact of persistent symptoms

A large majority of psychiatrists ($n = 142$, 71%) rated the contribution of negative symptoms to functioning as 'very important' and an additional 51 (26%) reported this relationship to be 'important'. Similarly, a large majority of psychiatrists ($n = 179$; 90%) indicated that negative symptoms were 'frequently' or 'always' a burden to carers. Avolition/apathy was rated as the largest burden by 148 (89%) psychiatrists.

A large number of psychiatrists endorsed the statement 'positive symptoms can lead to persistent negative symptoms' ('agree'; $n = 81$, 40%), while a smaller number ($n = 71$, 35%) were undecided about this. For complete responses, see Table 1.

Treatment of negative symptoms

Only 13.5% of respondents ($n = 27$) rated second-generation antipsychotics as 'effective' (in 50–74% of patients) or very effective ($n = 5$, 3%). Psychiatrists rated antidepressants as being 'ineffective' ($n = 95$, 48%; effective in only 11–24% of patients), or 'somewhat effective' ($n = 86$, 43%; 25–49% of patients) in treating negative symptoms. A large number of psychiatrists ($n = 119$, 60%) rated cognitive-behavioural therapy (CBT) as 'somewhat effective' (of benefit for 25–49% of patients) in the treatment of negative symptoms but only a minority ($n = 33$, 17%) rated it as being 'effective' or 'very effective'. For complete responses, see Table 2.

Discussion

Given the implications of persistent negative symptoms and the difficulty in treating them, knowledge of the issue is imperative for clinicians in the field. Our survey findings corroborate recent consensus guidelines (Kirkpatrick *et al.*, 2006) and suggest that the responding Canadian psychiatrists in this study see negative symptoms in psychosis as widely prevalent, resistant to treatment and of great consequence for functional outcomes in patients with psychotic disorders. This is generally in agreement with findings from both epidemiological (Malla *et al.*, 2002) and clinical studies (Malla *et al.*, 2011).

Our survey data indicate that the majority of psychiatrists consider persistent negative symptoms

in psychosis to have an impact on functional outcomes and to increase carer burden, especially in relation to the domain of avolition/apathy. The high endorsement of the relationship between negative symptoms and functional outcome is supported by research findings (Milev *et al.*, 2005).

Interestingly, half of the responding psychiatrists (50%) 'agreed' or 'strongly agreed' that persistent positive symptoms were a problem because of their effect on negative symptoms. This view is consistent with recent characterisations of the longitudinal relationships between symptoms, and emphasises the importance of monitoring secondary negative symptoms when positive symptoms worsen (Möller, 2007). Further, this may also reflect a belief psychiatrists hold that persistent positive symptoms lead to increases in negative symptoms over time, possibly due to some unknown toxicity. Such a hypothesis has been suggested in relation to the effects of prolonged duration of untreated psychosis (Malla *et al.*, 2011).

Only a minority of this sample of psychiatrists regarded antipsychotics (16%) or CBT (18%) as an effective treatment for negative symptoms. This view of antipsychotics is likely based on clinical experience. Antidepressants were rated by virtually all psychiatrists as being at best somewhat effective in the treatment of negative symptoms. While antidepressants may work in treating negative symptoms secondary to depression, they have been shown to be largely ineffective with persistent negative symptoms (Barnes & Paton, 2011). This perspective is consistent with research evidence (Malla *et al.*, 2002). It would, therefore, appear that this sample of psychiatrists no longer accept that second-generation antipsychotics are likely to be effective in treating negative symptoms. Possibly this is also related to the psychiatrists' reported clinical ability to distinguish secondary from primary negative symptoms. The overall ability of clinicians to discriminate among symptoms lends clinical validity to evidence that negative symptoms in psychosis are a unique and independent construct that may now be better measured (Fousias *et al.*, 2009; Cassidy *et al.*, 2012), and that can be specifically targeted for treatment if effective treatments were to become available (Malla *et al.*, 2002).

The level of experience psychiatrists have with the use of CBT is unknown but is anyway likely to be less than with the use of antipsychotic medication. CBT is reported to be somewhat more promising than antipsychotic or antidepressant medications (Rector & Beck, 2001; Wykes *et al.*, 2008). The utility of CBT, however, may be undermined in particular contexts. Moreover, CBT for negative symptoms is not widely available and is traditionally provided over relatively long periods of time. Further, CBT may not be appropriate for all patients, depending on their level of functioning (Lehman *et al.*, 2004).

Our results likely represent the opinion of only those psychiatrists who frequently treat patients with psychotic disorders and who volunteered to participate. The selection may well have been

Table 1Frequency, visibility and impact of symptoms: *n* (%)

How often do you see the following negative symptoms in your patients?	Almost always (>75% of patients)	Very frequently (50–74%)	Frequently (25–49%)	Occasionally (11–24%)	Rarely (<10%)
Asociality	30 (15%)	92 (46%)	61 (30%)	12 (6%)	6 (3%)
Avolition	44 (22%)	91 (45%)	46 (23%)	14 (7%)	6 (3%)
Anhedonia	13 (7%)	64 (32%)	89 (44%)	29 (14%)	6 (3%)
Alogia	15 (8%)	39 (20%)	72 (36%)	49 (25%)	24 (12%)
Flat affect	30 (15%)	71 (36%)	60 (30%)	30 (15%)	7 (4%)
According to you, what is the prevalence of negative symptoms at the onset of psychosis (first episode)?	0–10%	11–24%	25–49%	50–74%	> 75%
	3 (2%)	26 (13%)	93 (46%)	61 (30%)	18 (9%)
As part of my clinical practice, it is possible for me to distinguish between negative symptoms and depression or Parkinsonism	Strongly agree	Agree	Undecided	Disagree	Strongly disagree
	33 (17%)	117 (60%)	37 (19%)	11 (6%)	–
How important is the contribution of negative symptoms to functional outcome in persons with schizophrenia?	Unimportant	Of limited importance	Moderately important	Important	Very important
	–	–	7 (4%)	51 (26%)	142 (71%)
In your practice, do you observe that negative symptoms cause increased burden for caregivers of patients with such negative symptoms?	Always	Frequently	Occasionally	Rarely	Never
	43 (22%)	136 (68%)	18 (9%)	2 (1%)	1 (1%)
Persistent positive symptoms can lead to persistent negative symptoms	Strongly agree	Agree	Undecided	Disagree	Strongly disagree
	18 (9%)	81 (40%)	71 (35%)	32 (16%)	–

Not all respondents answered all questions. Percentages relate to number of responses on each item.

Table 2

Treatment and assessment of symptoms

Assessment	Always	Frequently	Occasionally	Rarely	Never
Do you routinely assess negative symptoms?	90 (45%)	87 (43%)	24 (12%)	1 (1%)	–
If so, do you use any rating scales or any specific questions?	22 (11%)	49 (24%)	57 (28%)	41 (20%)	33 (16%)
Treatment	Very effective (of benefit for >75% of patients)	Effective (50–74%)	Somewhat effective (25–49%)	Ineffective (11–24%)	Very ineffective (<10%)
How effective are atypical antipsychotics for the treatment of negative symptoms of schizophrenia?	5 (3%)	27 (13%)	101 (50%)	60 (30%)	9 (5%)
How effective are antidepressants for the treatment of negative symptoms of schizophrenia?	1 (1%)	5 (3%)	86 (43%)	95 (48%)	14 (7%)
How effective is cognitive-behavioural therapy for the treatment of negative symptoms of schizophrenia?	1 (1%)	32 (16%)	119 (60%)	44 (20%)	4 (2%)

Not all respondents answered all questions. Percentages relate to number of responses on each item.

biased towards those psychiatrists in this field who are more knowledgeable about negative symptoms. This would suggest the need for a greater effort to increase knowledge and awareness of the importance of persistent negative symptoms among the profession in general.

Despite the limitations of a relatively small sample size, this study represents, to our knowledge, the first survey to examine the state of knowledge and practice patterns of Canadian psychiatrists who work with patients suffering from psychotic disorders.

Our findings suggest the clinical validity and translation of current knowledge of persistent symptoms in clinical practice. However, while psychiatrists emphasised the importance of formally assessing persistent symptoms, few actually carried this out in practice, suggesting that some symptoms may be undetected. Future research may investigate means to increase the use of structured negative symptom assessment in clinical practice.

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Psychosocial research with children in Iraq: current health practice and policy in a context of armed conflict

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There is a need to show how psychosocial issues affect children in conflict areas like Iraq. Raising knowledge and awareness of children's mental health status in Iraq has been difficult and the knowledge base has been limited by the shortage of resources, international sanctions and the isolation of Iraqi scholars. Many obstacles to research in Iraq exist but an agenda should be developed emphasising the need for high-quality contextualised psychosocial research. Health researchers in the country need to clarify basic population parameters and to provide culturally appropriate, evidence-based interventions for practitioners.

Much attention has been paid to researching children affected by war and violent conflicts. Major areas of study explore the impact of war on children's health, including the relationship between experiences of conflict and mental health. People in conflict situations experience many psychosocial problems (e.g. personal isolation, interpersonal stress). However, communities rarely have capacity (e.g. mental health resources) to counteract such adverse circumstances. Research can aid in the evaluation of intervention programmes and influence both policy development and future practice, but logistics, methodological and ethical issues, as well as difficulties in measuring intervention effectiveness, present ongoing challenges for researchers in conflict zones. These issues are particularly concerning when researching children (Sondheimer & Rey, 2012).

Recent social and political instability in Iraq presents a particular dilemma for scholars and

investigators. War, economic sanctions and the departure of health professionals during the dictatorship destroyed the country's social service infrastructure. Moreover, after the 2003 war, direct death threats made against those with higher education, perceived as either powerful or wealthy, or both, has reduced the availability of teachers in tertiary education in particular, contributing to the collapse of research activity. This has led to the loss of the scientific research base for social studies in the community, particularly the evidence base for children's health and education services. The psychosocial status of Iraqi children and adolescents is substantially affected by the current environment, which undermines best practice and evidence-based interventions. The need remains to show how psychosocial issues affect health practices and policies involving children in conflict areas like Iraq.

Children's psychosocial issues as a research arena in Iraq

Various factors contribute to child development and psychosocial well-being (e.g. socioeconomic status, educational attainment). Investigation of these issues is a challenge in both peaceful and conflict areas. Globally, child and adolescent mental health problems present high demands on care services in the face of diminishing resources (Belfer, 2008).

Raising knowledge and awareness of children's mental health status in Iraq has been difficult due to unsystematic coverage of the topic in the literature. While there is some interest in scientific exploration, its scope is limited. For example, it is difficult to source publications targeting childhood mental health prior to 2003. Factors like the

shortage of resources, international sanctions and the isolation of Iraqi scholars from the rest of the world have limited scientific studies in general, including research involving children's welfare issues. However, there are exceptions worth noting.

During 1991, a study was conducted by members of an international team from the Centre for Crisis Psychology in Norway. This team assessed the impact of the 1991 Gulf War on Iraqi children using the Impact of Event Scale (IES) with 94 Iraqi children (Dyregrov *et al.*, 2002). Using this work, the United Nations Children's Fund (UNICEF) presented guidelines for child protection policy and programmes to assist Iraqi children who suffered in the war (UNICEF, 2003).

In 1998, a study on the prevalence of symptoms of post-traumatic stress investigated a sample of displaced children living on the Iraqi-Turkish border in Kurdistan (northern Iraq) in the aftermath of the 1991 Gulf War. It found that 20% of the sample was affected by post-traumatic stress disorder (PTSD) (Ahmad *et al.*, 1998).

In 1999, a study in Baghdad estimated the prevalence of attention-deficit hyperactivity disorder (ADHD) among primary schoolchildren at 11% (Al-Obaidi & Ali, 2009).

Since 2003, a number of studies and articles conducted by Iraqi and non-Iraqi researchers have been published in international peer-reviewed journals. Only 2% of all health research in Iraq conducted between 2000 and 2005 tackled mental health issues (World Health Organization & Iraqi Ministry of Health, 2006). One of the main themes was the post-war impact of violence on the mental and psychological well-being of Iraqi children. Some studies have estimated the prevalence of mental disorders among samples of Iraqi children. In Mosul (a large city in the north of Iraq), mental disorders were found in 37% of children attending primary healthcare (Al-Jawadi & Abdul-Rahman, 2007). Among a clinical sample of children in Baghdad, 22% had diagnoses of anxiety disorders and 18% behavioural disorders (Al-Obaidi *et al.*, 2010a).

A small number of research efforts have led to proposals for the development of child protection programmes and the building and promotion of a child-centred mental health system in Iraq. Also required is the development of curricula for training front-line paediatricians in children's psychosocial issues, and supporting inclusive education for children with physical and mental disabilities (Al-Obaidi *et al.*, 2009, 2010b, 2012, 2013; Al-Obaidi & Budosan, 2011).

The main obstacles confronting researchers in Iraq include: shortage of human resources to conduct studies; lack of funding; lack of appropriate research tools and research training of local professionals; low priority of data collection by state agencies; poor awareness of child mental health issues; and threats related to the safety of research teams in insecure areas. In spite of the above-mentioned studies, the paucity of published data makes it difficult to obtain precise numbers on the

prevalence and severity of childhood psychological problems in a country where child mental health services are almost non-existent (Al-Obaidi *et al.*, 2010b). This complicates the framing of evidence-based treatments, programme planning and the establishment of policy benefiting Iraqi children.

Child psychosocial research: health practice and policy

Research outcomes contribute to helping practitioners develop effective interventions (Hart & Tyrer, 2006). Research on childhood psychosocial issues in the context of war and conflict has a direct and an indirect impact on policy and practice (Boyden, 2003). Children need stable, continuous and predictable programmes, focusing on treatment, rehabilitation, family and social reintegration. Children's responses to adversities or catastrophes are universal, and family support in times of crises is of proven benefit (Boyden, 2003). Such attention has led to a shift in intervention programme priorities, from the supply of physical aid, to integrating mental health provisions within intervention programmes (e.g. in Kosovo, Bosnia, Rwanda, Afghanistan and Iraq).

Many obstacles to research in Iraq exist but an agenda should be developed emphasising the need for high-quality contextualised psychosocial research. Health researchers in the country need to clarify basic population parameters and to provide culturally appropriate, evidence-based interventions. Locally based research should avoid possible mistakes from poorly conceived intervention programmes. Iraq presents a good climate for research and a regrowth of the country's academic community is being seen. The assistance of outside agencies in collaboration with Iraqi colleagues can be a joint learning exercise benefiting both parties and the population in the development of context-specific practices.

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NEWS AND NOTES

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

Faculty of the Psychiatry of Old Age: bursary for psychiatrists from developing countries

The Faculty of the Psychiatry of Old Age has established an annual bursary to enable a psychiatrist from a developing country to attend the Faculty Annual Residential Meeting (usually held in March) in order to give an oral or poster presentation, or deliver a workshop. The bursary is intended to cover the cost of economy-class travel, accommodation, free registration and attendance at the conference dinner, up to a maximum of £1500. Informal mentors will be identified for the bursary holder to enhance their introduction to Faculty members and their enjoyment of the meeting. See <http://www.rcpsych.ac.uk/workinpsychiatry/faculties/oldage/aboutthefaculty/prizesandbursaries.aspx#develop>.

The closing date is 31 October.

The Dublin Declaration

On Friday 24 May, over 193 delegates from 21 European countries met in Dublin to discuss the needs of family carers for people with mental ill health. Addressing the conference, Dr Tonio Borg, European Commissioner for Health and Consumer Affairs, stressed the importance of family involvement in mental healthcare across Europe.

The Irish Minister of State, Kathleen Lynch TD, declared at the conference that good mental health was a partnership between government, professionals, people with experience of mental ill health and family members.

Throughout the day, the audience heard presentations on the importance of family involvement, the need for education, quality information and communication in helping families to cope with mental ill health.

Against this background, the delegates unanimously agreed the Dublin Declaration 2013, which is available from the website of the European Federation of Associations of Families of People with Mental Illness (<http://www.eufami.org>).

Rita Geerts, Administrator, European Federation of Associations of Families of People with Mental Illness

The mental health component of undergraduate medical training in Somaliland

Somaliland is a self-declared independent state, although recognised by the World Health Organization (WHO) and internationally as Northern Somalia. It is a region which has experienced conflict and severe poverty, although it has remained relatively stable in recent years despite the challenges it continues to face. Many healthcare professionals were forced to leave the region or were killed during the civil war, which began in 1991. This has led to a need to strengthen and build upon existing healthcare services.

There are currently no practising psychiatrists in Somaliland and there exists a stark shortage of good mental healthcare. The King's-THET Somaliland Partnership (KTSP) has been providing the mental health component of undergraduate medical training since 2008. Without this, there would be no mental health input for medical professionals.

May 2013 saw the annual training trip to Hargeisa, the capital of Somaliland. Both of the present authors (a CT3 in psychiatry and a consultant psychiatrist) led the training this year, in conjunction with Somaliland colleagues on the ground. The trip started in Nairobi, where a small plane was boarded to Hargeisa. An unexpected surprise entailed passing right over the runway in Hargeisa and landing in the bush as the runway was closed temporarily.

The next 2 weeks were spent carrying out intensive mental health training for medical students in their penultimate year of study. This was based on the WHO Mental Health Gap (mhGAP) Action Programme. The KTSP group has piloted the incorporation of the mhGAP Intervention Guide, an evidence-based guide for mental, neurological and substance misuse disorders, into the medical undergraduate curriculum for the first time worldwide in Northern Somalia. The aim is to ensure non-specialists, as many of the medical students will turn out to be, may deliver good mental healthcare as they become clinicians following graduation. This is important in a region

such as Somaliland where there is a shortage of people able to deliver healthcare.

This year the group comprised 52 medical students from two universities in the region, Amoud, in Borama, and Hargeisa. The students, as always, were keen to learn, filled with enthusiasm and greatly appreciated this training. It was a joy to be able to cover such a diverse range of topics, including child psychiatry. This took account of cultural and religious differences in practice. Resource limitations were also taken into consideration, as the traditional Western approach to training could not be simply translated to a region such as Somaliland without careful thought.

The lecturers had both visited Somaliland before. Close communication exists between colleagues and students throughout the rest of the year, in order to continue training and mentorship. This is done often on the online platform 'Medicine Africa', where tutorials and meetings take place to cement learning and continue professional development. As a result, colleagues on the ground assisted with the teaching, as they do every year. Two mental health representatives, who are intern doctors in Somaliland, are competitively selected to join the teaching. This provides them with further experience in teaching, teamwork and leadership, which complements their doctor training. They also provide the teachers with an added and greatly appreciated component to the training, which is the stance taken on psychiatry from a Somaliland perspective. This is imperative in a country where the practice of psychiatry, beliefs surrounding mental illness and current

availability of resources are so different from those in the UK.

A large portion of the teaching this year was carried out on the mental health ward at the main government hospital in Hargeisa. Students were afforded the opportunity to meet patients with mental health problems, take histories and perform mental state examinations, as part of their overall experience. Many cases this year were of psychosis, some associated with the use of khat, a plant commonly chewed in Somaliland for its stimulant properties. There were also cases of depression, dementia, mania, intellectual disability and catatonia.

The ward experience positively changed many of the students' views of psychiatry that they had held prior to the teaching. A number of them were initially scared to venture onto the ward, though none felt this way afterwards. Stigma and discrimination are very much associated with mental illness in Somaliland, as is the case worldwide. A lack of knowledge and experience, coupled with a complex belief system surrounding mental illness, means that patients are often chained. A young man on the ward had been chained for 8 years at home and as a direct result had developed severe leg contractures, which meant that he could no longer walk.

Unfortunately, the mental health ward had deteriorated somewhat over the preceding year. The conditions for the patients had dramatically improved, though, since the initial trip in 2008, when many patients were still chained on the ward.

Security was high on the agenda this year, in view of recent advice from the UK Foreign and Commonwealth Office, and with a 24-hour curfew for the days surrounding Somaliland Independence Day. Al-Jazeera reported from Hargeisa, with Independence Day taking first place in the headline stories in the world that day, much to the joy of many people in the capital.

The teaching was a success, with a lot of marking, analysis and meetings to discuss longer trips to be made later in the year. As always, the hard work and dedication shown by our Somaliland colleagues was a privilege to be witness to and part of, and we both greatly look forward to returning.

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Entrance to Hargeisa Group Hospital

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Sir: The professional life of psychiatrists can be divided into several phases, among which the transition period from psychiatric training to independent practice is one of the most important. This phase usually determines not only the choice of subspecialisation but also the rest of a professional's working life within psychiatry, including related aspects such as migration on either professional or financial grounds (Riese *et al*, 2013). Psychiatrists who are in the first years of their professional career have been defined as 'early career psychiatrists' (ECPs): the term relates to medical doctors who are trainees in psychiatry or specialists within 5 years of completion of their psychiatric training (Giacco, 2011).

Comprehensive data on psychiatric training in Europe, including the numbers of psychiatric trainees, have been already reported (Kuzman *et al*, 2012), but no data are available on even the approximate number of ECPs from the reports of relevant national authorities for postgraduate training (e.g. national ministries or institutes of public health, etc.). Such data, if available, would better inform efforts to harmonise policies and practices of training in psychiatry around Europe. With this objective in mind, two transcontinental bodies – the Early Career Psychiatrists Committee of the European Psychiatric Association (EPA-ECPC) and the European Federation of Psychiatric Trainees (EFPT) – have undertaken a survey.

While the results of this survey will be reported to the relevant European organisations, it is crucial that stakeholders at European national and continental level who are already engaged in monitoring the decline in recruitment of trainees into the field of psychiatry review its results with urgent attention. The interpretation of the data will have implications for planning and establishing retention strategies focused on the pool of ECPs across Europe and for planning specific developmental

activities based on the actual number of ECPs in each country. Moreover, prevention strategies and additional investments in primary and public mental health could be prioritised in countries with relatively low or declining numbers of ECPs. Furthermore, some countries with higher numbers of ECPs may provide examples of good recruitment strategies, although one might speculate whether these high numbers are actually not caused by 'imported' psychiatrists (e.g. in Ireland and the UK).

To conclude, the harmonisation of mental healthcare delivery across Europe must be grounded in the reality of workforce dynamics, especially utilising forward-looking indicators such as the numbers of trainees and ECPs. This survey should add valuable data that we implore national and European organisations to take note of.

Alexander Nawka, Martina Rojnic Kuzman, Domenico Giacco, Maja Pantovic, Amit Malik and Umberto Volpe

Members of the Early Career Psychiatrists Committee of the European Psychiatric Association (EPA-ECPC) and of the European Federation of Psychiatric Trainees (EFPT)

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Rizgar Amin, 1958–2013

The Editor and Board of *International Psychiatry* are saddened by the death of their esteemed colleague, on 15 April 2013.

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Forthcoming international events

12–13 September 2013
2nd World Congress of Clinical Safety: Risk in Clinical Care
Heidelberg, Germany
<http://www.iarmm.org/2WCCS/>

24–28 September 2013
International Association for Suicide Prevention 27th World Congress 2013
Oslo, Norway
<http://www.iasp2013.org/>

21 October 2013
Dementia: A National Priority
Surgeons' Hall, Edinburgh
<http://www.publicserviceevents.co.uk/programme/247/dementia-scotland>

23–26 October 2013
8th European Congress on Violence in Clinical Psychiatry
Ghent, Belgium
<http://www.oudconsultancy.nl/GhentSite/index.html>

23–26 October 2013
Spanish Society of Dual Disorders 3rd International Congress on Dual Disorders
Barcelona, Spain
<http://www.patologiadual.es/cipd2013/>

27–30 October 2013
World Psychiatric Association International Congress 2013
Austria Centre
Vienna, Austria
<http://www.wpaic2013.org/>

4–6 November 2013
1st Global Conference: Suicide, Self-Harm and Assisted Dying
Athens, Greece
<http://www.inter-disciplinary.net/probing-the-boundaries/persons/suicide-self-harm-and-assisted-dying/>

27–30 November 2013
German Association of Psychiatry, Psychotherapy and Psychosomatics: Congress
Berlin, Germany
<http://www.psychiatry-congress-berlin.org>

1–4 March 2014
22nd European Congress of Psychiatry
Munich, Germany
<http://www.epa-congress.org>

15–17 April 2014
10th International Conference on Psychiatry. 'Psychiatric Models: Biological and Psychological Perspectives'
Jeddah, Saudi Arabia
http://jed.sghgroup.com.sa/index.php?option=com_content&view=article&id=248&Itemid=42&lang=en

28–30 April 2014
International Society for Affective Disorders Congress
Berlin, Germany
<http://www.isadconference.com/>

13–16 May 2014
19th International Conference of the Association of Psychology and Psychiatry for Adults and Children (APPAC): Recent Advances in Neuropsychiatric, Psychological and Social Sciences
Athens, Greece
<http://www.appac.gr/displayITM1.asp?ITMID=18&LANG=EN>

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