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EDITORIAL

Tsunami, disaster and mental health consequences

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The tsunami in the Indian Ocean shocked the whole world – and rightly so. It wreaked havoc and devastation over a huge geographical area on a scale that most of us have never seen before. The numbers killed, injured, displaced and bereaved are too large to imagine or comprehend, yet the pictures are there, in the newspapers, on the television screens, forcing us to try to understand.

The disaster demanded an international response, and indeed one started slowly, gradually gathered momentum and then seemed to develop a life of its own in terms of the scale of generosity. How and why did this happen? This is not the worst natural disaster in terms of the sheer number of casualties but it seems to have touched hearts in a way that other natural disasters have not. This may, in part, be because many of the affected areas are popular tourist destinations; many people have visited them, or know others who have, and they are familiar from holiday catalogues and picture postcards. In addition, many industrialised countries have historical links with the affected countries and substantial minority ethnic populations from them. The diaspora naturally want to help their families, friends and fellow countrymen, and those with friends, neighbours and colleagues from these minority ethnic groups have been concerned on their behalf too. In other words, it feels very personal. Most people following the news must have considered how they would have coped if it had been them. And so they have responded with unprecedented generosity.

The first requirements, the urgent priorities are well understood: clean water, food, shelter, medical aid, followed by the need to repair or rebuild essential infrastructure. All of these things need money and that money has been forthcoming. But we as psychiatrists know that there are and will be mental health consequences that will require not just money to remedy them but specific skills too. The survivors will be suffering the grief of bereavement and loss and probably feelings of guilt from having survived while others, perhaps their children, have perished. They will be frightened and anxious about their future, and probably overwhelmed by feelings of helplessness. Aid workers, too, exposed to death and devastation on an unprecedented scale, may find it difficult to cope. Previous experience of natural disasters suggests that between a third and a half of all affected persons suffer from mental distress and that post-traumatic stress disorder, anxiety and depressive disorders are the most frequent diagnoses (Word Health Organization, 2000).

Unfortunately, apart from well developed tourist resorts, many of the areas deluged by the tsunami are poor. Few of those affected will have had insurance cover, so that the cost of this disaster to insurance companies will be far less than is typically the case with much smaller natural disasters in richer countries. Furthermore, poor countries do not have large numbers of trained professionals. The ratios of psychiatrists to population are far lower than in industrialised countries. Of those they have trained, some will have been killed or injured themselves by the tsunami; others have emigrated, often to wealthier countries that have benefited from their skill and training (see issue 7 of *International Psychiatry*). Now, therefore, faced with a huge need for mental health services, there is likely to be a severe shortage of skilled professionals available to help.

The Royal College of Psychiatrists has both the ability and a responsibility to contribute towards meeting those needs. It should do so thoughtfully and respectfully, recognising local culture, traditions and belief systems and seeking to build on and work with existing community support mechanisms, where these still exist. Informed input from colleagues from the affected countries will be of fundamental importance in ensuring that the response is sensible and sensitive. A working group has been established to steer this response and will seek links with sister organisations in the affected countries, as well as with other national and international bodies working in the same field.

Contributions for future issues are welcome – please contact Hamid Ghodse
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The earthquake that caused the tsunami on 26 December 2004 was so powerful that it literally shook the world, which moved on its rotational axis. It was truly a global event, not merely an international one. The challenge for us all now is to ensure that the global response, which has been heart-warming in its immediate generosity, continues for as long as help is needed. The Royal College of Psychiatrists should seek to play a full role in that response, utilising all the knowledge and skills at its disposal and all of its worldwide links.

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THEMATIC PAPERS – INTRODUCTION

Traditional medicines in psychiatry

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Our theme for this issue concerns the use of traditional medicines in the treatment of psychiatric disorders in three regions of the world: Africa (Alan Haworth), Bangladesh (Michael Radford) and Singapore (Ee Heok Kua and Chay Hoon Tan).

As Alan Haworth points out, the term 'traditional medicine' encompasses a wide range of health practices, ranging from the purely psychological (e.g. the spiritual therapies) to the administration of plant or animal preparations that may have pharmacological components. It is fascinating to learn that in Africa there are now attempts by local traditional healers to meet together and compare notes, although not altogether surprising that a lack of standard nomenclature can cause a few problems when specific botanical references are being made. It is particularly interesting to note that the medicines are unlikely to be effective unless they are administered in the right way, with the setting creating a psychological context in which improvement in the patient's condition is to be expected by all concerned. How true is that for psychiatric practice in the developed world, too?

In Bangladesh, Michael Radford reports that there is interest in discovering whether the outcomes of serious mental illness are rather better than they are in Western countries, with modern systems of psychiatric care. He asks, 'Is there something poisonous that comes with lots of expensive services? Or is there something missing?' The empirical basis of assertions that outcomes are rather better in 'developing countries' that strongly feature extended families and village life is by no means secure. He draws our attention to the fact that there are abuses of people with mental illness in both systems, and it is not unusual to find seriously mentally ill people with severe deprivation of their liberty. A fascinating account is given of Bangladeshi village life.

Finally, in the relatively developed urban landscape of Singapore, we learn from Ee Heok Kua and Chay Hoon Tan that traditional Chinese medical practices are still widely available and widely used. Up to a third of patients seeking modern psychiatric help for their disorders are also consulting traditional healers. It is fascinating to learn that age-old beliefs, such as the influence of a deity on behaviour, motivate this choice, which is regarded as less stigmatising than is resort to a Western-influenced psychiatric practice. Traditional healers are held in higher regard if they are also experts in a martial art. We have yet to consider this recommendation in training guidelines from the Royal College, but I hope it will receive appropriate attention!

THEMATIC PAPER – TRADITIONAL MEDICINES IN PSYCHIATRY

Traditional psychiatric practices in Africa

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Many leaders in Africa bemoan the disappearance of African culture, including the use of traditional medicines, and there have been numerous calls for recognition of their value and for the integration of these treatments into orthodox medicine. This is especially so with regard to psychiatric disorders. The literature on psychiatric practice in Africa contains very few references to herbal treatments, however, and more is to be learnt about the use of herbs as adjuvants in the solution of psychosocial problems from the anthropological literature. At a conference held in the

University of Ife in 1974, psychiatric disorders were not included in a list of nine conditions (e.g. cancer) in which it was recommended that herbal treatments be further investigated.

Questions of definition

The term 'traditional medicine' covers diverse health practices, approaches, knowledge and beliefs, as well as medicines that incorporate plant, animal and/or mineral substances, spiritual therapies, manual techniques and exercises (World Health Organization, 2002). Herbal treatments cannot be described separately and it should be noted that many 'traditional medicines' consist of mixtures containing, in addition to those listed, modern pharmaceutical products. I will use the terms 'traditional medicines' and 'herbal medicines' interchangeably. Traditional healers are called *isangoma* in South Africa, *ng'anga* in Zambia and *ngengang* in Cameroon, and many other variants, but all these names have a common origin.

African herbal medicine is rightly classed with complementary and alternative medicine, and also with systems such as Chinese medicine, Ayurveda and Unani, which have strong, coherent traditions. On the other hand, most traditional healers in Africa have relied largely upon verbal traditions and apprenticeships. Last (1990) has pointed out that traditional healers (especially of the 'sacred' kind, who also use herbal medicines) are too diffuse a group, and their knowledge and practices too rooted in local contexts, to be effectively standardised. This is not to say that traditional healers' associations do not exist in many African countries, and in some their members regularly meet for the exchange of information and views. Because of a lack of formal training, it is not surprising that disagreements arise between healers, even regarding the names of the shrubs or trees being used. In a meeting with traditional healers which I attended, we had to resort to members of the Forestry Department (who were well informed) to try to resolve disputes in identifying specimens.

Types of herbal medicine

Chavunduka (1994) has presented a list of herbal preparations classified largely according to their use. He starts with simple herbal medicines which can be used by anyone, such as those used for headache, the common cold, nose bleeds or diarrhoea. Other herbs with medicinal properties must be administered by a skilled practitioner, such as those for more complex medical conditions or medicines used for severe symptoms, which must be administered according to a special ritual. In his list, Chavunduka includes the following uses:

- prophylactic purposes – for example to ensure that a baby develops a good set of teeth, or to prevent convulsions, or as contraceptives, or to discourage unwanted behaviours
- as a way of enforcing law and morality – for example to bring harm to a woman committing adultery when she uses a bed in which medicine has been placed, or to detect crime (sometimes in the form of trial by ordeal).

Herbs are also used to bring luck, in potions with the purpose of injuring someone, to assist in a change of lifestyle (for example for heavy drinkers) and to change animal behaviour (for example to make guard dogs fiercer). Thus herbs have many uses besides their purely medical ones, and this is consistent with views on their function.

What herbal medicines are thought to do

Most traditional healers are willing to admit that the proximate cause of the symptoms and signs of illness are physical, but they will look at the cause of the disease not in terms of any pathological process but in terms of intent, which may arise within a person or some supernatural agent. Since it cannot be known how a person or supernatural agent manifests this intent, whether hostile or good (for example to protect against harm), there are no descriptions of how the medicines work. An explanation for an illness may be given as 'The spirit of your grandfather is displeased and has removed his protection'. Because a supernatural agent is involved here, who must presumably be communicated with via a ritual, herbs alone are unlikely to be effective unless they are administered or used according to a set of very strict rules.

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Boyer (2002) has conceptualised this in terms of misfortune (including illness) as social integration. He writes: 'the particular ways in which they [those explaining misfortune] represent these situations is framed by their social interaction inference systems', for instance evil spirits being seen as enforcers of unfair deals and witches as cheats. Contact must be made with these entities and it must be believed that they are subject to influence. Often these social explanations involve problems in personal relationships which, if looked at in a clinical setting, will be seen to be important factors in psychiatric disorders. Boyer links this conceptualisation to the existence of local specialists who are recognised as being different from other people; medicines will not be effective unless they are administered by those who have the knowledge and authority to use them. Boyer makes reference to *local* knowledge and *locally* recognised expertise, using *locally* known herbs. While it is evident that the clients using herbs will have no knowledge of how a medicine actually works, they will be expected to accept that they must be administered in a particular way.

Other herbs with medicinal properties must be administered by a skilled practitioner, such as those for more complex medical conditions or medicines used for severe symptoms, which must be administered according to a special ritual.

While in rural areas the traditional healer tends to use the approach described above, there are also many herbalists, who may be defined as people who study, collect, sell, or administer herbs or plants as medicines for the treatment of diseases in human beings. Many such herbalists are found in markets in major cities and

towns, and their herbs are sold with no stipulation of the details of their use in terms of ritual and so on. And there is another difference: buyers usually purchase single herbs, whereas the traditional healer may well provide a medicine which contains a mixture of herbs, or may use different herbs during various phases of a ritual.

Is use of herbal remedies decreasing in Africa?

There can be no doubt that Africans take a very pragmatic approach and they will seek the medicines they know to work – but much depends upon the criteria for success. For example, cessation of fits may have to be accompanied by propitiation of angry ancestors.

We can surmise that people living in rural areas and some living in towns will use common folk remedies. The extent to which people have access to orthodox medicine must inevitably be a factor in the degree to which they do so, besides the question of personal preference. Crude estimates of numbers are misleading. There are too few trained health workers in many rural areas of Africa. Comparisons are often made between the numbers of traditional healers (mostly estimates with no stated defining criteria) and the paucity of doctors, when, in fact, most basic health care is provided by clinical officers and nurses, who are far more numerous.

There are few estimates of the proportion of populations consulting traditional healers and there is little reliable information on preferences. In an on-going study of epilepsy and stigma in Zambia, in which church leaders (pastors and priests) were interviewed, 92% of the 149 respondents stated that they would seek orthodox medicines and 34% stated that they would use a traditional therapy; 32% of those advocating orthodox medicine would also seek traditional medicine. Of the 68 who stated that a member of their extended family had suffered from epilepsy, 42% stated that they would use traditional therapy. There can be no doubt that Africans take a very pragmatic approach and they will seek the medicines they know to work – but much depends upon the criteria for success. For example, cessation of fits may have to be accompanied by propitiation of angry ancestors.

The place of herbs in modern medicine in Africa

It has been remarked that few herbs appear to have any great potency, especially those which may be directly purchased. Seeking out herbs which are effective when mixtures are being used and when the constituents of mixtures may vary from healer to healer makes the task even more formidable.

It is often recommended that the use of traditional means of therapy, including herbs, be integrated into modern healthcare systems. There are various ways in which this could be done, and these are not necessarily mutually exclusive. One is to seek out promising herbs and to have them made available, either as traditionally prescribed or after processing into recognised pharmaceutical products. But the number of herbs used by healers is very large – 54 medicinal herbs used by one healer in Congo, for example (Janzen, 1978). It has been remarked that few herbs appear to have any great potency, especially those which may be directly purchased. Seeking out herbs which are effective when mixtures are being used and when the constituents of mixtures may vary from healer to healer makes the task even more formidable.

It is frequently stated that health professionals should work directly with traditional healers in the detection of potent medicines. I have said little of the rituals used by healers because of their complexity (see Janzen, 1978, for example) and their extreme variability in terms of choice of herb, so this would seem to be an impractical recommendation. The authors of a study from South Africa (Behr & Allwood, 1995) stated, after allowing a healer to examine and recommend her own therapy for four of their patients: 'Although there are probably advantages to unifying traditional and Western psychiatric care, we may have to conclude … that the two systems are best left to function independently'. Gureje & Alem (2000) state that when policy makers have talked about the need to integrate traditional healthcare into orthodox service delivery, the *modus operandi* of this integration has not been well articulated. They state that a policy of integration ought to have as one of its primary goals an examination of the nature of traditional practices, and that proof of efficacy and safety need to be available before any pharmacologically active compound (including herbs) can be used. This is endorsed by the World Health Organization (2002), which sets out a checklist of criteria that include: 'establishing safety monitoring of herbal medicines and the establishment of national standards, and technical guidelines and methodology, for evaluating safety, efficacy and quality of traditional medicines'.

Conclusion

The literature is insufficient to allow any general or comparative survey of the use of herbal medicines in managing mental illness in Africa. Mental health workers ought to try to gain some understanding of local beliefs surrounding the use of traditional medicine, including the use of herbal medicines. But caution must be used in engaging in more active collaboration in their use without applying the accepted international standards regarding efficacy and safety as are applied to modern pharmaceuticals.

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Alternative routes to healing in Bangladesh

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The mission to find 'the secret of the village' is one attraction of engaging in mental health services in Bangladesh. Over the last 15 years much attention in world psychiatry has been given to the fairly robust finding that the prognosis of people with established and severe mental illness is better in 'developing countries' than in 'developed' ones (e.g. World Health Organization, 1979; Leff *et al*, 1990; Jablensky *et al*, 1992). Earlier assumptions that 'developing' is a simple variable were almost certainly a result of racist ignorance (Kulhara, 1994). Developing countries are not homogeneous. The variation in mental health outcomes seems to be clearer in more remote villages and tribal areas (Chatterjee *et al*, 2003), especially those that have less contact with Western (colonial) models of psychiatry and ways of life. More studies on this topic across a wider range of rural and urban settings would have much to offer. Is there something poisonous that comes with lots of expensive services? Or is there something missing?

Determinants of prognosis

Many efforts have been made to identify the possible reason or reasons for such findings. Most reviewers emphasise the particular benefits for long-term mental health of extended family systems (see Thara *et al*, 2004, for a recent overall review). Is this nostalgia for an age when life seemed simpler, before the post-modern era? Alternative explanations are still being advanced: for example, Peet (2004) recently postulated dietary differences between 'developed' and 'underdeveloped' countries.

Major criticisms of the literature on mental health outcomes in different cultures include the failure to understand that there are important differences within cultures, as well as a lack of knowledge both of what they might be and of how the sub-cultural benefits are mediated (Edgerton & Cohen, 1994). 'The danger of not pursuing the subject of epidemiology in cross-cultural settings in its full complexity is that the findings of studies will not be readily translated into preventative programmes and nor will they inform planners of health services' (Bhui, 2001).

Many years ago there were warnings that the unchallenged hegemony of Western models may damage the pre-existing 'alternative' healing mechanisms already present in South Asia (Higginbotham & Marsella, 1988). However, there are abuses of people with mental illness within every system and each has something to learn from the others. Recently some evidence has been published that it is the presence of psychiatric pluralism (the easy availability of religious, indigenous and allopathic practice) that may be the beneficial factor in the superior prognosis in the subcontinent (Halliburton, 2004).

Within Western mental health services, groundbreaking findings in Australia started to document that better outcomes can be achieved in applying a 'recovery' model (Tooth *et al*, 1997). The point being made in such literature is to emphasise the validity of patient experience and the importance of personal growth. In thinking about prognosis in villages or anywhere else, it is necessary to distinguish between what can be called 'healing' and what might be called 'curing': a 'cure' is the restoration of 'part functioning' (Lewis, 1953), whereas 'healing' can be used to refer to the recovery of whole-person functioning and inclusion in valid social and family roles (on these key conceptual issues see Radford, 2000). The early transcultural studies by the World Health Organization looked at symptoms as an index of prognosis. In major mental illness, symptoms can come and go, depending on the level of stress as well as the presence of cure. Alternative practices may be better than allopathic methods at encouraging healing processes. The techniques associated with 'early-intervention teams' in England also seem associated with better prognosis. This evidence is concordant with the suggestion that 'psychiatric pluralism' of some kind has important benefits, and that sharing experiences of non-reductionist ways of working could lead to a better understanding – in a holistic sense – of the processes of healing.

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The Bangladeshi experience

Observations of the treatment of people with psychiatric illness by myself and others in the Bangladeshi Mental Health Association (BMHA) have recently involved looking over the shoulders of 'village doctors'. We were told many stories relating to the behaviour of people with mental illness on repeated visits to a wide variety of villages. The village effect was illustrated in various ways. People in villages appeared to need smaller doses of medication to control symptoms of mental illness and some people with related behavioural problems were more disturbed when moved to the city. Their condition improved when they moved back to the village. In casual visits to villages it was usual to hear denials of chaining or tying. We were particularly interested to find examples of this practice, because it is often quoted as a counter-example to the benefits of rural life.

People in villages appeared to need smaller doses of medication to control symptoms of mental illness and some people with related behavioural problems were more disturbed when moved to the city. Their condition improved when they moved back to village.

There is one national mental hospital in Bangladesh, which was opened in 1971 to replace the facility in West Pakistan after the independence war. After a World Health Organization seminar in the early 1980s, it was decided not to commission any more, but to establish beds at regional medical schools for acute admission. There are no other long-stay facilities. In a somewhat isolated Hindu tea pickers' settlement was a man with a history of recurrent mania who was taken repeatedly to the regional in-patient centre for the purpose of containment and to receive haloperidol. This man remained fully integrated in the life of his village, perhaps because his condition was seen as a visitation for which he was not to blame. Also, he was an important member of the community, for he was the only person who could fix the village pump. Those in isolated villages are inclined to believe more in passing jinns (genies) than in passing genes.

The main method of (occasional) contact that Bangladeshi psychiatrists have in villages is by holding 'camps'. A visit is advertised by word of mouth; people gather and wait for hours with their sick relatives.

The main method of (occasional) contact that Bangladeshi psychiatrists have in villages is by holding 'camps'. A visit is advertised by word of mouth; people gather and wait for hours with their sick relatives. On one such occasion, when a camp was held in a remote tribal area, the border police came to check what we were doing. At the same camp three men in chains were brought by their wives or mothers. They had not been thrown out of the community and, unlike what would have happened if they had been confined in the national mental hospital, they had carers who could speak their language and cook their food; and they would be released when they were more settled. One was sitting with his wife and children, two of whom were conceived after the chains were applied. Women are more likely to be tied with thin ropes. There were two such women seen on this day who answered to the eighteenth-century descriptions of 'raving madness'.

Hearing of our wish to see improvements in community services, two women were referred by journalists to the BMHA when other services were unable to engage them. We needed a police escort to bring one to the service, because she had run into trouble with the village authorities, who ordered her tying. She was manic and angry. After treatment by a senior Dhaka professor, we arranged micro-credit so that her brother and she could buy two cows and a cow shed. She called one cow 'chairman' and the other 'committee member'. Without the cows they could not afford medication and would not regain status in the village.

After treatment by a senior Dhaka professor, we arranged micro-credit so that her brother and she could buy two cows and a cow shed. She called one cow 'chairman' and the other 'committee member'. Without the cows they could not afford medication and would not regain status in the village.

Village doctors

Partnership with the Bangladeshi Village Doctors' Welfare Association and individual village doctors has enabled us to make proposals for further investigation of the 'secret' of the Bangladeshi village, and of how villagers cope with people who are mentally ill. We have also been able to respond to requests for training, so that members of this association can help people in their villages affected by mental health problems. There are an estimated 200 000 'village doctors' in Bangladesh. In spite of the objections of the MBBS-qualified doctors, such a training scheme was started about 30 years ago and was recognised by General Ershad when he became President of Bangladesh in 1983. Those in power had been impressed by the barefoot doctors' scheme in China as a way of bringing the benefits of allopathic medicine to village populations. As in China, the government no longer funds or controls such 'village doctors'. As in China, they have in more recent times been accused of doing harm, specifically by giving too many antibiotics or wrong treatments for diarrhoea. In China they were accused of spreading hepatitis through improperly washed syringes; this cannot happen in Bangladesh, as they cannot afford them.

There is evidence that such village doctors can improve the lives of many through their availability. The repeated phrase one hears in the villages and reads in newspaper articles is 'They do home visits at midnight'. A recent survey in Bangladesh found that 90% of villagers prefer village doctors to MBBS-qualified doctors. If a partnership could be forged between them and the regionally established departments of psychiatry at the medical schools, much more could be done.

In China, barefoot doctors do have acquaintance with Chinese as well as Western medicine. In Bangladesh, a background of alternative practice cannot be assumed. There is the widespread practice of homoeopathic medicine (another Western model) and Ayurvedic medicine (which is not). Both systems have training institutes in the country. Religious practices from local Islamic teachers using key verses from the Qur'an are common, and some Hindu and Buddhist shrines are visited for faith healing. We have been told of a special 3-year training for hakims in raising and controlling jinns.

Conclusion

Apart from what can be learned to improve practice in the West, studies in Bangladeshi villages may be important for the future of the Bangladeshi mental health system. Eighty per cent of the population are still villagers. Some workers are suggesting that depression in men remaining in villages is a critical block to development. There needs to be caution about pathologising possible effects of oppression, but the suggestion needs study. Improved alternatives to mental hospital care for people with the behaviours of long-term major psychosis could start with augmenting the potential for containment and healing already present in villages. There is no benefits system, and no alternative to family care except for urban destitution or the one mental hospital, which is currently full. While the West is developing an expensive system of post-hospital care, countries like Bangladesh, which is among the ten poorest, could capitalise on their opportunity to develop their pre-hospital mental health care in a way that preserves better outcomes.

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THEMATIC PAPER – TRADITIONAL MEDICINES IN PSYCHIATRY

Traditional Chinese medicine in psychiatric practice in Singapore

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Around three-quarters of the Singaporean population are of Chinese ethnic origin, and so traditional Chinese medicine is the most widely practised non-Western system of healthcare on the island.

Traditional Chinese medicine was first recorded some 2500 years ago in the ancient textbook of medicine *Classics of Internal Medicine* (*Huang-Di Neijing*), a collection of dialogues between the Yellow Emperor and his court physician, Ch'i Po. Written during the era of the Warring States (476–221 BCE), it showed an awareness of emotional and psychological factors in the causality of physical illness. A mind–body nexus rather than dichotomy was emphasised.

In Chinese culture, theories of health and illness are embedded in customs and religious philosophies. Religious beliefs and spirituality are therefore important issues in psychiatric practice. Since ancient times, religious practice and healing have been closely associated, and healing has often been performed by priests. With advances in scientific knowledge, the healing role has now largely been taken over by doctors, but priests or traditional healers are still consulted first in many Chinese communities.

The basis of traditional Chinese medicine is the belief that there is a finely balanced relationship between bodily functions and emotions. This belief is built on the concept of 'yin–yang', a bipolarity that is opposite and complementary. The yin represents coldness and yang warmth. When this homoeostasis is disrupted, physical or mental illness can result. The prescription of herbal medicine or the administration of acupuncture attempts to restore the imbalance of the yin and yang. Besides physical treatment, it is the shared cultural beliefs of the healer and the patient and the relationship between these two that are pivotal in recovery.

Health-seeking behaviour

Family and cultural beliefs often determine illness behaviour and the health-seeking tendency of the patient. In a study of the illness behaviour of 100 Chinese patients referred consecutively to the psychiatric clinic of the National University Hospital in Singapore, it was found that 36 had also consulted traditional healers (Kua *et al*, 1993). Most of these patients were suffering from depression, anxiety or schizophrenia. It is common in the Chinese community to consult both the traditional healer and the psychiatrist.

The possession trance is a common culture-related phenomenon in Singapore and many other countries in Asia. The characteristic features have been reported by Kua (1986). Because possession trance is not deemed an illness in the community, a traditional healer is often

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consulted. This socially sanctioned behaviour is recognised as a sign of distress and evokes the appropriate family response – support and sympathy. Those with the condition are treated with respect because they are perceived to be favoured by a deity. Treatment by the traditional healer lacks the stigma associated with referral to a mental hospital. In a follow-up study of depression among elderly Chinese people, it was noticed that many did not seek treatment in a hospital or out-patient clinic but preferred traditional medicine (Kua, 1993).

To the depressed patient, symptoms of poor sleep, loss of concentration and listlessness are interpreted as due to a 'weakness of mental energy'. It is difficult to explain or understand the patient's neurotic problems in Western psychoanalytic terms like the 'Oedipus complex' or 'ego strength'.

Physical treatment

In traditional Chinese medicine, herbs and acupuncture are the main methods of treatment for psychiatric conditions. Acupuncture has been used to relieve headache, insomnia, depression and chronic pain. A study by Luo *et al* (1997), from the Beijing Institute of Mental Health, showed that acupuncture was as effective as amitriptyline in the treatment of depression. Extracts of herbs like *Astragalus membranaceus*, *Angelica sinensis* and *Wikostroemia chamedaphre* have been claimed to be useful in the treatment of both depression and insomnia (Liu, 1981; Tien, 1985).

For many centuries, Chinese people have known about the effects on longevity of the consumption of *Ginkgo biloba* extract (from the leaves of the Ginkgo tree). However, there is a paucity of scientific data to support this assertion, although all round the world *Ginkgo biloba* extract is sold over the counter in pharmacies for the prevention of memory impairment in late life. De Smet (2002) reviewed the scientific evidence on the *Ginkgo biloba* extract as an antioxidant.

In traditional Chinese medicine there is also an emphasis on exercise as part of a healthy lifestyle to restore the yin–yang equilibrium. Tai-chi or kung-fu is encouraged as a form of exercise during the recuperation phase of physical or mental illness. It is interesting to note that many traditional healers and priests (e.g. the Shaolin monks) are themselves experts in kung-fu, which is taught in temples as an art of self-defence.

In Western psychotherapy, the focus is on the individual struggling with biological urges and social constraints. In Chinese culture, the emphasis is on the individual as a member of a family.

Psychotherapy

Particular types of what may broadly be termed psychotherapy reflect the cultural and religious milieu in which they are developed. In Western psychotherapy, the focus is on the individual struggling with biological urges and social constraints. In Chinese culture, the emphasis is on the individual as a member of a family. In Western psychotherapy, the patient plays an active role, whereas in the East, generally, the patient is more passive. In traditional Chinese medicine, psychotherapy is part of a holistic package of care, which includes herbs and acupuncture.

A powerful therapeutic factor is the rapport between the patient and the healer. The Confucian philosophy of the hierarchy in the state and family bestows high esteem on the healer. The aura of the healer is heightened if it is also known that he or she is an expert in tai-chi or kung-fu.

In the clinic, healers examine the patient largely through observation and feeling the pulse. There is minimal verbal communication and they explain to patients the state of their yin and yang. The healer explains the symptoms using the belief systems the patient is familiar with. To the depressed patient, symptoms of poor sleep, loss of concentration and listlessness are interpreted as due to a 'weakness of mental energy'. It is difficult to explain or understand the patient's neurotic problems in Western psychoanalytic terms like the 'Oedipus complex' or 'ego strength'.

The Japanese Morita model of psychotherapy (named after Shoma Morita, 1874–1938) is influenced by Buddhism. During treatment, there is a phase of disengagement from the precipitating factor (e.g. leaving an intolerable relationship or situation), introspection (rethinking the issues and planning different strategies in problem solving), conflict resolution (with suggestions by the healer to overcome the impasse) and finally the phase of acceptance of reality and solutions. The paternal transference on the healer is likened to the master–student relationship, as in martial arts training. The healer's suggestions help patients to accept themselves and to internalise the healer's wisdom. A healthy diet with herbal supplements and regular exercise or martial arts training are integral to the recovery process.

Conclusion

In the provision of psychiatric care in the East, the role of the traditional healer is gradually being acknowledged. In Indonesia, psychiatrists work closely with traditional healers and organise training programmes to help them identify patients with psychosis, to ensure their early referral to the hospital for treatment with antipsychotic medications. This collaborative effort is especially vital in countries where there is a perennial shortage of trained psychiatrists and other mental health professionals.

In a study of depression in elderly Chinese people (Kua, 1993), many patients preferred traditional healers partly because of their accessibility (the clinics were usually near their homes) and because the fees were affordable. Consulting a healer also avoided the stigma of being labelled a 'mental patient'.

With globalisation, the issue of 'cultural intelligence', as described by Earley and Mosakowski (2004) from the London Business School, is crucial as economic expansion crosses national boundaries and continents and so also very different cultures and customs. Modern psychiatry grew out of Western Europe and the United States. Most psychiatrists in the East are schooled in Western ideas of psychiatric practice. There is much to learn from the psychotherapeutic techniques of traditional healers in the management of psychiatric disorders. Fundamental in the therapeutic relationship is trust, and an understanding of the cultural belief system is a *sine qua non*.

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COUNTRY PROFILE

Mental health in Mongolia

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Contributions to the country profile section are welcome: please contact Shekhar Saxena (email saxenas@who.int).

Mongolia is a country with an approximate area of 1.5 million km^2. Its population is 2.5 million, nearly 90% of whom are ethnically Mongolian. Khalkh Mongols form the largest subgroup (approximately 79% of the population); the next largest subgroup is the Kazakhs (5.3%), followed by smaller groups such as Tuvins, Uzbeks, Uighurs, Russian and Chinese. The population is young, with 35.9% under the age of 15 years. The official language is Mongolian. Just under half the population live in rural areas and around a fifth live a nomadic life. About 80% of the land area is suitable for agriculture, mostly for animal husbandry.

According to the statistical data, gross domestic product (GDP) per capita was 500 744 tugriks (approximately US$420) in 2002. In 2000 some 36% of the population were living below the poverty line, and in 2002 the unemployment rate was 3.4%. Education is obligatory for all children aged between 8 and 15 years and the literacy rate is 98% for men and 95% for women.

Life expectancy at birth is 63.5 years (2002). The infant mortality rate is 23.5 per 1000 live births (2003), and the maternal mortality rate is 110 per 100 000 live births (2003). Socio-economic changes such as poverty, unemployment, the destabilisation of family structure, natural and man-made disasters, changes to traditional culture and lifestyle, and urbanisation are major factors affecting mental health. These current social changes result in suicide, street children, acts of violence and substance misuse, especially alcohol-related problems.

Epidemiological research

According to the results of an epidemiological survey conducted between 1976 and 1984, the prevalence of mental disorders per 1000 population varied widely across the country, from 9.8 in Altai (a mountainous region), to 13.1 in Khangai and Khentii (both also mountainous regions), 18.3 in Dornod (a steppe region), 23.5 in the Gobi (a desert region) and 24.0 in the capital, Ulaanbaatar (Byambasuren, 2000). These figures do not include those people with less severe psychological or psychosocial problems. Epidemiological studies on the prevalence of suicide (Byambasuren *et al*, 2003) and schizophrenia (Khishigsuren *et al*, 2004) have been conducted. According to this research, the number of suicides in Ulaanbaatar increased nearly threefold between 1992 and 2002, to reach 3.0 per 10 000 population. The prevalence of schizophrenia in Ulaanbaatar is 0.97 cases per 1000.

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Mental health legislation and the National Mental Health Programme

Mental health legislation passed in 2000 and the National Mental Health Programme of 2002 have been the key elements of a reform of mental health care in Mongolia.

The legislation covers all aspects of mental health, including:

- policy and principles
- the duties of state organisations, business entities and individuals
- mental health promotion
- the structure, management and financing of mental healthcare services
- the rights of people with mental illness
- involuntary admission
- the provision of security and social welfare assistance to people with mental illness.

The aim of the National Mental Health Programme is to reduce the prevalence of mental and behavioural

disorders, to create an environment which promotes mental health, and to improve the accessibility of mental healthcare.

Mental health resources

Budget

The health budget represents 4.6% of GDP (2003 figures). Of the overall healthcare budget, 5.0% is allocated to mental health. In turn, of the total state mental health budget (to cover treatment, rehabilitation and social care), 90% is spent on hospital care (i.e. the provision of in-patient and out-patient mental healthcare).

Thus, nationally, there are in total 594 psychiatric beds and 83 psychiatrists. This equates to 2.4 beds per 10 000 population (1.7 psychiatric beds in mental hospitals and 0.7 psychiatric beds in general hospitals) and 3.3 psychiatrists per 100 000 population.

Services

In 1974, the closure of four inter-provincial psychonarcotics hospitals with 50–75 beds each, located in Khovd, Arkhangai, Darkhan and Dornod provinces, was due to the transition from a centrally planned economy to a market economy.

At present, mental health services for the population are provided through general practice clinics, specialised out-patient clinics and the psychiatric units of general hospitals at the provincial level. There are 5–15 beds in psychiatric units at general hospitals in each of the 21 provinces, giving a total of 194 such beds; there are 23 psychiatrists attached to these units. At the state level, services are provided by the Mental Health and Narcotics Centre (an out-patient facility staffed by 26 psychiatrists), the State Mental Hospital and the Narcotics Hospital (which together have 400 beds and 34 psychiatrists). Thus, nationally there are in total 594 psychiatric beds and 83 psychiatrists. This equates to 2.4 beds per 10 000 population (1.7 psychiatric beds in mental hospitals and 0.7 psychiatric beds in general hospitals) and 3.3 psychiatrists per 100 000 population. There are 4.4 psychiatric nurses, 6.0 psychologists and 3.0 social workers per 100 000 population.

The Mental Health and Narcotics Centre regularly conducts training sessions, and holds meetings on mental health issues and the care of patients for family members, to help integrate patients into family and community life.

At present Mongolia has a shortage of mental health specialists. Ninety per cent of medical staff working in the field of mental health were trained during the 1970s and 1980s, and many lack the knowledge, attitude and skills required for community-based mental healthcare.

Rehabilitation

Clinics providing psychosocial rehabilitation for people with mental illness have been established in Ulaanbaatar (the Mental Health and Narcotics Centre, the State Mental Hospital and the Narcotics Hospital), Dornogobi, Orkhon, Khovd, Khuvsgul and Bayan-ulgii provinces. These teach music, carpentry, welding, cooking, sewing, herding and farming in order to improve the life skills of patients. For the development of psychosocial rehabilitation, the World Health Organization has provided support by giving 10 *gers* (Mongolian traditional tents) and a mini-van, and the Geneva Initiative has provided a supply of materials such as sewing machines, musical instruments and games equipment. Also, Open Society and the Soros Foundation supplied four *gers*. In 2004, the State Mental Hospital built houses for 30 people with mental illness, with support from World Vision.

Pharmaceuticals

Essential psychotropic drugs are available at all levels of service provision, although supplies are limited by a lack of funds. There is a centrally compiled list of essential drugs, but it is in need of review and update. The antipsychotics on it are chlorpromazine, haloperidol and fluphenazine injections. The chief antidepressant is amitriptyline and the anxiolytic is diazepam. Thus there is a need for the newer drugs.

Disability benefits for persons with mental disorders

Disability benefits are provided in accordance with the Law on Social Welfare as revised and adopted in 1998.

Medical education

At present Mongolia has a shortage of mental health specialists. Ninety per cent of medical staff working in the field of mental health were trained during the 1970s and 1980s, and many lack the knowledge, attitude and skills required for community-based mental healthcare. The implementation of the national healthcare reform has led to a need for the reorientation of the medical and nursing curriculum, with a new focus on training in community health, health promotion and prevention.

The Health Law of 1998 includes provisions related to the licensing of medical practitioners and the accreditation of health institutions.

Undergraduate education

In 2000, the National Medical University substantially revised the undergraduate medical curriculum. The new curriculum consists of 21 'blocks'. Block number 15 is mental healthcare, and is worth 5 credits. The mental healthcare course is run by the departments of anatomy, medical genetics, pharmacology, child psychiatry, psychiatry, medical psychology and general practice. The course time (a total of 200 hours) is divided into lectures, practice and independent practice, and the programme consists of psychiatry (80 hours in total), child psychiatry (36 hours), general practice (28 hours), medical genetics (8 hours), anatomy (12 hours), pharmacology (20 hours) and medical psychology (16 hours).

Postgraduate education

Postgraduate psychiatric education includes a training course (2–5 months), clinical residency (1–2 years), a Masters degree course (2 years), a refresher training course (2–3 months), PhD (3 years) and a scientific degree (Dr Sc Med).

International continuing medical education

As part of the Mental Health Project, the World Health Organization's Regional Office for the Western Pacific (WHO/WPRO) conducted a training programme for psychiatrists and family doctors on the integration of

mental health into general healthcare and psychosocial rehabilitation. In addition, the WHO has provided support for psychiatrists to receive training abroad on management, community-based mental health and narcotics. The Belgian agency Brothers of Charity sent at its own expense 17 Mongolian doctors and nurses from Ulaanbaatar on a 1-month study tour to visit Belgian mental health facilities for the psychosocial rehabilitation of people with mental illness.

The mental health information system

A mental health database has been established in the Statistics Department of the Mental Health and Narcotics Centre within the framework of the National Mental Health Programme, which is being implemented jointly with the WHO, for data collection at the national level.

Basic mental health data collected by family doctors are integrated into the national health information system. In 2002–03, the Mental Health and Narcotics Centre conducted a study using existing mental health data in collaboration with other government and non-governmental organisations.

Mental health promotion and advocacy

Comprehensive mental health promotion and advocacy have been carried out with a view to improving the knowledge and attitudes of the general population with regard to mental health. In 2001, the celebration of World Mental Health Day was later officially included in Government Resolution 224, with the aim of strengthening activities to enhance healthy lifestyles and behaviours.

The Ministry of Health in collaboration with the Ministry of Education, Culture and Science translated and printed the WHO documents *Life Skills Education in Schools* and *Mental Health Programmes in Schools*. The secondary school curriculum was revised to introduce elements of life skills, with the consequent preparation and distribution of guidelines and manuals in schools and teaching on this subject. In addition, training courses were held for teachers, school doctors and social workers on the development and implementation of a school mental health programme.

Mental health services for adolescents started with the support of the WHO's project Adolescent Friendly Service. Hope, a telephone counselling service, is present in the two provinces and three districts of Ulaanbaatar. In addition, two private counselling centres have been established in Ulaanbaatar.

Lessons and discussions have been organised for parents on the topic of the common mental and behavioural disorders in children and adolescents. This became an important measure to help parents understand the psychology of their children and to teach them how to assist their children to make the right decisions and overcome difficult issues in their daily life.

New 'relaxation clinics' have been opened in various health facilities across the country.

Training on psychological counselling for the population affected by *dzud* (wintertime natural disasters) was carried out in the 13 *dzud*-affected provinces with the assistance of the WHO; this involved around 170 doctors, social welfare workers, Red Cross staff, police and local administrators.

The United Nations Children's Fund (UNICEF), in collaboration with the Mental Health and Narcotics Centre and the National Children's Office, have implemented a project called 'Providing Social and Psychological Support to Children from Areas Affected by *Dzud*' in the provinces of Khuvsgul, Uvs, Zavkhan and Bayankhongor. Under this project, training was carried out for children from herding families, and promotional materials were disseminated to reduce stress in families and children caused by *dzud* and to teach the skills required to overcome stress.

The Mongolian Mental Health Association

The Mongolian Mental Health Association was created in 1999 with the support of the WHO. Its role is to contribute to mental health education and mental health promotion, and to uphold the international norms of rights and social protection of people with mental disorders.

The Association has a membership of psychiatrists, volunteers and representatives of non-governmental organisations. It has carried out a series of public education activities through newsletters and pamphlets which explain the basics of mental health to the public.

Conclusions

Mongolia is a country which is changing from socialism to a market economy following democratic political reform in 1990. This transition has affected all aspects of Mongolian life: political, economic and social. It has had an effect on the family. Many social problems have emerged as a result of economic decline and inflation, which affect the population generally but vulnerable groups especially.

The national healthcare reform shifted treatment from a specialist to a generalist healthcare delivery system. As a consequence, appropriate training in mental health and psychosocial skills is given to 40% of family doctors. These general practitioners have started to manage patients with mental health problems in their clinics and have included mental health topics in their health education activities in schools and in their home visits, as well as in campaigns promoting healthy lifestyles among the population.

The recent mental health legislation and the National Mental Health Programme have created an environment for the organisation and provision of community-based mental healthcare in Mongolia. Training was carried out not only among health sector personnel (health administrators, doctors at town hospitals, family doctors and mental health professionals) but also among administrators from other sectors, secondary school teachers

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The national health care reform shifted treatment from a specialist to a generalist healthcare delivery system. As a consequence, appropriate training in mental health and psychosocial skills is given to 40% of family doctors.

and patients' relatives. This training facilitated the creation of a supportive environment for mental health problems.

Since 1998, a decrease in the admission and length of hospital stay at the State Mental Hospital has been noted. At the same time, increases in the numbers of patients treated by family doctors as well as those referred have been recorded.

The collaboration and involvement of all key partners is crucial for mental health promotion and prevention. The WHO has played an important role in the introduction of a mental health component in primary healthcare and the development of psychosocial rehabilitation.

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COUNTRY PROFILE

Mental health policy and programmes in Kenya

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Following a 10-year war of liberation (fought by the Mau Mau against the British), Kenya attained full independence from colonial rule in 1963. For 10 years the country enjoyed rapid economic growth (6–7% per annum) but this slowed steadily to near stagnation in the 1990s. Poor governance, abuse of human rights, internal displacements of citizens, large numbers of refugees from neighbouring countries and the AIDS pandemic conspired to reduce Kenyans' life expectancy to 47 years (in the UK it is presently 77 years). Some 42% of the population now live below the poverty line, and 26% of Kenyans exist on less than US$1 per day. The annual per capita income in Kenya is US$360 (in the UK it is $24 000) (World Bank, 2002). AIDS currently has an estimated prevalence rate of 12%. In large parts of rural Kenya many sexually active adults are unable to work, and elderly grandparents are left to look after orphaned children (some already infected with HIV), as they struggle to deal with their own grief for the loss of many of their own children. In December 2002 a new government was elected, which gives some grounds for optimism in an otherwise bleak situation.

Mental health policy and resources

Given the circumstances, it is unsurprising perhaps that mental healthcare was relegated to near oblivion; at present there is no mental health policy. Little or no thought was given to mental health as the country struggled with more life-threatening conditions, including diarrhoeal diseases, measles, malaria and tuberculosis. Commendable efforts are, however, in place to develop a policy with the assistance of the UK's Department for International Development and the Institute of Psychiatry in London, which are now working on a collaborative project with Kenya, Tanzania and Zanzibar.

Existing programmes are hampered by the shortage of commitment, personnel and funds. There is a tangible lack of commitment to mental health in Kenya, reflected in the fact that it receives less than 1% of the Ministry of Health's budget, which is itself less than 7% of the national budget.

Existing programmes are hampered by the shortage of commitment, personnel and funds. There is a tangible lack of commitment to mental health in Kenya, reflected in the fact that it receives less than 1% of the Ministry of Health's budget, which is itself less than 7% of the national budget. There is also a lack of mental health legislation.

Kenya has only 47 psychiatrists for a population of 30 million, although there is the prospect of this number increasing, albeit slowly. More than half of them work in the major urban centres, while the majority of Kenyans live in the rural areas, which makes the relative shortage much worse.

Mathare Hospital started off in 1911 as an isolation unit for people with smallpox and is now a large, poorly resourced traditional mental hospital that houses approximately 750 mainly long-stay patients with psychosis, but it also serves as the forensic referral centre as well as an acute treatment centre. The buildings are in a state of disrepair and require major renovation. This is in marked contrast to the high morale of poorly paid staff, who work tirelessly without complaining and delivering, in their quiet way, a very high-quality service. A newly established drug rehabilitation unit is complemented by a well established occupational therapy department.

The school of nursing, which used to train a high calibre of registered psychiatric nurses, closed some years ago. A disused British army military camp, 100 km from the capital, Nairobi, houses several hundred chronically ill people, who have long since lost contact with their families. Some have been in hospital for more than 30 years.

Services

Kenya has eight provinces, each of which has a 30-bed psychiatric unit. These units are run by nurses and serve the catchment areas of the large provincial hospitals. Most units can prescribe basic drugs, generally limited to chlorpromazine, benzodiazepines, phenobarbitone and occasionally a tricyclic antidepressant. Although highly motivated, the staff, most of whom have worked in these units for many years, lack reading materials or indeed any contact with new knowledge in mental health practices. They are always keen to receive literature that could inform their practice. Most have no concept of mental health needs beyond psychosis and therefore do not diagnose or treat patients with depression or anxiety-related disorders.

Few people with mental disorders attending primary care clinics receive a psychiatric diagnosis. In one study, 45% of people attending a health centre in Nairobi had some form of psychiatric morbidity. All were misdiagnosed. Misdiagnosis is common because many people with a psychological disorder present with physical symptoms. This leads to frequent and unnecessary drug prescriptions and investigations.

Training

Although poorly resourced, Mathari Hospital is the main training centre for the University of Nairobi's medical and postgraduate students. A unique feature of the undergraduate training programme is the fact that psychiatry is a fully examinable subject taught to yearly classes of approximately 200 medical students. The department, which has 10 members of staff, also provides supervision and teaching to postgraduate students of paediatrics and internal medicine.

Kenya has had an active postgraduate training programme in psychiatry since the 1980s, and most of the psychiatrists in Kenya have obtained their qualifications (Masters of Medicine) from this programme. Following a period of low enrolment, psychiatry has in the last few years become a popular subject of study and currently there are 20 students in the programme. Significantly, this programme has trained many psychiatrists now working in the region. A postgraduate diploma in psychotrauma is the most recent addition to the training.

A number of local universities have programmes – both undergraduate and postgraduate – for the training of counselling psychologists, which is a very popular area of study, particularly following the 1998 bombing of the American Embassy in Nairobi, which brought mental health issues to the fore (Njenga *et al*, 2003, 2004). The tragedy had this one definite benefit to mental health.

A child psychiatry clinic was started by the principal author in 1981 at the Kenyatta National Hospital and now treats approximately 500 children per year. This unit serves as the main training venue for psychiatrists and paramedics in child psychiatry. There are, in addition, active if small programmes in private practice as well as active research in the areas of post-traumatic stress disorder and attention-deficit hyperactivity disorder. There are no formal training programmes in psychotherapy.

Research

Each postgraduate student of psychiatry at the University of Nairobi is required to conduct original research as part of training. There is a great deal of (unpublished) research data available in the department in all fields of psychiatry. A number of recent publications from the department are, however, indicative of the resurgence of the vibrant academic culture which formerly characterised the department (Othieno *et al*, 2001; Gatere *et al*, 2002; Maru *et al*, 2003). The department is a repository of much high-calibre research, spanning several decades, and any student of psychiatry in Africa would be well advised to consult the department before offering an authoritative opinion on African psychiatry.

Other Kenyan psychiatrists are active in research collaboration with international partners (Jenkins *et al*, 2002; Kiima *et al*, 2004). One area into which research is currently being undertaken is drug and alcohol misuse. In addition, an epidemiological survey of mental health disorders in a rural district of Kenya has recently been concluded; this was a unique project bringing together the Kenyan government, the Kenya Psychiatric Association and the Institute of Psychiatry in London (a World Health Organization Collaborating Centre) (Jenkins *et al*, 2002).

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Meetings

The main event for psychiatrists in East Africa is the annual meeting of Eastern Africa psychiatrists, which has taken place in different cities for the last 7 years; these meetings are always well attended and the presentations of great scientific interest. The last, held in Arusha, Tanzania, was attended by the majority of Kenyan psychiatrists and attracted a large variety of presentations, including ones on drug misuse and AIDS, domestic violence, attention-deficit hyperactivity disorder, policy and service delivery. It attracted presentations from the entire region, as well as from the UK, the USA and South Africa. The organisers are always keen to involve people from others parts of the world, as they continue to struggle with the problem in small communities of 'intellectual inbreeding', whereby younger psychiatrists are exposed to the 'wisdom' and experience only of their seniors, which in turn is limited by their own experiences, idiosyncrasies and areas of interest. Exposure to other senior colleagues is often described as liberating and refreshing.

Following a period of low enrolment, psychiatry has in the last few years become a popular subject of study.

Mental Health Act

The current Mental Health Act (1989) provides for the establishment of a mental health board, which in theory regulates mental health services in the country. The Act also provides for voluntary and involuntary admission to those hospitals designated for this purpose under the Act. It also prohibits discrimination by insurance companies against persons with a mental illness. Efforts are currently being made to update the Act, in particular in the areas of safeguarding the human rights of people who have a mental illness. This, however, is low on the list of priorities in Kenya.

International collaboration

There is much the North can learn from the South, in particular with regard to the utilisation of meagre resources.

The Royal College of Psychiatrists has a role to play in the promotion of mental health in Kenya, ranging from its participation in exchange programmes (to expose both members and the wider Kenyan public to the strengths and weaknesses of the systems in place in the two countries), as well as in its support of joint research programmes. There is much the North can learn from the South, in particular with regard to the utilisation of meagre resources.

Traditional practitioners have skills that are yet to be researched, while drug trials can take place in (natural) settings in Kenya, where patients previously unexposed to medications are still to be found. Being a largely English-speaking population, and being only 8 hours from London by direct flight (21 a week), Kenya is not only a booming tourist destination but, like the nation's long-distance runners, proposes to capture, in the long run, researchers from the UK and other Euro-pean capitals. Such adventurers will be met with traditional African hospitality, which includes (these days) a mandatory hunting safari (photographic) to any of the game reserves. Sandy beaches on the coast and the snow-capped Mount Kenya come as extras. As we say in Kenya, 'To go is to see'.

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COUNTRY PROFILE

Psychiatry and mental health in Malaysia

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Malaysia is a tropical country in the heart of South East Asia, at the crossroads of the ancient east–west sea trade routes. Although independent from British colonial rule only in 1957, it has a recorded history dating back to at least the first century CE, when the region was already the source of valuable mineral and forest produce that found markets in China, India and further west.

The development of both the east and west has reached a dizzying pace, with huge investments in both infrastructure and social services over the past two decades.

Malaysia has an area of over 330 000 km^2, divided between Peninsular Malaysia (formerly known as West Malaysia, south of Thailand) and Sabah and Sarawak (formerly known as East Malaysia, on the island of Borneo, on which are also Brunei and Kalimantan, part of Indonesia). Ethnically, the population comprises 55% Malay and other indigenous people, 33% Chinese and 9% Indians and other groups from South Asia. About 19 million of its 24 million inhabitants live in Peninsular Malaysia, while about 5 million live in the two states in Borneo, which have about three-fifths of the land area. The two eastern states joined independent Malaya in 1963. They are less developed and have fewer social and health services. The widely distributed population centres in these two states are separated by numerous rivers, mountains and few roads, which poses major challenges to the provision of good medical and psychiatric services. On Peninsular Malaysia, however, the long established infrastructure of roads and communications has contributed to better development of health services. Nonetheless, the development of both the east and west has reached a dizzying pace, with huge investments in both infrastructure and social services over the past two decades.

Development of health and mental health services in Malaysia

There are few records of health services that existed in ancient times but resort to traditional, herbal and

religious healing must have started then. They continue to flourish today, despite modern medical and healthcare services being available nationwide. Malay, Chinese, Indian as well as various religious healing practices are available alongside modern medicine.

The modern healthcare system that is in use today was started under British colonial rule largely to cater for the plantation and mine workers in the rubber, palm oil and tin industries, to ensure their productivity, and the expatriate administrators. Indeed, the health service of old was known as the Estates Health Service. This service was expanded gradually to care for others in the country but was almost wholly based in the towns.

The mental health service, similarly, was reportedly started in the late 1700s on the island of Penang to treat colonial sailors. This was later followed by the establishment of a mental hospital in the tin-mining town of Taiping in the 1800s but only in 1911 was a large (4000-bed) purpose-built mental asylum started, in Tanjong Rambutan in Perak, another tin-mining town. This was followed by another mental hospital, of 3000 beds, in Tampoi, Johore, in 1933, a 300-bed mental hospital in Penrissen Road in Kuching, and a smaller, 50-bed mental hospital in Buli Sim Sim in Sandakan, Sabah. There was reported to be only one expatriate psychiatrist in the Central Mental Hospital in Tanjong Rambutan in 1911, and this remained the case for most of the time until independence from British colonial rule in 1957. At independence there were about 1000 medical doctors, of all categories, in the country. There were certainly no local psychiatrists and very few specialists in other fields. Mental healthcare was wholly based on institutions and was custodial in nature.

Post-independence development of mental health training and services

At independence, Malaysia had no medical school and only a branch campus of the University of Malaya in Singapore. Doctors were trained in Singapore, Sri Lanka, India, Australia or other Commonwealth countries. In 1964, with the setting up of the country's first medical school at the country's first university, the University of Malaya, local training started. Fortunately, the first medical school in the country was blessed with a strong foundation. The Department of Psychological Medicine taught psychiatry in 10 weeks of clerkship. The students were also examined in psychiatry in their final year. This strong presence of psychiatry in the medical curriculum has set the pace for the training of all doctors in the basics of mental health. The model has largely been followed by the seven public medical schools that followed, and contributed in no small way to the general improvement in the detection and treatment by primary care doctors of mental illness in settings other than psychiatric clinics.

In 1973 the first three doctors started training in postgraduate psychiatry in the University of Malaya, to gain their Masters in Psychological Medicine (MPM). This 2-year training programme involved course work, a dissertation and the writing up of six cases treated by the trainee. Since 1988 this has been expanded to a 4-year Masters programme. Today there are three such training programmes in three universities, which together produce some 10–15 psychiatrists per year for the country. The total number of psychiatrists in the country today exceeds 170, of whom about 80 are employed by the Ministry of Health, in all states in the country. Many work in the eight public and four private medical schools. There are about 15–20 trainees in psychiatry entering training every year.

In 1958 the first general hospital psychiatric unit was started in Penang, almost in the very place where the country's first recorded mental hospital was sited about 180 years earlier. This was a major change from the institution-based services for people with a mental illness that was in existence in British times. With major revisions in healthcare that followed independence, and emphasis on community care and rural healthcare, the district or general hospital psychiatric units started to come on stream and efforts at deinstitutionalisation began.

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Service development in mental health

The move to short-stay psychiatric care based in general hospitals was slow because doctors regarded the large mental hospitals as the 'real' treatment agencies for those who were mentally ill. This often kept the units in general hospitals as mere way-stations for patients to be transferred to the two large mental institutions, which were overflowing, with 4000–5000 patients each in 1970. The shortage of psychiatrists – there were only about 17 in 1977 – meant that although there were by then four mental hospitals and about 10 general hospital units, many were not staffed by trained psychiatrists. With the country's economy expanding and shifting from producing primary commodities (whose prices were unpredictable) to producing manufactured goods for export, more resources were available to improve the health services, including mental healthcare. In the late 1980s there was a big push to produce psychiatrists and other specialists. Trainees in psychiatry, who then numbered two or three per year, jumped to 15–20 per year as more training centres were set up. This led to more psychiatrists for services in more parts of the country.

Today there are 32 psychiatric units in general hospitals and district hospitals, with a total of about 1000 beds for acute care. They each have between 20 and 100 beds, one to three psychiatrists, access to occupational therapists, social workers and psychiatric trained nurses, and most have community teams that visit high-risk patients at home. Most (if not all) run their own outreach clinics on a weekly or fortnightly basis in nearby health centres and hospitals that do not have psychiatrists. The two large mental hospitals have managed to bring down their numbers to 1200 and 2000 patients and the two smaller ones have 200 to 300 patients each. These mental hospitals, with just under 4000 beds combined, today treat fewer in-patients and out-patients per year than are treated in the 1000 beds in the general or

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There are small numbers of child and adolescent psychiatrists, forensic psychiatrists, liaison psychiatrists, rehabilitation psychiatrists, old age psychiatrists and substance misuse specialists, who were trained overseas, but more are being trained every year. As more medical schools come on stream, more academic departments are being set up and more research is being carried out in these departments.

The Ministry of Health's Family Development Division, in cooperation with the psychiatric services, has, since 1997, set up primary care services for people with a mental illness and over 1000 nurses and doctors in primary care help in this care. There are also over 40 day treatment centres for rehabilitation. Rehabilitation itself has changed from work therapy and vegetable farming based at hospital services to social, psychological and occupational therapies and work based on industrial subcontracts. Several of the products made by patients in the sheltered workshops are exported to other countries.

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Mental health of Malaysians

There have been a few recent community surveys, and these have shown that the figures for psychiatric morbidity are generally similar to those of other countries. The usual mix of the severely ill (with schizophrenia, severe depression or mania) in the acute care units is of course different from the case mix seen in primary care clinics or the non-psychiatric wards of hospitals. Around 20% of patients in primary care present with anxiety and depression in Malaysia.

Substance misuse, largely of heroin, is a major problem for which psychiatrists often have to advise treatment and rehabilitation agencies. There is a string of over 30 rehabilitation centres run by government agencies and numerous private and religious agencies that deal with substance misuse. Alcoholism is not as large a problem as it is in some other countries. There are currently no alcohol treatment centres in the country, although Alcoholics Anonymous groups exist in a few places.

Substance misuse, largely of heroin, is a major problem for which psychiatrists often have to advise treatment and rehabilitation agencies.

Child abuse, violence against women and domestic violence are the focus of attention by several non-governmental organisations and government agencies. The shortage of clinical psychologists, child psychologists, child psychiatrists and other professionals in these fields is a problem that is being addressed.

Mental health associations

The first mental health association was set up in 1969, in Ipoh Perak. Today there are over a dozen mental health associations covering many of the states. The members are relatives of patients, consumers, mental health professionals and others interested in mental health. Several of these associations also provide rehabilitation services in the community, besides undertaking advocacy and public education and providing advice to the Ministry of Health. The associations come under the umbrella of the Malaysian Mental Health Council and are supported by voluntary donations and fund-raising activities. Several of the mental health associations hold conventions every year, in which lay persons and professionals participate.

The psychiatric profession in Malaysia

The Malaysian Psychiatric Association (MPA) is the professional association that represents most of the psychiatrists in the country; it was founded in 1977. It has over 120 members (of whom about 20 senior members are also members or fellows of the Royal College of Psychiatrists) and its own *Malaysian Journal of Psychiatry*. The MPA holds national conferences (the Malaysian Conference on Psychological Medicine, now in its 10th session) every year. The MPA was a founder member of the ASEAN Federation for Psychiatry and Mental Health (AFPMH), which was formed in 1981 in Bangkok. It represents psychiatrists in the 10-member Association of South East Asian Nations (ASEAN), which has a population of over 500 million. The AFPMH holds the ASEAN Congress of Psychiatry, now also in its 10th session, every 2 years in rotation in each of the ASEAN countries. Malaysia has hosted the ASEAN Congress of Psychiatry twice, with two of the rotating presidencies being filled by Malaysians. The ASEAN Congresses attract over 500 delegates from the ASEAN countries and the region, as well as Australia and Europe.

Research

Research in psychiatry in Malaysia is largely university based and usually clinical or psychopharmacological in nature. There are limited resources and expertise in the field.

Conclusions

For a country that had no university, medical school or local psychiatrists, and which based all its mental healthcare in four mental institutions at independence from Britain in 1957, Malaysia has managed to develop its mental health care by moving away from custodial care towards community care. It has started training its own psychiatrists to meet the service and training needs of the country. The time is ripe to establish its own foundation of research, while expanding and consolidating basic and specialised mental healthcare.

Further reading

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The development of a mental health service in East Timor: an Australian mental health relief project

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Chris Tennant spent January 2004 in East Timor reviewing the mental health service on behalf of the Australian government's international aid agency.

East Timor (the Democratic Republic of Timor-Leste) occupies the eastern half of the island of Timor, which lies between North Western Australia and the Indonesian archipelago. East Timor has a population of around 860 000. It is predominantly rural and there are few large towns. The country has a largely subsistence agricultural economy; coffee is the principal cash crop. The population is extremely poor, and transport and communications are primitive.

Recent political history

The country was a Portuguese colony until 1975, when Indonesia invaded and annexed the territory. The indigenous resistance movement fought a low-grade guerrilla war for the next 24 years, a period which saw the widespread displacement of villagers. Throughout the 1990s Indonesia faced mounting international pressure over East Timor, until it finally allowed a referendum in 1999 on the future of the country, in which full independence was strongly endorsed.

Following the referendum, pro-Indonesian militias engaged in a campaign against the pro-independence majority. Most of the country's infrastructure was destroyed at this time and over 30% of the population was forcibly transported to West Timor, a province of Indonesia. An Australian military contingent supported by the United Nations (UN) secured stability and the UN administered the territory until 2001, when full independence occurred. The UN has continued to support the indigenous government since, but began to reduce its presence in Timor from May 2004.

Health services at independence

Government buildings, schools, universities, hospitals and houses are now starting to be rebuilt. At the time of independence there were but a handful of doctors in the country. There were two small hospitals capable of carrying out limited surgery, but even these were very poorly resourced in terms of pathology, radiology and other services. The country had no mental health services and no psychiatric in-patient beds (Silove, 1999).

Religious practice and healing

Timor's traditional religion is an animistic but monotheistic one in which God is believed to dwell in and around the sun. Spirits of the dead dwell in and around the village and each is represented by a specific stone placed in a sacred house after the person died. Each village or clan has its own living totem, such as a specific snake, dog, crocodile or other animal. The appearance of a totem (inhabited by some ancestral spirit) is a religious sign of 'unhappiness' in that ancestral spirit. This appearance requires interpretation by the clan's religious leader. Special ceremonies and sacrifices are used to placate these spirits.

Catholicism was introduced with Portuguese colonisation and now the two religions coexist comfortably, with most people practising both.

There is a strong belief in traditional health practitioners. The traditional healer is someone who has, in effect, undergone an 'occupational conversion' to become a healer and he begins practice with traditional medicines and sacrifices. Patients are expected to pay for treatment, usually with payment in kind, such as chickens or goats.

Mental illnesses are treated within this system. The traditional view of depression, for example, is that it is caused by the patient being tortured by a spirit and so 'thinking too much'. Themes of punishment are involved. Mania is believed to be caused by people 'talking too much', while psychosis is tantamount to 'losing your soul' and, again, being punished by some spirit. Treatment of such conditions by traditional healers involves returning to the scene where an ancestral spirit might have been 'insulted', the use of traditional herbs, negotiating with the spirit, physically hitting the patient and animal sacrifice.

Humanitarian mental health relief project

A humanitarian mental health relief project was initiated in 1999 by a multidisciplinary Australian coalition of mental health practitioners, PRADET (Psychosocial Recovery and Development in East Timor), through the University of New South Wales and funded by the

At the time of independence there were but a handful of doctors in the country. There were two small hospitals capable of carrying out limited surgery, but even these were very poorly resourced in terms of pathology, radiology and other services. The country had no mental health services and no psychiatric in-patient beds.

Diagnostic efficiency, furthermore, is somewhat restricted by the fact that while the culture is highly verbal, the local languages are not rich in vocabulary relevant to mental health constructs and translation is imprecise. Time concepts differ so that it can be difficult to specify the onset or course of symptoms, and a large emphasis is placed on 'the social story' and less on symptoms and disability.

Consultation is often disrupted by the presence of children and wandering animals. For the visiting psychiatrists, translation from a regional dialect to the main dialect and then into English is often required.

Australian government's overseas development agency, AusAID. The project included some dozen general nurses and a doctor, who were quickly trained in basic psychiatric skills, including diagnosis and psychopharmacology, so as to be able to treat the low-prevalence serious mental disorders, such as psychoses, affective disorder and epilepsy. They were equipped with a small selection of generic psychotropic drugs. The nurses were based in the capital, Dili, since their ability to travel into the outlying regions was severely limited (Zwi & Silove, 2002).

Following the success of this pilot programme, AusAID funded an East Timor national mental health project through a management company, AusHealth International. This project employed 16 nurses, this time mostly based in rural areas, a national coordinator and two mental health trainers. A nurse was attached to each of the 12 rural health centres, two to ones in Dili, and two in the enclave of Oekussi, which is within Indonesian West Timor. Eight vehicles were provided to the service, and in addition the nurses each had their own motorcycle. The Australian expatriate team included the Australian-based project director (the second author), the project manager, an in-country team leader, a trainer, a health promotion adviser and three rotating visiting psychiatrists.

Nurse education under Indonesian rule had consisted of a very basic 2-year training programme. Nurses were trained in a model where they were passive handmaidens to doctors and so had very limited independent case management skills. The 16 project nurses, who had no psychiatric training or experience, were given intensive preliminary training by Australian clinicians over 10 days, in the recognition of major psychiatric disorders and in managing these conditions with generic drugs, including chlorpromazine, depot fluphenazine, haloperidol, sodium valproate, carbamazepine, amitriptyline and diazepam. Nurses earn approximately US$40 per week but, commonly, each may be supporting a large extended family of up to 20 individuals, as unemployment is in the order of 40% and underemployment is far more common.

The community mental health nurses carry caseloads of between 60 and 120 patients. Broadly, psychiatric presentations are of acute psychosis (50%), untreated chronic psychosis (10%), acute mania with psychosis (30%) and severe (usually psychotic) depression (10%). In addition, the psychiatric case managers have taken on the task of treating epilepsy in the community; many such patients have had untreated epilepsy over many years and a significant proportion have hypoxic brain damage. Post-traumatic stress disorder is rarely seen in the core mental health service but there are other non-governmental organisations dealing with trauma. Most Timorese people lost relatives or close friends in the hostilities, and many women were raped.

The Australian psychiatrists visit for 2 weeks each month. Every 3 months, each psychiatric case manager (the project nurses) receives 1 or 2 days of clinical supervision in the field, from the same clinician. Personal observations by visiting psychiatrists and a formal review (by the first author) indicate that the diagnostic and management skills of these minimally trained nurses, for the conditions that are presenting, are excellent.

There are, however, significant barriers to efficient service delivery. Roads are in major disrepair, breakdown of the motorcycles is common and vehicles need to be sent to Dili for major repairs. In addition, there are communication problems between the nurse trainers and managers in Dili and the case managers in the rural areas; there is no effective telephone service available to nurses.

Diagnostic efficiency, furthermore, is somewhat restricted by the fact that while the culture is highly verbal, the local languages are not rich in vocabulary relevant to mental health constructs and translation is imprecise. Time concepts differ so that it can be difficult to specify the onset or course of symptoms, and a large emphasis is placed on 'the social story' and less on symptoms and disability. Patient consent is difficult to obtain and confidentiality is virtually nonexistent; consultations take place in the open and generally many members of the village are 'involved'. Consultation is often disrupted by the presence of children and wandering animals. For the visiting psychiatrists, translation from a regional dialect to the main dialect and then into English is often required.

It is not uncommon for patients with acute psychosis and mania to be chained, or put in foot-stocks, in order to prevent them behaving dangerously or fleeing and so becoming lost and perishing in the jungle. Chaining is thus an act of altruism, and families are actually very tolerant and take great care of the severely ill. Many patients have been managed in this way for several years as there has been no alternative, given the absence (until recently) of any treatment facilities or drugs.

Budgetary issues

The total health budget for East Timor in 2004 was approximately US$8 million. Some US$200 000 per annum (largely provided by the Australian government) is dedicated to mental health services (2.5% of the total health budget). It is apparent that a highly effective service is run on this very small sum.

The future

East Timor faces many problems. There remains a considerable lack of infrastructure. There has recently been civil unrest, partly as a result of the widespread unemployment. Militia activity continues. There is ongoing 'tension' within the country between the desire for total independence from external agencies and governments, and yet an economic dependence on such benefactors. Transportation, communication and trade are underdeveloped and there will be major budgetary problems at least until 2008. At this point in time, oil revenues will begin to flow, although there is widespread recognition that East Timor has done poorly in its agreement with

Australia on the joint development of this resource, which lies geographically between the two countries.

The government has decided that Portuguese and Tetum should be the 'official' and administrative languages, respectively. Indonesian (Bahasa) is widely spoken and, while English is not discouraged (indeed, it is called a 'working' language), the development of the nation, especially in education, will be restricted by lack of easy communication with external agencies and internet use.

At present the country has some 30 indigenous medical practitioners; half of them appear to be employed in an administrative capacity, running rural clinics. The country still depends on the provision of medical practitioners from countries such as the Philippines to support rural health clinics. In terms of developing a medical infrastructure and ongoing medical education, East Timor will require support from nations such as Portugal, Australia and Japan. East Timor will train nurses locally, initially with international support, and, despite the earlier problems with Indonesia, will need to train doctors at Indonesian universities because of their proximity, cost and cultural and linguistic compatibilities.

Conclusions

East Timor is emerging from a period of chaos, which saw the destruction of most of its infrastructure during the post-election turmoil in 1999. A mental health service has recently been established, with 16 nurse case managers employed largely in rural centres, within general medical clinics. These nurses have received 10 days of intensive formal training in psychiatry and ongoing intermittent supervision to equip them in a basic way to deal with the more serious, low-prevalence disorders using a handful of generic psychotropic medications. It is our experience that training a small cadre of specialist nurses was essential to initiating mental health services. The task remaining is to transmit the skills acquired by these specialist workers to a wider array of generic nurses in the community.

A recent formal review of this mental health service indicates it is functioning in an effective and cost-efficient fashion, treating serious mental disorders for the first time in a very impoverished nation. The health service faces many long-term problems in delivering healthcare to a very dispersed rural economy with extremely limited resources. The challenge is to institutionalise mental health as a priority service in East Timor and to ensure its sustainability with minimal external support.

It is our experience that training a small cadre of specialist nurses was essential to initiating mental health services. The task remaining is to transmit the skills acquired by these specialist workers to a wider array of generic nurses in the community.

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ASSOCIATIONS AND COLLABORATIONS

For contributions to the 'Associations and collaborations' column, please contact John Henderson, email john.henderson53@btopenworld.com

The European Society for Child and Adolescent Psychiatry (ESCAP): history and challenges for the future

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The European Society for Child and Adolescent Psychiatry (ESCAP) assembles 29 national societies of child and adolescent psychiatry of several countries belonging to the European Union or to its cultural and geographical area. It is the only association that gathers European psychiatrists who work with children and adolescents.

European child psychiatry is a dynamic entity. Its richness is progressively increasing, following the enlargement of the European Union. ESCAP includes among its membership countries that have joined the Union recently (such as Estonia, the Czech Republic and Hungary), some other countries that have not yet joined (such as Iceland and Turkey) and others that share similar cultural roots (such as Israel). The Association also publishes a scientific journal, *European Child and Adolescent Psychiatry*.

Origins and congress

ESCAP has its roots in the UEP (Union of European Paedopsychiatrists), an association whose first meeting was held in Magglingen (Switzerland) in 1954 and that was officially established in 1960, during its first congress in Paris. Since then, congresses have been held regularly every 3–4 years and have focused on the more clinically relevant, complex and current topics. During each congress, a general assembly takes place to

ESCAP website: www.dgkjp.de/escap/

elect the new board of the Society for the following 4 years. The board includes the President, Vice-President, Secretary and Treasurer. Many congresses have been organised. In Rome, in 1963, the congress topic was 'Character disorders in childhood and adolescence'; in Lausanne, in 1983, it was 'Aggression and the family'. More recently, in 1999, under the presidency of Professor Helmuth Remschmidt, the congress 'New challenges, new solutions' was held in Hamburg and the last one, in 2004, under the Presidency of Professor Philippe Jeammet, was organised in Paris on the subject of 'Developmental psychopathology – transmission and change'. The next ESCAP congress (the 13th) is proposed to be held in Florence in autumn 2007, under the new Presidency of Professor Ernesto Caffo.

What the different approaches to child and adolescent psychiatry in Europe have in common is the respect of children's rights.

Aims

According to its statutes, ESCAP has the following aims:

- to foster the European tradition of child and adolescent psychiatry
- to facilitate and extend the bonds between physicians practising child and adolescent psychiatry in European countries
- to spread the results of research and experience in this branch of medicine by publishing reports and organising scientific conferences and meetings
- to collaborate with international organisations with the same or related goals.

Mental health problems are a public health issue that Europe has to face. Mental disorders are widespread in all European countries. Their incidence is rapidly increasing and the situation is projected to worsen in the next few years.

Roots of European child and adolescent psychiatry

The culture of modern child psychiatry was born and developed in Europe and it later spread to other countries. Different approaches have been developed over many years, during which the European child psychiatric scenario has become rich and multifaceted (Remschmidt & Van Engeland, 1999). Among the main approaches there are:

- the tradition of child psychiatry based on a unified model of psychiatry and neurology, in countries such as Germany, France and Italy and in Eastern Europe (in Italy the discipline, founded by Giovanni Bollea, keeps the name of child neuropsychiatry)
- the remedial clinical tradition, which evolved into psychosomatic medicine, largely in Austria and Switzerland
- the psychodynamic/psychoanalytic approach, typical of Western Europe and of many schools, such as the French school of Serge Lebovici
- the empirical, epidemiological and statistical tradition (largely influenced by the United States), particularly in the United Kingdom (with the contribution of Professor Sir Michael Rutter), Scandinavia, Germany and Switzerland.

European child psychiatry offers wide psychotherapeutic (individual or group), pharmacological and psychosocial strategies. The richness of European child psychiatry arises from the dynamic coexistence of these different facets. By recognising the value of each of these different approaches, child psychiatry will be able to develop a versatile model of care. In fact, in European child psychiatry the focus is no longer on theoretical models but on the patient and the disorder.

What the different approaches to child and adolescent psychiatry in Europe have in common is the respect of children's rights. This is achieved in clinical practice by respecting the right that everybody has to receive adequate treatment, by helping families, by activating a social network to reinforce support and by informing the patient about the therapy and its goals through informed consent.

Typical of the European tradition is investment in the social and public field, by creating an active social network that involves several agencies able to offer support to everyone, of any age, gender and social and cultural background. In Europe, child psychiatrists work not only in a therapeutic direction, but also in terms of prevention, by respecting individual differences. In the third millennium Europe wants to be more open to different cultures. Migration from neighbouring as well as from more distant countries (mainly Africa and Asia) makes our system (and demands it to be) more flexible to respond to new cultures and habits.

Child and adolescent mental health in Europe

Mental health problems are a public health issue that Europe has to face. Mental disorders are widespread in all European countries. Their incidence is rapidly increasing and the situation is projected to worsen in the next few years. According to the World Health Organization (2005), in Europe 80% of young people report psychological well-being. However, that means that one adolescent in five has cognitive, emotional and behavioural difficulties and one adolescent in eight suffers from a diagnosable mental disorder. Among the most prevalent and discussed disorders are attention-deficit hyperactivity disorder (ADHD), anxiety and depression (a third of depressed adults are estimated to have shown the first episode before 21 years of age), eating disorders, pervasive developmental disorder and learning disability. Developmental psychiatric disorders are unlikely to have a spontaneous remission, cause problems with social adaptation and are associated with mental disorder in adult life if they are not diagnosed and treated early.

Child and adolescent psychiatry in Europe today

The branch of psychiatry devoted to children and adolescents is recognised at present as a specialisation or sub-specialisation in all European countries. Since 1994, child psychiatry inside the Union of European Medical Specialists (UEMS) has been a separate discipline from psychiatry and has its own section and board – Child and Adolescent Psychiatry/Psychotherapy

(CAPP) (Hill & Rothenberger, 2004). It is strongly linked to other disciplines, such as paediatrics, neurology, psychiatry and psychology, and to many others involved in children's physical and mental health, such as pedagogy, rehabilitation, logopaedics and physiotherapy. This interdisciplinary work is fundamental for prevention, treatment and research.

The member states of the European Union differ in their organisation of child and adolescent mental health services and in child psychiatry training. There are those that prefer an affiliation with adult psychiatry (e.g. France) and others that choose training immediately focused on developmental age, but including a neurological approach (e.g. Italy). For students, ESCAP foresees at least 12 months of practice in an adult psychiatric department, an optional experience in neurology departments and theoretical and practical knowledge in the paediatric field (Hill & Rothenberger, 2004).

An important challenge for a child psychiatrist is involvement in research, into both the pathogenesis of disorders and their treatment. Evidence-based medical practice is another challenge. In the last 20 years, the three main areas of child psychiatry research have been:

- physiology (molecular biology, genetics, neuro-imaging, pharmacology)
- child development (developmental psychology, psychopathology, neurology)
- assessment measures.

Perspective for the future

While balancing different national and ethnic realities, Europe has to face and overcome important challenges for the development of psychiatry, and more specifically of child and adolescent psychiatry. The main ones are developing effective and timely interventions, improving the accessibility and quality of services, and investing in primary and secondary prevention. In addition, those interventions, both therapeutic and preventive, individual and community, increasingly have to be based on scientific evidence. At the same time, a system of efficacy and efficiency checks on results and procedures has to be established; at present this is still largely lacking. To achieve this goal, it is useful to compare the experiences of different countries, during open discussions at congresses and through scientific journals. The main aim is to create European guidelines and protocols, but as a set of flexible and dynamic instruments. Such a protocol could be evaluated in each country. The North American model should no longer be simply imported and applied to the different European cultural settings. A tentative effort in this direction was made during the conference 'Caring for children in times of war, terrorism and disaster' organised by ESCAP, Foundation Child and the International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP) in Rome in July 2003. At the end of the meeting, which involved experts in the field of childhood trauma, the Declaration of Rome was endorsed, in order to summarise the key points of the conference (see Box 1).

Box 1. Declaration of Rome

At the meeting of ESCAP, Foundation Child and the IACAPAP in Rome in July 2003, on childhood trauma, the following principles were articulated:

- Care for children affected by war, terrorism, disaster and maltreatment should respect the culture of the child and society, respect individual differences, promote their reintegration into family and society, and enhance their normal development.
- The biological changes to the brain associated with trauma must be appreciated as a significant influence on physical brain development and behaviour. As knowledge advances in these areas, treatments will need to incorporate the means to ameliorate these biological changes.
- The trauma of maltreatment, war, terrorism and disaster is intergenerational. Care needs to be provided not only at the time of the trauma but also in its aftermath, if later generations are not to be affected.
- Governments should increase their investment in prevention, treatment and research in the area of caring for children affected by maltreatment, war, terrorism and disaster. Government officials and agencies responsible for health, education and social services need to collaborate to anticipate and prepare for the integrated responses needed in the aftermath of traumatic events. Government leadership is needed to facilitate inter-group understanding and reconciliation.
- The UN Convention on the Rights of the Child must be seen as applicable to children subject to maltreatment and affected by war, terrorism and disaster. Governmental bodies, at all levels, need to recognise and incorporate the protections and entitlements afforded by the UN Convention on the Rights of the Child. Policies and programmes should embrace the rights articulated in that Convention.
- Policy makers and carers should be informed of the latest findings from research, to inform the development of systems of care that afford responsive and responsible care for children.
- Ideally, the trauma of war and terrorism can be diminished and ultimately prevented through education, negotiation, mutual respect for rights and enhanced personal understanding. In the process of providing care, every effort should be made to foster a climate that will lessen the likelihood of continuing and future conflict. An accurate depiction of the dimension of human suffering following these events should be aired in the media.
- Legislators, clinicians and the general public should be educated about the public health problems associated with emotional, physical and sexual abuse, and about the recognition and treatment of children and families affected by child maltreatment.
- Care for children is an investment in the long-term health and productivity of nations. Therefore, care, treatment and prevention should be facilitated by more international cooperation, involvement of governments, non-governmental organisations and international organisations.

The need to share the same goals for the promotion of mental health among all European Union countries, despite their differing socio-political organisation and resources, is strongly supported by the World Health Organization (WHO). To this end, together with the European Union and the Council of Europe, the WHO European Regional Office organised a ministerial

The member states of the European Union differ in their organisation of child and adolescent mental health services and in child psychiatry training. There are those that prefer an affiliation with adult psychiatry (e.g. France) and others that choose training immediately focused on developmental age, but including a neurological approach (e.g. Italy).

The main aim is to create European guidelines and protocols, but as a set of flexible and dynamic instruments. Such a protocol could be evaluated in each country. The North American model should no longer be simply imported and applied to the different European cultural settings.

conference in Helsinki, 12–15 January 2005, which was open to 52 European member states and professional and non-governmental organisations. The preparatory work for this meeting began in 2003 in Copenhagen and was developed in the course of regular meetings (Athens, Brussels, Paris, Moscow and, more recently, Luxemburg and Tallin). The final documents of the conference contain an analysis of the current state of European psychiatry and some suggestions on how to improve treatment efficacy and efficiency, how to increase service quality and accessibility, and how to overcome stigma and protect human rights (World Health Organization, 2005).

Future challenges: research and training

A fundamental challenge in the future of child psychiatry is further research, particularly into:

- the aetiology and pathogenesis of psychopathological disorders in children and adolescents
- symptoms and disorders, stability and change
- externalising and internalising disorders
- developmental disorders
- evidence-based treatments and interventions, as well as preventive strategies (involving also the family and the more extended environment).

Another challenge concerns the training of young child psychiatrists and researchers. ESCAP, in collaboration with Foundation Child and the International Association for Child and Adolescent Psychiatry and the IACAPAP, has organised a research seminar in Italy every year over the last 5 years, which gathers leading professionals in child and adult psychiatry from all over the world. The research seminar is open to 35–40 young European child psychiatry students, sponsored by Foundation Child, to spend a week of study in order to be trained in a particular area, which changes every year (mood and anxiety disorders, treatment evaluation, etc.). In addition, every student is invited to present to the group his/her past or current research projects in order to get useful feedback from colleagues and senior supervisors. The next one is to be held from 10 to 15 April 2005 in Bocca di Magra (La Spezia).

For such scientific activities, for facilitating a continuous exchange of scientific knowledge and developing a common system of training, European child psychiatry needs to be supported by adequate funds and structures.

Scientific communication, both intra- and inter-disciplinary, should also be facilitated through the creation of international research projects, scientific meetings and scientific publications. Since knowledge in the field of child and adolescent mental health is constantly evolving, regular professional updating is necessary.

References and sources

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Hill, P. & Rothenberger, A. (2004) Can we – and should we – have a 'Euro-psychiatry' for children and adolescents? The work of the UEMS Section and Board for Child and Adolescent Psychiatry/Psychotherapy. *International Psychiatry*, no. 6, 20–21.

Lebovici, S., *et al* (1999) *Nouveau traité de psychiatrie de l'enfant et de l'adolescent*. Paris: Presses Universitaires de France.

Remschmidt, H. & Van Engeland, H. (eds) (1999) *Child and Adolescent Psychiatry in Europe: Historical Development, Current Situation, Future Perspectives*. Darmstadt: Steinkopff.

Rutter, M. & Taylor, E. (eds) (2002) *Child and Adolescent Psychiatry*, *Vol. IV*. Oxford: Blackwell.

World Health Organization (2005) Final documents of the ministerial conference, Helsinki, 12–15 January 2005: *Mental Health Action Plan for Europe* and *European Declaration on Mental Health*. Available at www.euro.who.int/mentalhealth2005.

The College website (www.rcpsych.ac.uk) has seen useful changes, so that links with the Board of International Affairs, *International Psychiatry* and international mental health organisations are much more accessible. Suggestions for further improvements are welcome. Contact jcarroll@rcpsych.ac.uk

News and notes

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International programme for the College Annual Meeting in Edinburgh

The Board of International Affairs has organised a stimulating programme within the College Annual Meeting in Edinburgh this year. The highlight will be the visit of the President of the World Psychiatric Association (WPA), Professor Okasha, who will be involved in a major discussion on Wednesday 22 June on 'The recruitment and migration of psychiatrists from developing countries: an ethical issue and a conflict between social responsibility and individual freedom of choice'. Some of the new international divisions are organising a day-long programme for Thursday 23 June. The themes will centre on the diversity of issues in psychiatry in different cultures and settings, and implications for training.

The European Task Force and progress in the evaluation of CME in Europe

The European Task Force – comprising official representatives of the Association of European Psychiatrists, the Section and Board of the Psychiatry subsection of the

Union of European Medical Specialists (UEMS), the WPA and the WHO Mental Health Regional Office for Europe – have agreed with the Secretary-General of the UEMS (Dr Bernard Maillet) that the Task Force should be the technical arm of the system for European accreditation of psychiatry where international accreditation is required. This agreement has been ratified by each of the organisations involved. This will therefore replace the current chaotic situation whereby there are several European accrediting bodies without common standards. The Task Force is currently developing procedures and standards.

Leaders of European psychiatry

The leaders of European psychiatry continued their series of meetings during the WPA International Congress in Florence in November 2004. Earlier in the year they had reached consensus on psychiatric services focused on the community (see News and notes in the January 2005 issue of *International Psychiatry*, no. 7) and in Florence they discussed expert presentations on the optimal range of mental health services in different settings according to the income level of the setting and the important question of how to evaluate mental health services. There was also a presentation on the system of continuing medical education mentioned above.

The afternoon was devoted to discussion of the Helsinki WHO Ministerial Conference on Mental Health that took place in January 2005 and discussion of key items that were anticipated to emerge in declarations from the Helsinki conference.

Plans have been agreed for the leaders meeting that will take place during the meeting of the Association of European Psychiatrists (AEP) in Munich in April. This will focus on the effectiveness of psychiatric organisations. Leaders will use the declarations that emerge from the Helsinki meeting to discuss how psychiatric organisations can use them to benefit the practice of psychiatry.

Specialist registrars and VSO

An opportunity exists for a specialist registrar to take up a placement with Voluntary Service Overseas (VSO) that would be approved for the Certificate of Completion of Specialist Training (CCST). It would be based at Batticaloa Teaching Hospital on the East Coast of Sri Lanka. For further details contact jcarroll@rcpsych.ac.uk.

Humanitarian fund

The Department of Health (DH), the British Medical Association (BMA) and the Royal College of Nursing (RCN) recognise that many National Health Service staff undertake humanitarian work overseas. In the last 2 years the DH has made available a fund to cover the incidental expenses of teams undertaking humanitarian projects. It has worked with the BMA International Committee and the RCN to allocate these funds. If you wish to be informed of funds for future years contact internationalinfo@bma.org.uk.

'No care for most young people with mental illness'

The WHO has issued a press release that expresses concern that some two million young people in the European region suffer from mental disorders and that most of them receive no care or treatment. The degree of coverage and quality of services for the young, including for serious disorders, are generally worse than those for adults. See www.euro.who.int/mentalhealth/ChildAdolescent/20040920_1.

Middle East Division regional meeting

The 6th regional meeting of the College in the Middle East was held on 3–4 October 2004 in Cairo, Egypt. The theme of the meeting was 'Developing psychiatric manpower – a global view', and it included topics on the current manpower situation in the region, with a focus on the psychiatric scene in Iraq, the integration of psychiatric services into primary care in Egypt, international perspectives on mental health services and the role of the World Psychiatric Association (WPA), as well as the development of manpower in the area of substance misuse and other general training issues.

A session was also dedicated to the topic of art and its role in psychiatric services in Egypt, and there was a free-paper session that included papers from the UK on the pathology of rare musical hallucinations, mental health literacy among women in Egypt, and dual-diagnosis research in the UK. Other topics included the presentation and management of anxiety disorders in Egypt and Saudi Arabia, services for the elderly in developing countries, the challenges of practising psychotherapy in the Middle Eastern culture, as well as a session on the status of sleep medicine in the region.

The meeting was attended by mental health professionals from Egypt, the UK, the USA, Iraq, the Gulf states and Lebanon. The College was represented by Dr Mike Shooter, Professor Hamid Ghodse and Mrs Vanessa Cameron.

To all those attending the opening session, Professor Ahmed Okasha from Egypt, as President of the WPA, extended an invitation to the WPA meeting due to be held in Egypt in September 2005.

During the business meeting, Dr Nasser Loza from Egypt was elected as chairman of the Middle East Division, Dr Fouad Antun from Lebanon as secretary and Dr Walid Sarhan from Jordan as financial officer.

World Psychiatry

World Psychiatry has become very well established as the official journal of the World Psychiatric Organisation. It is published three times a year and is distributed without cost to psychiatrists whose names are provided by WPA member organisations (the editor can be contacted at majmario@tin.it). It is also easily accessible from the WPA website, www.wpanet.org.

Arabic-speaking psychiatrists are reminded of the electronic journal for psychiatrists and psychologists, which has a wide range of scientific and professional material. There are also English- and French-language versions. See www.arabpsynet.com.

Forthcoming international events

Applications are welcome for a bursary to enable attendance at the Child and Adolescent Psychiatry Faculty conference, 21–23 September 2005, in Harrogate. The three bursaries are each worth £1000 and are open to applicants from low-income countries. Further information can be obtained from Dr Kedar Dwivedi (email Kedarnd@doctors.org.uk).

14–15 April 2005
XII International Symposium About Current Issues and Controversies in Psychiatry: Comorbidity
Barcelona International Conference Center, Barcelona, Spain.
Tel: 34 93 221 22 42
Fax: 34 93 221 70 05
Email: controversias@geyseco.com
Website: www.geyseco.com/controversias.htm

19 April 2005
International Congress of Personality Disorders, Association of Argentinean Psychiatrists (APSA)
WPA Section on Personality Disorders and APAL Personality Section.
Mar del Plata, Argentina.
Contact: Dr Nestor Koldobsky
Email: koldobsky@speedy.com.ar
Website: www.iaepd.com.ar

20–23 April 2005
Regional Meeting of the Collegium Internationale Neuro-Psychopharmacologicum
CINP WPA co-sponsored conference.
Cape Town, South Africa.
Contact: Dr Robin Emsley
Email: rae@sun.ac.za
Website: www.cinp.org

21–24 April 2005
WPA Regional Meeting and XXI Congreso Argentino de Psiquiatria
Organised by the Association of Argentinean Psychiatrists (APSA).
Mar del Plata, Argentina.
Contact: Dra. Graciela Lucatelli
Email: apsa@apsa.org.ar
Website: www.apsa.org.ar

12–13 May 2005
Balanced Care. Innovative Perspectives on Psychiatric Rehabilitation
Geel, Belgium.
Contact: Lieve Van de Walle
Fax: +32 (0)14 58 0448
Email: Congres2005@opzgeel.be
Website: www.opzgeel.be

21–26 May 2005
American Psychiatric Association Annual Congress
Atlanta, Georgia, USA.
Contact: apa@psych.org
Website: www.psych.org

12–15 June 2005
First IASSID Asia–Pacific Regional Congress
The International Association for the Scientific Study of Intellectual Disabilities (mental retardation and related developmental disabilities) Life Course Perspective of Research on People with Intellectual Disabilities Global Trends and Local Strategies.
Howard International House, Taipei, Taiwan.
Email: iassidoffice@aol.com
Webiste: www.iassid.org

17–20 June 2005
Quality and Outcome Research in Psychiatry
WPA thematic conference, Spanish Foundation of Psychiatry and Mental Health.
Valencia, Spain.
Contact: Dr Carmen Leal Carmen
Email: Leal@uv.es; attendance@wpa2005valencia.com
Website: www.wpa2005valencia.com

18–21 June 2005
9th European Conference on Traumatic Stress (ECOTS)
European Society for Traumatic Stress Studies (ESTSS), Swedish National Association for Mental Health (SFPH) in cooperation with the National Centre for Disaster Psychiatry (KCKP).
Themes: Effects of Disasters and Terrorism, Neurobiology and Trauma, Memory and Trauma, Children and Effects of Early Traumatisation, Sexual Exploitation and Trauma, PTSD and Complex Traumatisation, Exile Trauma, The Impact of Prevention and Acute Interventions.
Stockholm, Sweden.
Website: www.stocon.se/ecots2005

19–24 June 2005
Mental Health in Complex Emergencies
An intensive 6-day training course to equip mental health professionals to work in complex humanitarian emergency and relief situations.
New York City, USA.
Email: iiha@fordham.edu
Website: www.cihc.org; www.fordham.edu/iiha

20–23 June 2005
Royal College of Psychiatrists Annual Meeting
Edinburgh International Conference Centre, Edinburgh, UK.
Contact: College Conference Office.
Tel: +44 (0)20 7235 2351 × 142
Fax: +44 (0)20 7259 6507
Email: mbraithwaite@rcpsych.ac.uk

5–7 July 2005
Meeting Mental Health Needs: The Evidence from Epidemiology, Economics and Evaluation
WPA-sponsored conference, WPA Section on Epidemiology and Public Health.
Brisbane, Australia.
Contact: Professor Philip Burgess
Email: p.burgess@uq.edu.au
Website: www.icms.com.au/ephm2005

11–12 July 2005
Second International Conference on Conflict, Culture and Mental Health: The Contribution of Psychiatry and Psychotherapy to Conflict Resolution and Harm Reduction
Institute of Psychiatry, London, UK.
Contact: Rachel Jenkins
Email: Amy.Blakey@leedsmh.nhs.uk
Website: www.leedsmentalhealth.nhs.uk/andrew-sims/

24–27 July 2005
Improving Access and Delivery of Mental Health Care in South Asia
South Asian Forum on Mental Health and Psychiatry, United Kingdom Chapter. WPA co-sponsored conference, with the Sri Lankan College of Psychiatrists and the World Association for Psychosocial Rehabilitation.
Colombo, Sri Lanka.
Contact: Dr Afzal Javed
Email: afzal.javed@ntlworld.com

28–31 July 2005
Trauma. New Developments in Psychoanalysis
44th Congress of the International Psychoanalytical Association.
Rio de Janeiro, Brazil.
Website: www.ipa.org.uk

4–8 September 2005
World Federation of Mental Health: Equity and Mental Health
Cairo, Egypt.
Email: emrcwfmh@hotmail.com; conference@medical-design.net
Website: www.wfmh2005.com

10–15 September 2005
XIII World Congress of Psychiatry
World Psychiatric Association.
Cairo, Egypt.
Contact: Professor Ahmed Okasha
Email: secretariat@wpa-cairo2005.com
Website: www.wpa-cairo2005.com