

International psychiatry

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Non-communicable diseases and the mental health gap: what is to be done?

Vijay Ganju

Secretary General, World
Federation for Mental Health,
email vkganju@gmail.com

The increasing evidence base for cost-effective interventions and a fledgling advocacy effort have given momentum to mental health becoming a global priority. The contention of this editorial is that we are at a tipping point if we can exploit the opportunities that will be afforded to mental health professionals and advocates in the next year or two. The missing links are the development of consensus among mental health stakeholders, the formation of coalitions and partnerships with both advocates and policy-makers, and the mobilisation of a stronger advocacy effort built around consumer and family member 'voice' and empowerment.

As the *Mental Health Atlas 2011* report from the World Health Organization (WHO) shows, in most countries the implementation of mental health programmes over the past decade has been glacial, if not nonexistent. While the rationale for including mental health as a priority in global and national health agendas has been strengthened and refined – as reflected in the *Lancet* series on global mental health (*Lancet*, 2007) and the paper 'Grand challenges in global mental health' (Collins *et al.*, 2011) – this has not resulted in significant traction with policy-makers and national planners. Even though mental health advocates and some policy-makers presented arguments 'making the case' at the High-Level Meeting on Non-Communicable Diseases convened by the United Nations in September 2011 and the international meetings leading up to it (Ghodse, 2011; Ganju, 2011a), mental health was not included in a substantive way. This is especially disquieting because these arguments were not just general demands for the prioritisation of mental health in the policy schema, but contained specific recommendations regarding action and implementation, including treatment and programmatic interventions such as the World Health Organization's mhGAP programme (WHO, 2010a) and the infrastructural changes needed.

In the Political Declaration of the High-Level Meeting, there were several references to mental health, the most significant being the recognition 'that mental and neurological disorders, including Alzheimer's disease, are an important cause of morbidity and contribute to the global non-communicable disease burden, for which there is a need to provide equitable access to effective programs and healthcare interventions' (United Nations General Assembly, 2011).

The rationale for the inclusion of mental health in the agenda regarding non-communicable disease (NCD) is impeccable. Mental illnesses are highly

prevalent, affecting one out of every five persons each year. Neuropsychiatric disorders are estimated to contribute to 13% of the global burden of disease (WHO, 2011). Suicide claims the lives of at least one million people annually. Even in the least developed regions of the world, where infectious and parasitic diseases are prominent, mental, neurological and substance use disorders are a major burden. Over the next 20 years, it is estimated that neuropsychiatric disorders alone will account for the loss of an additional US\$16.1 trillion, with 'dramatic impacts on productivity and quality of life' (Bass *et al.*, 2012).

Besides the prevalence and burden argument, the other components of 'making the case' include: the link between mental health and economic and social development, as outlined in the WHO (2010b) report *Mental Health and Development*; the fact that we now have economically viable evidence-based interventions for specific mental illnesses and disorders; the humanitarian argument related to stigma, discrimination and equity; and the strong bi-directional link between mental health and NCDs such as diabetes, cancers, cardiovascular diseases and respiratory diseases (Ganju, 2011a). Mental illness is not only a risk factor for other entities, but is often a consequence of having diabetes, cancer, cardiovascular disease or respiratory disease. Here the argument is that without addressing mental and substance use disorders explicitly, outcomes related to NCD initiatives not only will be less effective but also, as the research shows, will cost more. For example, we know that people with diabetes have twice the risk of being depressed as those without the condition: treating both diabetes and depression results in improved medication adherence and lower healthcare costs.

Unfortunately, even though these arguments have been reiterated in journal articles, reports and international meetings, they have not resonated politically. The arguments are necessary but not sufficient: the expectation that the existence and presentations of the rationale will be the basis of action is, at best, wishful.

Reasons for the exclusion of mental health in the NCD agenda by policy-makers and mental health advocates include: the absence of mental health advocates at the NCD advocacy table over the past several years; the inability or unwillingness of mental health stakeholders to forge partnerships and alliances with the broader NCD coalitions; and the weakness of the 'voice' of persons with psychiatric illnesses and their family members.

Mental health advocacy related to the global NCD agenda started just a year before the United Nations High-Level Meeting. The rationale was presented at various forums, but by then the

course had been set, and the belated positions for mental health were hard to incorporate. Even at the WHO, where mental health is recognised as a global priority, administrators adopted a position where they acknowledged mental health but did not incorporate it fully because of the cost implications and in case the delicate balance in a series of compromises was undermined.

However, in the build-up to that UN High-Level Meeting, a foundation for future activities was laid. Under the auspices of the World Federation for Mental Health (WFMH), numerous mental health and health advocacy groups came together to present the case for mental health from a civil society perspective. The health ministers (or equivalents) of several countries – India, the USA, Uganda, South Africa, Canada, Brazil, Guyana, Liberia, to name a few – were proactive. A meeting convened by mental health advocates with several health ministers in New York on the eve of the High-Level Meeting developed positions and recommended next steps (Ganju, 2011b). These activities led to a draft resolution on mental health moved jointly by India, Switzerland and the USA for consideration by the WHO executive board meeting in January 2012. This resolution was passed and has tremendous implications for what needs to occur next, in fairly short order.

A major recommendation in the resolution is a request to the WHO Director-General 'to strengthen advocacy, and develop a comprehensive mental health action plan with measurable outcomes ... to provide treatment, facilitate recovery and prevent mental disorders, promote mental health and empower persons with mental disorders to live a full and productive life in the community'. Several provisions are also outlined for inclusion in the action plan, which will be submitted in 2013, through the WHO executive board, for consideration by the 66th World Health Assembly.

This resolution provides impetus and direction. Some activities that need to occur in the near future include: convening representatives of mental health

stakeholder groups to formulate consensus positions; developing partnerships and alliances with other NCD groups to explore how mental health and the NCD agenda can be aligned; and using existing consumer and family groups to ensure that their voice is an integral part of planning at both national and international levels. The development of a People's Charter for Mental Health (Bass *et al*, 2012) is a critical component, but this must be put in the context of a 'top-down, bottom-up' partnership between policy-makers and advocates, and lateral, horizontal alliances across both mental health and NCD stakeholder groups.

We are potentially at the cusp of a new era in mental health. We must work together to ensure that we take advantage of the opportunities that exist to make mental health truly a global priority.

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Mental health and the World Health Organization: translating strategy into practice

David Skuse

Behavioural and Brain Sciences Unit, Institute of Child Health, London, UK, email d.skuse@ucl.ac.uk

We asked the programme managers for mental health at the World Health Organization's Regional Offices for Europe, the Eastern Mediterranean and South-East Asia to provide an account of developments in the provision of mental health services within their regions.

We are very fortunate that these busy and influential individuals were able to set aside the time to prepare articles that shed a fascinating light on strategic thinking within the World Health Organization.

In Europe, Dr Muijen emphasises the importance of the movement that aims to encourage the establishment of community-based mental health services. Even in Europe, there is a serious treatment gap – estimated to be up to 50% (i.e. only half of those requiring mental health support are getting it). The UK is an example of a country that has relatively few in-patient services, and in fact is on a par with Albania and Turkey, but, unlike those countries, the UK has invested heavily in community mental health. There are exemplars of good practice in Eastern as well as in Western Europe, but they are few in number. The establishment of good quality community services is challenging at many different levels and cannot be achieved by centralised planning alone. Dr Muijen pleads for better training in managing service development for psychiatrists in general.

In the Eastern Mediterranean, Drs Saeed and Gater discuss how their Regional Office has recently devised a plan to promote mental health provision in the 23 countries incorporated into this authority. As in so many other parts of the world, despite there being a tremendous burden on mental health services arising from regional conflicts, economic challenges and immigration, the

investment by governments in mental healthcare amounts to no more than 5% of that recommended globally. These authors propose a six-point strategic plan, based on the development of community psychiatry provision, which could be implemented on a limited budget within the next 5 years. The strategy emphasises decentralised community services in the context of forward-thinking national policies, with a research infrastructure that will allow full evaluation of implementation and progress.

Finally, in South-East Asia Dr Anwar and colleagues discuss the changes in their region in the context of gross underfunding and a paucity of psychiatrists (just a sixth of the median number per head of population in global terms). In order to tackle this shortfall, which is not going to be correctable in the foreseeable future, the South-East Asia Regional Office has decided to train community-based health workers to recognise serious mental and neurological disorders; treatment will then be provided by a primary care physician. Their emphasis in the first phase of this plan will be upon epilepsy, psychosis and depression. A number of pilot projects have already been established.



Scaling up in Europe: learning from diversity

Matt Muijen

Programme Manager Mental Health, WHO Regional Office for Europe, email mfm@euro.who.int

Over the past decade, attention has increasingly focused on the need to increase the capacity of mental health services. *The World Health Report 2001 – Mental Health: New Understanding, New Hope* (World Health Organization, 2001) set the agenda, advocating the development of community-based mental health services. The case for scaling up, inspired by the World Health Organization's vision of 'no health without mental health', was powerfully argued first in the *Lancet* series in 2007 (Prince *et al*, 2007) and again in the *Lancet* in 2011 (Eaton *et al*, 2011). The forthcoming Global Mental Health Action Plan, requested in a resolution by member states of the World Health Organization at the 2012 World Health Assembly, is a great opportunity to formulate objectives and targets for countries, and to analyse experiences from around the world. The forthcoming European Action Plan builds on this, customising actions for European countries.

The case for scaling up has been persuasively and consistently made by these and many other papers. On the one hand, the need for care is great, as

demonstrated by annual prevalence rates estimated to be high as 38% (Wittchen *et al*, 2011) and a contribution of mental disorders to the global burden of disease of 13%. On the other, a treatment gap has been reported of about 80%.

Service capacity cannot cope with need. The world's median number of mental health beds is 7 per 100 000 and of psychiatrists it is 1.3 per 100 000 (World Health Organization, 2012). However, reliance on global medians risks overlooking diversity. In Europe, the median bed number in mental hospitals is 39 per 100 000, and the median number of psychiatrists is 8.6, rather contrasting with the medians of 1.7 beds and 0.05 psychiatrists reported in Africa. In Europe, median average expenditure on psychotropic medication per 100 000 population is US\$2.6 million, in Africa US\$2300, more than 1000-fold less. Obviously, such differences are a reflection of budgets. In Europe, 5% of the relatively high health budgets are allocated to mental health, in Africa 0.6% of the much lower health budgets. However, even in Europe the treatment gap is still between 35% and 50% (Kohn *et al*, 2004).

The relatively high resource level in Europe has enabled the development of comprehensive mental health services in many countries, but

the variation within Europe is also striking. The number of beds per 100 000 ranges from 150 to 8, and psychiatrists from 30 to 1 (World Health Organization Regional Office for Europe, 2008). Surprisingly, the diversity is not associated with resources alone. It is also related to differences in the models of care. For example, the lowest bed rates can be found in Albania, England, Greece, Turkey and Italy. England, though, has the highest mental health spending level as a proportion of total health budget. The explanation is that the proportion of the mental health budget allocated to psychiatric beds is only 26%, allowing heavy investments in a range of community-based services. Albania and Turkey, in contrast, with low mental health budgets, have low numbers of psychiatrists, beds and community-based services.

These differences in resources and models pose very different opportunities and challenges for policy and service development. For example, in Italy and England, the challenge was how to transfer the high investment in institutions to community services, with the aim of offering more humane and effective services. Each country approached this in a different fashion. Italy passed national legislation forcing the closure of hospitals. The development of community services was the responsibility of provincial health authorities. In England, a hospital closure programme was introduced. A national mental health service model was adopted, specifying in detail the number and type of teams and staff that should be available in every part of the country. Central funding was provided and progress was carefully monitored. As a consequence, Italian mental healthcare is very diverse, varying from excellent individual needs-based community care to very limited supply, depending on the wealth and the commitment of the local community. Similar challenges of decentralisation can be found in federal states such as Spain, Germany and Scandinavian countries. In England, services used to be remarkably homogeneous and comprehensive, covering crisis, early intervention, assertive outreach and psycho-rehabilitation, supported by beds in general hospitals. The challenges of monitoring quality and securing supply remain, particularly when budget cuts require decisions about priorities.

A very different challenge is to develop community-based mental health services starting from a low resource level. Most European countries outside the 'old' European Union have mental health services that are dominated by mental hospitals. Treatment is centred on the prescription of medication, since very few psychologists, occupational therapists and social workers are employed in mental health services. Typically about 80% of the budget is committed to such institutions. Some countries are taking on the challenge. In Turkey, the Ministry of Health launched a national action plan, supported by both the European Union and the World Health Organization, and community services have been introduced nationally. The large mental hospitals are due to close and beds

will be provided in district general hospitals. The workforce is being expanded and trained.

Not every country is moving forward on such a scale, but in every country some examples of exciting and innovative practice can be found. Romania is a country that is struggling to implement its national model of community services owing to austerity measures. In one area, Câmpulung Moldovenesc, a small mental hospital with 40 beds and 20 places in the day hospital separated from the large general hospital and developed a wide range of services. It now combines acute in-patient care with a community mental health centre. A mobile team offers social interventions in small towns and rural communities within the psychiatric sector. Social interventions are provided in close partnership with 12 local authorities and voluntary agencies. The mobile team also provides home treatment for people with mental health problems who have been placed in protected houses, on the basis of a personalised plan. The hospital offers church services in the hospital church that are attended both by patients and by the local population, and it organises community classes in cooking, painting, ceramics and sewing as well as birthday parties and cultural activities. This model was inspired by the vision of a local leader, Dr Alexandru Paziuc, who was able to galvanise mental health staff and community leaders.

Some countries benefit from external investment and expertise, although the effects are not always predictable. Such centres can succeed as pilot services, inspiring others. Alternatively, they can become isolated. In one Central European country, a foreign donor funded a local community centre. It was based on the ground floor of the poly-clinic, beautifully renovated, with many large rooms and well equipped. The centre employed a full-time psychiatrist, psychologist, occupational therapist, nurses and support staff. About 25 clients attended daily, involved in occupational activities, most from within walking distance of the centre since transport was not provided. In stark contrast, the standard clinic, referred to as obsolete by the community centre, comprised two crammed rooms on a first floor, and was staffed by three psychiatrists, each supported by a nurse. They were responsible for several thousand patients, from all over the district, and were in regular contact with family doctors. As a consequence of pressure and budget restrictions, they could offer only limited interventions, although they had many ideas on how to develop in response to local needs. The two services ran in parallel, with no cross-referrals.

The challenges and opportunities, even in the European region, with its relatively well resourced countries, are diverse, but there are some common conclusions. One is that tension exists between central planning and local implementation. National action plans, drafted in almost every country, are necessary, prescribing the model of care and identifying the necessary resources. A sufficient supply of specialist mental health staff working in close partnership with primary care

teams is crucial to success. In most countries, this requires an expansion of training places and an increase in the capacity of universities.

A second, connected conclusion is that the establishment of modern mental health services is not simply the rational dissemination of evidence-based models of care. Whereas the implementation of a national hospital plan can indeed be achieved by replicating the same building and workforce plans around the country, community services require major local adaptations and strong local commitments. Local leaders need to inspire change and instigate partnerships. Mostly, it is assumed that local psychiatrists can deliver this, and occasionally they can.

It needs to be recognised that the transformation of mental health services demands leadership and competence in change management. This should be considered a professional skill, as taught at management schools. However, it is all but absent from psychiatric curricula, and training opportunities are rare. It now needs to be accepted that such change management skills belong under the core competencies of psychiatrists.

Mental health reforms are proceeding around the globe, and the World Health Organization's

Global Action Plan and the European Action Plan identify some of the steps required. But essential are local commitment and the availability and skills of local change management, sustained over time. Respectful partnership between international guidance, national plans and local expertise is the recipe for progress.

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Strategic vision for mental health and substance misuse in the Eastern Mediterranean Region

Khalid Saeed¹ and Richard Gater²

¹Regional Advisor, Mental Health and Substance Abuse, Division of Health Promotion and Protection, World Health Organization Regional Office for the Eastern Mediterranean, Cairo, Egypt, email Saeedk@emro.who.int

²Senior Lecturer in Psychiatry, University of Manchester and Honorary Consultant Psychiatrist, Lancashire Care NHS Foundation Trust, UK

The Eastern Mediterranean Region of the World Health Organization has recently developed a comprehensive strategy and action plan to promote mental health and provide for the integrated prevention, treatment and rehabilitation of mental, neurological and substance use disorders. By strengthening national mental health policies, plans and legislation, scaling up integrated services, capacity-building, promoting human rights and prioritising vulnerable groups, the strategy aims to improve mental health and to help countries achieve their national development objectives.

The Eastern Mediterranean is one of the six regions of the World Health Organization (WHO). Its 23 member countries, from Pakistan in the east to Morocco in the west, have a combined population of almost 600 million (10% of the global population). The region is undergoing rapid demographic, sociocultural and political transition and several countries are experiencing

humanitarian emergencies. This has resulted in migration, internal displacement, unplanned urbanisation and changes in family role, which pose a threat to health and impair the capacity of health systems to deliver services. Wealth from the discovery of oil has facilitated significant improvements in education, literacy and life expectancy in some countries, while others are among the poorest in the world.

Mental, neurological and substance (MNS) disorders account for the loss of 11% of disability-adjusted life-years and for 27% of the years lived with disability in the region (WHO, 2004). Despite the burden and economic impact of MNS disorders, the median annual investment in mental healthcare of US\$0.15 per person in the region's countries (WHO Regional Office for the Eastern Mediterranean, 2010) is well below the US\$3–9 needed for a recommended package of cost-effective mental health interventions in low- and middle-income countries (Hyman *et al*, 2006).

The past decade has witnessed a number of global initiatives to improve mental health,

culminating in the World Health Assembly resolution 'The global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level' (WHO, 2012). The WHO's MIND (Mental Health In Development) programme encourages countries to recognise that mental health is central to economic progress, and supports the development of mental health policy, planning, legislation and integrated services in a manner that promotes human rights and quality of care.

Regional strategy on mental health and substance misuse

In 2011 the WHO Regional Committee for the Eastern Mediterranean endorsed a regional strategy on mental health and substance misuse (WHO Regional Office for the Eastern Mediterranean, 2012a), providing the foundation for the development of national strategies and action plans for the next 5 years. The strategy has six components, each with defined objectives and suggested activities at regional and country level, tailored to the resources of the countries, accompanied by a framework for monitoring and evaluation of their implementation.

Strategic component 1. Strengthen leadership and political commitment to mental health

The development and maintenance of an integrated mental health system require a well informed, government-led commitment, articulated through effective health and social sector policies, strategies, plans and legislation. Of the countries in the Eastern Mediterranean Region, 75% have officially approved mental health policies, 90% have mental health plans and 55% have dedicated mental health legislation (WHO Regional Office for the Eastern Mediterranean, 2012b).

The objectives of this component are to help set up national mental health units within ministries of health to develop, resource, implement and monitor mental health and substance misuse policies, plans and legislation, and to ensure inter-sectoral collaboration for mental health promotion. Regional activities include the creation of a mental health advisory group to review, guide and advise on implementation of the strategy. Country-level activities include review of existing mental health and social policies, strategies, plans and legislation to see whether they meet contemporary standards and are adequately resourced.

Strategic component 2. Scale up integration of mental health in primary healthcare

Although primary healthcare (PHC) has been affirmed as the cornerstone of efficient healthcare since 1978, progress in making mental healthcare available through PHC has been patchy (WHO & Wonca, 2008; Eaton *et al.*, 2011). A crude measure demonstrates that overall progress towards the integration of mental health into PHC can be achieved irrespective of country income (Table 1).

Table 1

Progress towards the integration of mental health into primary care: sum of seven relevant WHO *Atlas* indicators by World Bank income group (each dot represents a country in the WHO's Eastern Mediterranean Region)

WHO <i>Atlas</i> indicator	World Bank income group			
	Low	Lower middle	Upper middle	High
1		•••	•	
2		••••		•
3		•		•
4	•	•		••••
5	•	•		
6				
7			•	

This component aims to increase coverage of community-oriented mental healthcare by enhancing the capacity of PHC workers through training, support and supervision, task-shifting and robust referral/back-referral mechanisms. An example of a regional-level activity is the establishment of a regional working group of experts to collaborate in the delivery of training packages based on the WHO's mental health Gap Action Programme – Intervention Guide (mhGAP-IG) (WHO, 2010). Country-level activities include the review and reformulation of medical and nursing curricula to meet the needs of integrated community-oriented services.

Strategic component 3. Strengthen secondary and tertiary mental health services

Almost half of the region's mental health workforce is in mental hospitals (WHO Regional Office for the Eastern Mediterranean, 2010). The region has half the global rate of out-patient facilities, and only 1% of out-patient facilities offer follow-up community care. Other community facilities, such as day treatment, psychiatric beds in general hospitals and community residential facilities, are sparse in most of the region's countries.

The objectives of this component are to establish in-patient units in general hospitals, community out-patient clinics and day care facilities, to support PHC and to strengthen the capacity of the specialist mental health workforce, consistent with their role in the mental health system. Examples of regional activities are a review of postgraduate training programmes for mental health professionals and the development of a framework of training standards. Country-level activities include the decentralisation and reorientation of mental health services.

Strategic component 4. Identify and prioritise vulnerable persons

This component addresses the ethical imperative to provide for more vulnerable sections of society, such as women, children and adolescents. The objectives are to identify vulnerable persons and collaborate with other sectors to ensure that

appropriate mental health services are made available for them. Examples of regional-level activities are the development of regional preparedness and response plans for mental health and psychosocial support in emergency settings. Country-level activities include the implementation of the regional strategic directions and actions for maternal, child and adolescent mental healthcare.

Strategic component 5. Intersectoral coordination and collaboration to promote mental health and prevent mental disorders

Mental health services have tended to be insular, despite opportunities to link with existing prevention and health promotion programmes to realise mutually beneficial outcomes. School-based activities promoting mental health and preventing mental disorders are present in 85% of Eastern Mediterranean countries, but in most these cover less than 20% of schools (WHO Regional Office for the Eastern Mediterranean, 2010). There are fewer links with housing and employment, which limits opportunities for rehabilitation. Service user and family associations are present in 30% and 35% of the region's countries, and few of these are involved in the formulation and implementation of plans (WHO Regional Office for the Eastern Mediterranean, 2012b).

The objectives of this component are to increase awareness and reduce the stigma of MNS disorders and their treatment, through partnerships and collaboration. An example of a regional activity is collaboration with other United Nations agencies and non-governmental organisations (NGOs) to incorporate mental health into health and social sector programmes. Country-level activities include high-level collaboration with other government departments and bottom-up engagement in partnership with NGOs and others, ensuring wide access to information and public awareness programmes.

Strategic component 6. Promote operational research

Research informs best practice and gives the evidence base for policy decisions and actions, but only 1.8% of research publications on mental and substance use disorders are from North Africa or the Middle East (Patel *et al*, 2007). Accurate and up-to-date information systems can monitor the implementation of services and help identify areas for service improvement. Eighty per cent of Eastern Mediterranean countries collect and publish national data on mental hospital admissions and psychiatric out-patient contacts, but information about mental health provision in community settings and PHC is published in fewer countries (20–65%) (WHO Regional Office for the Eastern Mediterranean, 2012b).

The objectives of this component are to establish comparable information systems and to strengthen mental health operational research appropriate to each country's needs and resources. Examples of regional activities are support for the

development of an integrated system of databases across the region, and the facilitation of collaborative links between researchers within and outside the region. Country-level activities include the integration of mental health indicators within national health information systems and the establishment of national forums to identify and lobby for research priorities.

Conclusions

The principles of and evidence for decentralised community-oriented mental health services integrated with primary and general healthcare are not new. Despite many attempts, integration remains patchy, funding is inadequate and resources continue to be centralised in mental hospitals.

The present strategy aims to reinvigorate efforts to improve mental health provision (components 2 and 3) but recognises that this can be achieved only by strengthening leadership (component 1), working in partnership (component 5) and promoting operational research to provide evidence for placing mental health higher on the social and development agendas (component 6). The emphasis on the development of national policies, plans and legislation, scaling up integrated services, capacity-building, promoting human rights and prioritising vulnerable groups can create a positive region-wide response to the WHO's MIND call for synergy between mental health improvement and national development.

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Reorienting health systems in South-East Asia to deliver care for mental and neurological disorders

Nazneen Anwar,¹ Vijay Chandra² and Athula Kahandaliyanage³

¹Temporary International Professional, Mental Health and Substance Abuse, WHO SEARO

²Regional Advisor, Mental Health and Substance Abuse, WHO SEARO, email chandrav@searo.who.int

³Director, Department of Sustainable Development and Healthy Environments, WHO SEARO

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Traditionally, care for mental and neurological disorders has been concentrated in tertiary care hospitals located in large cities. These custodial types of facility were designed to ‘protect’ the community from patients with a mental illness, as such persons were considered dangerous and a threat to the community. Given the state of medical knowledge in the 19th and 20th centuries, this mode of care was considered appropriate. However, in recent decades more humane and effective concepts of care have evolved. These concepts recognise the stigma attached to hospital-based care and also its limited outreach to the community, leaving out the vast majority of people living in rural and remote areas. Violation of human rights, sometimes seen in mental hospitals, has also been of concern.

The burden of mental and neurological disorders is staggering. According to the World Health Organization (WHO), approximately 450 million people globally suffer from mental, neurological, behavioural or substance use disorders. These disorders account for 13% of the global burden of disease and significantly contribute to comorbidity in other diseases (WHO, 2008). Until recently, however, little importance was given to the morbidity caused by these disorders, as they did not appear in ‘cause of death’ statistics on which public health priorities were based. Accordingly, the WHO has developed the concepts of disability-adjusted life-years and years lived with disability. Using these measures as an indicator of suffering,

mental and neurological disorders are high on the list of causes of morbidity (Table 1).

To address this huge burden of mental and neurological disorders, there is a great scarcity of trained professionals and infrastructure in member states of the WHO South-East Asia Region (SEAR). According to the *Mental Health Atlas 2011*, the median number of psychiatrists globally is 1.27 per 100 000 population, whereas in SEAR the corresponding figure is 0.23 (WHO, 2011). The global number of psychologists is 0.3 per 100 000, compared with 0.03 in SEAR. Globally, while there are 0.23 and 0.05 social workers and occupational therapists per 100 000 population respectively, the numbers in SEAR are negligible. Mental health expenditure per capita is 200 times greater in high-income countries compared with low-income countries, such as the countries in SEAR (WHO, 2011).

Evidence of the limited effectiveness of the traditional hospital-based care for mental and neurological disorders is the large ‘treatment gap’ in the community. The treatment gap is the difference between the number of people with a disease and the number of people being appropriately treated in a given population at a given point in time, expressed as a percentage. The treatment gap has been documented in SEAR member states to be between 76% and 85% for epilepsy and psychosis. For high-income countries the estimates range from 35% to 50% (WHO Regional Office for South-East Asia, 2012). Such large numbers of people being deprived of treatment are unacceptable in light of commendable advances made in medical science, including better understanding of diseases, better treatment, better availability of effective psychotropic medication and better management.

Recognising the reality of the existing situation in the community – that is, the huge burden, large treatment gap, limited infrastructure and workforce, and the substantial rural and remote areas to be served – the WHO’s Regional Office for South-East Asia (SEARO), in collaboration with regional experts, has developed some innovative approaches. The SEARO strategy is to treat and manage patients in the community by empowering existing national primary healthcare systems. The strategy calls for training of community-based health workers in the identification of priority mental and neurological disorders and then treatment by a primary care physician.

Table 1

Leading causes of years lived with disability (YLD) in low- and middle-income countries, 2004

Rank	Disability	YLD (millions)	% of total YLD
1	Unipolar depressive disorders	55.3	10.4
2	Refractive errors	25.0	4.7
3	Hearing loss, adult onset	23.2	4.4
4	Alcohol use disorders	18.4	3.5
5	Cataracts	17.4	3.3
6	Schizophrenia	14.8	2.8
7	Birth asphyxia and birth trauma	12.9	2.4
8	Bipolar disorder	12.9	2.4
9	Osteoarthritis	12.8	2.4
10	Iron-deficiency anaemia	12.6	2.4

Source: WHO (2008).

However, it is unrealistic to expect the primary healthcare system to deliver comprehensive care for all types of neuropsychiatric conditions. The SEARO strategy addresses only the most common, most disabling conditions, easy to identify through observation, the availability of low-cost medication and good prognosis with treatment. Accordingly, epilepsy, psychosis and depression are the three conditions that have been identified in most of the member states as priority mental and neurological disorders for intervention.

In developing services through the existing primary healthcare system, SEARO has taken a 'five A' approach: Availability, Acceptability, Accessibility, Affordable medications and Assessment.

- *Availability.* Services that will address at least the minimum needs of populations in relation to mental and neurological disorders should be available to everyone regardless of where they live.
- *Acceptability.* Populations need to be informed and educated about the nature of neuropsychiatric illnesses, so that they accept these services.
- *Accessibility.* Services should be available to the community, in the community and at convenient times.
- *Affordable medications.* Every effort should be made to guarantee uninterrupted supplies of essential medications at reasonable cost.
- *Assessment.* These programmes need to be continually assessed to ensure their appropriateness and cost-effectiveness.

SEAR member states have excellent existing primary healthcare systems, which reach out to all areas of the country, including rural and remote areas. Bangladesh, for instance, has 11 500 community clinics, each of which caters for a population of around 6000 in rural areas. The next tier of care is the *upazila* health complex, where community-based doctors provide services to patients referred from the community clinics. In Bhutan primary healthcare services are provided through the basic health units located in villages. The district hospitals in Bhutan run community health programmes through 518 outreach clinics. These clinics give referral support to the basic health units. In Myanmar the primary healthcare system reaches out to the community. A well established referral system exists from the village to the township level and to the tertiary care hospital. In Timor-Leste primary healthcare services are provided through a network of district hospitals and community health centres. Facility-based services are provided to the community through a network of health posts. In Thailand there are two health volunteers in each village who serve as the first level of contact leading to a well developed primary, secondary and tertiary referral health service.

To pilot this strategy, SEARO has supported epilepsy projects in Bangladesh, Bhutan, Myanmar

Table 2

Epilepsy treatment gap (%) before and after intervention

Country	Before intervention	After intervention
Bangladesh	87.0	5.0
Bhutan	40.0	26.0
Myanmar	94.6	5.0
Timor-Leste	70.7	53.7

and Timor-Leste. Under this project community-level health workers were trained to identify and refer individuals with epilepsy to primary care physicians. An easy-to-use identification tool, developed by experts from SEAR, was used for the identification of the probable cases in the community. Training manuals were translated into the local language for convenience of the health workers. A continuous supply of medicine (phenobarbitone) was ensured.

An impact evaluation of each project was conducted, taking percentage reduction in the treatment gap for epilepsy as an indicator. On evaluation of the projects, a substantial reduction in the treatment gap for epilepsy was seen (Table 2). This proved that it was possible to deliver care for people with epilepsy efficiently through the existing primary healthcare system.

In conclusion, the findings of the pilot projects conducted in Bangladesh, Bhutan, Myanmar and Timor-Leste have been encouraging. They provide evidence that even in low-resource countries it is possible to deliver care for persons with mental and neurological disorders by empowering the existing primary healthcare system. This innovative service model is sustainable in the long term since it can be mainstreamed into the existing government healthcare system with minimal additional investment in infrastructure. It reaches out to all those in need of care, provides care to people in the community and is less stigmatising. Similar strategies will be developed for the identification and management of psychosis and depression.

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'He who has health has hope, and he who has hope has everything.' (Proverb)

Mental health law profiles

George Ikkos

Consultant Psychiatrist in Liaison
Psychiatry, Royal National
Orthopaedic Hospital, London,
UK, email ikkos@doctors.org.uk

In this issue, for the Mental Health Law Profiles we move to two economically developed Scandinavian countries, Denmark and Finland. Some may find it surprising how strongly Finnish legislation implies a degree of trust in medical professionalism as the guarantor of patient welfare. This difference from not only Danish but more broadly civil rights-based approaches, including Anglo-Saxon approaches, to mental health law probably reflects the social cohesion and experience of social solidarity in Finland, as the authors suggest.

Do different approaches to mental health law perhaps reflect the different histories of medicine and psychiatric practice in different countries, some generating more trust than others, or do they simply reflect and emphasise the importance of different cultural factors in general to core psychiatric practice? Do such different approaches lead to different patient experiences and outcomes in different countries? In an era rightly characterised by outcomes-based planning it would be useful to know.

Mental health law in Denmark

Mette Brandt-Christensen MD PhD

Clinical PhD Lecturer,
Copenhagen University
Hospital, Denmark, email
mettebrandtchristensen@dadlnet.dk

In Denmark, the parliament passed the first Mental Health Act (MHA) in 1938. A new Act was passed in 1989, based on a thorough report from the Ministry of Justice. The 1989 Act emphasised the protection of citizens' legal rights in relation to compulsory admission, detention and treatment in psychiatric hospitals. That Act is still in operation, although it has been amended several times. In 2006 the definition of 'compulsion' was changed, and a 2010 amendment introduced compulsory treatment in the community for a trial period of 4 years.

How mental disorder is defined in law

The Danish MHA (available at <http://www.retsinformation.dk>) applies the concept of 'insane or a condition entirely equivalent to this' to define the kinds of mental disorders for which compulsory measures can be used. In current psychiatric nomenclature 'insanity' is regarded as more or less equivalent to 'psychosis'. Several problems have arisen in consequence, as the current diagnostic system (ICD-10) does not include 'psychosis' but only 'psychotic symptoms'. Appendix 1 of the Danish edition of ICD-10 states which mental disorders should be considered equivalent to 'insane in a legal sense'; however, a number of Danish psychiatrists share the opinion that the concept of psychosis and insanity has narrowed since 1994, when ICD-10 was introduced in Denmark. This in

turn influences the way the MHA is used in daily clinical practice and might eventually pose a risk that adherence to one of the core intentions of the Act – to secure the treatment of persons with severe mental disorders – diminishes over time.

Grounds for compulsion

In Denmark, the only medical specialty allowed to use compulsion is psychiatry. Only hospitalised patients can be subject to compulsory measures, with the exception of compulsory treatment in the community.

The first criterion for compulsory admission or detention is that the patient is insane or in an entirely equivalent condition. Second, it should be regarded irresponsible *not* to deprive that person of his or her liberty because:

- the prospect of restoring or at least improving health will otherwise be seriously compromised (the 'treatment indication') *or*
- the patient presents an obvious and considerable danger to him- or herself or others (the 'danger indication').

The 'treatment indication' is the more widely used.

The Danish MHA provides detailed descriptions of the various compulsory measures (Box 1). According to the Act, each compulsory measure must be decided individually. It does not automatically follow from compulsory admission or detention that the patient will also receive compulsory medical treatment.

Box 1

Compulsory measures detailed by the Danish Mental Health Act

- (1) Compulsory admission to psychiatric hospital
- (2) Compulsory detention in psychiatric hospital
- (3) Compulsory medical treatment:
 - psychopharmacological treatment
 - electroconvulsive therapy
 - nourishment (e.g. for patients with severe anorexia nervosa, if necessary by gavage)
- (4) Compulsory medical treatment of life-threatening somatic conditions
- (5) Compulsory restraint
 - physical restraint (staff holding the patient)
 - mechanical restraint (belt, straps, gloves)
- (6) Compulsory treatment in the community
- (7) Constant surveillance performed by staff members (with the purpose of protecting the patient)

Generally, only medical doctors who are specialists in psychiatry (senior consultants) are authorised to decide upon the use of compulsory measures. However, a decision to initiate compulsory admission (item 1 in Box 1) or physical restraint (item 5) can be made by all physicians/medical doctors. In the former case, it will often be a general practitioner (GP) who makes the decision. The physician fills in a special application form, which is then delivered to the police in order to ensure that the formal conditions for compulsory admission obtain. The police in turn contact the senior consultant psychiatrist at the institution to which the patient is to be admitted, in order to obtain final approval. Item 2, compulsory detention, can follow compulsory admission but can also apply to voluntarily admitted patients. In both cases, the detention must be authorised by the senior consultant.

Regarding compulsory medical treatment (items 3, 4 and 6), the same prerequisites as for admission and detention must be fulfilled. For a decision regarding item 4, authorisation must be obtained from both a senior consultant psychiatrist and a senior consultant within the actual medical specialty involved. An amendment to the MHA in 2006 made compulsory treatment with electroconvulsive therapy (ECT) possible only if the patient's life is in threat. The same is the case for coercive somatic treatment (item 4).

Physical and mechanical restraint (item 5) can be decided upon by all physicians or even by nursing staff in emergencies. It is not mandatory that the patient is insane. Instead, one of the following conditions must be fulfilled:

- there is obvious danger to the patient him- or herself or to others
- the patient is grossly molesting other patients
- there is substantial damage to property.

The removal of all compulsory measures apart from item 5 relies solely on the senior consultant.

Specific administrative forms exist for each compulsory measure, providing the basis for the mandatory reporting to the Danish Health and Medicines Authority.

A person's family should call upon a medical doctor if it is believed that the person is insane and is not him- or herself seeking necessary medical assistance. Apart from this, the family has no role in relation to compulsory admission or treatment in Denmark.

The balance between protecting the public and protecting the human rights of people with mental disorder

The main concern of the Danish MHA is the protection of the legal and human rights of persons who are mentally ill. Only second to this comes protection of the public.

The MHA applies equally to non-offender patients and mentally disturbed offenders under a psychiatric treatment order. The only compulsory measures allowed under a treatment order are admission and detention. No other compulsory measures can be applied unless the general conditions mentioned above are present for the individual. This sometimes creates clinical dilemmas, as up to 30% of patients under a psychiatric treatment order are considered non-psychotic.

Mental capacity

According to the Danish Health Act, no treatment can take place without the informed consent of the patient. General exceptions, apart from the ones given in the MHA, are:

- children below 15 years, in which case the parents must consent
- emergency cases where immediate treatment is necessary and the patient temporarily lacks the ability to consent
- persons permanently lacking the ability to make decisions on their own behalf.

The last group primarily comprises persons with moderate to severe dementia, although some persons with intellectual disability and acquired brain damage may also qualify.

Traditionally, persons with other mental disorders, no matter the kind or severity, are considered to have the capacity to decide for themselves regarding medical treatment.

In Denmark, there is no specific law on a person's mental capacity with regard to consent to medical treatment. However, there is a law describing when a citizen can be subject to guardianship. The main issues of this law are lack of capacity to decide on economic or personal dispositions. Nevertheless, an appointed guardian can consent to medical treatment, including mental health treatment, on behalf of the patient. However, if the person 'in words or action' clearly refuses the treatment, it cannot be carried out, according to the Health Act.

In this case, a psychiatry specialist should evaluate whether it is relevant and legal to carry through the treatment involuntarily according to the MHA. Overall, there is agreement among Danish mental health professionals that patients with psychotic states (i.e. who are 'insane') should *not* be classified as 'persons permanently lacking the ability to make decisions on their own behalf'.

Rights to complain

If a patient is subject to compulsory measures, a patient counsellor will always be appointed. The counsellor is obliged to visit the patient within 24 hours and to assist if the patient wishes to complain. For healthcare services, Denmark is divided into five regions. Each has a regional state administration that arranges complaint boards for the settling of psychiatric patients' complaints concerning compulsory measures under the MHA. The tribunal of a complaint board comprises three members: the director of the regional state administration, presiding; an appointee of the Danish Medical Association, not necessarily with psychiatric expertise; and an appointee of the Disabled People's Organisation. If the tribunal approves the compulsory measure, the patient has the right to appeal to a court. If the tribunal disallows it, the hospital is given the right of appeal, but only in cases concerning medical treatment, not those concerning deprivation of liberty.

The MHA does not specify time limits for compulsory detention or treatment. However, in appeal cases it has been stated that if no improvement occurs within 6 months the patient should not be kept any longer for a 'treatment indication'. The MHA has been frequently amended in order to reduce the use of mechanical restraint, especially of long duration (i.e. days, weeks and in rare cases even months). Since 2006, the physician must examine a restrained patient four times every 24 hours, and this must be documented. Further, a second opinion from an external consultant psychiatrist is mandatory after 48 hours of continuous use of mechanical restraint.

Compulsory treatment in the community

Compulsory treatment in the community (CTC) has only recently been introduced. An intense debate took place over several years. Those opposing claimed that research was sparse and no evidence existed to prove its effectiveness, while the introduction of such far-reaching restrictions on personal freedom should presuppose a high degree of certainty that it will work better than measures already used. Supporters claimed that CTC was in the best interests of patients with

the most severe mental illness, and that not to introduce such measures might count as malpractice and lack of care.

The criteria for the use of CTC are strict: three instances of compulsory detention during the previous 3 years and the failure of both the discharge contract and assertive community treatment. CTC can last for a maximum of 1 year, during which it must be renewed every third month.

The introduction of CTC has allowed the compulsory first-line use of long-acting antipsychotic drugs, thus disregarding the expressed opinion of the complaint boards that oral antipsychotics should be regarded a less radical compulsory measure. Few patients are in fact subject to CTC (between 10 and 20 persons a year in a population of 5.5 million). Patients under a psychiatric treatment order cannot be subject to CTC.

The Danish Health and Medicines Authority has closely followed the trial of CTC and in 2014/15 parliament will decide whether it shall continue.

National regulation and statistics

Involuntary detentions take place only in psychiatric hospitals. In the case of compulsory somatic treatment administered on medical wards, the patient is technically registered as a psychiatric in-patient, but will actually seldom come to the psychiatric ward.

Each single compulsory measure must be reported to the Danish Health and Medicines Authority, which closely monitors the situation both nationally and regionally. Annual statistics on the use of compulsory measures (as listed in Box 1) are published and accessible on the home page (<http://www.SST.dk>) of the Authority in the form of a register, which is both detailed and regarded as very accurate. Mental health services in Denmark are provided almost entirely within the public sector and exhibit a very high degree of cooperation with instructions from parliament and the Danish Health and Medicines Authority. Another feature facilitating the accuracy of the register is the Danish identification system of all citizens – a unique ten-digit personal number – which is applied every time a citizen is in contact with a public authority, including being subject to compulsory psychiatric measures.

Despite the efforts to reduce the frequency of use of compulsory measures, the results do not seem satisfactory. The use of such measures in psychiatry is continuously subject to debate among politicians and the public, and in the media. This probably reflects the fundamental challenge of balancing the right to personal freedom and situations where this should temporarily be suspended.

Overseas volunteering by health professionals as a mechanism to improve global health is increasingly on the agenda. For further details on how to join the Royal College of Psychiatrists' Volunteer Scheme and make a real difference to people in low- and medium-income countries please contact Ellen Cook at the College:

Email: ECook@rcpsych.ac.uk. Tel: +44 (0)20 7235 2351, extension 6136

Mental health law in Finland

Allan Seppänen¹ MD PhD and Markku Eronen² MD PhD

¹Specialist Physician in Forensic Psychiatry, Vanha Vaasa Hospital, Vaasa, Finland, email allan.seppanen@vws.fi

²Associate Professor of Psychiatry and Forensic Psychiatry, and Medical Director, Vanha Vaasa Hospital, Vaasa, Finland

A tradition of Romano-Germanic or civil law defines the legal system in Finland. Laws of relevance to psychiatry are the 1990 Mental Health Act and, insofar as it pertains to forensic psychiatry, the Criminal Law (1889) and the Law on State Mental Hospitals (1987, revised 1997). These are outlined in the present paper.

All medical practice is, to a significant degree, controlled by law. Thus, although clinical goals are shared by most doctors around the globe, the practice of psychiatry is profoundly affected by the varying legal frameworks and other preconditions in different countries, ranging from the maximum-security units of some psychiatric hospitals in low- and middle-income countries, sometimes described as 'ghettos within ghettos' (Njenga, 2006), to the status of psychiatry and its various subspecialties as scientifically active independent disciplines in most higher-income countries.

Just as the legal tradition of common law defines the judicial system in the UK and Islamic law in the Middle East, it is the tradition of Romano-Germanic law ('civil law') that defines the legal system in most of continental Europe (Abdalla-Filho & Bertolote, 2006) and, indeed, in Finland. Finland is a northern European urbanised parliamentary democracy and a member of both the Organisation for Economic Co-operation and Development (OECD) and the European Union (EU), with a total population of approximately 5.4 million. Laws of particular relevance for psychiatry in Finland are the Mental Health Act 1990 and, insofar as it pertains to forensic psychiatry, the Criminal Law (1889) and the Law on State Mental Hospitals (1987, revised 1997) (Eronen *et al*, 2000).

The Mental Health Act

The Mental Health Act 1990/1116 stipulates that it is the responsibility of the Ministry of Social Affairs and Health, and the provincial and municipal administrators acting under it, to organise mental health services. The Act expressly stipulates that these services must be primarily arranged on an out-patient basis, so as to support the independence of psychiatric patients. Indeed, there has been a gradual process of deinstitutionalisation in Finland since the 1990s, although, if the condition of the patient warrants it, involuntary hospital detention can be mandated if certain preconditions are fulfilled (Box 1).

The actual diagnostic term used in the Act as a precondition for involuntary treatment translates

Box 1

The three preconditions for compulsory psychiatric hospital admission

- (1) The individual suffers from a mental illness, or, if under 18, a serious mental disorder, which necessitates treatment because leaving the condition untreated would result in:
 - and/or*
 - a threat to the health or safety of the individual him- or herself
 - and/or*
 - a threat to the health or safety of others.
- (2) worsening of the psychiatric condition
- (3) All other mental health services are inapplicable or inadequate

as 'mental illness' and is understood as a psychotic state, namely delirium, severe dementia and other so-called organic psychoses, schizophrenia and other schizophreniform psychoses, psychotic depression and mania (Putkonen & Völlm, 2007). For people under 18, the diagnostic criteria are more inclusive and 'serious mental disorder' (Box 1) is understood as including serious self-harm, serious substance use disorders and anorexia, in addition to the psychoses. It is noteworthy that the acceptance of these illnesses as preconditions for involuntary treatment arises from a non-formal understanding of the terms 'mental illness' and 'serious mental disorder' by both doctors and administrative bodies, rather than from unambiguous written guidelines or legal statutes. Nevertheless, it is generally accepted that these preconditions are adhered to.

Committal to a hospital based on these diagnoses does not in itself affect patients' rights in terms of mental capacity. That is to say, detained persons retain their basic right to judge their own best interests in areas other than the involuntary treatment of the mental illness. The process of restricting a person's right to make autonomous, legally binding decisions and the appointment of a substitute decision-maker for a person with reduced mental capacity do not fall within the remit of the Mental Health Act; they are legal decisions, although a medical statement may be requested.

Compulsory out-patient treatment is not currently permitted, although there have been attempts to instigate a change in the law to this effect in the case of forensic patients.

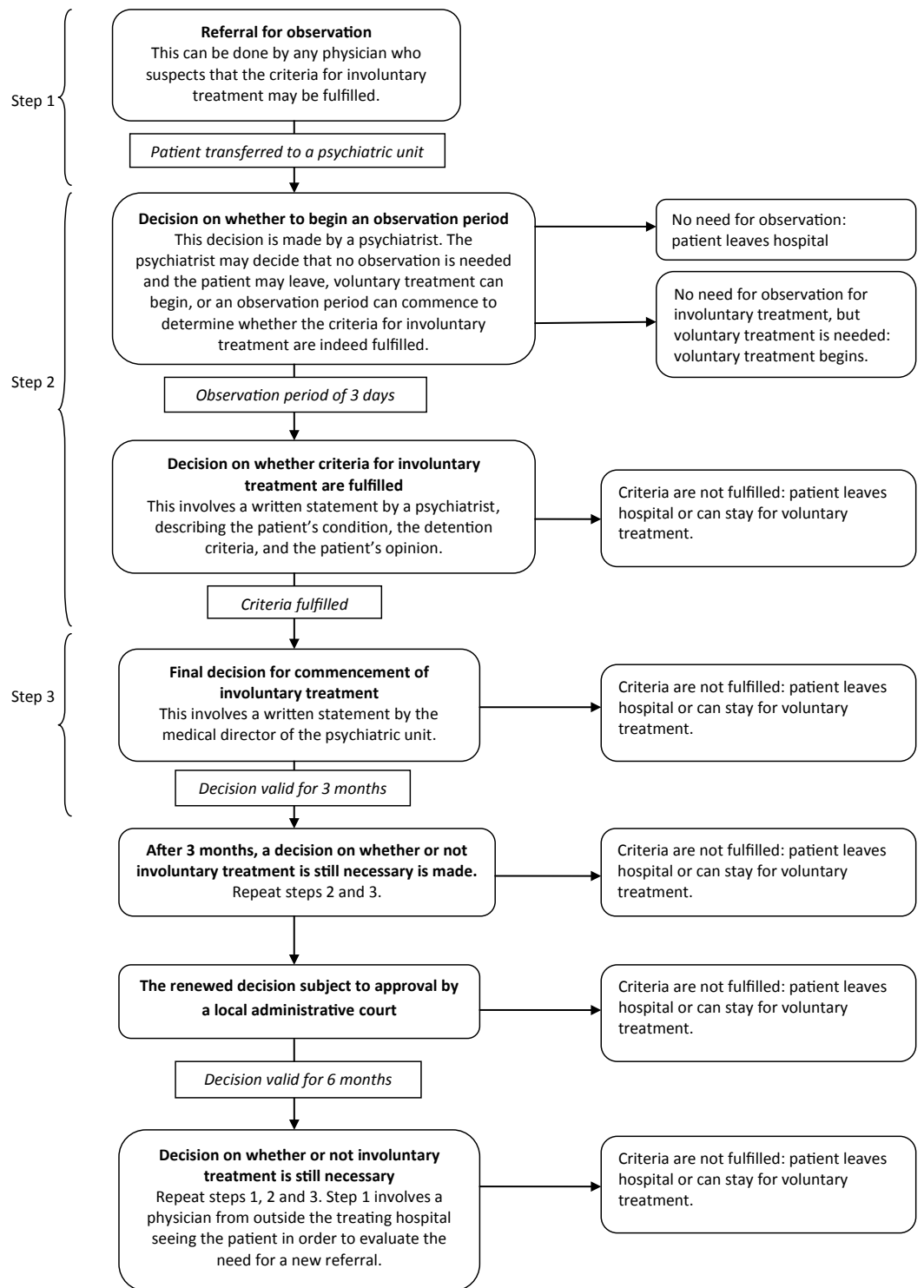


Fig. 1 The decision-making process for involuntary treatment. The process involves three doctors: one for each step

Decision-making responsibilities

In Finland, the decision-making process for involuntary treatment, including discharge, involves only medical doctors, although the local administrative courts oversee certain decisions (Fig. 1). No other legal authorities are regularly employed as

safeguards during the decision-making process for involuntary treatment. Neither does the law require the treating doctors to subject any other treatment decisions, such as those involving involuntary medication or electroconvulsive therapy (ECT), to a second opinion – unlike the situation in the UK, with the SOAD (second-opinion appointed doctor)

service – although where involuntary treatment is prolonged, a physician, usually a general practitioner (GP), from outside the treating hospital must evaluate the patient at regular intervals (Fig. 1). In effect, the Mental Health Act places the final responsibility for treatment decisions on the treating doctor, and it is notable that any generally recognised form of treatment can be administered even against the will of the patient, although in the case of ECT and psychosurgery only in life-threatening situations. This notwithstanding, the Mental Health Act stipulates that, whenever possible, the treatment must be in accordance with the wishes of the patient. When this is not possible owing to the psychiatric condition of the patient, the Act defines in detail the preconditions for various restrictions and compulsory measures, such as seclusion, body searches and confiscation of personal possessions. If patients are unhappy with their treatment or restrictions, they have recourse to the chief executive officer of the hospital, the courts, the Regional State Administration Agency, the National Supervisory Authority of Welfare and Health and, in the final instance, the parliamentary ombudsman. Although no comprehensive statistics exist, it can be estimated that these administrative bodies review hundreds of complaints annually concerning psychiatric care. In the majority of cases the decisions made by the treating physicians are upheld (THL, 2012).

The legal provisions relevant to forensic psychiatry

According to Criminal Law 39/1889, perpetrators of a crime are not criminally responsible if, at the time of the act, they were not able to understand the factual nature or unlawfulness of their act, or their ability to control their behaviour was decisively weakened owing to mental illness, severe mental deficiency, a serious mental disturbance or a serious disturbance of consciousness.

If necessary, the question of responsibility can be assessed in a court-ordered forensic examination, the most common form of which is the so-called full mental state examination. These examinations are performed in the most serious cases, namely violent and sexual crimes, at a rate of around 120–130 a year. If a person is not fully absolved from responsibility according to the terms of the law, but their ability to understand the nature of the act or its illegality or their ability to control their actions is, for the same reasons, severely impaired, this can result in a less severe sentence due to diminished responsibility. However, although the questions of responsibility and need for treatment usually coincide, the need for treatment is separately assessed, regardless of the level of responsibility.

Discussion

The rate of involuntary hospitalisation in Finland has been high in comparison with other countries

in Western Europe (Salize & Dressing, 2004), but has gradually begun to fall during the past decade. In 2010, 8455 people were subject to compulsory psychiatric hospitalisation and 2610 people were subject to compulsory treatment measures, including seclusion and involuntary medication (Rautiainen & Pelanteri, 2012). Thus, Finnish legislation and psychiatric units still prioritise the need for treatment over personal autonomy, particularly on the basis of risk of self-harm (Tuohimaki *et al*, 2003). Importantly, in a Finnish study focusing on seclusion, psychiatric patients themselves viewed compulsory measures as necessary in a psychiatric hospital setting (Keski-Valkama *et al*, 2010). Similarly, at the risk of paternalism, Finnish legislation emphasises the responsibility of the medical profession in ultimately deciding on treatment, albeit within clearly defined legal constraints. Although Finland is a liberal democracy, the population is as yet culturally quite homogeneous and holds a relatively high regard for expert opinion, somewhat counteracting pressures towards less medical discretion and stronger legal regulation of psychiatric treatment, of the kind which has been adopted in the USA and elsewhere in the EU. That said, although Finnish mental health law is generally seen to work well in practice (Putkonen & Völlm, 2007), the treatment of psychiatric disorders, which by their nature tend not to adhere to rigid legal concepts, continues to cause debate, if not controversy, between various interest groups, professions and within the psychiatric community.

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Global representation in psychiatric research

Michael Zhang¹ BS, Dawson W. Hedges² MD and Bruce L. Brown³ PhD

¹Graduate student, Department of Psychology, Brigham Young University, Provo, Utah, USA, email michael_zhang@byu.edu

²Professor, Department of Psychology, and Neuroscience Center, Brigham Young University, Provo, Utah, USA

³Professor of Psychology, Brigham Young University, Provo, Utah, USA

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To monitor global representation in the psychiatric literature, we compared publication rates in the ten psychiatric journals with the highest impact factors in 1998 and 2008 by world regions. In both 1998 and 2008, North America, Northern Europe, Western Europe and Oceania produced the majority of psychiatric research papers published in these journals, despite representing only a small fraction of the world's population. This suggests that much of the world's population continues to be underrepresented in highly influential psychiatric journals.

Psychiatric research productivity differs substantially between countries and world regions as measured by publication in journals with a high impact factor. For instance, comparatively little research published in such psychiatric journals comes from low- and middle-income nations (Patel & Kim, 2007; Mari *et al*, 2010). While the disparity between high- and low-income nations in producing and publishing in peer-reviewed psychiatric journals is well described (Patel & Kim, 2007; Mari *et al*, 2010) and understandable given the economic constraints inherent to lower-income countries, little research has investigated how well the nations producing considerable amounts of influential psychiatric research represent the world's population.

In 2001, Patel & Sumathipala compared numbers of publications in six high-impact psychiatric journals over 3 years (1996–98) by 'Euro-American' countries (including countries in Western Europe, North America and Oceania) and the rest of the world and found considerable underrepresentation by countries not from Euro-America in the influential psychiatric literature – only 6% of the research was published by countries that together accounted for over 90% of the world's population. They and other authors have offered prescriptions for increasing high-impact publication among international psychiatric researchers (Patel & Sumathipala, 2001; Maj, 2005; Coverdale *et al*, 2007; Balon *et al*, 2008).

In this study, we extend the work of Patel & Sumathipala (2001) by examining whether recommendations to facilitate more influential research and publications from underrepresented world regions have been successful and by estimating how well research published in psychiatric journals with a high impact factor represents the world's population. To do so, we replicate parts of Patel

& Sumathipala's study but use additional journals in 1998 and compare the results with findings a decade later, in 2008. While much of the previous research on this topic has focused on publication disparities between high-income countries and low- and middle-income countries, our primary objective is to examine how psychiatric research reported in these journals represents the world's population. Furthermore, we briefly outline some future directions for research to monitor global representation in the psychiatric literature.

Methods

From the Journal Citations Report Science Edition for 2008, we extracted the impact factor for each of the listed psychiatric journals. Impact factors can be considered an estimate of the influence a journal has on research. We selected the ten psychiatric journals with the highest 1-year and 5-year impact factors in 2008.

From the published author affiliation section of all papers published in the ten journals with the highest 1-year and 5-year impact factors in 2008, and in these same journals in 1998 (which were also among the journals with the highest impact factors at that time), we extracted the country of the institutional affiliation of the first author of each paper and tallied the number of first authors by country. We combined the published articles by country into world regions as defined by the Population Reference Bureau, a widely accepted source for regional populations.

We divided the total number of first authors for each world region by the population of the region according to population estimates obtained from the Population Reference Bureau to obtain an estimate of the ratio of articles published to population in each world region during 1998 and 2008. Finally, we compared the number of articles published (again, as a population ratio) for each region in 1998 and 2008 to examine whether underrepresented regions in 1998 had become better represented a decade later.

Results

The ten journals in psychiatry with the highest 1-year and 5-year impact factors in 2008 were: *Archives of General Psychiatry*, *Molecular Psychiatry*, *American Journal of Psychiatry*, *Biological Psychiatry*, *Neuropsychopharmacology*, *Schizophrenia Bulletin*, *British Journal of Psychiatry*, *Journal of Clinical Psychiatry*, *Journal of Child Psychology and Psychiatry* and *Journal of the American Academy of Child and Adolescent Psychiatry*. The top ten journals were the

Table 1

Number of papers published in the top ten psychiatric journals (by impact factor) from each of the 18 Population Reference Bureau regions in 1998 and 2008, number per million persons in each of those years, and change in number per million 1998–2008

Region	Number of papers published		Papers/million persons		Change in number of papers/million persons, 1998–2008
	1998	2008	1998	2008	
Northern Africa	0	0	0.00	0.00	0.00
Western Africa	0	0	0.00	0.00	0.00
Eastern Africa	0	0	0.00	0.00	0.00
Middle Africa	0	0	0.00	0.00	0.00
Southern Africa	1	2	0.02	0.03	0.01
North America	685	899	2.28	2.64	0.36
Central America	0	1	0.00	0.01	0.01
Caribbean	0	0	0.00	0.00	0.00
South America	3	12	0.01	0.03	0.02
Western Asia	19	23	0.11	0.10	-0.01
South Central Asia	4	5	0.00	0.00	0.00
South-East Asia	0	0	0.00	0.00	0.00
East Asia	20	53	0.01	0.03	0.02
Northern Europe	165	225	1.75	2.29	0.54
Western Europe	75	180	0.41	0.95	0.54
Eastern Europe	0	4	0.00	0.01	0.01
Southern Europe	31	57	0.22	0.37	0.15
Oceania	26	66	0.91	1.90	0.99
Total	1029	1527			

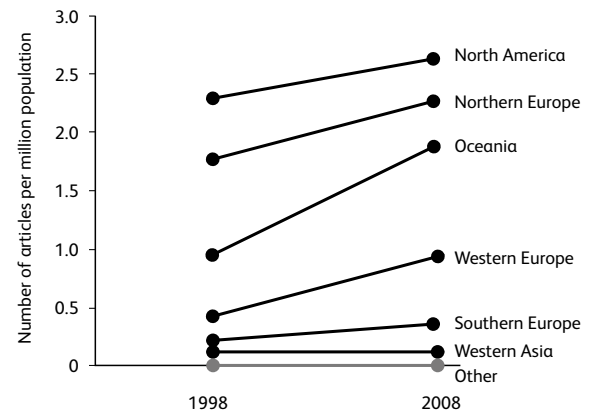
same for both 1-year and 5-year impact factors, although the order was not identical.

In 1998, among the 18 world regions as classified by the Population Reference Bureau, North America, Northern Europe, Western Europe and Oceania had the highest paper/population ratios (Table 1), producing 951 of the 1029 articles (92.4%) published in the ten journals in 1998 while representing only 10.3% of the world's population.

The results were similar in 2008 – the North American, Northern European, Oceanic and Western European regions had the highest rates of publication (Table 1), producing 89.7% of the 1527 papers published in these journals despite containing as a group only 9.8% of the world's population. Further, North America, Northern Europe, Oceania and Western Europe showed the greatest increases between 1998 and 2008 in publications per head of population (Table 1, Fig. 1).

Discussion

We found that the vast majority of psychiatric research published in journals with a high impact factor in 2008 came from lead authors located in world regions that represented only a small part of the world's population, a publication

**Fig. 1**

Comparison of the numbers of articles published per million population in 1998 and 2008, for the 18 Population Reference Bureau world regions. The grey line at the bottom of the graph represents the remaining 12 unlabelled regions (Northern Africa, Western Africa, Eastern Africa, Middle Africa, Southern Africa, Central America, Caribbean, South America, South Central Asia, South-East Asia, East Asia, Eastern Europe), superimposed on each other

pattern essentially unchanged from 1998 (Patel & Sumathipala, 2001). North America, Northern Europe, Oceania and Western Europe continued to produce most of the papers published in the top ten psychiatric journals, and few articles published in these journals came from lead authors in Africa, Asia or South America, regions that accounted for the majority of the world's population.

In fact, publication rates in these journals increased from 1998 to 2008 in North America, Northern Europe, Oceania and Western Europe (Table 1, Fig. 1). Although many regions showed little or no increase in publication per million people, some with low publication rates in 1998, such as Southern Africa, South America and East Asia, had small increases in publication rates between 1998 and 2008, with, for example, South America increasing from 0.01 to 0.03 and East Asia increasing from 0.01 to 0.03. While encouraging, these increases were smaller in absolute terms than the increases seen in North America, Northern Europe, Oceania and Western Europe, with, for example, Oceania increasing from 0.91 to 1.90 and Western Europe increasing from 0.41 to 0.95, suggesting that the factors underlying the disparities in publication rates in 1998 remained largely intact in 2008.

These findings suggest that psychiatric research published in journals with a high impact factor may represent only a small part of the world's population, despite strategies recommended by researchers and institutions to address the imbalance (Patel & Sumathipala, 2001; Maj, 2005; Coverdale *et al.*, 2007; Balon *et al.*, 2008) and the expansion of global mental health initiatives in the same period (Balon *et al.*, 2008).

We recognise that selecting those journals with a high impact factor is only one way to identify influential research. Future research could

examine collaborations between authors in different world regions (Maj, 2005) or the actual subject pools used in studies (Patel & Kim, 2007). Acceptance rates for submissions from underrepresented regions to the journals could also be compared with acceptance rates for submissions from overrepresented regions (Patel & Kim, 2007). We also realise that psychiatric researchers from underrepresented world regions could be improving their publication rates in psychiatric journals with lower impact factors, and this is another possibility to explore in future research.

Despite previous recommendations to improve global representation in psychiatric research, much of the world's population still appears to be underrepresented in highly influential psychiatric journals. More effective actions need to be taken to achieve truly globally representative psychiatric research (Maj, 2005).

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The diagnostic validity of depression scales and clinical judgement in the Kurdistan region of Iraq

Zerak Al-salihy¹ MBChB MRCPsych, Twana A. Rahim² MBChB FIBMSPsych, Mahmud Q. Mahmud,³ Asma S. Muhyaldin⁴ and Alex J. Mitchell⁵ MBBS MRCPsych

¹Specialty Registrar Level 5 (ST5) in Old Age Psychiatry, Norfolk and Suffolk Foundation Trust (NSFT), Bury St Edmunds, Suffolk, UK, email zeraksalihy@yahoo.com

²Senior Lecturer in Psychiatry and Behavioural Sciences, Faculty of Medicine, Hawler Medical University, Erbil, Iraq

³General Psychiatrist, Azadi Medical Centre, Erbil, Iraq

⁴Psychiatry Registrar, Tairawa Health Centre, Erbil, Iraq

⁵Consultant and Honorary Senior Lecturer, University of Leicester, UK

We aimed to find the depression rating scale with the greatest accuracy when applied by psychiatrists in Iraqi Kurdistan. We recruited 200 patients with primary depression and 200 controls living in the Kurdistan region of Iraq. The Mini International Neuropsychiatry Inventory (MINI) was used as a gold standard for DSM-IV depression. We also used: the two-item and the nine-item versions of the Patient Health Questionnaire (PHQ2, PHQ9), the Hospital Anxiety and Depression Scale (HADS), the Calgary Depression Scale for Schizophrenia (CDSS) and the Centre for Epidemiological Studies Depression (CES-D) scale. Interviews were performed by psychiatrists who also rated their clinical judgement using the Clinical Global Impression (CGI) scale and other mental health practitioners. All scales and tools performed with high accuracy and reliability. The least accurate tool was the PHQ2; however, with only two items it was efficient. Sensitivity and specificity for all tools were above 90%. Clinicians using the CGI were accurate in their clinical judgement. The CDSS appeared to be the most accurate scale for DSM-IV major depression and the PHQ2 the most efficient. However, only the CDSS appeared to offer an advantage over psychiatrists' judgement.

Üstün *et al* (2004) estimated that depression is the fourth leading cause of global disease burden. The burden of depression on the healthcare system is equally significant, with an estimated US national annual medical cost of approximately \$26 billion in 1990 (Broadhead *et al*, 1990; Greenberg *et al*, 1993). The National Comorbidity Survey Replication (NCS-R), conducted with people aged at least 18 years, found a 12-month prevalence of 9.5% for any DSM-IV mood disorder, with 6.7% for major depression and 1.5% for dysthymia (Kessler *et al*, 2005). A mental health survey in Iraq which was conducted in collaboration with World Health Organization in 2007 showed that 'anxiety' was the most common class of disorders (13.8%) and major depressive disorder (MDD) the most common disorder (7.2%) (Alhasnawi *et al*, 2009; World Health Organization, 2009).

The extensive literature on screening and case-finding for depression has been reviewed elsewhere. Screening for depression has been supported by recommendations from the US Preventive Services Task Force (Agency for Healthcare Research and Quality, 2002), the UK National Institute for Health and Clinical Excellence (2004) (NICE) and the Canadian Task Force on Preventive Health Care (MacMillan *et al*, 2005). Our aim was to find the tool with the highest accuracy relative to a robust gold standard.

Methods

We recruited 200 patients with primary depression and 200 people without depression living in the Kurdistan region of Iraq. The Mini International Neuropsychiatry Inventory (MINI) was used as a gold standard to define DSM-IV major depression. Ethical approval was granted by the relevant ethical committee for research in Erbil.

Recruitment was undertaken by trained psychiatrists and mental health practitioners working in both out-patient clinics and in the only psychiatric unit of the largest teaching hospital, as well as two health centres which provide out-patient psychiatric services in Erbil. Three trained mental health practitioners administered all the scales after three trained psychiatrists used the Clinical Global Impression (CGI) scale (severity of illness subscale) to evaluate their own clinical judgement based on a full standard psychiatric assessment. The psychiatrists then administered the MINI.

The controls were recruited via random sampling by dividing the city of Erbil into ten regions. The data were collected between April 2009 and March 2010.

A power calculation suggested that, in order to have an 80% chance to detect a 10% difference in sensitivity or specificity, 197.5 patients would be required in each sample. All those who consented were successfully followed up. We excluded patients who were severely unwell. We did not recruit those unable or unwilling to consent. We also excluded those with current substance misuse.

Tools

We used the following scales: the two-item and nine-item versions of the Patient Health Questionnaire (PHQ2, PHQ9), the Hospital Anxiety and Depression Scale (HADS), the Calgary Depression Scale for Schizophrenia (CDSS) and the Centre for Epidemiological Studies Depression (CES-D) scale. We also used the CGI in order to quantify clinical opinion. Scales were administered after the CGI and MINI. We collected reliability data for this approach using Cronbach alpha scores. The CDSS was developed at the University of Calgary and its use has been evaluated for both relapsed and remitted patients with schizophrenia (Addington *et al*, 1992).

Analysis

We used an ROC analysis for each scale against an interview standard diagnosis of depression based on the MINI. In addition we calculated the optimal sensitivity, specificity, positive predictive value (PPV) and negative predictive value (NPV).

Results

All scales and tools performed with high accuracy compared with the MINI for DSM-IV major depression. The least accurate tool was the PHQ2, but with only two items it was nevertheless very efficient. Sensitivity and specificity for all tools was above 90%. Judging by the area under the curve (Fig. 1), the most accurate scale was the CDSS. All

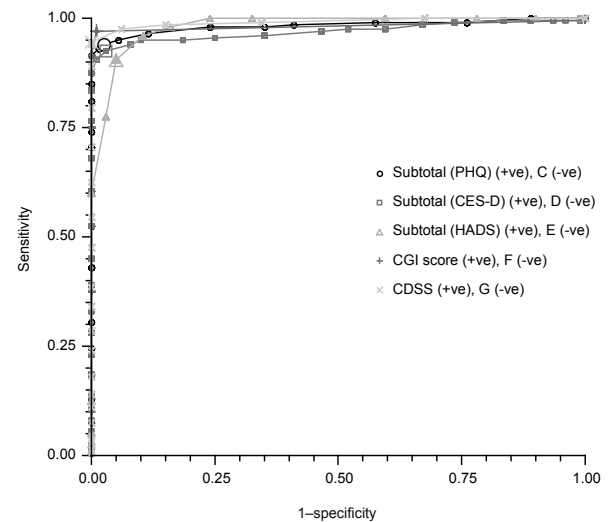


Fig 1
ROC plot

patients who scored positive with the CDSS were correctly classified as having depression.

Clinicians used the CGI to rate their opinion, blind to the results of the scales. Using the CGI their sensitivity was 97.0% and specificity 99.0%. Only in the case of the CDSS was accuracy better with than without the scale, and then only moderately so and short of statistical significance.

Discussion

We found that all five scales performed well in the hands of trained mental health practitioners. However, we also found that psychiatrists without assistance were accurate when evaluated against the MINI. This study may suggest that diagnostic tools are of limited value in specialist settings, when compared with clinical routine judgement.

Only a handful of studies have previously examined the accuracy of psychiatrists' clinical judgement. Taiminen *et al* (2001) compared routine discharge diagnoses based on DSM-IV and best-estimate diagnoses and results from the Schedules for Clinical Assessment in Neuropsychiatry (SCAN) in 116 first-admission patients with psychosis and severe affective disorder. Diagnostic agreement was moderate (κ 0.51), suggesting frequent errors in routine diagnosis, even when using DSM-IV criteria.

Our results show a high accuracy for psychiatrists in Iraq and also high accuracy of all tested tools. The CDSS appeared to be the optimal scale.

We wish to acknowledge several limitations to this study. First, the CGI and MINI were administered by the same researchers. Also, there was no formal matching of cases and controls. Although we intended to administer all the questions by self-report alone, in practice issues with literacy meant we administered them to some of the patients verbally, with the assistance of a trained interviewer.

In conclusion, we found that the CDSS was the optimal method to diagnose depression; however, we also found the psychiatrists' opinion alone was very accurate and therefore it is unclear from our sample whether questionnaires would appreciably help clinicians in their diagnoses.

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Judicial involuntary admission under the Mental Health Act in Goa, India: profile, outcome and implications

Anil Rane,¹ Abhijit Nadkarni,² Shilpa Waikar³ and H. A. Borker³

¹Institute of Psychiatry and Human Behavior, Goa, India, email dranilrane@gmail.com

²London School of Hygiene and Tropical Medicine, London, UK

³Institute of Psychiatry and Human Behavior, Goa, India

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Reception order (RO) by a magistrate is a mode of involuntary admission provided under the Indian Mental Health Act of 1987. To the best of our knowledge there has been no evaluation of this provision in clinical practice. The present paper is a descriptive study through retrospective case-note review of patients admitted by way of RO to a tertiary care hospital in Goa. Compared with those admitted voluntarily, those admitted by RO tended to be single, middle aged (40–60 years old) and non-Goan; on average they had a significantly longer hospital stay than voluntarily admitted patients. Non-affective psychosis and substance use disorders were the more common diagnoses. While admissions by RO serve a useful role in bringing patients who are not under proper care into the mental healthcare system, they do not address the issue of aftercare.

At times, people who are mentally unwell need to be admitted to a psychiatric hospital against their will for reasons of their own safety and/or that of others. In India, all admissions, both voluntary and involuntary, come under purview of the Indian Mental Health Act of 1987 (MHA). Under the Act there are two modes of involuntary admission: special circumstances (SC) and

magisterial reception order (RO). For SC, family members or friends can request an admission if this is supported by two medical certificates. This provision is valid for a maximum of 90 days, beyond which an RO has to be obtained to continue the admission. For the RO, family members or the police may apply to a magistrate requesting the admission of a person to a psychiatric hospital. The magistrate has to be satisfied that the person is suffering from a mental disorder that needs admission for treatment or for the safety of others. The magistrate has to take into consideration the evidence of mental illness as certified by a government doctor. The RO is valid for 30 days. Within this period, the treating doctor has to certify the presence of mental illness, failing which the order lapses. If certified, the patient can be detained indefinitely until the treating doctor deems the patient fit for discharge. The patient can appeal against the order or for discharge to the magistrate or higher appellate (*Gazette of India*, 1987).

The objective of the present case-note review is to describe:

- the sociodemographic and clinical profile of people admitted by way of RO (comparisons are drawn with patients admitted voluntarily)
- their clinical outcomes
- the procedural details of the RO process.

Methods

Goa, with a population of 1.5 million, is one of the smallest states in India. It has some of the best socioeconomic and health parameters in the country. Psychiatric services are provided by the public as well as the private sector. There is no active community-based psychiatric care. The onus is on the patient and family to access health-care and for the latter to provide adequate support in the community.

In this study we retrospectively assessed the case-notes of all patients admitted by RO to a tertiary care psychiatric teaching hospital in Goa in the year 2006. Data were obtained from case-notes and RO documentation, from various magistrates' offices, which accompanied the patients. Select data were also obtained from 100 randomly selected voluntarily admitted patients in the same period. Data were collected using a structured questionnaire recording the following:

- sociodemographic details – age, gender, ethnicity, religion, marital status and education for both RO and voluntarily admitted patients
- RO procedural details – who the complainant was, the nature of the complaint, whether the RO was supported by a medical report, duration of the RO, whether the patient was eventually certified as mentally unwell and the time taken to certify
- clinical profile and discharge outcomes – clinical diagnosis and time to discharge, for both RO and voluntary patients.

Diagnoses based on ICD-10 (World Health Organization, 1992) were made during the course of the admission by the treating team, headed by a consultant.

Analysis

The counts and frequency of all the variables were recorded. Chi-square and *t*-tests were used to compare the sociodemographic profiles and clinical diagnoses of RO admissions with those of patients who were voluntarily admitted.

Results

Admissions to the hospital in 2006 totalled 1640, of which 109 (7%) were by way of RO. Case-notes could be traced for 100 of these patients, while RO documentation was available for all 109.

The sociodemographic profile of RO patients is compared with that of voluntary patients in Table 1. Of Goan patients on RO, 62% were Christians and 50% came from a single *taluka* (administrative unit of the state), namely Salcete. Compared with voluntary admissions, patients on RO were significantly more likely to be middle aged (i.e. 40–60 years old), non-Goan, Christian and unmarried.

Table 2 gives the procedural details of the RO admissions. The predominant reason for taking the patient into custody was 'nuisance', which was described as interfering with others without causing harm to person or property. Violence was

Table 1

Sociodemographic details of patients admitted under reception order (RO) (*n* = 100) compared with voluntarily admitted patients (VP) (*n* = 100)

Variable	RO	VP	<i>P</i>
Age	<18	3	<0.001
	18–40	50	
	40–60	45	
	>60	2	
Gender	Male	73	0.06
	Female	27	
Ethnicity	Goan	51	<0.001
	Non-Goan (Indian)	36	
	Foreign national	13	
Religion	Hindu	43	0.003
	Christian	48	
	Muslim	9	
Marital status	Married	39	<0.001
	Single	42	
	Other	6	
	Not known	13	
Education	Elementary	9	<0.001
	Pre-university	40	
	University	12	
	Nil	11	
	Not known	28	

reported for 18 patients, described as harm to property or person. For all but two patients, mental illness could be certified. One of these patients was diagnosed with an intellectual disability, which does not fall in the ambit of the MHA. The other was an elderly man with no family who was admitted to the medical college hospital, from where he was referred to the study site by RO on certification of a casualty medical officer.

Table 3 describes the clinical profile and outcomes of the RO patients. While all the non-Goan RO patients and foreign nationals were admitted for the first time, 47 of the Goan RO patients had had prior admissions. The RO patients had a significantly longer hospital stay than the voluntary patients. However, no significant differences were noted in the diagnosis for which the patient was admitted.

Table 2

Reception order procedural details

Variable	<i>n</i> (%)	
Complaint made by (<i>n</i> = 109)	Police	65 (59.2)
	Public	27 (24.7)
	Relative	6 (5.5)
	Social worker	6 (5.5)
	Doctor	4 (3.6)
	Employer	1 (0.9)
Nature of complaint (<i>n</i> = 109)	Nuisance	70 (64.3)
	Wandering	18 (16.5)
	Violence	18 (16.5)
	Other	3 (2.7)
Medical report accompanied (<i>n</i> = 109)	Yes	102 (93.6)
	No	7 (6.4)
Mental illness certified (<i>n</i> = 100)	Yes	98 (98)
	No	2 (2)
Time (days) needed to certify (<i>n</i> = 98)	< 5	94 (96)
	> 5	4 (4)

Table 3

Clinical profile and outcomes of patients admitted under reception order (RO) ($n = 100$) compared with voluntarily admitted patients (VP) ($n = 100$)

Variable	RO	VP	P
<i>Diagnosis</i>			0.02
Acute psychosis	4	3	
Schizophrenia	29	35	
Schizoaffective disorder	2	2	
Mania	16	22	
Substance use disorder	27	31	
Unspecified non-organic psychosis	15	0	
Personality disorder	4	1	
Dementia	1	0	
Intellectual disability	1	0	
No psychiatric diagnosis	1	0	
Depression	0	5	
Other	0	1	
<i>Discharge</i>			<0.01
Time to discharge, days: mean (s.d.)	55.5 (97.9)	16.4 (17.9)	
Time to discharge, days: median	25.5	10.5	
Range, days	4–515	1–97	

Discussion

To our knowledge this is the first Indian descriptive study of involuntary admissions by way of RO. Significantly more middle-aged, unmarried and non-Goan people were admitted by RO compared with voluntarily admitted patients. A trend towards more male admissions was noted. Involuntary admission in other parts of the world has been similarly reported to disproportionately involve young, single people (Malla *et al.*, 1987; Bauer *et al.*, 2007) as well as middle-aged men (Brissos *et al.*, 2007). In India, where caring for the patient in the community is largely the responsibility of the family, being unmarried may be an added disadvantage. It is not uncommon for people who are mentally ill to wander far away from home, sometimes even out of state. These individuals, on account of their abnormal behaviour, are then picked up by the police under the provisions of the MHA, resulting in an overrepresentation of people from out of state.

There was also a significant overrepresentation of Christians, probably because 50% of the Goan patients on RO came from a single *taluka*, one which has a high Christian representation. However, the reason for the overrepresentation of patients from this *taluka* is not clear.

In 94% of cases the magistrate relied upon medical certificates before issuing the RO. Such safeguards can assuage concerns raised by the psychiatric community about whether the judiciary can properly be assigned the role of determining presence of mental illness (Antony, 2000). Interestingly, the time taken to certify the presence of mental illness was less than 5 days in 96% of cases. This suggests that these patients had overt signs and symptoms to indicate mental abnormality, which in turn aided the judicial system to channel them towards the mental hospital. Therefore the RO system appears reliably to serve the purpose

of getting persons with overt mental illness who are not in receipt of proper care into the mental healthcare system. However, the absence of any provision for periodic review after admission is a serious shortcoming in the MHA. In the absence of rehabilitation services, patients can languish in mental hospitals for years on end, itself a grave violation of their human rights.

Of those from our study who had previously been admitted, 75% had been brought back via a repeat RO admission. This raises important issues about the efficiency of aftercare and lack of social support, which need further evaluation. A community-based mental healthcare approach (which is largely missing in most parts of the country) might address such issues.

Lastly, those on RO spent significantly more time in the hospital than those voluntarily admitted. Longer stays for involuntarily admitted patients have also been reported in other studies (Malla *et al.*, 1987). In our study it could be partly explained by the large number of patients from other states, for whom arranging travel back home was difficult, for a host of logistical and administrative reasons. This should be a matter of concern for policy-makers and resolving it would go a long way towards the timely and appropriate relocation of such patients back to the care of their loved ones.

Our paper provides some important information to fill the literature gap and at the same time raises some important issues related to legislation and policy. The MHA is an upgrade of the Indian Lunacy Act of 1912. While many changes were made, it still draws considerable criticism from practitioners of psychiatry and the public at large (Kala & Kala, 2007). The government of India is currently drafting a new Mental Health Care Act (MHCA; Pathare & Jagade, 2010). A provision for those with intellectual disability needs to be considered for the new MHCA, as it is excluded from the purview of the current MHA. The new MHCA will have to stipulate more safeguards to prevent the misuse of involuntary admission. It should safeguard poor and homeless people from being admitted to mental hospital in the absence of appropriate alternative resources, as was evident in one of the present series of RO admissions. While there is scope to reduce the role of the judiciary to a minimum, a system to monitor the admissions should be considered, in order to safeguard the rights of those who are mentally ill.

We can conclude that the RO is a useful provision in the MHA, allowing for the treatment of patients with mental illness who would otherwise have been neglected, but it does little to address the issue of continuity of care and the 'revolving door' phenomenon. We hope that the new MHCA will address these issues.

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NEWS AND NOTES

Contributions to the 'News and notes' column should be sent to ip@rcpsych.ac.uk

The death of an eminent editor

Griffith James Edwards, an eminent international expert in addictions and Honorary Fellow of the Royal College of Psychiatrists, sadly died on 13 September 2012 following a stroke. Griffith's interest in substance misuse in general and in alcohol misuse in particular started from the 1960s, and led to the establishment of the Addiction Research Unit at the Institute of Psychiatry and the Maudsley Hospital. In 1976 Griffith, with Milton Gross, published a paper with the first provisional description of alcohol dependence as a clinical syndrome. This was a landmark paper – the first time that the now familiar concept of substance dependence had been articulated. It demonstrated several facets of Griffith Edwards: his intellect, his powers of analysis and conceptual thought and his ability to articulate complex ideas. He was also very supportive of the College and chaired two committees and working groups, which led to the publication for the College of two very informative and well received books: *Alcohol and Alcoholism: The Report of a Special Committee of the Royal College of Psychiatrists* (Tavistock, 1979) and *Drug Scenes: A Report on Drugs and Drug Dependence* (Gaskell, 1987).

Griffith was Editor-in-Chief of the *British Journal of Addiction* from 1978 until 2005, taking it from just four issues per year to six and then to monthly. He established Regional Offices in Australia and America so that it is now a highly esteemed, international journal, renamed *Addiction*. Griffith was passionate about the journal and remained its Commissioning Editor until his death.

His career attracted many, many national and international honours. He was an Honorary Fellow of the College, and was made Commander of the British Empire (CBE) in 1987 for his services to social sciences and medicine.

The true measure of his contribution to addiction sciences is his legacy. For Griffith, with his interest in everyone and everything, his superb verbal fluency, his ability to ask the penetrating question to get to the heart of an issue, stimulated everyone around him. His death is a great loss to academic medicine and to psychiatry.

Hamid Ghodse, Editor

Medical Training Initiative (MTI)

The Royal College of Psychiatrists will be joining the Medical Training Initiative (MTI) and establishing its own scheme, thereby fulfilling its important role as the leading organisation in promoting quality training in psychiatry in the UK and abroad. The MTI is a national scheme designed

to allow a small number of doctors to enter the UK from overseas so that they can benefit from training and development in the National Health Service before returning to their home countries.

Pan American Division

The Pan American Division of the Royal College of Psychiatrists hosted a grand reception at the 62nd Annual Conference of the Canadian Psychiatric Association in Montreal on 28 September 2012. The event was supported by the Canadian Psychiatric Association (which has signed a Memorandum of Understanding with the College) and was attended by more than 40 members of the Division. The event was fully funded by the College. Attendance has grown over the years and the reception is considered a valuable part of the Conference.

Dr Dhanapal Natarajan, Vice Chair, Pan American Division of the Royal College of Psychiatrists

Faculty of the Psychiatry of Old Age: annual bursary

The Faculty of the Psychiatry of Old Age has established an annual bursary to enable a psychiatrist from a low- or middle-income country to attend the Faculty Annual Residential Meeting (usually held in March) in order to give an oral or poster presentation, or deliver a workshop. The bursary is intended to cover the cost of economy class travel, accommodation, free registration and attendance at the Conference Dinner, up to a maximum of £1500. Informal mentors will be identified for the bursary holder. The closing date is 30 November. Email kkottasz@rcpsych.ac.uk.

Society for Emotional Well-being Worldwide

The Society for Emotional Well-being Worldwide (SEWW; <http://www.seww.org>) has evolved into a social media platform for professionals working in mental health. It facilitates networking, information exchange and collaboration through a web-based platform.

British Arab Psychiatrists Association

Several members have participated in voluntary work over the past few months. This included visiting Syrian refugee camps both in Jordan and Turkey as the unmet mental health needs of these people are great. The BAPA is keen to develop a new initiative with the College Volunteer Scheme in the Arab countries. For further information contact Dr Nadim Almoshmosh, Chair of the Association (email Nadim.Almoshmosh@nhft.nhs.uk).

The impact of the uprising in Egypt on mental health in a private hospital

Sir: After the recent uprising in Egypt, doctors expected a rise in the incidence of mental health disorders, especially cases of post-traumatic stress disorder (PTSD), but saw, surprisingly, a reduction in the number of admissions in the first few weeks. It is assumed that the curfew and the reduction in family income for many was behind this. Having said that, many other disorders – including organic mental disorders, such as traumatic brain injury, substance use disorders and subsequent drug-induced psychoses – seemed to have increased in incidence. Exacerbation of episodes of schizophrenia was also observed, with some of the persecutory delusions being related to surveillance by the police. Some patients had manic episodes that they correlated with the stress during the uprising. Depression and adjustment disorder were an expected occurrence. Bereavement reactions were observed not only over lost lives, but also among families of members of the old regime who were arrested.

There were logistical challenges as well. Shortages of medication became one of the difficulties that patients and doctors encountered. One new antidepressant's launch was postponed for a few months to accommodate the unrest. A local unit could not administer electroconvulsive therapy (ECT) owing to the erratic electrical supply and an ECT anaesthetist admitted to feeling exhausted because of the number of people that she treated elsewhere.

Early in the uprising, the curfew prevented some doctors from making it to work. Communication and access to information were a bit difficult without internet and mobile phones. Later, many doctors found themselves engaging in discussions with acutely ill patients who were asking for their rights to participate in parliamentary and later in presidential elections.

The uprising seems to have had both expected and unexpected consequences for mental health services and their users in the short term, and both time and a more systematic analysis will be required to ascertain the longer-term consequences.

Emad Sidhom

Registrar in Psychiatry, Behman Hospital, Cairo, Egypt (pre-Membership psychiatric trainee), email e.sidhom@gmail.com

Report on drug and alcohol use in Iraq: the inaugural meeting of the Community Epidemiology Work Group

Sir: The initial meeting of the Iraq Community Epidemiology Work Group (CEWG), 8–9 May 2012, held in Baghdad, brought together leaders and representatives from the public health and mental health sectors, law enforcement agencies, the universities, the governorates, non-governmental organisations (NGOs) and the Ministries of Health, Interior, Labour and Social

Affairs, Youth and Sports, and Justice, as well as international technical assistance experts. The 2-day meeting reviewed the importance of and methods for developing a capacity in Iraq for better understanding the nature and extent of the drug and alcohol problem in the country and reviewed some of the existing data on this topic. Iraqi and international speakers provided background and a rationale for using the CEWG methodology as an optimal approach. Fourteen reports presented data on the current use of drugs and alcohol in Iraq. Ways of improving future CEWG meetings by expanding the types and sources of data were discussed in a workshop.

The findings from this meeting suggest that, since the reports by Aqrawi & Humphreys (2009) and Al-Diwan (2011) on drug use in Iraq, summarised by Rawson (2011), some things have remained relatively stable, while there have been significant changes in other areas. The psychoactive substances most widely used in Iraq continue to be alcohol, benzodiazepines, benzhexol, codeine and a variety of psychiatric medications. This set of 'primary drugs' is consistent with the earlier reports. However, there was near universal agreement that the use of hashish, tramadol (an opioid-type analgesic) and amphetamine-type substances (ATS) is increasing rapidly in some areas and that drug and alcohol use overall is increasing. Reports from Basrah from health officials and police were noteworthy. Two types of ATS have made an appearance in Iraq: '01 pills' (tablets of captagon, an amphetamine-type drug) and 'crystal' (methamphetamine) have been seized in considerable quantities in Basrah. The 01 pills appear to be the same type of ATS that are being used in epidemic amounts in Saudi Arabia, and they appear to be coming into the country via the port of Basrah. 'Crystal' is likely coming from Iran, since drug seizures have been near the Iranian border and use of the drug in Iran is extensive. In addition, reports from Mosul and federal drug seizure data suggest that the use of tramadol is increasing substantially in many parts of Iraq. This drug is available to users from pharmacies and from street drug dealers. At present, there is little evidence of increased use of heroin in Iraq, and rates of injection drug use appear to continue to be relatively low.

The CEWG will continue to meet annually or more often to provide an ongoing monitoring programme regarding drug and alcohol use in Iraq.

Nesif Al Hemiary MD, Jawad Al-Diwan MD PhD, Albert Hasson MSW and Richard A. Rawson PhD

Iraq Community Epidemiology Work Group, email rawson@mednet.ucla.edu

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Forthcoming international events

10–12 December 2012

18th International Congress of Rural Health and Medicine

Goa, India

Organiser: International Association of Rural Health and Medicine (IARM), Japan; Pravara Medical Trust Institute of Medical Sciences – DU (PIMS), Loni; Association of Agricultural Medicine & Rural Health in India (AAMRHI), Loni; International Arbitration Centre (IAC), Goa
Website: <http://www.ruralhealthgoa2012.org/>

4–7 March 2013

5th World Congress on Women's Mental Health

Lima, Peru

Organiser: International Association for Women's Mental Health
Website: <http://www.iawmh2013.com/>

6–9 March 2013

Crises and Disasters: Psychosocial Consequences

Athens, Greece

Organiser: World Federation for Mental Health in collaboration with the Hellenic Psychiatric Association and the Society of Preventive Psychiatry
Website: <http://psychcongress2013.gr/en/index.html>
Email: info@era.gr

6–9 April 2013

EPA 2013: 21st European Congress of Psychiatry

Nice, France

The 2013 Congress will bring psychiatrists and other discipline-related professionals together to address the complex theme of 'Europe challenges the burden of mental disorders'. The programme will tackle research and clinical/therapeutic aspects. In addition the meeting will again feature the highly successful EPA early-career psychiatrists programme.

Organiser: European Psychiatric Association
Website: <http://www.epa-congress.org/>
Email: reg_epa2013@kenes.com

18–21 April 2013

9th International Congress on Mental Disorders and Other Non-Motor Features in Parkinson's Disease and Related Disorders

Seoul, South Korea

Website: <http://www2.kenes.com/mdpd>

18–22 May 2013

American Psychiatric Association Annual Meeting

California, USA

Organiser: American Psychiatric Association
Website: <http://www.psych.org/annualmeeting>

30 May–2 June 2013

3rd International Congress on Neurobiology, Psychopharmacology and Treatment Guidance

Thessaloniki, Greece

Organiser: European Psychiatric Association, World Psychiatric Association and School of Medicine, Aristotle University of Thessaloniki
Website: <http://www.psychiatry.gr/>

5–8 June 2013

14th International Congress of the International Federation of Psychiatric Epidemiology: The Uses of Psychiatric Epidemiology in Improving Population Mental Health

Leipzig, Germany

Organiser: International Federation of Psychiatric Epidemiology
Website: <http://ifpe2013.org/>
Email: sjansen@eventlab.org

29 June–3 July 2013

XXI World Congress of Social Psychiatry. The Bio-Psycho-Social Model: The Future of Psychiatry

Lisbon, Portugal

Website: <http://www.wasp2013.com>

2–5 July 2013

Royal College of Psychiatrists International Congress 2013

Edinburgh, UK

Organiser: Royal College of Psychiatrists
Website: <http://www.rcpsych.ac.uk/eventsandcourses/internationalcongress2013.aspx?theme=print>

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