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Young people and the problems of today

Hamid Ghodse

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

The foundations of adult health are established early in life, and at all stages of growing up – in infancy, childhood and adolescence – young people need healthy and supportive environments in which to grow to their full potential. At different stages of their lives they have different health and developmental needs but they are especially vulnerable during adolescence, when they are faced with a range of internal and external challenges, biological, psychological and social.

The vulnerability of children and adolescents to a variety of diseases and health problems is well known. This is so marked that childhood mortality is used as an indicator of a country's developmental stage and progress, one which often provides stark evidence of inequity in health and health services between different communities. Malnutrition and infectious diseases are particularly important causes of ill health early in life in many countries, and other factors play a greater role as children grow up. For example, substance misuse – by parents, peer groups, society in general and by the young people themselves – is a major threat to health. It encompasses the misuse of various psychoactive substances, both illicit and licit, including alcohol and tobacco (McArdle *et al*, 2002; Crome *et al*, 2004). It is a preventable condition and vividly illustrates the new challenges facing young people in the 21st century.

Young people live in a complex world that provides many of them with previously unimagined opportunities but also with new challenges. Because of globalisation, peer influences, which can be very powerful for the young, are no longer exerted solely at the local school and in the local neighbourhood but may originate thousands of miles away. New technologies and easier travel spread ideas, knowledge and behaviours quickly and efficiently. This may have huge benefits in terms of extending young people's experiences and understanding beyond their local communities but it also carries risks – for example, of exposure to aberrant behaviour and unsuitable role models – all at a time when young people are at their most impressionable and most likely to experiment with new things and to rebel against parental authority. At the same time, long-established socio-cultural restraints on behaviour are becoming weaker.

Such factors make it more difficult to feel confident that children are growing up in the healthy environment that they need. Indeed, in many cases it is apparent that they are not and that, in consequence, both their mental health and their physical health are

likely to be impaired (Baily, 2003). Substance misuse, for example, may directly increase the risk of accidental overdose and intoxication and, in the longer term, may lead to the development of drug dependence. Youngsters are also more likely to engage in unsafe sexual practices. These carry the risk of hepatitis, HIV and other sexually transmitted diseases, as well as of unintended pregnancy. Such immediate consequences can lead to a host of physical, mental and social problems, whose effects may be felt way into adulthood (Kumpulainen, 2000; Gue *et al*, 2001; Department of Health, 2002; Crome *et al*, 2004).

These long-term consequences drive home the fact that risky adolescent behaviours should not be dismissed as passing phases of little importance. They require and deserve serious efforts at prevention and intervention, for the sake of both the individual young person and society as a whole. Psychiatrists in general, and child and adolescent specialists in particular, have an important role to play in this and are called on for advice on prevention and education, as well as intervention for individual patients. For all of the reasons outlined above, the demands upon these specialists are increasing and yet there are countries in the world with little or no access to child and adolescent psychiatry services and where adult mental health services are already stretched to the limit.

Nearly 40% of the world's population is composed of children and young people. They will form the backbone for development of their nations and we have a responsibility to do all we can to ensure that they grow up healthy and strong. Many communities will need particular help to develop the specialist skills that are required to nurture the next generation and to respond to their needs in an increasingly complex and challenging world.

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Risky adolescent behaviours should not be dismissed as passing phases of little importance. They require and deserve serious efforts at prevention and intervention, for the sake of both the individual young person and society as a whole.

Natural disasters and their aftermath

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Less attention is now paid to isolated incidents that came in an instant but then passed by, leaving in their wake terrible destruction. Initial concern has not exactly turned into indifference, but in the aftermath of acute events it is hard to sustain great interest for months on end.

Entire societies find ways of adjusting, of supporting one another, of coming to terms with what has happened, and they do not always need focused psychiatric intervention to work through their grief.

The chronic trauma endured by the people of Iraq, Darfur and Zimbabwe is a subject regularly brought to our attention in the UK by the news media. The mental health risk attributable to living in a situation in which each day brings the threat of more disruption, another risk to life and limb, the loss of people you love, perhaps of your home, is great. Less attention is now paid to isolated incidents that came in an instant but then passed by, leaving in their wake terrible destruction. Initial concern has not exactly turned into indifference, but in the aftermath of acute events it is hard to sustain great interest for months on end. Yet, for those who inhabit the rim of land in the Indian Ocean affected by the tsunami of December 2004, one single event did bring about unimaginable destruction and loss of life. In Kashmir in October 2005, an earthquake destroyed communities within a huge geographical area, one that was far more isolated, and hence less accessible to reporters, than the beaches of Phuket. From time to time we may wonder what happened to the survivors of these disasters – how are they coping, what help has been made available to them since, and to what extent have political complexities in Indonesia, Sri Lanka and Kashmir influenced the availability of aid and assistance?

To an extent, we gain some answers to these questions from this issue's thematic papers. Professors Chadda and Malhotra travelled to the earthquake-affected region of Kashmir to support local teams who were attempting to provide mental health services to the surviving population. The immediate need was to provide appropriate training to doctors and associated professionals who were already there, and who were going to be in a position to give continuing support to the population traumatised by the quake. Was there an immediate need for psychiatric intervention? The visiting psychiatrists were met with initial scepticism, yet they did manage to give advice on follow-up treatment to a great many medical and paramedical teams during brief training programmes.

In northern Sri Lanka the threat of terrorism has complicated the response of teams assisting the local population in the wake of the tsunami that killed over

40 000 people in that country. The review of psychosocial adjustment 10 months later by Danvers *et al* is an important contribution to our understanding of population responses to such a tragedy. The scale of loss was so great and so many families were affected that a community response was inevitable. Sensibly, the psychiatric intervention teams focused on that minority who had serious mental health needs before the disaster, or who had unusually severe or prolonged responses afterwards. Previous traumas affecting those who lived in territories disputed by the Tamil Tigers had apparently steeled them to cope, and they did so rather better than might have been expected. Sadly, despite unprecedented quantities of aid being available, this is still not reaching all those who need it.

Professor Diyanath Samarasinghe has summarised key issues concerning the response to the tsunami-related havoc in Sri Lanka, and in a valuable contribution sets out specific needs that are associated with acute disasters. He emphasises, as do our other contributors, that disasters affecting whole communities differ in their impact, and their implications for mental health, from traumatic events that affect individuals (such as terrorist bombings). Entire societies find ways of adjusting, of supporting one another, of coming to terms with what has happened, and they do not always need focused psychiatric intervention to work through their grief. There is a danger inherent in the power imbalance between those who are victims and the authorities set up to assist them, but the instigation of some formal system of societal control is urgent and necessary.

Finally, in a Point of View piece, Professor Murad Khan finds confusion and lack of leadership among the authorities in Pakistan in the provision of psychiatric assistance to those affected by the October 2005 earthquake. In a hard-hitting review of the psychosocial relief programmes provided, he makes a plea for a greater role to be played in future by the Pakistan Psychiatric Society. This institution could, and should, be responsible for the coordination and provision of mental health programmes – and there is no time like the present to press for reform.

Politicians (and psychiatrists) on the couch

A colleague writes of the widespread concern in some African countries about the behaviour of politicians in office. But this is not a matter of concern only for Africans. The press has been speculating whether aspirants to high political office should undergo psychiatric or psychological testing before being deemed eligible for election. This may not be a novel idea, as in many industries it is common to conduct such screening before selection for key posts. It has always interested this member of the editorial board that psychiatrists do not have to go through such assessments. These are surely all serious matters and psychologists and psychiatrists should contribute to the debate. — *Brian Martindale*

An experience of provision of psychiatric services in the earthquake-affected area of Kashmir in India

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Developing psychiatric services for disaster-affected populations in a place with meagre resources is a challenge, especially if the place is remote and offers limited access, and the weather conditions are harsh. The earthquake in October 2005 posed just such a challenge (Makhdum & Javed, 2005). Massive damage was reported from Pakistan, as the epicentre was in Muzaffarabad, in Pakistani-controlled Kashmir. There was also extensive damage to life and property in some areas of Kashmir in India. The road and communication network had been completely destroyed in many of the affected areas.

Mental health resources in Indian Kashmir are few. According to one of the latest surveys by the government of India, the state of Jammu and Kashmir (J&K) had just four psychiatrists for a population of more than 10 million (Goel *et al*, 2004), and even they were available only in the cities of Jammu and Srinagar. In light of this, a team of mental health professionals from the All India Institute of Medical Sciences, New Delhi, and the Postgraduate Institute of Medical Education and Research, Chandigarh, visited the area in November 2005 to assess the mental health needs and to provide the required interventions. The team was in the state for about 2 weeks. It consisted of three psychiatrists, two clinical psychologists and four psychiatric social workers.

The team reached Srinagar on 8 November 2005. Its objectives included assessing the mental health needs of the earthquake-affected population, and screening and providing treatment and psychosocial counselling for the people who were either simply distressed or diagnosed as having psychiatric problems. Since it was not possible for the team to stay in the area for a long time, it was decided to sensitise and train local doctors and paramedical professionals in the management of disaster-associated mental health problems.

Extent of the problem

Although the damage was worse in Pakistan-controlled Kashmir, in India the earthquake none the less badly affected two districts of the state of J&K, Kupwara

and Baramulla, with populations of 1 167 000 and 640 000, respectively. Each household in the state has an average of 6.5 family members (according to the 2001 census). The towns of Tangdar and Uri and surrounding areas bore the brunt of the tragedy. More than 50 villages were seriously damaged. Over 73 000 houses were damaged, of which 42 750 were completely destroyed. Some of the villages had all their houses damaged. In the earthquake, 1 195 civilians lost their lives and 4373 were injured. Nearly 150 security force personnel were also killed in the earthquake. (The number of casualties was reported to be nearly 100 000 in Pakistan.)

The problems were compounded by the after-shocks in the region. Being a difficult and remote terrain, it was difficult to reach many places. The Indian army and the government of J&K provided aid to most of the affected areas. The Department of Health of the government of J&K despatched medical relief teams immediately after the tragedy. Teams of doctors from the Indian army and the Directorate General of Health Services of the Government of India were sent to provide medical care for the affected people. The local police were also involved in the relief work.

Although the medical problems were managed by the general medical teams, there had not been much provision for the mental health needs of the population. We anticipated that the affected people would have mental health problems related to the tragedy. The team was also informed by the local doctors about acute stress reactions in the affected population during the first few days following the earthquake.

Clinical services

Considering the vastness of the area affected and the limited time available for the team, it was decided to send two small groups, of four or five members each, to Uri and Tangdar. Another group stayed in Srinagar and conducted a training programme for the medical officers and paramedical professionals in coordination with the Regional Institute of Health and Family Welfare, Dhobiwan (J&K).

The teams were stationed in the respective areas and visited the worst-affected villages, where clinics

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In recent years PTSD has often received too much publicity in the aftermath of disasters and has sometimes consequently attracted disproportionate resources.

were conducted. The teams visited more than 30 villages in the area. They carried essential psychotropic medications with them. Advance notice of the visit was usually sent to the villages. A public address system was also used in the villages to inform people about the arrival of the team. The teams travelled for 4–5 hours every day. The army gave help with the logistics. The roads were very bad and some villages were near the line of control (the border between the two territories of Kashmir).

The team provided psychiatric assessment, medications, counselling and psychoeducation to people with psychiatric disorders or psychosocial problems. This included new-onset cases as well as persons having mental health problems before the earthquake.

The teams provided help to 450 people during their stay. Since many of the local health professionals were from the affected areas, they also experienced mental health problems. Interestingly, when the team was about to start the work, some of the health professionals in the area were sceptical of the purpose of the team, and said that they had not encountered any mental health problems. But when the team members started their work and interviewed affected people, some of the local health professionals also accepted themselves as having experienced psychological symptoms in the aftermath of the earthquake, and requested help.

Findings of the team

Common psychiatric problems detected during assessments included adjustment disorders, depression, generalised anxiety disorder, symptoms of post-traumatic stress disorder (PTSD), panic disorder and insomnia. In many cases, people had experienced stress-related symptoms immediately after the earthquake in the form of sleep disturbance, nightmares and anxiety, but these had settled down with support from other survivors and the rescue teams. The local population had shown tremendous strength in dealing with the trauma. This might be partly explained by the fact that the region has both frequently harsh weather conditions and difficult terrain, and this has fostered great resilience on the part of the local populace.

The patients were evaluated, counselled and provided with sufficient medication for 3–4 weeks. They were advised to visit the local government dispensaries for follow-up and further management. Patients seen at various places were informed that, in case of need, they could meet the team again at the Uri Health Centre on the last day of the contact programme.

Training programme

The training-cum-sensitisation programme lasted 1 day, divided into two sessions. It was conducted for the doctors and paramedical professionals separately at the Regional Institute of Health and Family Welfare, Srinagar, 14–19 November 2005. A total of 160

doctors and 216 paramedical professionals attended. Handouts were distributed to all those present. The participants were very happy with the programme and had felt the need for such training for a long time. Although it was a very short interaction, it was expected that, with this sensitisation, it would be possible for the health professionals to provide satisfactory follow-up treatment for the mental health problems of the earthquake-affected population. It would also help them to deal with similar issues in their clinical practice, and to identify and refer such people for help.

Discussion

In the present case, it was not possible to carry out an epidemiological survey of the population, as the team had gone primarily to provide services. Generally, about 10–12% of any normal population is expected to suffer from some form of mental disorder. But in areas affected by a disaster on the scale of this earthquake, more than 50% of the population would be expected to experience mental health problems (Van Ommeren *et al*, 2005). The 12-month prevalence of severe mental disorders (e.g. psychosis, severe depression, severe anxiety disorders) has been estimated at 3–4% in a disaster-affected population, from a baseline of 2–3%. Mental disorders of mild to moderate severity (including PTSD) have been projected to have an annual prevalence of about 20% in the year after a disaster, as opposed to a baseline prevalence of about 10%. About 30–50% of the affected population would be expected to suffer from moderate-to-severe psychological distress that does not meet criteria for a mental disorder, and which may resolve over time or become mild but chronic. Another 20–40% of the affected population will suffer from mild psychological distress which resolves over time. Such figures ought to apply to the affected people of Kashmir.

In recent years PTSD has often received too much publicity in the aftermath of disasters and has sometimes consequently attracted disproportionate resources. PTSD is only one of various mental disorders seen following disasters, along with depression and anxiety disorders, although it occurs specifically in such populations (de Jong *et al*, 2003). In non-Western cultures, PTSD has been associated with low levels of help-seeking, which is an indirect indication that it is not a pressing concern of many survivors of trauma (Jones *et al*, 2003; Silove *et al*, 2004).

In the assessments conducted by our teams, we did not find significant numbers of cases of PTSD, but it was too early for the full syndrome of PTSD to appear, since the team was assessing the patients 5–6 weeks after the disaster. However, a number of patients had complained of nightmares, intrusive thoughts and hyperarousal. The area had also been facing after-shocks and there were earthquakes of milder intensity in late November and mid-December.

The World Health Organization (WHO) (2003) recommends that everyone with mental health problems induced by trauma and loss, ranging from pre-existing severe mental disorder to non-pathological psychological distress, should have access to basic mental healthcare from general health services and community mental health services. The WHO has advised countries to make social and basic psychological interventions available to the whole population in the community through a variety of sectors, including the health sector. These interventions may also provide some support to those people with mental disorders who do not seek help within the health sector. Such intervention could include restarting schooling, organising child-friendly spaces, family reunification programmes and economic development initiatives (Van Ommeren *et al*, 2005).

In the limited time available, the main objective of our team was to give as much help as possible to the affected population. This was achieved by providing clinical services at various peripheral settings. Training programmes for the doctors and the paramedical professionals were conducted to prepare them to provide help to the affected population.

It was not possible to collaborate with the local mental health professionals during the team's visit, as the area had also been affected by terrorism and the team was advised to be back to their bases by 6 p.m.

Future plan

It would be good to reassess the situation after 6–9 months and to identify the mental health needs of the population at that time, to inform service provision. It would be advisable to include the local mental health professionals in planning such work.

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THEMATIC PAPER – NATURAL DISASTERS AND THEIR AFTERMATH

Ten months on: qualitative assessment of psychosocial issues in northern Sri Lanka following the tsunami

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The tsunami which affected South Asia on 26 December 2004 caused over 41 000 deaths in Sri Lanka, representing 0.2% of the total population, and displaced over 880 000 people from their homes and livelihoods (World Health Organization, 2004). Kilinochchi, Jaffna and Mullativu districts in the Northern Province of Sri Lanka were affected by the tsunami and, as of April 2005, in the whole province, 6200 people had lost their lives, 961 were still missing, 19618 were still housed in welfare centres and 45548 were housed with relatives and friends (Government of Sri Lanka, 2005).

The Northern Province of Sri Lanka is populated predominantly by Tamils and has experienced many years of civil war. There is currently a ceasefire, but because of the war many people in the north had experienced trauma and displacement before the tsunami. Although government mental health services in the province are chronically underfunded, over the years these have been supplemented by the development of local non-governmental organisations (NGOs) with expertise in community psychosocial interventions aimed at targeting the effects of war, particularly its post-traumatic effects. On 29 December

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2004 many of the agencies based in the Jaffna District came together to form the Mental Health Task Force in Disaster, with the aim of coordinating psychosocial aid after the tsunami.

Qualitative assessment of psychosocial issues 3 months after the tsunami

The scale of the loss was immense: many members of single families were killed and in some communities all families lost relatives or close friends. Deaths were often very traumatic and were witnessed by the surviving relative.

As psychiatrists working directly with people affected by the tsunami, and as supervisors of the counsellors and psychosocial workers who were visiting the welfare centres, we made the following observations about the impact of the tsunami.

The scale of the loss was immense: many members of single families were killed and in some communities all families lost relatives or close friends. Deaths were often very traumatic and were witnessed by the surviving relative. For example, there were many reports of mothers having young children pulled from their arms by the force of the water. Those who did not lose family members often experienced property and financial loss. Shortly after the disaster, many had to search for family members, as surviving relatives were often separated, staying in different welfare centres, for instance. There was less opportunity to carry out traditional funeral rituals and in many cases bodies were never recovered. Village structures and organisations were destroyed, and there was large-scale displacement. Because of these factors, the usual community support available after bereavement was not available, since all in the affected communities were dealing with their own losses.

Immediately after the tsunami, many people experienced an acute stress reaction – feeling dazed and highly emotional; this typically lasted a few days. Unsurprisingly, grief was the predominant psychological symptom. Factors which complicated grief reactions included the following:

- *Guilty feelings.* Commonly, survivors questioned themselves about what they could have done differently to save physically weaker family members.
- *Anger and hostility.* These were directed towards nature or the gods, at family members (e.g. parents blaming each other for the deaths of children), or at outside agencies, such as the government or staff in welfare centres.
- *Missing people.* In cases where no body was recovered, unanswered questions and ongoing hopes of survival were common.
- *Suicidal ideation.* Guilt was a risk factor for suicidal ideation, as was losing a large proportion of close family. There was one case of suicide due to property loss in the first few weeks.
- *Alcohol misuse.* This was especially common in men who had lost their wives and were struggling to cope with young children.

Fear of the sea and nightmares were initially common, as were fears relating to the future and a

return to coastal areas. Most of the affected areas were fishing communities, and mistrust of nature was expressed as 'She who gave everything also destroyed everything'. Vivo, a psychosocial NGO working in Sri Lanka, carried out a brief survey of 71 children (aged 8–15) 3–4 weeks after the tsunami. The survey showed that 40% were at risk of developing post-traumatic stress disorder (PTSD) and many others showed symptoms. There were rumours relating to the cause of the tsunami and reports of another tsunami coming were initially common. Some people developed magical thinking about the disaster or about ways to keep safe.

There is an elevated incidence of schizophrenia in the Jaffna Tamil community compared with other East Asian communities (Somasundaram *et al.*, 1988). After the tsunami there was an increase in relapse of schizophrenia, exacerbation of symptoms and failure to follow regular treatment routines. Some individuals lost their medical records and medications, and defaulted clinic appointments and treatments. Some cases of schizophrenic illness or other psychotic episodes were not identified, or were misidentified as normal reactions to the disaster, and were managed only with psychological methods.

Jaffna town, where government offices and most of the NGOs are based, was not affected by the tsunami. In the first 2 weeks after the tsunami, in the town there was a sense of excitement and arousal which at times seemed to border on mass hysteria. Many of those providing practical or psychosocial help to the affected people expressed satisfaction (and some even elation) at being able to help and in the community there was a general wish to visit the tsunami-affected areas, even when this was not strictly necessary. We were surprised by the number of volunteers wanting to carry out psychosocial activities, and were concerned that some went to the affected communities offering 'counselling' despite not having any psychosocial skills or training. We were also concerned about the psychological effect of this desire to help, on both the tsunami-affected people and the volunteers, and were aware of some volunteers who experienced severe and acute stress reactions in response to traumatic experiences such as witnessing the aftermath of the tsunami or disposing of dead bodies.

Some aspects of the systems put in place after the tsunami to deliver aid seemed to lead to more difficulties for the affected people. There was a complex official registration process for receiving aid, which many found stressful. Initially agencies were poorly organised and coordinated, and there were some cases of political interference in the supply of aid and provision of psychosocial support. Many felt this led to aid and psychosocial interventions not reaching all those in need, which caused resentment and anger among the affected people. Initially, few structured activities were available in the welfare centres, and this particularly affected children and adolescents who had

After the tsunami there was an increase in relapse of schizophrenia, exacerbation of symptoms and failure to follow regular treatment routines.

lost parents. As time went on, there were reports of a lack of sensitivity and sympathy on the part of some authorities dealing with tsunami survivors, including school principals and government officers.

Psychosocial interventions in the 3 months after the tsunami

Research suggests that, for most people, psychological reactions resolve during the first or second month after a disaster. Early, in-depth psychological interventions that force the client to talk about experiences in detail can prove harmful to some (Rose *et al.*, 2002), so the Task Force advocated avoiding this approach. Instead, we disseminated information about normal psychological reactions, with an emphasis on the expectation of natural recovery (World Health Organization, 2003), while also ensuring that a system for psychiatric referral was in place for the minority with more severe or abnormal psychological reactions.

Counsellors and psychosocial workers from Jaffna NGOs were sent to the welfare centres to offer support and information. All were given a training session focusing on how they could adapt their skills to the immediate post-disaster context and the dangers of compulsory debriefing sessions. They were also given information on how to identify and refer individuals at risk of harm. Primary healthcare workers (e.g. public health inspectors and midwives) were given a similar training programme and asked to look into psychosocial issues as well as their normal work.

The Task Force coordinated articles in the local papers, gave interviews and a press conference, and also produced information leaflets for affected people and aid workers. Through contacts with the media we hoped to encourage social agencies to promote normality and resettlement as soon as possible, and to influence newspapers' reporting style to avoid increased public distress.

The Task Force attended coordination meetings of the various government agencies and NGOs in order to highlight and advocate psychosocial issues and contribute to planning.

Reflections 10 months on

Saraceno & Minas (2005) estimate that, of those directly affected by disaster, 50% will have psychosocial problems needing help and support and 5–10% will develop severe problems (e.g. pathological grief, PTSD and depression) needing specific intervention and treatment. In our area, pathological grief, phobias, depression and PTSD were the most common psychiatric disorders emerging after the tsunami. To date, in the Jaffna district, we have not experienced the expected large rise in numbers of people directly seeking psychiatric support as a result of the tsunami. Many of those we have seen have been referred from other medical units, such as out-patient departments, with somatisation. Quite a number may be in the

community with unrecognised psychiatric problems. When special efforts were made to identify people with psychological problems, large numbers were found. For example, in a badly affected coastal area, Maruthenkerny, regular psychiatric clinics found almost half of those attending had a post-tsunami psychiatric disorder, particularly PTSD and depression.

Against our initial expectations, there was a high level of interest within the national and international community in the possible psychological effect of the tsunami and, hence, funds were easily available for psychosocial interventions. In the Jaffna district there were already many NGOs specialising in trauma and psychosocial interventions, so our district was perhaps better prepared than other tsunami-affected areas to mobilise resources quickly. However, in areas of the north less well provided with such NGOs, occasional psychiatric field trips have identified many people with depression who have not been referred to appropriate services.

Some felt that because the whole population of Jaffna has previous experience of being displaced (as a result of conflict), our area was better prepared to support those affected. Local people said they know first-hand that when you are displaced you need not only donations of rice but also donations of a pot to cook it in, water to boil and fuel for the fire. Previous traumatic experiences due to war may also have made the population more resilient. Local traditional healers and religious communities already had experience of helping people who have suffered traumatic experiences. The combined effects of resilience resulting from previous trauma and quickly mobilised community psychosocial programmes may have prevented some from developing problems needing referral to hospital-level psychiatric services. However, some people may have suffered without appropriate psychiatric support, because of a perception that they *should* be resilient and not seek help, or because they mislabelled their symptoms as 'normal'.

The widespread availability of community psychosocial support may also have prevented some from accessing appropriate psychiatric support for their mental health problems. We had concerns that some organisations offering to provide psychosocial support had insufficiently trained staff, who may have struggled to identify mental health problems. People themselves may not be aware that they have problems that could be helped by psychiatric services. In response to these concerns, the Task Force continues to offer education on how to identify people with severe difficulties, and where to refer for appropriate help, as well as awareness-raising sessions in the community.

Despite the amount of time that has passed since the tsunami, very little rebuilding has begun in the north, and many people are still displaced. Political concerns have led to a block in the distribution of aid, resulting in many projects being delayed. There is a perceived unfairness in the aid system, as those who are most affected struggle to access the support

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available. This situation increases the suffering of the affected people and could mean fewer people with psychiatric problems present to the psychiatric service, as they are preoccupied with the day-to-day practical issues of re-establishing their homes and livelihoods.

Since the tsunami, some services (particularly community-based programmes) have been diverted to the tsunami-affected areas, and away from areas which have a high level of psychosocial need as a result of other factors, including poverty and conflict.

Looking to the future, we may yet see more psychiatric disorders emerging as a result of the tsunami, causing increased demand on already overstretched services, but the needs of those affected by the tsunami must be balanced and integrated with those of the rest of the population. The past year has seen unprecedented attention given to mental health by the Sri Lankan government, media and public. We hope this will provide an opportunity for Sri Lanka to

reinforce and restructure mental health services for the benefit of the whole population.

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THEMATIC PAPER – NATURAL DISASTERS AND THEIR AFTERMATH

Different disasters, different needs

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With the tsunami ... numerous families lost more than one member. Indeed, in some instances, not altogether rare, just a single member survived. The needs of such special survivors are not addressed adequately in the usual responses to disasters.

Different kinds of disaster create dissimilar conditions for survivors, and the specific realities associated with each must guide our helping responses. This in no way negates the importance of having general principles to follow in responding to major disasters (Sphere Project, 2004; van Ommeren *et al*, 2005).

For instance, many of the families who lost one or more members in the tsunami that hit Sri Lanka in December 2004 also lost their homes, the rest of the community infrastructure and virtually all their belongings, but they lived alongside others similarly affected. Their experiences are of a different kind altogether from, for example, those who lost loved ones in the terrorist attacks in the United States on 11 September 2001 – many of whom were geographically distant and for whom the physical infrastructure was mostly intact (Roxane *et al*, 2002; Simeon *et al*, 2003). Reactions against the presumed perpetrator, too, are of contrasting kinds in the two examples. Extreme anger and hostility are commonplace in disasters engineered by humans but virtually impermissible when the disaster is classed as an 'act of God'. These and other factors lead to major differences in what happens, and what we need to do, after any particular disaster.

I set out below some developments following the tsunami-related havoc in Sri Lanka which point to specific needs associated with disasters of this kind.

Direct destruction affected whole families and communities

Some disasters claim individual victims from any one family or social network. An example would be a terrorist bomb blast on a tube train, as happened in London in July 2005. Each bereaved family then usually has to respond to the loss of a single relative. With the tsunami, in contrast, numerous families lost more than one member. Indeed, in some instances, not altogether rare, just a single member survived. The needs of such special survivors are not addressed adequately in the usual responses to disasters. Their psychological needs are generally a later consideration in our formal planned responses.

There is perhaps a need to question the widespread acceptance of the benefits of medications and psychological intervention to facilitate emotional ventilation and cognitive adjustment among those affected by severe trauma (de Vries, 1998; Pupavac,

2001; International Federation of Red Cross and Red Crescent Societies, 2001; Davidson, 2002; Rose *et al*, 2002; Alexander, 2005). The emotional support required urgently by the single survivor of a family battered by the tsunami was not at all of this kind. This person mostly needed just human contact. In massive destruction that wipes away 'natural' helpers, others have to step in. Our guidelines must emphasise that, in the wake of huge destruction, there will be isolated survivors who need urgent psychological help. The urgent help required, though, is simply to have a consistent and caring human being simply 'to be there', to hold or hug. This is rather more basic than what is called 'psychological first aid' (Sphere Project, 2004). Normal human contact is the most important psychological support – and this fact becomes evident only when its natural providers have all been wiped out.

The best longer-term path for the isolated survivor is not very clear either. Our tested strategies for helping people adjust and resume their previous lives, having come to terms with the loss, need not be the exclusive model on which to base interventions. Some victims may have benefited from being given room to consider starting altogether new lives by making this option part of the overt agenda and by creating the means of facilitating it. Several children had the opportunity to embark on entirely new lives, although through processes not within their control, while adults had to sit tight and adjust. The perception that starting anew reflects an unhealthy escape from proper grieving probably contributes to this avenue not being encouraged for adults.

Wide scale and range of destruction

The destruction of natural sources of help and comfort was the major impediment to a rapid and smooth transition into a recovery mode. Absence of family members was an obvious impediment to recovery. However, the absence of key staff and facilities also hampered helping responses. The local family health worker, too, may have, for example, suffered the loss of a family member or home. When plans are formulated to utilise staff in the affected areas, it is worth remembering that some of them may be unavailable or not in a fit state to participate in relief efforts.

Normal facilities, which are essential for the delivery of relief and other helping services, also form a basis for psychological recovery. School education was rapidly restored after the tsunami, often in alternative locations. This was a strong symbol of a return of normality – especially for the displaced still living in makeshift camps. There was, however, a delay in the return of other routines that could have implied a return to normality, such as going out to work and doing household tasks such as cooking and cleaning. Getting their children off to school was, for quite some time, the only regular meaningful function for many families – especially for those displaced and

living in camps. Creating space and opportunities for as many normal routines as possible is an important ingredient in community and family adjustment.

Understanding psychological needs and adjustment

A woman who lost a child in the tsunami may often have had the survival of a remaining child, and of herself, to contend with immediately. The struggle to keep a surviving child alive probably serves to sweep away, temporarily, the classical reactions of numbness, denial, anger and even depression. What are swept away for the moment may return, to haunt, when conditions permit. On the other hand, they may not resurface at all.

Some of us may not want to believe that grief can somehow be bypassed, preferring instead the notion that these allegedly suppressed emotions must at some later stage be exorcised for complete comfort to reign. We try to allow, and perhaps even encourage, victims to ventilate and work through unhealthily suppressed emotions. How much of this need is that of the therapist or helper, as opposed to that of the victim, deserves more study.

Those directly affected can contribute to our understanding of people's reactions to loss and trauma. One aspect of this is the extent to which our grief is modulated by unavoidable involvement with life. Ensuring food, shelter and protection for surviving children is too pressing a task to allow distraction by grief for a child who has just died. An extreme conclusion from this would be that grief as we know it is a luxury permitted only to those who have the time and energy to spare. However, less extreme conclusions are worth exploring for their potential implications. Grief in animals in the wild is remarkably short-lived. Instances of profound and lasting grief, on the other hand, are recorded in domesticated animals, especially dogs.

Another lesson is the assuaging impact of seeing massive suffering right beside one's own. It may not be particularly useful, in trying to console a troubled client at a clinic, to point out that others have undergone similar bad experiences, but it is quite another matter to see others' suffering at first hand. When people devastated by the tsunami were crowded together with others in a similar condition, it appeared to have somehow made things easier to process. Many group treatments work by helping people share and learn from others with similar experiences. In adjustment after the tsunami, this happened in real life. The lesson is that helping services should actively encourage, or at the least allow, communal healing to work – rather than restricting themselves to models based on individual client-centred work.

Fear of recurrence

A characteristic associated particularly with the tsunami type of disaster was the continuous fear that

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People who have been 'officials' all their lives may especially need guidance on how they should deal with powerless victims of disaster.

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another wave was in the offing. Panic-driven fleeing from the coast happened several times, set off by local false alarms as well as news of further quakes in the sea off Sumatra. In a few instances the mass media, too, with newly found concern for minimising harm from approaching tsunamis, fanned fears without good reason. Everybody was keen to ensure that they could not be accused of negligently failing to raise the alarm.

A tsunami affords scope for adequate early warning, to give people time to move to safety. In such circumstances a single designated agency that gives authoritative information is a great asset. Needless instances of dreadful panic-stricken fleeing could have been forestalled had we anticipated this occurrence and set up the means for people to recognise the real from the mythical next giant wave.

Spontaneous v. organised helping responses

The immediate reaction of most people in the rest of the country, on first hearing news of the tsunami, was to rush to help in whatever way they could. A few, though, did seek to loot, plunder and exploit the vulnerable. The spontaneous public response managed admirably to ensure the survival and comfort of the vast numbers who were distraught, dispossessed and at risk of death or serious harm. There were no reports of anybody dying or suffering injury, infection, or even serious hunger or thirst after the first few hours, although in a few places women or girls were molested in the first day or two. 'People action', including that of medical volunteers, overall did a splendid job of ensuring the safety and survival of thousands at high risk.

The authorities moved in after things became more settled. Spontaneous humanitarian responses would gradually have dwindled and there was a need for this more systematic provision of materials, facilities and services. Many of those who felt insecure began to feel safer, but some of those who were making good progress by themselves probably began to feel restricted. A necessary consequence of the formal systems taking over was the shift of power away from the citizen to the official.

Having control over one's circumstances is an essential element of well-being. Control, even over their day-to-day lives, is hard to generate among people who are bereft of virtually all possessions. Helpers must then try extra hard to optimise autonomy.

People who have been 'officials' all their lives may especially need guidance on how they should deal with powerless victims of disaster. Two sources of potential authoritarianism have to be addressed. One is the stance generally adopted by some officials towards members of the supplicant public, simply from habit. The other is the unavoidable inattention to individual needs and sensitivities by people charged

with the pressing task of providing essentials for the many. Efforts to moderate such tendencies in oneself and others would not go amiss. A brief session or two, say, to discuss how to deal with 'disaster victims' may be useful.

Health professionals, particularly mental health professionals, should not just see their role as helpers of traumatised individuals but recognise also their public health duty.

Order v. disorder

The time of initial disorder was disastrous for some. Stories circulated of women being molested and people fighting over meagre supplies. The nastiest examples were reported from highly disorganised settings. There were at the same time reports of sublimely selfless responses.

Some groups of displaced persons managed quickly to secure a system and order for their group, based on need and fairness. Such groups fared much better than those in which individuals and families were left to their own devices in the struggle for survival. Communally imposed order was accompanied by autonomy, with people collectively taking control of their situation, long before outside authority became established. Suffering was greatly mitigated in such settings. External authority was, however, life-saving when it established order in settings where the 'law of the jungle' had operated.

In approaching displaced groups and communities, government and non-government agencies would do well to modify their helping strategy according to the situation at hand. In communities with a high degree of collective responsibility, fairness and order, outside helpers must facilitate rather than replace the nascent efforts within. In others, they must first strive to create the necessary community processes.

Conclusion

Victims of the tsunami had their specific profile of characteristics. These included the loss of most anchors and normal routines, exposure to the real threat of a repetition of the onslaught, being in groups that shared similar traumas, not having opportunities to grieve in the ongoing struggle for survival, and being robbed of autonomy. Each of these has a strong bearing on how people respond and what others need to do to optimise adjustment.

Recommendations

- Include, in general guidelines on responding to disasters, a paragraph or two on the special features of different classes of disaster, with suggested specific responses in each. Examples relevant to the tsunami have been discussed above.
- Consciously review the degree of autonomy available to those affected and ensure that all feasible

means to increase it are sought and pursued. This requires taking authority away from government and non-government agencies outside the community and placing it, to the maximum feasible extent, in the hands of those allegedly being helped.

- Facilitate the meaningful participation of the entire displaced (or otherwise affected) community in mutual support and reconstruction efforts. Look out for people being excluded.
- Include appropriate mental health considerations in the relief effort from the immediate aftermath onwards. Hardly any of the relevant public health promotional measures require expertise in client-centred psychological help.
- Review the applicability to populations collectively exposed to major disasters of models for understanding grieving that have been derived from those surviving in very different circumstances. Grief reactions seen in more ordinary circumstances are modified here by two peculiar influences. First is the desperate struggle, at the same time as loved ones are lost, to ensure survival of those still alive. The forced and unremitting exposure to many others similarly affected is the second.

Mental health professionals must contribute to decisions on what will be optimal with regard to each

of these and to the delivery of what such an analysis yields. This will at times call for much patience and determination.

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Hardly any of the relevant public health promotional measures require expertise in client-centred psychological help.

COUNTRY PROFILE

Psychiatry in the Republic of Belarus

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The Republic of Belarus (ROB) covers 207 600 km² and has a population of about 10 million (Ministry of Statistics and Analysis, 2005). It was a member state of the former Soviet Union until it gained independence in 1991. Belarus is located between Poland, Lithuania and Latvia in the west, Russia in the east, and Ukraine in the south. Seventy-two per cent of the population live in an urban environment and 28% in rural areas. The average life span for men is 63 years and for women 75 years (Ministry of Public Health, 2005).

Mental health policies and programmes

Historically, psychiatry in the ROB has been strongly influenced by the classical Russian–German school of thought. This implied a biologically oriented approach and an emphasis on hospital in-patient treatment. Over the past 10 years there has been a dramatic shift in ideology, views, priorities, legislation and care models in psychiatry in several former Soviet republics. Many of these countries have welcomed modern

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In accordance with mental health legislation, people with schizophrenia, epilepsy, bipolar affective disorder and other psychiatric illnesses must receive their medication free of charge.

The Ministry of Public Health has made it a requirement that every person diagnosed with a mental disorder is put on a register. Some employers may require a certificate from job applicants to demonstrate that they are not on this register before they consider hiring them.

Anglo-Saxon approaches to mental health, but have implemented them to varying degrees. In the ROB, ICD-10 (World Health Organization, 1992) was officially introduced in 2002.

Mental healthcare is provided by the Health Service under the auspices of the Ministry of Public Health. The Health Service is funded by the state through general taxation. The country is in the World Bank's lower-middle-income group. The proportion of gross domestic product allocated to the health budget is 5.6%. The per capita total expenditure on health is \$464 (all prices here are reported in international dollars, i.e. after adjustment for purchasing power parity), and the per capita government expenditure on health is \$402 (World Health Organization, 2005).

There is no private psychiatric system and the state provides psychiatric care free of charge. Psychotropic drugs have increasingly been used since the early 1960s and are the main component of treatment today. In accordance with mental health legislation, people with schizophrenia, epilepsy, bipolar affective disorder and other psychiatric illnesses must receive their medication free of charge. For example, typical antipsychotics and some early atypicals, such as clozapine and sulpiride, are widely and freely available to patients. In recent years, one of the second-generation antipsychotics, risperidone, has also become available.

Mental health policy is set out annually by the Chief Psychiatrist at the Ministry of Public Health. For a few years now, a bio-psychosocial model and multidisciplinary teamwork have been advocated, as well as deinstitutionalisation and the development of community-based mental healthcare. However, in practice, the only component that has been realised so far is a substantial reduction in the number of psychiatric beds. The system of psychiatric care none the less remains highly centralised, with often large psychiatric hospitals and almost undeveloped social and community mental health services.

The first port of call for people with mental health problems is the so-called regional dispensary, where predominantly out-patient primary psychiatric care is provided by psychiatrists and psychiatric nurses. Patients receive counselling, are prescribed psychotropic medication or are referred for admission to the hospital. Some dispensaries have a few in-patient beds and some provide ambulatory psychotherapy. In addition, there are also specific dispensaries for children and adolescents, and for people with drug or alcohol addiction.

In-patient care

There are 14 general psychiatric hospitals, nine psychiatric departments at general medical hospitals, and six in-patient wards in dispensaries. There are 7225 beds available to psychiatric patients, of which 405 are for children. In addition, there are 1285 beds for addiction treatment. Over the past 5 years, the total number of beds has been reduced by about 30%

(Ministry of Public Health, 2005). The State Mental Hospital in Minsk (the ROB's capital) is the largest general psychiatric hospital, with almost 2000 beds.

Day care

An intermediate type of psychiatric care is provided at day hospitals. Usually, this day care takes place on a special ward of a general psychiatric hospital or at a psychiatric dispensary. The patients come in the morning, receive their medications, participate in occupational therapy and return home in the evening.

Out-patient care

Out-patient psychiatric care is predominantly provided at psychiatric dispensaries by a psychiatrist and a nurse. They are located in cities and towns and cater for a geographically defined catchment area. In addition, some patients who attend the out-patient clinic are occasionally visited at home.

Long-term care institutions

Institutional care is under the auspices of the Ministry of Social Welfare. People with a chronic mental illness and people with learning disabilities are accommodated in special institutions. The standard of care and comfort is poor.

Mental health legislation

In 1999 the Mental Healthcare and Civil Rights Guarantee Law, inspired by its Russian equivalent, was adopted. This law stipulates that mental healthcare is guaranteed by the state and based upon the principles of law. It is voluntary and provided free of charge. Diagnoses are made in accordance with ICD-10. Treatment can be started only after written informed consent has been obtained from the patient.

Compulsory admissions of patients with mental disorders who pose a risk to themselves or others are overseen by local courts. These should be dealt with within 3 days of admission, but there is a significant delay in court procedures and patients are often well and fit to be discharged, or competent to consent to treatment, by the time the court attends to their case. Assessments are performed by at least three psychiatrists. Patients have the right to appeal at any time.

In addition, the Ministry of Public Health has made it a requirement that every person diagnosed with a mental disorder is put on a register. Some employers may require a certificate from job applicants to demonstrate that they are not on this register before they consider hiring them. Also, when a person on the register commits an offence a forensic psychiatric assessment is mandatory.

Manpower and psychiatric associations

In 2004, the incidence of mental disorders was 53 931 and the overall number of people registered

at psychiatric services reached 227 300. In the same year, there were 1073 psychiatrists (of whom 328 worked in addiction treatment settings), 162 psychotherapists, 10 clinical psychologists and 7 sexologists (Ministry of Public Health, 2005). There are no statistics concerning the number of psychiatric nurses.

In the State Mental Hospital in Minsk there are about 85 psychiatrists. Typically, two would be responsible for wards containing 50–60 patients. A typical psychiatrist in a dispensary would see more than 5000 patients per year (Ministry of Public Health, 2005).

The Belarusian Psychiatric Association (BPA) was created in 1996; it is a member of the World Psychiatric Association. The BPA initiated the drafting of the Mental Healthcare and Civil Rights Guarantee Law (see above) and implemented it in psychiatric practice. It drives all innovations in education and professional development and clinical practice. The vast majority of psychiatrists hold membership, for a small annual fee.

Mental health training

Psychiatrists

It takes 6 years to get a medical degree. There are 12 semesters of 5 months each and 6 weeks of clinical training in the summer. Only the very basics of psychiatry are taught during medical school. This leads to poor psychiatric knowledge among non-psychiatrists, to whom people with mental health problems may present for the first time. To qualify as a psychiatrist takes only 1 year of training in a psychiatric hospital. This 1-year training programme includes a full-time 3-month theoretical course in psychiatry, organised by the Belarusian Medical Academy for Postgraduate Training. At the end of this 1-year programme, trainees have to pass a theory and practical examination before they can start practising independently. Every psychiatrist is required to attend a 2-week refresher course at least once a year.

Child and adolescent psychiatrists

A division for child and adolescent psychiatry and psychotherapy is being developed at the Belarusian Medical Academy for Postgraduate Training (the project began at the end of 2005). It is envisaged that training will be similar to that for general adult psychiatrists. Previously, people working in this field were general psychiatrists who had gained practical experience in child and adolescent psychiatry or psychotherapy.

Psychiatric nurses

Any generally trained nurse can work in a psychiatric hospital: there is no specific training for psychiatric nurses, nor are there any particular requirements to work in a mental health setting. However, when they

have been working in a psychiatric setting for 3 years, they have to attend a 2-week course in psychiatry.

Clinical psychologists

Before 1994, psychology training did not involve clinical or psychotherapeutic components. Therefore, most psychologists in clinical posts perform only psycho-diagnostic testing. In 1994, the first faculty of clinical psychology was established, at Hrodno State Medical University. Since 2001, it has produced 30 clinical psychologists per year with advanced knowledge of clinical psychology and psychiatry.

Research

There has been some participation in a few international projects, such as the Collaborative Study on Alcohol and Injuries by the World Health Organization (2001), but in general research activity has been sparse.

Human rights

The Mental Healthcare and Civil Rights Guarantee Law states that mental healthcare should be provided by the state on observance of the principles of law, humanity and human rights. It explicitly stipulates that no one can have his or her civil rights restricted solely on the basis of having a mental illness, being on the register or living in a long-term care institution. It also states that methods of treatment should be used only with diagnostic and curative intentions and cannot be applied for punishment.

Conclusions

Psychiatry in the ROB has undergone major changes in the past decade. Modern mental health legislation has been implemented and deinstitutionalisation has been pursued. However, the latter has not been matched by the implementation of adequate community mental health services. Further development of professional training and research to underpin evidence-based practice are urgently needed.

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Psychiatry in Papua New Guinea

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Although Papua New Guinea has less than 0.1% of the world's population, it is home to over 10% of the world's languages.

Apart from clinical services, mental health services available to the public include mental health talks to schools as part of the 'healthy schools programme', radio broadcasts on mental health issues and a weekly mental health column in one of the daily newspapers.

Papua New Guinea is an independent commonwealth in the South Pacific, lying just north of Australia and sharing its western border with Indonesia. The population of Papua New Guinea is 5.2 million, of whom 87% live in rural areas (2000 census) (National Statistics Office, 2003). The country has a very rich culture; for example, there are over 800 distinct language groups (although Papua New Guinea has less than 0.1% of the world's population, it is home to over 10% of the world's languages).

Administratively, Papua New Guinea is divided into four regions, which are further divided into a total of 20 provinces. The capital city is Port Moresby. Travel between the capital city and the provinces is generally by air, since Papua New Guinea's limited road network does not connect all the provinces to one another.

The gross national income is US\$580 per capita and the government spends 7% of its total budget on health (UNICEF, 2006). Only 0.7% of the total health budget is spent on mental health (World Health Organization, 2005).

Health indicators

The average national infant mortality rate is 82.2/1000 live births for males and 72.2/1000 for females, while the maternal mortality ratio is a horrific 370/100000 live births (National Statistics Office, 2003). There are, however, wide provincial variations. Life expectancy at birth is 56 years (UNICEF, 2006). The doctor: population ratio is currently about 1:11000, but disproportionately more doctors work in the urban areas than in the rural areas. The nurse:population ratio is 1:400.

Mental health resources and services

Public psychiatric services fall under the Social Change and Mental Health section of the Division of Curative Services within the National Department of Health. The resources in terms of facilities and manpower at the different care levels are summarised in Table 1. There are only five psychiatrists practising in the country, giving a national ratio of 1 per 1000000, but since all the psychiatrists are in the capital city, the true ratio is 1 psychiatrist for every 70000 people in the city and zero for the rest of the country. The number of psychiatric nurses per 100000 population is 0.09

and the number of social workers per 100000 population is 0.04 (World Health Organization, 2005). The number of psychiatric beds per 10000 population is 0.24, of which 0.17 per 10000 are in the sole mental hospital and 0.07 per 10000 are in the general hospitals (World Health Organization, 2005).

The commonest psychiatric conditions treated at out-patient level are depression and anxiety disorders. The commonest causes of admission are psychotic illnesses, mostly schizophrenia, bipolar disorder and cannabis-induced psychosis. Nearly all patients admitted with cannabis-induced psychosis are men under the age of 30 years. Papua New Guinea does not (at least as yet) have a problem with hard drugs such as heroin.

There are at present no private psychiatrists, no private psychiatric hospitals and no clinical psychologists in the country. Neither are there any neurologists, although there is one neurosurgeon.

There are no community-based services for people who are mentally ill. Patients in the community are looked after by their families.

Apart from clinical services, mental health services available to the public include mental health talks to schools as part of the 'healthy schools programme', radio broadcasts on mental health issues and a weekly mental health column in one of the daily newspapers. World Mental Health Day is celebrated publicly every year in several provinces; in addition to this, the mental health services are represented at the annual 'Health Expo' in the capital city. Posters and leaflets explaining mental health issues are distributed to the public free of charge at such venues. The public's response to these services has always been very encouraging.

Mental health policy

The goal of the mental health programme is to improve access to mental health services at provincial and district levels and to improve the capacity at community level to support and maintain patient care and rehabilitation (Ministry of Health, 2000). This is to be achieved by 2010 through the following strategies (Ministry of Health, 2000):

- psychiatric patient care and treatment shall be free of charge
- Laloki Psychiatric Hospital shall remain the national referral centre
- four referral and supervising units shall be established at regional level

- psychiatric units shall be established at all provincial public hospitals
- all physicians caring for adult patients in public hospitals shall be responsible for hospital-based psychiatric units in the absence of psychiatrists
- community-based treatment and rehabilitation shall be established and supported.

psychiatry from the second year to the final (fifth) year of their MBBS course. During the final year, students undergo a 4-week rotation in psychiatry.

Postgraduate specialisation

The medical school offers a 4-year degree course (Master of Medicine in Psychiatry, MMed), but psychiatry is a less popular career choice than other disciplines. All the students are required to write a research-based thesis. Students also spend several months of their third year attached to a psychiatric unit in Australia in order to gain exposure to psychiatry in a setting other than Papua New Guinea.

Psychiatric nurses

In order to specialise in psychiatry, nurses need to undergo a 1-year postgraduate degree course at the medical school.

Other health workers

Regular mental health workshops are held every 2 years to provide basic mental health training to non-specialists from all over the country to help them manage psychiatric patients. In addition to this, regular VHF radio sessions are broadcast live to all parts of the country, including remote health facilities. The facilitator teaches the topic for that session and health workers participate live and raise questions or seek advice about specific clinical cases. This has been found to be a very convenient and effective way of reaching health workers in remote areas.

Students also spend several months of their third year attached to a psychiatric unit in Australia in order to gain exposure to psychiatry in a setting other than Papua New Guinea.

Legislation

Mental health legislation in Papua New Guinea dates back to the Insanity Ordinance of 1912. This was superseded by the Mental Disorders and Treatment Ordinance of 1960. The latter was annulled in 1997 and replaced with a subsidiary chapter (no. 226) of the Public Health Act known as the Public Health (Mental Disorders) Regulation. This is the current mental health legislation in Papua New Guinea, but a review of the legislation is underway to make it more relevant to the mental health needs of 21st-century Papua New Guinea.

Training

Undergraduate medical students

There is one medical school in the country, the School of Medicine and Health Sciences of the University of Papua New Guinea, in Port Moresby. The undergraduate curriculum is based on the problem-based learning (PBL) approach and students are exposed to

Table 1 Mental health facilities at different healthcare levels in Papua New Guinea

Level	Facilities	Staffing	Services offered
Tertiary (capital city)	60-bed Laloki Psychiatric Hospital	2 psychiatrists ^a 12 psychiatric nurses 29 other general clinical health workers	Long-stay care Forensic services
	16-bed psychiatric ward within Port Moresby General Hospital, the national teaching and referral hospital	4 psychiatrists ^a 6 psychiatric nurses 7 other general clinical health workers	Acute in-patient care Occupational therapy Out-patient clinics
	Family Support Centre within Port Moresby General Hospital, the national teaching and referral hospital	Social workers 1 psychiatrist ^a Other doctors and nurses Other non-medical agencies	One-stop centre for trauma counselling, child abuse counselling, crisis management, paralegal support and information, overnight emergency accommodation for victims of violence or abuse, liaison with other agencies
	Rehabilitation Centre	1 psychiatrist ^a 2 psychiatric nurses 1 social worker	Day care Rehabilitation Occupational therapy Family support group
Secondary (provincial hospitals)	Psychiatric wards in only two provincial hospitals Most provincial hospitals have only psychiatric clinics	Psychiatric nurses ^b in some hospitals Community health workers Other general health workers Visits once or twice a year by psychiatrists Physicians responsible when psychiatrist is absent	In-patient care where there are units; otherwise, only out-patient clinics Referral to Laloki for admission
Primary (district health centres and below)	No psychiatric wards No psychiatric clinics	General nurses Other general health workers	Minimal out-patient care Referral to provincial hospitals

^aSome psychiatrists work in more than one place: the country has only five practising psychiatrists.

^bPsychiatric nurses are often deployed in non-psychiatric sections.

Cannabis grows readily in the highlands of Papua New Guinea and the number of patients with cannabis-related psychosis has risen greatly over the past 15 years as the cultivation of the plant has increased, both for local consumption and as a cash crop to be smuggled into Australia in exchange for guns, which are then used in tribal fights.

Research

Earlier research in psychiatry, for example by the pioneering psychiatrist Burton-Bradley (1973), identified common forms of mental illness in the country and elicited the public's views about the aetiology of mental illness (often attributed to sorcery). Later research confirmed the occurrence of substance misuse (Johnson, 1991), post-traumatic stress disorder (Johnson, 1989) and so on. However, despite the requirement for all MMed students to carry out research as part of their training, most make no attempt to get their work published after qualifying. As a result, there is still a dearth of research in psychiatry in Papua New Guinea.

Professional groups

The Papua New Guinea Psychiatric Association comprises all psychiatrists and psychiatric registrars in the country – a total of 11 members.

Non-governmental organisations

The Mental Health Foundation is a non-governmental organisation that provides support to people who are mentally ill, for example through donations.

The Family Support Group comprises carers of patients with a mental illness who are attending the Rehabilitation Centre. Their functions include education, mutual support, advocacy, fundraising and so on.

Challenges

The challenges include a shortage of trained staff, frequent shortages of basic psychiatric drugs, the absence

of in-patient facilities at the provincial level and an increase in substance misuse, especially cannabis. Cannabis grows readily in the highlands of Papua New Guinea and the number of patients with cannabis-related psychosis has risen greatly over the past 15 years as the cultivation of the plant has increased, both for local consumption and as a cash crop to be smuggled into Australia in exchange for guns, which are then used in tribal fights.

Traditional beliefs about mental illness (e.g. sorcery) also hinder some patients from accessing services or adhering to the treatment prescribed.

An inadequate road network means that patients who need referral to the only psychiatric hospital but who are too disturbed to fly are frequently held not in general hospitals but in local police cells as the only available secure place. They are held until they are stable enough to be transferred by commercial aircraft without posing a risk to others on board.

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COUNTRY PROFILE

Psychiatry in Bangladesh

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The People's Republic of Bangladesh is located in South Asia. The total land area of Bangladesh is 147 570 km². Its total population in 2001 was about 123 million. The population growth rate is 1.47%; of the total population, 75% live in rural areas and 25% in urban areas (Bangladesh Bureau of Statistics, 2000).

Health indicators

Life expectancy at birth in 1998 was estimated to be 61 years for both sexes. The infant mortality rate was 57 per 1000 live births in 1998. The number of hospital beds is 43 143 and the number of registered physicians is 30 869 (Bangladesh Bureau of Statistics, 2000).

History of psychiatric services in Bangladesh

In what is now Bangladesh, there were no mental health facilities until 1947, when India was divided. (Psychiatric patients had to go to the Central European Asylum in Ranchi, which was too far away for many people.) In that situation the government (of what was then East Pakistan) decided to establish a mental hospital, and in 1957 one was opened in Pabna, a district town 175 km from the capital, Dhaka. Initially it was a 50-bed hospital, but it grew to become today a 500-bed hospital. In 1974 Dhaka Medical College introduced a mental health service. This service was then extended to the Institute of Postgraduate Medicine and Research (now Bangabhandu Sheikh Mujib Medical University, BSMMU) and other medical colleges, as well as to the Institute of Mental Health and Research. This service included both out-patient and in-patient departments. At present, all 13 government medical colleges and hospitals and some of the non-government medical college hospitals provide psychiatric services, both out-patient and in-patient.

Prevalence of psychiatric disorder

Psychiatric disorder is common in Bangladesh, as in any other country, but the psychiatric service at present is confined to Pabna Mental Hospital, the Institute of Mental Health, the BSMMU and the medical college hospitals (Islam *et al*, 1993). Although the results of a recent national survey of psychiatric morbidity are yet to be published, the evidence from smaller surveys suggests that psychiatric disorder is prevalent in both the urban and rural communities. In a survey of the rural population of Dasherbandi (a village near Dhaka) it was found that 29 per 1000 people suffered from psychiatric disorder, and an additional 36 per 1000 had both a psychiatric and a physical disorder (Chowdhury *et al*, 1981).

In another study it was found that 29% of patients seen in a medical general practice during the course of 1 year were suffering from a purely psychological or emotional disorder (Alam, 1978).

At the medical out-patient department of the Institute of Postgraduate Medical Research, it was found that 31% of patients had a purely psychological condition and an additional 15% had a condition with both organic and psychogenic features (Chowdhury *et al*, 1975).

In a study of 600 patients attending a psychiatric clinic in Chittagong city, schizophrenia and affective disorder were found in 30% and 25% of patients, respectively. Neurosis and personality disorder in combination were found in 30%. Organic disorder and learning disabilities were found in 7% and 3% respectively (Ahmed, 1978).

Medical education

Undergraduate education

Psychiatry is included in the undergraduate curriculum. The course comprises 15 lectures (1 hour each) and 15 days of clinical clerkship in the fourth-year MBBS class, which is mandatory for all students. In the MBBS, 12.5% of marks are allotted to mental health in the written final examination.

Postgraduate education

Postgraduate courses in Bangladesh include fellowship and membership of the Bangladesh College of Physicians and Surgeons (FCPS and MCPS), master of philosophy (MPhil) and doctor of medicine (MD). The FCPS course is run by an autonomous body following the curriculum of the MRCPsych. It has part I and part II examinations and also requires 2 years of full-time clinical experience. There have been 34 fellows to date. The MD course is run by the BSMMU. It has had one successful student complete the course and another 11 are currently taking it. The MD is a 5-year course, which includes 3 years of training. The MPhil course is run by both the BSMMU and Sylhet MAG Osmani Medical College. It is a 3-year course, including 1 year of residential training. So far 25 students have gained the MPhil and 18 students are presently on the course. At the end of both the MD and the MPhil courses, students have to submit a thesis, and FCPS students have to submit a dissertation.

Training

The BSMMU, the Institute of Mental Health and Research and the 13 government-run medical colleges provide postgraduate training in psychiatry. Doctors interested in psychiatry work as 'indoor' medical officers, assistant registrars or honorary medical officers. The institutes do not pay the non-government doctors, who work as honorary medical officers. The training is full time and residential.

Child psychiatry

Child psychiatry has not been developed in Bangladesh, although there is a child psychiatry wing at the BSMMU and another child psychiatry department at the Institute of Mental Health and Research. The country has only three psychiatrists trained (abroad) in child psychiatry.

Psychotherapy

Psychotherapy (which is still in a rudimentary state) is mostly done by psychiatrists. In the University of Dhaka there is a clinical psychology department. Students are trained in psychotherapy at the psychiatry department of the BSMMU.

Doctors interested in psychiatry work as 'indoor' medical officers, assistant registrars or honorary medical officers. The institutes do not pay the non-government doctors, who work as honorary medical officers. The training is full time and residential.

Research

Research is mainly epidemiological, although some research into different disorders and on drug misuse, suicide and child psychiatry is ongoing. The Bangladesh Association of Psychiatrists publishes journals.

Mental health professionals

There are 73 psychiatrists nationally. The Institute of Mental Health and Research is training medical graduates and primary health workers throughout the country. In total, 2048 doctors and some 4000 health workers have been trained in psychiatry.

Mental health services in Bangladesh

As the number of psychiatrists is low relative to the size of the population, psychiatric patients are taken care of by psychiatrists, doctors trained in psychiatry, doctors practising relevant specialties and general practitioners. There is no formal referral system, although patients are referred by other health professionals to psychiatrists for proper management.

Many patients attend psychiatrists after 'referral' from people in their local community. Some patients are now referred to psychiatrists by traditional healers, faith healers and unqualified medical practitioners (so-called 'village doctors'). There are approximately 800 beds sanctioned for psychiatric patients in government hospitals. In non-government sectors, there are about 1000 psychiatric beds, most of which are occupied by drug misusers, whereas in the government sector people with a psychosis occupy almost all the beds. There is one government drug addiction treatment centre, with 75 beds, situated in Dhaka.

Doctors who have been trained in psychiatry work mostly in primary care centres. They are supposed to take care of the psychiatric patients in their areas, but there are no statistics regarding the patient care undertaken by these doctors. Also, there are no refresher courses for these trained doctors, so they are not in touch with recent advances in psychiatry.

Mental health legislation and policy

Still there is no mental health act in Bangladesh. The Indian Lunacy Act 1912 (modified in 1957 and 1973) is generally followed. A draft mental health policy has been formulated by the Ministry of Health in collaboration with the World Health Organization and the Bangladesh Association of Psychiatrists; this policy is presently at the Law Ministry for finalisation.

Human rights

As mentioned above, a large number of psychiatric patients receive treatment from traditional and faith healers, local religious leaders and practitioners of indigenous medicine. They believe that illness is related to supernatural influences, and so many patients are reluctant to consult practitioners of modern allopathic medicine. The non-medical healers are less concerned about the human rights of patients and people generally are not conscious of the proper rights of those with a mental disorder. In some special circumstances, for example when these patients are the focus of stories in the news media, then human rights activists often come forward to help them. Practising psychiatrists and the Association of Psychiatrists have very little influence in maintaining the human rights of psychiatric patients in the community, but in hospital settings psychiatric patients are treated as general patients.

Associations

There are two psychiatric associations: the Bangladesh Association of Psychiatrists (BAP), of which all psychiatrists practising in Bangladesh are members; and the Forum of Psychiatry, which has emerged only recently.

Overview

Education and services in psychiatry are gradually increasing, but still psychiatrists and psychiatric services tend to be available only in big cities. Most of the psychotropic medications are available in Bangladesh. On the other hand, psychotherapy is not widely available. Bangladesh lacks a mental health act. The BAP has been struggling to have an act passed and to expand psychiatric services in remote areas.

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There are approximately 800 beds sanctioned for psychiatric patients in government hospitals. In non-government sectors, there are about 1000 psychiatric beds, most of which are occupied by drug misusers, whereas in the government sector people with a psychosis occupy almost all the beds.

Use of South American plants for the treatment of neuropsychiatric disorders

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Two conditions greatly encourage the folk use of plants to cure diseases and alleviate ailments:

- plant biodiversity (the richer the better)
- particular cultural traits of local populations.

Where these conditions are met, local scientific advancement may result from experimentation with and elaboration of folk remedies. Unfortunately, little scientific research has been done on South American plants that may be useful in the treatment of central nervous system (CNS) disturbances.

The 13 countries of South America possess several ecosystems and a rich cultural diversity; the population is descended from pre-Colombian cultures (such as the Maya and Inca ancient civilisations), many other indigenous ethnic groups, African slaves and European colonisers. All these segments of the population have traditionally relied on plants to treat their ailments and had at their disposal a very rich flora. In fact, more than 50% of all plant species are concentrated in tropical forests, in which Brazil and Colombia are particularly rich. For example, taking into consideration only three out of the five main Brazilian ecosystems, it is estimated that nearly 8000 endemic species are present in Atlantic forest, 4400 in the Cerrado and nearly 30000 in the Amazon rain forest (including other South American countries) (Cunningham, 1996). Unfortunately, all this biological and cultural richness has led to only a meagre number of ethnopharmacological (preclinical, clinical and toxicological) research studies.

We scrutinised what research had been published through bibliographical surveys, conducted on databases such as LILACS (Literatura Latino-Americana e do Caribe em Ciências da Saúde) and Medline (PubMed). The keywords for the surveys were: SOUTH AMERICA, each one of its 13 countries and PLANTS or HERBS or EXTRACT or HERBAL or PHYTOTHERAPY and PRECLINICAL or CLINICAL or PHYTOCHEMICAL or PHARMACOLOGY or PHARMACOLOGICAL STUDIES. From the published studies retrieved, only those referring to psycholeptic and psychoanaleptic effects were selected, specifically: antidepressants, memory enhancers, stimulants, antiparkinsonian agents, hypnotics, anxiolytics, anticonvulsants and aphrodisiacs.

After that, another survey was carried out using the same databases, but this time excluding the terms SOUTH AMERICA and the countries. This permitted

us to obtain a similar set of data for all other areas of the world on plants that may have psycholeptic or psychoanaleptic properties. The results of these surveys are shown in Table 1. It may be seen that only 1.3% of world research on plants possibly possessing CNS activity was conducted with South American plants, despite the continent's rich flora.

Although several preclinical studies have been performed under adequate laboratory conditions, very few clinical studies have been carried out under double-blind randomised conditions. Furthermore, these clinical studies generally had a poorly defined patient population, used non-standard measures and had small sample sizes.

Plants tested pharmacologically or phytochemically

Banisteriopsis caapi and *Psychotria viridis*

Although there were 13 articles on the Medline database concerning the pharmacological and phytochemical properties of these species, they were not revealed in our literature search as they have hallucinogenic effects and the terms PSYCHODYSLEPTIC and HALLUCINOGEN were not included as keywords.

Ayahuasca is a beverage derived from these plants (Carlini, 2003; McKenna, 2004). It is consumed by certain Indians in the Amazon area (Brazil, Peru and Colombia) and by some religious cults in the cities of northern Brazil, and the practice is spreading to southern Brazilian cities and other countries.

Unfortunately, little scientific research has been done on South American plants that may be useful in the treatment of central nervous system (CNS) disturbances.

Table 1 Number of preclinical, clinical and phytochemical studies reported for some psychoanaleptic and psycholeptic effects of plants, by region of origin

Effect	South America				Other countries	Percentage South American
	Pre-clinical	Clinical	Phyto-chemical	Total		
Antidepressant	3	0	0	3	564	0.5
Memory	3	0	0	3	642	0.4
Stimulant	2	1	1	4	298	1.0
Antiparkinsonian	4	4	2	10	97	9.3
Hypnotics	14	1	1	16	1160	1.3
Anxiolytic	11	4	0	15	863	1.7
Anticonvulsant	8	0	0	8	969	0.8
Aphrodisiacs	2	1	0	3	46	6.1
Total	47	11	4	62	4639	1.3

After the introduction of reserpine, it was to be expected that other species from this genus would be a target for pharmacological investigation. However, with the exception of *R. canescens*, for which preclinical and clinical investigations have suggested a sedative effect, no other *Rauvolfia* species have been investigated in this way.

Ayahuasca is interesting as its pharmacological activity is dependent on a synergism between the two plants. *B. caapi* contains β -carboline alkaloids, mainly harmine and harmaline, whereas *P. viridis* has *N,N*-dimethyltryptamine (DMT) in it.

Rauvolfia serpentina

There were 63 articles on the Medline database concerning the pharmacological and phytochemical properties of this species (common name *sarpagandha*). Reserpine, an alkaloid isolated from *R. serpentina* during the middle of the 20th century, was an important clinical advance in the treatment of schizophrenia. According to the database of the Missouri Botanical Garden, consulted in 2004, there are at least 41 other species from this genus in South America, 17 of them belonging to the Brazilian flora.

After the introduction of reserpine, it was to be expected that other species from this genus would be a target for pharmacological investigation. However, with the exception of *R. canescens*, for which preclinical and clinical investigations have suggested a sedative effect, no other *Rauvolfia* species have been investigated in this way. Furthermore, only four other species have undergone some phytochemical investigation: *R. bahiensis*, *R. macrophylla*, *R. sellowii* and *R. tetraphylla*. In marked contrast, the Medline database refers to 308 studies performed with *Hypericum perforatum* (St John's wort), a plant from Europe with antidepressant properties.

Passiflora incarnata

Thirty articles were found on the Medline database concerning pharmacological and phytochemical studies of this species (common name *maracujá*, or passion flower) (Carlini, 2003). There are nearly 500 *Passiflora* species, most of them occurring in the tropical Americas; among them, *P. incarnata* has received most attention from the scientific community: there are dozens of studies dealing with its ethnopharmacology, as well as clinical and preclinical pharmacological studies. *P. incarnata* is commonly used in association with other species, including *Erythrina mulungu*, *Matricaria chamomilla* and *Valeriana officinalis*.

P. incarnata and other species of the same genus (*P. alata*, *P. coerulea*, *P. edulis*) are widely used in traditional medicine all over Europe and in the Americas for their seemingly sedative and anxiolytic properties.

Several compounds isolated from *Passiflora* species have been suggested as being responsible for the alleged anxiolytic/sedative effects; these include flavonoids (apigenin, vitexin, kampferol, homorientin, chrysin) and pyrone derivatives (malthol), but to date the active principles have not been identified.

Paullinia cupana* var. *sorbilis

Fifteen articles were found on Medline concerning the pharmacological and phytochemical studies of this species (common name *guaraná*) (Carlini, 2003). Found growing in the central region of the

Amazon basin and utilised in folk medicine for cases of physical and intellectual stress, the seeds of *guaraná* contain caffeine (2.5–5%) as well as theophylline and theobromine in small amounts; they also contain large quantities of tannins.

Through its methylxanthine content, *guaraná* is able, among other effects, to block adenosine receptors and to inhibit phosphodiesterase. Because of the latter effect, it enhances the actions of noradrenaline, which can be released from stores by plants containing ephedrine. Therefore, the existence of commercially available herbal mixtures containing ephedrine and *guaraná* as active ingredients is not surprising. One of the mixtures, in a randomised, double-blind, placebo-controlled study, effectively promoted weight loss and fat reduction of overweight men and women. Its effects were accompanied by stimulatory symptoms characteristic of ephedrine and caffeine.

Plants analysed only through ethnopharmacological studies

Plants employed by Colombian Indians for the treatment of senile dementia

Schultes (1993) recorded a total of 25 plants used by Colombian Indians for treatment of the signs and symptoms of senile dementia. In this sense, these 25 plants are administered mostly to older people, mainly those who have motor and mental disturbances. A bibliographical search carried out on the Medline and LILACS databases in 2004 revealed that none of these species had been studied from the pharmacological or phytochemical point of view, despite their undeniable therapeutic potential.

Plants employed by the Brazilian Krahô Indians and by the Quilombolas

A survey among the Krahô Indians (who live in the Cerrado ecosystem) revealed that 64 plants were used in ritual contexts for their seemingly psychoactive properties, including 14 used as anxiolytics, 10 as antidepressants or stimulants and 11 for sleep disorders (Rodrigues & Carlini, 2005). Similarly, work with a group of the Quilombolas (descendants of former African slaves, living in an isolated area of Brazil) revealed the use of 38 plants for the treatment of several CNS disturbances, including three for 'insanity', four as sedatives and another 11 for insomnia, and 11 to 'fortify' the brain (Rodrigues & Carlini, 2004).

Conclusion

It seems that South America possesses a treasury of plants. These have been little researched to date, and may harbour new therapies for psychiatric and neurological disturbances.

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POINT OF VIEW

Earthquake 2005: challenges for Pakistani psychiatry

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At 8.52 a.m. on 8 October 2005 an earthquake measuring 7.6 on the Richter scale struck the northern part of Pakistan and devastated large areas of North West Frontier Province and Azad Kashmir. Almost 90 000 people died and many thousands were reported missing. Half the dead were estimated to be children, killed in their classrooms. Some 3.5 million people were rendered homeless. The mountainous terrain made relief work a logistical nightmare.

Mental health issues in disasters

According to the World Health Organization (WHO), 3–4% of survivors are affected by severe mental disorders (psychosis, severe depression or anxiety), and up to 15% can be expected to suffer from mild to moderate mental disorders (Ashraf, 2005). In the context of Pakistan after the earthquake, this would mean between 120 000 and 160 000 in need of treatment for severe mental disorders and up to 600 000 for mild to moderate disorders. It was obvious that mental health services as they existed were grossly inadequate to deal with the scale of the disaster.

Why are mental health services so inadequate in Pakistan?

Pakistan is a country with huge contradictions. On the one hand, it is the sixth most populous country in the world (its population is approximately 150 million), one of the largest Muslim countries and a nuclear power. On the other hand, more than a third of its people live below the poverty line, the literacy rate is around 35% and its national health indicators make sorry reading. As in many other developing countries (Dyer, 2006), corruption has been one of the major impediments to progress. The lack of transparency and accountability coupled with poor governance has led to high failure rates for health initiatives in Pakistan.

Mental health services are poorly developed. Health spending is a pitiable 0.5–1% of gross national product. Mental health does not have a separate budget but is believed to account for 1% of the health budget. There is about 1 psychiatrist to 0.5–1 million of the population, but the distribution is unequal, as most psychiatrists are in large urban centres, while more than 70% of the population live in rural areas.

Government primary health services and the few psychiatric facilities are poorly organised and resourced and are accessed only by the very poor. Most healthcare is out-of-pocket expenditure, with the private sector contributing 77–90% nationally. On the other hand, community-based prevalence studies give very high figures for common mental disorders, with an estimated 25–66% of women and 10–40% of men suffering from them (Mumford *et al*, 2000).

Psychiatry and behavioural sciences are neither taught nor examined as a separate subject on the undergraduate medical curriculum in most medical colleges in Pakistan. Most graduating doctors, therefore, have little exposure to mental health issues.

Programmes galore

After the earthquake, many different psychological programmes were launched by a variety of organisations. Even the computer giant IBM, in collaboration with the Ministry of Social and Population Welfare, flew in two experts from the USA to conduct trauma management workshops. While all these organisations were well intentioned, there was little coordination between them. Some programmes focused only on post-traumatic stress disorder (PTSD), and others focused on generic counselling skills. Almost all the programmes had separate training manuals and teaching materials. The target audience was not clearly identified. In many cases the same people ended up in various workshops without any clear idea of how or where they were going to use their newly acquired

The author has been part of a team that has developed and conducted training of health professionals in primary care health centres in Kashmir and North West Frontier Province.

There were also questions regarding the ethics of conducting research on disaster survivors. How could it be ensured that survivors were not used as research guinea pigs?

The Pakistan Psychiatric Society, the country's main body of psychiatrists, which should and could have played a pivotal role in mental health activities following the earthquake, was marginalised.

skills. Some participants were in administrative positions and had very little contact with survivors, and were unlikely to do so.

The lack of coordination led to inevitable confusion. How were the trainees to be deployed? Who would supervise them? How long should the psychosocial intervention continue? Should this be a voluntary or paid activity? Should people coming from abroad be allowed access to the survivors? How could vulnerable survivors be protected from well meaning but insensitive professionals? Were the so-called foreign experts aware of and sensitive to the sociocultural and religious values of the survivors?

There were also questions regarding the ethics of conducting research on disaster survivors. How could it be ensured that survivors were not used as research guinea pigs? Who would ensure their consent would not be obtained under duress or in compromised circumstances? How could it be ensured that research is not linked to aid? Were there any ethics review committees to vet these projects?

Many of the problems existed because there was no clear psychiatric leadership in the country. The Pakistan Psychiatric Society, the country's main body of psychiatrists, which should and could have played a pivotal role in mental health activities following the earthquake, was marginalised (Dawn, 2005).

What can be done?

Looking beyond the disaster: investing in health systems

It is imperative not to focus on short-term psychosocial relief programmes for survivors, as many organisations and individuals have done, but to look beyond the disaster. One-off programmes should be strongly discouraged. They are extremely expensive, are a waste of valuable resources and do not address the underlying mental health issues of the population. Without any proper mechanism for supervision and monitoring, they are virtually useless. Similarly, psychological debriefing as an early intervention after trauma is likely to be ineffective and some evidence suggests that some forms may actually be counterproductive, by slowing natural recovery (van Emmerik *et al*, 2002).

Instead, there is a need to establish long-term, sustainable and culturally relevant health systems, with a primary care/public health approach, of which mental health is an integral part (van Ommeren *et al*, 2005). The advantage of this would be its greater acceptability than any stand-alone mental health programme. The establishment of primary care facilities in the affected areas is necessary, as is mental health training for primary care physicians and nurses, followed by supervision and monitoring of their acquired skills. The training of primary care professionals should include the recognition and management of mental disorders using both pharmacological and non-pharmacological approaches. Use of counselling (Ali *et al*, 2003) and a cognitive-behavioural model for patients with medically

unexplained symptoms (Sumathipala *et al*, 2000) are just two examples of the latter. The critical issues here again are post-training supervision and monitoring.

Need for national coordination

There is an urgent need for national coordination of all relief work related to mental health. At the moment there is very little, and organisations have pursued their own programmes. In many cases there has been duplication of work while some areas are without any mental health input. Efforts should be made to standardise training through manuals and 'master' trainers, to ensure a uniform level of training.

Programmes anchored in integrity

Although the need for psychosocial interventions is increasingly recognised, it is imperative that professionals work in a concerted manner. The Pakistan Psychiatric Society can take on the important role of bringing together all mental health professionals. This will be possible only if there is a new approach, based on principles of integrity, honesty, fairness, competence and professionalism. All office holders of the Society should be elected by a democratic and transparent process. The Society should aim to become the authoritative voice of psychiatry in Pakistan.

It is vital that any mental health programme that is developed and adopted is strongly anchored in integrity. There must be complete transparency and full accountability of all processes and individuals involved in programmes, so that pilferage, fraud and cheating, endemic in many respects in Pakistan, are neutralised.

Expatriate Pakistani mental health professionals

Following the disaster, many expatriate Pakistani mental health professionals offered their time, money and expertise for psychosocial relief work. While some groups were well organised, others were not, and many had little idea how their expertise could be best used. The most cost-effective use of their time and expertise would be in the area of training of local health professionals, capacity-building and strengthening of local health systems. This, rather than the one-off PTSD or counselling skills programmes, which are neither needed nor sustainable in the long term, would ensure the best 'returns' on their investment. It is imperative that expatriate professionals interact with credible institutions and individuals in Pakistan and commit themselves to raising the standard of psychiatry in the country in the long term.

Facing the challenges

Today, Pakistani psychiatry stands at the crossroads. The challenges facing it, following the disaster, are enormous. Paradoxically, the tragedy has also given wide publicity to the importance of psychology and psychiatry as they relate to health and well-being.

Mental health professionals in Pakistan must seize the opportunity and use the influx of resources and

raised awareness to establish mental health systems for the long term.

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NEWS AND NOTES

European Commission

The Commission has launched a green paper on mental health for wide public consultation which is intended to lead to a European Union strategy. This is a response to the successful European ministerial meeting held in Helsinki in January 2005. Its overall aim is to develop evidence-based policies that will promote cooperation and coordination and better information in the service of improving 'mental health for all', as well as research and exchange of information in such areas as stigma, suicide, child conduct disorders, care of the elderly and social inclusion. The document can be found at http://europa.eu.int/comm/health/ph_determinants/life_style/mental/green_paper/mental_gp_en.pdf

News from the Association of European Psychiatrists (AEP)

Three AEP Research Prizes, worth €2500 each, were awarded in Nice on 8 March 2006, during the closing ceremony of the 14th European Congress of Psychiatry. The prizes were awarded by Henning Sass, AEP President, to those young psychiatrists, working in Europe, who had published the best scientific papers in the year 2005 in the following areas:

- 'Clinical psychopathology and refinement of psychiatric diagnostic categories', the winner of which was Dr Matthew Broome, from the Institute of Psychiatry, London, UK, for his paper on a clinical service for prodromal psychosis, published in *European Psychiatry*.
- 'Biological correlates and treatments of mental disorders', the winner of which was Dr Ursula Bailer, from the Medical University of Vienna, Austria, for her paper on receptor binding after recovery from anorexia nervosa, published in *Archives of General Psychiatry*.

- 'Psychiatric epidemiology, social psychiatry and psychotherapeutic interventions in mental disorders', the winner of which was Dr Paul Ramchandani, from the University of Oxford, UK, for his paper on paternal depression in the postnatal period and child development, published in the *Lancet*.

The 15th European Congress of Psychiatry will be held in Madrid in March 2007 (see <http://www.aep.lu>).

Quarterly Journal of Mental Health

This new peer-reviewed international journal (published by Psychological Healthcare Ltd in London, England) will be complementary to the purposes of *International Psychiatry*. Its key aims and objectives are: to publish original research in all aspects of psychiatry, from the five continents; to promote debate on issues relevant to mental health; to raise awareness of developments in mental health service provision; to promote mental health service development in the developing world; to promote collaborative research between investigators from different countries. Those wishing to submit papers should send them directly to profcasey@esatclear.ie or to manuscripts@qjmh.org.uk.

XIV World Congress of Psychiatry

Invitation from Professor Juan E. Mezzich, President of the WPA

The XIV World Congress of Psychiatry will take place in Prague, 20–25 September 2008. All of our 130 member societies and 60 scientific sections are expected to be present along with a full representation of all our partners in mental healthcare, from our patients (who are at the centre of our work) to health professionals, health planners and relevant industry (see <http://www.wpa-prague2008.cz>).

For contributions to the News and Notes column, please contact Brian Martindale FRCP FRCPsych, South of Tyne Early Intervention in Psychosis Service, Northumberland Tyne and Wear NHS Trust, Monkwearmouth Hospital, Newcastle Road, Sunderland SR5 1NB, UK, email Brian.Martindale@stw.nhs.uk

The World Health Organization's *Child and Adolescent Mental Health Atlas* project is a systematic attempt to collect information on existing services and resources. It is available online at http://www.who.int/mental_health/resources/Child_ado_atlas.pdf

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@sgul.ac.uk

International Volunteers' Programme

Sir: I would like to share my experience of the College's new International Volunteers' Programme. I spent 3 months last year working for the World Health Organization in Aceh, Indonesia, following the Boxing Day tsunami of 2004, where we were working towards setting up a community-based mental health service with the Ministry of Health, Indonesia. As a specialist registrar working in London, I brought my experience of community mental health-care as practised in the UK into a multinational and multidisciplinary team to work with our Indonesian colleagues in developing a system that would meet the aspirations as well as the social, cultural and economic realities of modern Indonesia.

I found it a wonderful and enriching experience, particularly as I am lucky enough to speak Indonesian reasonably fluently. I was involved in the development of a curriculum and training, as well as having input into systems development. A lot of time was spent with fellow healthcare professionals, learning about local issues and challenges, and looking at ways of addressing them. Probably the most useful thing was sharing some of my day-to-day clinical experience in managing patients in the community with fellow clinicians who have had experience only of a more custodial approach to psychiatry. I had the opportunity to lead a team of my Acehnese colleagues to see a community mental health team in action in neighbouring Malaysia.

For me, the programme was extremely helpful in arranging this experience. In particular, I had to arrange unpaid leave from my National Health Service job, and I believe that this would have been difficult without the support of the College. I also had additional support and mentoring via email from Professor Jenkins in the UK, as well as extremely helpful advice and support from the College's Western Pacific International Division, principally from Professor Deva in Malaysia.

I would thoroughly recommend the Programme to any specialist registrar. I would also recommend it to colleagues in the developing world who are looking at ways of adapting experiences and practices from the UK to local services. Specialist registrars usually have at least 5 years' specialist training and

have all passed their MRCPsych examinations. Many are actively involved in research and service development, and yet, because of their unique position of being supernumerary to service requirements in the National Health Service, are more able to spend a longer period abroad.

The International Volunteers' Programme is not only an ideal opportunity for capacity building in developing countries but also a wonderful opportunity for two-way learning and developing practices to bring back to the UK.

Ian Soosay

Specialist Registrar and Honorary Lecturer, University College London, email r.soosay@ucl.ac.uk

Health inequalities

Sir: Your editorial in the April 2006 issue of *International Psychiatry* highlighted the important and complex relationships between mental illness and poor physical health. It is difficult to address these health needs in a climate of constrained resources and increasing specialisation. Health promotion for patients with severe mental illness is particularly challenging. Much attention is given to the management of physical health problems in patients with mental illness; this is generally related to the reversal of the unwanted effects of psychotropic medications and lifestyle modification, and may be highly proactive, involving frequent invitations and follow-up (Osborn *et al*, 2003). Behavioural lifestyle interventions, for example for managing body weight, albeit intuitively appealing, may fail if the pharmacological properties of medications are not sufficiently taken into account (Werneke *et al*, 2003).

Implementation of population-based cancer (e.g. breast and cervical) screening may be even more difficult to achieve. Although most of the studies have been conducted in patients with learning disabilities, evidence is emerging that women with severe mental illness may also be less likely to take up such screening (Bergmann *et al*, 1996; Lasser *et al*, 2003; Werneke *et al*, in press). Psychiatrists and keyworkers may not be sufficiently familiar with the process of these screening programmes to offer an effective but balanced intervention. Patients with mental illness may more

War, tragedies, infections and intercultural insensitivity

There have been many disturbing international events in recent months that have had significant mental health consequences. We have heard that there is a list of more than 200 doctors and scientists who have been executed or kidnapped in Iraq. Elsewhere in the Middle East there have been the ferry boat tragedies in the Red Sea and in Bahrain. The bird flu virus is causing panic in many countries. Mental health services are frequently asked to work closely with other services to advise and deliver support systems. However, our training and manpower do not often prepare us enough for these roles. We welcome news, discussion and debate on these issues. — Brian Martindale

often postpone presentation or otherwise delay the diagnostic process (Kunkel *et al*, 1997). Yet, for some screening programmes, including mammography for breast cancer, highly proactive encouragement may not be appropriate, because the benefit of detecting cancers early and at a more treatable stage needs to be weighed against the risk of false-positive results.

Although in many patients the anxiety related to false-positive cancer screens seems transient (McGovern *et al*, 2004), others may experience severe and persistent distress, despite reassurance (Barton *et al*, 2004). In contrast to the case in many women with significant learning disabilities, most women with severe mental illness have the capacity to consent unless acutely unwell. However, even if capacity to consent is retained, residual symptoms, including bluntness of affect and pervasive anxiety, as two possible extremes of emotional disturbance, may lead to different decisions over whether to attend screening. Most probably, for patients with severe mental illness, cancer screening can be facilitated only if the interface between primary and secondary care works well. Keyworkers could facilitate screening by ensuring that their patients understand the benefits and risks of screening, and that invitation letters are not missed, or by arranging postponement of screening invitations for patients who are acutely unwell until their capacity to consent is restored. Once patients have attended screening it is important to ensure that abnormal results are followed up. To promote cancer prevention appropriately and effectively, psychiatrists and mental health teams would benefit from some specific training in this area.

Ursula Werneke

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International recruitment: individual choice or ethical dilemma?

Sir: I am writing in response to the point of view put forward by Dr Amit Malik concerning international recruitment in the January 2006 issue of *International Psychiatry* (pp. 22–23). The article highlights a number of issues; however, I would like to point out the differences between those recruited as consultants and those who come as trainees.

In relation to consultants, national governments need to put in place a structure which respects and values health professionals. They do not need extravagant salaries and generous incentives, but rather adequate remuneration, job satisfaction, support networks and good opportunities for their families. All these have been looked into by the Department of Health in the UK. Can you blame any health professional for wanting to move for such reasons? I believe we must look into these issues, for happy health professionals are able to give a better service to the people they serve.

With regard to trainees, I believe a number come to the UK for the issues highlighted by Dr Malik. However, having attained the higher qualifications they do not return to their home countries for many of the reasons highlighted above. The UK has always welcomed people who have more to offer to its citizens and in return has provided them with adequate remuneration and support. However, we need to analyse what implications the recent change in visa regulations (brought in without any consultation) will have for those trainees here and those who are planning to come.

Some of the issues which may have persuaded the Department of Health could be the unemployed local graduates and restructuring of the National Health Service (NHS). We already have the largest number of medical students in training and more countries are set to join the European Union (EU). We have had a major influx from Poland already. Romania and Bulgaria are set to join the EU on 1 January 2007. We have major restructuring of the NHS and expect a reduction in the number of consultants. This can already be seen in Scotland, where there is a freeze in the number of consultant posts.

With the current reforms in place, I do not believe the ethical dilemma will exist for much longer. The time to discuss this further, with respect to the UK, has passed. With respect, I think there is more to discuss in world forums – for example, war, poverty, hunger, water supply and fairer world trade.

Mukesh Kripalan MBBS MD MRCPsych

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For the changes in visa regulations see http://www.ind.homeoffice.gov.uk/ind/en/home/laws__policy/immigration_rules/explanatory_memorandum10.html

The Royal College of Psychiatrists and its Middle East Division are holding a regional conference in Lebanon, 23–25 November 2006. The theme of the conference is 'Sociocultural Aspects of Mental Health', covering various aspects of mental health ranging from psychopharmacology to social psychiatry. Emphasis will be placed on presentations from the Middle East, but invited speakers will also come from Europe and North America. The various countries of the region. For details of topics, registration, abstracts, etc. please visit the conference website at <http://www.rcpsych-me.com/index.htm>.

10–13 July 2006

Royal College of Psychiatrists' Annual Meeting
Glasgow, UK
Email: conference@rcpsych.ac.uk
Website: <http://www.rcpsych.ac.uk/2006>

12–16 July 2006

Psychiatry: Uniqueness and Universality
WPA International Congress in collaboration with the Psychiatric Association of Turkey and the Turkish Neuropsychiatric Society
Istanbul, Turkey
Email: kueyl@superonline.com
Website: <http://www.wpa2006istanbul.org>

17–22 July 2006

International Congress of Group Psychotherapy: Groups: Connecting Individuals, Communities and Cultures
São Paulo, Brazil
Email: iagp2006@eventus.com.br
Website: <http://www.iagpcongress.org>

16–19 August 2006

28th Nordic Congress of Psychiatry: New Tools for Clinical Practice
Tampere, Finland
Website: <http://www.psy.fi/ncp2006>

22–26 August 2006

19th World Congress of Psychotherapy in conjunction with the 12th Malaysian Conference on Psychological Medicine
Kuala Lumpur, Malaysia
Contact: Sheryn Leong
Email: sheryn@icem.com.my
Website: <http://www.2006wcp-mcpm.com>

13–16 September 2006

VI World Congress of Depressive Disorders and International Symposium on Addictive Disorders
WPA co-sponsored conference
Mendoza, Argentina
Contact: Dr Jorge Nazar
Email: jorge_nazar@hotmail.com
Website: <http://www.mendoza2006.org>

19 September 2006

Urban Areas and Mental Health International Conference
Italian Psychiatric Association with WPA Section on Urban Mental Health
Bologna, Italy
Contact: Dr Mariano Bassi
Email: bassisp@mailbox.dsn.it

25–28 September 2006

XIX World Congress of the International Federation for Psychotherapy
Tokyo, Japan
Contact: Dr Tsutomu Sakuta
Email: Sakuta-nakayama@cb.wakwak.com

26–30 September 2006

A World of Drugs, a Universe of Treatments
International Society of Addiction Medicine (ISAM)
Oporto, Portugal
Contact: Dr Antonio Pacheco Palha
Email: apalha@sapo.pt
Website: <http://www.isamweb.org>

27–30 September 2006

VI World Congress of Depressive Disorders and International Symposium on Addictive Disorders
Mendoza, Argentina
Contact: Dr Jorge Nazar
Email: jorge_nazar@hotmail.com
Website: <http://www.mendoza2006.org>

4–6 October 2006

5th International Conference on Early Psychosis
Birmingham, UK
Email: E.event@happenings.com.au or secretariat@iepa.org.au
Website: <http://www.iepa.org.au>

5–8 October 2006

Third International Conference 'Together Against Stigma'
Psychiatric Association of Turkey
Istanbul, Turkey
Contact: Aslihan Polat
Email: stigma@stigmaistanbul.org
Website: <http://www.stigmaistanbul.org>

6–8 October 2006

Pacific Rim College of Psychiatrists Congress
Taipei, Taiwan
Contact: Dr Allan Tasman
Email: allan.tasman@louisville.edu

12–15 October 2006

9th World Congress of Psychosocial Rehabilitation
Athens, Greece
Contact: Dr Michael Madianos
Email: madianos@nurs.uoa.gr

13–15 October 2006

International Conference on Schizophrenia
Schizophrenia Research Foundation and the WHO
Chennai (Old Madras), India
Contact: Dr R. Thara
Email: scarf@vsnl.com
Website: <http://www.scarfindia.org>, <http://www.icons-scarf.org>

18–21 October 2006

8th World Congress of the International Psycho-oncology Society
WPA Section on Psycho-oncology and the International Psycho-oncology Society
Venice, Italy
Contact: Dr Carlo L. Cazzullo
Email: arsmilano@tiscalinet.it

1–4 November 2006

XXIV APAL Congress, Latin American Psychiatric Association
Santo Domingo, Dominican Republic
Email: cesarm2@verizon.net.do

9–12 November 2006

56th Annual Meeting of the Canadian Psychiatric Association
WPA co-sponsored conference
Toronto, Ontario, Canada
Contact: Alex Saunders
Email: asaunders@cpa-apc.org
Website: <http://www.cpa-apc.org>

17–19 November 2006

Second International Conference, South Asian Association for Regional Cooperation (SAARC) Psychiatric Federation
Kathmandu, Nepal
Contact: Prof. Mahendra K. Nepal or Prof. Roy Abraham Kallivayalil
Email: mhp@healthnet.org.np or ktm_roykalli@sanchanet.in

29 November–1 December 2006

6th International Forum on Mood and Anxiety Disorders
Vienna, Austria
Email: ifmad@publiccreations.com
Website: <http://www.aim-internationalgroup.com/2006/ifmad>

30 November–3 December 2006

WPA Regional Meeting with the Peruvian Psychiatric Association
Lima, Peru
Email: app@amauta.rcp.net.pe

23–24 January 2007

WPA Regional Meeting and Hungarian Psychiatric Association
Budapest, Hungary
Contact: Dr Tury Ferenc
Email: tury@axelero.hu
Website: <http://www.mpt.iif.hu>

19–20 March 2007

Working with Families – Developing Caring Partnerships
Stratford-upon-Avon, UK
Email: meridenconference@conferenceline.co.uk
Website: <http://www.meridenfamilyprogramme.com>