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EDITORIAL

Psychiatry for tomorrow's doctors: undergraduate medical education

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The importance both of undergraduate education in forming the knowledge base for the next generation of doctors and of their continuing professional development is widely acknowledged. The changes that are occurring to the undergraduate medical curriculum in many countries are therefore likely to have a long-term effect, although their specific effect on psychiatric teaching and the future of psychiatry is not yet apparent. This is of particular significance in the context of a continuing crisis in the recruitment and retention of mental health professionals in general, and of psychiatrists in particular, when the need to attract doctors into the specialty has never been greater (Sierles & Taylor, 1995).

Furthermore, there has been extensive reorganisation of health services in many countries around the world, as well as changes of similar magnitude at institutes of higher education (Ghodse, 1997). These changes have already affected recruitment and training, and there are more changes on the horizon. Psychiatry will have to become more responsive to such changes, and to anticipate them whenever possible, rather than merely reacting to them. In this climate of change and reorganisation, more needs to be done to adapt the general professional education of medical students so that they are as well prepared as possible for the new circumstances that they will undoubtedly face (Ring *et al*, 1999).

It is also important to note that change is not confined to education and training. The nature of research has also changed, with dramatic advances in basic biomedical, behavioural and clinical areas. Simultaneously, pressure has grown, both in Europe and elsewhere, for universities to place more emphasis on research than on teaching, which has led to some departments being evaluated only in terms of the number of their publications and the value of their research grants (Goldberg, 1997). This is very different from times gone by, when the primary role of universities was to provide teaching and service, with research very

much in second place. It is perhaps not surprising, therefore, that standards of undergraduate teaching in psychiatry have declined in many countries and that academic staff are less interested than previously in local service provision and postgraduate education. It is encouraging that some of these imbalances are now being addressed in several countries by competitive exercises on teaching, similar to the Research Assessment Exercise (RAE) in the UK.

While this acknowledgement of the importance of teaching is welcome, it is not yet clear how helpful it will be in practice. There are few rules and regulations relating to teaching capabilities, and issues such as who teaches the teacher how to teach have often been neglected in universities, even though it is recognised that teaching is a skill in its own right, requiring formal training. It is not uncommon, for example, for an appointment to a post of professor or associate professor to be based on the individual's research record rather than teaching abilities. In part this may be attributed to the difficulty of evaluating the quality of teaching.

The reason for placing so much emphasis on teaching is that inspirational teachers and inspired teaching inspire students (Sierles & Taylor, 1995). Indeed, one might say that part of a teacher's job is to make students enthusiastic about their subject, which in turn will influence their later choice of specialist training. Thus, good undergraduate psychiatric teaching will make more students feel that psychiatry is an interesting and wonderful area of medicine in which to spend their professional life, and good teaching will ensure that those who do *not* specialise in psychiatry – the next generation of physicians and surgeons – have the basic knowledge of the subject necessary to make them better doctors, with a greater understanding of the interface between physical conditions and psychosocial issues. Nowhere is this more important than in those who become general practitioners (Ney & Jones, 1985).

One of the major problems confronting psychiatry all over the world at the moment is the fact that it is largely becoming a service for disturbed psychotic people. As a

Contents

Editorial

Hamid Ghodse 1

Thematic papers – telepsychiatry

INTRODUCED BY
David Skuse 2

Ricky J. Richardson 3

Peter Yellowlees 4

Donald M. Hilty *et al* 6

Paul McLaren 8

Country profiles

INTRODUCED BY
Shekhar Saxena 10

Nalaka Mendis –
Sri Lanka 10

Bulent Coskun –
Turkey 13

Fuad Ismayilov –
Azerbaijan 16

Special paper

James Satriano 18

Associations and collaborations

Angelo Barbato 20

News, notes, events 21

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result, the skills for helping those with other disorders are disappearing (Goldberg, 1997). The Royal College of Psychiatrists, psychiatric associations and academic departments of mental health and psychiatry have not really addressed this worrying issue and there are some important consequences, particularly in relation to the training of future general practitioners (Ney & Jones, 1985). Traditional learning/teaching still takes place in mental illness institutions in many countries and teaching tends to focus on severe mental disorders, even though those who will become general practitioners are likely to see each year only a few patients with major psychiatric disorders, while they will probably treat depressed and anxious patients every working day. Proposals in some countries for curriculum revision, so that undergraduate teaching concentrates on fundamental concepts and common conditions rather than psychosis, therefore seem particularly pertinent (Working Party of the Education Committee of the Royal College of Psychiatrists, 1997).

The apparently logical next step – of teaching psychiatry in the community – although attractive in principle, is challenging in practice, as there are various problems to be overcome, such as how to structure library time, research time, discussion and meeting time with colleagues.

A particular challenge confronting psychiatry is the continuing stigmatisation of mental disorders. Excellent education of all undergraduates in the subject, to enable all doctors to meet and treat people with mental disorders confidently, is one way to tackle this. But stigmatisation extends beyond the disorders to the specialty itself, and can create a lack of credibility for psychiatry as a whole. This will be remedied only by good departments that offer good teaching and carry out good research, preferably in institutions where the subject is represented at the highest level (i.e. on multi-faculty academic boards).

Academic psychiatry by its very nature cannot be provincial. Collaboration and cooperation between different medical schools within the same country as well as

across national boundaries are fundamental if the issues relating to undergraduate education and training are to be adequately addressed, worldwide. Psychiatry today, more than at any other time, is in need of far greater inter-collegiate and cross-national collaboration and cooperation in the psychiatric education of future doctors and in the training of psychiatrists. The initiative of the World Psychiatric Association and the World Federation for Medical Education to develop a core curriculum has undoubtedly been a major step in that direction (Walton & Gelder, 1999). The World Health Organization, the Royal College of Psychiatrists and its International Regional Groups, as well as national psychiatric associations and academic departments of psychiatry, can and should play their part, too. Although the challenges are considerable, we should not lose sight of the fact that good progress has been made. However, there is still a long way to go.

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THEMATIC PAPERS – INTRODUCTION

Psychiatry and the internet: a new dawn?

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There seems a certain inevitability that traditional methods of health care delivery are going to change in the age of the internet. To a degree, change is already happening, as specialists around the world share information via broadband links that enable them better to assess and treat patients, for example in the fields of radiology or dermatology, where the presentation of visual information is critical. It is less obvious that specialists would find it valuable to share clinical observations in psychiatry, a specialty where the aural medium of communication is so much more

important than the visual. We have asked four experts in telemedicine to give us their views on the current status of novel communication technology with special relevance to psychiatry.

Dr Ricky Richardson is the Chairman of the UK eHealth Association and he gives an upbeat analysis of how clinical practice is likely to change dramatically over the next decade. There is no doubt the UK government is strongly supportive of proposals to use electronic media to increase efficiencies in the National Health Service, but the degree to which inequities in health provision can be addressed by eHealth initiatives is open to question. A

more specific discussion of these issues is provided by Professor Peter Yellowlees, a community psychiatrist who has been influential in the development of eHealth applications in Australian psychiatry. There is obviously merit in using internet-based technology to consult with remote rural communities who lack their own specialist psychiatrist, and the theme is taken up in our third contribution, from Dr Donald Hilty and colleagues at the University of California. They write from a US perspective, and discuss the difficult question of whether telepsychiatry

is a cost-efficient way of delivering services. The answer appears to be 'Maybe, in some circumstances'. Finally, Dr Paul McLaren, a consultant psychiatrist from London, brings us back to Europe and cautions that, although professionals like to use videoconference facilities to organise discussions or teaching around clinical matters, there is still resistance to the use of the technology for direct clinical contact. Whether such prejudice will evaporate as we all become more 'internet literate' is likely to vary according to culture (in every sense of that word).

THEMATIC PAPER – TELEPSYCHIATRY

eHealth and ePsychiatry for Europe

Ricky J. Richardson

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The use of the term 'eHealth' is gathering momentum across Europe as the wider implications of the health care reforms enabled by information technology become apparent. There is a growing realisation by both health care providers and consumers alike that change in the sector is now imperative and timely. Member states of the European Community are all facing an increase in the requirement for health care provision because of changing demography, in particular ageing populations. In the face of an increasing demand for services, the existing model for health care delivery is arguably inadequate. In many ways it is economically unsustainable, even by the wealthiest countries in Europe.

To date, the use of information technology in the European health care sector has been on a pilot basis. On the other hand, we are beginning to see the widespread deployment of managed clinical networks, electronic patient records and other applications made possible by information technology. It is arguable that such applications are now challenging a traditional model of health care delivery that has remained largely unchanged for over 6000 years.

The generic term 'eHealth' embraces four central pillars of activity. These are:

- clinical applications
- eLearning tools
- use of the media
- lifetime health records.

Clinical applications

The first pillar supports an array of clinical applications, which include teleconsultations. These may be arranged in a variety of ways, including interactive videoconferencing (previously known as 'telemedicine', a now obsolete term) or face-to-face consultations via video-links. Other eHealth

applications include software that supports clinical decision-making, vital signs monitoring services managed by call centres, telephone-enabled health information (such as the nurse-led service established through NHS Direct in the UK), national eBooking and ePrescription services, home telecare and eNursing. Few of these facilities are yet applicable to the provision of psychiatric services, but they could become relevant as the infrastructure of eHealth grows.

eLearning tools

The second pillar is the use of eLearning tools to deliver personalised continuing educational programmes to professionals. The traditional, hierarchical health care professional community is being replaced by a more horizontal structure, based around the multi-disciplinary team.

Within this evolving structure, there is a different work ethic. Patients are increasingly involved in decision-making about their own clinical management. In the future, the patient will be placed at the *centre* of the care pathway. In other words, gone are the days when the patient said 'Yes doctor', 'No doctor', 'I will do what you say doctor' and was grateful for a few minutes of the doctor's valuable time. Patients are becoming *informed partners* in the health care exchange process: empowered patients know exactly what they want and from where they wish to obtain the service, and if they do not get what they want from one physician, they are willing to go elsewhere.

Use of the media

The third pillar of eHealth concerns the proactive use of the media – television, radio, newspapers, journals and magazines – to deliver appropriate health care messages to specific segments of the general public. Educating the public about health is no longer the province of public

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If consultation by electronic media, rather than face to face, were to be widely implemented, we could look forward to a time when diagnostic assessments are carried out in the retail environment or in people's homes, where they spend most of their time, and not in hospitals or clinics.

information films. Nevertheless, the aim is similar: to inform the general public, so that their demand for health care is more focused and appropriate.

Lifetime health record

The fourth pillar is perhaps the most exciting of all, namely the building of a lifetime health record for each citizen. The envisaged European model includes the issuing of an electronic record to a foetus when the mother's pregnancy is first recognised. This can then become a record of every health care event that the individual experiences over a lifetime. To this accumulating and dynamic dataset can be added genetic information, the individual's changing socio-economic status throughout life, environmental data such as ambient temperature and pollution levels, as well as information on lifestyles.

There are, of course, major obstacles to the implementation of the lifetime health record, notably the ethical implications of such centralisation of personal data. These will need to be fully debated and controversies regarding civil rights and privacy resolved.

The European future

The challenge ahead is enormous, but eventually, once the process has started to gather momentum, the benefits for the European patient community are likely to be massive. For example, the duplication of resources that currently exists, with each member state having a pyramidal structure of health care delivery, could be rationalised.

There is an urgent need to move the health care exchange point outside the existing infrastructures (i.e. hospitals and clinics) and, where possible, to make services available within the community. If consultation by electronic

media, rather than face to face, were to be widely implemented, we could look forward to a time when diagnostic assessments are carried out in the retail environment or in people's homes, where they spend most of their time, and not in hospitals or clinics. For those vulnerable citizens who have chronic diseases, and especially those who are unable or unwilling to attend hospital for follow-up appointments, it will be possible to conduct many diagnostic tests in the home. With the increasing number of elderly citizens in our community, there will be a need for 'sentinel' devices in homes, which will support their independence and provide a safe environment for them. Such devices could be especially relevant to those with dementing illnesses. Some countries in Europe have already begun this process. In the UK, the national programme for health care reform is under way, with a massive increase in investment by the government in the National Health Service (NHS) over the next 8–10 years. Much of the early spending will be on strengthening the information technology component of the NHS, thus making the changes alluded to above possible.

Not least of the challenges will be the need to accommodate the very disparate health care provision and outcomes in those countries that will be joining the European Community over the next few years. The health care needs of their citizens must be taken into consideration, as, when these countries become full members of the Community, they will have the right to receive health care services matching those received by citizens of the other member states. The time for pilot studies in telemedicine and eHealth is long past. What is necessary now is the large-scale and widespread implementation of eHealth programmes that will enable European citizens to benefit from quality health care services with equity across the European Community as a whole.

THEMATIC PAPER – TELEPSYCHIATRY

Broadband telecommunications: the bricks and mortar of future eMental health systems

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Health care will undoubtedly change over the next 20 or 30 years as eHealth technologies become increasingly used and accepted (Treister, 1997; Yellowlees, 1997, 2001). At a global level, the health care system is moving away from episodic care to concentrating on continuity of care, especially for patients with chronic diseases (Yack, 2000), who will give rise to the greatest disease burden in the future (Murray & Lopez, 1999). Many countries are gradually moving away from a focus

on the service provider to a focus on the informed patient, and from an individual approach to treatment to a team approach. Increasingly there is a concern less with the treatment of illness and more with the need for wellness promotion and illness prevention, which, of course, parallels a shift away from traditional care to community care.

This is the model of the 'information age health care' described by Ferguson (1994). To move to this future, there needs to be a strengthening of the availability and use

This article is based on a book chapter published in *Telepsychiatry and e-Mental Health* (eds R. Wootton, P. Yellowlees & P. McLaren). London: Royal Society of Medicine (2003). Professor Yellowlees is a director of HealthShare.

of information to facilitate changes in health service delivery (Smith, 1997). The requisite technologies should have four main objectives:

- to empower consumers and clinicians in day-to-day health care delivery by improving access to evidence-based information at the point of care
- to facilitate the delivery of a wider range of services within primary and community care
- to provide accurate data to support research, clinical policy and governance arrangements
- to ensure that there is a sustainable, secure and reliable electronic environment, which, of course, must be underpinned by strong, policy-driven privacy protection.

All of the potential barriers to the adoption of eHealth are gradually being overcome. Prices have come down, technology has become more user-friendly, especially software, and doctors themselves have gradually started to become convinced of the usefulness of eHealth programmes. The single most important change, however, is the increasing availability of broadband access, which allows the development of sophisticated video-based applications, particularly on the doctor's desk. The increase in the availability of broadband systems, whether these be satellite-based, cable, fibre or digital subscriber lines (DSL), means that, with their reduced prices, there is simply more opportunity to provide effective eHealth services.

Health care networks of the future

Whatever technological changes occur, the major challenge will be to make new technology available at the point of care with the patient. Here is where the use of broadband networks, such as internet2 (www.internet2.edu), is crucial. As health care is increasingly undertaken on the internet, some of the business models relevant to the distributed environment of the internet will become important in mental health. The traditional doctor-patient relationship is mirrored by the business-to-consumer (B2C) relationship. The B2C market will continue to amalgamate and expand, based on the core doctor-patient relationship but with fewer boundaries and more potentially difficult ethical contradictions and problems, especially for the doctors, including psychiatrists, involved.

The business-to-business (B2B), or doctor-doctor or health system-health system market, is probably even larger. At a clinical level, eMental health will allow psychiatrists to consult via the primary care doctor's desktop, using video technology. This will allow primary care doctors to seek rapid referrals and assessments from specialists, yet to maintain their relationship with their patient and not duplicate tests that might otherwise be performed by both themselves and the specialist to whom a patient is referred. Increasingly, this liaison style of consultation, where the specialist both sees the patient and teaches the primary care provider, will become routine; in many instances the patient will not necessarily be present, as the primary care practitioner is essentially supervised by the specialist.

This approach could lead to major changes in how health care is organised and delivered. Psychiatrists in, for

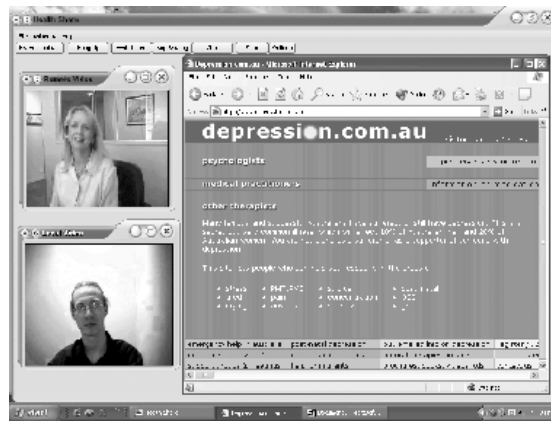


Fig. 1. The HealthShare portal, demonstrating an online health service environment in use in Australia.

instance, Sydney might supervise practitioners and their patients in New York because the international exchange rates make that financially acceptable, whereas practitioners in Boston might consult to Saudi Arabia, perhaps because of a particular individual expertise that makes up for the added cost. It is likely that, in the near future, global health care portals using broadband internet-based systems such as that developed by HealthShare (www.healthshare.com.au) (see Fig. 1), an Australian company, will be common.

Global clinicians of the future

It is inevitable that, over time, we will move to global health care systems, with psychiatrists and patients interacting in electronically distributed environments around the world, supported by broadband technologies, either wired or wireless. These global delivery environments on the doctor's desktop or in the patient's home will incorporate a variety of features, including video technology to allow video consultations in real time, or video email for store-and-forward programmes, as well as electronic consumer-owned or provider-shared, voice-driven health records. On the doctor's desktop there will be appropriate practice management and communications software that will be serviced from central servers or that may be kept on the doctor's own local network to allow him/her to link seamlessly in a peer-to-peer relationship with colleagues. This same desktop will have a very strong educational focus, as psychiatrists and other health care professionals will be able to receive their continuing health education, for professional credits and re-accreditation needs, via their desktop. They could achieve this by taking part in interactive video-conferences and virtual conferences on the internet, given by experts in their field and relayed to, potentially, many thousands of different sites; in addition, they could achieve this in a large number of flexible, work-based teaching environments, using video, audio and text, which will allow interactive quizzes simultaneously to be taken and marked and to be recorded for long-term monitoring.

The roles of some psychiatrists will change: many, for instance, will increasingly focus on the teaching and supervision of other health professionals and of groups of

It is inevitable that, over time, we will move to global health care systems, with psychiatrists and patients interacting in electronically distributed environments around the world, supported by broadband technologies.

There is absolutely no reason why future university programmes will not head in the same direction as our current sports teams, and this will be supported by the eHealth environments of the future, which will allow such 'superstar' teachers to be fitted easily into prearranged courses and programmes, anytime, anywhere.

consumers. Some specialists who are particularly good teachers will probably gradually migrate into the role of 'world authority' in certain areas. This is already happening in commercial university programmes, where some individual professors, mainly in areas such as business and economics and from universities like Yale and Harvard, have already become educational 'superstars'. Students will now enrol as much to hear their lectures as to take a particular course, and teachers will increasingly be employed to 'headline' particular teaching programmes, to attract students. There is a parallel here with how sports teams buy individuals with special talents to ensure success both on the field and financially. There is absolutely no reason why future university programmes will not head in the same direction as our current sports teams, and this will be supported by the eHealth environments of the future, which will allow such 'superstar' teachers, many of whom will come from the health world, to be fitted easily into prearranged courses and programmes, anytime, anywhere. Health education programmes will become more flexible and will be available ubiquitously.

A future distributed eHealth care environment

All of this will require a focus on distributed or enterprise systems of information and communications technology, and countries around the world are now beginning to address the variety of technical issues involved.

The health system has to meet the challenges contained in the recent crucially important report from the Committee on Quality Healthcare in America, published

by the Institute of Medicine (Ross *et al*, 2001). This influential report notes that 'information technology must play a central role in the redesign of the healthcare system' and suggests that the United States needs a renewed national commitment to build an information infrastructure to support health care delivery, and that 'commitment should lead to the elimination of most handwritten clinical data by the end of the decade'. For that to happen, the health system has to think seriously about its basic infrastructure requirements, and in the next century these will increasingly involve close collaboration with telecommunications providers.

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THEMATIC PAPER – TELEPSYCHIATRY

Cost issues with telepsychiatry in the United States

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Videoconferencing has increased patient access to psychiatric care by linking specialists at academic or regional health centres with primary health care professionals in shortage areas (Hilty *et al*, 1999, 2002). Preliminary studies have

demonstrated positive outcomes and user satisfaction (Hilty *et al*, 2002). Information is still being sought regarding costs because of a paucity of clinical outcome studies, cost data and randomised trials.

The overall effectiveness of telepsychiatry has recently been evaluated (Hilty *et al*, 2004a). Ideally, effectiveness should be considered in terms of the patient, the provider of services, the programme receiving services, the community receiving services and society at large. Telepsychiatry appears effective with regard to access to care, quality of care (in terms of outcomes, reliability, satisfaction and comparison with in-person care), education and the empowerment of rural communities. It may be premature to claim it is cost-effective because of a lack of data. This article reviews the cost data, discusses issues that affect costs and makes recommendations to reduce costs.

Methods

A comprehensive review of the telepsychiatric literature was conducted in the Medline, PubMed, PsychInfo, EMBASE, Science Citation Index, Social Sciences Citation Index and Telemedicine Information Exchange databases (1965 to July 2003). Key words included 'telepsychiatry', 'telemedicine', 'videoconferencing' and 'costs'. Article titles and abstracts were reviewed by the first author and references were reviewed for additional potential articles.

Results

Currently, there are over 50 telepsychiatry programmes in the USA and another 14 in Canada (Hilty *et al*, 2004b). Nearly all telepsychiatry services use dial-up integrated service digital network (ISDN) or T1 lines, and transmit at 128–512 kbit/s (there is typically a 0.3 s audio and video delay at the lower end of this range). Satellite transmission is eight times as costly and almost always involves a 0.5–1.0 s delay in communication between parties.

Telepsychiatry works well in a number of regards. Most studies have shown it to be diagnostically reliable compared with in-person care for a wide range of diagnoses for adults, children and geriatric populations (Hilty *et al*, 2004b). It appears to be generally acceptable to patients. Telepsychiatry appears to allow the building of relationships, with clear advantages over telephone consultation and few disadvantages compared with in-person care. It may improve outcomes; for example, in a study by Nesbitt *et al* of specialty consultation to primary care providers, including telepsychiatry, specialists changed the diagnosis in 91% of cases and recommended medication changes in 57%. Subsequently, 56% of patients showed clinical improvement (further details available from TSN on request).

Formal studies of cost-effectiveness are limited because:

- the scope of data collection is often limited
- cross-sectional rather than longitudinal measurement is done
- data have not been collected in a systematic, controlled, prospective fashion.

One meta-analysis found that only 38 of 551 articles contained any quantifiable cost data (Whitten *et al*, 2000). Ideally, direct and indirect costs should be collected for patients, clinics, providers and society at large. Many detailed guidelines have been published with recommendations for

the assessment of cost-effectiveness measures in health provider systems (Weinstein *et al*, 1996; Hailey & Crowe, 2000; Hilty *et al*, 2004b).

Costs of telepsychiatry services

Direct costs include equipment, installation of lines and other supplies. Fixed costs include the rental cost of lines, salaries and wages, as well as administrative expenses. Variable costs include data transmission costs, fees for service, and maintenance and upgrades of equipment. Costs are dependent on utilisation; for example, a break-even cost analysis is used in Alberta, Canada (Hilty *et al*, 2004b). In addition, the cost of telepsychiatry may seem high compared with that of 'usual care' in remote rural communities, where 'usual care' is often no care at all.

Telepsychiatry is in general less expensive for patients than a conventional consultation, largely because it reduces both travel and time away from work. Studies have been inconsistent in their estimation of whether telepsychiatry services are less expensive, as expensive or more expensive than outreach services that involve personal contact with the patient. Telepsychiatry, though, appears to be cost-effective in terms of reducing the numbers of patient transfers (e.g. Alessi, 1999) and hospital use (e.g. Lyketsos *et al*, 2001). Communities have been able to treat their patients locally and they have therefore retained money that would otherwise have been lost to suburban centres upon referral (Dimand *et al*, 2004).

The ongoing costs of maintaining telepsychiatry services have been a major problem throughout the United States. Start-up grants generally pay for technology, but not for staff coordination and long-term psychiatric (physician) service. Insurance or third-party payers have agreed to fund physician time in most regards, although they often require preliminary educational and administrative interventions. County mental health systems often deny telepsychiatry claims, partly in order to keep costs low but also because the services are provided outside of their system, in the medical sector. This is a problem because patients receive 60% of their mental health services from the medical sector, which they generally prefer because it generates less stigma and gives patients the ability to maintain their relationship with the primary care provider, and because of what is widely perceived to be inadequate care in the mental health sector.

Federal programmes have been established with high specialist reimbursement for some rural patients, but telepsychiatry services do not qualify. This is because telepsychiatry consultations are viewed as being provided 'outside' the designated clinics.

When rural agencies have funds available, contracts with academic consultation–liaison services have proved successful in terms of patient outcomes. The use of residents with faculty supervision appears to reduce costs and provides them with a meaningful learning experience. Consultation–liaison services benefit from an expansion in the scope of their work to the out-patient sector and improved reimbursement (e.g. salary and benefits, as reimbursement for an in-patient medical centre consultation is limited) (Bourgeois *et al*, 2003).

Telepsychiatry appears effective with regard to access to care, quality of care, education and the empowerment of rural communities.

It may be premature to claim it is cost-effective because of a lack of data.

The ongoing costs of maintaining telepsychiatry services have been a major problem throughout the United States. Start-up grants generally pay for technology, but not for staff coordination and long-term psychiatric service.

Little information is available about the cost-effectiveness and cost-benefit of telepsychiatry programmes.

Discussion

Little information is available about the cost-effectiveness and cost-benefit of telepsychiatry programmes; and data need to be collected in a standard, prospective, preferably longitudinal fashion. However, cost-effectiveness could be improved by use of a consultation-liaison model, whereby the telepsychiatrist evaluates the patient and makes recommendations for management by the primary care provider, who thereby gains skills that could benefit patients and the community setting. This educational role of telepsychiatry is especially important for the primary care providers of rural communities, in which 20% of the US population lives.

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THEMATIC PAPER – TELEPSYCHIATRY

Telepsychiatry in Europe

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The uses of videoconferencing included meetings (50%), supervision, training and teaching (31%), clinical consultations (14%) and tests or demonstrations (5%).... The low rate of clinical videoconferencing reflects a reluctance of key professionals to offer services this way.

Telepsychiatry, the use of videoconferencing in mental health care, has been piloted in European settings as diverse as northern Norway and inner London. These studies have been initiated to improve access to services and have been limited in scale. Nevertheless, some common themes have emerged.

Telepsychiatry in Norway

Gammon *et al* (1996) surveyed the use of videoconferencing in mental health services in northern Norway in 1995. Over six months, 1028 persons participated in 140 videoconferencing sessions from 35 institutions. The uses of videoconferencing included meetings (50%), supervision, training and teaching (31%), clinical consultations (14%) and tests or demonstrations (5%). The forms of contact that videoconferencing replaced included travel (59%), no contact (25%), telephone (14%) and mail or fax (2%). No problems were reported in 55% of the sessions. The majority of users reported that they were satisfied or very satisfied with the facility. The low rate of clinical videoconferencing reflects a reluctance of key

professionals to offer services this way. This network has continued to grow.

Gammon *et al* (1998) also reported the use of videoconferencing for psychotherapy supervision, over 384 kbit/s integrated service digital network (ISDN) connections. Trainees had five face-to-face sessions, alternating weekly with videoconferencing. The quality of supervision could be satisfactorily maintained by videoconferencing, for up to half of the 70 hours required for training. A precondition for this estimate was that the supervision dyad should meet face to face and establish a relationship characterised by mutual trust and respect. Major concerns reported by the participants were the loss of non-verbal cues and the effects this had on spontaneity, the expression of personal emotional material, and the experience of social and emotional presence.

Telepsychiatry in Finland

Mielonen *et al* (1998) reported on the use of videoconferencing in Oulu, where videoconferencing at 384 kbit/s was used for family therapy, occupational counselling, clinical consultation and teaching. In 1996, video-

conferencing was used in this area for a total of 249 hours, which increased to 434 hours in 1997. During 1997, 45% of the time was used for teaching, 26% for occupational counselling, consultations and therapies, 23% for training and 6% for administration.

Mielonen *et al* (2000) also reported on the use of videoconferencing for planning discharge from a mental health unit. The majority of participants stated that they would prefer to have their next meeting by video-conference. The most common reasons given were the reduced need for travel and the ease and speed of the consultations. An economic analysis showed that at a volume of 50 care-planning consultations per year, the videoconferencing alternative was about FM2340 cheaper than conventional meetings and the municipality would save about FM117 000 by using the medium. Six hours of travel time could be used for other purposes when the meeting was held by videoconferencing.

Telepsychiatry in the UK

The earliest UK work was reported from Guy's Hospital in London (McLaren *et al*, 1996). A link was established with the Speedwell Mental Health Centre, about six miles away, using a 2 Mbit/s leased line. Of 26 patients approached, 11 refused (five said they were concerned about confidentiality and video-recording, three said they had used it before and three said they did not understand). Patients' perceptions were more positive than clinicians' for every question on the satisfaction instrument and this reached statistical significance. Clinicians were less confident in judging the presence of psychiatric symptoms by videoconferencing than in person.

The Guy's group has gone on to pilot videoconferencing in an inner-London adult mental health service, for a population with high levels of morbidity and social deprivation. Videoconferencing has been used between a general practice and a community mental health centre serving the same area (McLaren *et al*, 2002). This work found high levels of service user acceptance. Information on refusals has been a useful aspect of this urban telemedicine research, where the benefits to service users are more marginal than in areas of low population density. Some service users believed it was an advantage to be seen in the general practitioner's surgery. Others felt they were 'missing out' and preferred to travel to the psychiatrist. Dropout rates were no higher for patients treated by videoconferencing, but patients treated this way may stay in contact with the specialist secondary service longer than those seen face to face.

May *et al* (2000) reported qualitative data from a telepsychiatry referral service for patients being treated by general practitioners for anxiety and depression, using the British Telecom VS1 desktop videophone operating at 128 kbit/s. Twenty-two patients and 13 doctors were interviewed after a videophone consultation. The doctors stated that they did not see a need for videoconferencing where accessibility is not a problem. The most important problem identified was the extent to which communication skills needed to be adjusted to meet the demands

of the medium. In a further qualitative analysis, it was reported that the use of videoconferencing in this way threatened professional constructs about the nature and practice of therapeutic relationships (May *et al*, 2001).

Frier *et al* (1999) described the use of videoconferencing in a psychology service in the Highlands of Scotland, which has one of the lowest population densities in the European Union. This service operated from 1997 and extended over a distance of 200 km between Inverness and the Isle of Skye, using BT VC7000 videoconferencing units connected by ISDN at 128 kbit/s. Twenty-seven adults and seven children were treated with cognitive-behavioural therapy by videoconferencing. Most service users complained of poor sound and picture quality, but were still satisfied with the consultations. A third expressed a preference for face-to-face consultation.

Ball (2003) has reviewed the use and potential of videoconferencing in old age psychiatry.

Pilot studies have begun in several forensic settings to explore the potential of videoconferencing to improve access to services for mentally disordered offenders.

Other projects

Gonçalves & Cunha (1995) described a telepsychiatry component in a telemedicine link between Lisbon and the Azores. Mannion *et al* (1998) in Galway reported on a link established with the island of Inishmore, off the west coast of Ireland. The European Union is currently funding the 'ISLANDS' telepsychiatry project. An international research group is studying the use of videoconferencing to support psychiatric service delivery in the Canary Islands, the Greek Dodecanes, French Guyana and Martinique.

Conclusions

Telepsychiatry has been piloted with a wide range of geographical locations and service models. Service user responses have been generally, but not uniformly, positive and these responses need further clarification. Professionals have embraced videoconferencing for supervision, education and administration, but are still wary of using it for communicating with service users for clinical tasks. This wariness may owe more to prejudice and professional defensiveness than to objective assessment. The costs of equipment and communication links have limited the diffusion of such applications to areas with low population density, where economic benefits are obvious. Costs of both are falling rapidly and the readiness with which service users, even while suffering from acute and severe mental illness, adapt to clinical consultations by videoconferencing suggests that this mode of service delivery could become commonplace, both for accessing scarce national and international tertiary expertise and for improving communication between elements of distributed urban community services.

Mental health services are facing growing demands and struggle to deliver effective treatments in sufficient quantity. Efficient communication between service elements and getting effective treatment to service users in a timely

Pilot studies have begun in several forensic settings to explore the potential of videoconferencing to improve access to services for mentally disordered offenders.

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Within two decades videoconferencing could be the preferred medium for contact between professionals and mental health service users in Europe.

fashion are two of the major challenges facing mental health services this century. Telepsychiatry has been shown to have the potential to improve both. Larger-scale economic evaluations are required and professional concerns need to be addressed through studies of the effects of the medium on clinical outcomes and therapeutic relationships. Within two decades videoconferencing could be the preferred medium for contact between professionals and mental health service users in Europe.

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COUNTRY PROFILES

Introduction

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Country profiles provide summary information on mental health policy, services, training and research in the country, along with key references for more details. The aim is to give a bird's eye view of the situation within about 1500 words. It is hoped that this will not only increase the reader's awareness of distant and often forgotten countries, but also provide an opportunity for learning from others' experiences. The profiles can also open possibilities for further dialogue and even collaboration.

This issue of *International Psychiatry* presents country profiles from Sri Lanka, Turkey and Azerbaijan. As well as giving rich descriptions of the situation within the countries, all three profiles clearly bring out the need for comprehensive mental health policies, supported by enhanced training of professionals for improving psychiatric care.

If you wish to make a contribution to the country profile section, please contact Shekhar Saxena (email saxenas@who.int).

Negative attitudes to mental illness, social stigma and a lack of appreciation of the suffering and disability caused by mental illness have resulted in low priority being given to mental health care services in Sri Lanka.

COUNTRY PROFILE

Mental health services in Sri Lanka

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Relative to its economic indicators, Sri Lanka has a high health status. The life expectancy in the year 2001 was 70.7 years for males and 75.4 years for females. Maternal and infant mortality rates have shown a downward trend over the past half century and now are around 2.3 per 10 000 live births and 16 per 1000 live births, respectively.

These trends are mainly due to the high literacy rate and comparatively large investments made in health and social welfare.

The situation regarding mental health care services is very different. As in many developing countries, negative attitudes to mental illness, social stigma and a lack of appreciation of the suffering and disability caused by mental

illness have resulted in low priority being given to mental health care services in Sri Lanka. This situation is, however, beginning to change.

Overview

Major psychiatric illnesses form the bulk of the clinical load of psychiatrists in Sri Lanka. The suicide rate, though declining, is still higher than global average rates (De Silva & Jayasinghe, 2003), and alcohol-related problems are rising (World Health Organization, 1999). Drug misuse, which appears to be less of a problem than alcohol misuse, is mainly confined to heroin and cannabis (Ratnayake & Senanayake, 2002).

Long-term mental illness has a considerable social, economic and health burden (De Mel, 2001). The fast-growing elderly population, which will amount to 21% of the overall population by 2020, is likely to pose enormous mental health problems. Thirty years of civil disturbances coupled with ethnic violence have resulted not only in trauma but also a range of other problems, including loss of life, refugees, displacement, the disruption of the physical and social infrastructure as well as the poor economic performance of the entire country. The inevitable mental and psychosocial distress associated with the above problems, especially in the north and the east, compounds the existing mental health burden.

In the absence of a formal referral system, patients have the liberty to consult any mental health professional – or any other type of healer – in any part of the country. In view of the concentration of services in urban areas and also because of the perception that services in urban areas are of better quality, many patients gravitate towards these centres.

Increasingly, the majority of acutely disturbed patients tend to seek psychiatric help early; however, others, especially those with somatic manifestations, tend to seek psychiatric help when the initial treatment by a range of healers, including those in the general health care services, fails.

Most psychiatrists working for the government or for a university additionally engage in private practice after their contracted working hours. Almost all patients prefer to seek private services at least initially and resort to public services only when they are pressed financially to do so.

Mentally ill offenders and those coming under the Mental Health Act are directly referred to mental hospital for admission and care. Police and social care agencies are generally reluctant to force the involuntary admission of patients living in the community.

Responsibility for the development of mental health services belongs to the Director of Mental Health Services, who works with the Advisory Council on Mental Health. Because all health services are organised in a very complex and bureaucratic manner, taking decisions and implementing them is a tedious process. However, attempts are being made to implement, in stages, both the recommendations of a presidential taskforce set up 1998 and the National Plan to strengthen mental health services,

which was prepared by a consultant from the World Health Organization (Ministry of Health, 2001).

The present public mental health services are organised around hospitals, which have no direct formal responsibility to a catchment area or a community.

In-patient services

The two large mental hospitals located in the suburbs of Colombo provide nearly 2500 in-patient beds. Long-stay patients occupy more than half of these. In addition to voluntary patients from all over the country, those referred by the courts, other units and involuntary patients reside in these institutions. The mental hospitals at present operate with severe staff constraints, as many positions are vacant. It is inevitable that, under these circumstances, the quality of patient care often has to be severely compromised. Although the need to develop provincial mental health services while phasing out the mental hospital facilities in Colombo is accepted by all stakeholders, practical steps towards realising this have not been taken.

The teaching hospitals and provincial general hospitals have a total of about 500 mental health beds in open wards. The average duration of an in-patient stay in a general hospital unit is around one to two weeks.

Out-patient services

Most major hospitals and some small hospitals offer out-patient clinics and day facilities. Basic psychotropic drugs and facilities for electroconvulsive therapy are available in most of these, while almost the whole range of drugs is available at the teaching hospital units, including newer drugs, which are also available in the private sector.

Non-medical mental health professionals carry out mainly psychological interventions. However, except in a few academic departments there are no clinical psychologists working in the publicly funded mental health services.

Rehabilitation services

With the assistance of the Nations for Mental Health programme, a project has begun to settle long-stay patients from the mental hospitals in the community. Recently, the Ministry of Health initiated a programme to develop intermediate-stay units at provincial level. Already about five such units are functioning. A few non-governmental organisations conduct residential rehabilitation programmes in the community.

An organisation called Sahanaya has been conducting a community-based rehabilitation programme since the early 1980s through its community mental health centre in Colombo. In addition, a number of innovative community-based programmes are being conducted in the central, north and eastern provinces at the initiative of psychiatrists and other mental health professionals.

The general health services provide detoxification and support for those with alcohol- or drug-related problems. In addition, a few state and non-governmental facilities provide residential care.

Major psychiatric illnesses form the bulk of the clinical load of psychiatrists in Sri Lanka.

The suicide rate, though declining, is still higher than global average rates and alcohol-related problems are rising.

With the assistance of the Nations for Mental Health programme, a project has begun to settle long-stay patients from the mental hospitals in the community.

Most non-governmental organisations are engaged in providing of a range of services, but advocacy and activism in mental health receive minimal attention.

At national level, the budget for mental health care, which amounts to about 1% of the overall health budget, is wholly allocated to the mental hospitals.

Specialised mental health services

Two child psychiatrists provide a specialised service in the children's hospital in Colombo, while a general psychiatrist with training in forensic psychiatry provides a forensic service at one of the mental hospitals. Residential facilities run by the social services tend to house children with severe learning difficulties and behaviour problems.

During the past two decades there has been a steady growth of counselling centres in the country, mostly in the non-governmental and private sector. There has been a phenomenal growth of counselling programmes conducted by foreign organisations in the north and the eastern provinces, many of which are directed at war-related issues.

Promotion, prevention and social care

Health programmes – such as school health, maternal and child care and adolescent programmes – have been successful in incorporating aspects of mental health.

The Ministry of Social Services has been increasingly active in supporting the social needs of those with mental illness, especially those with a long-term illness.

The Mental Health Act and mental health budget

The Mental Health Act, amended in 1956, focuses on involuntary treatment and it mandates a mental hospital to house all patients coming under the Act. The inability of the present Act to meet the needs of those with mental illness was recognised as far back as 1971 and since then a number of committees have produced drafts at various times.

At national level, the budget for mental health care, which amounts to about 1% of the overall health budget, is wholly allocated to the mental hospitals. However, individual general hospitals meet their own mental health care expenses.

Training

The academic departments of psychiatry in all six medical schools have undergraduate training programmes, which feature one to two months of clinical attachments as well as classroom teaching. The five-year postgraduate training programme in psychiatry initiated in 1981 at the Postgraduate Institute of Medicine, University of Colombo, has so far produced more than 70 psychiatrists, but Sri Lankan mental health services have been able to retain less than half this number.

The requirement of a research thesis as a part of the postgraduate programme in psychiatry has resulted in trainees being introduced to research. The numbers of research presentations by psychiatrists at scientific meetings and publications in local and international journals have increased over the past 10 years. Suicide, trauma, epidemiology, alcohol and long-term mental illness are some of the areas focused on.

In order to take psychiatry to the secondary care level, Sahanaya, with the support of the Ministry of Health,

initiated a three-year training programme for doctors in 1999. At present, nearly 40 medical officers in mental health serve at secondary care hospitals, thus complementing services rendered by psychiatrists. In 2001, at the request of the Ministry of Health, a one-year diploma programme was initiated and already 10 people have graduated. They are to be posted to secondary care hospitals to develop new hospital and community services.

The general nursing programme includes training in psychiatry for two months at a mental hospital. A post-graduate training programme established in 1965 unfortunately continued only for two years; however, a similar training programme was initiated in 2001.

Professional bodies

The Professional Association of Psychiatrists (which is to be renamed the College of Psychiatrists), established in the 1970s, has become more active in the recent past. There are a number of civil society or non-governmental organisations working in the area of mental health, the National Council for Mental Health being the oldest and most active. Most non-governmental organisations are engaged in providing a range of services, but advocacy and activism in mental health receive minimal attention.

Future challenges

During the past few decades there have been significant developments in the field of mental health. Most of these have been on the initiative of local groups in universities, non-governmental organisations or in the private sector.

There is an urgent need to provide accessible basic services of good quality to meet the emerging needs of people living in the community. In order to realise this objective, there is a requirement for a coordinated development strategy at national level, with political leadership and the support of an effective mental health planning and implementation unit.

The challenge for the Ministry of Health is to strengthen its leadership role in the development of mental health at a national level and to work towards a common goal in partnership with other government agencies, non-governmental agencies, universities, other groups and international agencies.

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Psychiatry in Turkey

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The Republic of Turkey has a population of 67.4 million (year 2000) and covers 783 563 km²; administratively it is divided into 81 provinces. A few national statistics from 2000 are: infant death rate 41.9/1000; life expectancy at birth 68 years; unemployment rate 6.6%; gross national product (GNP) per capita US\$2965; and adult literacy rate 87.32% (females 80.64%; males 93.86%) (State Statistics Institute, 2003).

Turkey is going through a period of continuous transition. Geographically, the country is a bridge between Asia and Europe (for this reason it has historically been a path for invasions and cultural exchanges) and therefore between the Western world and the Middle East. It is a secular republic but a large majority of the population is Islamic, and it is the only country with these features in NATO and Europe.

Even physically the land is in continuous transition – it is not stable and suffers great damage from earthquakes almost every four or five years, the largest in recent times being on 17 August 1999 in the Marmara region. The state of change is reflected in daily life as well. For example, the traditional, extended family structure is transforming into the more nuclear type. Some traditional national characteristics are being challenged. 'Turning the corner' has been the motto of many people, as the values and preferences of individuals, families and even institutions keep changing. The effects of the long-term high inflation rate, serious financial limitations and separatist activities (with armed conflict in the eastern part of the country) have all played a crucial role. Many people living in the villages have migrated to the peripheries of some of the larger cities or have left the country to work abroad, typically in Germany, France, The Netherlands or Belgium. The specific mental health problems of these migrants have been the subject of comparative studies (Gilleard, 1983; Van der Stuyft *et al*, 1993; Diefenbacher & Heim, 1994; Yazar & Littlewood, 2001).

Another characteristic feature of Turkey is the series of contrasts seen in almost all aspects of life, which inevitably is reflected in mental health issues, in terms of both psychosocial structure and psychiatric treatment.

None the less, there is stability in many respects, and this has an impact on psychosocial well-being. Solidarity often extends beyond family bonds, to members of the same village or even region. In almost every city there are areas where people from the same region of the country live together and offer each other social support.

Another important factor to be considered is the strong interpersonal links among the people. Traditionally people tend to talk about their difficulties and to share their feelings. Although sometimes such social support may be

undermined by intrusive and prescriptive attitudes, it is still possible to say that solidarity among people in general helps them to adapt to and overcome difficulties. This was observed after the devastating earthquake in August 1999 in Marmara. While therapeutic help was made available, most of the inhabitants of the tent cities served as 'patient listeners' to each other all through the long, empty days after the earthquake (Aydin, 2001).

Forty years of mental health policy development

The psychiatry practised in ancient Anatolia and even the relatively well developed psychiatric services during the period of the Ottoman empire are beyond the scope of this paper, which focuses on current psychiatry in Turkey. But to understand today and the vision for tomorrow, a brief overview of the recent development of mental health policy is necessary.

In the 1960s, improvements to the curative and rehabilitative services through their vertical organisation was the goal. Mental health dispensaries in Istanbul and Ankara served as extensions of the mental hospitals and so had only a limited remit regarding prevention and mental health promotion. At that time, a stand was taken against use of the Turkish equivalent of 'lunatic' and for its replacement by a term equivalent to 'mentally ill patient'. Efforts were made by the Ministry of Health to prepare a mental health policy, although only a few meeting notes remained when the next attempt at the same Ministry was made in the 1980s (Bayülkem, 1998).

At the time of the second attempt to draw up a policy on mental health, in the 1980s, I was in charge of the mental health department at the Ministry of Health. The goal then was the integration of mental health into primary health care (i.e. a horizontal approach) with promotion and prevention activities in addition to the improvement of curative services. For inter-sectoral and inter-disciplinary coordination there were efforts to get the involvement of different ministries, universities and non-governmental organisations, with the support of the World Health Organization (WHO). Five regions were established, each with one of the country's five mental hospitals at the centre. Regulations were put in place regarding referral to those centres and the follow-up of patients after discharge. The role of provincial mental health divisions was detailed, with emphasis on local mental health coordination councils (Coskun, 1987, 1988). Although most of the plans were prepared in close collaboration with regional and local staff, their implementation was limited and not much could be achieved in terms of a permanent outcome.

At the time of the second attempt to draw up a policy on mental health, in the 1980s, I was in charge of the mental health department at the Ministry of Health. The goal then was the integration of mental health into primary health care (i.e. a horizontal approach) with promotion and prevention activities in addition to the improvement of curative services.

Among a representative sample of 7479 people the prevalence of psychiatric disorders in the past 12 months according to ICD-10 criteria was 17.2%. The three most common psychiatric illnesses were pain disorder (8.4%), major depression (4%) and a specific phobia (2.7%).

Psychiatrists mainly work in large cities and in the western parts of the country. According to the figures of the Psychiatric Association of Turkey, 760 psychiatrists out of 1149 (i.e. around two-thirds) are located in Istanbul, Ankara and Izmir.

Through the early 1990s, there were health reform studies at the Ministry, where mental health issues were discussed once more. Most important in that decade was the epidemiological study of mental health (Erol *et al*, 1998). After the Marmara earthquake in 1999, the need for an overall policy with local action plans was once more realised at ministry level. A more organised process has been planned, with the financial support of the World Bank; a permanent but flexible structure is now being worked on, with contributions from different sectors and disciplines (Ulug, 2003).

Provision of psychiatric services

Most psychiatric services are provided by hospitals attached to the Ministry of Health. The private sector accounts for only 150 of the total of 6146 beds. At the five mental hospitals run by the Ministry of Health there are 5570 beds in total, while the two hospitals attached to the Ministry of Social Security have 426 beds (Ministry of Health, 2002). A considerable portion of these beds are still occupied by long-stay patients, which limits the number of beds available for other patients, many of whom are therefore repeatedly re-admitted shortly after being discharged too soon. The programme on referral procedure mentioned above, with special guidelines for patient follow-up at a local health centre after discharge, was planned to decrease the number of repeat admissions, but the new procedure has not been universally adopted.

The number of psychiatric beds in general hospitals is not detailed in the current statistics, but the number of psychiatrists working at general hospitals gives an idea of the scale of those institutions' provision of psychiatric services: of the 398 psychiatrists working at hospitals attached to the Ministry of Health, 238 work in general hospitals and 138 at the five specialist psychiatric hospitals. The tendency to set up psychiatry divisions at general hospitals has increased the provision of local help for people with psychiatric problems. Psychiatrists mainly work in large cities and in the western parts of the country. According to the figures of the Psychiatric Association of Turkey, 760 psychiatrists out of 1149 (i.e. around two-thirds) are located in Istanbul, Ankara and Izmir.

This uneven distribution also pertains to psychologists. Six psychology departments provide master and doctorate education. Legally (as set out in a statute dating from 1930) clinical psychologists must work under the supervision of psychiatrists. But especially in large cities there are many private clinics run by psychologists, a few of whom are without proper clinical psychology training. On the other hand, most clinical psychologists are well trained, but they need their legal status to be looked at urgently. Similar to psychiatrists, 149 of 266 psychologists working within the Ministry of Health are at general hospitals, compared with 34 working in specialist psychiatric hospitals.

There are few psychiatric social workers and psychiatric nurses; most of the latter work within higher nurse education. None the less, there are many highly experienced nurses working in psychiatric clinics, although they are not entitled to call themselves psychiatric nurses.

Consumers of mental health services

An epidemiological study was carried out by the Ministry of Health on the mental health status of the Turkish population (Erol *et al*, 1998). Among the representative sample of 7479 people the prevalence of psychiatric disorders in the past 12 months according to ICD-10 criteria was 17.2%. The three most common psychiatric illnesses were pain disorder (8.4%), major depression (4%) and a specific phobia (2.7%). The professional first contacted for psychological problems was: a psychiatrist (39%), another specialist (e.g. an internist or neurologist) (33%), a general practitioner (21%) or a religious healer (3.6%). The three disorders with the highest rates for any contact were: panic disorder, obsessive-compulsive disorder and somatisation disorder.

The same report revealed that antidepressants were the most commonly used psychotropic medication. Five per cent of the general population interviewed were using psychotropic agents (antidepressants were used by 66% of these, sedatives by 23%, antipsychotics by 7% and anti-epileptics by 2%). Fifty-one per cent had received medication from 'other' specialists, 22% from psychiatrists, 18% from general practitioners and 5% from pharmacists, while 4% had taken them without making a professional consultation (Erol *et al*, 1998).

Other than the above-mentioned disorders, conversion disorder and dissociative disorders are commonly observed and draw scientific attention (Tutkun *et al*, 1998; Sar *et al*, 2000; Kuloglu *et al*, 2003).

There are some newly founded associations that focus on the rights and welfare of psychiatric patients and their relatives, most of which are currently led by professionals who wish to promote 'consumer-led' services (Ankara University Psychiatry Department, 2000). This support for patients' rights follows on from more general discussions of human and consumer rights in the country.

Education and research

Mental health education and education in the behavioural sciences are overlapping areas in the formal training of different disciplines. At medical schools, in addition to behavioural sciences in the first year, theoretical and practical psychiatry is provided in later years, and there is a four-week practical course in the final year.

It is often argued that six years of medical training is not sufficient to equip the practitioner with the necessary knowledge and skills to handle psychiatric evaluation and care, so that in-service training is needed to provide better integrated care at primary health care level. Sometimes there are discussions regarding the motivation for those in-service training programmes – there is a view that some programmes are too closely associated with the pharmaceutical industry and attempt to encourage the use of medication by specialists other than psychiatrists and by local primary care practitioners.

Psychiatric training is provided at 36 university psychiatry departments and 12 training hospitals, most of

which are attached to the Ministry of Health. Child and adolescent psychiatry has been a separate specialty since 1995.

An increasing number of multi-centre research projects are being carried out, some with international collaboration (Ustun & Sartorius, 1995). The psychiatry department at Hacettepe University is a collaborating centre of the WHO.

Some other topics for research include: the pathways to psychiatric care, the use and effectiveness of psychotropic drugs, the effects of disasters, consultation–liaison psychiatry, attitudes and behaviour towards people with a mental illness, and the epidemiology of some psychiatric disorders.

Law and ethics

Ethical rules for psychiatric practice were established in June 2002 by the Psychiatric Association of Turkey; the rights and responsibilities of psychiatrists were underlined with reference to patients' rights, and recommendations were set out on ethical issues regarding research and publication procedures.

Some mental health issues are covered in articles of the Turkish constitution, such as the duty of the state to provide for the physical and mental health of individuals, and the rights to live freely and to develop physical and mental well-being; limitations to these rights can be defined only by law, and there is a prohibition against torture and the undermining of human dignity.

The civil law was renewed in January 2002. It now details the civil rights of citizens and the conditions for the limitations of those rights; it also covers the marriage and divorce of mentally ill people.

The criminal law stipulates special conditions for the treatment of mentally ill offenders.

Lack of an overall mental health law continues to be a concern for the mental health profession. The Psychiatric Association of Turkey has chosen to begin work on a draft law for the protection of the rights of psychiatric patients, rather than a 'mental health law'. In this draft there are items on principles relating to, for example, the rights of patients, including issues on privacy, consent to treatment and involuntary hospitalisation, as well as the roles of psychiatrists and judges. Currently the congruency of this draft and implementations of the new civil law are being studied. The next step will be to send the revised draft to the Ministry of Justice for amendment, before it is submitted to parliament.

Conclusions

In Turkey at present, the main concerns for psychiatry are:

- the development of a mental health policy
- improved education and training in psychiatry
- better psychiatric care
- increasing the amount of collaborative research
- work against stigmatisation
- collaboration with the consumers of mental health services and their relatives

- the integration of a mental health component into primary health care and general health care
- mental health promotion and illness prevention.

The rapid changes in socio-economic conditions, the effects of the media, the unstable socio-political situation, the high percentage of young people in the population, unemployment and people not being able to get higher education are other, more general areas of concern.

The national decision makers do not seem to be aware of the effects of psychosocial realities beyond referring to these issues in their public speeches. Mental health specialists should spare more time and energy to collaborate with decision makers at local and national level, bearing in mind that the improvement of mental health and psychosocial well-being is far beyond the capacity of (mental) health specialists to deal with by themselves.

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Mental health services in Azerbaijan

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This brief summary is drawn from a more extensive, detailed country profile available at <http://193.164.179.95/imhpd/>.

Azerbaijan is a nation with a Turkic population which regained its independence after the collapse of the Soviet Union in 1991. It has an area of approximately 86 000 km². Georgia and Armenia, the other countries comprising the Transcaucasian region, border Azerbaijan to the north and west, respectively. Russia also borders the north, Iran and Turkey the south, and the Caspian Sea borders the east. The total population is about 8 million. The largest ethnic group is Azeri, comprising 90% of the population; Dagestanis comprise 3.2%, Russians 2.5%, Armenians 2% and others 2.3%.

The gross domestic product (GDP) per capita in 2002 was US\$755 and 0.9% of the GDP was allocated to health. The proportion of the national budget spent on the overall health system is 6.6% and mental health expenditure is 0.33% of the total national budget. The numbers of physicians (of all specialties), paramedical staff and beds per 10 000 population are, respectively, 36.3, 74.6 and 86.0 (State Statistical Committee, 2002).

Azerbaijan is one of the first republics of the former Soviet Union to face a large-scale refugee problem. At present there are 819 000 refugees and internally displaced people, who had to leave their homes owing to the 1988–93 armed conflict with Armenian military forces in Nagorno-Karabakh (Ismayilov & Ismayilov, 2002).

Current mental health system

In line with the old Soviet model, mental health care in Azerbaijan is oriented to the institutional approach, but the conditions within the psychiatric institutions do not meet basic standards. Primary care for people with mental illness is not well developed, although almost all kinds of service are available at the level of specialist care. The principal mental health care providers are psychiatric hospitals, psychiatric dispensaries and psychiatrists in private practice.

There are 5.0 psychiatrists per 100 000 population. Each administrative district of the country has an out-patient clinic with a consulting room for a psychiatrist. Moreover, eight cities have inter-regional psycho-neurological dispensaries (PNDs), with out-patient and in-patient facilities. In the city of Baku there are two PNDs: one of them provides services to children, the other to adults (Aliyev, 1999).

In-patient treatment is provided by nine psychiatric hospitals. In addition, there are psychosomatic departments in two large general hospitals and psycho-neurological departments in the military hospitals. The total number of beds is 5670, or 71 per 100 000 population.

Some metropolitan districts, such as Baku, Soumgaıt and Gandja, are able to provide round-the-clock psychiatric teams working in an ambulance service.

The main restriction on mental health care in Azerbaijan is financial. A doctor's salary is around US\$10–20 a month. As a rule, physicians also demand a fee for their services, and there is therefore little difference between the private and public sectors. Illegal demands for payments are often made for mental health services, as well as for drugs, and food in hospital. In fact, most people are not able to afford hospital treatment, which costs on average US\$200–250, and most patients do not wish to go into hospital even if they are financially secure. The other disadvantages of the existing system are the over-centralisation of services and a paternalistic approach towards people with mental illness. Community care and rehabilitation are carried out by a few non-governmental organisations involved in local mental health projects (Akhundov, 2001).

Since the arrival of the large number of refugees, the national government has passed several acts related to privileged services for refugees. One of the first of them was Order 145, which simplifies the process for the admission of refugees to psychiatric institutions, regardless of their place of residence and the availability of referral from a primary care institution. In addition, some special pharmacies that supply medicines free of charge to refugees were established.

Epidemiology

Systematic epidemiological studies have not been performed in Azerbaijan. According to official statistics (Ministry of Health, 2001), the number of patients with a first psychiatric diagnosis in 2001 and the total number of psychiatric patients registered in PNDs per 100 000 population were 85.8 and 1034.5, respectively. (These figures relate to severe mental disorders only.)

Despite a relatively low rate of suicide, of 2.7 per 100 000, there is a consensus among mental health professionals that the prevalence of depressive, anxiety and somatoform disorders has dramatically increased recently (Ismayilov, 2000). Also evident is an increase in alcoholism and drug misuse (presently with a prevalence of 274.4 and 191.3 per 100 000, respectively).

Training in psychiatry

At undergraduate level, psychiatric education is available at the Azerbaijan Medical University. In the fourth and fifth years of their course, medical students are obliged to study

In line with the old Soviet model, mental health care in Azerbaijan is oriented to the institutional approach, but the conditions within the psychiatric institutions do not meet basic standards.

psychiatry (including medical psychology); this involves about 150 hours of academic work at the Department of Psychiatry. At this level the training programme is divided in two sections – a series of lectures on the theoretical foundation to the subject, and workshops on general psychiatry (psychiatric disorders). Additionally, medical students have to acquire skills in the interviewing and assessment of psychiatric patients.

A medical graduate who wishes to become a psychiatrist spends one year as an intern at a psychiatric hospital and after passing the special examination can start working independently. The intern programme is focused on obtaining initial experience in diagnostics and treatment. Such training is insufficient and the administration of the Medical University, jointly with the Ministry of Health, has planned a four-year programme of training, which is due to be implemented from 2005.

Every five years psychiatrists have to have four months' training at postgraduate level at the Department of Psychiatry of the Azerbaijan State Doctors' Advanced Training Institute. Unfortunately, because of the obsolete training programmes and old-fashioned approaches, this continuing education is not particularly effective. There are no subspecialty programmes (e.g. in child and adolescent, geriatric or forensic psychiatry or psychotherapy). Before the collapse of the USSR, mental health professionals from Azerbaijan could be trained at the accredited Soviet scientific centres, generally those in Moscow and St Petersburg. At present the country does not have bilateral arrangements with other countries for training in psychiatry.

A two-year programme is provided for the training of nurses. This includes a 32-hour combined course on psychiatry and neurology. Psychiatric nurses need not have any specialist psychiatric training and can start working as soon as they leave nursing school. Psychiatric nurses do, however, receive 192 hours of specialist training once every five years. This continuing education is formally encouraged by linking it to further qualifications; if a further degree is obtained, this is rewarded by an increase in salary (although this increase amounts only to US\$2–3 per month). However, it has to be said that most mental health professionals are not satisfied with the standard of this continuing education for psychiatric nurses.

In 1999 a training programme for clinical psychologists was launched at Baku State University; however, their official involvement in the provision of mental health services has not yet been established. There are at present no training programmes for other mental health professionals, such as psychiatric social workers and occupational therapists.

Azerbaijan Psychiatric Association

Over the past five years the Azerbaijan Psychiatric Association (AzPA) has worked in partnership with the World Psychiatric Association, the Association of European Psychiatrists and the Geneva Initiative on Psychiatry to improve mental health care in the country. One initiative of the AzPA has been to translate important documents,

including ICD–10, guidelines on ethics in psychiatry and the Madrid Declaration, into the Azeri language and to distribute them among mental health professionals. More than 50 members of the AzPA have participated at international scientific meetings. Also several members of the Association were involved in the ANAP Project (Attitudes and Needs Assessment in Psychiatry) conducted in six countries of Central and Eastern Europe.

Mental health reform

One of the first steps towards reform of the mental health services resulted in the adoption of the Mental Health Law by the Azerbaijan parliament on 29 June 2001. Derived from Western standards of mental health care, the Law is focused on the protection of the civil and human rights of mentally ill people and it regulates mental health service provision. With the help of international organisations (including the Geneva Initiative on Psychiatry and the International Consortium for Mental Health Policy and Services) a working group has been established to draft documents on mental health policy and a national mental health programme. This working group has indicated that the main priority is a programme of deinstitutionalisation, with the simultaneous development of community services; also required are an improvement in the financing and distribution of services, and the establishment of effective links between the different sectors involved in mental health (Musabayova & Zeynalova, 2000; Manuchery-Lalei, 2000; Ismayilov, 2001).

Collaborative efforts should be undertaken to prevent stigma and to involve users in the planning and evaluation of services. Finally, the priority for any mental health policy must be to improve the system of training. The training of psychiatrists should meet contemporary standards of professional education, and specialist training programmes in clinical psychology, psychiatric social work, psychiatric nursing, occupational therapy and so on need to be developed.

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Psychiatric response to the AIDS epidemic in the United States

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The first case of AIDS in a state psychiatric facility was diagnosed in 1983, when a woman in her mid-20s, who had been hospitalised for several months, developed *Pneumocystis carinii* pneumonia.

In the early 1980s, when the first cases of AIDS were being reported in the gay population and among intravenous drug users, epidemiological research indicated that the disease was both blood-borne and sexually transmitted. Mental health care workers had little concern about infection among people with serious and persistent mental illness, because this population was felt to be too disabled to engage in the sexual or needle-sharing behaviours that put one at risk. Yet the first case of AIDS in a US state psychiatric facility was diagnosed in 1983, when a woman in her mid-20s, who had been hospitalised for several months, developed *Pneumocystis carinii* pneumonia (Cournos *et al*, 1989). This case was quite shocking to the treatment team, for two reasons: first, AIDS had unexpectedly entered the psychiatric population; and second, the person infected was a woman, when the disease was being reported almost exclusively in men in the United States.

The scale of the problem

From the early to mid-1990s, studies began to appear in the literature reporting HIV infection rates among people with serious mental illness. Reported rates of HIV infection varied widely, from a low of 4.0% to a high of 22.9% in samples of psychiatrically ill subjects (Cournos & McKinnon, 1997). It should be noted that most of these studies were conducted in New York City on in-patient psychiatric units and that the infection rate in the general population of that region at that time was estimated to be approximately 1%.

The wide range of reported rates of infection may be examined in terms of the sub-population of people with psychiatric illness that the studies targeted. The lowest reported rate of infection, 4.0%, was found among long-stay psychiatric patients (Volavka *et al*, 1991). These patients had been hospitalised for at least a year in a state psychiatric facility and were considered to represent those with the most chronic mental illnesses. Among patients admitted to psychiatric units, excluding those with a primary diagnosis of substance misuse, the rates of HIV infection ranged from 5.5% to 8.9% (Cournos *et al*, 1991; Sacks *et al*, 1992; Empfield *et al*, 1993; Meyer *et al*, 1993; Stewart *et al*, 1994; Schwartz-Watts *et al*, 1995). Infection rates among those admitted to special units for the treatment of combined diagnoses of serious mental illness and alcohol/substance use disorders ranged from 16.3%

to 22.9% (Lee *et al*, 1992; Susser *et al*, 1993; Silberstein *et al*, 1994). Most of these research projects used convenience samples of consecutive admissions over a circumscribed period of time and anonymously tested the patients using waste blood that was drawn at the time of admission. Two studies that examined the HIV detection rate by hospital staff of those who had anonymously tested positive reported that only 28% (Cournos *et al*, 1991) and 35% (Stewart *et al*, 1994) of those who were found to be HIV positive were identified as being infected during their hospital stay.

A number of interesting findings have been reported in recent years that indicate that mentally ill people are over-represented among those with HIV infection, that they are not being adequately assessed for HIV risk behaviours and that they are diagnosed later in the course of infection. A study of the HIV Medicaid database in New Jersey revealed that over 12% of that population had a major mental illness (Walkup *et al*, 1999). Two studies among psychiatric out-patients in New York State revealed that less than one-third of the programmes were conducting routine HIV risk assessment (McKinnon *et al*, 1999; Satriano *et al*, 1999). A preliminary look at the cost of providing HIV-related medical care to the New York State Medicaid population indicated that it was significantly more costly to provide such care to persons who had a concurrent diagnosis of a major mental illness (Mental Health, Drug Use and HIV Medicaid Data Workgroup, 1999). The implication of this finding is that they were much more physically ill with HIV-related disease when diagnosed than those without a mental illness.

Reluctance to assess risk

In spite of these greatly elevated rates of HIV infection among people with mental illnesses, mental health care workers remain reluctant to assess patients for a history of risk behaviour and to recommend voluntary testing to those found to be at risk. Other than the two studies cited above which found that only about one-third of out-patient mental health care settings routinely screened for HIV risk among new admissions (McKinnon *et al*, 1999; Satriano *et al*, 1999), little research has been done to quantify this reluctance. Anecdotal evidence, however, suggests that several factors may come into play. First, there is a resistance to recognising HIV risk behaviour among mentally ill people. Despite reports of elevated rates of infection and of behaviours that transmit HIV among them, care workers often underestimate the occurrence and frequency of

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these behaviours. Second, some mental health care providers have voiced concerns that merely asking about sexual and drug use behaviour may exacerbate psychiatric symptoms. They believe that broaching these topics is contraindicated in this population. Third, the knowledge that a patient is infected with HIV may raise a number of clinical and ethical dilemmas for the treatment team. Do sexually active or sexually provocative patients infected with HIV represent a risk to others? Is there a duty to warn others of the infected patient's status? Should condoms be provided on in-patient services? Should HIV status be taken into account in room or ward assignment? Finally, it is frequently true that mental health care providers must assume responsibility for helping patients with serious mental illness to access medical care. Many psychiatrists are reluctant to take on the coordination of the increasingly complex clinical management of HIV infection. In addition, some of the currently prescribed antiretroviral agents have psychiatric side-effects and overlapping toxicities with psychotropic agents, and can also cause significant drug interactions with psychotropic medications (McDaniel *et al*, 2000).

Improving the treatment of HIV-positive patients

Our current systems of care generally separate treatments for medical conditions, mental health problems and substance misuse, to the extent that the provision of each is overseen by a distinct agency. Individuals needing all of these arenas of service frequently find them poorly coordinated and unavailable at a single site. Although we need to develop a coordinated system of care that is able to integrate treatments, there are still many things that mental health care providers can do to improve the treatment of patients who are HIV infected and to prevent infection in those who are not.

Routine comprehensive HIV risk assessment should be part of all patient intake evaluations for in-patient and out-patient programmes, and this assessment should be repeated at least annually. For those found to be at risk of HIV infection on assessment, counselling for voluntary HIV testing should be conducted and this should emphasise the benefits of early detection and treatment, and the importance of preventing transmission of the virus to others. Risk-reduction and harm-reduction groups should be ongoing and offered to the HIV infected and uninfected alike.

For those testing positive for HIV, mental health care providers should be aware of where patients can go to receive comprehensive medical follow-up and help them to get care. The prescribing of psychotropic medication needs to be coordinated with the provision of antiretroviral medication by the providers of medical care, in order to

avoid adverse reactions. Finally, since mental health care staff may see patients frequently, even daily, their role in medication monitoring cannot be overemphasised. Many of the antiretroviral medications must be taken on a strict schedule in order to prevent viral drug resistance. Mental health care providers should be aware of the varied needs of people infected with HIV who also have a mental illness and be ready to meet those needs.

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Do sexually active or sexually provocative patients infected with HIV represent a risk to others?

Is there a duty to warn others of the infected patient's status?

Should condoms be provided on in-patient services?

Should HIV status be taken into account in room or ward assignment?

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The World Association for Psychosocial Rehabilitation

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The primary aim of the WAPR is to provide to all stakeholders a forum for the ongoing discussion of the relevant issues concerning the long-term care of people with mental disorders.

The World Association for Psychosocial Rehabilitation (WAPR) could be considered as a newcomer among scientific societies in the mental health field, because it was established in 1986 in France, when about 100 professionals from 35 countries met at its founding congress. That congress was preceded by an extensive international planning process, which began with the First World Congress on Rehabilitation for the Mentally Ill in Helsinki, in 1970. Subsequent meetings of key professionals and agency representatives from various countries, mainly supported by the World Health Organization (WHO) and the International Labour Office, resulted in the formation, in 1980, of a promoting group which planned, through its international secretariat, the foundation of the WAPR. Therefore, close links with the mental health programme of the WHO have been maintained by the WAPR since its beginnings.

Dr Benedetto Saraceno, the current director of the WHO's Department of Mental Health and Substance Dependence, was President of the WAPR between 1993 and 1996. The present Executive Board is shown in Table 1.

Table 1. The WAPR Executive Board, 2003–06

Office	Current holder
President	Angelo Barbato (Italy)
Immediate past President	Zebulon Taintor (USA)
President-Elect	Michael Madianos (Greece)
Secretary General	Lourdes Ladrido-Ignacio (Philippines)
Treasurer	Ernesto Muggia (Italy)
Vice-President	Ida Kosza (Hungary)
Vice-President	Ana Fernandes Pitta (Brazil)

Table 2. The WAPR Regional Vice-Presidents, 2003–06

WHO region	Vice-President
Africa	Paul Sidandi (Botswana)
Americas	Humberto Martinez (USA)
Eastern Mediterranean	Haroon Rashid Chaudhry (Pakistan)
Europe	Edvard Hauff (Norway)
South East Asia	Thyloth Murali (India)
Western Pacific	Naotaka Shinfuku (Japan)

The growth of the WAPR in the following years reflected the increasing importance of the prevention and reduction of social disability as a framework for the long-term community care of people with severe mental disorders.

Today, the WAPR is recognised as a non-governmental organisation with consultative status with the WHO, the United Nations (UN) Economic and Social Council, and the International Labour Office. Moreover, it also maintains relations with the European Commission and the African Rehabilitation Institute.

Organisational structure

Currently, the WAPR has a 46-member International Board of Directors, which includes six past Presidents and a Regional Vice-President with one or more deputies for each of the six regions of the world, following the regional structure of the WHO (see Table 2). Moreover, the Board includes representatives of consumers, families and voluntary organisations, as well as permanent representatives located in Geneva and New York, to link with WHO and UN agencies. More than 80 national secretaries represent the same number of national chapters across the world.

Membership of the WAPR is open not only to mental health professionals but also to researchers of various disciplines, administrators, policy makers, consumers and their relatives, and advocacy associations. This is because the primary aim of the WAPR is to provide to all stakeholders a forum for the ongoing discussion of the relevant issues concerning the long-term care of people with mental disorders.

Publications

The WAPR publishes a quarterly *Bulletin*, while the *International Journal of Mental Health*, edited in New York by a WAPR past President, Martin Gittelman, serves as a medium for publication of scientific papers and conference proceedings related to various aspects of psychosocial rehabilitation. Local bulletins are published by several national branches, such as in Spain, South Africa and India.

Mission and goals

The mission of the WAPR is the dissemination of principles and practices of psychosocial rehabilitation. In the

WHO/WAPR consensus statement jointly endorsed in 1996, psychosocial rehabilitation is defined as a process that facilitates the opportunity for individuals impaired, disabled or handicapped by a mental disorder to reach their optimal level of functioning in the community. It implies both improving individuals' competencies and introducing environmental changes in order to improve their quality of life.

It is therefore clear that psychosocial rehabilitation is a complex and ambitious strategy encompassing many different sectors and levels, centred on the relation between the individual with a mental disability and society as a whole. In consequence, the bodies involved with psychosocial rehabilitation are varied, and their means and tools vary as well, depending on the geographic, cultural, economic, political, social and organisational characteristics of the settings in which care is provided.

Within this broad frame of reference, the WAPR's activities cover a number of areas:

- promotion of national and international legislation, policies and programmes to meet the basic and special needs of people with a mental illness
- international exchange of experiences and best practices in the field of rehabilitation of mental disorders
- organisation of training opportunities for health professionals, to introduce strategies for psychosocial rehabilitation in specialist and primary health care services
- consultation to local, national and international agencies

to promote improved care, rehabilitation and services for people with a mental illness

- educational programmes to ensure maximum public, professional and government understanding of the needs and rights of people with disabling mental illnesses
- enhancement of the development and organisation of consumers' and families' associations, and mutual and self-help groups of individuals and carers affected by disabling mental illnesses
- promotion of open dialogue among consumers, policy makers and professionals
- collaboration with the UN, the WHO and the International Labour Office, by supporting the strategies for the treatment and rehabilitation of people with a mental disability within a community-based care approach
- technical assistance to developing countries with regard to the funding and development of community-based rehabilitation programmes
- research on innovative approaches to the integrated care of people with mental disorders
- definition of standards, benchmarks and quality improvement tools in relation to community care.

As can be seen, the WAPR is at the same time a scientific society, a multi-disciplinary professional organisation and an advocacy group. It will celebrate its twentieth birthday at its ninth congress, to be held in Athens in October 2006. We will welcome everybody interested in fighting the disability related to mental disorders and raising the quality of life of people with mental illnesses.

Psychosocial rehabilitation implies both improving individuals' competencies and introducing environmental changes in order to improve their quality of life.

NEWS, NOTES, FORTHCOMING INTERNATIONAL EVENTS

News and notes

For contributions to this column, please contact Brian Martindale FRCPsych, Psychotherapy Department, John Conolly Wing, West London Mental Health NHS Trust, Uxbridge Road, Hanwell UB1 3EU, UK, email brian.martindale@wlmht.nhs.uk

2004 College Annual Meeting

This meeting in Harrogate should be a special attraction to our international members. As well as the important overall focus on 'Caring for Carers', there will be our now 'traditional' full-day stream organised by the Board of International Affairs involving presentations from the College International Groups. See www.rcpsych.ac.uk/2004.

The 12th Congress of the Association of European Psychiatrists (AEP)

14–18 April 2004, Geneva

A very attractive scientific programme will include:

- *Interactive main sessions*, on challenging issues directly relevant to the identity and future of European psychiatry (conflicts of interests; the role of psychodynamic psychotherapy in training and practice; community

psychiatry – myth or reality?). Experts with opposing views will debate and the audience can vote

- *Meet-the-expert sessions*, in which leading European psychiatrists will interact, especially with younger psychiatrists
- *High-quality symposia* on many contemporary European research and clinical issues
- *Continuing medical education courses*
- *Poster sessions*
- *Workshops* debating ongoing research

The Congress website, for further information, is www.kenes.com/aep2004.

Launch of South Asian Overseas Group in Sri Lanka

The South Asian Overseas Group (SAOG) was launched on 19 August 2003, during an International Conference

Two pilot placements in Sri Lanka are now available for 2004 in the RCPsych/VSO Fellowship scheme.

on Psychiatry, organised by the UK Chapter of the South Asian Forum on Mental Health and Psychiatry. The countries involved in the SAOG are India, Pakistan, Bangladesh, Sri Lanka, Nepal, Malaysia and Singapore.

Professor Ghodse, Director of International Affairs at the Royal College of Psychiatrists, chaired the session. Dr Shooter (President), Professor Bhugra (Dean) and Dr Mahadeshwar also represented the College. Dr Shooter described the changing role of the College and hoped the Overseas Groups would develop identities of their own. He invited the International Groups to be innovative and progressive. Dr Mahadeshwar gave the background to the development of this Group and the perspective of the College's Board of International Affairs.

Questions from the floor related to Fellowships, international recruitment and affiliateships. Professor Ghodse advised that these issues would need to be taken up by the SAOG through appropriate College channels. Dr Patel stressed the need to involve the local psychiatric associations and South Asian psychiatrists in the UK.

Dr Patel convened an election of a Chairman for the SAOG and E. K. Rodrigo, President of the Sri Lanka College of Psychiatrists, was unanimously elected for one year in the first instance (because within this period it is anticipated that International Groups would become Divisions in the College). A shadow Executive Committee was formed with members from different countries in South Asia. Our special thanks to Professor R. Mohan and Dr A. Javed for organising the Royal College session.

The next meeting of the SAOG will be on 17–20 September 2004 in Lahore.

Dr Shridhar Mahadeshwar

The EU and mental health

Mental health is increasingly on the agenda of the European Union (EU). One way of finding out where interest is currently focused is to access the EU health website and search for mental health publications. Within a short time, learned articles were found on such diverse areas as promoting mental health in children aged up to 6 years, a similar one on adolescents and young people, indicators for monitoring mental health in Europe, and future mental health challenges in Europe. The website is http://europa.eu.int/comm/health/index_en.htm.

The Faculty of Old Age Psychiatry

The Faculty celebrates its 30th anniversary this year. It has much to be proud of. It has made a unique contribution in the UK to better diagnosis, treatment and care of older people with mental illness, to training and to research, so that the UK is pre-eminent in this field. It now seems timely to consider how we can help, through teaching and service, in developing countries, where, in sharp contrast, there are few or no specialist services. To this end there will be a workshop on this subject at the next residential meeting of the Faculty of Old Age Psychiatry in Liverpool, on 4–5 March 2004. Please email norigraham@aol.com if you are interested in contributing or participating.

Royal College of Psychiatrists and VSO Fellowships

These one-year accredited RCPsych/VSO Fellowships are a new venture offering unique and rewarding experiences for UK-enrolled specialist psychiatry registrars and will be recognised as part of the CCST programme (see *International Psychiatry*, issue 1, July 2003, p. 21). Two pilot placements in Sri Lanka are now available for 2004.

For more information, contact Margaret English, VSO Placement Advisor for the Health Team: tel. 020 8780 7647; email enquiry@vso.org.uk; post VSO, 317 Putney Bridge Road, London SW15 2PN, UK; www.vso.org.uk.

The scheme has been developed by the College Board of International Affairs (BIA) and is coordinated by a small sub-group. Contact jcarroll@rcpsych.ac.uk, or see the BIA website: www.rcpsych.ac.uk/college/spcomm/bia.htm.

The International Society for the Psychological Treatments of Schizophrenia and Other Psychoses

The Society has a 47-year history of bringing together clinicians and researchers in this now rapidly expanding area. It recently held its 14th conference in Melbourne, Australia, which attracted nearly 600 participants. The organisation is encouraging the formation of local groups of clinicians. It is in the process of producing a book series, and has a twice yearly newsletter and a modern website. For further details email isps@isps.org or look at www.isps.org.

Recent news from the World Psychiatric Association (WPA)

- College members should place firmly in their diary the dates of the WPA World Congress in Cairo (11–15 September 2005) and be ready to submit proposals for symposia and workshops (deadline November 2004) and free communications (deadline February 2005).
- College members are directly involved with the WPA Presidential Global Child Mental Health Task Force, developing training protocols and educational material to assist in alleviating mental disorders in children. This programme includes full awareness of the impact of mental disorder in parents on their offspring.
- The Secretary for WPA Sections, Professor Christodoulou, a College Fellow, is convening an Institutional Programme on Mental Health in the Balkans.
- Regarding the alleged abuse of psychiatry in China, there is no reply as yet from the Chinese Minister of Health to a request for an independent WPA evaluation.
- *World Psychiatry* is the official journal of the WPA and is sent free of charge to all psychiatrists when WPA member societies supply their names and addresses. Current and back numbers can also be easily accessed from within the WPA website, www.wpanet.org. The journal contains a wide range of articles for psychiatrists working with all age groups. Recent topics

EU health website:
http://europa.eu.int/comm/health/index_en.htm.

cover ethics, pharmacology, psychoanalysis, attention-deficit hyperactivity disorder, global and cultural psychiatry, and mental health policy initiatives, as well as articles and commentaries on many other subjects.

- *Monthly WPA electronic bulletin.* All psychiatrists can obtain extensive up-to-date information about international news, publications and conferences (and much more) by signing on electronically to the monthly eBulletin of the WPA. See www.wpanet.org/sectorial/bulletin/suscript.php.

The North American Group of the Royal College of Psychiatrists

For more than 20 years this Group has received members and visitors at the annual meetings of the American Psychiatric Association (APA) and this tradition will continue in 2004 in New York City, probably on 2 May (see Forthcoming international events). The 2003 meeting in San Francisco was fun, with good food, drink, company and brief, lively speeches by Mike Shooter, Robin Murray and Paul Jessop. Our activities now include scientific

presentations at both the APA and College meetings. Our topics in the USA have ranged from risk factors in schizophrenia and the history of schizophrenia, to war, terrorism and refugees, with experts from several countries and cultures, sometimes speaking to overflowing audiences. Topics at the College meetings have included 'Hot topics in American psychiatry', 'Suicide in the elderly and physician-assisted suicide', 'Lessons learned in disaster psychiatry for children after 9/11 in New York' and 'What happened to the severely mentally ill after deinstitutionalisation'.

For the 2004 APA meeting symposium we have submitted proposals on 'The provision of psychiatric services where there is a shortage of psychiatrists', with speakers from five countries, and a workshop entitled 'Psychiatry in Afghanistan and Afghan refugees'.

For the College's 2004 annual meeting in Harrogate there will be a session on 'Serving the underserved in the US' (the elderly, children and those with severe mental illnesses).

All these events have been organised and chaired by the chair of the Group, Nigel Bark.

Forthcoming international events

15 January 2004

Conference on Religious Psychopathology

Foundation for Psychiatry and Religion in collaboration with the WPA Section on Religion, Spirituality and Psychiatry. Amsterdam, The Netherlands.

Contact: Dr Herman M. Van Praag.
Email: h.m.van.praag@vanpraag.com.

29 January–2 February 2004

International Conference on Schizophrenia

WPA co-sponsored conference. Schizophrenia Research Foundation (SCARF) in collaboration with the WHO. Chennai (Old Madras), India.

Contact: Dr R. Thara.
Email: scarf@vsnl.com.

Website: www.scarfindia.org.

1–28 February 2004

Fifth Virtual Congress of Psychiatry (Interpsiquis 2004)

Palma de Mallorca, Spain.

Contact: Dr Pedro Moreno.

Email: secretaria@psiquiatria.com.

Website: www.interpsiquis.com/2004/participation.html.

12–14 February 2004

Bienestar y Calidad de Vida en el Siglo XXI

WPA Section on Mass Media and Mental Health, with Havana Psychiatric Hospital.

Havana, Cuba.

Contact: Dr Miguel A. Materazzi.

Email: materazzi@arnet.com.ar.

5–10 March 2004

Second Biennial Conference of the International Society for Affective Disorders (ISAD)

WPA co-sponsored conference. In collaboration with the WPA Section on Affective Disorders.

Cancun, Mexico.

Contact: David Beck.

Email: d.k.beck@soton.ac.uk.

Website: www.isad.org.uk.

17–20 March 2004

Second World Congress on Women's Mental Health

WPA Section on Women's Mental Health and the WPA Section on Interdisciplinary Collaboration.

Washington, DC, USA.

Contact: Dr Donna Stewart; Dr Uriel Halbreich.

Email: donna.stewart@uhn.on.ca; urielh@acsu.buffalo.edu.

Website: www.womenmentalhealth.com.

17–20 March 2004

National Association of Dually Diagnosed. International Congress – V

In collaboration with the WPA Section on Mental Retardation.

Boston, Massachusetts, USA.

Contact: Dr L. Salvador Carulla.

Email: l.salvador@telefonica.net.

23–25 March 2004

First International Conference on Psychiatry, Law and Ethics

WPA Section on Psychiatry, Law and Ethics in collaboration with UNESCO, WAML, ICLE and SMLI.

Eilat, Israel.

Email: seminars@isas.co.il.

Website: www.isas.co.il/psychiatrylaw2004.

29 March–2 April 2004

Congreso Panamericano de Salud Mental Infanto-Juvenil

Organised by Cuban Society of Psychiatry in collaboration with the WHO and the Latin American Psychiatric Association.

Palacio de Convenciones, Havana, Cuba.

Contact: Dr Cristobal Martinez Gomez.

Email: crisma@informed.sld.cu.

Website: www.sld.cu/eventos/psiquiatria/felices;

www.loseventos.cu/saludmental2004.

14–18 April 2004

European Psychiatry: Evidence and Experience. 12th AEP Congress

Geneva, Switzerland.

Call for abstracts ends 30 October 2003.

Email: aep12@kenes.com.

Website: www.kenes.com/aep2004.

1–6 May 2004

American Psychiatric Association Annual Congress

New York, USA.
Contact: apa@psych.org.
Website: www.psych.org.

14–19 May 2004

History of Psychiatry: 18th Congress of the Hellenic Psychiatric Association

In collaboration with WPA Sections on History of Psychiatry and Humanities in Psychiatry.
Island of Kos, Greece.
Contact: Prof. George Christodoulou, Hellenic Psychiatric Association, 11, Papadiamandopoulou str., 11528 Athens, Greece.
Fax: +302107242032.
Email: gnchrist@compulink.gr.

27–29 May 2004

International Conference on Education and Promotion in Mental Health

The annual conference of Mental Health Europe.
Ljubjana, Slovenia.
Contact: Mental Health Europe, Boulevard Clovis7, B-1000 Brussels, Belgium.
Tel: +32 2 280 0468.
Email: info@mhe-sme.org.

10 June 2004

Poder de la Resiliencia en el Desajuste Social Actual

WPA Section on Mass Media and Mental Health in collaboration with Hospital Psiquiatrico Jose T. Borda.
Buenos Aires, Argentina.
Contact: Dr. Miguel A. Materazzi.
Email: materazzi@arnet.com.ar.

25–27 June 2004

XVIII Peruvian Psychiatric Congress and III Regional Meeting of the APAL

WPA co-sponsored conference.
Lima, Peru.
Contact: Dr Elard Sanchez Tejada.
Email: app@amauta.rcp.net.pe.

6–9 July 2004

Royal College of Psychiatrists Annual Meeting

International Centre, Harrogate, UK.
Contact: College Conference Office.
Tel: +44 (0)20 7235 2351 x 142.
Fax: +44 (0)20 7259 6507.
Email: mbraithwaite@rcpsych.ac.uk.

4–8 August 2004

Solidarity/Moral Displacement

Stockholm Group Conference on Social Issues and International Association of Group Psychotherapy.
Email: Soci2004@hotmail.com.
Website: www.psykoterapisallskapet.se.

17–19 September 2004

WPA Regional Meeting

Mental Health Resource Center (MHRC) in collaboration with the Pakistan Psychiatric Society.
Lahore, Pakistan.
Contact: Dr Haroon Rashid Chaudry.
Email: pprc@wol.net.pk.

22–26 September 2004

14th World Congress of the World Association for Dynamic Psychiatry (WADP)

WPA co-sponsored conference.
Cracow, Poland.
Contact: Dr Maria Ammon.
Email: wadp.congress2004@dynpsych.de.

28 September–1 October 2004

Translating the Evidence. International Early Psychosis Association

Vancouver, Canada.
Contact: congress@venuewest.com.
Website: www.iepa.org.au.

6–9 October 2004

8th Congress of the International Association for the Treatment of Sexual Offenders (IATSO)

WPA co-sponsored conference.
Athens, Greece.
Contact: Dr Orestis Giotakos.
Email: giotakos@tri.forthnet.gr.
Website: www.iatsoathens.gr.

7–10 October 2004

Mental Health Perspectives in Public Health Conference

WPA co-sponsored conference. Armenian Association of Psychiatrists and Narcologists.
Yerevan, Armenia.
Contact: Dr Armen Soghojan.
Email: majoria@arminco.com.

8–10 October 2004

The Individual and the Group: Bridging the Gap

EFPP Conference on Psychoanalytic Group Psychotherapy.
Lisbon, Portugal.
Email: admedic@mail.telepac.pt.
Website: www.efpp.org.

24–26 October 2004

3rd World Congress on Men's Health

WPA co-sponsored conference. International Society for Men's Health in collaboration with the International Forum of Mood and Anxiety Disorder and the Austrian Association of Neuropharmacology.
Vienna, Austria.
Contact: Dr Siegfried Kasper.
Email: sk@akh-wien.ac.at.
Website: www.wchm.info.

24–27 October 2004

XVIII World Congress of World Association for Social Psychiatry

The Japanese Society of Social Psychiatry in collaboration with the WHO.
Kobe, Japan.
Contact: Dr Yoshibumi Nakane.
Email: yonakane@net.nagasaki-u.ac.jp.
Website: www.congre.co.jp/18wasp.

10–13 November 2004

Treatment in Psychiatry: An Update

International Congress of the WPA.
Florence, Italy.
Contact: Prof. Mario Maj, Institute of Psychiatry, University of Naples, Largo Madonna Delle Grazie, I-80138, Italy.
Fax: +39 081 566 6523.
Email: majmario@tin.it.

12–15 January 2005

Facing the Challenges, Building Solutions

WHO Ministerial Conference on Mental Health. An invitational conference of all 52 member states in the WHO European Region and of selected organisations.
Contact: Mental Health Programme, Regional Office for Europe, Scherfigsvej 8, DK 2100, Copenhagen, Denmark.
Fax: +45 39 17 18 65.
Email: jke@euro.who.int.

12–15 March 2005

Advances in Psychiatry and Meeting of the WPA Scientific Sections

WPA Regional Meeting.
Athens, Greece.
Contact: Prof. George Christodoulou, Athens University Department of Psychiatry, Eginition Hospital, 74, Vasilissis Sophias, 11528 Athens, Greece.
Fax: +302 10 724 2032.
Email: gnchrist@compulink.gr.

21–26 May 2005

American Psychiatric Association Annual Congress

Atlanta, GA, USA.
Contact: apa@psych.org.
Website: www.psych.org.