



Royal College of
Psychiatrists

International Psychiatry

Issue 9, July 2005

Bulletin of the Board of International Affairs of the Royal College of Psychiatrists

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Subscriptions

International Psychiatry is published four times a year.

Subscription: £15.00 per annum.

For subscription enquiries please contact:

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The Royal College of Psychiatrists is a registered charity (no. 228636).

Printed in the UK by Henry Ling Limited at the Dorset Press, Dorchester DT1 1HD.

Contributions for future issues are welcome – please contact Hamid Ghodse

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Tsunami survey: estimating the need for services in the UK and Ireland

Can you give us 5 minutes of your time?

The College has established a Task Force, chaired by the President, Dr Mike Shooter, which, among other things, has been gathering and disseminating information about the relief effort, primarily through the website, and also supporting and coordinating longer-term solutions to the training needs identified in the areas most affected.

What about survivors from the UK and Ireland? Many people who were directly affected by the tsunami have now returned home. It is currently very difficult to estimate how many people – survivors, families, friends and relief workers – have been affected and may need to access mental health services. We are keen to assess the need for mental health services, how services are coping with these referrals and how the College can provide help or support.

A brief questionnaire has been designed for this purpose; it can be downloaded from the College website: www.rcpsych.ac.uk. Copies of the survey are also available from Deborah Hart, Head of External Affairs, The Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG, UK, or email dhart@rcpsych.ac.uk.

Please take 5 minutes of your time to complete our survey. The more information we receive, the clearer the picture will be and the better the College can respond to the needs of tsunami survivors, their families and friends in the UK and Ireland. We hope to publish the results of the questionnaire in the *Psychiatric Bulletin* in due course.

Board of International Affairs' Senior Volunteer Programme

We are pleased to announce that the database for the Senior Volunteer Programme (SVP) is now up and running.

The SVP project, designed to provide a vital link between Members and Fellows in the UK who wish to offer their expertise to low-income countries and international Members and Fellows who would like to use it, is primarily a matchmaking exercise between volunteers and host institutions.

If you wish to find out more about this initiative, please visit the Board of International Affairs page on the College website (www.rcpsych.ac.uk/college/spcomm/bia/index.htm) or contact the International Unit at the College, telephone 020 7235 2351, extension 112 (Miss Smith) or 123 (Mrs Carroll).

Doctors' health and performance

Hamid Ghodse

Director, Board of International Affairs, and Editor, *International Psychiatry*

Concern about doctors' health has increased over the past decade. This is related to a growing awareness that their health problems are often work-related. A work-related health problem is defined by the Health and Safety Executive in the UK as any illness, disability or other physical problem which reduces, either temporarily or permanently, the functioning of an individual and which has been caused, in whole or in part, by the working conditions of that individual (see Ghodse, 2000).

There is considerable international evidence that doctors are suffering from high levels of stress. A national postal survey investigating occupational stress levels in accident and emergency (A&E) departments found high levels of psychological stress (Burbeck *et al*, 2002); for example, 44% of consultant staff were above a threshold level for 'distress', with 18% reporting depression and 10% reporting suicidal ideation. In The Netherlands, a survey found that 55% of medical specialists acknowledged high levels of stress (Visser *et al*, 2003). Burnout was experienced as a combination of a high level of stress and a low level of job satisfaction, rather than as stress alone, and the protective nature of high job satisfaction was demonstrated. Statistics from physicians' health programmes in the US have shown that some specialties carry a higher risk than others. For example, family doctors were over-represented among 'impaired' physicians, as were emergency medical practitioners, psychiatrists and anaesthetists (Bennett & O'Donovan, 2001; Winter & Birnberg, 2002).

Work-related ill health is usually the consequence not of unintended discrete events but of exposure to conditions over a considerable period. For some diseases, for example hepatitis, the causal factor or aetiology is clear cut but for many, such as anxiety disorder or depression, there are often several contributory factors. Moreover, even when ill health is work-related, this may reflect past rather than present working conditions and, with the rapidly changing patterns of work that occur nowadays, the number and type of illnesses in doctors and other healthcare professionals may change.

Public and professional concern about doctors' ill health naturally focuses on its potential effects on the standard of care provided to patients, which may become sub-optimal through incompetence, unethical behaviour or psychiatric impairment. Although such concerns are justifiable, it is also important to remember that ill doctors are patients too, needing and deserving the same standard of professional care as any other patient. In this context, a particular problem for doctors with health problems is a reluctance to reveal that they are indeed ill, particularly if they are suffering from a

psychiatric condition. They often perceive this as a personal failure and fear that their livelihood may be affected if their illness becomes public knowledge. They therefore often make strenuous efforts to hide symptoms of stress, for example anxiety, depression and substance misuse, and such concealment is often supported by others in the doctor's family and professional environment, who may suspect that something is wrong but be reluctant to intervene (Ghodse, 2000). The consequent conspiracy of silence and denial, albeit well intentioned, impedes early intervention. This is especially disadvantageous because the most successful outcomes of treatment occur when a sick doctor is approached in a friendly fashion by a fellow professional with an offer of aid and support, rather than a coercive approach and the imposition of sanctions, which are more likely if severe impairment is affecting professional competence.

When examining the cost of doctors' ill health, it is necessary to consider the various parties on whom such costs fall – first and foremost, the sick doctors themselves, but also their families, friends, colleagues, patients, employers and society as a whole. The financial implications of ill health include loss of income in the short term, as a result of absence from work, and long-term losses for those unable to return to the same work and for those who give up work prematurely. In addition to financial losses, there is also a deterioration in the doctor's quality of life resulting from the pain and suffering associated with illness, the worry and grief caused to family and friends and, in some cases, permanent incapacity. Although the financial costs are comparatively simple to assess, it is often impossible to put a value on all the other losses.

For all the above reasons, it is important that the problem of doctors' ill health is recognised, that appropriate treatment programmes are available and accessible, and that everyone involved in their care acknowledges their distress and suffering. There can be particular difficulties in caring for sick colleagues, and so appropriate training is required. For example, a doctor might find it embarrassing to carry out a full examination of a colleague and, indeed, may fail to do so in the absence of appropriate training; this would result in the sick doctor having a lower standard of care than other patients. Treatment programmes for doctors vary widely in different countries, in both the form of treatment and the way in which it is offered, but they should be based on the principle that sick doctors should be protected from the loss of their job. Temporary restrictions on practising may be necessary, which may include an agreement to practise only under supervision for a time (Ghodse, 2000).

A particular problem for doctors with health problems is a reluctance to reveal that they are indeed ill, particularly if they are suffering from a psychiatric condition.

There can be particular difficulties in caring for sick colleagues, and so appropriate training is required.

As the principal conditions potentially impairing doctors' fitness to practise are mental health problems, and alcohol-related and drug-related problems, psychiatrists have an important role to play.

Finally, as society's expectations of professionals become even higher, there must be greater understanding for doctors and the risks that they personally take when dealing every day with the pain and suffering of others. As a minimum, patients' rights should surely extend to doctors when they themselves are patients, and healthcare professionals must acknowledge the fact that healers, when they are ill, may also suffer profoundly. They need healing too, not just by other experts, but by the understanding and compassion of their colleagues.

As the principal conditions potentially impairing doctors' fitness to practise are mental health problems, and alcohol-related and drug-related problems, psychiatrists have an important role to play, both in the destigmatisation of mental illness and by providing appropriate assessment and treatment. The National Clinical Assessment Authority (NCAA, 2004) in the UK comprehensively reviewed health-related factors

involved in doctors' performance as well as the personal characteristics and behaviour of doctors.

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THEMATIC PAPERS – INTRODUCTION

Women's mental health in a context of violence, exploitation and oppression

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In this issue we address the sensitive issue of societal attitudes towards women, in particular violence, exploitation and oppression, and their consequences for women's mental health. The subject of exploitation and abuse of women, by men, is rarely out of the headlines. Yet the prevalence of the problem does not seem to diminish, despite widespread publicity. In their fascinating review of the confluence of partner violence and substance misuse with mental health problems, Cari Jo Clark and Grace Wyshak estimate that up to two-thirds of women are subject to such violence, extrapolating from studies conducted in a wide variety of countries and cultures. They make the point that substance misuse and mental health disorders are both risk factors for such behaviour and outcomes of it.

Psychiatric interventions to mitigate the effects of violence upon women's mental health must be sensitive to local cultural contexts, but there are formidable complexities. These are exemplified in the contribution from Drs Lari, Alaghebandan and Joghataei, on the psychosocial and cultural motivations for self-inflicted

burns among Iranian women. They provide an insight into aspects of a social phenomenon that is truly disturbing: the rising incidence of self-immolation among Iranian women, especially during the early years of marriage. There is a supposition that in many cases this course of action is taken to escape from a violent relationship, or one in which the woman is exploited by traditional male values, but the truth is we cannot be sure. In many cases the women concerned are killed by their actions; in others they deny intent and ascribe the burns to an accident.

Finally, Drs Medina-Mora and Lara have contributed a review of attitudes to women and their mental health in Mexico, a culture where the term 'machismo' still holds meaning. Mexican society has, by this account, clear divisions into what are regarded as appropriate male and female roles. Yet, as women in many countries in the Western world have found following their 'liberation' in the 1960s, all too often the freedom to join a male-dominated world of work means dual responsibilities and limited opportunities to advance along a parallel path to men outside the home. In

Psychiatric interventions to mitigate the effects of violence upon women's mental health must be sensitive to local cultural contexts, but there are formidable complexities.

Mexico, there is an additional twist to the differentiation of gender roles, in the sense that women are expected not to drink alcohol, because it is not compatible with their domestic responsibilities. And so we come back to the issue of domestic violence which was raised by Clark and Wyshak, with the misuse of alcohol by men

being closely correlated with physical violence against female partners.

Psychiatrists around the world need to be alert to the continuing stresses on women, from family, partners, work and many other obligations; cultural influences on female mental health are rarely trivial.

THEMATIC PAPER – WOMEN'S MENTAL HEALTH AND OPPRESSION

The confluence of violence towards an intimate partner, substance misuse and mental health: a worldwide problem affecting women

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Violence towards an intimate partner, substance misuse and other mental health disorders are problems that tend to cluster together and result in multiple burdens for afflicted individuals (Desjarlais *et al*, 1995; Wyshak & Modest, 1996; Wyshak, 2000). They are prevalent not only in high-risk groups but also among members of the general public seeking primary healthcare (Bauer *et al*, 2000; World Health Organization, 2001), where their afflictions often go undiagnosed and untreated (Edlund *et al*, 2004; Kramer *et al*, 2004). Furthermore, violence towards an intimate partner, substance misuse and other mental health disorders involve common symptom pathways, such as psychiatric distress, headache, abdominal pain, gastrointestinal problems and multiple somatic complaints (Berwick *et al*, 1991), which suggests that the use of an integrated set of screening instruments may lead to early detection and treatment for patients who are suffering from one or more of these problems.

The role of gender

Violence directed at an intimate partner disproportionately affects women: between 10% and 69% of women have at some time experienced such violence, according to a review of 48 population-based studies from a variety of countries around the world (Krug *et al*, 2002). Similarly important, tobacco smoking, alcohol consumption and the use of illicit drugs

(excluding ecstasy, solvents and cannabis) cause a total of approximately 6.9 million deaths annually: 4.9, 1.8 and 0.2 million, respectively (World Health Organization, 2002). Although men use these substances at higher rates than women, the health impact for women is no less significant and for some substances may be even greater (Cormier *et al*, 2004). Furthermore, neuropsychiatric disorders as a whole afflict approximately 450 million individuals worldwide (World Health Organization, 2001). Of these disorders, depression, which disproportionately affects women, is the leading cause of disability worldwide (World Health Organization, 2001).

Confluence of the three types of problem

Violence towards an intimate partner, substance misuse and other mental health disorders are highly correlated with each other. Substance misuse and other mental health disorders are risk factors for and health outcomes of violence perpetrated by an intimate partner (Riggs *et al*, 2000). Substance misuse and other mental disorders themselves are highly correlated under the rubric of dual diagnosis. Research specifically addressing these interconnections has found high correlations between the experience of violence, substance misuse and psychiatric distress, characterised by gender and ethnic differences; notably, in women depression and alcoholism are highly correlated (Wyshak & Modest, 1996).

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The confluence and common symptom pathways of violence, substance misuse and other mental health disorders call for integrated screening ... and treatment interventions for women.

Cultural contexts underpin the feasibility and acceptability of any healthcare interventions, but this is especially true where attitudes to violence against women (including victim blaming) as well as the stigma attached to mental illness and substance misuse are to the fore.

Screening

Wyshak & Modest (1996) have demonstrated the feasibility of screening for these multiple but interrelated problems. Screening efforts for alcohol, drug and mental disorders have increased over time, but recent survey research of primary-care patients in the United States indicates that such screening is generally still lacking. For example, in one survey approximately half of those who reported substance misuse or mental disorder were screened; even among those screened and found to have a disorder, 40% received no treatment (Edlund *et al*, 2004). Even fewer female respondents (25%) reported being screened for violence in another sample of primary-care patients, although 83% supported the idea (Kramer *et al*, 2004).

These findings suggest that while screening efforts continue to proliferate, they remain under-used tools for early detection and treatment. Screening instruments that address these interrelated conditions – violence, substance misuse and mental disorders – may lead to improved identification and treatment of afflicted individuals. Moving beyond recognition of violence directed at an intimate partner requires the development and examination of culturally relevant interventions.

Intervention and the role of culture

Effective interventions in mental health and substance misuse exist (World Health Organization, 2001) but the effectiveness of those that seek to reduce violent incidents remains understudied (Wathen & MacMillan, 2003), which presents a barrier to the provision of ethical, safe, evidence-based interventions for women. There is a further problem, in that these interventions have been designed in and for the populations of developed countries: they therefore require context-specific adaptation for their use elsewhere in the world, for different populations. Such adaptation will need to take into consideration the obstacles and resources available, including referral sources in the case of violence towards an intimate partner (Garcia-Moreno, 2002).

Cultural contexts underpin the feasibility and acceptability of any healthcare interventions, but this is especially true where attitudes to violence against women (including victim blaming) as well as the stigma attached to mental illness and substance misuse are to the fore. Therefore, context-specific programming and evaluation are necessary. This will prove difficult given the resource constraints that violence, substance misuse and mental health programmes face worldwide, but especially so in low-income countries.

Conclusions

The confluence and common symptom pathways of violence, substance misuse and other mental health disorders call for integrated screening (Wyshak & Modest, 1996) and treatment interventions for women. This will require training for healthcare providers, to enable them to recognise and treat these interrelated problems, and to deal with the associated ethical issues, such as privacy and confidentiality (Wyshak, 2000). Research and funding are required to develop culturally appropriate interventions and to evaluate their effectiveness (Garcia-Moreno, 2002). These efforts are necessary to ensure that all those women, worldwide, who face these problems receive effective, culturally appropriate health interventions in the primary-care setting.

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Psychosocial and cultural motivations for self-inflicted burns among Iranian women

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When the world of public health considers the health of women, one tendency is first and foremost to link the well-being of women to that of children and the family, and, legitimately, to the health of society overall. Epidemiological data point to sex differences in the patterns and clusters of psychiatric disorders and psychological distress. The origins of much of the pain and suffering particular to women can be traced to their social circumstances. Depression, hopelessness, exhaustion, anger and fear grow out of hunger, overwork, domestic and civil violence, entrapment and economic dependence. Understanding the sources of women's ill health demands awareness of how cultural and economic forces interact to undermine their social status. This article highlights aspects of social suffering among women in Iran. Self-inflicted burns, a significant indicator of mental health among Iranian women, are discussed in order to increase awareness of the phenomenon among the international community, as a first step towards initiating an improvement in the health of women in Iran.

Cultural context

Self-inflicted burns are known to occur mostly in countries in the Middle East, such as Iran. Self-inflicted burns represent a mental health challenge that many men but mostly women are facing in Iran (Rastegar Lari & Alaghebandan, 2003). Although self-immolation is becoming an increasingly common cause of death and disability among young women in Iran, little has been written about it in the Western professional literature, although there have been reports of its increasing incidence (Panjeshahin *et al*, 2001; Groohi *et al*, 2002; Rastegar Lari & Alaghebandan, 2003; Maghsoudi *et al*, 2004; Saadat *et al*, 2004). Groohi *et al* (2002) reported that the female:male ratio of patients with self-inflicted burns was 8.8 during 1994–2000 in Kurdistan. Panjeshahin *et al* (2001) showed that, in the Province of Fars (south-east Iran), the majority of self-inflicted burns occurred among young women of low socio-economic status. Also, 99% of self-inflicted burns patients in Tabriz (northern Iran) were women (Maghsoudi *et al*, 2004).

Reasons and consequences

Almost all studies of self-inflicted burns in Iran have found that young married women are at greater risk of suicide than others (Groohi *et al*, 2002; Maghsoudi *et al*, 2004). This is contrary to the notion of marriage acting as a protective factor against suicide as reported in Western literature. Alaghebandan (2002) and Maghsoudi *et al* (2004) reported that quarrels between married couples were the most common precipitating factor for self-inflicted burns in Iran. Most patients attempted suicide in the hope of resolving a chronic interpersonal problem or to make the partner feel guilty (Alaghebandan, 2002). It was not a planned action and therefore the consequences had not been considered. According to Alaghebandan (2002), more than 95% of women who attempt suicide by burning later regret doing so. Most victims did not realise that they were at risk of a slow, painful death or horrific disfigurement (further details available from R. A. on request). Most of the patients initially insisted that the burn was an accident and went to great lengths to explain how the kerosene lamp had fallen over them, for example (further details available from R. A. on request). In fact, the initial reaction in coping with any major stress is denial. In addition, there is widespread religious and social disapproval of suicide attempts. With time, however, denial recedes.

Some women set themselves on fire as a form of protest against social discrimination. Often the act is done in the presence of others, in an attempt to force the people abusing them to suffer feelings of guilt. In such a scenario, death, which often results, is not the goal. On the other hand, some women who feel they have no other choice find death preferable to a life of domestic violence and suffering.

In a large survey conducted by Noorbala *et al* (2004) in Iran, women (mainly married) were found to be more at risk of mental disorders (26% v. 15% of the men surveyed). We believe that family problems (such as drug addiction of the spouse, difference of age, bigamy, lack of love, premature marriage and the taboo of divorce) are the most common reasons for suicide and acts of self-harm among women in Iran. Unemployment, illiteracy, the sexual inequality of opportunity,

Maryam (a fictitious name), a 20-year-old woman in Iran, is sitting in a dark room working on a small carpet. Her face is partially covered by a scarf. When the scarf is removed, the reddish purple leathery scars of a burn are revealed on her face and scalp. Sadly, this burn was self-inflicted. This act is known as self-immolation.

With more attention being given to women's rights, some non-governmental organisations, such as Amnesty International, have started to keep accounts of incidents of self-immolation by women. It is necessary to transfer our limited knowledge of this issue (and similar ones) to healthcare professionals around the globe.

traditional male domination and less respect for their work place women in an unequal and unfair situation in Iran.

Conclusions

Human rights are founded on the principles that all members of the human family are equal, and should accordingly be granted equal dignity and equal rights. However, where social discrimination against women exists, they are often excluded from effective participation in identifying and securing their rights. In recent years, some have argued that health – defined in the World Health Organization's 1948 constitution as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' – requires the protection and promotion of human rights. With more attention being given to women's rights, some non-governmental organisations, such as Amnesty International, have started to keep accounts of incidents of self-immolation by women. It is necessary to transfer our limited knowledge of this issue (and similar ones) to healthcare professionals around the globe. It is also necessary to inform people in developed countries

about female self-immolation, to stimulate attention and discussion of the issues, and generate health research, interventions and policies for the prevention and reduction of self-immolation among women in Iran.

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THEMATIC PAPER – WOMEN'S MENTAL HEALTH AND OPPRESSION

Attitudes to women and their mental health in Mexico

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Despite globalisation and the influence of the feminist movement, traditional roles still prevail in Mexico. The dominant male role is known as 'machismo', which amounts to a cult of virility, where the main attributions are an exaggerated aggressiveness and intransigence among males and an arrogant and aggressively sexual attitude towards women.

In Mexico, there are two females with depression for each male (Medina-Mora *et al*, 2003) and the rate among poor females is three times higher than that among those with the highest income (Berenzon *et al*, 1998). Most research findings suggest that depression cannot solely be explained by a simple biological theory but that sociocultural variables also play a major role. These include the different degree of control and power that women and men have over socio-economic determinants and the differences in social position, status and gender role expectations. Traditional gender roles are expressed in prescriptions such as 'women should be passive and submissive in relation to men', while the lower value attributed to them, their higher rates of exposure to violence and other stressful risk factors and their scarce opportunities for development affect women's susceptibility to

specific mental health problems. The present paper describes Mexican attitudes towards women and women's exposure to stressful life experiences that may contribute to their increased psychiatric morbidity, and shows what it means to be female in different Mexican contexts.

Attitudes towards women

Despite globalisation and the influence of the feminist movement, traditional roles still prevail in Mexico. The dominant male role is known as 'machismo', which amounts to a cult of virility, where the main attributions are an exaggerated aggressiveness and intransigence among males and an arrogant and aggressively sexual attitude towards women; the complementary female role is one of submissiveness or the 'syndrome of the suffering woman', which amounts to a cult of superior

feminine spirituality over males, submission and shyness, their value being in part measured by how much they suffer (Lara, 1993). Men are expected to work outside the house and support the family, and women, especially those of child-bearing age, are expected to stay at home and take care of the children and the elderly.

The assimilation of traditional gender roles varies across social classes, being more prevalent among the poor. The values attributed to females of lower social class have been described as 'being responsible for the family', 'being the male companion' and 'being made for housework', while those attributed to females of higher social class are also 'being the male's companion' but also 'being equal to males' (Lara, 1993).

More depressive symptoms have been reported in women who adopt traits of the traditional passive-submissive role, while feminine affiliation, instrumental-pragmatic traits and androgyny in women are associated with fewer depressive symptoms. High levels of depressive symptoms have been reported among Mexican women at socio-economic disadvantage. They have been found to perceive their roles as mothers and homemakers as not being appreciated or valued by themselves or their families, to experience role conflict and to perceive a lack of choice (Lara & Salgado, 2002). Their role as mothers can be a major source of stress, as they feel they are constantly being evaluated by society, which still views motherhood as the ideal status for women. Further risk of depression arises from difficulties in their relationships with partners, where they feel double standards remain and they have a lower status. At the same time, and perhaps derived from the fact that society expects females to endure adversity, despite being depressed they remain active and are able to fulfil their family and work responsibilities, even when they are not receiving treatment (Lara *et al*, 1996).

Social context of depression

As in many developing societies, gender roles are in transition. Nowadays females have fewer children (an average of 2.2 compared with 7 in the middle of the last century) yet a vocation for marriage is more or less general and it occurs at young ages, because of the high value attributed to the role of housewife.

Social transitions that have forced women to take over roles formerly attributed to men include international migration; furthermore, internal migration, especially the diminution of the proportion of males living in rural communities, has often meant that women have had to perform roles previously attributed to men. Although these social trends have increased the visibility of females and thereby enhanced their role as major contributors to social development, they have not resulted in more benefits for them (Salgado de Snyder & Maldonado, 1992). Similarly, economic crises have forced females, including married women and those of child-bearing age, to engage in paid employment, yet still only 34% of females are economically active, compared with 72% of males; women are still receiving lower

salaries and have access to less highly valued employment than males, and therefore earn on average 36–50% less. A feminisation of poverty is being observed, as the proportion of households headed by a woman (presently estimated at 18%) is increasing and these households tend to be poorer than those headed by a man.

Females have higher educational attainment than in previous decades, yet poor females leave school at younger ages than males because education is not regarded as crucial for them. In higher education, to which only 9% of the population has access, these differences disappear, however. For instance, an equal proportion of males and females are university students, yet although 40% of the staff are female, only 25% occupy high positions.

Male roles have not changed at the same rate at which women have adopted more diverse roles. As a result, females are now more stressed and often have a double workload since, in addition to their work responsibilities, they continue to care for the family. In short, many women experience work overload, and there are few resources to help them cope.

Stress derived from having to work and raise small children has been shown to increase the risk of depression, although better mental health as regards depressive symptoms has been found among female employees than among housewives. Hypotheses explaining these findings suggest that employed women increase their sources of social support and have more independence regarding their use of economic resources, whereas being a housewife encourages social isolation and dependence (Lara, 1999). Women in paid jobs still perceive that society is critical of them for not performing full time what is considered their main role as mothers and expects them to compensate for this by being almost perfect.

Alcohol and domestic violence

Although males are more often victims of violence, females are exposed at an earlier age and to types of violence that profoundly affect their identity and value in a male-oriented society. Rape and sexual abuse are more frequent among females and happen at earlier ages, and this is associated with high rates of post-traumatic stress disorder (Medina-Mora *et al*, 2005).

Few women drink alcohol, but men are expected to drink and occasional inebriation is considered part of the male role. Therefore when females drink and develop alcohol-related problems they are more often socially rejected than are men (Medina-Mora, 2001). It is more common for females to have been abandoned or divorced by the time they receive treatment for alcohol misuse. Rejection is not due to differences in their behaviour from that of males but to the fact that drinking is considered to be incompatible with female roles. Mexican females married to men with alcohol dependence are not likely to increase their drinking; nor do they get divorced more frequently than other women. In

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Mexican women married to men with an alcohol problem experience shame and are more likely to be financially dependent on their husbands.

addition to the feeling of guilt shared with other cultures, Mexican women married to men with an alcohol problem experience shame and are more likely to be financially dependent on their husbands (Natera *et al*, 2002).

Victimisation is also common: 29% of women report having experienced physical violence by their partners, and alcohol is involved in 66% of these cases. The estimated risk of family violence is 3.3 times higher when the male partner is drunk every day than when the partner has no alcohol problems. Depression has been estimated to be 4 times more frequent among women exposed to such violence than among women who have not, and the risk is considerably higher (8 times) when physical abuse has been experienced during pregnancy (Medina-Mora *et al*, 1999). Females have attributed this behaviour to the man's jealousy of the unborn baby and suspicions of infidelity, which challenge masculinity in the local culture.

Conclusion

Traditional gender roles, increased work overload, fewer opportunities for development and high rates of victimisation have been found to be related to the increased rates of depression among Mexican females, especially among the poor.

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COUNTRY PROFILE

Psychiatry in Spain

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Spain covers an area of some 506 000 km² and has a population of just over 41 million. It is a high-income country (according to World Bank criteria) and devotes 7.5% of its gross domestic product to health.

Organisation of healthcare

Spain's National Health System has universal coverage and is financed through the general budget of the state,

although the system is organised territorially. Healthcare has two levels: primary care, which is the gate into the system, and specialised care, which is managed independently of primary care, although some regions are considering unifying the two. Psychiatric care is part of specialised care.

Around 6% of the population have additional health insurance and can be treated privately, which gives them greater choice in their healthcare. The private insurance companies set limits on the length of psychiatric hospital

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stays and the number of out-patient consultations per year that can be reimbursed.

Mental health policy and service organisation

The budget, planning and provision of health services are taken care of by each of the 17 *comunidades autónomas* (regions), which are responsible for their own mental health policies under the framework of the 1986 General Health Law and the 1995 Decree for Psychiatric Reform. The Law on the Cohesion and Quality of Healthcare reinforces the uniformity and standards of the care provided in each *comunidad autónoma*.

Each of the *comunidades autónomas* has a mental health plan, framed as part of a general health plan. Social reintegration is a key feature of mental health policy. The details of each region's policy are set out in its plan. There is a specific national plan for drug misuse, which is drawn up by the Ministry of Internal Affairs, since it includes actions pertaining to the control of the traffic in illicit drugs.

For mental health services there is also a general (i.e. national) decree that covers clinical diagnosis and follow-up, pharmacological therapy, individual, group and family psychotherapies and hospitalisation; hypnosis and psychoanalysis are excluded. The cost of all psychotropic drugs is covered by the National Health System.

All *comunidades autónomas* share the following organisational principles for their mental health services (Reneses, 2003):

- Care is based on the principles of community psychiatry.
- Services are sectorised. Each sector (district) has from 50 000 to 200 000 inhabitants. Mental health services in each sector consist of a multidisciplinary team of psychiatrists, psychologists, nurses, occupational therapists and social workers. Each sector has one or more mental health centres and one or more admission units for acute processes, as well as day hospitals and psychosocial rehabilitation centres.
- People experiencing acute psychiatric episodes are preferably hospitalised in general hospitals. Traditional mental hospitals have been progressively transformed to fit their services to the needs of the population in areas such as rehabilitation, units for sub-acute processes and units for residential care.
- There are specific programmes for the care of children and adolescents in general mental health services or in independent centres. These programmes include out-patient care, day hospitals and admission units, although only some regions have specialist mental health units for minors (in the others they are admitted to general paediatric units).
- The net of social services is tightly coordinated with the healthcare one in different forms in the different *comunidades autónomas*. In some of them out-patient rehabilitation services are provided by the social services.

- Residential non-hospital care is perceived to be less and less sufficient and is usually provided by social services.
- Specific programmes of psychotherapy, the treatment of alcohol-related problems and rehabilitation are present in all regions but have different degrees of development.

There are some further differences in the way the *comunidades autónomas* organise their services:

- Some of them have an independent net for the care of people who misuse drugs.
- Some have non-hospital admission units for the long-stay care of people with sub-acute and chronic processes.
- The number of resources, both structural and human, varies among the *comunidades autónomas*, as a result of the differing budget allocations for mental health.

Mental healthcare resources

The territorial organisation of health services means that there is no easily accessible national source of information on resources. However, the National Health System publishes online statistics on hospitals (*Establecimientos Sanitarios con Régimen de Internado*; ESCRI) and these provide the following information. The number of psychiatrists providing out-patient care in public health services varies from 7.2 psychiatrists per 100 000 population in Asturias to 1.6 in Extremadura; the average is around 4 psychiatrists per 100 000. Across the regions, the number of beds in units for acute care in public hospitals is between 7.2 and 12.0 per 100 000 population. The total number of beds, public and private, is 50.4 per 100 000 inhabitants, of which 12.6 are in services for acute processes and 38.6 are for long-stay patients. For acute cases, 60.2% of beds are located in general hospitals.

The number of hospital discharges with a main psychiatric diagnosis per 100 000 inhabitants in the year 2002 was 279 (Instituto Nacional de Estadística, 2002).

Information systems

The national minimum data-set (CMBD) facilitates the collection of basic healthcare data. It covers the whole of public hospital care and collects data on all hospital discharges, and includes information on mental health. The Questionnaire on Hospital Morbidity (Instituto Nacional de Estadística, 2002) and the ESCRI provide statistical information on the structure, activity and finances of all public and private hospitals.

The specific information systems for mental health are decentralised, each *comunidad autónoma* having its own system. At least five *comunidades autónomas* have information systems based on cumulative case records; the rest have systems based on group activity (Ministerio de Sanidad y Consumo, 2003). There is no specific national information system for mental health.

Social reintegration is a key feature of mental health policy.

ESCRI and CMBD statistics are available from the website http://www.msc.es/Diseno/sns/sns_sistemas_informacion.htm

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Patients' rights

The national civil and penal codes have been modified to protect the rights of psychiatric patients and improve conditions of detention for offenders with a mental illness. As a part of these reforms, prison hospitals were closed and special units within the National Health System were opened.

The latest civil legislation relating to mental illness was enacted in 2000; this regulates all involuntary admissions and treatments, which can be carried out only after judicial authorisation and with supervision.

Training and education

Training of specialists

The training of psychiatrists, clinical psychologists and psychiatric nurses is regulated at state level; services have to be authorised to undertake training (Ministerio de Sanidad y Consumo, 1996). There is no specialisation in child psychiatry or in geriatric psychiatry. A limited number of residency posts are offered, again organised at state level. There is a state examination common to all medical disciplines. (In the case of psychologists and nurses, the examination is specific to each specialty.) The attainment of a residency post depends on the results obtained in the selective examinations.

The training of psychiatrists takes 4 years and includes: psychiatric in-patient and community care, liaison psychiatry, child psychiatry, day-hospital care, neurology and internal medicine (Ministerio de Sanidad y Consumo, 1996).

The training of clinical psychologists takes 3 years and includes hospital and community care, care of children and adolescents, and psychosocial rehabilitation.

Training in psychotherapy is in preparation. At present it is not carried out in a systematic way nationally, although some hospitals do provide their own.

Undergraduate training

Two mental health disciplines generally feature in the curricula of medical schools: medical psychology in the preclinical, basic curriculum; and psychiatry during the clinical period. Some medical faculties have a third discipline, psychopathology, which is otherwise taught as part of either the medical psychology or the psychiatry curriculum. Several non-compulsory disciplines are also included, among them drug dependence and eating disorders.

Mental health professions

Professional practice is regulated at national level by the 2003 Law for the Regulation of Healthcare Professions. The specialty of child psychiatry does not exist, officially,

and this has impeded the organisation of psychiatric care for children and adolescents.

The practice of psychotherapy is not regulated in Spain. Normally training in psychotherapy is carried out by psychiatrists and clinical psychologists in the private sector.

Clinical practice is not allowed to psychologists not qualified as clinical psychologists.

Psychiatric associations

The two best-established national associations are the Sociedad Española de Psiquiatría (SEP), a scientific medical association of psychiatrists, and the Asociación Española de Neuropsiquiatría (AEN), whose membership consists of all mental health professionals. In the past it also included a significant number of neurologists and neurosurgeons. The SEP holds a national congress every year jointly with the Sociedad Española de Psiquiatría Biológica (SEPBB), which is a smaller, mainly research society. The AEN also organises annual congresses. There are various regional associations, most of which are linked to the SEP or to the AEN.

Other national scientific associations cover more specific fields, such as child psychiatry, psychogeriatrics, psychiatric epidemiology, alcoholism and drug addiction and forensic psychiatry.

Scientific journals

The oldest Spanish psychiatric journal still published is *Archivos de Neurobiología. Actas Españolas de Psiquiatría* is the most widely distributed psychiatric journal in the Spanish-speaking world and is among those with the highest impact factor of all non-English psychiatric journals. Another widely distributed journal is the *Revista Española de Psiquiatría Biológica*.

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Psychiatry in Venezuela

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The Bolivarian Republic of Venezuela covers 916 445 km²; to the north is the Caribbean Sea, to the south-east the Amazonian region and the plains of Brazil and Colombia, and to the west the Andes and the Colombian Guajira peninsula. Its estimated population (2004) is 25 226 million, which is concentrated along the north coastal area, where the population density exceeds 200 inhabitants per km²; most of the territory remains almost uninhabited (fewer than 6 inhabitants per km²), in particular the border areas. The population is mainly urban: 70% live in cities with more than 50 000 inhabitants.

The annual mean rate of population growth is 2%, approximately, but this is reducing in line with a progressive reduction in the birth rate (from 27.4 per 1000 inhabitants in 1994 to 22.3 per 1000 in 1998), fertility (3.17 children per 1000 women in 1994 to 2.93 in 1998) and an increase in emigration. The population is predominantly young: 54.4% are under 25 years of age, while the 25- to 64-year age group represents 41.3% of the population. Life expectancy is presently estimated at 72.8 years.

The budget assigned to health amounts to 3.9% of gross domestic product, or US\$6402 per capita.

Constitutionally, Venezuela is a free and independent republic. It is also a federal state, consisting of 25 states and a capital district; Caracas is the capital city. According to the constitution, the states are autonomous and have political integrity. They are called on, however, to maintain the integrity of the nation and to obey and abide by national law.

Health system

Civil rights and the state's duties to its citizens set out in the constitution provide the framework for the health system. The state must guarantee opportunities for education and development in an environment of freedom, and must preserve the dignity of its inhabitants, for example. The constitution requires that a technical committee organises the administration of healthcare in Venezuela. This committee has the following duties:

- to study and recommend programmes for the control of important epidemiological diseases
- to study and develop strategies aimed at eradicating some recurrent (high-prevalence) diseases of social importance

- to suggest action programmes to be developed in the National Commission for the Zoonoses
- to evaluate, from the epidemiological and malarial point of view, the status of the border states in order to suggest action programmes, considering in particular the health status of indigenous ethnic groups
- to coordinate the organisation of symposia in environmental hygiene, together with government, municipal authorities, schools and universities, and other civil bodies
- to promote community health
- to take on any other function defined by the Ministry of Health and Social Development (in Spanish MSDS) or its representatives.

There is, however, a need to democratise the health structure, to widen social participation, in order to consolidate the role of the MSDS.

Mental health policies and programmes

There is a mental health policy, which covers promotion, prevention, treatment and rehabilitation. This policy, based on the 1990 Caracas Declaration, seeks to integrate psychiatric care within primary care; this involves the decentralisation of services through the provision of day-care hospitals, health centres, prevention programmes and community participation.

There is a national programme of mental health, contained in the Nation's Ninth Plan (which is a 5-year plan for economic and social development, from which the priorities of the executive power are derived). The public health sector in Venezuela accounts for 214 hospitals (181 general and 33 specialised hospitals) and a network of 4605 ambulatory clinics for medical care (in 890 urban and 3715 rural centres).

Psychiatric services are provided in both the public and the private sectors. The public system looks after a large portion of the population, but access to psychiatric care is restricted in rural areas. There are few specific services for children and elderly people, even in urban areas.

Psychiatric care tends to be centred on psychiatric hospitals. Patients are referred from general hospitals or other institutions. From the 1960s, 11 rural sanatoriums, which house around 1800 chronic mental patients, were established. The main objective of this project was to create a psychiatric community but

In 1990, the Pan American Health Organization (PAHO/WHO) convened the regional conference on Restructuring Psychiatric Care in Latin America, held in Caracas, Venezuela. The Declaration of Caracas was adopted in the framework of that conference. The full text of the declaration is reproduced in Levav *et al* (1994).

unfortunately this was never accomplished. Currently these institutes serve the private sector.

There is an overall lack of practical psychiatric care, reflected in an under-provision of institutional structures and poor access to the health system.

Mental health legislation

Venezuela does not rely on a specific law to regulate all aspects of mental health from a holistic perspective. Issues related to mental health are usually addressed in health codes or general health laws, which set out universal principles. Commissions and technical committees govern the administration of some services and regulate the organisations devoted to mental healthcare.

Resolution number 1223 (15 October 1992), however, does emphasise the responsibility of the MSDS to provide comprehensive medical care for people with a mental illness, oriented towards the patient's full recovery and his/her reintegration in society. The resolution also refers to the principles contained in the Caracas Declaration and asks general hospitals appointed by the MSDS to study and adopt procedures related to the admission of acute psychiatric patients; more specifically, it seeks to guarantee that at least 10% of beds are available for those with a mental disorder.

There was also a decree in 1992 to regulate the sanatoriums. It refers to the humanitarian treatment of patients, in particular their individual freedom and security; it also relates to the admission of patients, technical and professional assistance, specialised medical care, health records and the assumption of responsibilities in the event of injury to patients.

Mental health financing

There are budget allocations for mental health. The primary sources of mental health financing, in descending order, are: tax revenue, social insurance, out-of-pocket expenditure by the patient and family, and private health insurance.

Mental health training and facilities

Disability benefits for persons with mental disorders require a certificate provided by the Venezuelan Institute of Social Security.

Table 2. Numbers of psychiatric beds and professionals

	Number per 10 000 population
Psychiatric beds	1.15
Psychiatric beds in mental hospitals	0.29
Psychiatric beds in general hospitals	0.15
Psychiatric beds in other settings	0.76
Psychiatrists	0.4

Treatment for severe and acute mental disorders is available at primary level in some regions of the country, for example the states of Merida, Tachira and Zulia.

Regular training of primary-care professionals is not carried out in the field of mental health. However, there are eight regular training programmes (for a university degree) in general psychiatry and one training programme in child and adolescent psychiatry. These account for 2.82% of the total resources invested in postgraduate health education programmes.

The establishment and maintenance of mental health services are governed by the MSDS. The resources it provides are set out in Tables 1 and 2.

Scientific societies

The most important of the several psychiatric societies is the Venezuelan Society of Psychiatry, which has approximately 900 members. It is affiliated to the Latin American Psychiatric Association and the World Psychiatric Association. It organises scientific activities, workshops, symposia, meetings, and a national congress every 3 years.

Mental health research

The areas of mental health being investigated, in descending order of amount of research activity, are as follows:

- affective disorders (including post-partum depression)
- schizophrenia and other psychotic disorders
- childhood mental and behavioural disorders
- anxiety disorders
- drug misuse and dependence
- suicide
- dementia
- learning disabilities
- stress disorders (including post-traumatic stress disorder)
- mental comorbidity of AIDS
- neuropsychiatric disorders
- eating disorders
- epilepsy.

Violence and mental health

Venezuela has an internationally high rate of homicide (principally involving young men). Statistics from the Institute of Legal Medicine show a present average of

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Table 1. Central and regional mental health resources

	Caracas metropolitan area	22 states
Psychiatric hospitals	2	4
Ambulatory clinics	7	30
Day-care hospitals	1	1
Psychiatric units in general hospitals	3	31
Ambulatory clinics for children and adolescents	1	1
Psychiatric units for children and adolescents	2	1

about 100 violent deaths every week. The number of injuries is much higher. Between 1990 and 1999, the annual homicide rate increased in Venezuela from 13 to 25 per 100 000 inhabitants. In Caracas, this rate increased from 44 to 81 homicides for every 100 000 inhabitants in the same period. Most of these violent events take place during the weekends in the area called 'Great Caracas' and other urban areas in the country. This represents an enormous drain on health resources, and has a serious psychological impact, notably anxiety disorders and post-traumatic stress disorders. Such psychological effects have not been properly quantified. Violent events have important physical and psychological consequences for both the victim and others, and this represents a considerable burden for the health and rehabilitation services.

The overall mortality rate is 4.6 per 1000 inhabitants. Accidents are the third most common cause of death, whereas suicides and homicides rank seventh. These two categories account for the highest number of years of life potential lost (in Spanish AVPP), mostly among males. The useful years of life lost as a consequence of accidents and violent events are higher or equal to those caused by cancer or cardiovascular diseases, because they mainly affect the infant, juvenile and young adult population.

Non-governmental organisations

Some non-governmental organisations run ambulatory clinics and there are associations that care for vulnerable groups. These organisations provide their own resources or obtain direct help from the government to carry out their projects, which often involve prevention, treatment and rehabilitation in the area of mental health.

Information systems

Currently there is a lack of an information system or epidemiological study in mental health. The mental health system narrows its scope by reporting exclusively on mental disorders.

Programmes for particular populations

The country has specific programmes for the mental health of children and for people affected by natural disasters. There is a National Institute of Child Psychiatry (Instituto Nacional de Psiquiatría del Niño) and also a 2-year programme for university-level child and adolescent psychiatry (see above). This is the only specialised programme in the field of mental health in Venezuela.

In Venezuela in 1999 there were massive land slides in Vargas state. A plan for psychological care and rehabilitation was created to care for any victims of future similar tragedies.

Conclusion

Venezuela has long had adequate health plans and programmes, which have provided immediate responses, sometimes improvised ones, in the area of mental health. The problem has been in their implementation, since priorities have not been properly ascertained, experiences are not taken into account and on-going training and research are not promoted. Venezuela therefore needs to strengthen the implementation of health plans and policies, to meet needs in the area of health, to protect patients' rights, to preserve mental and physical integrity and, consequently, to guarantee the population a good quality of life.

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COUNTRY PROFILE

Mental health services in Norway

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Few countries (if any) have experienced the abundance of material welfare Norway has had for the last decades. The report of the Organisation

for Economic Co-operation and Development (OECD) for 2004 places Norway on the very top of the list of 'best countries to live in'. One might

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therefore expect that mental disorders would not thrive in Norway, but this is not so.

Norway is a constitutional monarchy: its parliament decides new laws; a government with a parliamentary basis executes political decisions; and the judicial system interprets and enforces the laws.

The total population is about 4.5 million, approximately 1 million of whom are under 18 years of age. The population is concentrated around the major cities in the southern part of the country, Oslo, Bergen and Stavanger; large areas of the country feature only small towns and villages and a scattered population. This creates challenges for the provision of an equal health service to all the country's inhabitants.

The predominant political ideology throughout the last 50 years has been based on social democratic ideas of equality in health and social services and education. Therefore most health services are in the public sector, in which hospital treatments are free and most out-patient services are financed by public means. Patients pay a small amount, not exceeding 150 euros per year. Over the last decade, the number of private services have increased, some of which are purchased by the public healthcare system. In the mental health services, this has given rise to private services for people with less severe disorders, who would otherwise fall outside the priorities of the public system.

History of mental healthcare

Norway passed a Law of the Treatment and Care of the Insane in 1848. It declared that the responsibility for the care of the insane was the government's. A Control Commission was established to inspect the asylums and the private residencies that lodged people with a mental illness, and it looked after patients' legal rights. The law stated that isolation and restraint should be kept to a minimum.

This law underwent only minor amendment until it was replaced by the 1961 Law on Mental Healthcare. The major change was that the new law introduced the possibility of admission for observation when there was doubt about the mental state of the patient, that is, whether the patient suffered from a psychosis. This observation period could last up to 3 weeks. In 2001 this law was revised and the maximum observation period reduced to 10 days. The revised law allows more use of compulsory treatment for out-patients.

The mental asylums established from 1865 to 1920 have gradually been replaced by smaller hospitals and psychiatric wards in general hospitals. Over the last 10–20 years, however, decentralisation and deinstitutionalisation have taken place, with a dramatic decline in the number of hospital beds and far greater provision of out-patient services. There is presently an intense discussion – political, professional, in the media and in the public – of whether this has proceeded too quickly. The critics say more time is needed to establish new services and establish professional competence locally, and that the psychiatric patients most in need of welfare

and treatment are paying the price of an ideologically driven process of decentralisation. The supporters advocate the local design and implementation of mental health services, with patients living in their homes or in small community health centres. There is agreement, however, that there are too few professionals, principally psychiatrists and clinical psychologists, to assure the professional quality of the many local services. This is indeed a great challenge for the structure of services.

Today's mental health system: economy and personnel

There is broad political agreement in Norway that the mental health services need to be improved, both quantitatively and qualitatively, especially the services for those under 18 years of age. In 1997 the Norwegian parliament approved a plan for better, and more decentralised, mental health services, the so-called Escalation Plan for Mental Health (EPMH). In 1996 the total expenditure on mental health services was about 1.16 billion euros. Over the period 1999–2008 this annual figure is due to increase by some 0.7 billion euros, and an additional investment of around 1 billion euros will be made.

Services for children and adolescents

It has been estimated that 5% of the population under 18 years, or a total of 54 000 young people, require treatment in specialised child and adolescent services, almost entirely on an out-patient basis. In 2003 this number was 33 000. Some 3000 people work in the services for children and adolescents; as of 2003, there were 340 in-patient beds, but expansion to 500 by 2008 is planned. There are 154 doctors working in the out-patient units, 120 of whom are child psychiatrists. There are 450 psychologists working in these out-patient units. Consultations per 'professional year' (i.e. how many consultations each doctor or psychologist has annually) total about 380. This level of 'productivity' is a very much debated subject, as some politicians find this number far too low, given that the norm established by some health trusts is 450.

Adult services

There are about 1050 psychiatrists and 500 residents working with adults; 1525 clinical psychologists work within adult psychiatry. Hospital beds total 5600; the norms set out by the EPMH are 9 hospital beds per 10 000 inhabitants and 6 beds per 10 000 in local district psychiatric centres (an equivalent to community-based mental health centres). The average length of stay is about 42 days (averaged over acute wards as well as long-stay departments).

For out-patient units the norm is one professional health worker per 1500 inhabitants aged over 18 years, and the suggested norm for productivity is 500 consultations per professional year.

Training

The training period for a resident to become a specialist in psychiatry is 5 years (with an extra half year's training for child and adolescent psychiatry). There are clinical programmes of training in specified fields and areas (acute, long-term, out-patient etc.), and educational (theoretical) programmes covering therapy, service models and the client–therapist relationship, leadership and judicial matters. One year of residency might be in another relevant medical specialty (e.g. in child psychiatry or in research). Psychotherapy education, practice and supervision are for a minimum of 3 years: 2 years with psychodynamically based therapies, and one year with cognitive or group analytic treatment (a minimum of 110 hours). Most psychiatrists go on to further training in cognitive or psychodynamic psychotherapy; group analysis has declined in popularity and training in classical psychoanalysis is undertaken only by the dedicated few. In child and adolescent psychiatry, everybody has 40 hours of psychodynamic therapy and some have a 2-year programme in psychotherapy training. There are also training programmes within psychopharmacology, family therapies and community-based treatment of psychosis.

Fifty per cent of residents start training directly after internship, and 50% after 4–10 years of clinical work, mainly in general practice. There is no examination before approval as a psychiatrist, but the clinical training and the clinical supervisors evaluate personal suitability. Training for child and adolescent psychiatry involves 6 months of paediatric practice.

Main areas of research

The universities and colleges, together with the Department of Health and Social Affairs, support a vast range of research activities. There are major programmes on early intervention in first-episode psychosis and extensive programmes of psychotherapy research, including studies of its effects, patient compliance and combined treatments. A national network is examining the efficacy of group analysis for personality disorders. Epidemiological research is undertaken at both regional and community level. Other important fields of interest are genetics, brain imaging, dementia, neuropsychiatry and neurophysiology, psychophysiology, psychopharmacology, sleep disorders, trauma and forensics. In child and adolescent psychiatry the major areas of research are autism, epidemiology, transcultural psychiatry, eating disorders, low birth weight and behaviour problems.

Norwegian Psychiatric Association

The Norwegian Psychiatric Association (NPA), of which most psychiatrists and residents are members, is part of

the Norwegian Medical Association. The NPA is concerned with professional conditions and professional development, and the general conditions and structure of the mental health services. It has special sections on preventive psychiatry, biological psychiatry, psychotherapy, forensic psychiatry, old age psychiatry, emergency psychiatry, private practice, quality issues, basic problems in science and psychiatry, and a section on resident education and specialist approval. The association and its sections work in close collaboration with the Norwegian Medical Association, the health authorities and other professional organisations, especially the Psychologists' Association.

The board meets 8–10 times a year, and the sections 2–6 times.

The NPA takes part in public and political processes in developing and changing mental health services. The restructuring and decentralising of the psychiatric services, together with legislative changes in leadership – reducing the administrative and clinical influence of psychiatrists and putting psychologists forward to equal leadership positions – have greatly influenced the role and function of psychiatrists in Norway. There is also an extensive discussion of quality issues, indicators, diagnostic guidelines and treatments, treatment programmes, and quality assurance.

Conclusions

There is great pressure on the emergency wards in the large cities, mainly due to a combination of the reduction in hospital capacity, increasing drug misuse and drug-related psychopathology, and a failure to provide enough housing and services for long-term patients in the community. Although Norway has more resources at its disposal than most other countries, we are struggling with long waiting lists and unacceptably long waiting times. Hence the government recently has introduced an absolute 'maximum allowed period' for different diagnostic and functional categories; priority is always accorded to the more serious disorders.

The NPA is an active partner in formulating priorities in psychiatry, quality-improvement work and developing quality indicators. There is – and will probably always be – a gap between the expectations of the public and the services that can be provided. The government is determined to give most to those most in need, but in so doing faces the dilemma of how to help those patients with the greatest potential for improvement.

The main ideological basis of modern Norwegian psychiatry rests on a humanistic, bio-psychosocial model of understanding and treating psychiatric illness, with the expressed goal of developing better, more specialised and more differentiated hospital treatment, combined with accessible, low-threshold community-based services.

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Establishing a mental health system in the Occupied Palestinian Territories

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What is 'mental health' during the societal crisis and upheaval occasioned by war? Perhaps the primary psychological effect of war on victims generally is through their witnessing the destruction of a social world embodying their history, identity, values and roles of everyday life. Such suffering has largely to be resolved collectively, in this same social world, albeit one which has been intentionally weakened. Thus, as the World Health Organization and other authorities confirm, the major thrust of humanitarian interventions must be towards the depleted social fabric and its institutions, for herein lie the sources of resilience and capacity for recovery for all (Kawachi & Berkman, 2000). Beyond that, history has shown that social or political reform is the best medicine, and for victims of oppressive violence this means acknowledgement and justice (Summerfield, 2002).

The mental health of war-affected populations attracted little attention until 20 years ago, since when terms like 'psychosocial', 'trauma' and 'counselling' rapidly became points of reference in assistance programmes imported into war zones, and elsewhere for refugee services. This development reflected a globalisation of Western cultural trends towards the medicalisation of distress and the rise of psychological therapies. The assumption that Western mental health technologies had universal validity, and were relevant to or wanted by the largely non-Western populations affected, has been the subject of critical review. Indeed, even in the West itself, the evidence base for the efficacy of mental health services in assisting recovery from highly aversive events like war and atrocity is not compelling (Summerfield, 1999).

West Bank and Gaza: current social context

Since Israeli military re-occupation began in September 2000, everyday social, economic and cultural life has become increasingly difficult for all Palestinians. Military checkpoints that split villages and towns into ghettos, curfews, closures, raids, mass demolition of houses, land expropriation and the indiscriminate use of lethal force (over 3200 civilians have been killed) are pushing Palestinian society and its civil institutions towards

breakdown. Over the following three years, by World Bank estimates, the numbers of people subsisting at or below poverty level (US\$2 per day) tripled, and is now 60% of the total population (Barghouti, 2004).

The construction of the new separation wall deep into Palestinian territory has added to the sense of crisis, as well as further damaging the functioning of an already hugely stretched health system by cutting off both primary health clinics and hospitals from the populations they are meant to serve (a violation of the Fourth Geneva convention, which asserts the rights of war-affected populations to unimpeded access to medical facilities) (Palestinian Environmental NGOs Network, 2003).

While there is a dearth of data across the population, studies of children and adolescents show high levels of distress and hopelessness (Giacaman *et al*, 2005), and post-traumatic stress disorder (Thabet & Vostanis, 2000), as well as anecdotal evidence of increasing violence in the home and in schools – as noted in conflict zones elsewhere (Jewkes *et al*, 2002).

Current mental health provision in the West Bank and Gaza

There are currently 57 institutions offering mental health or psychosocial services. The Ministry of Education, which serves one million schoolchildren, employed 382 counsellors in the West Bank and 150 in Gaza in 2003. The Ministries of Health and of Social Affairs also provide services, and the United Nations Relief and Works Agency employed 55 school counsellors in West Bank and 85 in Gaza during the same year. There are also at least six international non-governmental organisations operating, some working with local groups and others independently. Finally, there are a number of local, small-scale groups with considerable experience of the communities they serve (Giacaman & Mikki, 2003).

There are currently nine psychiatrists and at most 15 clinical psychologists in the West Bank, who serve 2.7 million people. The only in-patient facility is Bethlehem Mental Hospital (which had 250 patients and 75 staff when subjected to missile attack by the Israeli army on 1 April 2004). Many of the counsellors or other psychosocial providers have been based on projects funded and formulated from abroad. Interviews with counsellors in

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training suggest that they feel a lack of clarity about their role, as that training often has an emphasis on individual therapy and emotional ventilation, when the latter is unfamiliar in this cultural milieu. Reservations about counselling are expressed fairly widely within the community and there is an issue of stigma. In schools, pupils would often rather go to a teacher.

In summary, these developments betray a lack of planning based on need assessments, a lack of evaluation and the lack of an overall strategy. Many projects have been driven by international agencies, each with its own agenda and focus, with too much emphasis on biopsychomedical approaches – a short-term technical fix – and too little on the strengths and (war-induced) weaknesses of the local situation, and on local priorities and traditions. This has little in common with World Health Organization (WHO) perspectives on best practice in emergencies. The WHO has just published a consensus statement which questions the public health value of post-traumatic stress disorder as a concept, of vertical trauma-focused services, and of a separate psychosocial field in war-affected, low-income countries (Van Ommeren *et al*, 2005).

Mental health and the Palestinian primary healthcare model

The Palestinian primary healthcare (PHC) model was started in the late 1970s in the face of the suspicions both of the Israeli authorities and of a local medical establishment sceptical about the shift of focus from clinic to community. By the 1980s, Palestinians could boast a PHC system which was one of the best in the Arab world, and one which had addressed the common imbalance in provision between urban and rural/social disadvantaged areas (Barghouti & Giacaman, 1990). Planning and implementation drew on grassroots opinion within communities, including women's and youth groups, to ensure that developments would be maximally acceptable and sustainable. Services needed to be able to evolve as circumstances dictated in a politically brittle environment. Officially recognised training schemes for a new type of worker – the community health worker – were started and there was in-service training on PHC approaches for newly qualified doctors. The onset of the first intifada in 1987 necessitated new initiatives in physical rehabilitation to accommodate large numbers of young men sustaining major disability as a result of Israeli army gunfire. This included the training of community-based rehabilitation workers (Giacaman, 2001).

The WHO has always emphasised that in developing countries mental health should be viewed as an integral part of public health and social welfare programmes, and not as a specialist activity, set apart. Until recently, PHC workers in the West Bank and Gaza were only informally drawn in to provide assistance. Their input was seen as being a form of social work rather than mental health work, and it did not involve Western-style counselling; instead it focused on family problems, for example, or

women who had been abused. It is only now that there are moves to put such work on a more formal conceptual and practical basis within the PHC system, and within the training of community health workers. The question, then, is how 'mental health' is to be understood and addressed in this particular cultural context at this point in its history. Further, such an understanding must also take account of an oppressed and impoverished social context.

There is evidence from other low-income countries of the role of social support in preventing disorders like depression, and a balance needs to be struck between local, time-honoured understandings and approaches, and those drawn from Western mental health, including counselling, medication and specialist referral (McKenzie *et al*, 2004). Community voices must be at the heart of striking the balance if service developments are to mean more than the mental health melee described above has done. If the local traditions of mutual support and coping on the part of the ordinary people were to be recast as professional activity (which has arguably happened in Western societies), this would probably be for little gain.

There may also be lessons to be drawn from work elsewhere, like the three-tiered community-based rehabilitation model developed in India. There, case workers are drawn from the populations they serve and initiatives are planned in a forum called a village health group. Compared with out-patient treatment, this model led to better outcomes for disability and compliance with treatment (Chatterjee *et al*, 2003).

The PHC system is short of funds (particularly of funding not dependent on external donors), is under a Palestinian Authority too weak and fractured to focus on anything except survival, and is under daily assault by the Israeli military occupation described above. The work of 25 years is gravely threatened, as is, therefore, the mental health of over three million people who depend on the PHC system.

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

ASSOCIATIONS AND COLLABORATIONS

The American Psychiatric Association

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The American Psychiatric Association (APA) is a medical specialty society that represents nearly 36 000 psychiatrists from the United States and Canada, as well as around the globe. It is the longest serving medical specialty society. As a leader in the mental health field, the APA continually supports the diagnosis and treatment of patients with mental illnesses, including substance use disorders, and also supports prevention and research. The APA acts as an advocate for psychiatrists and their patients.

The APA works to secure increased funding for psychiatric research and education. It also lobbies for parity of health insurance coverage for mental illnesses, for patient protection against abuses by managed-care organisations, as well as for the protection of confidential medical records.

The APA, which is accredited by the Accreditation Council for Continuing Medical Education, supports the education, training and career development of psychiatrists and other physicians. It offers educational programmes that support lifelong learning through annual scientific meetings, journals and other publications.

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM), published by the APA, remains the world's gold standard for the diagnosis of psychiatric illnesses. The APA's *Practice Guidelines* show how evidence-based guidelines should be developed. That publication also helps guide clinicians in making scientifically sound decisions in the evaluation and treatment of patients with mental disorders, and it is recognised by the American Medical Association.

The APA also defines and supports professional values, by publishing primers on ethics and working with psychiatrists to provide the highest level of care.

A brief history

Founded in 1844, the APA formed from a group of 13 superintendents from the then 24 mental hospitals in the United States who met in Philadelphia and established the Association of Medical Superintendents of American Institutions for the Insane. The Association's objectives were 'to communicate their experiences to each other, to cooperate in collecting statistical information relating to insanity and assisting each other in improving the treatment of the insane'.

That same year, the first psychiatric journal, the *American Journal of Insanity*, was published in June by Amariah Brigham, superintendent of the Utica State Hospital in New York state.

In 1851, the Association adopted proposals by Thomas Kirkbride, MD, superintendent of the Pennsylvania Hospital for the Insane, for the design and organisation of mental hospitals. These policies dictated the architecture of state hospitals in the United States for more than 50 years.

Some 45 years after the Association's founding, the name was changed to the American Medico-Psychological Association; physicians working in mental hospitals or private offices became eligible for membership in 1892. The Association increased its scope by acquiring the *American Journal of Insanity* from Utica State Hospital to be its official journal.

In 1917, during the First World War, the Association officially adopted the *Statistical Manual for the Use of Hospitals for Mental Diseases* as a system for uniform statistical reporting. Over the next 3 years, the National Committee for Mental Hygiene (publisher of the *Manual*) successfully introduced the new classification and statistical system into mental hospitals throughout the country.

Website: <http://www.pscyh.org>

Five years later, in 1922, after two earlier changes, the Association adopted its current name – the American Psychiatric Association (APA). The name of the Association's journal became the *American Journal of Psychiatry*.

As the years moved on, the APA became increasingly involved in helping to ensure proper training of the providers of psychiatric care and the humane, effective treatment of patients. In 1934, the American Board of Psychiatry and Neurology (ABPN) was established under joint sponsorship of the APA, the American Neurological Association and the American Medical Association to certify standards of training and specialty competence. In addition, the APA expanded its eighth edition of the *Statistical Manual* to include a new area, 'Standard Classified Nomenclature of Diseases'.

After putting these two areas together, the APA published the first edition of *The Diagnostic and Statistical Manual of Mental Disorders*, now in its 4th edition. In response to physicians' need for psychiatric texts and also to continue the production of the DSM, the American Psychiatric Press, Inc. (APPI) was established in 1981.

To support the needs of its member physicians, the APA formed a Steering Committee on the *Practice Guidelines* in 1989 to take the lead in describing the best, evidence-based treatments and the range of appropriate treatments available to patients with mental illnesses.

In 2000, the APA reincorporated the membership organisation and its subsidiaries (the American Psychiatric Foundation, the American Psychiatric Institute for Research and Education, the APPI) to position the Association for a greater role in public policy and advocacy. Two years later, in 2003, the Board of Trustees adopted 'A Vision for the Mental Health System', a proactive set of guiding principles for promoting the availability, accessibility and quality of mental health services in the United States.

The APA lives out its 'vision'

Today, the APA has set the following mission and values for the Association and its membership to follow.

Mission

The mission of the APA is:

- to promote the highest-quality care for individuals with mental disorders (including mental retardation and substance-related disorders) and their families
- to promote psychiatric education and research
- to advance and represent the profession of psychiatry
- to serve the professional needs of its membership.

Values

The APA's values concern:

- best standards of clinical practice
- highest ethical standards of professional conduct
- prevention, access, care and sensitivity for patients and compassion for their families

- patient-focused treatment decisions
- scientifically established principles of treatment
- advocacy for patients
- leadership
- lifelong professional learning
- collegial support
- respect for diverse views and pluralism within the field and the Association
- respect for other health professionals.

The APA continually strives to meet an ever-expanding standard of excellence in medical care, both by its members and for their patients. As an organisation, the following goals have been set forth with the agreement of the APA's Board of Trustees:

- to promote the rights and best interests of patients and those actually or potentially making use of psychiatric services for mental disorders, including mental retardation and substance-related disorders
- to improve access to and the quality of psychiatric services
- to improve research into all aspects of mental illness, including the causes, prevention and treatment of psychiatric disorders
- to improve psychiatric education and training
- to promote optimal conditions for practice and career satisfaction
- to foster collaboration among all who are concerned with the medical, psychological, sociocultural and legal aspects of mental health and illness
- to improve the functioning of the APA in the service of its mission.

The APA today, tomorrow and beyond...

Since the 2003 release of the 'Vision for the Mental Health System', the APA has been working with its members, allied medical groups and government agencies to ensure that the vision is being implemented. In the past 2 years, it has identified specific objectives and potential strategies to achieve the principles set forth in the 'Vision':

- *Advancing insurance non-discrimination.* The APA, with support from various groups, has generated widespread support for non-discriminatory coverage of mental healthcare in the United States. The APA continually lobbies for support to end the insurance industry's practice of providing coverage for physical ailments but not comprehensive coverage for mental health needs.
- *Protecting patient safety.* The APA helped its state associations and district branches to head off legislation that threatens the safety and quality of mental healthcare by allowing non-physicians to prescribe psychotropic medications. The APA continues to monitor this issue and provide support and information to state legislatures where necessary.
- *Advancing minority mental healthcare.* The APA, with special projects developed by the Office of Minority and National Affairs, is stepping up efforts to

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The APA's annual meeting continues to be the largest gathering of psychiatric professionals in the world. This year, the APA's 158th annual meeting, in Atlanta, Georgia, saw the presentation of more than 1000 clinical papers, as well as symposia, new research poster sessions and workshops.

improve mental healthcare for minority and underserved communities. The APA is working diligently to attract more minority medical students into the field of psychiatry.

- *Raising general awareness of mental health issues and increasing access to care.* Through several programmes, the APA is taking an even greater lead in trying to reduce the stigma of mental illness. The National Partnership for Workplace Mental Health, a programme of the American Psychiatric Foundation (APF), is an APA-created coalition of 27 public and private employers that advocate quality psychiatric care for the nation's workforce. In addition, the APA launched a new public information campaign in May 2005 designed to educate the public and reduce the stigma of mental illness and raise public understanding of the field of psychiatry.

In addition to the 'Vision' statement, the APA continues its long-running tradition of promoting excellence in care through lifelong learning and ensuring an adequate supply of well trained psychiatrists. The APA has accelerated development of a range of educational activities for members – from a major recertification initiative, to special sessions for residents at its annual meetings and new online continuing medical education (CME) programmes.

The APA's annual meeting continues to be the largest gathering of psychiatric professionals in the world. This year, the APA's 158th annual meeting, in Atlanta, Georgia, saw the presentation of more than 1000 clinical papers, as well as symposia, new research poster sessions and workshops. Each year, the APA annual meeting provides an opportunity for mental health professionals from all around the world to hear the latest in mental health research and information, as well as a chance for allied groups to gather. In 2004, 8974 international registrants attended the annual meeting in New York. Of that total, 1131 were APA members and 7843 non-members. The meeting was the largest in the APA's history, drawing more than 26 000 registrants.

In addition to its annual meeting, its subsidiaries – the APPI, the American Psychiatric Institute for Research and Education (APIRE) and the APF – continue to grow and advance as leaders in each of their respective areas.

The APPI has proven itself an able ambassador for psychiatry around the world. By producing the premier collection of psychiatric literature, the APPI promotes quality continuing education and enhances the image of

psychiatry as a science-based profession concerned with real medical conditions. It now publishes 75–80% of the psychiatric literature in English that is most often cited by others. In addition, the APPI's books and journals are available in 30 countries and in 29 languages. DSM–IV (TR) is available in 23 languages alone. In addition, the *American Journal of Psychiatry* is now the most frequently cited psychiatric journal in the world, as determined by the Institute for Scientific Information.

Through the interlocking efforts of APIRE and the APA Division of Research, the APA works to help expand the science base of psychiatry, strengthen the broad research infrastructure in the field, and improve the quality of care by conducting and supporting clinical and health services research and related educational activity. In 2004, APIRE developed the *Parents Med Guide* and *Physicians Med Guide* for parents and physicians to use when weighing the decision of whether or not to medicate children and adolescents who struggle with major depression. This effort came after a decision by the US Food and Drug Administration to include 'black box' warnings for children and adolescents on antidepressant medication. As this issue became the subject of public debate, the APA and APIRE took multiple actions to provide the public with the most accurate information about the drugs, endeavouring to ensure proper prescription and usage of these psychotropic medications for young patients.

The APF, the APA's self-supported charitable arm, has become involved in funding both research and educational initiatives that propel the profession of psychiatry forwards. The APF provides grants for programmes in public education that promote the early recognition of mental illnesses, remove financial, cultural and societal barriers to quality mental healthcare, and encourage those with mental illnesses and their carers to participate actively in their treatment. The APF also administers fellowships that educate psychiatry residents about development of public policy related to the care of patients and awards that recognise excellence in psychiatric research.

With so many initiatives, the APA is an ever-evolving body. But through this advancement, its mission, values and goals drive its actions and lead psychiatry into the future. With the leadership of the board, the strong foundation of its highly skilled members, and the perseverance of its professional staff, the APA will continue to be the leading mental health association in the United States and across the globe.

The Royal College of Psychiatrists goes 'international': the European International Division

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The initiative of the Royal College of Psychiatrists to establish international divisions has created considerable enthusiasm. College members have some common characteristics, mainly their training and success in the Royal College examination. Thus College members share a common approach to the practice of psychiatry as well as some common experiences; it can be argued that they share a common language in psychiatry.

Aims of the European International Division

Members of the Royal College in Europe now have the opportunity to come into contact with the realities of practice across the continent. Europe now comprises 51 countries. The branches of European psychiatry, including the British, share a long tradition in diversity of teaching, research and clinical practice. European psychiatry also has gross differences between countries in the allocation of funding for mental health and, of course, many different psychiatric 'schools'. Practically all major schools of thought in psychiatry were born in Europe. Additionally, Europe in general is characterised by big differences in the provision of psychiatric care. Currently there is a large gap between east and west, with the former offering mostly 'institutional' care and the latter 'community' care.

Furthermore, there are differences in the perceptions of ethical issues and human rights among the various countries. College members, with their common training in psychiatry, are uniquely placed to assess, comment upon and improve psychiatric training in Europe. A 'core curriculum' has been developed by the World Psychiatric Association. In addition, there is a core curriculum developed by the Union of European Medical Specialists (UEMS) of the European Union, but it is unclear whether this curriculum is acceptable and

applicable in every European country. One of the first priorities of the College's European Division is to have an overall view of the psychiatric training actually offered in every country. It might be appropriate (and very interesting) for every division to have a similar 'mapping' of the training offered in its countries. There is also a need to draw realistic and pragmatic agreements on the best way of teaching future psychiatrists, bearing in mind the realities and restrictions of every country.

Challenges for the Division

One of the major challenges facing European psychiatry is a degree of hostility between particular European countries. This can breed contempt and rejection of cultures and beliefs, and can mask itself as quasi-scientific dispute. The list of countries would include: Serbia and Croatia, Greece and Turkey, England and Ireland, Albania and Serbia, Russia and Chechnya. Hostility can also be between religions, for example between Moslems and Christian Serbs or between Moslem and Christian Croats.

The hostilities between countries are not the only challenge. Language and cultural barriers can increase prejudice and discrimination as well as rejection of other countries' achievements. There are also large differences in material wealth and medical facilities between countries. In addition, there are big differences in the use and availability of communication technology, such as the internet.

Across Europe, working conditions and the status enjoyed by psychiatrists vary hugely. The status and facilities a Nordic European psychiatrist enjoys bear little resemblance to those that colleagues in the Balkans have. This, of course, is not a problem that psychiatrists can solve but western European colleagues can do much more to highlight the problems of the eastern European psychiatrists and press for solutions.

On a different level, other major challenges are the different priorities between European countries. For example, in the west one of the priorities is to discover new and more effective (and more expensive) drugs with fewer side-effects, while in the east of Europe there

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is a lack of basic psychiatric medication, poor resources for mental health, and treatment is based mainly in hospitals. In the west, psychotherapy and similar therapies are often freely available, which is not always the case in other countries.

Western European psychiatrists are concerned with patients' rights; there is great emphasis on the individual and there is always concern in striking the right balance between the need to protect the patient, society in general and individual liberties. In the east European countries such concerns are only just emerging and they evoke painful memories of the abuse of psychiatry when regimes used psychiatric diagnoses and treatments to silence political opponents.

Community psychiatry and asylum closure have been the most prominent developments in the west in the past 30 years, whereas in the east the available resources are very limited and psychiatric care is offered mainly in poorly staffed, under-resourced large mental institutions. The problems facing those with a mental illness and their carers, professional or not, should be highlighted. Colleagues in eastern Europe need to be supported to improve the standards of care and be congratulated on their achievements. We must also be aware of the fact that, in certain European regions, psychiatrists share the problems of the rest of the local population and are struggling for survival in a hostile environment. It is hoped that the Psychiatric Association of Eastern Europe and the Balkans, established in Athens in March 2005, and the World Psychiatric Association's Institutional Programme for Eastern Europe and the Balkans will collaborate with the European Division of the College in an effort to improve mental healthcare in the area.

Perspectives of the European Division

The leadership of the College needs to be congratulated for this initiative, which should be the focus of attention of members residing in Britain as well as of members of

continental Europe, since their contributions and support are necessary for the success of this venture.

The European Division of the College should do its best to promote communication between psychiatrists from different European countries and actively involve all College members. This can be achieved with the introduction (initially) of meetings between psychiatrists from a defined geographical area (e.g. the Nordic countries, the central European countries or the Balkans). If these meetings are fruitful and yield encouraging results, at a later stage a pan-European Royal College of Psychiatrists' meeting can follow. The purpose of these meetings, apart from the opportunity to meet colleagues with similar training and experiences who live and practise in a different country, should be partly educational for the wider psychiatric community of the host country. The European Division should make full use of its members' common language and strive to produce consensus and position statements, for example on training in psychiatry and on patients' rights. The large differences between psychiatric practices in the east and west should not be an obstacle to the efforts to promote the best proven treatments for all psychiatric patients and in this respect support for psychiatric reforms throughout Europe should be strengthened.

Finally, we are all aware that the European Division of the Royal College is not alone. Many psychiatric associations have established themselves on the European scene. These include the European Zones of the World Psychiatric Association, the UEMS, the Association of European Psychiatrists, the European College of Neuropsychopharmacology, the Psychiatric Association of Eastern Europe and the Balkans as well as the European Division of the World Health Organization, to name but a few. The Royal College European Division aims to cooperate with these bodies and gain from their experience, since they share a common aim, which is to promote mental health and provide the best treatment for patients through evidence-based practice, research, training and education.

News and notes

For contributions to this column, please contact Brian Martindale FRCPsych, Early Intervention in Psychosis Service, South Tyne and Wearside NHS Mental Health Trust, Monkwearmouth Hospital, Newcastle Road, Sunderland SR5 1NB, email Brian.Martindale@stw.nhs.uk

Table 1. Officers of the College's International Divisions, 2005

International Division	Chair	Secretary	Financial Officer
African	Professor Tuviah Zabow (South Africa) zabowt@curie.uct.ac.za		
European	Professor George Christodoulou (Greece) psych@psych.gr; gnchrist@compulink.gr		
Middle Eastern	Dr Nasser Loza (Egypt) nloza@behman.com; nloza@hotmail.com	Dr Faud Antun (Lebanon) antun@cyberia.net.lb	Dr Walid Sarhan (Jordan) sarhan@nets.com.jo
Pan-American	Dr Nigel Bark (USA) nbark1@pol.net		
South Asian	Professor S Haroon Ahmed (Pakistan) nharoon@super.net.pk	Dr Nalaka Mendis (Sri Lanka) nalaka@sri.lanka.net	
Western Pacific	Professor Scott Henderson (Australia) ashenderson@netspace.net.au	Professor M. Parameshvara Deva (Malaysia) devaparameshvara@yahoo.com	

Election results for the College's International Divisions

The results of the first elections to the International Divisions are shown in Table 1.

Board of International Affairs at conference of the World Psychiatric Association

The Board of International Affairs of the Royal College of Psychiatrists organised its first 'roadshow' session of its international divisions during the World Psychiatric Association's international conference in Athens, March 2005. Professor Christodoulou, chairman of the WPA meeting, welcomed the participants and Professor Ghodse in his introductory address briefed the participants about the aims of the College's international divisions. Dr Javed outlined how these divisions would be organised and function, and gave a detailed account of their future role in College activities.

The other speakers included Professor Christodoulou and Dr Douzenis (European Division), Dr Nasser Loza (Middle Eastern Division), Professor Parameshvara Deva (Western Pacific Division) and Professor Haroon Chaudhry (South Asian Division), who presented reports from their respective divisions and their plans for future activities. The presentations generated lively discussions and a number of ideas emerged about establishing future links among the overseas members of the College.

Dr Mike Shooter, President of the College, in his concluding remarks expressed positive and optimistic thoughts about the College's new roles through the creation of the international divisions.

Besides the division meetings and presentations at the College's annual meeting in Edinburgh, there will be division meetings in Cairo in September 2005.

Western Pacific International Division

The officers of the Western Pacific International Division of the College (Chair, Scott Henderson, Australia; Secretary, Parameshvara Deva, Malaysia; Finance Officer, Helen Chiu, Hong Kong) are examining possible contributions that could be made in particularly needful areas, geographically and professionally. It is hoped that collaboration with major organisations in the region will give greater efficiency and better outcomes. A balance is needed between service delivery, professional training and scientific opportunities. It will be important to avoid duplicating what other organisations have already been doing and it may be that the College has as much to benefit as to give in its future activities in the Western Pacific region.

Mental health for Europe

Ministers of Health of the 52 member states of the World Health Organization's European Region endorsed a declaration for Europe and an action plan for the next decade at a historic meeting in Helsinki in January 2005, organised by the World Health Organization. A major focus of the action plan is social inclusion, to mitigate practices that lead to marginalisation, abuse and economic and other forms of discrimination. It is anticipated that consumers will have increasing prominence, aided by legislation about rights for people with a mental disability. Changes are unlikely to happen until governments fund mental health services in proportion to the economic burden they represent. The Helsinki conference

established the principle of parity. The Helsinki declaration and action plan can be found at <http://www.euro.who.int/mentalhealth2005>.

Cairo, September 2005

The XIII World Congress of Psychiatry (WCP) organised by the World Psychiatric Association (WPA) will be held on 10–15 September 2005 in Cairo, Egypt. The congress will offer psychiatrists and other mental health professionals the opportunity to learn more of the science and art of psychiatry from experts in the field, to share knowledge with colleagues from all over the world and to socialise with friends. Delegates are offered a series of tours to see Egypt's cultural jewels, including an evening dinner and show cruise on the Nile, as well as visits to: the Egyptian Museum; the Coptic Museum (old Cairo); the Museum of Islamic Art; the Military Museum (the Citadel); the 14th-century Khalili Bazaar and Sagh; the Giza and Saqqara pyramids; the Valleys of the Kings and the Queens; the Temple of Luxor and Karnak; the Temple of Abu Simbel and the Aswan High Dam; the St Catherine Monastery; and the Red Sea.

For further information about this congress and Egypt, visit the website http://www.wpa-cairo2005.com/xiii_pres.html.

South Asian Association for Regional Co-operation (SAARC) Psychiatry Federation

The psychiatric societies of India, Pakistan, Sri Lanka, Bangladesh, Nepal, Bhutan and the Maldives have formed a federation. The dream of coordination was first mooted in 1978, because these countries have so much in common culturally, politically, economically and in the mental health field. The federation at last came into being as a result of a meeting in Lahore in September 2004 during the WPA Regional and Inter-zonal Meeting.

Among its first officers are:

- President – Professor Achakzai of Quetta, Pakistan
- Vice-Presidents – Dr Mendis of Colombo and Professor Sobhan of Dhaka
- Secretary-General – Professor Kallivayalil of India.

The executive committee includes the presidents and secretaries of the member countries' psychiatric societies.

There will be a SAARC Psychiatric Federation annual conference at Agra, India, in November 2005. Further details are available from Professor Kallivayalil, Secretary-General, email ktm_roykalli@sancharnet.in.

Thoughts of an Indian psychiatrist

Sir: I am writing in response to Professor Srinivasa Murthy's thematic paper on international recruitment in issue 7 of *International Psychiatry* (January 2005, pp. 3–5). To put things in context, I am currently a specialist registrar in general adult psychiatry in the Oxford Deanery. However, I am from India and graduated from Medical College, Calcutta. After taking the MBBS and a year's internship as a pre-registration house officer (PRHO) I trained as a senior house officer (SHO) in psychiatry. I then took the test of the Professional and Linguistics and Assessment Board (PLAB) to further my training in psychiatry in the UK. The question is why, or may be even why not?

The system prevalent in India is very different to the one in the UK. In the UK after a year as a PRHO one applies for a SHO rotation in a specialty of one's choice. However, in India there are a number of bottlenecks through which a medical student must pass. After getting through the rigorous final MBBS examination and a 1-year internship, new graduates take up a house staff appointment in a discipline of their choice and simultaneously start preparing for the MD/MS entrance examination. In this medics are tested in over 21 subjects. A large majority of the questions asked have very little clinical relevance. The idea is not to test knowledge so much as to eliminate a sufficient number of examinees to match the number of seats available. After this initial lottery comes a second, in which disciplines are allocated. The discipline in which one was a house staff officer or in which one was interested has hardly any bearing on what one gets. On the allocation day, if there are a couple of people ahead in the merit list interested in the discipline that one is vying for, one may say goodbye to a prospective career. Thus, most medics begin their careers with a compromise. Aspiring physicians become surgeons, surgeons become psychiatrists and so on.

Even as a medical student I was interested in psychiatry but, as there was very little in the undergraduate course on psychiatry, I was unsure whether, in the long run, it would be the right discipline for me. In October 1999 I had just begun my placement as a house staff officer in psychiatry and within a month I knew this was what I wanted to do for the rest of my life. Now I was faced with the decision of either going through the lottery (examination) conducted by the Medical Council of India or coming to the UK and applying for psychiatry

SHO rotations. Needless to say, I took the much easier second option.

There are only a couple of institutes in India, the National Institute of Mental Health and Neuroscience (NIMHANS) and that at Kanke, which conduct examinations specifically for aspiring psychiatrists by including a paper or a certain percentage of questions on psychiatry. However, seats are very limited; NIMHANS, the institute to which Professor Murthy belongs, had six seats in the general category in 1999 and there would have been literally thousands of people competing for these. Thus the trip to the UK is a choice that many aspiring psychiatrists in India are making.

Fierce competition is not the only reason that causes would-be psychiatrists to travel to the UK. Resources are another big issue. India, like any other developing nation, is still fighting with major killers such as malaria, tuberculosis, typhoid and cholera. When it comes to healthcare investment, psychiatry is very low on the list. This scarcity of resources has an obvious effect on training. Since I have not helped in anyway with resources by coming to the UK, it would be inappropriate for me to complain about this. None the less, I could contribute to the human resources for mental healthcare in India in the near future, after gaining the Certificate of Completion of Specialist Training (CCST). However, every time I see a psychiatrist who has an MD from India but who is still applying for SHO jobs in the UK, I find myself pondering why he or she is here – for further training, an easy life, higher pay, frustration with the Indian private sector or government setting, or perhaps a combination of these factors?

The bottom line is that, when I came to the UK, I wanted to complete the College Membership examination and CCST and go back to India, where I hoped to make a difference with the knowledge that I would acquire. In all fairness this resolve has weakened and is getting weaker every day. Being in Oxford, I have had the opportunity to work with some of the 'big names' in psychiatry. My own interest is in the genetics and neuroimaging of schizophrenia and I would like to go into full-time research. I know that would be the end of my dream to return to India. I have put off making the decision but I do not know for how long I will be able to delay. Either way I will have regrets.

Manaan Kar Ray

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Correspondence is welcome on any of the articles or issues raised in *International Psychiatry*. Letters of no more than 500 words should be sent to the Editor, Hamid Ghodse, email hghodse@sghms.ac.uk

Forthcoming international events

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: <http://www.icms.com.au/epm2005>

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@leedsnmh.nhs.uk
Website: <http://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: http://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: <http://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

8–9 September 2005

Confidentiality and Privacy in Healthcare
EuroSOCAP Workshop.
Brussels, Belgium.
Email: c.harper@qub.ac.uk
Website: <http://www.eurosocap.org>

10–15 September 2005

XIII World Congress of Psychiatry
World Psychiatric Association.
Cairo, Egypt.
Contact: Professor Ahmed Okasha
Email: secretariat@wpa-cairo2005.com
Website: <http://www.wpa-cairo2005.com>

12–16 September 2005

World Congress: International Association for Suicide Prevention (IASP)
WPA Suicidology Section, International Association for Suicide Prevention.
Contact: Dr Lourens Schlebusch
Email: IASP2005@nu.ac.za
Website: <http://www.interaction.nu.ac.za/IASP2005>

6–8 October 2005

V European Congress on Mental Health in Mental Retardation: Integrating Research and Practice
Barcelona, Spain.
Contact: Dr Luis Salvador-Carulla
Email: luis.salvador@telefonica.net
Website: <http://www.aeecrm.com>

20–21 October 2005

4th European Conference on Violence in Clinical Psychiatry
Otto Wagner Hospital, Vienna, Austria.
Email: conference.management@freeler.nl
Website: <http://www.oudconsultancy.nl>

20–23 October 2005

Fourth International Congress on Vascular Dementia
Porto, Portugal.
Contact: Kenes International – Global Congress Organisers and Association Management Services, 17 Rue du Cendrier, PO Box 1726, CH-1211 Geneva 1, Switzerland.
Tel: +41 22 908 0488
Fax: +41 22 732 2850
Email: vascular@kenes.com
Website: <http://www.kenes.com/vascular>

30 October–2 November 2005

WPA Regional Meeting, Mexican Psychiatric Association
Los Cabos, Mexico.
Contact: Dr Luis E. Rivero Almanzor
Email: http://aspsiqm@prodigy.net.mx

3–6 November 2005

55th Annual Meeting of the Canadian Psychiatric Association
Vancouver, British Columbia, Canada.
Email: asaunders@cpa-apc.org
Website: <http://www.cpa-apc.org>

12–13 November 2005

1st Asia-Pacific Conference on Trauma Psychology: Life Adversities and Challenges
Chinese University of Hong Kong.
Email: trauma@psy.cuhk.edu.hk

15–18 November 2005

XIV Russian Congress of Psychiatry
WPA co-sponsored conference with the Russian Society of Psychiatry.
Email: krasnov@mtu-net.ru

16–20 November 2005

WPA Regional Meeting and XIX Congreso Nacional de la Asociacion Psiquiatrica Mexicana
Los Cabos, Mexico.
Contact: Dr Luis E. Rivero Almanzor
Email: http://aspsiqm@prodigy.net.mx

17–20 November 2005

2nd Congress of the International Society on Brain and Behaviour
Thessaloniki, Greece.
Website: http://www.psychiatry.gr/intro_brain2_eng.html

25–26 November 2005

Second Workshop of Franciacorta. New Developments on Diagnosis and Treatment of Mood Disorders
WPA Section on Private Practice.
Provaglio d'Iseo, Brescia, Italy.
Contact: Dr Giuseppe Tavormina
Email: president@censtupsi.org
Website: <http://www.censtupsi.org>

25–27 November 2005

Second International Mental Health and Cultural Psychiatry Conference
WPA co-sponsored conference with the Indo-Australasian Psychiatric Association, Australasian South Asian Psychiatry Forum.
Sydney, Australia.
Email: RDSOUZA1@bigpond.net.au

2–4 December 2005

First Conference of the South Asian for Regional Cooperation (SAARC) Psychiatric Federation
WPA co-sponsored conference.
Agra, India.
Contact: Dr Roy Abraham Kallivayalil.
Email: ktm_roykalli@sancharnet.in; ucg@sancharnet.in; uttam_garg@yahoo.com