

International Psychiatry

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Psychiatry for the person and its conceptual bases

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The 2005 General Assembly of the World Psychiatric Association (WPA) established the Institutional Program on Psychiatry for the Person (IPPP) in response both to a recognition of our profession's historical aspirations and to recent international developments in clinical care and public health. These considerations point to the relevance of a comprehensive understanding of health and the centrality of the person in the delivery and the planning of healthcare. The IPPP's goals can be summarised as the promotion of a psychiatry of the person (of the totality of the person's health, both ill and positive), by the person (with clinicians extending themselves as full human beings), for the person (assisting the fulfilment of the person's life project) and with the person (in respectful collaboration with the person who consults). Operationally, the IPPP has four components: conceptual bases, clinical diagnosis, clinical care, and public health. What follows is an initial review of the IPPP's conceptual bases and an outline of its emerging activities.

Initial exploration of conceptual bases

Many physicians lament that modern medicine (and psychiatry) is dominated by a fragmentation of care and a hyperbolic dependence on technology. To specialise in a specific area of science and clinical practice is both inevitable and desirable. The quantity of knowledge is so great that competence and expertise in a specific area is a necessity. So, fragmentation of care is, to a certain degree, inevitable. Dependence on technological achievements has also become inevitable in recent times and the admirable technological progress that has occurred has contributed immensely to the advancement of medicine and psychiatry.

It would, therefore, be naive and unproductive to deny the importance of these two developments. However, the Hippocratic dictum 'nothing in excess' is applicable in this case as well (Jouanna, 1999). Overspecialisation has reached, in some cases, a degree where it deprives physicians of their bio-psychosocial approach, and excessive dependence on technology has reduced the physician from the status of 'equal to God' (professed by Hippocrates) to that of a mere technologist. Issues related to ethics and to the identity of the physician are relevant here.

An approach that would integrate excellence in certain clinical areas with scientific and technological advances, within a framework of holistic medicine, and that would refocus our attention on the person has become a necessity. The concept of 'person' is, of course, a protean one. It changes geographically and diachronically and it is subject to cultural, political, religious, socio-economic and ethical considerations.

The need for holism in medicine was strongly advocated by Ancient Greek philosophers and physicians. Socrates and Plato taught that 'if the whole is not well it is impossible for the part to be well' (Christodoulou, 1987) and such was also the position of Aristotle.

These ideas are re-emerging in our times, not only within the Western medical tradition but also in a number of other rich traditions around the world. For example, Ayurvedic and Chinese medical traditions, ancient and still practised, with sound philosophical, experiential and experimental bases, focus on the patient's total health rather than only on disease. Both articulate a comprehensive and harmonious framework of health and life, and promote a highly personalised approach for the treatment of specific diseases and the enhancement of quality of life (Patwardhan *et al*, 2005). Concern for the centrality of the person is also being adopted by influential international health organisations (Presidential Commission on Mental Health, 2003; WHO European Ministerial Conference on Mental Health, 2005). The psychosomatics movement, with its emphasis on the totality of the person, has contributed considerably to the holistic and personified perspective, and so has the emphasis on positive mental health, in other words, on the factors and approaches that keep people healthy, in contrast to the factors that produce illness.

The context of each person is closely linked to identity. Nobody lives in a vacuum. This is exemplified by a dictum of the philosopher Ortega y Gasset, 'I am I and my circumstance'.

The holistic approach has been extended to include the environment. It is being increasingly recognised that, in addition to the social environment, the natural environment is a very important contributor to health on a group basis but also on an individual basis. Thus the teachings of Hippocrates, with the emphasis he gave to the protective and healing powers of nature, are re-emerging in our times. Holism on an individual level has recently been extended to include broadness in the provision of psychiatric services, that is, the integration of mental health in general health and public health practice (Herrman *et al*, 2005). This kind of perspective results from

the realisation that mental illness and physical illness are fundamentally similar; indeed, they differ in no respect other than clinical expression, and consequently should be managed both in hospital and in the community in a similar manner, thus minimising stigmatisation of those with a psychiatric illness and fragmentation of the provision of care.

Another trend towards personified medicine has emerged with the introduction of the concepts of recovery and resilience (Anthony, 1993; Allott *et al*, 2002; Amering & Schmolke, 2007). These concepts support the involvement, active participation and responsibility of people to protect themselves from illness and to promote and maintain health and recovery from illness.

These developments are emerging in response to many deficiencies in general health and mental healthcare that have been identified not only by a number of clinicians, ethicists and philosophers (Strauss, 1992; Bloch, 2005; Sharfstein, 2005) but also by health administrators and policy makers (Office of the Surgeon General, 1999; Department of Health, 2005a,b).

Clearly, a different, more comprehensive, more humanistic, more holistic and more person-centred perspective is needed (Antonovsky, 1987; Christodoulou, 1987; Ricoeur, 1990; Sensky, 1990; Fulford *et al*, 1995; Cloninger, 2004; Mezzich, 2005).

Additionally, a more person-centred approach on the part of the physician is strongly encouraged (Cox *et al*, 2006; Department of Health, 2005c). This touches on the ethics of the medical profession. Indeed, consideration of the patient as a person and not as a carrier of illness is a fundamental ethical obligation of the physician. This is consistent with the 'respect for autonomy' in the 'principle-based ethics' theory (Beauchamp & Childress, 1994) and with each of the wide range of other ethical theories that support healthcare (Fulford *et al*, 2002).

The above considerations led to the preparation and then the establishment of the IPPP by the WPA General Assembly in 2005. Furthermore, this perspective is highlighted in this triennium's presidential theme and is informing the overall topics of many congresses of the WPA and its member societies (Mezzich, 2007a). As part of this, a person-centred integrative diagnostic model is being designed (Mezzich & Salloum, 2007). Another crucial development has been the engagement of patient/user groups, including those critical of psychiatry, reaffirming the dialogical bases of our profession (Mezzich, 2007b). The IPPP is emerging as a long-term initiative that aims at refocusing the objectives of psychiatry, in particular, and, potentially, medicine at large on the needs of persons.

First steps of the IPPP conceptual component

Several key concepts underlying the IPPP are being analysed as follows:

- a broad concept of health, including illness or pathological aspects as well as positive ones, such as adaptive functioning, protective factors and quality of life
- the concept of 'person' and its key characteristics, including autonomy, history, context, needs, values and life project, in addition to illness experience
- the historical evolution of person-centred concepts in psychiatry and medicine

- the philosophy of science underlying broad conceptualisations of health and person-centred care
- the ethical implications of a person-centred psychiatry and medicine, relevant to the *raison d'être* of the field and the profession (this may offer a valuable approach to dealing with stigmatisation against persons in psychiatric care)
- the biological (genetic, molecular, physiological) bases for a psychiatry and medicine for persons, including an individualised understanding of illness, health and care processes
- the phenomenological, learning and other psychological bases of person-centred care
- the socio-cultural framework of a broad concept of health and the plural meaning of 'a person' in the medical field
- the value of and need for comprehensive diagnosis and care, as well as integration of services to achieve a person-centred psychiatry and medicine
- the conceptual basis for engaging interactively all stakeholders in the health field for the development and implementation of person-centred concepts and procedures, including persons and families in healthcare, health professionals and planners, industry, social advocates, and so on.

The conceptual issues listed above are being investigated through the preparation of the following set of papers, to be assembled as a prospective special issue or supplement of an international journal:

- historical perspectives
- philosophy-of-science perspectives
- ethics and values perspectives
- biological perspectives
- psychological and phenomenological perspectives
- social, cultural and spiritual perspectives
- perspectives of health stakeholders and partners
- psychiatry of the person in literature
- psychiatry of the person in art
- psychiatry of the person in film.

Additionally, other journal papers as well as books relevant to the conceptual bases of the IPPP are being prepared.

As the general theoretical groundwork is completed, conceptual analyses will be extended to strengthen the development of the clinical diagnosis, clinical care and public health components of the overall programme.

Concluding remarks

The initiative on psychiatry for the person represents a paradigmatic shift in our profession and field, refocusing its central objectives on what can be argued is psychiatry's (and medicine's) fundamental soul. The importance and complexity of this endeavour require pointed attention to its conceptual bases. This effort should not only firmly anchor our perspectives but also open creative paths to extend their reach.

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THEMATIC PAPERS – INTRODUCTION

European service perspectives for people with intellectual disabilities and mental health problems

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Services for people with intellectual disabilities, in the UK as elsewhere, have changed dramatically over the last 30 years; deinstitutionalisation has probably been the largest experiment in social policy in our time. The vast majority of people with intellectual disabilities, their families and carers have benefited from having a better quality of life as a result of deinstitutionalisation. However, much still needs to be done to integrate this population more into society and to ensure they are offered the appropriate supports to meet their needs.

There has been considerable variation nationally in the provision of services, particularly for those people with intellectual disabilities who have additional mental health problems. There is a relative lack of provision in some regions, despite the fact that evidence-based practice has shown that there is a high prevalence of undiagnosed and

untreated mental disorder among people with intellectual disabilities. We also know that mental illness among people with intellectual disabilities often presents in atypical ways and that it may coexist with a wide range of neurodevelopmental disorders. Finally, we are aware that many people with intellectual disabilities have impaired communication and hence are unable to describe subjective symptoms; these individuals are particularly at risk of being overlooked or misdiagnosed.

Despite the uneven provision of services for people with intellectual disabilities, an international consensus has emerged and most countries have been trying to develop relevant policies and services for them. Although models of care are changing, the pace of change varies dramatically between countries. This issue's thematic papers provide an insight into services for people with intellectual disabilities and mental

health problems in Greece, Austria and Switzerland. The three papers provide interesting comparisons.

In Greece, services have been undergoing radical reform in recent years, starting from a rather low base. An increasing number of community-based services and support schemes have been developed, while the proportion of the population with intellectual disabilities who were formerly confined to institutions has been greatly diminished. In Austria there are no national registers of intellectual disabilities, a state of affairs that has arisen partly for historic political reasons. Austria offers a dramatic example of how a country's history (in this case the close association with Nazi Germany) can shape its policies, legislation and services. New, supported community-based services have been developed away from the large psychiatric institutions. In contrast, in Switzerland most adults with intellectual disabilities seem to be still living in institutions, although some smaller community-based residential units have also been set up recently.

In all three of these European services there is a disparity for the provision of people with intellectual disabilities and mental health problems. The UK has also been struggling with this state of affairs. The assumption that mainstream psychiatric services are able to address the complex mental health needs of the heterogeneous population with intellectual disabilities is obviously flawed. Although evidence about the effectiveness of provision is limited, research suggests

that some individuals with intellectual disabilities have particularly complex needs, which cannot be met as effectively or even as quickly by generic services as they could by specialised services (Xenitidis *et al*, 2004).

The need for specialist training for those professional workers who are supporting adults with intellectual disabilities and mental health problems is recognised in Greece, Austria and Switzerland. To be effective, these workers should aim to function within a policy framework that enables collaboration between the relevant agencies. There should be clear care pathways, so that service users, their supporters and service providers all understand the roles and responsibilities of different professionals (Holt *et al*, 2005).

We hope that with the emerging evidence base, these thematic papers will stimulate debate about how to institute a European initiative on planning effective services for people with intellectual disabilities and mental health problems.

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THEMATIC PAPER – EUROPEAN PERSPECTIVES ON INTELLECTUAL DISABILITY

Greece

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The history of mental healthcare offered to people with intellectual disabilities in Greece runs in parallel to that of people suffering from severe psychiatric disorders. Until the early 1980s, it was based on 9 overcrowded and understaffed state and 40 private psychiatric hospitals with a mixed population of patients with psychosis and of those with intellectual disabilities (Madianos *et al*, 1999). The psychiatric reforms began with Law 1397 in 1983, which introduced the National Health System, and, in the following year, European Council Regulation 815/84, through which financial aid was approved and a 5-year plan adopted. The main goal was the development of a network of community-based services in geographically sectorised areas, to replace the large psychiatric hospitals. Mental health centres, psychiatric units in general hospitals and many other community services were to be established, according to local requirement.

The implementation of these plans was initially very slow. The exposure in 1989 of the distressing conditions in the Leros Mental Hospital, which had many patients with intellectual disabilities (Bouras *et al*, 1992), resulted in the rehousing of a large number of them to fully staffed community residential facilities near their areas of origin (Tsiantis, 1995). The original 5-year plan was extended to cover a whole decade, by the end of which the improvement of the infrastructure of mental

health services was considerable and several pilot community projects had been developed, including staff training projects (Tsiantis *et al*, 2006). However, mental health sectors, the basic structural elements of the new community-based service system, had not been implemented and the desired network of services still had big gaps, leaving some regions without access to community psychiatric care, but instead with only the old-style psychiatric hospitals, although considerably transformed.

National indicators of prevalence

Intellectual disability is defined as significantly sub-average general functioning (IQ below 70), existing concurrently with deficits in adaptive behaviour, manifested during the developmental period. Eligibility for services is established by a local health committee and is based on medical diagnosis, a percentage disability rating and insurance status. Additionally, people with intellectual disabilities are eligible for all the services and benefits generally provided to people with disabilities, such as healthcare, vocational training, employment, housing, transportation and tax exemption (Pandeliadou, 2003).

Information on the prevalence of intellectual disability in Greece does not exist.

Policy framework and legislation

The ideological basis for the changes brought by the mental health reform is that people with mental health problems should have the opportunity to have a reasonably good quality of life in the community. This can be achieved by the closure of asylums, the integration of that population into the community, the provision of facilities for treating mental disorders in general hospitals, improved primary care services, and the prevention and early detection of mental health problems in the community.

There is no legislation concerning the provision of mental healthcare for people with intellectual disabilities and mental health problems, other than that applying to the rest of the population. The Ministry of Health and Social Solidarity funds the public sector services, although many of them initially started as European Union projects funded jointly with the Greek state.

Residential service provision for people with intellectual disabilities and mental health problems

In 1997 the 'Psychargos' Programme of the Ministry of Health came into effect. This is a 10-year programme aimed at gradually meeting the needs of the mental health sector at a national level. Phase I (1997–2001) placed emphasis on deinstitutionalisation, phase II (2002–06) on the development of community services. A total of 66 hostels, 14 boarding houses and 10 apartments were set up during phase I and 1000 patients from psychiatric hospitals were resettled (Spyraki, 2001). Phase II added to the services 3 mobile units, 11 hostels, 66 boarding houses (of which 32 are for people with intellectual disabilities and mental health problems), 80 apartments, 5 services for people with autism, 2 for people with dementia and 11 day centres.

Nearly all people with intellectual disabilities and mental health problems who were still residing in psychiatric hospitals are now living in community settings. More services have been planned for the near future.

Mental health services for people with intellectual disabilities and mental health problems

In the context of the Greek National Health Service, primary mental healthcare for all is provided in mental health centres and hospital out-patient departments. Hospital treatment is brief and is offered through the psychiatric wards of general hospitals or acute units in psychiatric hospitals. Rehabilitation

services include residential facilities as well as occupational/employment settings. All these services are linked as parts of the mental health sector.

Training for mental health professionals on mental health problems in intellectual disability

All professionals working in community care projects have attended training courses on basic mental health issues, community care and intellectual disability. Training packages have been developed for this purpose. A total of 1200 professionals were trained in phase I and 1450 in phase II of the 'Psychargos' programme.

Suggested national priorities

As have other countries, Greece has been struggling to develop decent mental health services, although it can safely be said that substantial progress has been made. However, decentralisation, sectorisation and completion of the network of mental health services are still to be completed (Karastergiou *et al*, 2005).

Present priorities are:

- the integration and collaboration of psychiatric services with social services and primary care
- the development of community emergency services
- ensuring sufficient support for families
- the involvement of families in the planning of services
- evaluation of the quality and cost-effectiveness of services
- patients' rights and empowerment.

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Ferdinande Johanna Kanjilal Travelling Fellowship 2008

This travelling fellowship has been established from funds donated by Dr G. C. Kanjilal, in memory of his wife, Ferdinande Johanna. The fellowship, valued at £2000, is awarded biennially to further the experience of senior trainees in psychiatry from overseas countries. The award is intended to cover the expenses, either wholly or in part, of overseas doctors who wish to come to the UK or Ireland for a short period of further study, research or clinical training. Visits are expected to be no longer than 2–4 weeks. Members and Fellows of the College working in countries overseas are requested to bring the fellowship to the attention of their trainees. Applications for the 2008 fellowship should be submitted to the Dean of the College by the end of February 2008. For further details please contact the College International Affairs Unit (ljordan@rcpsyh.ac.uk).

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In the past two decades, national as well as regional policy agendas for people with disabilities and especially people with intellectual disabilities have followed strategies of inclusion and rights, with the promotion of a community-based approach.

In the decades before and after the Second World War, support for people with intellectual disabilities was chiefly in the form of large, isolated, public or church-run institutions, with restricted opportunities of self-determination on the part of their residents. Initially, many people with intellectual disabilities lived in such settings from their early years of life. However, after the war, most children with such disabilities entered special educational programmes outside large institutional settings, and continued to live with their families. Emanating mainly from parents' initiatives, the first community-based sheltered workshops were set up for young people with intellectual disabilities during this period. Such initiatives were followed by the establishment of group homes, mainly run by private associations, which allowed people with intellectual disabilities to move out of their family homes.

Following a major reform of the legal regulation on admissions to psychiatric hospitals at the beginning of the 1990s (Hopf & Aigner, 1993), people with intellectual disabilities moved from psychiatric hospitals to community-based accommodation. Nowadays, the institutional model of care for people with intellectual disabilities is highly contested and largely rejected, for two main reasons. First, during the Second World War, institutions, psychiatrists and psychiatric nurses were actively involved in the Nazis' systematic killing of (among others) people with intellectual disabilities. Second, within the medical model intellectual disability was seen on equal terms with psychiatric disorders. A majority of psychiatric services still operate in line with this traditional view or very close to that line. Only a few mental health service structures have integrated the advances in mental healthcare and intellectual disability. These services follow a community integrated service model for people with such disabilities.

National indicators of prevalence

Following the Nazis' euthanasia programmes, Austria was reluctant to set up a national register for people with intellectual disabilities. However, Badelt & Österle (1993) estimated a total population of 48 000, which is similar to an estimate produced by the leading Austrian non-governmental organisation (NGO) in this field, Lebenshilfe Austria, of 47 000 (Lebenshilfe, 2006), which is equivalent to a prevalence of 0.6%.

National indicators of mental health problems in intellectual disability

Health indicators, including of mental health, for people with intellectual disabilities are not established in Austria's national

health programme and are not referred to in the national health report (BMGF, 2005; Hofmarcher & Rack, 2006).

Policy framework and legislation

People with intellectual disabilities are explicitly referred to in major disability and mental health laws. With respect to admission to psychiatric hospitals, a law of 1991 discriminates between people with mental health problems and people with mental disabilities (i.e. intellectual disabilities): it states that admission to psychiatric hospitals on the basis of a diagnosed intellectual disability alone is illegal. In general, national documents refer to intellectual disability in terms similar to the following:

Individuals with disabilities are persons of any age who are physically, sensorially, mentally or psychologically substantially and persistently impaired in an essential social field. Equal opportunity programmes support people who are in danger of this impairment within a foreseeable time. Essential social fields are, in particular, formal education, vocational training, paid employment, communication, housing and recreation. (BMSSGK, 2003)

There are no national or provincial legal criteria for intellectual disability. In general, a medical certificate is requested attesting an intellectual disability, based upon the classification of the World Health Organization of low intellectual functioning, as defined under F7 of ICD-10 (Dilling *et al*, 1993).

Policy framework

The national policy framework is based on human and civil rights, including equal opportunities for people with disabilities affecting essential areas of life.

In general, people with intellectual disabilities and their families are financially supported by various direct and indirect measures. Families with children with disabilities have a right to higher family allowance payments, as long as the child continues to live with them, independent of age. Children and adults with intellectual disabilities are allocated orphans' pensions after the death of their parents. A dependency/nursing allowance is allocated to people with intellectual disabilities according to their level of dependency. Finally, the regional governments financially support people with intellectual disabilities living in group homes, community-based homes or institutional settings.

In general, the financial support from the various sources is managed directly by parents, or the programme's or institution's manager. People with intellectual disabilities, when living outside the parental home, have a right to 'pocket money' (the official term) of €40–70 per month, depending on the province; to this can be added €40–60 if the person is admitted on the dependency scheme. In the most western

regions of Austria 'pocket money' can go up to €250 per month, depending on the person's capacity for productive work. People with intellectual disabilities are not registered in the general social security programme, as they are offered special allowances, which also cover their health needs.

In summary, the financial support system for people with intellectual disabilities is designed from a perspective of supporting children, which contrasts with disability policies that aim at participation and self-determination during adulthood.

Residential service provision for people with intellectual disabilities and mental health problems

New assisted accommodation for adults with intellectual disabilities is generally developed in the form of small, community-based homes, typically for 8–12 persons, although some are for individuals or couples. Other options include residential facilities developed many years ago, such as institutional settings for up to 120 persons and group homes for 20–40.

Within the programme of deinstitutionalisation, small community-based homes have been developed in most of the provinces. However, in some regions provision has been outsourced from the hospital system and smoothly adapted to a more individualised, supported residential living community. Recently, in some places, residential service providers have begun to offer special accommodation for people with intellectual disabilities and challenging behaviours.

Mental health services for people with intellectual disabilities and mental health problems

There is no nationwide structure specialised in the mental health problems of people with intellectual disabilities. In general, large public hospitals covering acute medical needs have generic psychiatric departments. These theoretically also cover the mental health needs of people with intellectual disabilities. However, in reality in most places appropriate services for people with such disabilities are not offered, as professionals are not accustomed to serving that population.

Within the programmes of deinstitutionalisation, the psychiatric centres of some regions have committed themselves to offering in-patient and out-patient support specifically for people with intellectual disabilities, and some are offering training programmes for younger adults with such disabilities and severe challenging behaviour. Such services are examples of best practice with respect to coordination between mental health specialists and community-based small group homes for this population. However, they are still the exception.

Training for mental health professionals on mental health problems in intellectual disability

Professional groups providing mental healthcare receive little or no specific training in the aetiology and assessment of, or interventions and care for, mental health issues and behavioural problems in people with intellectual disabilities.

For both psychiatrists and clinical psychologists, some training in developmental psychology and the mental health of children with disabilities is offered. However, knowledge and practical training in the area of mental health for adults with intellectual disabilities are not formally covered. In general, the knowledge and experience of intellectual disability of psychiatrists and primary care physicians are very limited, as are those of clinical and health psychologists. This is especially the case when it comes to mental health and behaviour problems. However, psychotherapists have recently become interested in the mental health needs of adults with intellectual disabilities. Moreover, psychotherapy is no longer seen as inappropriate for people with such disabilities by the health insurance system.

Suggested national priorities

Emerging trends

- The mental health needs of older and ageing adults with intellectual disabilities will need to be addressed, from psychogeriatrics to emotional assistance at the end of life.
- Formal relationships will need to be developed between residential service providers and specialised psychiatric units with mobile out-patient support for people with intellectual disabilities.

Changes and opportunities

- Health indicators need to be developed, including mental health indicators for people with intellectual disabilities from a life-span perspective.
- Health and mental health themes, such as prevalence, formal support and outcomes of such support, for people with intellectual disabilities should be included in the national health reports.
- Formal training in intellectual disability should be promoted for psychiatrists, primary health physicians and clinical psychologists, as well as in the training of front-line staff.
- Research on intellectual disability and mental health should be supported.

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Switzerland

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In Switzerland, most adults with intellectual disability live in institutions. By the end of the 19th century some institutions had been founded, most of them in a Christian context. Over the last 10 years, autonomy (independent living) and integration/inclusion have become issues. From 1980, when individuals with intellectual disabilities left psychiatric hospitals, several smaller residential units were set up (Heer, 2005).

In Switzerland, learning disability (defined as an IQ under 85) is differentiated from mental retardation (an IQ under 75). Individuals with learning disability and mental health problems do usually have access to the same services (psychological and psychotherapeutic) as the remainder of the population. This article looks at individuals with severe intellectual disability.

Services for individuals with intellectual disabilities vary enormously across the cantons of Switzerland. These differences are likely to become even larger with the passing of a new federal law, Neugestaltung der Finanzen und Aufgaben zwischen Bund und Kantonen, as a result of which the government is no longer funding institutions – the cantons will be solely in charge from 2008.

National indicators of prevalence

Unfortunately, there are no detailed statistics available concerning intellectual disability in Switzerland. There are some data on special financial benefits and on social security support, but they do not cover the whole group; some statistics specifically on individuals with Down syndrome are collected (Bundesamt für Sozialversicherungen, 2005). For social security, an IQ under 75 is the indicator for intellectual disability. There are no other indicators considered, such as communication or social skills. The local psychological and medical services have responsibility for children and adolescents with intellectual disabilities; in the case of adults, the medical services connected to social security are in charge. Based on the World Health Organization's assumption that 1–3% of a population will have an intellectual disability, there will, nationally, be some 70 000–210 000 individuals with this condition.

National indicators of mental health problems in intellectual disability

Consequently, there are no statistics concerning individuals with intellectual disabilities and mental health problems. According to Lotz *et al* (1994), 30–40% of individuals with intellectual disabilities are also affected by mental health problems. Therefore, we can assume that between 21 000 and 84 000 individuals in Switzerland are affected.

How are mental health problems within this specific group diagnosed? So far there are no diagnostic tests available. The

same diagnostic approach is used as for people with no additional cognitive problems (i.e. ICD–10 and DSM–IV categories are applied). Where the patient has poor language skills, the diagnosis is based on observations made by carers. Usually it is very difficult to make a clear diagnosis. We assume that many mental health problems in individuals with severe intellectual disabilities are not diagnosed as such and are, rather, considered to be part of the disability.

Policy framework and legislation

At the national level there is the Behindertengleichstellungsgesetz of 2004, a law that promotes the integration and equalisation within society of people with disability. This law should enable the integration/inclusion of individuals with disabilities; it includes public transport, education, public services, housing and public buildings, but we have yet to see its impact. Also important for adults with intellectual disabilities are the Sterilisationsgesetz of 2005 (sterilisation of individuals who do not have the capacity to consent is allowed only where the person is at least 16 years of age and where no other contraception is possible), a law on guardianship and the Ethischen Richtlinien für medizinische Massnahmen bei Menschen mit eingeschränkter Urteilsfähigkeit, which refers to medical treatment and research on non-consenting individuals.

At canton level there are again some rather big differences, especially in relation to individual assistance and support, for which there are few national standards. In the two cantons of Basel there is a law that stipulates a maximum of 12 residents to a residential unit.

Residential service provision for people with intellectual disabilities and mental health problems

Most adults (around 70%) with intellectual disabilities live in institutions or in assisted accommodation. Others live with their parents or independently. Bigger institutions usually not only offer a place to live but also a place to work. Over the past 20 years institutions have increasingly offered residential units for 6–10 people with professional assistance and care. In a few cantons there are *Wohnschulen*, where adults have training to allow them to live independently. In three cantons social security is running a pilot scheme, Assistenzbudget (2006–08), where individuals have their own budgets to buy the assistance they need. Just a few adults with intellectual disabilities are involved, probably because there is no service available to help organise the assistance.

Finding a place to live is often very difficult for those with additional behavioural disorders. There is a risk that these individuals are passed on from institution to institution. There is no legal right to a place to live, which means that in such cases there is hardly any choice. Residential care in smaller units is usually available only to those people with disabilities who have at least some independence.

Mental health services for people with intellectual disabilities and mental health problems

It is difficult to describe the services available in Switzerland because they are organised at cantonal and regional levels. It is possible to say, however, that there are few specialised services for individuals with intellectual disabilities and mental health problems. In the canton of Bern, there is a *Fachstelle* that offers counselling for behavioural disorder, and there is a psychiatric centre in the city of Geneva (Galli Carminati, 2003). Some of the institutions employ a psychologist or counsellor to assist the care team.

Most of the professionals working in institutions are trained either as nurses or in *Agogik*, a term denoting the daily work done with adults (organisation, care, assistance and support at work as well in leisure time). The focus of assistance and support is on autonomy, not on care. There is, however, little collaboration between the institutions that are oriented towards *Agogik* and the professionals trained in psychiatry (although here, too, there are big differences between cantons, as well as between institutions).

Public health services are largely unable to respond to the needs of individuals with intellectual disabilities and mental health problems, partly because of accessibility, partly because of a lack of appropriate structures or simply because there is no knowledge of how to deal with this group. This is particularly the case if the individual does not speak or has difficulties communicating. Even psychiatric clinics are often not prepared or are simply unable to care for individuals with intellectual disabilities. Again, there are big differences between the cantons. In the canton of Lucerne there is close collaboration between professionals working with individuals with intellectual disabilities in a psychiatric hospital and the out-patient psychiatric services in order to train the professionals working there to become aware of the specific needs of this group. Just a few psychiatrists work with individuals with intellectual disabilities in their own practice.

Training for mental health professionals on mental health problems in intellectual disability

In their training, professionals working in the field of psychiatry and psychology learn little about individuals with intellectual disabilities and mental health problems (again, though, there are large regional and cantonal differences). In the field of *Agogik*, the topic of mental health problems is more frequently discussed.

Suggested national priorities

- There is a need to strengthen collaboration between professionals in order to support individuals with intellectual disabilities and mental health problems better than at present.
- Residences have to be created to prevent individuals with intellectual disabilities and mental health problems from being placed in psychiatric hospitals (or, if there is no other choice, only for a short period). Once discharged there is a big need for additional support for these individuals by a team of psychiatric, psychology and psychotherapeutic professionals.
- There are a few psychotherapists who work with individuals with intellectual disabilities. It is important to create a much greater interest in this group among psychotherapists and out-patient services.
- It is important to react whenever difficult behaviour is shown and to support the family and carers to enable healthy emotional development. Prevention has to play a very big role.

Acknowledgement

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European Federation of Psychiatric Trainees

The College has extended its long-standing commitment to engage with trainees to the international stage by supporting the European Federation of Psychiatric Trainees (EFPT). The EFPT is a federation of 24 national trainee organisations. For many years the College has supported its activities, not least by sending delegates via the Psychiatric Trainees Committee (PTC). The organisation is currently grappling with many complex issues, including the implementation of competency-based training in Europe, the development of a European exchange programme for trainees and harmonisation of training in Europe. The College has been a leader in many of these issues and has both facilitated and contributed to many of these discussions. This year we are pleased to announce that Dr Amit Malik, the immediate past chair of the PTC, was elected President of the EFPT for 2009.

The country profiles section of *International Psychiatry* aims to inform readers of mental health experiences and experiments from around the world. We welcome potential contributions. Please email ip@rcpsych.ac.uk

Mental healthcare in Poland

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Modern mental healthcare in Poland has its foundations in the 19th century, when the country was subject to three different organisational and legal systems – of the Austrian, Prussian and Russian Empires. These differences prevailed even after the First World War. Professionals lobbying for a mental health act had no success. The Second World War left mental healthcare with significant losses among its professional groups. More than half of all Polish psychiatrists lost their lives; some of them were exterminated as Jews, some as prisoners of the Soviets. The Nazi occupation in Poland had dramatic consequences for people with a mental disturbance, as Action T4 turned into genocide on the Polish territory. The majority of psychiatric in-patients were killed. After the Second World War, the mental health system had to be rebuilt, almost from scratch. Major political changes in the country across the second part of the 20th century and revolutionary changes in mental healthcare around the world influenced psychiatric services. The purpose of this paper is to describe mental healthcare in Poland today.

Mental health policy and legislation

The national mental health policy emphasises promotion, prevention, treatment and rehabilitation; it was initially formulated in 1995 as the National Mental Health Programme. This was followed by the development of regional mental health programmes, specifying particular tasks in each of Poland's voivodships (provinces). However, their realisation is far from satisfactory.

The Mental Health Act enacted in 1994 regulates:

- the promotion of mental health
- the prevention of mental disorders and discrimination
- the provision of accessible mental healthcare services in the community
- the protection of the civil rights of people with mental disorders.

The Act also regulates involuntary treatment. Other acts concern the prevention of alcohol and drug misuse, rehabilitation and employment of people with disabilities; the Penal Code and the Civil and Care Codes also have a bearing on people with mental illness.

The treatment of severe mental disorders is largely free of charge (in-patient treatment, community care, consultations, psychotherapy, rehabilitation and a significant part of medication). Policy regarding the provision of therapeutic drugs is based on a parliamentary act that divides drugs into

two groups: 'basic' compounds and 'additional' compounds. The latter include new drugs. The Minister of Health decides which drugs will be supplied free of charge, or at low or reduced prices for persons with specific disorders.

Mental health service delivery

Mental healthcare is included within the primary care system, although most of it is undertaken within the mental health out-patient clinic system, which is well developed and easily accessible. Primary care physicians are trained in psychiatry, including family psychiatry. However, systemic changes in healthcare financing have disrupted services. Nonetheless, deinstitutionalisation has been continued, and the numbers of day centres, psychiatric units in general hospitals and mobile community teams are increasing. In spite of this, the majority of psychiatric beds are still in psychiatric hospitals (5.2 per 10 000 population) rather than general hospitals (1.2 per 10 000). The overall number of mental health professionals is not satisfactory (Fig. 1); in addition, they are unevenly distributed across the country.

Mental healthcare, as one aspect of general healthcare, is financed by the National Health Fund (NHF), an obligatory, tax-based health insurance system. The NHF, in cooperation with the regional governments, is responsible for satisfactory provision of services. In-patient treatment is financed by the NHF, as is the majority of out-patient care (82% of such care for adults in 2004–05, 94% for children in 2005; Institute of Psychiatry and Neurology, 2006).

In addition, consultation and psychotherapy facilities within the social care system have an important role in the provision of mental healthcare, as do programmes appointed by local authorities and within the educational system (for children, adolescents and their families).

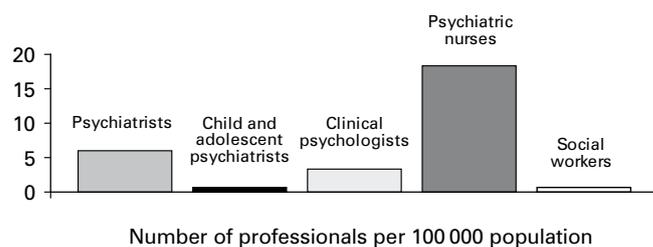


Fig. 1 Numbers of mental health professionals (Institute of Psychiatry and Neurology, 2006).

Psychiatric training

Undergraduate

Undergraduate training in psychiatry is based upon a national curriculum. However, medical schools have developed their own programmes, often more extended than the national curriculum. Many specific subjects are taught within elective courses. For example, the programme at the Jagiellonian University Collegium Medicum, Krakow, in addition to a basic course in psychiatry covering child and adolescent psychiatry, general psychiatry and old age psychiatry, also includes medical psychology and basic psychotherapy (which are obligatory), as well as psychoanalysis and sexology (elective).

Postgraduate

Since 1999, postgraduate training in psychiatry has been a 5-year residency programme based on standards developed by the Section of Psychiatry of the European Union of Medical Specialists. The rotation scheme is dominated by general psychiatry in in-patient settings; however, out-patient services, community psychiatry and psychotherapy centres are also obligatory. Child and adolescent psychiatry, intellectual disabilities, old age psychiatry and forensic psychiatry, although obligatory, are not given adequate amounts of time (Table 1). The theoretical part of training is organised as a series of courses that training centres are obliged to deliver.

Psychiatric sub-specialties

In 1999, postgraduate training in child and adolescent psychiatry was organised as an additional 2 years of residency-based programme for psychiatrists. The number of trainees then significantly decreased, endangering the future of mental healthcare for children and adolescents. To prevent this, a 5-year training programme for physicians was introduced.

Allied professions

Psychiatric nurses have a two-stage undergraduate university training in general nursing (3 years to become a licensed nurse and a further 3 years to obtain an MSc). Postgraduate training in psychiatric nursing follows a national curriculum and comprises 300 hours of theory and 560 hours on rotations.

Psychologists have a 5-year undergraduate training that is based on a national curriculum, although the final programme is designed by the universities. Postgraduate training in clinical psychology was suspended in the late 1990s because of major legal changes to the profession; it was reintroduced in 2004. It comprises a 5-year rotation-based training scheme that follows a national curriculum.

The regulation of postgraduate training in psychotherapy is presently being discussed. Until now, the Polish Psychiatric Association, Polish Psychological Association and several other psychotherapeutic societies have provided training and certification procedures (the two named organisations being the main ones; only their certificates are recognised by the NHF).

Research

The majority of research in the mental health field is conducted at the governmental Institute of Psychiatry and Neurology and research centres in medical schools across the country. Research projects can be supported by grants

Table 1 Postgraduate training in psychiatry (numbers of hours)

	1st year	2nd year	3rd year	4th year	5th year
Mandatory practical training					
In-patient unit, short stay	8				
In-patient unit	3	4	3	4	
Child and adolescent psychiatry service		4			
Neurology		3			
Neurotic disorders service			6		
Community psychiatry service			2		
Out-patient service				5	
Consultation-liaison psychiatry				2	
Substance dependency service					3
Facultative					8
Theoretical courses					
Foundations of psychiatry	80				
Health promotion	25				
Psychotherapeutic relations		40			
Foundations of child and adolescent psychiatry		40			
Introduction to family therapy			40		
Clinical practice of psychotherapy				40	
Forensic psychiatry				35	40
Balint Seminar (recommended)	20	20	20	20	20

from the Ministry of Science and Higher Education, and by international sources. Several research groups participate in collaborative projects run by the World Health Organization and the European Union. These are mainly studies of the genetics of mental disorders, the epidemiology of mental disorders, economics, health promotion and combating stigma. Affective disorders, schizophrenia, cognitive disorders, child and adolescent mental health problems, and old age mental disorders are approached from different perspectives.

A long-term prospective study of people diagnosed with schizophrenia, being carried out in Krakow, deserves special mention (Cechnicki, 1998).

The effectiveness of psychotherapy has been extensively studied. The problem has been approached by tracking changes in symptoms and personality traits in response to psychotherapy in the treatment of patients with neuroses (Aleksandrowicz, 1991); additionally, symptoms, defence mechanisms and quality of life have been looked at in the integrated treatment of patients suffering schizophrenic and affective disorders (Bomba & Cichocki, 2005; Zieba *et al*, 1997).

Methods of rehabilitation and community care and their effectiveness are yet another group of problems researchers are concerned with (Meder & Cechnicki, 2002).

Eating disorders, which have significantly increased in incidence in recent decades, have also been given special attention (Józefik & Pilecki, 2004).

For the last 50 years, starting with the group of Auschwitz concentration camp survivors, the consequences of trauma have been studied (Kepinski, 1970). Also studied have been Holocaust survivors (Orwid *et al*, 2002) and prisoners of the former political Soviet and communist regime (Heitzman & Rutkowski, 2002); second- and third-generation survivors have been studied consecutively. Methods of treatment for the various forms of post-traumatic stress disorder will form the next important research topic.

Results of studies are published in both international and Polish journals. The major Polish psychiatric journals are *Psychiatria Polska* (in Polish, with English, French, German

and Russian abstracts) and *Archives of Psychiatry and Psychotherapy* (in English).

Human rights issues

From the late 1940s to the 1980s, as the Polish Psychiatric Association watching group noted (Bomba *et al*, 1993), there was no abuse of psychiatry for political reasons. Since 1994 the Mental Health Act has provided for the prevention of abuse of the right to personal freedom in psychiatric practice. Professionals are obliged to offer treatment, if needed, after obtaining informed consent. The major human rights issue remains deprivation of privacy in psychiatric wards due to chronic unsatisfactory funding (Buda *et al*, 1998).

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COUNTRY PROFILE

Mental health in New Zealand

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New Zealand's healthcare system has undergone significant changes in recent times, among them being the establishment in 1993 of a purchaser/provider split and the specific attention given to the development of mental health services. Funding for mental health services (Fig. 1) increased from NZ\$270 million in 1993/94 to NZ\$866.6 million per annum in 2004/05, a real increase (adjusted for inflation) of 154% (Mental Health Commission, 2006). The bi-partisan political commitment sustaining this funding has had a major impact on the development of recovery-based and culturally specific models of care unrivalled by few countries in the world. However, recent reports (Mental Health Commission, 2006) indicate that, particularly with regard to access, much still remains to be done to address the mental health needs of New Zealanders.

New Zealand is a Pacific country of 4.15 million people. At the last census (2001), with three responses allowed per person, 80% identified themselves as being European, 15% as being indigenous Maori, 6.5% Pacific Island and 6.6% Asian, with other ethnicities accounting for less than 1% of the population. These categories are very broad and only partially describe the situation that exists in New Zealand. For example, while 91% identified with one ethnicity, 44% of

Maori identified with multiple ethnicities (Ministry of Social Development, 2006).

The median age of the population is 36 years. The overall male/female gender ratio is 0.99. The unemployment rate currently stands at around 4%.

Healthcare structure

While there is a substantial private sector in medicine and particularly in surgery, the public and not-for-profit sectors dominate over the private sector in the delivery of mental health services. For example, less than 10% of psychiatrists in New Zealand work in the private sector.

The Ministry of Health oversees the development and delivery of health services. It implements government policy and is responsible for the regulation and statutory oversight of the Mental Health Act 1992.

Health services are funded by the Ministry via 21 district health boards, which are responsible for the health of defined populations and catchment areas. Each district health board, guided by the objectives of the Ministry of Health's 2000 New Zealand Health Strategy and 2001 New Zealand Disability

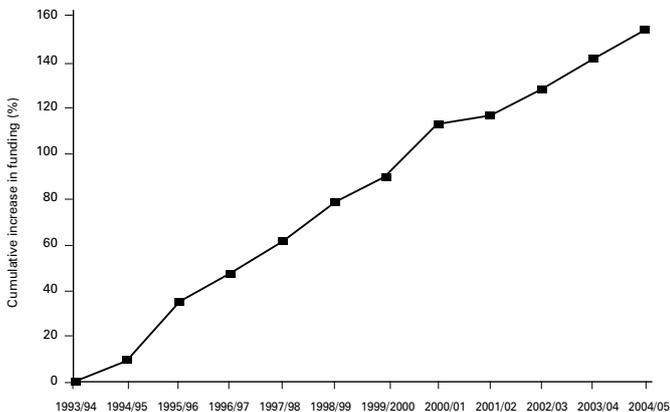


Fig. 1 Real cumulative percentage increase in public funding for mental health services in New Zealand, 1993/94 (NZ\$270 million baseline) to 2004/05. Source: Mental Health Commission (2006).

Strategy, has a board comprising appointed and elected members that reports to the Minister of Health through the Ministry of Health. Specialist public services, non-governmental organisations (NGOs) and primary healthcare organisations are funded by the district health boards to provide a range of in-patient and community mental health services.

Epidemiology

The recently published New Zealand Mental Health Survey (Ministry of Health, 2006) indicated that mental disorder is common: 46.6% of the population were predicted to meet criteria for any mental disorder with the exception of psychoses (because the Composite International Diagnostic Interview – 3 instrument used does not generate diagnoses for such disorders) at some time in their lives, with 39.5% having already done so and 20.7% having a disorder in the past 12 months.

The prevalence of disorder in any period is higher for Maori and Pacific people than for other ethnic groups. For instance, the prevalence of disorder in the past 12 months is 29.5% for Maori, 24.4% for Pacific people and 19.3% for others. Much of this burden appears to be associated with the youthfulness of the Maori and Pacific populations and their relative socio-economic disadvantage.

Psychotic disorders have an estimated prevalence of approximately 0.3% of the population; however, in a study of in-patient units in Auckland, New Zealand's largest city, they accounted for around half of all acute psychiatric admissions, with schizophrenia being the most common diagnosis (Wheeler *et al*, 2005).

Workforce

Recent reports show that major improvements in the workforce have taken place over the past 10 years. There are still, however, significant workforce deficits in mental health services in New Zealand (Ministry of Health, 2005a). For example, although most positions in urban districts are now filled, overall the psychiatric workforce remains depleted compared with international benchmarks. New Zealand has 288 psychiatrists (albeit 528 medical officers overall – see Table 1), including 59 child psychiatrists, representing overall

Table 1 Selected mental health and addiction occupational group workforce

Occupational group	Total number	Proportion of workforce who are Maori (%)	Proportion of workforce who are Pacific Islanders (%)
Addiction practitioners ^a	950	22	4
Nurses	3052	13.2	2.7
Support workers ^b	1423	33	8.2
Psychiatrists and other medical practitioners ^c	528	3	0.4
Psychologists ^d	1404	4.3	0.2
Social workers	311		

^a There are approximately 850 alcohol and drug workers and 100 problem gambling practitioners.

^b This is the number of graduates of the National Certificate in Mental Health Support Work. Note that not all mental health support workers have completed the National Certificate, and not everyone who has completed it is working in mental health.

^c Includes specialists (288), medical officers special scale (65), registrars (166) and 'other' (5). Although the survey recorded no Pacific doctors working in psychiatry, this table includes two Pacific practitioners because there is at least one psychiatrist and one training in psychiatry who would identify themselves as Pacific.

^d Of the current surveyed registered psychologists (907), a total of 788 work in the fields of clinical psychology, rehabilitation, psychotherapy and counselling. The ethnicity percentages are from those surveyed.

Source: Ministry of Health (2005a).

ratios of approximately 1 general psychiatrist per 18000 people and 1 child and adolescent psychiatrist for 70000 people, compared with recommendations from the World Health Organization of 1/10000 and 1/50000, respectively (Andrews, 1991). Major deficits in the workforce remain in child and adolescent mental health services, Maori and Pacific Island clinicians and in-patient care (Table 1).

Legislation

The main pieces of legislation relating to persons with mental health disorders are the Mental Health (Assessment and Compulsory Treatment) Act 1992, the Protection of Personal and Property Rights Act 1998, the Human Rights Act 1993, the Privacy Act 1993 and the Health and Disability Commission Act 1994. Other legislation relevant to mental health includes the Criminal Procedure (Mentally Impaired Persons) Act 2003, which gives the court powers to order individuals with mental impairment who have been charged with or convicted of an imprisonable offence to accept compulsory care and rehabilitation under the Mental Health Act if mentally ill, or, in the case of people with intellectual disabilities, the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.

The Mental Health Act seeks to protect the rights of the individual, including treatment in the 'least restrictive' circumstances, and to promote community care. It set a high threshold in terms of determining disorder by specifying that disorders must be severe and pose a serious risk to the patients themselves or others.

Planning and development

The process of deinstitutionalisation began in New Zealand in the 1970s and resulted in the closure of most of the

psychiatric hospitals during the 1980s. It was not, however, until the 1990s that the process was comprehensively planned, implemented and realistically funded.

Three key documents from the Ministry of Health now form the National Mental Health and Addiction Strategy. These include:

- *Looking Forward: Strategic Directions for Mental Health Services* (1994)
- *Moving Forward: The National Mental Health Plan for More and Better Services* (1997)
- *Te Tahuhu – Improving Mental Health 2005–2015: The Second New Zealand Mental Health and Addiction Plan* (2005).

Looking Forward confirmed the strategic commitment to the shift from institution-based to community-based delivery of services, backed up by sufficient in-patient services for acute care. The two main goals of the strategy were:

- to decrease the prevalence of mental illness and mental health problems within the community
- to increase the health status of (and reduce the impact of mental disorders on) consumers, their families, carers and the general community.

In 1996, a nationwide review of mental health services was undertaken by Judge Ken Mason. Recommendations from the resulting report (Ministry of Health, 1996) included a major increase in funding for mental health services, and the establishment of a three-member Mental Health Commission with a remit:

- to monitor the implementation of the National Mental Health and Addiction Strategy
- to reduce discrimination against people with mental illness
- to ensure the mental health workforce was strengthened.

Several factors have been responsible for the progress made in the development of mental health services in New Zealand. However, the Mental Health Commission's (1998) 'blueprint' for mental health services has proven to be one of the most important initiatives spurring change. The blueprint specified costed configurations of mental health services for populations of 100 000 people. It aimed to deliver services, when fully implemented, to the 3% of the population most severely affected by mental illnesses, including age-related services for adults, children and youths, and the elderly. It has been augmented by a series of national strategies covering mental health promotion and prevention, workforce development, Maori, Pacific Island and Asian mental health, primary healthcare, activity and outcomes measurement. Maori mental health in particular has received attention through the development of culturally specific services run 'by Maori for Maori'.

More recently, a second Mental Health and Addictions Plan, *Te Tahuhu – Improving Mental Health*, has been developed by the Ministry of Health (2005b). Covering the period 2005–15 it encompasses:

- promotion and prevention
- building mental health services
- responsiveness
- workforce and culture for recovery
- Maori mental health
- primary mental healthcare
- addiction
- funding mechanisms for recovery
- transparency and trust
- working together.

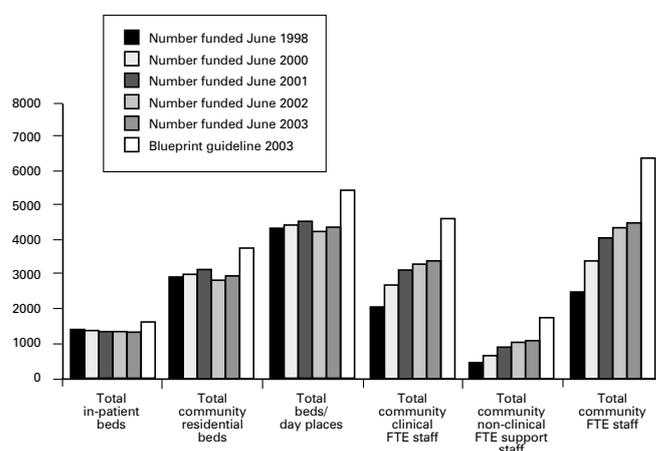


Fig. 2 Overall trends in beds and community staff funded from June 1998 to June 2003. (FTE, full-time equivalent.)

Source: Mental Health Commission (2006).

Progress

Fig. 2 indicates how resource development in mental health services has increased relative to the blueprint guidelines over the period 1998–2003. Although relatively static since 1993, the configuration of in-patient and community residential beds had changed dramatically before that time, with reductions in in-patient beds and increases in community NGO beds. Since 1993, significant increases in both community clinical and non-clinical staff have taken place, in line with the blueprint. Community services now account for 69% of mental health services, whereas in the late 1980s the reverse was the case.

The Mental Health Commission (2007) has estimated that, at best, 1.9% of the population are now accessing public mental health services. This result falls below expectations – the target was 3% – but needs to be seen in the context of the increasing range and quality of services. It is also anticipated that, as primary healthcare initiatives unfold, access to services for people with low-prevalence disorders and specialist services for those who are more seriously mentally ill will increase.

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Lessons from an Australian community dialectical behaviour therapy programme for borderline personality disorder

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In 2003, the National Institute for Mental Health in England (NIMHE) published guidelines for the development of services for people with personality disorders (NIMHE, 2003), prompting community mental health teams (CMHTs) to reassess their service provision for this patient group. The guidelines did not recommend any particular treatment approach, but CMHTs were encouraged to develop specialist programmes. For many CMHTs the focus has been on borderline personality disorder, as it is one of the most prevalent personality disorders seen in adult mental health services and has high costs for both the patient and the service (Moran, 2002). The evidence base for which treatment may be most effective within the community remains small, however, and this has left many CMHTs unclear regarding a suitable programme. Here I will outline a CMHT-based dialectical behaviour therapy (DBT) programme operating in Western Australia and reflect on why I feel it is an option that CMHTs in the UK looking to develop their service should consider.

Dialectical behaviour therapy is just one of the emerging treatments with evidence for its effectiveness in borderline personality disorder. It was developed by Marsha Linehan specifically to address the needs of patients with this disorder (Linehan, 1993a,b). The model combines both cognitive and behavioural therapies within a framework of understanding borderline personality disorder; the dialectic in this therapy is between validation and acceptance of patients as they are, while at the same time encouraging change in behaviours and emotional regulation. Palmer (2002) provides further details on the components of DBT.

The model in action

Peel Community Mental Health serves a mixed rural and suburban population of approximately 92 000 within Western Australia (Peel Development Commission, 2005). It comprises both a general adult and a separate child and adolescent mental health service (CAMHS). It employs an equivalent of 30 multidisciplinary clinicians, including occupational therapists. The population of the area is rapidly growing, but has a relatively low socio-economic profile and a lack of community infrastructure associated with the development of a new region. The epidemiology of disorders, service provision, workload and skill base of clinicians are comparable to those seen in my experience of UK services.

The DBT model was selected by Peel Community Mental Health because, at the time of implementation (2000), it was

felt to be among the best researched, and the manualised approach allowed for ease of training within the community setting. The Peel service did not receive funding for the development of the programme and DBT was felt to be cheaper than other programmes. Also, most of the clinicians had some experience of cognitive-behavioural therapy and felt more comfortable with learning the related DBT skills than with psychodynamic techniques.

The programme at Peel is essentially true to Linehan's original model, although with a few alterations to account for the practical constraints of a CMHT. The programme was initially devised to be an early intervention and was targeted at those aged 15–25 years (i.e. incorporating some CAMHS patients); it has since broadened to include all ages. People with comorbid diagnoses are accepted to the programme but these conditions should not dominate the clinical picture.

Patients with borderline personality disorder identified at assessment are encouraged to engage with the DBT programme. A contract is agreed with each patient for psychotherapy for at least 1 year and a maximum of 3 years, with an undertaking to attend a skills group for an hour once a week. A primary therapist is allocated from within the multidisciplinary team, who agrees to provide regular individual psychotherapy, on average once every 2 weeks, and to coordinate psychosocial rehabilitation. Cases are divided equally among the team in order to ensure a balanced case-load, and a maximum case-load of three is recommended. In-patient admissions are encouraged to be brief and planned; any necessary crisis admissions should be less than 3 days, with in-patient staff agreeing not to engage in therapy and any changes in medication to be made in collaboration with the out-patient team. Management with adjunctive pharmacological agents is encouraged to be via primary care, and general practitioners have been educated with regard to the presentation patterns of borderline personality disorder and the nature of the programme in place at Peel.

More complex cases and those with comorbidity may be managed pharmacologically by psychiatrists within the service, who need not act as the primary therapist. Contrary to Linehan's model, out-of-hours telephone contact is not provided by the primary therapist and instead all patients presenting in situational crisis are referred to the duty worker if the therapist is not available; this decision was made principally on the practical grounds of CMHT workers not being able to provide a 24-hour service for patients. The duty officer is trained to manage crises as appropriate, but not to intervene in therapy.

A weekly peer supervision group is held, in which the skills group facilitators feed back on the progress of the group in

the previous session. Therapists offer support to each other and collaborate in management strategies.

Personal perspective

Before working at Peel, my experience of managing patients with borderline personality disorder had been generally negative: I often felt ill-equipped to deal with their behaviour and I was conscious that my management was not always consistent. My perceived lack of skill fuelled counter-transference towards them.

I do not believe that DBT represents the gold standard in treatment for borderline personality disorder, but it has given me a framework from which to work and the results I have seen are positive. I was surprised at how quickly I was able to learn the theory of DBT and, like some other clinicians at Peel, I have received only brief training in the basic theory of DBT. However, I believe that with the support of more experienced peers, clinicians are able to draw on their previous mental health experience to offer the validation required in individual therapy and reinforce skills learnt in the group; this makes DBT a practical option for CMHTs, which can, with a little extra training, utilise a skill base already in place.

I had previously worked in CMHTs with no specific treatment programme, where lack of structure and guidance on how to manage borderline personality disorder frequently resulted in splitting within the team. I recall lengthy hospital admissions being used for want of any alternative. I have also worked in CMHTs which have had access to specialist programmes, one run on a psychodynamic basis and another based on a DBT model. I was not directly involved in either programme and cannot comment on the efficacy of the therapy itself, but I do recall a sense of detachment of these services from the CMHT. There was a tendency for clinicians immediately to refer patients with borderline personality disorder to these services, without thinking of a management plan themselves; if the patient were then to present in crisis to the CMHT, management could turn to panic and often resort to hospital admission. The holistic and multidisciplinary approach of a DBT programme based within, and run by, a

CMHT ensures all clinicians are exposed to the often demanding cases of borderline personality disorder and yet no group is overwhelmed by them. It also ensures that no clinician becomes deskilled in the management of such patients and provides the patients with vital continuity of care.

I have also been able to apply these new skills to other patients, such as those with eating disorders and substance misuse problems.

The peer group supervision was invaluable in gaining support and provided an opportunity to interact with other disciplines, one which I have often found lacking in other CMHTs.

The clinicians at Peel were keen to innovate and develop services; their sense of pride in this programme was tangible and well deserved. Perhaps it is this team approach which, at least in part, transfers to and benefits the patient group. Bearing in mind those treatments that have been shown to be effective, the determination of which of these to employ may be less important than the team developing a common approach with a sense of purpose, which in itself leads to successful treatment. I believe that DBT allows for such an approach and my time at Peel inspired me with hope that even a small service with relatively few resources and little extra funding can provide an effective treatment option for borderline personality disorder. CMHTs in the UK looking to develop their service would do well to consider a similar approach.

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ORIGINAL PAPER

The yield from national surveys of mental health

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At least 21 countries have now carried out national surveys of mental health under the aegis of the World Health Organization's World Mental Health Surveys. This has meant interviewing some 157 000 people in their homes. The countries are as varied as Australia, China,

Iran, six continental European nations, Nigeria, the UK and the USA (Andrews *et al*, 2001; Demyttenaere *et al*, 2004; Mohammadi *et al*, 2005). It is therefore timely to consider what this very large body of information has yielded and to what use it can be put, especially in relation to the costs

and human resources expended in a field where unmet need is so conspicuous.

Methods

The surveys have many attributes in common. They were all undertaken to inform health policy. Most used the same standardised interview with the same (DSM-IV) diagnostic criteria (American Psychiatric Association, 1994) for the common mental disorders. The latter are anxiety, depressive disorders and alcohol or substance misuse. All surveys were conducted by lay interviewers and the data are derived solely from self-report. The morbidity described is categorical (present or absent) rather than dimensional, and refers to symptoms both in the previous 12 months and across the respondent's lifetime. Independent variables have usually been confined to age, gender, marital status and indicators of socio-economic status. Most surveys covered the age range 18–65 years, and only a minority included children or the elderly. Most included measures of disability and recent health service use.

Findings

There have been some consistent findings. The total prevalence rates for adults have been much higher than might be expected, with the median 12-month prevalence for all disorders being 12.2%. The range, however, is considerable, from 4.3% in Shanghai to 26.4% in the USA. Anxiety and depressive disorders are more common in women and substance use disorders are more common in men. The median age at first onset of anxiety disorders is 11 years, of substance use disorders 20 years, and of mood disorders 30 years. Mental disorders are therefore disorders that begin in the young. The burden of disability, in terms of the number of days lost from work or family life, is very much greater than might have been expected and yet the majority of sufferers received no treatment. This is so in higher-income as well as lower-income countries, even though inexpensive and effective treatments exist.

Response rates ranged greatly, from 51% in Belgium to 88% in Colombia (Demyttenaere *et al*, 2004). Some of the differences in total prevalence may also depend on the number of disorders included in the interview. But there are some striking differences in the prevalence estimates of individual disorders. For example, the 12-month prevalence of depressive disorder is 9.6% in the USA, 6.6% in Lebanon (conducted in 2002–03), 3.1% in Japan, 1.7% in Shanghai and 0.8% in Nigeria. The survey in Iran (Mohammadi *et al*, 2005) reported lifetime rather than 12-month prevalence, which was only 4.3% for depressive disorder. When the US 1991–92 national survey was repeated in 2001–02, the prevalence of depressive disorder had increased from 3.3% to 7.1% and treatment rates from 12% to 20% (Compton *et al*, 2006).

The value of the surveys

What does this massive body of data mean? It shows that psychiatric morbidity is common, although it would be wrong

to conclude that a 1-year prevalence rate of 12% means that one in eight citizens of a country wish for or need treatment. Where the investigators have included a measure of disability, this has allowed a better estimate of unmet need. It has shown that the economic and social burden arising from mental disorders is highly significant for health policy. These two findings, the high prevalence and the proportion of all disability that comes from mental illness, have been the most influential products of the surveys. They have been noted by senior administrators and politicians, often accompanied by an increased allocation of funds for services and research. The increased prevalence of major depression observed in the USA shows the value of repeating surveys to monitor the mental health of a nation.

By contrast, the scientific advance in understanding the causes of these mental disorders has been slight. The gender differences in anxiety and depressive symptoms were already known. The data on age of first onset in community samples are new, but, that apart, no new hypotheses on aetiology of any fundamental significance have been generated. The psychoses, which are so disabling, are too low in prevalence for useful data on their aetiology to be obtained from a cross-sectional survey in the community. For aetiological research, data on environmental risk factors and temperament could have been included, but it has proved difficult to persuade funding bodies to include these measures to inform aetiology when what they want are answers to three questions:

- How many people have which disorder?
- How disabled are they?
- What services do they need and want?

As a result, new information on causation has been sparse, despite the massive sample size.

It is always tempting to compare prevalence rates between countries. Where differences are observed, as in the above examples, it is tempting to put them down to intrinsic attributes of the population, such as lifestyle or social cohesion. However, the estimates must inevitably be affected by differences in method, such as the response rates in each survey, the use of different instruments or versions thereof, and the readiness of respondents in different countries to acknowledge the presence of psychological or physical symptoms. Also, it may be a mistake to assume the diagnostic criteria are equally applicable across countries. Four decades ago, in his influential paper 'Are international comparisons timely?', Kessel (1965) concluded that they were not and that epidemiological work on the aetiology of mental disorders would be better directed to within-country studies. We believe the situation remains the same today. It has to be concluded that the massive effort to obtain data on the mental health of nations, involving over 150 000 respondents, has contributed little to the understanding of the causes of mental illness.

Future surveys

It is likely that some countries will repeat their national surveys and others will conduct their first. The justification must be largely to keep mental health on the political agenda and to monitor changes in service use. The use of standardised interviews, matched to ICD-10 (World Health Organization, 1992) and DSM-IV classifications (American Psychiatric Association, 1994) or their successors, will

continue, because rates for such categorical diagnoses seem to have an administrative impact.

The scientific value of this categorical approach is less certain. Much greater scientific value will come from the analysis of dimensional scales such as the Kessler Psychological Distress Scale (K-10; Kessler *et al*, 2002) and 12-item General Health Questionnaire (GHQ-12; Goldberg & Williams, 1988). Unlike the diagnostic interview, which can take over an hour, these take only a few minutes to administer, even for persons with limited literacy. The scales cover the full range of symptoms of epidemiological interest and they detect the sub-clinical level of morbidity that is of such relevance to disease burden. Their continuous scores avoid the loss of statistical information that comes with categorical diagnoses. They are also less open to the biases that make international comparisons of prevalence rates so difficult to interpret. As Rose (1993) emphasised, the distribution of scores can be used to characterise whole populations. The K-10 has been included in many of the surveys, but has not yet been used to test aetiological hypotheses.

Further large-scale epidemiology needs to contribute to knowledge of aetiology. For example, in addition to obtaining psychiatric measures and exposures to adversity, obtaining genetic data is now feasible. This would allow the study of interactions between genotype and environment in very large samples. National surveys of mental health are major epidemiological undertakings. Their yield can now be expanded.

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ORIGINAL PAPER

A re-evaluation of the yield from national surveys of mental health

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Having spent a considerable amount of time thinking about the uses of large-scale descriptive psychiatric epidemiological needs assessment surveys in our capacity as co-directors of the World Health Organization's World Mental Health Survey Initiative, we agree with many of the conclusions of Henderson and Andrews. Most importantly, we agree:

- that among the most important benefits of these surveys have been their political value in documenting high prevalence and high disability
- that the time has come to expand the focus to study causes.

Preparation of this commentary was carried out in conjunction with the WHO World Mental Health (WMH) Survey Initiative, which is supported by the US Public Health Service (R01-MH070884, R13-MH066849, R01-MH069864, and R01-DA016558), the Fogarty International Center (FIRCA R01-TW006481), the Pan American Health Organization, the John D. and Catherine T. MacArthur Foundation, the Pfizer Foundation, Eli Lilly and Company, Ortho-McNeil Pharmaceutical, GlaxoSmithKline, and Bristol-Myers Squibb. More information about WMH is available at <http://www.hcp.med.harvard.edu/wmh>. The views expressed in this article are those of the authors and do not necessarily represent the official position of the World Health Organization, Harvard Medical School, or any of the organisations that fund the WMH research.

However, we also disagree with Henderson and Andrews on several points.

The first paragraph of their article raises a concern that the resources used to carry out psychiatric epidemiological surveys might be better used to address the problem of unmet need for treatment. This criticism is ill-conceived. These surveys make it clear that an increase in healthcare resources is required to address the enormous problem of unmet need for treatment of mental disorders. Needs assessment surveys must be carried out to document this unmet need, as well as to track changes in unmet need as mental healthcare policies change. It is a mistake to set the cost of carrying out these surveys in opposition to the need for increased treatment resources. This is especially so in light of the fact that the resources needed to carry out a typical large-scale psychiatric epidemiological survey (e.g. face-to-face interviews with a representative sample of 5000 respondents) are trivial in relation the resources needed to provide treatment. The former resources amount to about 25 person-years. In a country of 40 million people with a 15% prevalence of mental illness, this comes to roughly 1 minute per person with a mental illness. Not much good

can be done in 1 minute of treatment. Much more good could be done by investing that minute in a needs assessment survey that documents the magnitude of unmet need for treatment, obtains information about misallocation of treatment resources, and provides a firm foundation for seeking expanded treatment resources and implementing more efficient outreach and treatment initiatives.

We also take issue with the characterisation by Henderson and Andrews of recent psychiatric epidemiological surveys being based exclusively on categorical diagnostic assessments and excluding environmental risk factors. The World Mental Health Surveys include structured versions of disorder-specific symptom severity scales, such as the Quick Inventory of Depressive Symptomatology (Rush *et al*, 2003) for major depression and the Panic Disorder Severity Scale (Houck *et al*, 2002) for panic disorder. In addition, all respondents are administered the dimensional Kessler Psychological Distress Scale (K-10) (Kessler *et al*, 2002), as well as separate dimensional assessments of disability. With regard to environmental risk factors, the surveys include a detailed assessment of childhood adversity, which is a focus of ongoing causal analysis.

We agree with Henderson and Andrews that differences in fundamental survey conditions make it most useful to study comparative, within-country correlates. We also agree that socio-demographic correlates, such as the higher prevalence of depression among women than men, are by now so well known that we need to investigate causes rather than merely replicate these associations in new surveys. The survey analyses are doing just that. For example, we are examining the role of cross-national differences in age at menarche and in gender roles in accounting for time-space variation in the association between gender and depression. Preliminary results suggest that the gender gap in depression is becoming significantly smaller in numerous countries because of changes in the social roles of women (as indicated by trends in such things as rates of female labour force participation, access to birth control and delays in age at first child-bearing).

We agree with the spirit of Henderson and Andrews' conclusion that future surveys might profitably use brief screening scales rather than diagnostic interviews. However, the use of screening scales needs to be coupled with diagnostic interviews in targeted sub-samples to realise their full potential. At least three different types of integration are important in this way. We briefly discuss each of these three below.

There is a key question in this regard. What do we gain and what do we lose by using short screening scales rather than long diagnostic interviews to assess mental illness in community epidemiological surveys? The first part of the answer is very simple: the brevity of screening scales allows them to be included in ongoing omnibus government health-tracking surveys, whereas diagnostic interviews are too lengthy to be included in omnibus surveys. By the term 'omnibus survey' we mean multi-purpose surveys that ask respondents about the presence, severity and course of physical and mental disorders, often along with questions about health service utilisation, health protective behaviours and health risks.

Screening scales are commonly included in omnibus health surveys, making it possible to assess many more people than

in psychiatric epidemiological surveys. For example, the K-6 screening scale of non-specific psychological distress (Kessler *et al*, 2002) is included in all three major omnibus government health-tracking surveys in the USA:

- the Behavioral Risk Factor Surveillance Survey (BRFSS; <http://www.cdc.gov/brfss>; 350 000 respondents per year interviewed by telephone in monthly replicates representative of each city, county and state in the USA)
- the National Household Survey of Drug Use and Health (NHSDUH; <http://www.oas.samhsa.gov/nhsda.htm>; 70 000 respondents per year interviewed face-to-face in quarterly replicates representative of the largest states as well as of each census division in the USA)
- the National Health Interview Survey (NHIS; <http://www.cdc.gov/nchs/nhis.htm>; 50 000 respondents per year interviewed face-to-face in monthly replicates representative of each census division in the USA).

Clinical calibration studies show that the K-6 is an excellent screening scale for the global assessment of broadly defined DSM-IV anxiety and mood disorders (Kessler *et al*, 2003). Simple transformation rules consequently can be applied to K-6 scores to estimate the prevalence and correlates of recently occurring anxiety and mood disorders. To do this, though, we need to have faith in the calibration rules that link K-6 scores with DSM-IV diagnoses. This requires *ongoing* calibration in the omnibus surveys in which the K-6 is administered, because we need to know if any significant time trends in estimated prevalence are due to changes in true prevalence or to changes in the concordance of the K-6 with true prevalence. Recognising the importance of ongoing calibration, an initiative is currently under way in the USA to administer follow-up diagnostic interviews to a representative sub-sample of respondents in government omnibus health surveys, to refine K-6 calibration rules over time. This is the first of the three important ways in which clinical interviews can be integrated with screening scales.

Screening scales are limited because they include only broad-gauged information. When we discovered, for example, that the K-6 scores in the NHIS increased dramatically after the terrorist attacks of 11 September 2001, we had no way to know the extent to which this was owing to rises in adjustment disorder, post-traumatic stress disorder, major depression, other disorders, or various combinations of disorders. Nor could we tell the extent to which the K-6 increases were owing to first onsets versus recurrences of mental disorders. It would have been fairly simple to obtain this information with in-depth follow-up interviews. We might even have followed such cases over time to study the persistence and severity of post-disaster mental illness, patterns of help-seeking and modifiable barriers to treatment. Such information could have been of great value to the authorities. This is the second important way in which clinical interviews could be integrated with screening scales. An initiative of this sort is currently under way in the USA to embed follow-up psychiatric diagnostic risk factor interviews into the BRFSS in the wake of future large-scale natural and human-made disasters (Kessler *et al*, in press).

The same limitations of screening scales also exist in interpreting cross-sectional associations. Furthermore, typical omnibus surveys include only superficial questions about treatment of emotional problems, and no questions about barriers to such treatment or about disablements caused

by emotional problems. More in-depth assessments are needed to collect such data. An argument consequently could be made that a probability sub-sample of respondents in omnibus health surveys should be administered in-depth follow-up psychiatric interviews to collect this additional information. The second-stage sub-samples would over-sample respondents with high K-6 scores so as to enrich the sample for cases, making this the third important way in which clinical interviews could be integrated with screening scales.

We are currently investigating the possibility of using this design in the USA. Rather than continue to replicate the National Comorbidity Survey (NCS) in point-in-time surveys each decade (Kessler *et al*, 1994, 2005), we would administer an NCS interview to a probability sample of omnibus survey respondents every month of every year, accumulating a sample of 12 000 cases over each decade. This approach has several advantages over the stand-alone survey method:

- increased statistical power to study respondents with mental illness by over-sampling those who are 'positive' according to the screening scales
- expansion of information on respondents from the omnibus survey
- fine-grained time trend information
- the ability to modify assessments quickly, rather than once a decade, when modifications would be useful.

Finally, as omnibus surveys are typically very large, we could target selection of follow-up sub-samples in ever-changing ways over time for purposes of refining causal analyses in a case-control framework. Respondent burden

would increase and further elaboration would be needed to launch longitudinal studies, but this general approach holds much promise to realise the greater potential of general-purpose psychiatric epidemiological surveys along the lines so rightly urged by Henderson and Andrews.

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ORIGINAL PAPER

A comment on the yield from national surveys of mental health

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Henderson and Andrews have written a timely paper to examine the yield from national surveys, and pose questions of value for money, survey methods, delineation of pathology by categorical boundaries rather than dimensions, and breadth of risk factors examined. We would like to address the points they raise, exemplified by the purposes (Jenkins *et al*, 1997) and yield of the British survey programme.

First, Henderson and Andrews ask whether national surveys give good value, when considered against the unmet need for services. The sheer scale of unmet need has in fact been delineated only by national surveys – without them we would not know the scale of need, and how far it is met and unmet by clinical services (Bebbington *et al*, 2000). Moreover, without the use of repeat surveys, we would not have known

about the considerable changes in Britain in the use of services and the delivery of treatment (Brugha *et al*, 2004).

Henderson and Andrews focus on surveys using the DSM diagnostic criteria, standardised lay interviews and data derived solely from self-report. However, the World Mental Health Survey (WMHS) includes a clinical component in some countries, although psychosis, developmental disorders and personality disorder are not covered throughout the WMHS. The British adult survey programme does use lay interviewers to administer the Clinical Interview Schedule – Revised (CIS-R) to cover anxiety and depressive symptoms, but it is augmented by clinical assessments using the Schedules for Clinical Assessment in Neuropsychiatry (SCAN) and the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II), in the case of adults (e.g. Brugha *et al*,

2005), and by clinical assessments of qualitative and quantitative data from three sources in the case of children (Goodman *et al*, 2000). Because CIS-R assessments are based on the last 7 days, they minimise recall bias and are likely to be more accurate than the Composite International Diagnostic Interview (CIDI) default lifetime and 12-month assessments, and are perhaps more helpful from the point of view of health policy in prospectively estimating incidence and persistence (Skapinakis *et al*, 2006). The CIS-R is half the length of the CIDI used in most of the other surveys referred to by Henderson and Andrews, and CIS-R surveys have therefore been able to include a range of assessments omitted from the CIDI-based surveys. In the British survey, over 20 classificatory variables have been used, quite apart from a wide range of questions on risk factors, protective factors and service use. The last have included measures of primary group size (e.g. Brugha *et al*, 2003) as well as far more service use and treatment data (e.g. Farrell *et al*, 2006).

The use of an instrument like the CIDI enables diagnosis but has not hitherto allowed a dimensional approach to psychiatric disorder, hence the recent decision to add further dimensional measures to the WMHS. In the British surveys, owing to the use of the CIS-R, and the Patient Satisfaction Questionnaire (PSQ), data collected are both dimensional (symptom scores) and categorical (symptoms present or absent, and diagnoses based on clusters of symptoms) (e.g. Melzer *et al*, 2003; Johns *et al*, 2004).

Arguably, a key limitation of the CIDI-based surveys is their relatively meagre information on determinants and use of care and services, because most of the survey interview time is taken up by the detailed coverage of a wide range of current and lifetime DSM and ICD categories, as conceived and perceived in specialist mental health service settings, which have relatively little relevance to primary care or to low-income countries. However, the WMHS exercise covers a uniquely wide range of countries (wide ranging in income and indeed in economic progress and stability), many of which never before had any information to influence national policy. It can therefore claim to be truly global and hence highly authoritative and, importantly, destigmatising.

Henderson and Andrews say 'Most surveys covered the age range 18–65, and only a minority included children or the elderly'. The British surveys have covered increasingly wider age ranges; indeed, the third household survey, currently in the field, includes a representative sample of the whole adult age range, there have been two surveys of children and a number of surveys of hard-to-reach populations, including people in institutions, people in prison, homeless people, carers and children in care. This spread of surveys provides synergy. (Interested readers can find the full list of British survey technical reports on <http://www.ons.gov.uk>, and of academic papers on <http://www.iop.kcl.ac.uk/departments/?locator=430>.)

Henderson and Andrews use 1-year prevalence figures to highlight the striking differences in prevalence estimates in different countries. Some of these differences may arise from the inaccuracy resulting from recall bias inherent in asking about time periods longer than the last few weeks, as well as from poor translation protocols, different methods of administration, quality of data-collection procedures, and sampling methods, some of which are now being addressed in the emerging WMHS results.

Henderson and Andrews argue that assessment of need should include appreciation of the disability 'that comes from mental illness'. In fact, the links between mental illness and disability are extremely complex and physical illness can contribute to both and be a consequence of both (e.g. Moran *et al*, 2007), which structured lay interviews may not be capable of disentangling.

Henderson and Andrews suggest that 'the scientific advance in understanding the causes of these mental disorders has been slight'. However, the additional material incorporated in the British surveys has enhanced understanding of likely risk factors, the aetiological significance of which can then be tested further in longitudinal studies. Examples of secondary analyses that have greatly enriched our understanding of risk factors include detailed work on the role of age, gender, primary support groups, lone mothers and parenting (e.g. Bebbington *et al*, 1998; Brugha *et al*, 2003; Targosz *et al*, 2003; Vostanis *et al*, 2006). The British survey programme has also illuminated our understanding of the links between: mental illness and substance misuse (including nicotine); physical illness and personality disorder; mental disorders and personality disorder; mental disorder and violence (e.g. Coid *et al*, 2006); and victimisation experiences and psychosis (Bebbington *et al*, 2004). It has also advanced our understanding of health service use and the factors leading to suicidal behaviour (e.g. Jenkins *et al*, 2005).

While Henderson and Andrews feel that it is tempting to compare prevalence rates between countries and to put differences in prevalence rates down to intrinsic attributes of the population, such as lifestyles or social cohesion, earlier cross-country comparisons would have been limited by differences in response rates, instruments used and respondent acknowledgement of symptoms, many of which are now addressed by the WMHS.

Henderson and Andrews argue that the justification for future surveys 'must be largely to keep mental health on the political agenda and to monitor changes in service use'. However, besides continuing to flag up unmet need, monitor service use and monitor changes in prevalence rates, surveys that contain a longitudinal element do provide us with unique opportunities to test aetiological hypotheses. Such information is crucial for developing prevention and promotion interventions. They inform governments' work on social exclusion. They help us understand vulnerable groups such as carers, homeless people and people in orphanages. They enhance our understanding of under-investigated conditions such as developmental disorders. Future surveys should continue to enhance their interdisciplinary collaborative components, for example by including biological sampling.

Thus, while acknowledging the urgency of what Henderson and Andrews say, we think that, because of design advantages and the continuing support of the Department of Health and the Scottish Executive, the British surveys of psychiatric morbidity have avoided many of the criticisms levelled by Henderson and Andrews, and that a programme of surveys jointly developed by scientists and policy makers will indeed address many of the issues they raise, so that national surveys provide immense value, both to governments and to scientists.

In conclusion, we feel from our collective various experiences of responsibility, both as researchers and as policy makers, that national mental health surveys have had a

considerable impact on both policy dialogue and policy making in health, education, social welfare and criminal justice (e.g. Layard, 2006). National governments, economists and public health advisors, as well as local services, depend on such information. It would be a shame for other countries if the UK were to remain the only country with the required precise and customised information available. We feel the British approaches and methods have been able to provide a cost-effective balance of information on dimensions and categories, determinants and consequences, health and social service use and other behaviours.

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SPECIAL PAPER

Perambulations of a President

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Previous Presidents wrote Council reports of their overseas visits and one wonders how wide an audience their reflections actually reached. What good fortune for me, then, that I can share my reflections in the pages of *International Psychiatry*. The title of this paper was given to me by a disgruntled senior member of the College working in England, who felt that I was paying far too much attention to international matters, and so I thought I should explain further why I consider the international role of the College to be so important.

The College has some 13 000 Members and Fellows, of whom about a fifth work overseas. Of those members working in the UK, about a quarter graduated from an overseas medical school and then came to the UK either for postgraduate studies in psychiatry or as an economic migrant, sometimes in direct response to active recruitment by UK governments. Many of those who came here after graduation have retained strong family and even professional links within their country of origin. Some 40% of members

have ongoing active links with another country, whether as residents or non-residents. This does not even include doctors in staff-grade posts, where the proportion of international medical graduates is even higher. For several years now, overseas members have been able to belong to an international division and the Board of International Affairs has been working hard to determine their needs.

When I became President I made a commitment to visit all the College's divisions. To my surprise, invitations have been more forthcoming from the College's international divisions than from the UK and Ireland. The College has agreed that I should try to time my visits to coincide with meetings of the officers and members of these divisions, and that the College should host a social event for all division members and friends, to facilitate networking. For financial reasons, such meetings need to 'piggy back' on to conferences in the appropriate region of the world, but even so it is often difficult for many of our members to join in such events. It is, of course, a privilege to visit another country and to hear about

the aspirations and challenges facing our Members and Fellows, and their patients and carers.

America

Most of us share a common language and some common experience; after all, most of our Members and Fellows understand the UK situation, having trained here. This is not always the case, however, as I found during my recent visit to the American Psychiatric Association (APA) conference in San Diego, where the College participated in a joint presidential symposium with the APA President on health inequalities for people with developmental disabilities or people with mental illness. The stark contrast between our different healthcare delivery systems and the different fundamental concepts underlying the commissioning (funding) of services certainly served to obfuscate our attempts to communicate fully. I suggested that our two countries are divided by a common language – a language which we understand differently because of our cultural differences. That said, listening to each other about clinical issues and human factors affecting people's lives brought us closer together again.

I was shocked when one young resident in child psychiatry told me that in her specialty no one 'needs' to work in the public sector, nor to accept patients covered by insurance (I think she meant through a preferred provider contract, where doctors are paid a smaller fee) because there are enough wealthy parents to employ all the child psychiatrists in the land. Quite a contrast, then, to hear an inspiring call, from an American psychiatrist working with people with intellectual disabilities, for every psychiatrist to take on 17.5 patients with an intellectual disability in order to provide a service to the number of people in this group he estimates to have a concurrent mental illness. I left the conference feeling pleased that there was some shared interest in the mental health of populations.

I also had an opportunity to visit an independent mental healthcare provider in Baltimore that first opened its doors in 1891, having been built by a Quaker gentleman of means (the Sheppard Pratt Health System; <http://www.sheppardpratt.org>). There I was also asked to talk about similarities and differences between our healthcare systems. It would have been so much easier to talk about mental disorders and current treatment approaches!

Africa

In Nairobi in March 2007 I was able to attend the first regional meeting of the World Psychiatric Association (WPA) in Africa. This was one of the best conferences I have attended in recent years, with a very high quality of presentations and excellent opportunities to meet colleagues.

I was interested to meet the psychiatrists from Tanzania, whose response to the lack of psychiatrists (around 12 for a population of 34 million) has been to train primary care doctors to diagnose and treat mental disorders. I had seen this in action in a small town in Tanzania the week before the conference, and been impressed by the attitude and interest in mental health of the single-handed primary care physician working in the community hospital.

At the division's business meeting with other College officers, we were convinced that benefits for our members working in Africa should be tailored to their actual needs and ability to pay, and discussions are ongoing about this.

Pakistan

The South Asian Division organised a demanding schedule for me in Pakistan in February to coincide with the First International Conference of the WPA Section on Psychiatry in Developing Countries. Besides the now customary party for members and guests (and our chief guest on this occasion was the Foreign Minister of Pakistan), and a College symposium at which members of five international divisions spoke about psychiatry in developing countries, my hosts also wanted me to help raise awareness of mental health issues across northern Pakistan. Their concerns were particularly in response to the longer-term mental health needs of survivors of the earthquake in October 2005, and so a visit to Kashmir was essential. It was a 1500-mile bumpy ride in a small bus over 3 days.

The trip to Muzaffarabad was on a rainy, misty and chilly day that began at dawn and ended at midnight. We were welcomed by the two local psychiatrists (the only psychiatrists working in the area), who described some of the mental health problems experienced by those affected by the earthquake, and their own need for ongoing support and training. Each time we stopped, local dignitaries who wanted to talk to us about the earthquake also greeted us. This culminated in a meeting with the Prime Minister of Kashmir, when we spoke to parliamentarians and civil servants and heard their perspective on how mental health problems were delaying recovery and reconstruction for many of those who had survived. This meeting was televised and an extract appeared on the national news that day – a good outcome as our aim was to raise the profile of mental disorders and the role of psychiatrists in a country where there are only 350 psychiatrists for a population of over 164 million – over twice that of the UK.

To put this in perspective, approximately 350 Pakistani psychiatrists are working in the UK, many of whom return regularly to Pakistan to share their skills. I visited one such doctor who joined the College Volunteer Scheme on unpaid leave from the National Health Service (NHS), in response to a request for a child psychiatrist to work in and near Rawalpindi. Her clientele include children affected by the earthquake, but an important role is to provide some training in child psychiatry. This is likely to be an ongoing need and the College International Manager is seeking a successor for this post as well as for other similar requests.

International recruitment

The Board of International Affairs has for some time been worried about the effect of international migration on the sustainability of psychiatry and the development of mental health services in many parts of the world. The College has not supported past government policy in the UK to actively recruit doctors from developing countries to fill specialist vacancies in the NHS. However, it has been keen to support the training needs of colleagues coming from abroad to gain

experience and qualifications. At the quadrennial meeting of the WPA in Cairo in 2004, I raised this issue for discussion and asked the WPA executive to set up a task force to examine the problem and to see what action could be recommended to introduce some reciprocity into this situation, recognising that individuals are free to make their own decisions about where they live and work, subject to different countries' immigration rules. The task force held its first meeting in April 2007 under the chairmanship of Professor Oye Gureji.

Conclusion

As I left our annual meeting this year I was thanked by an African psychiatrist for making it possible for him and some of his colleagues to join us in Edinburgh. He said he wanted the College to know just how important it is that we do offer this kind of support to colleagues from Africa. He said, 'You can't know just how important your interest and support is to us'. This is a good enough reason for me to continue my listening perambulations!

NEWS AND NOTES

For contributions to the 'News and notes' column, please email ip@rcpsych.ac.uk

European Division

The European Division of the College contributed to the 1st Psychiatric Congress of Eastern Europe, organised by the Psychiatric Association for Eastern Europe and the Balkans (www.paeeb.com), held in Thessaloniki, Greece, 21–23 September 2007. We arranged two courses, one on organisation of psychiatric services, chaired by Anne Lindhardt, and one on forensic psychiatry, chaired by Athanasios Douzenis and Christos Tsopelas.

During the General Assembly representatives from 13 countries passed the Declaration of Thessaloniki, which urges the international scientific community, the World Psychiatric Association (WPA), the World Health Organization, the political leadership and all other relevant organisations to contribute to the reconstruction and advancement mental health services in Eastern Europe and the Balkans. The full text of the declaration is available on the PAEEB website.

Professor George Christodoulou

Western Pacific Division

The Western Pacific Division continues to promote the aims of the College in its vast region, with over 700 Members and Fellows but also one-third of humankind. We believe that organising training in services and research is by far the greatest priority, where this is practicable. In this context, the Division is eager to support and contribute to activities of the College in the Western Pacific, including the proposed Royal College Membership Examinations in Hong Kong. There is interest in identifying similarities and differences between the RCPsych and the Royal Australian and New Zealand College of Psychiatrists (RANZCP) in relation to training, examination and accreditation, and whether these are likely to change.

The Division is most grateful to Professor Bruce Singh for his assistance in organising a symposium held at the WPA conference in Melbourne in November 2007, jointly with the RANZCP and the Australasian Society for Psychiatric Research.

Professor Scott Henderson

College international travel

The WPA Regional Conference and the Chinese Psychiatric Society Annual Congress were held in Shanghai, China, 20–23 September 2007. The College delegation included

Professor Sheila Hollins, President, Professor Sue Bailey, Registrar, Dr Tony Zigmond, Vice-President, and Joanna Carroll, International Manager. In addition to presenting a session on mental health legislation around the world, our main objective was to initiate contact with psychiatrists in mainland China and to meet representatives of relevant organisations with a view to discussing collaboration. We had a very fruitful meeting with the British Council. Our public education materials and the volunteer programme were of particular interest to them and we will be exploring this further with the Chinese Health Bureau in Shanghai. Our impromptu visit to the Shanghai Mental Health Centre gave us a valuable overview of Shanghai mental health services. The formal business at the Congress included a poster presentation about the College's international work and a College symposium on developing and implementing mental health legislation around the world. The full post-conference report is available on the College website (<http://www.rcpsych.ac.uk/college/internationalaffairsunit/westernpacificdivision.aspx>).

UEMS Section and Board of Psychiatry

At the Section and Board of Psychiatry autumn meeting held in Geneva last October, Dr Kari Pylkkänen, of the Finnish Medical Association, was elected President of the Section of Psychiatry; Dr Brigitte Mauthner, of the Austrian Medical Chamber, is the new Vice-President of the Section, and Dr Brendan Cassidy, of the Irish Medical Organisation, was elected Treasurer of both the Section and the Board. Dr Joseph Saliba, from Malta, continues in his final term of office as Honorary Secretary, and Professor Slavko Zihelr was re-elected Vice-President of the European Board of Psychiatry.

Bobby Somasunderam memorial

The South Asian Federation (SAF) has joined forces with the WPA Section on Psychiatry in Developing Countries to launch a fundraising project for the Bobby Somasunderam Memorial at Government Mental Hospital in Angoda, Colombo, Sri Lanka. A ward at Angoda Hospital for patients with intellectual disability will be named after him; the project will also offer training for the staff. For further details please contact Dr Afzal Javed, email afzal@afzaljaved.co.uk.

Dr Afzal Javed

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Smoking

Sir: As a medical student who has been researching global trends in smoking, it was enlightening for me to read Professor Ghodse's editorial in the January 2007 issue and Dr Symonds' correspondence in the July 2007 issue on smoking and mental health. I did not know that there was a relationship between smoking and people suffering from mental health problems and both pieces make excellent points.

In the UK and other higher-income countries, decreasing the number of patients with mental health problems who smoke is an admirable goal; however, it is unlikely this will be the priority around the world. The smoking epidemic will disproportionately affect low- and middle-income countries. For instance, mortality from tobacco-related causes is set to rise by 2020 to an estimated 10 million people (Murray & Lopez, 1996), of whom 7 million will be in low- and middle-income countries (Peto *et al*, 1994). In such countries, therefore, the issues will not pertain to mental health specifically but how to prevent a future public health catastrophe.

As mentioned in Dr Symonds' correspondence, political action has to be taken to prevent this from occurring, but whether the World Health Organization initiative, the Framework Convention on Tobacco Control (FCTC), is up to the job is debatable. It remains to be seen whether the FCTC can overcome its lack of enforcement mechanisms, the sometimes contradictory priorities of ratifying states (Assunta & Chapman, 2006) and the sheer economic and political power of the tobacco multinationals.

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Medical student bursaries

Sir: I believe that your medical undergraduate readers would be interested to know about medical student bursaries in psychiatry instituted by the Royal College of Psychiatrists.

Traditionally, only 4% of those leaving medical school choose psychiatry as a career, while 10% would be needed to fulfil the UK's requirements for consultant psychiatrists with indigenous medical workforce. The College is taking steps to attract high-calibre doctors to the specialty and to foster good attitudes towards psychiatry.

Last year, as part of this campaign, the College, prompted by the Psychiatric Trainees Committee and the Board of International Affairs, introduced bursaries for medical students to take up electives in psychiatry or to undertake research. The bursaries, open to undergraduate medical students enrolled on a full-time course of studies in medicine at a medical school in the UK or Ireland, are offered for three types of activities:

- to undertake an elective in psychiatry (five bursaries a year)
- to undertake a period of research on a psychiatry-related topic (three bursaries a year)
- to prepare a research presentation (three bursaries a year).

In 2007, five bursaries were awarded in category 1 (£1200 each) and three in category 2 (£1200 each).

Applications are now open for 2008 and should be submitted to the Dean by 29 February 2008. For further information please contact Miss Dela Goka on dgoka@rcpsych.ac.uk. It is hoped that medical students across the UK will avail themselves of these opportunities to further promote their career interests in psychiatry.

Dr Amit Malik¹ and Kate Holliday²

¹Immediate past Chair, Psychiatric Trainees Committee

²Workforce and Education Manager, Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG, UK

Apologies and clarification

Sir: It was both heartening and relieving to read Saeed Farooq's letter in the October 2007 issue regarding the recommencement of the publication of *Journal of Pakistan Psychiatric Society* since 2005. I extend my apologies to the editor for giving factually incorrect information and any inconvenience caused to readers.

I would just like to point out that the statement in my original letter was actually referenced from an article published in May 2006 in the *Journal of Pakistan Medical Association*. The reference was also quoted at the end of the article. Nevertheless, I should have made more effort to corroborated the information.

I would like to extend my congratulations to the journal and wish that it continues to encourage young researchers in the field of psychiatry in Pakistan.

Dr Yasir Abbasi

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Forthcoming international events

27–30 January 2008

3rd Biennial Conference of the International Society for Bipolar Disorders – ISBD
Delhi and Agra, India
Email: isbd@kenes.com
Website: <http://www.kenes.com/isbd>

25–29 February 2008

11th International CPD Conference: Psychiatric Challenges for 2008
Montego Bay, Jamaica
Organiser: Canadian Psychiatric Association
Email: icpd@cpa-apc.org
Website: <http://www.cpa-apc.org/>

2–5 March 2008

4th CINP Pacific-Asia Regional Meeting
Kuala Lumpur, Malaysia
Website: <http://www.cinpasia.com/>

14–17 March 2008

IV Biennial Conference: Integrative Approaches to Affective Disorders
Cape Town, South Africa
Organiser: International Society for Affective Disorders in collaboration with the WPA Section on Affective Disorders
Contact: Caroline Holebrook
Email: caroline.holebrook@iop.klc.ac.uk
Website: <http://www.isad.org.uk>

16–20 March 2008

Third World Congress on Women's Mental Health
Melbourne, Australia
Organiser: WPA Section on Women's Mental Health
Contact: Dr Donna Stewart
Email: Donna.Stewart@uhn.on.ca
Website: <http://www.IAWMHCongress2008.com.au>

28–29 March 2008

3rd Italian International Workshop of Franciacorta on Mood Disorder
Iseo, Italy
Organiser: Centro Studi Psichiatrici
Contact: Dr Giuseppe Tavormina
Email: dr.tavormina.g@libero.it
Website: <http://www.censtupsi.org>

5–9 April 2008

16th European Congress of Psychiatry
Nice, France
Organiser: Association of European Psychiatrists
Website: <http://www.kenes.com/aep2008/index.asp>

13–17 April 2008

9th Congress of the European Federation of Sexology
Rome, Italy
Organiser: European Federation of Sexology
Contact: Dr Rosi Romagnolo
Email: r.romagnolo@aimgroup.it
Website: <http://www.aimgroup.it/2008/efs>

14–15 April 2008

From Innovations to Practice: The Promise and Challenge of Achieving Recovery For All
Hyatt Regency Hotel, Cambridge, Massachusetts, USA
Organiser: Center for Psychiatric Rehabilitation, Boston University
Contact: Joan Rapp joanrapp@bu.edu
Website: <http://www.bu.edu/cpr/workshops/>

15–17 April 2008

4th International Conference on Psychiatry: Globalization, Psychiatry and Mental Health
Jeddah, Saudi Arabia
Organiser: Saudi Psychiatric Association
Contact: Dr Mohamed Khaled
Email: moh.khaled@gmail.com

17–19 April 2008

Annual Conference of the African Association of Psychiatrists and Allied Professions: Mental Health and Social Changes
Ibadan, Nigeria
Organiser: African Association of Psychiatrists and Allied Professions
Contact: Dr Oye Gureje
Email: ogureje@comui.edu.ng

22–25 May 2008

18th Alzheimer Europe Conference
Oslo, Norway
Email: maija.juva@nasjonalforeningen.no
Website: <http://www.alzheimer-conference2008.org/>

29–31 May 2008

International Congress of Dual Pathology
Madrid, Spain
Organiser: Spanish Society of Dual Pathology
Contact: Carolina Garcia Sicilia
Email: secretariat@cipd2008.com
Website: <http://www.cipd2008.com>

19–21 June 2008

WPA Thematic Conference on Depression and Relevant Psychiatric Condition in Primary Care
Granada, Spain
Organiser: Wonca-Europe, the Spanish Psychiatric Association and the Spanish Society of Family and Community Medicine (SEMFYC)
Contact: Dr Francisco Torres-Gonzalez
Email: ftorres@ugr.es; patricia@fase20.com
Website: <http://www.WPA2008granada.org>

12–15 July 2008

Brain Development and Learning Conference
Vancouver, Canada
Email: devcogneuro@gmail.com, melinda.mackey@gmail.com
Website: <http://www.interprofessional.ubc.ca/bdl.html>

13–17 July 2008

XXVI CINP Congress 2008
Munich, Germany
Website: <http://www.cinp2008.com>

25–30 August 2008

13th World Congress of the International Association for the Scientific Study of Intellectual Disabilities (IASSID)
Cape Town, South Africa
Website: <http://www.iassid.org>

27–30 August 2008

12th European Symposium on Suicide and Suicidal Behaviour
Glasgow, Scotland
Email: organising@esssb12.org

19–25 September 2008

14th World Congress of Psychiatry
Prague, Czech Republic
Website: <http://www.wpa-prague2008.cz>

26–29 September 2008

11th Congress for Bridging Eastern and Western Psychiatry
Antalya, Turkey
Website: <http://www.turkeybipolar.com/>

6–8 November 2008

2nd International Conference on Intellectual Disability/Mental Retardation
Bangkok, Thailand
Organiser: World Health Organization (WHO)
Contact: Dr Shekhar Saxena
Email: bangkokconference2007@sss.gov.qc.ca
Website: <http://www.bangkok-id-conference.org>

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