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Academic refugees

Robert Boyd, John Akker and Laura Wintour

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At the end of last year, a symposium was held at the British Academy in London to celebrate a 75th anniversary. The anniversary was of the establishment in 1933 of a unique organisation: the Academic Assistance Council, now the Council for Assisting Refugee Academics (CARA); the Council in 1937 became formally incorporated as the Society for the Protection of Science and Learning (SPSL), and in the 1980s assumed its current title. Although a celebration, the anniversary was in reality a reason for sadness, in that, 75 years after its establishment as a short-term measure to cope with the German Nazi government's policy of firing all Jews from their jobs, its work remains and its activities are currently more in demand than at any time since the 1930s.

The Council was founded by such luminaries as William Beveridge, the father of the welfare state, J. Maynard Keynes, the father of global economic policy, and A. V. Hill, a Nobel laureate in physiology and medicine (and Keynes's brother-in-law). While such famous names and those of other academic leaders were of critical importance as signatories of the letter of appeal establishing the Council, an equally important ingredient was an ethos of individual personal care for academic refugees, provided from the Council's earliest days by Esther Simpson, who worked for the organisation from its inception for over four decades. Personal involvement with and support for individual academics in re-establishing a life and a career remain central to CARA's work.

Those in the specialty of psychiatry, perhaps above any other, will understand the inner desolation of losing job, status, livelihood, country and often family on becoming a refugee. Economic support without friendship is insufficient. Albie Sachs, twice a grantee of CARA and now a Justice of the Constitutional Court of the Republic of South Africa, gave an anniversary lecture at University College London in 2008. He movingly described how, on becoming a refugee, 'you feel crushed. You lose self-esteem, and although the political will remains strong you suffer… I received just the right touch of warmth of heart and practicality [from the organisation].' That was in 1966. Following a second arrival in 1988, after he had been blown up by the defence forces of the apartheid regime, losing an arm, his job, his home and his income, 'The organised love of nurses, doctors and physiotherapists was one thing: the help of the SPSL was the emotional equivalent'. But things are often not so positive. One recent refugee from Iraq, a psychiatrist, commented that losing one's country was like losing a limb but that the difficulty of becoming re-established in Britain felt like being paralysed in addition.

Several thousand individual academic refugees to the UK have been helped by CARA and its predecessors over the 75 years. Some have stayed permanently in the UK, some have gone back as conditions have improved, and others moved on to other countries as a final destination. Eighteen grantees were awarded Nobel prizes. Among those who stayed in the UK have been Ernst Chain (penicillin), Hans Krebs (Krebs cycle), Bernard Katz (neuroscience), Max Perutz (haemoglobin) and Max Born (a physicist who declined to work on the military uses of atomic fission). Ludwig Guttman, another grantee, though not a Nobel laureate, transformed paraplegia, through his clinical practice, from being a delayed death sentence to being a disability. His socialisation of those disabled by paraplegia reached its zenith with the establishment of the Paralympics Games. In the UK alone, 130 academic refugees have become fellows of learned academies such as the Royal Society and the British Academy.

At present there are over 180 academics being supported, who have come from more than 30 countries. The plight of Iraqi academics in particular has been under-publicised: over 350 have been assassinated in recent years and others have been kidnapped. Enormous numbers remain displaced in nearby countries where CARA is, for the first time, working outwith the UK in developing local support systems to provide help to refugee academics nearer home.

One, but by no means the only, reason for developing local support, where possible with others, is the difficulty of obtaining entrance for refugees into the UK and similar countries. This is not a new problem. In the early years of the Academic Assistance Council, Britain refused many refugees entry and a large number subsequently lost their lives. Britain also made it difficult for others, once admitted, to function professionally, for example by declining to recognise their medical degrees. In a panic at the start of the Second World War, alien academics in Britain – the great majority anti-Nazi refugees – were deported, some dying through torpedo attacks en route, or interned on the Isle of Man. They were gradually released only through the persistent political pressure exerted by A. V. Hill, then a Member of Parliament in addition to being an academic. At that time, many British doctors lobbied against the professional recognition of their German fellow physicians. A memo declares that 'the number of foreign medical scientists who could teach us anything could be counted on the fingers of one hand'. Seabrook (2008) suggests that, sadly, such prejudice still exists, and this matches CARA's experience; on the other hand, the efforts and support of others are also, fortunately, still frequently found.

It is perhaps unsurprising that academics (about one-third of whom in CARA's experience are in medicine or other related disciplines relevant to psychiatry) are overrepresented among refugees from the professions. When regimes are, or become, dictatorial, or where civil strife intensifies, those who 'speak truth unto power' through criticism, through pointing out alternative possibilities, or through upholding ethical standards – key academic duties – are all too likely to suffer job loss, imprisonment, torture or expulsion. Furthermore, the loss of the academic members of a society will, unless they can maintain skills in exile and later return, permanently affect that society's future. Germany was a world leader in scholarship before Hitler but never fully recovered its academic position (Medawar & Pyke, 2000); the USA, Australia, Canada and the UK all gained immeasurably, as to a lesser extent did others.

The number seeking CARA's help has quadrupled in the past 3 years and continues to grow. There has been a very significant increase in the number of medical and other healthcare professionals seeking refugee status in the UK and in other countries according to our own figures. This is partly because of the situation in Iraq, where healthcare professionals are still being targeted by extreme elements, despite media reports that the situation is improving. Several hundreds have been assassinated there since 2003, mostly because they have sought to continue their work in their specialty. Also, in Zimbabwe extremely harsh conditions apply and many have gone to South Africa and neighbouring countries after finding it impossible to practise.

Practical details of how an interested reader, of whom we hope you may be one, can support the work of CARA can be found on our website, www.academic-refugees.org. Psychiatrists across the globe can do much to assist this constituency of academic colleagues by speaking up against the stigmatisation of such refugees, supporting the correct view that they are and may increasingly become key local and global assets for a better future and, importantly, helping them to become re-established in their careers.

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THEMATIC PAPERS – INTRODUCTION

Compulsory treatment in the community: concept and controversy

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On 3 November 2008, new powers which allowed supervised community treatment, implemented by community treatment orders, came into effect in England. These orders were presaged by the Mental Health Act 2007 and contain specific conditions with which a patient must comply. The thinking behind the new orders was that patients in the community who are likely to be non-adherent to treatment could be treated under compulsion at an early stage in a relapsing phase of their illness, in order to prevent further relapse into serious illness, which could lead to their recurrent and compulsory admission to hospital. If patients who are to be treated in the community refuse to comply, they can be held in hospital against their will for up to 72 hours and forcibly treated. They cannot be forcibly compelled to accept treatment in the community. The legislation was controversial and was by no means universally supported. Some have argued that the motivation behind the introduction of new powers to allow 'compulsory treatment in the community' was more to assuage public anxiety about the potential threat to them caused by some people with mental health problems, a threat that is arguably in the public mind far greater than reality, than to provide a more liberal regime for the management of seriously ill psychiatric patients.

Since the introduction of this legislation, the Mental Health Act Commission reports that the use of community treatment orders has far exceeded official estimates. In fact, recent reports suggest mental health services are struggling to deal with the high demand: more than 1200 people in England had been made subject to compulsory treatment 5 months after the powers were introduced. There have been delays processing the new orders because of a shortage of psychiatrists appointed to provide second opinions, who are able to authorise them.

England is not the only country to have introduced the option of compulsory treatment in the community, and in this issue we discuss the experience of a range of countries from Europe (James Strachan), the Middle East (Moody Magdy Zaky) and the Antipodes (John Dawson). Controversies are discussed by each of these authors. One key issue concerns the infrastructure that is provided to support compulsory treatment in the community or, rather, the lack of it. Another is the exact configuration of people (professionals and kin) needed to authorise such treatment, to protect the rights of the patient from potential abuse. It is particularly interesting to read the experience of New Zealand, which has had a community treatment order scheme since 1992: it seems that psychiatrists and even patients find the scheme works well, and they broadly support it. In view of this happy state of affairs, those responsible for framing legislation in other countries would be advised to learn from the New Zealand experience.

Compulsory treatment in the community: considerations for legislation in Europe

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In late 2008, the Regional Office for Europe of the World Health Organization (WHO, 2008) issued a report based on a survey of the policies and practices for mental health within its area of operation. Forty-two European states were examined and a great diversity in practice was recorded. Almost everywhere, the report suggested, policy making and legislative initiatives were seen; since 2005, some 57% of the countries studied had adopted new mental health policies and 48% had introduced new legislation. Many countries were reported to be closing mental hospital beds and replacing them with community-based services. In some countries, however, the report suggested, desks in ministries were collapsing under the weight of policies that had never been implemented, and compliance with legislation by planners and psychiatrists was distinctly variable. The WHO felt that even the role that general practitioners played in treating people with mental illness was limited in many European states and that the availability of home treatment options, assertive outreach for people with complex mental health needs and community-based early intervention was not only variable but often severely limited. Given the wide discrepancies of procedure and practice, it was difficult for the WHO to gain any clear perspective on such legislative matters as arrangements for compulsory care in the community.

In this respect, the European Union may offer a more manageable focus. The Section of Psychiatry of the Union Européenne des Médecins Spécialists (UEMS) is a body of delegates acting as representatives of their respective national medical associations and presenting the views of the medical specialty of general adult psychiatry to the European Commission. Mindful that Europe has a great diversity of legal systems and that arrangements for the development and implementation of mental health law vary widely, it has issued a guidance document (UEMS, 2008) on the principles it suggests should underpin the introduction of legal measures associated with compulsory treatment in the community. This has met with considerable medical and legal interest.

Research findings underpin this document. Pinfold & Bindman (2001) explored whether compulsory community treatment can ever be justified. A Cochrane review by Kisely *et al* (2005), based on the few available trials on involuntary outpatient commitment in the USA, held that the benefits in the management of dangerous individuals are limited. Applebaum (2001), also using US evidence, was more positive concerning its role for those with schizophrenia, bipolar disorder and other serious illnesses, but only where this was not primarily related to the prevention of acts of violence and only if there was an appropriate plan of care. In summary, the current evidence base for the efficacy of this form of intervention is limited. Kisely & Campbell (2007) have further questioned, on the basis of Australian and US studies, whether compulsory community treatment really reduces the 'revolving door' nature of care. If it does not, they suggest, the argument that it can be regarded as a less restrictive option is open to challenge.

While taking these reservations concerning compulsory community care into account, the UEMS felt that, particularly at this early stage of legislative change for many countries, it would be helpful to offer some suggestions and to propose some points of guidance for those considering the matter. It took as a template many of the recommendations made by the expert committee advising on mental health law reform in Scotland (Millan, 2001).

Criteria and conditions

With the development of effective psychotropic medications and increased sophistication in the delivery of safe mental healthcare, it has long been widely realised that community care offers a less restrictive option than the in-patient institution. The preference for less intrusion into the lives of patients has often been the motive for legal reform, to enable such care to take place outwith the hospital. Where reform has taken place, the focus has usually been on those service users who have benefited from treatment in the past but who have repeatedly been unable to adhere to it in the longer term, resulting in relapse. The dominant view, which the UEMS endorses, is that the level of mental disorder to be considered for compulsory out-patient treatment should equate to that otherwise necessitating in-patient compulsory admission.

Compulsory community treatment, however, is not envisaged by the UEMS as a first-line intervention for an acute care episode, for which in-patient assessment and stabilisation remain the approach of choice. It is also not favoured if adopted simply on the grounds of being the cheapest option.

In considering treatment and care, the UEMS found, the focus of discussion can all too readily rest on medication alone. Although this is often an essential if, from a service user's perspective, contentious component, legislation, as Millan indicated, also needs to take into account wider factors. These may or may not need to be specified as part of a treatment plan, depending on least restrictive necessity. Consideration needs to be given, for example, to access arrangements for care providers and supervisors, such as medical professionals, community psychiatric nurses, social workers and general carers. Thought is also required on specialised housing needs, such as sheltered housing or residential care in the community for people who are severely incapacitated. Arrangements may have to be made so that the location of the service users is made known to their carers should their address change. If some form of community care service, such as a day unit, is needed, this too may require specification, as does where, and at what intervals, the patient is required to attend if medication is to be deployed. Service users and their representatives expressed grave concerns to Millan about the potential abuse of their home environment should medication be administered there under such an order. It seemed preferable, therefore, for administration of medication to take place instead at another location, such as a day unit, out-patient clinic or local general practice surgery.

In summary, compulsory community intervention, as envisaged by the UEMS, ought to maintain service users' well-being and avert deterioration and risk to self or others. The intention is to reduce the likelihood that the service user will again require in-patient commitment. In practice, this means that legislation needs to have the flexibility to account for the individual's needs and to place under duress only those elements which are least restrictive and considered essential for the effective implementation of the clinical and social care plan. This inevitably renders application of the law significantly more complex, as negotiation is entailed.

Process

As a compulsory care order is potentially a major restriction on civil liberty, it would seem appropriate for there to be more than one applicant. In Europe, it seems generally agreed that at least one of these must be a fully trained psychiatrist and that a second opinion should also be sought. Options favoured by the UEMS include a second psychiatrist, a general medical practitioner, a social worker or an experienced community psychiatric nurse. In many European legislatures, carers or relatives are drawn directly into the application process to sign documents. But there is evidence that this is often associated with later recriminations and damage to family relationships and many feel it is best avoided. Nonetheless, a mechanism whereby the views of carers are taken into account is widely thought essential and has usually been incorporated into the process.

Such legal measures clearly require an appeals procedure. To facilitate this, both the service user and carers may need access to advocacy services, to guide and support them through the process, and to legal assistance, to effect proper representation before legal authorities. The costs of these arrangements should not, in the UEMS's view, be borne by the service user or the carer. How appeals are heard varies greatly in Europe. Some states utilise the opinion of a judge; others devolve matters to a panel consisting of legal, medical and other expertise.

In practice, a degree of cooperation from the service user is required for a community treatment order to operate smoothly. Without this, the process is likely to fail. The question then arises as to what should be done if the service user is non-compliant. Alternative strategies have been considered, including compulsory readmission to hospital. Since, however, the criteria for out-patient and in-patient compulsory measures often differ, a process of clinical reassessment and legal review is inevitable in such circumstances.

Attitudes

Mental health law presents unique challenges to those involved: the lawyer, psychiatric practitioner, service user and carer. Particularly as, at times, it may be difficult to reconcile their approaches, an agreed set of principles to be used in the application and administration of such laws would seem important. The recommendations made in relation to Scottish law reform set out by the Millan Committee (Millan, 2001) were considered and adapted by the UEMS in its report (UEMS, 2008). Basically, both reports sought to embrace the fundamental principles of medical ethics, namely justice, autonomy, beneficence (seeking to do good) and non-malificence (avoiding doing harm).

Crucially, the principles outlined centre on 'least restrictive practice'. Any necessary care, treatment and support services, in this view, should be provided in the least invasive and least restrictive manner and in an environment compatible with effective care that takes into account the safety of both the patient and others. The principles also include the commitment that any legislative intervention on behalf of the service user should be likely to produce benefit for that person which cannot be achieved by other means. Where society imposes an obligation of compliance with a programme of treatment, a parallel obligation must fall on health and social authorities to respond with the necessary care and service provision, including follow-up care.

Changes ahead

The debate on compulsory care, especially in the community, is ongoing in Europe. The Netherlands, for example, is in the process of reconsidering its provisions, as it is now felt that treatment options under current legislation have been restrictive. Turkey is likewise in the process of discussions on reform. But it seems already agreed that, inevitably, all legislatures will have to reflect on the realities of local psychiatric care systems and legal structures. A wholesale adoption of strategies from other legislatures or from any centralised source would not be appropriate or effective. The healthy diversity for which Europe is renowned is not under threat.

Declaration of interest

Dr J. G. Strachan is President of the European Board of Psychiatry of the UEMS and was a member of the Millan Committee.

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Egyptian legislation on the compulsory treatment of persons with psychiatric disorders: the old and the new

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Compulsory admission to and treatment in psychiatric facilities have recently been brought into the spotlight by both psychiatrists and the media in Egypt. Interventions of this kind have always inherently involved deprivations of liberty and infringements on privacy. The debate around this issue acquired considerable heat after it was joined by the legislatures during the discussion of a Bill in Parliament. The Parliamentary Committee for Constitutional and Legislative Affairs questioned the constitutionality of the process of compulsory detention and requested more robust safeguards to protect the rights of persons with mental illness. The new Bill was passed by the Egyptian Parliament on 26 April 2009 and was due to come into force once ratified by the President and published in the *Egyptian Gazette*, expected in May.

The old Act

In 1944, Egypt gained its first legislation on mental health (Law 141/1944) and that Act has governed the detainment of patients affected by mental disease – it is still in effect at the time of writing and has never been amended. Detainment under the Act carries with it the possibility of compulsory admission and treatment in a psychiatric facility. Article 4 stipulates the criteria for such intervention:

> Detainment may not be made of a patient affected by mental disease except in case such disease constitutes a breach of the public order or security or endangers the patient or third parties' safety.

Mental disease was defined in conformity with the once prevailing conceptualisation of mental disorder as a dichotomy between neurosis and psychosis. Only psychotic symptoms were regarded as being diagnostic of mental disease such as to allow commitment under the Act.

The Act does not specifically regulate the internment of persons who lack mental capacity, as it does not make any distinction between those who possess and those who lack mental capacity. It does not in fact address 'mental capacity' and its legal implications at all (though it does give a guardian, if there is one, the right to apply at the behest of the patient for voluntary admission and treatment). That technically means that the civil law is used to decide this particular matter. It is worth mentioning that civil law in Egypt gives the guardian a permanent power to decide on all matters on behalf of the person under guardianship.

A person can be admitted compulsorily by virtue of a written application from a person among their kin. The application has to be supported by two certificates from physicians who are not on the staff of the hospital that will detain the patient, and one of whom should be a government employee. They should attest that a mental disease that meets the criteria for compulsory admission affects the person whose detention is being requested. The physicians' certificates are valid only if less than a 10-day period has elapsed before their submission to the director of the hospital receiving the patient. (There is also a provision relating to certificates drawn up by a physician who is a relative of the hospital proprietor or director, to safeguard against any conflict of interest that might arise.)

Should the physicians find that a patient has a mental illness that meets the criteria for compulsory admission, they must order that the police detain the patient in the first instance. If detained, then the prosecuting authority or the police have the right to keep the patient under custody, and subject to medical examination by the physician, for a maximum of 24 hours from the time of apprehension. Should the physician find, after an examination, that the person does not suffer from any of the mental illnesses fulfilling the criteria for compulsory admission, they are immediately discharged.

Should the physicians have a suspicion – upon medical examination – that the person does have one of the conditions that give grounds for compulsory admission but they are unable to make a final decision on whether the condition is present or not, they must give orders to place the person under supervision at a government hospital, for a maximum of 8 days. This could be a hospital other than one allocated for mental diseases, provided that the person is subject to daily examination and at the end of the period of medical supervision the physicians make a final decision about the patient's discharge or detainment.

The 1944 Act set up a quasi-judicial body, the Control Board, to monitor and inspect all cases of compulsory admission. The director of the hospital in which a patient is subject to compulsory detention has to notify the Control Board within 3 days, in writing, about the detainment of any patient. The director also has to present a report on the case within the 4 subsequent days. Within a maximum of 30 days of the initial detainment, after studying the patient's case, the Control Board has to approve the decision to detain them further, or it could decide to discharge them.

Use of the provision

In 2006, a review of compulsory admissions registered at the Control Board in Egypt revealed that only seven had been registered over the period 1999–2006. This is surprisingly low, for the population of Egypt is 75 million and the country has about 13 000 psychiatric beds. The number was in stark contrast to the number of compulsory admissions to psychiatric hospitals in the UK for the year 2006 – a total of 7416 (Mental Health Act Commission, 2008, p. 107).

The Egyptian findings were partially explained by the unlawful practice of hospital staff forcing patients to sign voluntary forms for admission, regardless of whether their condition met the criteria for compulsory admission or not. Hospitals also failed to report these informal admissions, as they should have done according to legal stipulations.

The new Act

In 2006, the General Secretariat for Mental Health, within the Ministry of Health, decided to review the provisions of the Act with regard to psychiatric hospitals. The General Secretariat instigated the drafting of a new Mental Health Act. Debates heated up around the criteria for compulsory admission. Some suggested there should be looser criteria for compulsory admission; these criteria would make it possible for persons with any psychiatric disorder that fulfils the criteria for admission and treatment in a psychiatric facility to be detained. Alternatively, they could be admitted if there is a possibility of further deterioration of their condition that could be averted by compulsory admission. Others advocated the tightening of criteria, restricting involuntary admission to those patients who present a serious likelihood of imminent and grave danger to themselves or others.

In 2008, a final draft of the Mental Health Act was submitted to the Egyptian Parliament for approval. The new Act distinguished between compulsory admission and compulsory treatment and established different criteria and procedures for each. Criteria and conditions for compulsory admission became very controversial during the parliamentary discussion.

Criteria for compulsory admission are now as follows:

- the existence of severe psychiatric disorder that cannot be treated unless the person is admitted to a psychiatric hospital
- the person has refused such intervention voluntarily
- the person presents a likelihood of grave and imminent deterioration that could be averted by such intervention; *or* there is a likelihood of imminent danger to the person's or to a third party's safety.

The legal process now includes notifying a judicial authority and a quasi-judicial body called the Council of Mental Health of the detention, in order to get an independent assessment within 7 days of admission. The patient's condition should be reviewed 2 days, 7 days and 1 month after their compulsory admission, as well as every month thereafter. Discharge will depend on the result of the evaluation and the patient's condition ceasing to meet the criteria for compulsory admission.

The term 'mental capacity' has been defined clearly in the new Act. Voluntary admission or treatment has been prohibited for persons who lack mental capacity unless requested by a guardian. That is, patients can be admitted voluntarily if they have mental capacity to give informed consent. If they lack this capacity, the provisions of compulsory admission, with all the safeguards connected to it, are to be applied, unless the patient has a legally appointed guardian who can apply for voluntary admission. The criteria for involuntary admission and treatment are the same for those with and without full mental capacity.

The new Mental Health Act has outlined provisions to allow a treatment order to be implemented within the community. The criteria for application include the following:

- The patient has been previously subjected to both compulsory admission and treatment.
- The patient has a history of poor adherence to medication that has contributed to the compulsory admission and treatment, on at least two occasions.
- The patient's condition is likely to deteriorate if he or she is not maintained on the proposed treatment.
- The patient's condition does not meet the criteria for compulsory admission to hospital.
- The Council of Mental Health, entrusted with monitoring implementation of the law, should be notified.
- An independent assessment should be conducted before the application of such an intervention.
- The order can last for only 6 months in the first instance, but it can be renewed by the Council of Mental Health for further periods of 6 months.

Treatment orders in the community have legal force to ensure that the patient attends hospital at times determined by the treating team. Treatment orders also ensure that the treating team is able to pay visits to the patient at his or her place of residence, in pursuance of the treatment plan. If a community treatment order is breached, because the patient absconds or is non-compliant with the treatment plan, compulsory admission may be applied.

The right to integration in the community has been mentioned in the preamble of the new Act and as a part of the aftercare plan that should be made for each patient before discharge from hospital, but no provisions have been made to enforce that right.

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Community treatment orders in New Zealand

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Many legal mechanisms can be used to authorise compulsory community mental healthcare: leave or conditional discharge for compulsory in-patients; adult guardianship (or incapacity) legislation; treatment as a condition of a community-based criminal sentence, like probation, or of parole from imprisonment; or a full-fledged community treatment order (CTO) scheme. It is the specific mix of mechanisms employed in a particular jurisdiction that will characterise how that legal system manages the delivery of compulsory (or quasi-consensual) community psychiatric care.

In New Zealand, the preferred mechanism since 1992 has been a clearly structured CTO regime. This regime is widely used, endorsed by most New Zealand clinicians (Romans *et al*, 2004) and the most common mechanism for delivering any form of involuntary psychiatric care. In 2007, 61 persons per 100 000 were on a CTO in New Zealand. This is 4 times the number under compulsory in-patient care and 12 times the number on in-patient leave (Office of the Director of Mental Heath, 2008).

The New Zealand context

This extensive use of CTOs in New Zealand occurs within a particular service environment, involving the thoroughgoing deinstitutionalisation of mental healthcare and the build-up of mobile community mental health teams (Dawson, 2005). It also proceeds against the backdrop of New Zealand's relatively strong social welfare traditions.

The CTOs are implemented mainly through a network of experienced community mental health nurses, who visit patients wherever they live and supervise their medication. These nurses, and other members of community mental health teams, work as the salaried employees of regionally organised public health services that provide both in-patient and out-patient care. In addition, in many places supported accommodation run by not-for-profit organisations is available for CTO patients, along with long-term social welfare payments to support their community tenure.

No unreasonable form of liability is imposed by law on clinicians who operate the CTO regime. There is no entrenched bill of rights within New Zealand's constitutional arrangements that constrains the design of the mental health legislation, and a less libertarian political culture obtains – that puts less emphasis on the right of individuals with a mental illness to be left alone, and more emphasis on maintaining their connections with their family – than might be found in some other parts of the world.

In this milieu, the New Zealand CTO regime has been aimed at those with a serious and continuing mental illness who are considered by clinicians to need ongoing medication and supervision. The regime is used in a preventive manner, mainly for patients who fit the common profile of those placed under CTOs wherever such regimes are found. This profile is described by Churchill *et al* (2007, p. 109) in their review of the research: the majority of CTO patients are male, with an average age of about 40 years, 'with a long history of mental illness, previous admissions, suffering from a schizophrenia-like or serious affective illness, and likely to be displaying psychotic symptoms, especially delusions, at the time'.

In practice, imminent danger to self or others is not required in New Zealand for the CTO to be maintained. It is usually considered sufficient that the patient would, without treatment, have a seriously diminished capacity for self-care. Clear enforcement mechanisms are then provided, but substantial elements of due process and professional accountability also apply. A CTO is made in New Zealand by a lower court judge, usually about a month after a patient's compulsory admission to hospital, when a private judicial hearing is held, at which the patient may be represented by a lawyer and at which the family may appear.

Once made, the CTO lasts initially for 6 months and may be renewed, but mandatory clinical reviews must be conducted. The patient may be discharged from the order at any time by the responsible clinician, and may appeal periodically for release to a multidisciplinary review tribunal. Lawyers, called district inspectors, are appointed to advise compulsory patients of their review entitlements. The use without the patient's consent of either long-term medication or electroconvulsive therapy is subject to mandatory peer review by a second, senior psychiatrist appointed by the review tribunal.

The precise legal criteria

Under New Zealand's Mental Health (Compulsory Assessment and Treatment) Act 1992, four distinct legal criteria must be met for a CTO to be made (sections 2, 27, 28):

❍ the patient must have an 'abnormal state of mind' of the necessary kind
❍ this must be 'of such a degree that it poses' a serious danger to the health or safety of that person or others, or seriously diminishes the person's capacity for self-care
❍ involuntary treatment must be 'necessary'
❍ adequate out-patient care and community support must be 'available'.

The New Zealand legislation specifically lists the necessary characteristics of this 'abnormal state of mind'. It may be 'continuous or intermittent', but must be 'characterised by delusions, or by a disorder of mood or perception or volition or cognition' (section 2). Those with personality disorders may be treated under the Act, therefore, only if they present one of those listed disorders of mental function. Furthermore, no person may be placed under compulsory treatment 'by reason only of intellectual disability' (section 4(e)). In effect, New Zealand has adopted into legislation the position taken by Aubrey Lewis, that mental illness is best defined in terms of 'evident disturbance of part-functions' of the mind, not in terms of disturbed social functioning alone (Lewis, 1953, p. 118). The overwhelming majority of patients under CTOs in New Zealand have a diagnosis of schizophrenia, schizoaffective psychosis or major affective disorder (Dawson & Romans, 2001).

Conditions of a CTO

Patients under a CTO will usually be required to accept visits (often weekly) at their residence from a community nurse, attend out-patient appointments with a psychiatrist (often monthly) and take medication as prescribed. They may also be required to live in a specified kind of accommodation, with certain levels of support, and to avoid substance misuse. The main legal mechanism for enforcing these conditions is the threat of return to in-patient care, as the responsible clinician may revoke the CTO whenever the patient 'cannot continue to be treated adequately as an outpatient' (section 29). Police assistance is available with that recall process, if required.

There is no express power, however, to use 'forced medication' in a community setting. That practice is widely considered unsafe and unethical, and is explicitly rejected in the New Zealand Ministry of Heath's guidelines to the Act (Dawson, 2006). If patients adamantly refuse treatment, they must be returned to hospital for it to proceed, where proper assessment and observation can occur.

Whether a patient will be returned to hospital in practice for breaching the conditions of a CTO remains a matter of discretion, however, for the clinical team. The critical factors seem to be the relapse profile of the patient, the likely consequences of a relapse and the impact of recall on the therapeutic alliance (Mullen *et al*, 2006*a*). Also, a bed must be available. In practice, recall is not common: we found patients averaged 2.3 years of involuntary out-patient care per recall to hospital. Nevertheless, a small minority of patients were repeatedly recalled (Mullen *et al*, 2006*a*).

The attitudes of participants to this regime

A national survey of psychiatrists conducted 10 years into the operation of this regime (Romans *et al*, 2004) found the great majority endorsed it, seeing it as a useful tool in pursuit of core clinical aims for people with a serious mental illness. CTOs were considered to work in a largely structural and indirect fashion, providing the authority to maintain contact with out-patients, binding into place the necessary services, and promoting medication compliance and early identification of relapse. CTOs were considered to support the involvement of families and other agencies in patients' care, and to have a significant impact on patients' attitudes to their illness, by communicating the seriousness with which others viewed their condition. Compulsion was not seen as a substitute for adequate service provision. On the contrary, success was seen to depend on the quality and extent of services available, especially the skills of community nurses and an adequate range of supported accommodation.

A small minority of New Zealand psychiatrists, though, did not endorse the regime, mainly because they had concerns about the long-term impact on the therapeutic alliance. The predominant view, however, was that, while compulsion can harm relations in the short term, the advantages of sustained community treatment usually outweigh this problem, and that, when greater insight follows treatment, therapeutic relations often improve in the end.

Family members interviewed also showed high levels of support for the regime (Mullen *et al*, 2006*b*) and even many patients under CTOs were found, to our surprise, either to be ambivalent about their own compulsory community care or to be mildly supportive of their treatment under the regime, often because of their strong desire to avoid further institutional care (Gibbs *et al*, 2005).

In these circumstances, there is currently no major political momentum in New Zealand for repeal or significant reform of the CTO regime. It is widely viewed as an adequate means of delivering compulsory care to those with a serious and persistent mental illness, in a radically deinstitutionalised environment, within the welfare state.

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Mental health in Armenia

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Armenia is a landlocked mountainous country between the Black Sea and the Caspian Sea, in the southern Caucasus. It shares borders with Turkey to the west, Georgia to the north, Azerbaijan to the east, and Iran and the Nakhchivan exclave of Azerbaijan to the south. Its total area is 29 743 km^2. A former republic of the Soviet Union, Armenia is a unitary, multi-party, democratic nation state with an ancient cultural heritage. Armenia prides itself on being the first nation formally to adopt Christianity (in the early 4th century).

According to the census of 2001, the population of Armenia is 3 219 200 but the July 2009 estimate is 2 967 004. The population of Armenia is homogeneous – Armenians form 97.9% of the population. The spoken language is Armenian. The main religious group is Armenian Apostolic (94.7%). The age structure is as follows: 14 years or under, 18.2% (male 289 119, female 252 150); 15–64 years, 71.1% (male 986 764, female 1 123 708); 65 years and over, 10.6% (male 122 996, female 192 267) (2009 estimates). The population growth rate is estimated to be 0.03% per year, the birth rate per 1000 population to be 12.53 and the death rate 8.34 per 1000. The infant mortality rate is 20.21 per 1000 live births. Life expectancy at birth is 72.68 years (69.06 years for males, 76.81 years for females) and healthy life expectancy at birth 66.7 years. A majority of the population (64.2%; 2 066 700 persons) resides in urban areas. Most adults (99.5%) are literate.

Healthcare system

As a post-Soviet state, the Republic of Armenia inherited a health system organised according to the Semashko model, with guaranteed free medical assistance and access to a comprehensive range of medical care for the entire population. The system was highly centralised, with vertical management dominating. Financial and other allocations were based on national norms and failed to take account of population health needs. There was an emphasis on structural and quantitative indicators, resulting in the expansion of physical capacity, an oversupply of health personnel and a surplus of hospital beds, along with an unequal distribution of resources.

Since independence, the health system in Armenia has undergone numerous changes. Following the decentralisation of public services, the ownership of health services has been devolved to local and provincial governments.

The population, especially those in need, has limited access to health services. The services delivered are sometimes of questionable quality. Many health facilities, especially in rural areas, lack modern medical technology and human resources.

Armenia is increasingly engaged in changing the system from one that emphasises the treatment of disease and response to epidemics to one that emphasises prevention, family care and community participation. Although the emphasis of reform has been on increased state budgets and more efficient use of resources, the majority of financing is still derived from out-of-pocket payments, both formal and informal. The shift towards an orientation on primary care is noticeable, with gradually increased roles for health workers to influence the determinants of health (Hakobyan *et al*, 2006).

Mental health legislation

After 1991, when Armenia became independent, Parliament passed a few laws on public health and healthcare but no law on mental health, until comparatively recently. Up until 2004, mental healthcare in Armenia was regulated by an order of the Minister of Health of the USSR, although the order did not have power of law. In September 1998, the Board of the Mental Health Foundation began to draft a mental health law and to publish a series of materials on mental health legislation. In January 1999, a draft Bill was presented to the Minister of Health and mental health is now regulated by the Law on Psychiatric Care, adopted on 25 May 2004. This regulates involuntary treatment, the civil and human rights of people with mental disorders, and other mental health issues. The Law was amended in 2006.

The criminal law also has a bearing on mental health, mainly in relation to involuntary treatment.

Amendments to the Law on Psychiatric Care have been proposed by the National Assembly of the Republic of Armenia. These focus on treatment facilities and service structures as well as human rights. It would also be useful if future revisions could address areas of potential conflict between mental health specialists and other service providers and patients' interests. For example, the terms of voluntary and involuntary admissions have not been clearly defined within the legislation. A maximum duration of involuntary admission is fixed by criminal law but is not stated in the Law on Psychiatric Care. Similarly, the rights of family members and other carers are not stated.

Policy on mental health is still not well developed and there is no governmentally approved and adopted mental health programme in Armenia. General approaches to mental health require modernisation, as some strategies and practices have been retained from the Soviet period.

Another concern is that there is no emergency/disaster preparedness plan for mental health (WHO Regional Office, 2007).

Mental health services

Because of the country's transition from the Soviet period, the mental health system in Armenia has changed significantly over the past two decades.

Mental health services in Armenia are lacking and those available are poorly integrated into the primary care system. The current system focuses on in-patient care. There is a lack of trained social workers and other mental health professionals, which limits the potential for service provision at community level. Essentially, psychiatric care is still exclusively provided in specialised mental health institutions, including hospitals and social psychoneurological centres. Currently, only 3% of the overall public healthcare budget is given to mental health. In turn, around 88% of the mental health expenditure is on mental hospitals.

The essential psychotropic medicines are provided free of charge to all registered patients. In addition, all severe and some mild mental disorders are covered by social insurance schemes under which patients get free treatment. Also, those who are recognised to have chronic disorders get financial support from the government in the form of a disability pension.

There are 135 hospitals in Armenia with 13 100 beds: 99 hospitals with 8732 beds are in the public sector (that is, under the management of the Ministry of Health), 27 are private and 9 are run by other governmental bodies or departments. An overcapacity of in-patient beds leads to the unnecessary admission of individuals with chronic illness who would better be treated in out-patient settings. Unfortunately, there is no systematic approach to developing community mental health services except for some small-scale pilot projects, usually supported by international organisations (Hakobyan *et al*, 2006).

There are 467 primary healthcare clinics in Armenia, of which 380 are physician-based in the public sector and 69 physician-based in the private sector, while the other 18 are under other governmental bodies or departments.

Psychosocial rehabilitation is underrepresented in the mental hospitals and few patients receive psychosocial interventions. In contrast, psychotropic medicine is highly accessible in in-patient mental health facilities. All mental hospitals have available at least one psychotropic medicine of each therapeutic class (antipsychotic, antidepressant, mood stabiliser, anxiolytic, or anti-epileptic).

There are only five out-patient mental health facilities. All of them are organisationally integrated with mental hospitals; two are for children and adolescents only. There are 1311.5 users per 100 000 general population in these out-patient facilities. Of these out-patients, 29% are female and 2% are children and adolescents. Of all those treated in out-patient facilities, 28% have a primary diagnosis of schizophrenia or schizotypal and delusional disorders.

Three mental health facilities provide day care, all for adults only (there are no day treatment facilities for children and adolescents). Day treatment mental health facilities treat 9.5 users per 100 000 population.

In general, in Armenia mental health and mental disorders in children and adolescents are not regarded with anything like the same importance as their physical health. Although some programmes have been initiated recently concerning general mental health, there are no plans that would include children and adolescents.

Training, education and research

In 2008, per 100 000 population, 11.1 medical doctors (not specialised in psychiatry) graduated in Armenia, as did 50 nurses (not specialised in psychiatry). There are no psychiatrists, psychologists or nurses and social workers with more than 1 year of training in mental healthcare. Around 20% of psychiatrists emigrate to other countries within 5 years of the completion of their training.

In 2008, no mental healthcare staff received more than 2 days of refresher training in the rational use of drugs, psychosocial interventions or child and adolescent mental health issues. The major problem for mental health education, as in the field of public health in general, is that there is no regular provision of continuous medical education for psychiatry and clinical psychology. The government supports training for professionals once in every 5 years, but even then this training is generally formal and psychiatrists are not satisfied with it.

International exchange experience is lacking at governmental level. This means that new trends in treatment and drugs are neglected. There are some donor organisations supporting international exchange for a few professionals, and others try to participate in internationl conferences and workshops using their personal resources.

Mental health research is underdeveloped and lacks governmental support. There is, though, some research based on the interests of individual investigators or some priorities suggested by donor organisations. This tends to be focused on epidemiological studies in community samples, epidemiological studies in clinical samples, biology and genetics, policy, programmes, financing/economics, and pharmacological, surgical and electroconvulsive interventions.

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Mental health services in the Republic of Niger

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The Republic of Niger is a large, landlocked west African country. Around 80% of its vast land mass (1 300 000 km²) is in the Sahara Desert. Its neighbours are Mali, Algeria, Libya and Chad to the north, and Nigeria, Benin and Burkina Faso to the south. The country came under French rule in the 1890s and gained its independence in 1960, but development has been slowed by political instability, lack of natural resources and drought. In 1999, voters overwhelmingly approved a new constitution, allowing for multi-party elections, which were held later that year. An ongoing rebellion in the north makes access to much of the country difficult.

There is a wide diversity of peoples, including nomadic tribes in the north (the Tuareg and Fulani) and settled groups mainly in the south (the Hausa, Zarma and Songhai as well as many others). The majority of the population are Muslim but animist beliefs and ancestor worship are common.

Niger is one of the world's poorest countries, with a gross national income of US$280 per capita in 2007 (World Bank, 2007). The population is estimated at 14.2 million, over half of whom are under 15 years of age (UNICEF, 2008). The majority are subsistence farmers and over 60% of people live on less than US$1 a day. Most of the national export income is derived from uranium mining and cattle-rearing.

Health indicators for Niger are poor. The average life expectancy at birth is 58 years for men and 56 years for women. Niger has the highest fertility rate in the world, with an average of 7.2 births per woman, but infant mortality is also extremely high, and one in four (253/1000) children die before the age of 5 years (UNICEF, 2008). In the year 2000, total health expenditure as a percentage of gross domestic product was 3.7%. Per capita total expenditure on health is US$22, with the government providing US$9 of this total.

Mental health services

Traditional medicine is the only option available for the majority of the population when they encounter mental or neurological health problems, as there are few modern services outside of the capital city, Niamey. Widely held beliefs that mental illness has a spiritual cause, low levels of literacy, huge distances and poverty are all factors that compound poor access to orthodox psychiatric services.

There are no specialist psychiatric hospitals in the country, but four of the eight regional hospitals have a psychiatry department (Niamey, Tahoua, Zinder and Maradi). There is no specific government budget for mental health other than what is spent in these general hospitals, but even here the budgets for mental health are not fixed. Despite its focus on policy and planning, the World Health Organization (WHO) gives some regular funds for the provision of psychotropic drugs.

Community-based mental health services are currently limited to the activities of one large non-governmental project in Niamey (Projet de Réadaptation a base communautaire aux Aveugles et autre personnes Handicapées du Niger, PRAHN). These services mainly consist of occasional outreach 'camps' in remote areas, each requiring several days' travel, rather than a constant presence.

Epilepsy is the most common neuropsychiatric disorder that presents. This reflects the stigma associated with other mental disorders and lack of knowledge about treatability, as well as the positive results of basic treatment for epilepsy.

The availability of psychotropic medication is poor, despite a relatively well organised national medication supply system based on the Bamako initiative (Eaton, 2008). Although in principle this should ensure affordable medication is available, of the basic WHO standard list, only phenobarbital, carbemazepine, chlorpromazine, haloperidol, diazepam, benzhexol and amitriptyline are readily accessible in major hospitals. Beyond these hospitals, only phenobarbital and diazepam are routinely available.

Human resources

There are five psychiatrists in the country, all of whom work in the general hospital in Niamey. There are around 30 psychiatric nurses and a similar number of psychologists, again mainly in Niamey (WHO, 2005). The psychiatry departments in the other three hospitals are run by nurses, and a few district hospitals have a psychiatric nurse. Some training of general nurses and physicians has taken place but there is anecdotal evidence that people who present with neuropsychiatric disorders are neglected in primary healthcare settings (Cohen, 2001). The basic mental health training for primary care staff is not reinforced by ongoing supervision.

Until recently, all training for doctors and nurses took place outside the country – in Morocco, Senegal or Burkina Faso. Psychiatrists now receive specialist training in a programme based in the Republic of Benin and France, and one is about to finish this training. Four psychiatrists have trained in the past 10 years. Unlike in many surrounding countries, they have generally remained in the country, apart from one who now works for the WHO. A psychiatric nursing school opened in Niger in 2003. Typically, seven or eight specialist nurses graduate from here every 2 years, all of whom are employed in government services.

There is no national mental health professional association, though there are service users' and carers' groups supporting people with epilepsy and intellectual disabilities. There is some professional interaction with other Francophone African countries (e.g. through the West African Health Organisation, WAHO) and French universities have some academic collaboration with Nigerien institutions. The division between Francophone and Anglophone traditions is a significant barrier to accessing information, given that the majority of journals and online resources are in English.

Research

There has been little systematic epidemiological data collected, but some ethnographic research was carried out in the 1970s and 1980s (Osouf, 1980). A national survey is currently being undertaken by the Ministry of Health as part of the process of policy development and planning.

National policy and plans

A national mental health policy was formulated in 1993, and a national mental health plan was developed with help from the WHO in 1995, revised in 2000 and 2004 (Ministère de la Santé, 2000). Unfortunately, practical implementation of the plan did not progress beyond some training activities. There has been little long-term impact of the principles of decentralisation of services that formed the core of these policies and plan.

Even with strong advocacy, it is unlikely that there will be adequate funds in the national budget for implementation of a programme unless it is supported by an outside agency. This is in common with other sectors, but the fact that mental health is not specifically mentioned as a Millennium Development Goal makes finding resources more challenging. The integration of mental health as a cross-cutting issue within other areas is one option (Prince *et al*, 2007), but working towards a specific mental health policy is also important (Jenkins, 2003).

A good relationship is emerging between the government, the WHO country office, and the non-governmental sector (a major healthcare provider in Niger), who are working together to revise the national policy and plan. The ultimate aim of this process is more accessible care, in line with recent international initiatives to scale up services in low- and middle-income countries and to ensure that human rights issues are taken into account (Chisholm *et al*, 2007). The national plan also incorporates participation of service users and other stakeholders in order to ensure that the process has a meaningful impact on their quality of life.

A pilot programme of service delivery following the latest evidence-based guidelines (Thornicroft & Tansella, 2004) is in development; it integrates a modified community-based rehabilitation model (Chatterjee *et al*, 2003) into primary care. This takes into account the importance of the non-governmental sector in a country like Niger. If successful, the pilot will be replicated nationwide.

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COUNTRY PROFILE

Psychiatry in Switzerland

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Switzerland – officially the Swiss Confederation – is a federal republic situated in central Europe. It covers an area of 41 287 km^2 and has a population of just over 7 600 000. Switzerland consists of 26 federated states, of which 20 are called cantons and 6 are called half-cantons. German, French and Italian are Switzerland's major and official languages.

Switzerland has the second highest per capita level of healthcare spending as a proportion of gross domestic product (11.3%). Although there are no exact data available, based on international comparisons, one may assume that at least 10–12% of total healthcare costs are attributable to mental health problems. A characteristic of Swiss society and therefore of Swiss psychiatry is the federal and liberal tradition. Although there is hardly any central state coordination of mental health policy, there is to some degree a homogeneous level of care services throughout the whole country. The cohabitation of the public and private sectors reflects the liberal tradition. Swiss modern psychiatry goes back to the second half of the 19th century, when the first psychiatric hospitals and chairs and a professional association of psychiatrists were founded.

Mental health policy and legislation

On a political level, there is no national mental health policy, common strategy or binding principles to ensure the uniform national delivery of psychiatric care. The national strategy for mental health, developed in 2004 by the Federal Department for Health, is actually only a guide to help the cantons and the federal government design concrete projects.

Even with respect to involuntary admission, there is no uniform legal framework at a national level, but only basic federal legislation (article 397 of the Code of Civil Law), with corresponding supplementary laws on preventive custody at the cantonal level. With respect to compulsory treatment there is only a guideline entitled *Compulsory Measures in Medicine of the Swiss Academy for Medical Sciences*. Further legal documents relevant to psychiatry are, at the national level, those regarding the right of self-determination, bodily injury and a duty to take care, as well as, at the cantonal level, health laws and patient decrees. There are several decisions of the Federal Tribunal determining the duty to obtain informed consent.

An important milestone of Swiss health law, the federal health law of 2006 regarding the academic medical professions, regulates the training, specialty-related and personal licensing conditions and the professional duties of physicians. This law strongly influences not only the universities but also private practice, as well as the law-makers at canton level.

Mental health services

Funding

In Switzerland, the cantons are in charge of the organisation of mental health services. The cantonal healthcare concepts differ to a certain extent as far as the services offered and the health delivery structures are concerned. However, in recent years a certain degree of convergence has occurred, although the federal structure has favoured a fragmentation of the funding agencies and the healthcare providers.

Services provided by the psychiatric hospitals are reimbursed mainly by health insurance companies – mandatory insurance being imposed since 1996 by the Law on Sickness Insurance for all Swiss residents – and by the cantons. Private funding, additional private insurance and the municipalities contribute to the funding to a much more moderate extent. Out-patient treatment is covered mainly by health insurance, followed by self-payment for such treatment.

Consultations in private practice are reimbursed also for those patients who have only basic (mandatory) health insurance, provided that the psychiatrist is recognised by the cantonal authority. Those with additional, private health insurance have a choice of hospital, even if this is situated in another canton or if it is a private one.

Besides psychiatrists there are also many psychologists practising in the private sector, their bills being reimbursed only for patients with additional insurance.

Traditionally, the Swiss greatly value the ability to make their own choice in matters related to healthcare, but in the last decade political pressure has come from both the state and the insurance companies to limit the number both of doctors in private practice and of reimbursed sessions of psychotherapy, as well as to introduce a system of managed care, including gatekeepers. This pressure, aimed at reducing healthcare costs, has stirred up some controversies and confrontations in Switzerland.

Service delivery

At present there are 1.06 psychiatric beds (forensic and addiction psychiatry beds not included) per 1000 inhabitants; there has been a continuous reduction in recent years in the number of beds in hospitals, in favour of community-based settings. Under the slogan 'ambulant before hospital', out-patient care and day hospital care have been extended to assume a major role in prevention, crisis intervention and rehabilitation. Despite the expansion of community-based services in recent years, there are differences in the availability of psychiatric services – as well as private practices – between urban and rural areas.

Mental health services are delivered by the state as well as by the private sector. The cantonal governments are responsible for the organisation of psychiatric care in the state sector. The state sector includes a wide range of well equipped services with a high degree of specialisation. In addition to general adult psychiatry and child and adolescent psychiatry, the psychiatric institutions also have substance dependence, old age, psychosomatic medicine and liaison psychiatry services, as well as forensic psychiatry services.

The private sector consists of eight private psychiatric institutions and psychiatrists working in private practice. The private institutions offer in-patient as well as out-patient facilities for a range of mental disorders, with the exception of severe psychotic illness and hostile, agitated or self-harming behaviours.

It should be emphasised that mental healthcare in Switzerland involves cooperation between psychiatric services (both state and private) and adjacent sectors, such as public health, disability services, social services, youth welfare services and senior services, as well as justice and police.

Workforce issues and professional organisations

Relative to its population, Switzerland has the highest number of psychiatrists in the world: 30 per 100 000 inhabitants, according to the World Health Organization (WHO). At present, Switzerland has, according to the Federal Department of Health, 2603 adult psychiatry specialists, of whom 2016 are in private practice, the rest being employed in public institutions. For child and adolescent psychiatry the numbers are 1257 (overall) and 439 (in private practice). However, the overall number of psychiatrists is actually significantly higher, given that many psychiatrists with foreign diplomas, working mainly in state hospitals, are not included in these statistics. Thirty-nine per cent of adult psychiatrists and 47% of child and adolescent psychiatrists are female.

The Swiss Society of Psychiatry and Psychotherapy (SSPP) – which includes among others the cantonal psychiatric societies and the affiliated subspecialty organisations – has 1884 members; the Swiss Society of Child and Adolescent Psychiatry and Psychotherapy (SSCAPP) has 592 members.

In 2002, the SSPP and SSCAPP co-founded an umbrella organisation, the Foederatio Medicorum Psychiatricorum et Psychotherapeuticorum (FMPP), to promote the common interests of the two psychiatric associations. The *Bulletin Psy & Psy* is the common organ of the SSPP and the SSCAPP, informing its readers about issues of professional politics. The joint website is www.psychiatrie.ch.

Training

Undergraduate training

Undergraduate medical education in Switzerland lasts 6 years. There are six medical schools, in Basel, Berne, Geneva, Lausanne, Zurich and Fribourg, though the last offers only the pre-clinical, basic curriculum. All medical schools are subsidised by their home cantons. At the undergraduate level there are three disciplines concerned with mental health: psychosocial medicine, adult psychiatry and child and adolescent psychiatry.

Postgraduate training in psychiatry

Responsibility for the education of medical specialists lies with the Swiss Medical Association (Foederatio Medicorum Helveticorum, FMH) and the medical professional associations, on behalf of the Federal Department of Home Affairs. The professional associations develop the training programmes, which are afterwards examined and put into force by the FMH, whereas the diplomas are issued by the Federal Department. Devising the psychiatric training curriculum and its periodic review, organising and administering the specialty board examinations as well as visits to the training centres are the responsibility of the Standing Committee on Psychiatric Training and Education of the SSPP. The Committee includes representatives of the universities, of the training directors, of psychiatrists in private practice, of trainees, and so on.

The recently revised competence-based training programme is due to become effective in 2009. It stipulates a 6-year residency, of which 1 year is to be spent in a somatic specialty and 5 in psychiatry. Both in-patient and out-patient settings need to be part of the residency experience, and a rotation between different institutions is required.

Training in psychiatry and psychotherapy is decentralised and not a matter only for university centres. Around 150 psychiatric institutions of varying size are recognised by the FMH as places of residency, each with an *a priori* specified period of recognised training, in a hospital or ambulant setting, and psychiatric subspecialty.

Theoretical psychiatric education is offered within the framework of the eight regional networks for postgraduate education. Together with psychiatric training in the narrow sense, trainees are taught the basics of health economics, the legal foundation and ethical aspects of psychiatric practice. Training in psychotherapy, which accounts for a considerable part of the postgraduate programme, is provided by SSPP-recognised private institutes of psychotherapy in German-speaking Switzerland, as well as by the universities in the French-speaking part. The current residency programme stipulates 3 years of training in one of the recognised models (psychoanalytic, cognitive–behavioural or systemic). Traditionally, efforts have been made to ensure the Swiss curricula have a well balanced biological and psychosocial content.

Psychiatric subspecialties

Child and adolescent psychiatry developed at the beginning of the 20th century out of adult psychiatry and paediatrics. In Switzerland, the development started early, in comparison with other European countries, with the establishment of care structures specific to this age group. Child and adolescent psychiatry became a separate psychiatric discipline in 1953. It has its own chairs in all medical schools, 30 postgraduate training centres as well as more than 17 cantonal services with out-patient as well as in-patient or day hospital structures. Although Switzerland boasts a higher incidence of child and adolescent psychiatrists than its neighbours, the supply of such services is insufficient, in particular outside the densely populated cities.

The first subspecialty of adult psychiatry to be officially recognised by the Medical Chamber was old age psychiatry (2005), followed by consultation–liaison psychiatry (2008). For old age psychiatry, several university chairs have already been established; there are 37 training centres and about 100 certified old age psychiatrists. At present, there are ongoing efforts to establish two further psychiatric subspecialties (forensic psychiatry and addiction psychiatry).

Research and scientific journals

Swiss research in psychiatry has always been valued nationally and internationally. Research is done at all the universities, mostly of a clinical nature or on basic science. Currently, there is a tendency to form collaborative research groups connecting several neurosciences.

The only Swiss psychiatric journal still published is *Swiss Archives of Neurology and Psychiatry* (founded 1917, eight issues a year, published in German, French and English). Swiss authors are frequently present on the editorial boards of widely distributed scientific journals in English, German, French and Italian.

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Training in the management of post-traumatic stress disorder in Uganda

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The aims of this study were to establish the feasibility and effectiveness of training Ugandan mental health workers in the management of post-traumatic stress disorder (PTSD) based on guidelines from the UK National Institute of Health and Clinical Excellence (NICE). The Butabika Link is a mental health partnership between the East London Foundation NHS Trust (ELFT) and Butabika National Psychiatric Referral Hospital, Kampala, Uganda, supported by the Tropical Health Education Trust (THET), and based on the recommendations of the Crisp report (Crisp, 2007). The Link has worked on the principle that the most effective partnership between high-income and low- or middle-income countries is through organisations already delivering healthcare, that is, through the support of existing services. Butabika Hospital is a centre of excellence, serving an entire nation of 30 million people, many of them recovering from 20 years of armed conflict that took place mainly in the north of Uganda. In addition, Uganda has received refugees from conflicts in neighbouring states, including Congo, Rwanda, Kenya, Sudan and Burundi. The Ugandan Ministry of Health's Strategic Plan (2000) has prioritised post-conflict mental disorders and domestic violence, which is reflected in the vision of the Link's work.

Epidemiological data on PTSD in Uganda are scarce, though specific studies in war zones suggest a prevalence rate of 39–44% (Boardman & Ovuga, 1997; Ovuga *et al*, 1999, 2008; Liebling-Kalifani *et al*, 2008).

This paper describes how the East London and Ugandan trauma teams planned, delivered and evaluated a staff training programme in Butabika.

Method

The London team emailed training slides to Butabika staff. These included an introduction to a neurological model of traumatic memory (Brewin, 2001), trauma-focused cognitive–behavioural therapy (CBT) (Ehlers & Clark, 2000) and our own work with interpreters (d'Ardenne *et al*, 2007). THET provided training in the evaluation of partnership projects in June 2007 and also provided a third of the team's travel costs.

The London team arrived in September 2007 and spent 2 days with the Butabika staff for a briefing and to meet staff working with traumatised patients. The hospital has access to selective serotonin reuptake inhibitors (SSRIs) and CBT-trained psychology trainees from Makerere University. Training priorities were agreed with the executive director of the hospital, the consultant psychiatrist, the lead nurse in trauma and other clinical staff. Managers agreed to release clinicians for 4 days' training and ongoing time for further reading, supervision and trauma-related practice.

There were two key aims of the training:

1. to establish its feasibility – whether it would be possible to arrange workshops for the numbers and range of staff at Butabika
2. to establish its effectiveness – whether it would increase professionals' ability to recognise and diagnose PTSD, and whether local clinical practice for PTSD patients would change.

Workshops were devised to cover:

- first principles of PTSD
- evaluation of trauma work
- child abuse
- psychological treatments of PTSD in adults
- psychological treatments of PTSD in children
- grounding exercises with PTSD patients – theory and practice
- dual representation model of traumatic memory
- identification of 'hot-spots' and revisiting traumatic memory
- case discussion of child soldiers and the management of aggression
- psychological effects of war on children
- group therapy with traumatised adults
- working with interpreters and PTSD.

Four morning workshop sessions were advertised. The format was interactive, with slides, group exercises, role-plays, plenary feedback, discussion and written exercises. Three 90-minute workshops were held per morning, with breaks. Afternoons were spent on feedback, case-note audits and preparation. Forty-one mental health staff attended two or more workshops, including psychiatric nurses, occupational therapists, psychologists, counsellors, psychiatrists, trainee paediatricians and psychiatric clinical officers.

A written quiz was given at each workshop to clarify trauma experience and understanding. Participants were given evaluation sheets including a five-point Likert scale with these questions:

- How understandable was this workshop to you?
- How helpful was this workshop to you personally?
- How relevant was the workshop to your clinical practice with traumatised patients?
- What else would you have liked to learn?

Table 1 Trainee outcome: mean item ratings on a 5-point Likert scale[a] ($n = 18$–40 for attendance at individual workshops)

	Day 1	Day 2	Day 3	Day 4
How helpful was this workshop?	3.2	3.2	4.0	4.2
How relevant was this workshop?	4.6	4.3	4.9	4.8
How understandable was this workshop?	2.0	2.5	3.0	3.9

[a] 0 = not at all; 5 = completely.

The evaluations were scored and discussed, and training was adjusted accordingly. Clinical log-books were distributed to record ongoing changes in clinical practice with PTSD patients. General psychiatric staff identified group projects for their PTSD patients.

Results

A large majority of the participants (80%) reported increased confidence in recognising trauma. Outcome scores improved as the training progressed (Table 1). For example, on day 1, 25% of participants could name all PTSD symptoms by DSM–IV criteria and by day 4 this increased to 100%.

Ward groups for PTSD patients were identified to help rape victims, survivors of floods, war-affected children and survivors of childhood sexual abuse. Examples of written feedback, taken from clinical logs and from workshop forms, were published in a THET report in October 2007. Before the training, interventions for these patients were either non-existent or they were given supportive counselling. An education programme for carers was established to inform them of the meaning of intrusions, avoidance and hyperarousal.

Training was followed by further requests for training, reading materials, online supervision and exchange visits. Staff undertook evaluation of their trauma interventions and recorded this in case notes or clinical logs, as reported by the trauma manager.

A strategy has been developed to use the unit as a centre that trains trainers, who will be able to reach rural communities unable to access a national centre. The unit will use psychiatric clinical officers already working across the 16 districts of Uganda to complete and evaluate its training as the next stage of work.

Discussion

The aims of this study had been to establish the feasibility and effectiveness of training Ugandan mental health workers in the management of PTSD. The Ugandan team requested a Western training and clinical model for severely traumatised patients already in their care.

A PTSD training programme was devised rapidly that could engage significant numbers of clinicians working across mental health settings. Role-play and demonstrations were valued, as were presentations of local cases. Comprehension, utility and relevance improved with time, although data on reliability were affected by extreme ratings at the ends of the scales. London pronunciation, speed of speech and reliance on psychological jargon were quickly altered on feedback from participants.

Training involved cross-cultural and mutual learning. The London team learned how to phase work, about how limited resources can be built up, and about community approaches involving village elders in the rehabilitation of traumatised boy soldiers.

The study had many limits. It was very brief and small, and the training needs of a national referral centre considerably exceeded resources. But it provided hope as a first step and this was acknowledged, with a plan for sustainable training over future years and further exchanges, which continue today.

It is feasible to train mental health staff in Uganda to diagnose and refer PTSD patients. The effectiveness of the training was demonstrated but it will require ongoing evaluation for real and sustained development.

Dedication

This study is dedicated to the memory of Dr James Walugembe, who died shortly after completing this paper and whose work inspired this training.

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Investigating the quality of psychotropic drug prescriptions at Accra Psychiatric Hospital

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Quality of prescribing is an important aspect of clinical practice. In a study of the effect of electronic prescriptions on prescription quality in the UK, Donyai *et al* (2008) found errors in 3.8% of their sample before the introduction of electronic prescription. In a psychiatric setting in Leeds in the UK, Nirodi & Mitchell (2002) found that 16.1% of prescriptions written for a cohort of elderly patients were illegible, and a third lacked information on dose, frequency or indication of use of medications. They found that only 18% were legible and free of all errors.

The quality of prescriptions has also been subject to study in Africa: Akinola *et al* (2008) found that 53.5% of in-patient prescriptions were written in non-generic form and a significant minority involved polypharmacy.

Accra Psychiatric Hospital is a 700-bed facility in the centre of the city of Accra, the capital city of Ghana on the west coast of Africa. It has 1200 in-patients and holds regular out-patient clinics. The hospital pharmacy is a busy unit dealing with hundreds of prescriptions a day. After discussions with the psychiatrists and pharmacists, there was an agreed need to audit the quality of prescriptions.

Method

Because of the large number of prescriptions submitted to the pharmacy every month, it was deemed pragmatic to focus on one randomly chosen month in the year preceding the study. All prescriptions dispensed by the pharmacy in April 2008 were reviewed to find out whether the following criteria were met:

- The patient's age or date of birth should be mentioned.
- The prescription should be written legibly and not abbreviated.
- The spelling of the drug name should be correct.
- The dose of the drug should be stated without any ambiguity.
- The route of administration should be documented.
- The duration of treatment should be clear.
- Monotherapy should be preferred to polypharmacy.
- The generic name should preferably be used.

The above criteria were adopted from the *British National Formulary* (BNF) guidelines and modified *a priori* in consultation with the chief psychiatrist and chief pharmacist of the hospital.

A prescription was deemed illegible if all attempts failed to unravel the name of the medication. Where prescriptions contained more than one drug, the prescription was considered illegible if just one drug was written illegibly. The spelling of the drug name was checked using the *BNF*. The dose of medication had to be clear and legible. For the route of medication, phrases like p.o., oral, Tab, Cap and IM were all accepted.

Naturally, some patients were diagnosed with more than one condition and therefore needed to be on more than one medication. In this audit, polypharmacy was defined as the use of more than one psychotropic. Two categories of polypharmacy were also investigated *a priori* following discussions with the chief psychiatrist and chief pharmacist. One was the use of antipsychotics with or without anticholinergics. According to guidelines from the UK National Institute of Health and Clinical Excellence (2002), anticholinergics should not be prescribed routinely with first-generation antipsychotics and there should be minimal need for them with second-generation antipsychotics. The second category of polypharmacy was where more than one antipsychotic had been prescribed.

Results

In April 2008, 2410 prescriptions were issued. The results of the audit are summarised in Table 1.

In this investigation, 1226 antipsychotic prescriptions were issued in April 2008, 1106 of which were for conventional antipsychotics, 96 were for atypical antipsychotics and 24 included both conventional and atypical antipsychotics. In 871 (71%) of the 1226, the antipsychotic was prescribed along with an anticholinergic drug. Of the 355 prescriptions where antipsychotics were prescribed without anticholinergics, 63 were atypical antipsychotics and the rest were conventional ones.

There were 120 prescriptions of atypical antipsychotics (including the 24 combined with a conventional antipsychotic), and 57 (47%) of these also prescribed an anticholinergic. Finally, 826 (74%) of the prescriptions of conventional antipsychotics included an anticholinergic drug.

The audit results were presented to the medical staff of the hospital, as part of the audit cycle.

Discussion

This study showed that there is room for improvement in the quality of prescription writing. In many of the prescriptions, the age of the patient was not specified. This might not be

Table 1 Results of the review of the quality of prescriptions ($n = 2410$)

	Number	Percentage
Patient age recorded	410	17%
Legible prescription	1949	81%
Correct spelling	1525	63%
Clear documentation of the dose	2104	87%
Clear documentation of the route	2104	87%
Clear documentation of the duration	2397	99%
Polypharmacy	859	36%
Multiple antipsychotics in a prescription	116	3%
Unable to determine polypharmacy because of illegibility	314	13%
Use of generic name	309	13%
Use of generic name undetermined because of illegibility	397	15%

a significant problem in adults, but with children and the elderly, for whom the dosage is different, documentation of age is particularly important.

The legibility of prescriptions was questionable in a significant minority. Of note, the criteria chosen for assessing legibility were strict. Nonetheless, it must be acknowledged that prescriptions are legal documents and therefore should be legible. In 13% of prescriptions, the dose of the medication was not specified clearly, which could have jeopardised patient care.

One conspicuous practice was the use of non-generic names of drugs (87%). One report from Nigeria has shown a similar pattern of practice (Akinola *et al*, 2008). This can incur unnecessary costs, as it limits the drugs to ones produced by the original pharmaceutical company. However, no financial analysis was undertaken in the present study.

A third of prescriptions used two or more psychotropic medications and in 3% there was more than one antipsychotic prescribed. Although polypharmacy is not recommended in day-to-day practice, lack of pharmacological resources, such as not having access to drugs like clozapine, means many patients who do not respond to initial treatments end up being on more than one psychotropic medication.

There was a high prevalence of concomitant use of anticholinergic drugs with antipsychotics. As most of the prescriptions were for conventional antipsychotics, one might have expected anticholinergic co-prescribing, which was indeed the case in 94% of anticholinergic prescriptions. What is perhaps more alarming is that 47% of atypical antipsychotic prescriptions included an anticholinergic drug, something not endorsed by the guidelines (National Institute for Health and Clinical Excellence, 2002) and in fact discouraged. In the case of first-generation antipsychotics, the prevalence of extrapyramidal side-effects is 10% for acute dystonic reactions (American Psychiatric Association, 1997) and 20% for Parkinsonism (Bollini *et al*, 1994). Therefore, the high percentage (74%) of co-prescribing anticholinergics with first-generation antipsychotics is surprising. This practice should be subject to regular review and patients should not receive anticholinergics unnecessarily. It also increases the financial burden. This fact was confirmed by the chief pharmacist.

Conclusion

Considering the outcomes detected in this study regarding the quality of prescribing, there is a need for developing standards that are suitable for local practice. The standards chosen for this study were adopted from British ones and modified to suit local needs. They will not substitute for standards produced by local practitioners. This point was agreed when the results of the audit were presented at the Accra Psychiatric Hospital.

Having regular workshops for prescribers to update themselves with current standards of practice is worth considering. The hospital was in the process of organising one. Also, re-auditing the quality of prescriptions and regular feedback should be carried out, as this has been shown to have a beneficial effect. Ved & Coupe (2007) discovered after three audit cycles that 99.5% of the prescriptions in one mental health setting were legible.

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A month at the Hôtel-Dieu: a reversal of perspectives

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International medical graduates (IMGs) account for more than 30% of the first-year positions filled in US psychiatric residencies (Nation Residency Match Program, 2007). At the time of writing, the first author was 4 months away from finishing his residency at the University of Connecticut (UCONN) when the opportunity arose to turn the tables and use his fluency in French to complete a month-long elective in France. During this period, he spent time as an observer in the psychiatric service of a Parisian hospital, l'Hôtel-Dieu. The realisation of this elective was helped by the fourth author, who knew various members of World Psychiatric Association. This paper presents some comparative observations of the clinical milieus at UCONN and the Hôtel-Dieu.

History

Created around 650 AD, Hôtel-Dieu – Hostel of God – is Paris's first (and smallest) hospital and France's oldest (Abecassis, 1993). Its 14 centuries of history have included grim periods, such as the insanitary conditions that led to public criticism by Voltaire in 1768, as well as proud ones, like the production of such notable physicians as Laënnec, Dupuytren and Paré (Abecassis, 1993). Today, Hôtel-Dieu enjoys a reputation not just as a historical monument but as an institution among France's top hospitals, particularly in ophthalmology and thoracic surgery. Its psychiatric service is noted for being the first in France to move away from the free-standing asylum and into a general hospital.

Academia

French medical education begins after high school and consists of two cycles of roughly 3 years each (Segouin *et al*, 2007). A ranking examination determines the residency location and choice of specialty for the graduates. Psychiatric residency lasts 4 years, with the option of an additional year dedicated to either research or specialisation in child and adolescent psychiatry. Medical students are called *externes*, and residents, irrespective of year, *internes* – the term *internes* originated in the 18th century under Hôtel-Dieu's head-surgeon, Jean Mery, in reference to students who lived in the hospital (Abecassis, 1993). Residency rotations each last 6 months and their allocation is dependent on an *interne*'s seniority and results achieved in the national examination – *internat* (Segouin *et al*, 2007). The daily patient load and academic responsibilities of the *internes* at Hôtel-Dieu parallel those of UCONN residents. The *internes* have a maximum case-load of six patients each, compared with seven for UCONN residents. Though the *internes* cover the emergency department until 6.30 p.m., they do not have overnight calls, nor are they expected to manage out-patients, both of which are requirements for UCONN residents. In contrast, even under supervision, *internes* tend to be more clinically independent, even when it comes to administering electroconvulsive therapy.

Clinical approach

Much as in the USA, the clinical approach in Paris is based on a biopsychosocial model. The team is led by a psychiatrist and includes ancillary staff. Morning report takes place at 9.00 a.m. and that is when nurses report the latest information on every patient. In contrast to UCONN, where every day of in-patient stay needs approval by an insuring entity, with universal healthcare in France there is a relative lack of urgency in the discharge planning for patients at Hôtel-Dieu. Collateral information, social history and developmental facts are gathered judiciously. As the teams get to know the patient, days may pass in establishing a diagnosis before medications or other treatments are started. In 1999, the mean duration of an in-patient psychiatric stay in France was 32 days (Verdoux & Tignol, 2003). Given the relatively slow process of psychiatric treatments, this setting provides any psychiatrist in training an excellent opportunity to witness the natural course of psychiatric disease and its management.

Though medications and other approaches are similar to how care is delivered in the USA, traditional psychoanalytic theories have a prominent influence on French psychiatry, even on in-patient services. Many patients routinely receive psychoanalytic out-patient therapy and a large number of French private psychiatrists restrict their practice to psychoanalysis only (Verdoux & Tignol, 2003). The clinical usefulness of psychodynamic principles becomes especially evident when the team tries to engage a patient's family. Biologically, communication with other medical specialties is emphasised and French psychiatrists seem exquisitely well trained in the principles of internal medicine and neurology. French patients seem to recognise and revere their psychiatrists, the same way they do with physicians in other specialties.

In terms of boundaries, a mandatory white lab coat, worn by all hospital staff, makes the distinction between patient and doctor inescapable. On the other hand, classical French culture, with its routine greetings, pleasantries and ways of respecting others, makes being empathic that much more automatic and that much easier.

French psychology plays an important role in the diagnosis of patients, with the application of both traditional – Rorschach – as well as neuropsychological testing modalities. When a specific mode of psychotherapy is desired, psychologists with the necessary expertise are available. An in the USA, the title 'psychotherapist' is ill-defined and various professional backgrounds serve as qualifiers for the trade (Verdoux & Tignol, 2003). In contrast to the USA, in France the idea of psychology expanding into medication management is as absurd in reality as it is in theory.

Mental health organisation

In 1998, mental disorders accounted for 9.4% of France's total health expenditure (Verdoux & Tignol, 2003). In the USA, this proportion declined from 8% in 1986 to 6% in 2003 (Mark *et al*, 2007). French psychiatric in-patient units are centralised under the direction of the Ministry of Health (Verdoux & Tignol, 2003). These units are responsible for a catchment area or *secteur*. Community clinics – *centres medico-psychologique* (CMP) – will refer a patient who needs to be admitted to the in-patient facility serving that *secteur*. The set-up at Hôtel-Dieu is unusual in that, since it is the only institution in Paris that provides forensic psychiatric care, the service cares for patients who are referred from all over the city.

Regardless of locality, it is standard practice for a physician evaluating a patient in crisis to call the local CMP, which, based on the psychiatrist's recommendations, assists in the management and possible transfer of the patient. Unfortunately, since the homeless do not have a primary place of residence, they are at risk of falling through the cracks in the system. In cases of discharge or consultation without CMP involvement, a handwritten clinical letter is always sent to the primary psychiatrist or physician – private or public – who is always kept abreast of the patient's developments. This standard of communication between physicians, and the centralised structure of the system, makes the care of patients with acute and chronic psychiatric illness very effective.

Hôtel-Dieu's in-patient service is an open unit – *unite libre*. Individuals admit themselves and leave when they wish. Once in-house, patients are expected to follow rules that pertain to the care that they will receive. If a psychiatrist gives them permission, patients are allowed to leave the premises for a certain predetermined period. Patients use this leave, which can last up to 48 hours, to go out for strolls and meals with friends and family. Patients also continue their outpatient visits with their therapists, who then communicate their findings to the in-patient team. Though patients are allowed to smoke, they are prohibited from self-intoxication with alcohol or drugs of misuse. For high-risk patients, to ensure security and safety, privileges for leaving the premises are withheld and the patient is put under close observation in anticipation of a transfer to a closed unit. This open philosophy is in stark contrast to the closed-unit model at UCONN. Evidently, the severity of psychopathology at Hôtel-Dieu tends to be of a mild to moderate degree for patients to enjoy such liberties. Regardless, in terms of adherence to the recommended regimes, this open philosophy puts the responsibility on the patients to exercise a choice in their willingness to participate in their care. It is not that the hospital is not responsible for the welfare of patients, but that French common law is strict in its protection of civil liberties (Abgrall-Barbry & Dantchev, 2007). In comparison with the USA, where the brunt of the burden is on the hospital to ensure safety for patients, it was refreshing to see psychiatry practised in a setting that is not dictated by adherence to knee-jerk, risk-aversive management protocols, but that of true collaboration between patient and psychiatrist.

In France, involuntary admission is rare, since a signature from a 'concerned third party' such as a friend, family member or a social worker familiar with the patient is necessary for admission or discharge (Abgrall-Barbry & Dantchev, 2007). For example, a floridly manic patient with paranoid thinking was discharged because her partner opted for her release in the face of recommendations to the contrary.

In a minority of cases, with behaviour that is dangerous or disruptive, the police become involved and the patient can be admitted without a consenting third party.

Conclusion

The goal of this experience was to view psychiatry from a different perspective. The opportunity gave the first author a particular appreciation for the effectiveness of the centralised structure and governmental support of French psychiatry, the clinical usefulness of psychodynamic principles in acute settings, as well as the chance to observe the natural course of psychiatric disease and its management. This has inspired other IMG residents in the department to look at opportunities in other countries, such as China, India and Colombia. Given the number of IMGs within the US psychiatric workforce, it seems that the field is ripe with opportunities for global communication, education and progress.

Acknowledgement

The authors would like to thank Allan Tasman MD and Leighton Huey MD for their efforts in the realisation of this paper.

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Mental health promotion for the widows of injecting drug users in north-east India

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The prevalence of HIV is high in the north-east Indian states of Manipur and Nagaland. The major route of HIV transmission is injecting drug use. Most injecting drug users (IDUs) are male and about 40% are married. The widows of IDUs are among the most disadvantaged people. Many are HIV-infected and experiencing poverty, poor health, social isolation and discrimination, all factors likely to compromise their mental health. Some widows are engaging in HIV risk behaviours, including alcohol and drug misuse, sex work and unprotected sex. There is increasing recognition of the links between poverty and mental health status and risk of HIV infection. People with poor mental health are more likely to engage in HIV risk behaviours.

Mental health can be promoted by public health actions with vulnerable population groups. The World Health Organization (WHO) has recently published reports on mental health promotion and women's mental health (WHO, 2000; Herrman *et al*, 2005) and these have highlighted the emerging evidence base for effective public health actions, as well as the need for practical collaboration between health and non-health sectors. Mental health is more than simply the absence of mental illness; it is the foundation for the well-being and effective functioning of individuals and communities (WHO, 2007). Mental illness is associated with indicators of poverty, including low levels of education, poor housing and low income, and with a range of illnesses, including HIV infection (Freeman *et al*, 2005). HIV infection and depression, as well as other health and social problems such as substance misuse and violence, are more prevalent and more difficult to cope with in conditions of low income, limited education and unemployment (Desjarlais *et al*, 1995).

A public health framework adopted by the WHO and proposed initially by the Victorian Health Promotion Foundation (Walker *et al*, 2005) identifies three key social and economic determinants of community and individual mental health: (1) social inclusion; (2) freedom from discrimination and violence; and (3) access to economic resources. This framework recognises that psychosocial and economic factors influence a number of health-related behaviours, such as substance misuse and risky sexual behaviours (Chandra *et al*, 2003).

Although the health benefits of community participation are well understood in development work, health policy does not always reflect this, partly because the published evidence related to this approach is limited. Our intervention drew on participatory action research (PAR) approaches to health development. Researchers work with specific communities to identify problems and develop solutions. This enhances self-confidence and leadership skills, and helps members of the community to address their own health and social needs. For example, a study in Nepal demonstrated that community-based participatory action had a significant positive impact on maternal and infant mortality (Manandhar *et al*, 2004).

We aimed to take the first steps to evaluate the use of participatory action groups (PAGs) to promote the mental health of IDU widows, as a strategy for HIV prevention (Devine *et al*, 2007; Kermode *et al*, 2008).

Method

We designed a pilot intervention study to assess the feasibility and impact of PAGs to promote the mental health and well-being of widows of IDUs in Manipur and Nagaland, as a strategy for reducing the risk of engagement in HIV risk behaviours. An intervention over 20 weeks included 74 widows in six peer-facilitated PAGs, with a focus on promoting mental health.

Changes in quality of life, mental health, somatic symptoms and HIV risk behaviours were assessed using questionnaires and rating scales. This paper, though, reports the value of the intervention from the perspective of the participants, captured using a qualitative evaluation method, 'most significant change' (MSC). This method is a qualitative, participatory approach to monitoring and evaluation used in development projects (Davies & Dart, 2004). We collected 'stories of change' from participants during the eighth PAG meeting, and involved different stakeholders in the systematic selection of those stories that best captured what they considered to be the 'most significant change'. Reasons for selecting particular stories were also documented. The point of MSC is that both the content of the selected stories and the reasons for choosing them make the values of the different stakeholders explicit. This can be used to foster dialogue between potentially competing perspectives, in this case that of the IDU widows and the non-governmental organisations (NGOs). As the MSC approach tends to elicit positive stories (in relation to the intervention), this method is not used as an evaluation tool in isolation.

The study was funded by the UK Department for International Development (DFID) through the Research and Learning Fund. Ethics approval was obtained from the University of Melbourne Human Research Ethics Committee (Australia) and the Emmanuel Hospital Association Institutional Review Board (India) in early 2006.

Results

The questionnaire responses indicated that the participants' quality of life, mental health and physical health improved over the course of the intervention. The women told stories about 'significant changes' highlighting the positive impact of the intervention, with themes of economic participation, social inclusion, discrimination, physical health and future orientation. Information about HIV risk behaviours was limited by inhibitions about reporting sexual behaviours.

Each of the groups developed an action plan for promoting mental health and the longer-term sustainability of the group. Several of these plans included proposals for income generation.

A relatively generous allowance was paid to the women to cover travel and childcare costs. No allowance was paid to the women after the PAGs concluded, but support for continuing meetings was given by NGOs. Although we do not know the extent to which the allowance influenced participation, this was important in motivating and recruiting women to participate in the intervention at the outset. Six months after the last PAG meeting, five of the six groups were still meeting and some have since expanded their activities.

Discussion

This participatory intervention study to promote the mental health of widows of IDUs apparently had a positive impact on the participants' quality of life and mental health. However, the sustainability of the improvement and the links between this and their engagement in HIV risk behaviours remain to be demonstrated. The intervention also increased awareness among the NGO leadership of the situation faced by the widows of IDUs. The MSC process was important in this.

Widows in India are socially and economically disadvantaged, and the situation for widows of IDUs is often worse. They are frequently stigmatised on three levels – for being a woman, for being a widow and for being HIV-positive. Participatory approaches to mental health promotion may well have a positive impact on the lives of vulnerable women and potential to contribute to HIV prevention. Poverty alleviation through economic participation is likely to be a mediating factor, as well as a consequence of improved mental health. Further investigation is warranted.

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NEWS AND NOTES

Contributions to the 'News and notes' column should be sent to: Amit Malik MRCPsych, Consultant Psychiatrist, Hampshire Partnership NHS Trust, UK, email ip@rcpsych.ac.uk

College at the TOP conference

The TOP (Teachers of Psychiatry) conference in Singapore (24–25 February 2009) was organised by the Department of Psychological Medicine, National University of Singapore, with the participation of the Western Pacific Division of the Royal College of Psychiatrists, Pacific Rim College of Psychiatrists and Asian Federation of Psychiatric Associations. There were 270 participants, from Asia, Australia, the USA and Europe. The College provided financial assistance to 16 young psychiatrists from Asia.

The keynote lecture, 'Training psychiatrists for the future', was delivered by Professor Norman Sartorius. The College President, Professor Dinesh Bhugra, spoke on training the trainers, Emeritus Professor Scott Henderson gave tips on teaching research skills and Professor M. P. Deva discussed issues of primary care psychiatry in Asia.

The conference stirred renewed interest in psychiatric education and academic psychiatry. The participants indicated that the most stimulating and relevant topics discussed were:

- training the trainers
- psychiatric education for primary care doctors
- campus mental health
- rethinking psychological therapy in Asia.

The TOP club intends to organise future workshops in Asia on these four topics.

Workshop on mental health for the Prisons Department, Kenya

In December 2008, the African Division of the College, in collaboration with the Department of Prisons of the Government of Kenya, the Kenya Psychiatric Association, the University of Nairobi, the Africa Mental Health Foundation and others organised a training workshop for Prison Health Service staff. The aim was to provide basic skills in identifying mental disorders, to introduce evidence-based mental health practices, to improve interdepartmental cooperation and to reduce stress and burn-out among prison staff. The workshop, held in Nairobi, was supported by a financial grant from the College (£3000). Of the 50 clinicians (clinical officers, nurses, laboratory and nutrition staff and technicians) attached to the Prison Health Service, 27 were able to attend. They were selected on the basis of seniority at their stations and geographical location to ensure a regional representation of all the prisons in the country.

The topics included stress management and burn-out, mental health and crime, schizophrenia and other psychotic disorders, personality disorders, sexual behaviour and HIV/AIDS, drug use, depression and suicide, and quality of data assurance. At the end of the workshop, participants and the organisers agreed the following were needed to improve mental health in prisons:

- a 2-week training course for all clinical staff, which should additionally cover record keeping
- a 2-day exposure workshop for senior clinicians and officers in all prison facilities in Kenya
- a survey of mental disorders and substance misuse in prisons (a protocol has already been developed and approved by the Research and Ethics Committee but funding is lacking).

Fund-raising trek to Kerala for the International Volunteer Programme

In February, 14 psychiatrists and friends completed a demanding sponsored trek in aid of the College's International Volunteer Programme. The participants, who persuaded other people to sponsor this challenge, raised over £30 000. The College is repeatedly made aware of the difficulties faced by members who are working as lone psychiatrists with little support, and the International Volunteer Programme is one way in which the College is responding. The funds raised will support psychiatrists to offer assistance at the request of overseas College members in countries such as Malawi, Ghana, Iraq and Sri Lanka. The trek and the fund-raising activities of the trekkers also raised awareness about the lack of provision for people with mental disorders in low- and middle-income countries.

The trekkers successfully climbed Meesapuli (8700 feet), the second highest peak of the Western Ghat Mountains in India, a challenging endeavour in temperatures ranging from 7°C to 40°C. They slept in tents, walked with backpacks and used torches for light.

This is the first time the College has organised such a fund-raising event. Readers wishing to contribute to the International Volunteer Programme fund can do so online: http://www.justgiving.com/rcpsych or by cheques sent to Liz Cowan at the College.

The Faculty of Child and Adolescent Psychiatry in Kenya

The Faculty of Child and Adolescent Psychiatry has been supporting the development of better child and adolescent mental health services in Kenya since 2006, and each year has generously provided a small budget to support this work. In 2009, the Faculty is supporting the International Institute of Special Needs Offenders in its work to develop youth offending services in Kenya, with a particular focus on the mental health needs of young offenders. This work builds on previous work developing multi-agency protocols and training in youth offending work in Nairobi, which was evaluated by the University of Lancaster and found to be highly effective in developing services. In addition, a scoping exercise in 2009 will look at how best to enhance the capacity of the specialist child and adolescent mental health team at Nairobi University by means of further training.

For further information contact Dr Michael van Beinum via the Faculty of Child and Adolescent Psychiatry at the College London office.

The European Division World Congress of Mental Health

The European Division of the College will participate in the World Congress of the World Federation for Mental Health in Athens, 2–6 September 2009, with a symposium on 'Ethical challenges in medicine and psychiatry', chaired by the chair of the Division, Professor George Christodoulou.

Professor Christodoulou will also speak on 'Ethical issues in research: the declaration of Helsinki', Professor George Ikkos will speak on 'Professionalism and ethics', Dr Thanassis Douzenis on 'Ethics and compulsory admissions' and Dr Maria Margariti on 'Ethical issues in telecommunications'. The discussants will be Professor John Copeland and Professor Jitendra Trivedi.

The Congress is organised by the World Federation for Mental Health (the organisation that sets the theme of the World Mental Day, 10 October) in collaboration with the Hellenic Psychiatric Association and the Society of Preventive Psychiatry.

Further information is available on the Congress website, http://www.wmhc2009.com, or by emailing info@era.gr, gchristodoulou@ath.forthnet.gr, psych@psych.gr.

African Journal of Psychiatry

The *African Journal of Psychiatry* has been selected for inclusion in the MEDLINE database. This has been years in the making but worth all the effort. Africa now has representation for psychiatry in one of the world's major databases.

Editor's dilemma on low-income countries

Sir: Peter Tyrer's editorial in the October issue makes interesting reading and certainly deserves credit for its balanced view on a subject seldom discussed yet pertinent to intellectual growth in a supposedly globalised world. There are two poignant issues.

First, publication bias is very difficult to avoid in the context of the inordinate disparity in socioeconomic development between high-income and low-income regions. This subtly instigates a prejudice against outputs from the low-income countries in general, and assessment of a paper from a low-income country for publication in a journal in the West is just one aspect of this global prejudice.

Second, an editor has a repertoire of reasons for rejecting a paper at the in-house level not necessarily related to the quality of the paper and any of these reasons could be an avenue of the editor's transference – political or cultural or both. To illustrate this point, I recall a non-plenary discussion at a meeting of the West African College of Physicians at Accra, Ghana, in 2003, at which African psychiatric authors mentioned some 'editorial' reasons for rejection of their papers submitted to journals in high-income countries. These included 'constraint of printing space', 'the theme of your paper is outside the current interest of the journal', and so on. Could these reasons be euphemisms for poor-quality submissions or simply biased rationalisations?

Richard Smith, former editor of the *BMJ*, in an address to a coterie of Nigerian medical academics in Lagos, Nigeria, in 2002, stressed the need to blend editorial scrutiny (peer review) with achieving an ecumenical (my term) spread of published papers in any international journal. The quest for quality, of course, is paramount and I express my total abhorrence at the idea of applying less demanding criteria in the assessment of papers from low- and middle-income countries in order perhaps to placate their authors.

It should be borne in mind that there are ample intellectual and motivational resources in low- and middle-income countries, though these have often been substantially emasculated by political misgovernance. It would be helpful to use existing support from high-income countries: discounted publications (journals and books), the restructuring of the composition of editorial boards to include assessors from low- and middle-income countries (Horton, 2003), the offer of learning facilities (e.g. access to e-databases) and sponsored exchange programmes for collaborative research, as implied in the programme for Young Investigators in Biological Child and Adolescent Psychiatry (Ehrlich & Stegemann, 2007). These forms of assistance, aside from being salutary to understanding trans-regional patterns of psychiatric epidemiology and enhancing intellectual advancement, would be tantamount to ploughing back to low- and middle-income countries some of the huge gains of colonialism to the West.

Oluwole Famuyiwa
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Correspondence is welcome either on articles published in *International Psychiatry* or on aspects of current policy and practice in psychiatry in different countries. Letters (of up to 500 words) should be sent to: Amit Malik MRCPsych, Consultant Psychiatrist, Hampshire Partnership NHS Trust, UK, email ip@rcpsych.ac.uk.

Author's reply

Sir: Professor Famuyiwa raises some relevant points which are difficult to answer easily. Do editors live in leafy worlds of global prejudice or are some of them just being hard-nosed climbers in the Journal Impact Table? The sad conclusion is that US papers will be cited most in the literature and those from low-income countries the very least, and although I agree this may often not be based on merit, it is the current fashion. When an editor such as Richard Horton does stick his neck out and publishes a series on global mental health (those who think he was just a vehicle in this enterprise are mistaken – he was the prime mover) in which the low-income countries do get a proper mention and also a boost to their influence that goes far beyond lip service (*Lancet*, 2008), it is difficult to know what the rest of the editorial world thinks. The series has gone down well (Patel *et al*, 2008) and I am sure at least a few editors have regretted not being in the forefront of this movement themselves.

We also need to be aware that the major medical journals of the world are going through a difficult time at present because the influence of what is euphemistically called special interests, but in essence mainly consists of the pharmaceutical industry, has handicapped some of the advice that has been delivered, and paradoxically better information has flowed forth in low-income countries (Adams *et al*, 2006).

Forthcoming international events

13–14 July 2009
Fourth International Conference on Child and Adolescent Psychopathology
London, United Kingdom
Organiser: School of Human and Life Sciences, Roehampton University
Contact: Professor Cecilia Essau
Website: http://www.roehampton.ac.uk/staff/CeciliaEssau/

22–26 August 2009
Quality of Life in Child and Adolescent Mental Health
Budapest, Hungary
Organiser: European Society for Child and Adolescent Psychiatry and the Hungarian Association for Child Neurology and Child and Adolescent Psychiatry
Contact: CongressLine Ltd
Email: vamos@congressline.hu
Website: http://www.escap2009-Budapest.com

1–2 September 2009
1st Australasian Refugee Health Conference
Perth, Australia
Organiser: Department of Health, Western Australia
Contact: Dr Bernadette Wright
Email: info@themhs.org
Website: http://health.wa.gov.au/mentalhealth/events/refugee_health.cfm

2–6 September 2009
World Congress of Mental Health
Athens, Greece
Organiser: World Federation for Mental Health
Contact: Prof. George Christodoulou
Email: gchristodoulou@ath.forthnet.gr
Website: http://www.wmhc2009.com

14–17 September 2009
2nd Global Conference: Madness – Probing the Boundaries
Oxford, UK
Organiser: Inter-Dyscyplinary.Net
Contact: Dr Rob Fisher
Email: mad2@inter-disciplinary.net
Website: http://www.inter-disciplinary.net/probing-the-boundaries/making-sense-of/madness/call-for-papers/

21–23 September 2009
Second European Conference on Schizophrenia Research (ECSR)
Berlin, Germany
Organiser: German Research Network on Schizophrenia
Contact: Dr Wolfgang Gaebel
Email: schizophrenia@cpo-hanser.de
Website: http://www.schizophrenianet.eu

22–25 September 2009
29th Nordic Congress of Psychiatry
Stockholm, Sweden
Organiser: Swedish Psychiatric Association, Swedish Association for Child and Adolescent Psychiatry
Email: ncp2009@mci-stockholm.se
Website: http://www.ncp2009.org

24–26 September 2009
VII World Congress of Depressive Disorders and International Symposium on Posttraumatic Stress Disorder
Mendoza, Argentina
Organiser: University of Cuyo
Contact: Dr. Jorge Nazar
Email: jorge_nazar@hotmail.com

6–9 October 2009
16th World Congress of the World Association for Dynamic Psychiatry (WADP)
Munich, Germany
Organiser: World Association for Dynamic Psychiatry
Contact: Dr Sabine Funk
Email: sa.funk@t-online.de
Website: http://www.wadp-congress.de

14–16 October 2009
Fifth International SIVUS Conference on Mental Retardation
Dhaka, Bangladesh
Organiser: SIVUS International
Contact: Dr Anwarul Hasan Sufi
Website: http://sivusconference.synthasite.com

22–24 October 2009
6th European Congress on Violence in Clinical Psychiatry – Assessing, Treating and Caring for Potentially Violent Patients
Stockholm, Sweden
Organiser: Oud Consultancy
Contact: Mr N. E. Oud
Email: conference.management@freeler.nl
Website: http://www.oudconsultancy.nl

22–24 October 2009
WPA Sponsored Regional Meeting
Abuja, Nigeria
Organiser: African Association of Psychiatrists and Allied Professions in collaboration with the Association of Psychiatrists in Nigeria
Contact: Dr Oye Gureje
Email: ogureje@comui.edu.ng

7–10 November 2009
2nd World Congress of Asian Psychiatry, 'Working Together for Excellence of Asian Psychiatry'
Taipei, Taiwan
Organiser: Asian Federation of Psychiatric Associations (AFPA) in collaboration with the Taiwanese Society of Psychiatry (TSP)
Contact: Prof. N. Shinfuku
Email: shinfuku@seinan-gu.ac.jp
Website: http://www.2ndwcap.org.tw/

12–15 November 2009
10th World Congress of the World Association of Psychosocial Rehabilitation
Bangalore, India
Organiser: World Association of Psychosocial Rehabilitation
Contact: Dr Afzal Javed; Dr T. Murali
Email: afzal@afzaljaved.co.uk; muralithyloth@gmail.com
Website: http://www.wapr.info

26–28 November 2009
XIV Annual Course of Schizophrenia
Madrid, Spain
Organiser: General University Hospital 'Gregorio Marañón' of Madrid; International Society for Psychological Treatments of Schizophrenias and Other Psychoses
Contact: Viajes Iberia Congresos
Email: sec.tecnica@cursoesquizofreniamadrid.com
Website: http://www.cursoesquizofreniamadrid.com

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Organiser: SIVUS International
Contact: Dr Anwarul Hasan Sufi
Website: http://sivusconference.synthasite.com

22–24 October 2009
6th European Congress on Violence in Clinical Psychiatry – Assessing, Treating and Caring for Potentially Violent Patients
Stockholm, Sweden
Organiser: Oud Consultancy
Contact: Mr N. E. Oud
Email: conference.management@freeler.nl
Website: http://www.oudconsultancy.nl

22–24 October 2009
WPA Sponsored Regional Meeting
Abuja, Nigeria
Organiser: African Association of Psychiatrists and Allied Professions in collaboration with the Association of Psychiatrists in Nigeria
Contact: Dr Oye Gureje
Email: ogureje@comui.edu.ng

7–10 November 2009
2nd World Congress of Asian Psychiatry, 'Working Together for Excellence of Asian Psychiatry'
Taipei, Taiwan
Organiser: Asian Federation of Psychiatric Associations (AFPA) in collaboration with the Taiwanese Society of Psychiatry (TSP)
Contact: Prof. N. Shinfuku
Email: shinfuku@seinan-gu.ac.jp
Website: http://www.2ndwcap.org.tw/

12–15 November 2009
10th World Congress of the World Association of Psychosocial Rehabilitation
Bangalore, India
Organiser: World Association of Psychosocial Rehabilitation
Contact: Dr Afzal Javed; Dr T. Murali
Email: afzal@afzaljaved.co.uk; muralithyloth@gmail.com
Website: http://www.wapr.info

26–28 November 2009
XIV Annual Course of Schizophrenia
Madrid, Spain
Organiser: General University Hospital 'Gregorio Marañón' of Madrid; International Society for Psychological Treatments of Schizophrenias and Other Psychoses
Contact: Viajes Iberia Congresos
Email: sec.tecnica@cursoesquizofreniamadrid.com
Website: http://www.cursoesquizofreniamadrid.com

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