International Psychiatry

Journal affiliated to *International Psychiatry*: *African Journal of Psychiatry*

RCPSYCH
ROYAL COLLEGE OF
PSYCHIATRISTS

Notice to contributors

International Psychiatry publishes original and scientific articles, country profiles and points of view, dealing with the policy and promotion of mental health, the administration and management of mental health services, and training in psychiatry around the world. Correspondence as well as items for the news and notes column will also be considered for publication.

Manuscripts for publication must be submitted electronically to the Editor (hghodse@sghms.ac.uk), with a copy sent to the Secretariat (ip@rcpsych.ac.uk). The maximum length for papers is 1500 words; correspondence should not be longer than 500 words. The Harvard system of referencing should be used.

A declaration of interest must be given and should list fees and grants from, employment by, consultancy for, shared ownership in, or any close relationship with, any organisation whose interests, financial or otherwise, may be affected by the publication of your submission. This pertains to all the authors.

Manuscripts accepted for publication are copy-edited to improve readability and to ensure conformity with house style. Contributions are accepted for publication on the condition that their substance has not been published or submitted elsewhere.

About our peer-review process
All articles submitted as 'special papers' will be peer-reviewed to ensure that their content, length and structure are appropriate for the journal. Although not all papers will be accepted for publication, our peer-review process is intended to assist our authors in producing articles for worldwide dissemination. Wherever possible, our expert panel of assessors will help authors to improve their papers to maximise their impact when published.

Mission of *International Psychiatry*
The journal is intended primarily as a platform for authors from low- and middle-income countries, sometimes writing in partnership with colleagues elsewhere. Submissions from authors from International Divisions of the Royal College of Psychiatrists are particularly encouraged.

Governance, choice and the global market for mental health

Philip Sugarman[1] and Andrew Kakabadse[2]

[1]Chief Executive and Medical Director, St Andrew's Healthcare, Northampton, UK, email psugarman@standrew.co.uk
[2]Professor of International Management Development, Cranfield University School of Management, Bedford, UK

The provision of health services to vulnerable members of the population should be regarded as one of the prime duties of government. However, it will be apparent to any reader of *International Psychiatry* that access to effective mental healthcare varies widely across the world, an impression powerfully reinforced for those who have the chance to visit and work in countries facing different developmental challenges. On World Mental Health Day 2010, the Secretary-General of the United Nations called for this shortfall to be remedied (United Nations, 2010). With the globalisation of knowledge and culture affecting every facet of life across national boundaries, it is worth reviewing how such changes could influence the development of mental healthcare across the planet.

There is some agreement that the improvement of mental health services depends on resourcing, service infrastructure and government policy (Thornicroft, 2002; Jenkins, 2003). The current focus is on scaling up global resourcing in mental health (World Health Organization, 2010). Of course, different infrastructures may be appropriate for different challenges, including levels of resourcing. The country profiles in *International Psychiatry* set out overviews of facilities, services and professionals, and give creative examples of how targeted intervention has brought benefit. For some years advice has been available to governments on policy models for rolling out community mental health services (e.g. World Health Organization, 2010).

The value of inter-country cooperation and teaching (including the less formal transmission of knowledge) is undoubted, especially when they foster an accurate understanding of cultural diversity and local conditions. The World Psychiatric Association and the World Health Organization are key in the sharing of expertise, including the evidence base for treatments and infrastructure models. However, the success of such initiatives depends crucially on both resourcing and government planning (*Lancet*, 2010).

In some well-resourced high-income countries, a diverse market of providers has developed, often unplanned, but meeting a great deal of need, and enabling comparisons of efficiency and of outcome for service users. This is one way in which the concept of choice in mental health is gaining ground (Sugarman *et al*, 2010). Taking the UK as an example, annual expenditure on mental health, across state-funded health and social care services, currently runs at around £21 billion (Centre for Mental Health, 2010), covering an infrastructure of hospitals, care homes and extensive community mental health services. While most of this is provided directly by the state-run National Health Service and local authorities, in recent years the commercial sector has made an increasing investment in care homes and hospitals, now funded by the public purse at around £8 billion annually (Laing & Buisson, 2010).

There is great value in this diversity of players in mental health, not least because it has started to highlight what is needed, what works, the relative strengths and weaknesses of provider models, and the role of government in commissioning services in an open market. In the UK there are at present interesting tensions between public and private providers (Pollock *et al*, 2010). The voluntary ('third') sector in the UK is also an important mental health service provider, especially strong in innovative forms of community support, and at its most effective when it brings together commercial-style efficiency with public healthcare values. In addition, provider charities often campaign for improved resourcing and awareness of mental health, and are closely linked with the wider mental health knowledge sector, which includes universities, professional bodies and think-tanks.

In an age when knowledge can be shared so easily, and when successful industries roll out models of healthcare across the world, from pharmaceutical companies to hospital corporations, there is an emerging alternative to governments in lower-income countries importing information and advice, setting policy and also running service programmes directly. They have the option of a conscious policy decision to exercise choice in selecting providers and their models of care, and to concentrate on an effective model of service commissioning. The coalition government in the UK is now extending this market-based approach with a policy of 'any willing provider', which emphasises commissioner and patient choice (Department of Health, 2010).

At present there is very little systematic information available on the market diversity of mental health providers in countries across the world. In addition to public services, there are of course private hospitals (taking wealthier patients), charitable institutions (filling some gaps in provision) and scattered examples of public purchasing of mental health services from independent providers. Community support is generally publicly run, but families still take a predominant role in most societies, especially in those with less well developed services. Of course, cultural factors greatly affect models of service governance, including the balance between older, leaner forms of management led by medical and nursing staff, and more modern, general-management-led styles. There is also great variation in the subculture of psychiatry and mental health work by country, including divergent patterns and quality of care and administration, visible between, for example, Europe East and West, the Far East and North America (Gijswijt-Hofstra *et al*, 2005).

Some of this service diversity is no doubt also seen within countries, offering some basis for choice.

Developments in the UK suggest that a market based on provider diversity could offer an alternative to total state provision, allowing governments to focus on their aspirations for the population and on the assurance of outcomes for service users. This may be most effective and efficient for middle-income countries with adequate but not abundant resources. Calling on a spread of mental health service providers is likely to be equally attractive to those fast developing countries that intend to build infrastructure quickly. Rather than investing directly, the creation of a market attracting new providers with international experience may be a partial answer to the common plea to scale up investment in services. Such providers could vary from commercial corporations to charities, cooperatives and state-sponsored foundations, as well as expatriate mental health professionals training abroad. Government policy to move away from the default of state provision towards state commissioning, with an inclusive approach to providers, both for-profit and not-for-profit enterprises, could bring a mix of investment in infrastructure as well as a long-term focus on service development and outcomes.
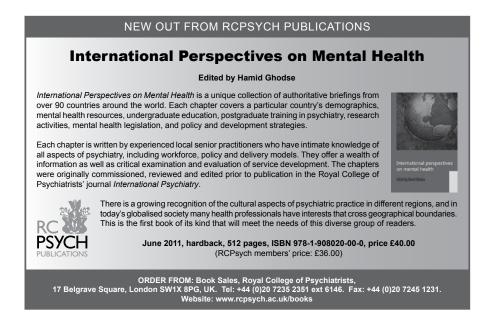
Effective service commissioning requires a coherent policy approach to healthcare quality governance. Amid an abundant recent literature on healthcare governance, there is little on the specific topic of mental healthcare governance. It is, however, possible to develop contemporary concepts in mental health – such as rights, risk, rehabilitation and recovery (e.g. Sugarman & Kakabadse, 2008) – into a governance model which turns on reporting to purchasing commissioners adverse events, organisational learning, therapeutic activity and patient outcomes, as required by the current framework in England and Wales. Other key elements of the market are an intelligence- and inspection-based industry regulator, and transparent public sector accounting, so that the true cost to government of state-run services is available for comparison.

The advent of competition in global healthcare raises fears for vulnerable groups, but it also offers a healthy challenge to monopoly state provision of services, which risks inefficiency and ineffectiveness in delivering outcomes. Such competition requires a planned regulatory and commissioning environment, which has the interests of the patient at heart. Governments which concentrate on the creation of a socially managed market, and on effective mental health-care governance, may be able to realise major benefits for the most vulnerable groups in the population. By planning now to harness the power of globalisation of markets and information, the vision of improved care through choice for patients could become a reality.

Declaration of interest

Philip Sugarman is Chief Executive Officer of St Andrew's Healthcare, the largest provider of charity sector services to the UK National Health Service, and a trustee of the Royal College of Psychiatrists.

References

Centre for Mental Health (2010) *The Economic and Social Costs of Mental Health Problems in 2009/10*. Centre for Mental Health.

Department of Health (2010) *Equity and Excellence. Liberating the NHS*. Department of Health.

Gijswijt-Hofstra, M., Oosterhuis, H., Vijselaar, J., *et al* (eds) (2005) *Psychiatric Cultures Compared*. Amsterdam University Press.

Jenkins, R. (2003) Supporting governments to adopt mental health policies. *World Psychiatry*, **2**, 14–19.

Laing & Buisson (2010) *Mental Health and Specialist Care Services: UK Market Report 2009–2010*. Laing & Buisson.

Lancet (2010) Mental health: WHO minds the Gap. (Editorial.) *Lancet*, **376**, 1274.

Pollock, A., Murphy, E. & Sugarman, P. (2010) Head to head. Maudsley debate. Should NHS mental health services fear the private sector? *BMJ*, **341**, 5382.

Sugarman, P. & Kakabadse, N. (2008) A model of mental health governance. *International Journal of Clinical Leadership*, **16**, 17–26.

Sugarman, P., Ikkos, G. & Bailey, S. (2010) Choice in mental health: participation and recovery. (Editorial.) *The Psychiatrist*, **34**, 1–3.

Thornicroft, G. (2002) The global response to mental illness. *BMJ*, **325**, 608.

United Nations (2010) Secretary-General's message for World Mental Health Day. At http://www.un.org/News/Press/docs/2010/sgsm13164.doc.htm (accessed October 2010).

World Health Organization (2010) Mental health gap action programme. At http://www.who.int/mental_health/mhgap/en/index.html (accessed October 2010).

The English market model is not fit for export

Morris Bernadt FRCPsych

Consultant Psychiatrist, South London and Maudsley NHS Foundation Trust, London, UK, email mbernadt@hotmail.com

Commissioning of health services has become an intensely political issue in the UK and there is no reason to believe that the conflicts that have arisen domestically would not be mirrored overseas. A key ideological issue in the UK concerns the relative merits of public and private provision of services. In their guest editorial in this issue, 'Governance, choice and the global market for mental health', Sugarman & Kakabadse take a particular ideological stance: they write on the one hand of commercial-style efficiency and on the other of monopoly state provision risking inefficiency and ineffectiveness. This perspective is addressed here.

Inefficiency

Commissioning itself has the underlying assumption that there is a market in which there are buyers and sellers. It was introduced into the National Health Service (NHS) between 1999 and 2003. Before that, the state provided and paid for health services. How well has commissioning performed? The report of the House of Commons Health Committee (2010) on commissioning stated that whatever the benefits of the purchaser/provider split, there had been an increase in transaction costs, notably management and administration costs. Research commissioned by the Department of Health, but not published by it, estimated these costs to be 14% of total NHS spending. That is, 14% of total expenditure is spent on the process of buying services! The Committee was suspicious that the Department of Health did not want the full story to be revealed and was appalled that four of the most senior civil servants in the Department were unable to give accurate figures for staffing levels and costs dedicated to commissioning and billing in primary care trusts (PCTs) and provider NHS trusts.

Other problems identified by the Committee were:
❍ the PCTs' belief that they were working effectively, whereas in many cases they were not
❍ the expensive and inefficient use of outside management consultants by PCTs to fill skills gaps in commissioning
❍ tensions between purchasers and providers.

The Committee concluded that, if reliable figures for the costs of commissioning prove that it is uneconomic, after 20 years of costly failure, the purchaser/provider split may need to be abolished.

In Scotland the purchaser/provider split was ended in 2003, in response to pressures from doctors and the public. Direct administration of the NHS in Scotland was restored and the market option was closed off. In 2007 the purchaser/provider split was dropped in Wales, where in 2009 just seven integrated local health boards were established to plan and operate the NHS. These boards have a strong emphasis on linking health and social care. This contrasts with more than 200 general practice consortia that would arise from the Health and Social Care Bill presented to Parliament in 2011.

Fragmentation

Sugarman & Kakabadse write of the great value of having a diversity of providers in mental healthcare. The Health and Social Care Bill has provoked controversy by its promotion of competition arising from 'any willing provider' of services. Are there drawbacks to diversity? Integrated care refers to collaborative working between primary and secondary care, between health and social care, and other forms of care, and is a cornerstone of good practice (Ham *et al*, 2011). In both the UK and the USA, a diversity of providers predisposes to a fragmentation of services (Roland & Rosen, 2011). Organisations with different governance arrangements face difficulties in coordinating services between them, such that patients do not move easily between primary care and secondary care, or between hospital and the community.

European competition law applied to general practice commissioning in England (Dunbar-Rees & McGough, 2011) would, if the Health and Social Care Bill as originally presented to Parliament became law, make it illegal for general practitioners to talk to their secondary care colleagues about commissioning of secondary care services. This is because such collaboration would compromise the fair and transparent process of tendering of the service to 'any willing provider'. The Royal College of Psychiatrists (2011) in considering those mental health services that have been subject to commissioning by 'any willing provider' reports:
❍ serious problems of service fragmentation
❍ decisions made on the basis of cost, not quality
❍ disruption to continuity of care
❍ loss of integration of care pathways.
The College 'believes it would be a disaster if this experience was repeated across mental health services'. In the English context of 'any willing provider', the Academy of Medical Royal Colleges (2011) has expressed 'serious concerns about possible risks to coherent, equitable healthcare brought about through the proposed market approach'. The Academy states that organisational viability is generally contingent on the interdependencies between services and that removal of a service from a hospital or the community is liable to weaken cross-specialty care.

The profit motive

Problems of profit, fraud and morale afflict the commercial sector, which constitutes part of the diversity of providers mentioned by Sugarman & Kakabadse. Making a profit is the *sine qua non* of commercial companies. Every care pathway is governed by the need to make a profit. What lowers profit margins are highly trained, well-paid staff in recommended numbers. For example, it is often the case that the workforce in the UK private home care sector is abysmally paid, is poorly qualified and has a high turnover (Social and Health Care Workforce Group, 2002; Pollock, 2004, p. 183). Cost reductions achieved by outsourcing, and the profits made by outsourcing companies, are largely made by paying workers less. To maximise profit, private treatment centres tend to cherry-pick patients with uncomplicated, easy-to-treat conditions, who are obviously more lucrative on a fixed tariff than those with comorbidity (Woolhandler & Himmelstein, 2004).

The global healthcare industry includes notorious cases of fraud; in fact, such fraud is endemic in the US system (Pollock, 2004, p. 13). According to the Health Policy Network (1996), the FBI estimated that in the years 1990–95 healthcare fraud in the USA totalled no less than $418 billion. Examples of such fraud include overcharging the government, 'upcoding', not rendering a service to insured individuals and not reimbursing them. Huge fines have been levied by the US Department of Justice. In the UK, the medical director of one private health insurer and provider, BUPA, acknowledged that, in a healthcare market, 'conflicts of interest are everywhere' (Leys & Player, 2011, p. 137).

The assumption that staff in private healthcare might be motivated by the 'bonus culture' (i.e. that better performance results from financial incentives) is false (Fleming, 2011). There seems to be an intrinsic difference between doing what one believes to be right and performance based on reward, and this applies with particular emphasis to healthcare. In fact, rewarding people for doing something tends to reduce intrinsic motivation, to stop individuals taking responsibility and in the long run to lead to inferior work (Fleming, 2011). Sharp practice arising from commercial competition has an adverse effect on relationships between individuals in the same organisation and generates tensions between organisations. This contrasts with a system based on trust and common purpose (Woolhandler & Himmelstein, 2004).

Education and training

In keeping with a market philosophy, the Department of Health's 2010 White Paper *Liberating the NHS: Developing the Healthcare Workforce* plans to give employers greater responsibility for planning and developing the healthcare workforce. It states that:

> individual employers are best able to plan and develop their own workforce. Healthcare employers and their staff will agree plans and funding for workforce development and training; their decisions will determine education commissioning plans.

Providers of healthcare will pay to meet the costs of education and training and there is to be a level playing field between providers.

The White Paper itself points to the problems of:

❍ providers making short-term decisions in response to short-term pressures

❍ the length of time it can take to correct an undersupply of key healthcare professionals, due to the length of training

❍ providers having to buy in the educational skills they need

❍ individual providers not being able to offer the appropriate range of training opportunities and breadth of training required for a complex workforce

❍ the training needs of particular professional groups needing to be considered across a large area (for example, a diversity of providers impact on the core and specialty training of psychiatrists).

One might add great concern about the stability of training programmes in an inherently unstable business environment, in which the commissioners might tender a service to 'any willing provider'.

Conclusion

The marketisation and privatisation of health services being rolled out in England, which have reached their apotheosis in the Health and Social Care Bill, represent the wrong model for the development of psychiatric services. Middle-income and fast-developing countries should contrast this model with the integration of services and absence of the profit motive that would arise from a national, state-run service.

Declaration of interest

Morris Bernadt is a member of the British Medical Association and of the executive committee of the NHS Consultants' Association. Both organisations have policies supporting the concept of a publicly funded and publicly provided NHS.

References

Academy of Medical Royal Colleges (2011) Academy briefing statement to NHS Bill 2011. At http://www.aomrc.org.uk/component/content/article/38-general-news/213-health-and-social-care-bill-2011.html (accessed May 2011).

Department of Health (2010) *Liberating the NHS: Developing the Healthcare Workforce*. Department of Health.

Dunbar-Rees, R. & McGough, R. (2011) Challenges of EU competition law for general practice commissioning. *BMJ*, **342**, d2071.

Fleming, F. (2011) The bonus myth. *New Scientist*, 9 April, pp. 40–43.

Ham, C., Dixon, J. & Chantler, C. (2011) Clinically integrated systems: the future of NHS reform in England? *BMJ*, **342**, 740–742.

House of Commons Health Committee (2010) *Commissioning. Fourth Report of Sessions 2009–2010*. HC 268-1. House of Commons.

Leys, C. & Player, S. (2011) *The Plot Against the NHS*. Merlin Press.

Health Policy Network (1996) *Health Care – Private Corporations or Public Service? The Americanisation of the NHS*. NHS Consultants' Association.

Pollock, A. (2004) *NHS plc. The Privatisation of Our Health Care*. Verso.

Roland, M. & Rosen, R. (2011) English NHS embarks on controversial and risky market-style reforms in health care. *New England Journal of Medicine*, **364**, 1360–1365.

Royal College of Psychiatrists (2011) Health and Social Care Bill 2011. Royal College of Psychiatrists. Second reading briefing. House of Commons. At http://www.rcpsych.ac.uk/policy/parliamentandpublicaffairs/neils pages/healthandsocialcarebill.aspx (accessed May 2011).

Social and Health Care Workforce Group (2002) *Independent Sector Workforce Survey 2001. Provisional Report*. Employers' Organisation.

Woolhandler, S. & Himmelstein, D. (2004) The high costs of for-profit care. *Canadian Medical Association Journal*, **170**, 184–185.

Faith and psychiatry

John Cox

Past President, Royal College of Psychiatrists; Professor Emeritus, Keele University, UK; Co–Chair, Centre for the Study of Faith, Science and Values in Healthcare, University of Gloucestershire, UK, email john1.cox@virgin.net

Worldviews, spirituality, existentialism, and even religion, atheism and the transcendental, are making a comeback in the language of both the users and the providers of mental health services. The liveliness of correspondence in recent issues of the College's journals and their polarised opinions, the growth of national and international interest groups and the thoughtful papers in this issue of *International Psychiatry* suggest more widespread interest in these topics than was apparent two decades ago (Bhugra, 1996; Cox, 1994). The then anticipated rampant secularism, the predicted death of God and the growth of 'religionless Christianity' have not happened. Instead, multifaith issues, new mainstream churches in Asia and Africa, the wider understanding of Islam and the search for new 'meaning-making rituals' in secular countries have each prompted a renewed interest in transcultural psychiatry, in comparative religion and in psychospirituality (Verhagen *et al*, 2010; Cox & Verhagen, 2011).

There is these days therefore a 'coming out' of the spiritual dimension of mental health service provision in multifaith communities. Although the 'religiosity gap' between service users and providers remains a challenging issue for doctors – particularly for those with no apparent worldview, or for those who unknowingly have incorporated their particular faith tradition into their work-related values, and have difficulty understanding the validity of other traditions. Yet psychiatrists and other health professionals are expected to be more public about their own stance on these matters – which hitherto were regarded as personal and private – and to declare any 'conflict of interest'.

The taboo – don't touch religion – which was a common currency in the 1970s is breaking down, and Freud's apparent antithesis to religion is being replaced by a greater understanding of cultural relativity and of the scientific evidence that religious beliefs can be good, as well as bad, for health (Koenig, 2008). Furthermore, it is now better known that several continental philosophers (Jaspers, Buber, Kirkegaard, Levinas) and Bill Fulford – as chief protagonist for values-based medicine (see Atwell & Fulford, 2007) – have crossed the boundary between religion and psychiatry, and contributed to the philosophy of religion and to a practical theology.

These new developments have led secular countries, which may have lost faith-based healthcare, to rethink their service provision values. They are challenged by the faiths of health professionals from religious countries (Dura Vila *et al*, 2011) and by their patients' desire for a more explicit *médecine de la personne*.

In this issue, Alison Gray, a liaison psychiatrist and Anglican priest, suggests that 'worldview' is a more inclusive concept than religion or spirituality in clinical practice, as it encourages a legitimate exploration of a patient's values and beliefs in a secular setting. She underlines also the necessary task of facilitating insight into the practitioner's own worldview, which, for the religious, may overlap with faith and spiritual practices.

With a different faith perspective, Walid Khalid Abdul-Hamid correctly pinpoints a major gap in ICD-10, which, unlike DSM-IV, had no specific guidance on religion and psychopathology. He urges the ICD-11 Advisory Group to incorporate the best from DSM-IV with regard to both the assessment of religious delusions and the identification of patients referred with religious or spiritual problems but no mental disorder.

Finally, Cristiane Schumann, André Stroppa and Alexander Moreira-Almeida from Brazil cogently point out that faith-based healthcare worldwide makes a huge, but often neglected, contribution to public health. They call for more active evaluation of this provision, which taps religious sources of compassion and altruism.

These three papers should challenge readers of *International Psychiatry*, the academic community and the policy planners at the World Health Organization and national governments. The challenge is to fill in these glaring conceptual and practical gaps in research, education and clinical work – and to reconsider the religious and spiritual dimensions of healthcare. In so doing, the well-being of patients and practitioners is likely to be enhanced, compliance with evidence-based therapies increased, and faith-based healthcare re-energised.

References

Atwell, R. & Fulford, B. (2007) The Christian tradition of spiritual direction as a sketch for a strong theology of diversity. In *Medicine of the Person: Faith, Science and Values in Health Care* (eds J. L. Cox, A. V. Campbell & B. Fulford), pp. 83–95. Jessica Kingsley.

Bhugra, D. (ed.) (1996) *Religion and Psychiatry: Context, Consensus and Controversies*. Routledge.

Cox, J. L. (1994) Psychiatry and religion: a general psychiatrist's perspective. *Psychiatric Bulletin*, **18**, 673–676.

Cox, J. L. & Verhagen, P. J. (2011) Spirituality, religion and psychopathology: towards an integrative psychiatry. *International Journal of Person Centered Medicine*, **1**, 146–148.

Dura Vila, G., Hagger, M., Dein, S., *et al* (2011) Ethnicity, religion and clinical practice: a qualitative study of beliefs and attitudes of psychiatrists in the United Kingdom. *Mental Health, Religion and Culture*, **14**, 53–64.

Koenig, H. (2008) *Medicine, Religion and Health: Where Science and Spirituality Meet*. Templeton Press.

Verhagen, P. J., van Praag, H. M., Lopez-Ibor, J. J. Jr, *et al* (2010) *Religion and Psychiatry: Beyond Boundaries*. Wiley-Blackwell.

Worldviews

Alison J. Gray MA MB BChir MRCPsych MMedSci

Research Associate, University of Birmingham; Visiting Lecturer, Centre for the Study of Faith, Science and Values in Healthcare, University of Gloucestershire, UK, email a.j.gray@doctors.net.uk

Common human questions include 'Why are we here?' and 'How should we live?' The search for meaning, purpose and values is fundamental to most religions and philosophies. In the UK these views used to be derived from a shared Judaeo-Christian faith. People defined themselves as accepting or rebelling against the faith community. In postmodern times we no longer trust in meta-narrative and there is no consensus on how to deal with existential issues, nor on how to label and map the territory; some would deny that the territory even exists.

Before the 1980s what research existed in this field was on health and religion. We know that, in the USA at least, religion has a positive impact on health outcomes (Koenig, 2008), but not everyone adheres to a formal religion. In the 1990s attention shifted to the broader concept of 'spirituality'. This incorporates more people, including some atheists. However, spirituality is notoriously difficult to define or operationalise. Many would say that they have meaning, purpose and values, but deny the meaningfulness of 'spiritual' (La Cour, 2010).

Some have seen this lack of precise definition as a virtue, because it allows the term 'spiritual' to be used 'as a way of naming absences and recognizing gaps in healthcare provision as well as a prophetic challenge to some of the ways in which we practise health care' (Swinton & Pattison, 2010). However, such flexible use of 'spiritual' makes comparison of research findings difficult. In the highly secular societies of northern Europe 'spiritual' has little meaning. Here researchers usually use 'existential meaning making' (La Cour, 2010). I, for one, have a resistance to using this term, which carries such heavy philosophical baggage of nihilism and atheism.

A more neutral concept is 'worldview'. Everyone has a worldview. If you think you do not have a worldview then probably your view is the default one of your society, which in the UK's case is a form of agnostic, capitalist, scientific materialism.

Worldview: a definition

A worldview is a collection of attitudes, values, stories and expectations about the world around us, which inform our every thought and action. Worldview is expressed in ethics, religion, philosophy, scientific beliefs and so on (Sire, 2004). A worldview is how a culture works out in individual practice. When you encounter a situation and think 'That's just wrong', your worldview is active. We have a natural tendency to think that what we believe is normal: his views are backward and superstitious; your views are a result of how you were brought up; my views are rational, balanced and true. We are largely unaware of the wheels moving on our car until there is an abnormal noise; similarly, we become aware of worldviews and their corresponding values only when there is a clash or crisis (Fulford, 2011). Now that people of different faiths can travel easily around the globe and live in culturally mixed communities, there are increasing opportunities for such clashes.

Worldviews are complex. People brought up in two different cultures can hold two competing sets of values and code-shift between the two, depending on context (Hong *et al*, 2000).

It is much easier to recognise cultural influences at work when they are at a geographical or temporal distance (Joralemon, 2009). We can see the influence of culture on the diagnosis of drapetomania (a 'condition' found in the 1850s which led to running away in slaves) and of *susto* ('soul loss', currently found in some South American cultures). But do we readily recognise the culture-laden nature of sex addiction, road rage and burnout, or anorexia nervosa, premenstrual syndrome and self-harm? A similar process occurs in considering worldviews; more exotic worldviews are more easily recognised as having an impact on values and choices.

Worldviews can be usefully categorised by their view of ultimate reality (Fig. 1). Do you think there is anything beyond what we can directly experience? Is there a spiritual realm of some sort? If so, what is it like?

Worldviews are absorbed from the culture which surrounds us, our earliest human interactions, the stories and nursery rhymes we are told, the teaching of our parents.

Relevance of worldviews to medicine

We need to know the views and values held by those we are seeking to help, to make an accurate diagnosis, to recognise risk and protective factors, to improve diagnostic accuracy, to reveal sources of conflict and to bolster the therapeutic alliance.

Exploring worldviews is not often relevant in, for example, orthopaedics, although some who believe in faith healing may even reject the setting of a broken leg. Worldviews are important in psychiatry, where issues of values and meaning are often raised. We can start the exploration by asking if the service user has 'any faith or beliefs which are important to you at this time'. If their worldview is one of the major religions, that gives us a short-cut to comprehension (Josephson & Peteet, 2004), although we need to continue to ask questions about how these views are worked out in individual practice; I know an observant pious Sikh who is clean-shaven and has short hair because of his wife's wishes.

What is really real?

Fig. 1 Worldview map

Worldviews and treatment conflicts

Conflicts over treatment may occur due to differing worldviews; most doctors know that Jehovah's Witnesses will commonly refuse blood transfusions for religious reasons. Many Christians and Muslims would decline an abortion because their worldviews emphasise the sacredness of human life (Gray, 2010). Another example would be cochlear implants and the deaf community. Many deaf users of sign language see themselves not as disabled but as a linguistic minority, oppressed or ignored by the hearing majority. Politicised deaf parents are less likely to allow their children to have cochlear implants (Gale, 2011); some even see cochlear implants as a form of genocide.

Among the Ntomba peoples of the Congo there is a belief that the high energy level of their chief is essential to the well-being of the tribe (Bikopo, 2010). The chief agrees on accession that he will undergo euthanasia for the good of the tribe when his vitality wanes. Suppose the Ntomba chief were to collapse at an international meeting and end up in a Western hospital with a chronic illness; there could be a great treatment dilemma due to opposing worldviews.

Clinical implications

We routinely treat the abnormal beliefs of those diagnosed with schizophrenia because their beliefs are idiosyncratic, distressing and may lead to harm to self or others. Some New Age beliefs around channelling of spirits and alternative realities can sound psychotic. When does *folie à deux* become the accepted worldview of a new religious community?

How does respecting others' worldviews work when this will lead to the euthanasia of a sick but treatable individual who happens to be the leader of an African tribe; or, to put it in tribal terms, the inevitable, generous, right and proper self-sacrifice of the good leader for the sake of the survival of his people?

Clearly, we do not accept worldviews which lead to the harm of third parties. Some small Christian groups trust in the power of prayer to the exclusion of the possibility of God working through Western medicine. Children have died because the parents refused treatment; in one US review around 90% of these cases could have been easily treated (Hughes, 2004). This has led to legal changes. In Oregon, for example, parents have been forced to get medical care for their children, but several states still allow a faith-based exemption. At what point do the beliefs of a parent overrule their child's right to a 'normal' life? What about the deaf lesbian couple who specifically chose a deaf sperm donor so as to conceive a deaf child, in order that their child would grow to be a full member of the deaf community (Spriggs, 2002)?

Values-based practice

Values-based practice (Woodbridge & Fulford, 2004) provides a framework for working with differing worldviews and differing values. In a situation with a conflict of worldviews, it is important to be aware of your own values, those of the other individuals involved, and the values of the state and healthcare provider. These values are learned about and explored with clear, open communication between all parties. The service user's values are listened to first in the discussions, then the different perspectives held are balanced. Decisions are made, with weight given to both evidence-based practice and the values of those involved. This is a collaborative, multidisciplinary way of working with the service user at the heart of the team.

A case example

A 36-year-old man with a diagnosis of schizophrenia was consistently non-compliant with medication, leading to

conflict with the previous treating team. When we explored this with him we discovered that he valued being a good father above everything else. To him this meant being able to pick up the children from school. If he took his tablets then he was too sleepy to meet the children reliably. Understanding his values led to a change in medication. He experienced voices more intrusively but he preferred to cope with his hallucinations if it enabled him to act as a good father.

Conclusions

Worldview is a useful concept to discuss the area where values, meaning and purpose, religion, spirituality and existential issues overlap. All individuals have a worldview, but so too do institutions. A values-based approach helps professionals to work with the worldviews and values of service users and to reach a consensus on the appropriate way forward.

References

Bikopo, D. B. (2010) Reflection on euthanasia: Western and African Ntomba perspectives on the death of a chief. *Developing World Bioethics*, **10**, 42–48.

Fulford, K. (2011) Bringing together values-based and evidence-based medicine: UK Department of Health initiatives in the 'personalization' of care. *Journal of Evaluation in Clinical Practice*, **17**, 341–343.

Gale, E. (2011) Exploring perspectives on cochlear implants and language acquisition within the deaf community. *Journal of Deaf Studies and Deaf Education*, **16**, 121–139.

Gray, A. (2010) Whatever happened to the soul? Some theological reflections on neuroscience. *Mental Health, Religion and Culture*, **6**, 637–648.

Hong, Y., Morris, M. W., Chiu, C., *et al* (2000) Multicultural minds. *American Psychologist*, **55**, 709–720.

Hughes, R. (2004) The death of children by faith-based medical neglect. *Journal of Law and Religion*, **20**, 247–265.

Joralemon, D. (2009) *Exploring Medical Anthropology.* Prentice Hall.

Josephson, A. M. & Peteet, J. R. (eds) (2004) *Handbook of Spirituality and Worldview in Clinical Practice*. American Psychiatric Publishing.

Koenig, H. G. (2008) *Medicine, Religion and Health: Where Science and Spirituality Meet.* Templeton Press.

La Cour, P. (2010) Research on meaning-making and health in secular society: secular, spiritual and religious existential orientations. *Social Science and Medicine*, **71**, 1292–1299.

Sire, J. W. (2004) *Naming the Elephant: Worldview as a Concept*. Inter-varsity Press.

Spriggs, M. (2002) Lesbian couple create a child who is deaf like them. *Journal of Medical Ethics*, **28**, 283.

Swinton, J. & Pattison, S. (2010) Moving beyond clarity: towards a thin, vague, and useful understanding of spirituality in nursing care. *Nursing Philosophy*, **11**, 226–237.

Woodbridge, K. & Fulford, K. W. M. (2004) *Whose Values? A Workbook for Values-Based Practice in Mental Health Care*. Sainsbury Centre for Mental Health.

THEMATIC PAPER – FAITH AND PSYCHIATRY

The need for a category of 'religious and spiritual problems' in ICD-11

Walid Khalid Abdul-Hamid

Consultant Psychiatrist and Honorary Senior Lecturer, Centre for Psychiatry, Wolfson Institute of Preventive Medicine, Barts & The London Medical School, London, UK, email Walid.Abdul-Hamid@nepft.nhs.uk

The World Health Organization's International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders is currently working on the development of ICD-11 (World Health Organization, 2007). A more responsive ICD coding system should incorporate recent work which suggests that the religious and spiritual domain is important for a comprehensive, culturally sensitive diagnosis and management plan (e.g. Sims, 1992, 2004; Koenig *et al*, 2008). A 'religious or spiritual problems' category, similar to that in DSM-IV (American Psychiatric Association, 1994), should be included in ICD-11.

I was alerted to the importance of this domain when undertaking a project in 1988 to assess the mental health problems and psychiatric needs of homeless people in London, using the observer-rated Social Behaviour Schedule (SBS) to detect behavioural problems associated with chronic psychiatric disorder. For one hostel resident, the SBS recorded posturing, mannerisms, and talking and laughing to oneself. There had been no indication of any such problems during a psychiatric interview conducted earlier. What were perceived as 'behavioural problems' by the staff were the resident's daily Muslim prayers carried out in the hostel corridor, as there was no space for prayer in his cubicle.

This experience gave the author an insight into the importance of understanding the nature of religious practices when undertaking psychiatric assessments. Personal spiritual practices, such as prayer or reading from holy books, as well as communal events such as worship and shared prayers, are found in most of the world faiths. 'Spirituality' (the quality of being spiritual) is a term used to refer to these practices, corporate rituals and beliefs that give meaning and purpose to life, which may be independent of the institutional structures and prescribed beliefs of a particular world religion.

Psychiatry and religion

Although psychiatry and psychology are linguistically associated with spirit (psyche), their boundary with religion has been fraught with many complications and misunderstandings (Albuquerque *et al*, 2003). Marks (2006) suggested that the subject of religion in psychiatry and medicine is

often avoided because of its association with the terrifying existential question 'Is this life all there is?' Sims (2004), commenting on the finding that some forms of mainstream religious practice were good for health, asked whether this was epidemiological medicine's 'best-kept secret'. Those who were religious were found by Dein (2006) to have a lower incidence of depression and recovered more quickly.

Much of the research in this area has been carried out in Western, high-income countries. Most of the studies reviewed by Koenig *et al* (2008), for instance, were carried out in Europe and North America. Two recent exceptions may be cited. Abdel-Khalek (2006) surveyed 2210 Kuwaiti undergraduate students using a self-rating scale that covered religiosity, happiness and mental health and found that those who were religious reported greater happiness. Vasegh & Mohammadi (2007) in their cross-sectional study of 285 medical students at Tehran University found that those reporting higher scores on scales assessing religious feeling were less likely to score highly on depression and anxiety, although this association was statistically significant only for anxiety. There is still, though, a pressing need to conduct research in other regions of the world and to review the existing world literature on this subject.

Religion and psychopathology

The American Psychiatric Association's 1994 classification (DSM-IV) included the category V62.89, 'Religious or spiritual problems', in response to the perceived need to assist clinicians working in multifaith communities and to encourage training in this field. This category of problem was not included in the World Health Organization's 1992 ICD-10, although clinical experience in other regions of the world, as well as the published literature, suggest that religious and spiritual problems are universal, with a consequent need to distinguish, for example, a possession state from a psychotic illness. In many non-Western cultures the patient may ascribe mental disorder to religious beliefs or to spiritual or religious causes. In many traditional cultures there is a strong belief in the power of evil to inflict misfortune and illness, particularly mental illness. In the UK and the USA, about a third of the population report having at some stage of their lives mystical religious experiences of a type that could easily be misidentified by health professionals as mental disorders (Dein, 2004).

Psychiatric classification and religion

Any comprehensive diagnostic system should include criteria that ensure that the social, cultural and spiritual contexts are fully considered. This diagnostic approach requires a combination of descriptive and narrative considerations, as well as the need for recovery strategies and for an understanding of the nature of positive health (Cox, 1994).

The present dominant biochemical–behaviourist model emphasises neither these transcultural perspectives nor the humanistic, relationship-based therapies – an apparent neglect that has resulted in the dehumanising of psychiatry and its promotion solely as a technical craft (Albuquerque *et al*, 2003; Browning, 2003; Meares, 2003).

The American Psychiatric Association's Committee on Religion, Spirituality, and Psychiatry has been helpfully proactive in this regard by ensuring greater sensitivity in DSM-IV to religious factors, and this work is continuing with DSM-V. The Association's book *Religious and Spiritual Issues in Psychiatric Diagnosis* (Peteet *et al*, 2011) is likely to have international relevance and its content will be pertinent to the development of ICD-11. In summary the DSM-IV category V62.89, 'Religious or spiritual problems', is found to be very useful in clinical practice, as is the associated advice about the cultural formulation, which states that this category is used:

> when the focus of clinical attention is a religious or spiritual problem. Examples include distressing experiences that involve loss or questioning of faith, problems associated with conversion to new faith, or questioning of spiritual values that may not necessarily be related to an organized church or religious institution. (American Psychiatric Association, 1994)

ICD-10 did not include a similar category to cover these aspects of the religious or spiritual dimension of mental health, which could have provided assistance with complex differential diagnoses. Applying diagnostic criteria without consideration of religious factors could lead to an inappropriate diagnosis and to an inadequate management plan. ICD-11 should therefore encourage greater consideration of religious belief and spiritual practice by incorporating more specific advice in this area of human experience.

References

Abdel-Khalek, A. M. (2006) Happiness, health, and religiosity: significant relations. *Mental Health, Religion and Culture*, **9**, 85–97.

Albuquerque, J., Deshauer, D. & Grof, P. (2003) Descartes' passions of the soul: seeds of psychiatry? *Journal of Affective Disorders*, **76**, 285–291.

American Psychiatric Association (1994) *Diagnostic and Statistical Manual of Mental Disorders* (4th edition) (DSM-IV). APA.

Browning, D. (2003) Internists of the mind or physicians of the soul: does psychiatry need a public philosophy? *Australian and New Zealand Journal of Psychiatry*, **37**, 131–137.

Cox, J. L. (1994) Psychiatry and religion: a general psychiatrist's perspective. *Psychiatric Bulletin*, **18**, 673–676.

Dein, S. (2004) Working with patients with religious beliefs. *Advances in Psychiatric Treatment*, **10**, 287–294.

Dein, S. (2006) Religion, spirituality and depression: implications for research and treatment. *Primary Care and Community Psychiatry*, **11**, 67–72.

Koenig, H. G., McCullough, M. E. & Larson, D. B. (2008) *Handbook of Religion and Health*. Oxford University Press.

Marks, L. D. (2006) Mental health, religious belief, and the terrifying question. *Journal of Child and Family Studies*, **15**, 135–141.

Meares, R. (2003) Towards a psyche for psychiatry. *Australian and New Zealand Journal of Psychiatry*, **37**, 689–695.

Peteet, J. R., Lu, F. G. & Narrow, W. E. (2011) *Religious and Spiritual Issues in Psychiatric Diagnosis: A Research Agenda for DSM-V*. American Psychiatric Publishing.

Sims, A. C. P. (1992) Symptoms and beliefs. *Journal of the Royal Society of Health*, **112**, 42–46.

Sims, A. (2004) Epidemiological medicine's best-kept secret? Invited commentary on… Working with patients with religious beliefs. *Advances in Psychiatric Treatment*, **10**, 294–295.

Vasegh, S. & Mohammadi, M. R. (2007) Religiosity, anxiety, and depression among a sample of Iranian medical students. *International Journal of Psychiatry in Medicine*, **37**, 213–227.

World Health Organization (1992) *The ICD Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines* (10th revision) (ICD-10). WHO.

World Health Organization (2007) Meeting of the International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders. 11–12 January 2007, Geneva. http://www.who.int/mental_health/evidence/icd_advisory_group_meeting_jan_%202007_summary.pdf (accessed June 2010).

The contribution of faith-based health organisations to public health

Cristiane Schumann, André Stroppa and Alexander Moreira-Almeida

Research Center in Spirituality and Health (NUPES), School of Medicine, Federal University of Juiz de Fora (UFJF), Brazil, email alex.ma@ufjf.edu.br

Religiousness and spirituality are recognised as important factors to consider in both health services research and clinical practice. A large and growing number of studies have examined the relationship between, for example, religiousness and spirituality and physical and mental health, and many of these point to a positive relationship between them. Increased psychological well-being, lower prevalence of depression, substance misuse and suicidal ideation, as well as better physical health, are reported in those who are religious when compared with control groups (Koenig et al, 2001).

In spite of the current recognition of the importance of this relationship, its clinical applications have not been well explored. In particular, few studies have analysed the nature of the work carried out by faith-based health organisations, or investigated their public health impact. The purpose of this brief paper therefore is to consider some of the work familiar to the authors in this field.

Health services provided by faith-based organisations

Since early times, medicine and religion have been closely associated. In ancient Mesopotamia, Egypt, India, China, Greece and the Americas, priests were commonly responsible for healing practices. There was great respect for medicine among the Jews, who were forbidden to live in towns where there was no doctor. During the Middle Ages, medicine was taught in schools maintained by the Church, or in monasteries; and in Europe many hospitals were founded, most of them connected with religious orders (often Catholic or Islamic). They were regarded as charitable guest-houses and instruments of pious benevolence; medicine was seen as evidence of God's love in the face of human suffering. This tradition of caring for sick people through religious hospitals has continued until the present time, in the numerous religious-based charitable hospitals that currently exist across the world (Risse, 1999; Koenig et al, 2001). According to the Catholic News Agency (2010), the Catholic Church manages 26% of healthcare provision in the world, through a total of 117 000 facilities such as hospitals, clinics and orphanages.

The European Study of the Epidemiology of Mental Disorders compared European and US data and found that, among those consulting with mental health problems during the previous year, 6.9% of Europeans had seen religious advisers (ranging from 12.2% in Germany to 2.1% in Spain), compared with 18.8% in the USA (Kovess-Masfety et al, 2010).

A study carried out by the World Health Organization (WHO) estimated that between 30 and 70% of the health infrastructure in Africa is currently owned by faith-based organisations. Yet there is often little cooperation between these organisations and mainstream public health programmes. Christian hospitals and health centres, for example, provide about 40% of HIV care and treatment services in Lesotho, and almost a third of the HIV/AIDS treatment facilities in Zambia (Karpf, 2007).

A report on integrating mental health into primary care by the WHO and the World Organization of Family Doctors (Wonca) (2008) specifically commented on the importance of mental health services provided by faith-based non-governmental organisations in Australia and in Uganda, where 59% of respondents sought help from religious leaders for depression, compared with 0.6% who consulted a traditional healer and 2.3% who visited a public health facility.

A study that analysed trends in the healthcare literature on spiritual, pastoral and chaplain care on MEDLINE between 1980 and 2006 found that there was an increase in the rate of published articles in this field, especially on spiritual care, and that this was particularly noticeable in nursing, mental health and general healthcare journals. However, in the last decade there was a decrease in the number of papers published within the field of pastoral care (Harding et al, 2008).

In Brazil, where healthcare facilities provided by religious organisations are common, a census carried out by the Brazilian government in 2002 found that there were 1718 'philanthropic hospitals' in Brazil, mostly run by religious organisations, with 155 503 beds, which represented 32% of all Brazilian hospitals. Most of these provided a service for low-income patients and were in small towns (over a half of these were the only hospital in the town) (Crisóstomo, 2002). Their funding was mostly from the Unified Health System (SUS), although some services were financed by private health insurance. In Brazil there is a universal health system (the SUS) funded by the government, which provides basic and complex healthcare. It is commonly a partnership between public and private sectors in terms of service provision.

Psychiatric hospitals related to spiritism (a French branch of spiritualism common in Brazil that accepts mediumship, believes in reincarnation and 'Jesus ethics', and has a strong emphasis on the practice of charity) are common in Brazil; about 50 were built throughout the country between 1930 and 1970. The majority of philanthropic mental health institutions located in the state of São Paulo (the most populous state in Brazil) are linked to spiritism (Moreira-Almeida & Lotufo Neto, 2005).

In most of the Catholic hospitals there is a chapel for the celebration of mass; visits are made by a priest for the distribution of the Holy Communion, and there are duty chaplains who respect the beliefs of non-Christian patients, their families and other visitors. Spiritist hospitals also offer counselling to patients, 'passes' (laying on of hands), talks based on ethics and spiritual issues, prayers, and other forms of spiritual healing.

Impact on health

A systematic literature review of articles published between 1990 and 2000 identified 53 studies evaluating the effectiveness of faith-based health programmes, all of them from the USA. It showed that most were focused on primary prevention (50.9%), general health maintenance (25.5%), cardiovascular health (20.7%) or cancer (18.9%). Results showed reductions in cholesterol and blood pressure, weight and disease symptoms, and increases in the use of mammography and breast self-examination – suggesting that this kind of intervention can improve the health of the population (DeHaven *et al*, 2004).

A very clear example of the role of religious organisations in health promotion and prevention is the work of the Children's Pastoral Care (CPC), an organ of the National Conference of Brazilian Bishops (CNBB). The CNBB has been identified as one of the most important organisations around the world working in health, nutrition and education of children under 6 years of age; its work involves families and communities, and the CNBB tracks monthly over 1.5 million children in about 3300 towns all over Brazil. The data from an information system that collects and analyses the indicators of coverage and the impact of the CPC have shown a positive effect of these interventions, when compared with areas not covered by the CPC. In 2006, approximately 260 000 volunteers supported the development of 1.8 million children and the care of 95 000 pregnant women in more than 42 000 communities in Brazil.

In a study conducted in the city of Criciúma (Brazil) with 2208 children below 3 years of age, it was found that pastoral visits were significantly associated with increased maternal knowledge about appropriate feeding methods during a child's episode of diarrhoea, the contraindications to formula milk, the interpretation of the growth curve and increased knowledge of immunisation schedules. There was also an increase in the duration of breast-feeding and the later introduction of bottle-feeding. In addition, the researchers found an increased number of infant weighings in the quarter that preceded the survey, and in the possession of measuring spoons for oral rehydration (Neumann *et al*, 2003).

Another study also found that mothers followed by CPC, when compared with a control group, had better knowledge about the management of diarrhoea and attended more prenatal consultations (at least six); their children were born with higher birthweight and they received iron supplementation more often during pregnancy (Neumann *et al*, 2002, 2003).

The mortality rate among children less than 1 year old in communities where there is CPC provision is up to 50% lower than in those where the CPC is not present. It has also been observed that there is a reduction in violence and criminality

in the areas served by the CPC. In order to disseminate the CPC programme more widely, the International Pastoral Care was established. Other Latin American countries, the Caribbean and Haiti already have branches of this organisation contributing to improvements in healthcare and education. Children's Pastoral Care was nominated for the Nobel Peace Prize 2011 in recognition of the work done by its founder, the paediatrician Dr Zilda Arns Neumann, and the achievements of the CPC (Coordenação Nacional da Pastoral da Criança, 2011).

Conclusion

Given these findings, and despite the overall shortage of studies on this subject, it is clear that faith-based health organisations are relevant to any consideration of public health worldwide, especially in low-income countries. There is limited but consistent evidence that points to their positive effect on health-related outcome measures. However, there is a need to know more about the nature and motivations of these organisations and to assess in greater detail their impact on healthcare provision and on public health (DeHaven *et al*, 2004).

Although there are some instances of mistrust between religious communities and health services, the data presented above would suggest that it would be very fruitful to foster this partnership for health promotion. Further studies in this vital field should therefore be undertaken, as faith-based healthcare is an important source of health provision worldwide.

References

Catholic News Agency (2010) Catholic hospitals comprise one quarter of world's healthcare, council reports. See http://www.catholicnewsagency.com/news/catholic_hospitals_represent_26_percent_of_worlds_health_facilities_reports_pontifical_council/ (accessed June 2011).

Coordenação Nacional da Pastoral da Criança (2011) Pastoral da Criança – CNBB. Rede Brasileira de Informação e Documentação sobre Infância e Adolescência. REIBIDIA. See http://www.rebidia.org.br/index.php?option=com_content&view=article&id=211&Itemid=122 (accessed June 2011).

Crisóstomo, M. (2002) *Hospitais Filantrópicos no Brasil*. [*Philanthropic Hospitals in Brazil.*] BNDES. See http://www.bndes.gov.br/SiteBNDES/export/sites/default/bndes_pt/Galerias/Arquivos/conhecimento/bndes_social/bndes_social5_3.pdf (accessed June 2011).

DeHaven, M. J., Hunter, I. B., Wilder, L., *et al* (2004) Health programs in faith-based organizations: are they effective? *American Journal of Public Health*, **94**, 1030–1036.

Harding, S. R., Flannelly, K. J., Galek, K., *et al* (2008) Spiritual care, pastoral care, and chaplains: trends in the health care literature. *Journal of Health Care Chaplaincy*, **14**, 99–117.

Karpf, T. (2007) Faith-based organizations play a major role in HIV/AIDS care and treatment in sub-Saharan Africa. WHO Media Centre. See http://www.who.int/mediacentre/news/notes/2007/np05/en (accessed June 2011).

Koenig, H. G., McCullough, M. & Larson, D. B. (2001) *Handbook of Religion and Health: A Century of Research Reviewed*. Oxford University Press.

Kovess-Masfety, V., Dezetter, A., de Graaf, R., *et al* (2010) ESEMeD/MHEDEA 2000 Investigators. Religious advisors' role in mental health care in the European Study of the Epidemiology of Mental Disorders survey. *Social Psychiatry and Psychiatric Epidemiology*, **45**, 989–998.

Moreira-Almeida, A. & Lotufo Neto, F. (2005) Spiritist views of mental disorders in Brazil. *Transcultural Psychiatry*, **42**, 570–579.

Neumann, N. A., Victora, C. G., Valle, N. J., *et al* (2002) Impacto da Pastoral da Criança sobre a nutrição de menores de cinco anos no Maranhão: uma análise multinível. [Impact of the Children's Pastoral Care on the nutrition of five-year-olds in Maranhão: a multilevel analysis.] *Revista Brasileira de Epidemiologia*, **5**, 30–40.

Neumann, N. A., Tanaka, O. U., Victora, C. G., *et al* (2003) Qualidade e eqüidade da atenção ao pré-natal e ao parto em Criciúma, Santa Catarina, Sul do Brasil. [Quality and equity of prenatal and childbirth services in Criciúma, Santa Catarina, South Brazil.] *Revista Brasileira de Epidemiologia*, **6**, 307–318.

Risse, G. B. (1999) *Mending Bodies, Saving Souls: A History of Hospitals*. Oxford University Press.

WHO & Wonca (2008) *Integrating Mental Health into Primary Care: A Global Perspective*. See http://whqlibdoc.who.int/publications/2008/9789241563680_eng.pdf (accessed June 2011).

Mental health in Argentina

Daniel Moldavsky[1] MD PGDipPsych (Tel Aviv), Ceri Savage[2] MA PhD DClinPsy, Enrique Stein[3] MD DipPH and Andy Blake[4] MD MPH

[1]Specialist in Psychiatry (Argentina), Consultant Psychiatrist, Millbrook Mental Health Unit, Kings Mill Hospital, Sutton-in-Ashfield, UK, email Daniel.moldavsky@nottshc.nhs.uk; [2]Clinical Psychologist (UK) and Visiting Research Fellow, Institute of Cognitive Neurology, Buenos Aires, Argentina; [3]Specialist in Psychiatry, Professor of Public Health, Comahue National University, Neuquen, Argentina; [4]Specialist in Psychiatry (Argentina), Consultant for the National Parliamentary Commission for Mental Health, Argentina

Argentina, the second largest country in South America, is a federation of 23 provinces and its capital, the autonomous city of Buenos Aires. Its population is a little over 40 million, 50% of whom reside in its five largest metropolitan areas. The rural areas are extensively under-populated. The city of Buenos Aires and its suburbs contain 15.5 million inhabitants, making it one of the largest urban areas in the world.

Although Argentina belongs to the high- to middle-income countries according to the World Bank, its socioeconomic inequalities are extensive. Sharp contrasts exist between the urban and rural areas. Between 29 and 33% of its population live below the poverty line.

During the 20th century, the country saw several military coups and administrations in between periods of precarious democratic government. Military regimes, repression of the opposition, hyperinflation and several collapses of the economy took a heavy toll on the mental health field. Importantly, more than one generation of professionals and academics were effectively exiled abroad, damaging the country's scientific system and research capacities. Argentina is currently experiencing its longest unbroken period of democracy in its history, and the most recent signs indicate a trend for academics and professionals to return, in response to improving conditions and government incentives, but the consequences of the earlier turbulent history cannot be ignored.

Argentina as yet lacks a national system for data collection for mental health. Each province has its own system. Data pertain mainly to the public system, and exclude the substantial private sector, making the information incomplete.

Policy and legislation

The National Mental Health Authority provides advice to government on policy and mental health legislation. However, it is not involved in planning, monitoring or evaluating the quality of services. These domains are under the independent responsibility of each province.

In 2010, the National Parliament approved the Law for Mental Health Services, which covered service planning and policies, mental health in primary care, as well as monitoring of compulsory admissions to hospitals. It is not yet clear how this change will affect existing services.

A survey by the World Health Organization (WHO) on the state of mental health services in Argentina gathered much useful information (some reported below), although it covered only ten provinces. Nine of these have explicit mental health policies drafted. A Federal Plan for Mental Health was drafted in January 2008, but is still vague and not widely supported by all the provincial authorities.

The budget for mental health is below WHO recommended levels. Allocations vary among the provinces, from 0.5 to 5.0%. Nationally, 68% of the mental health budget goes to psychiatric hospitals, leaving community services underresourced.

Six provinces have an official list of essential medications. However, the lack of clinical guidelines leaves the availability of medical treatment potentially subject to market mechanisms, with pharmaceutical companies exerting pressure for the approval of medication that is not necessarily supported by clinical evidence.

Service delivery

Health services are delivered by several systems that coexist in a structure that is subject to little formal regulation, being essentially a free market health economy. The federal state bears no responsibility for health cover for the population, which is instead devolved to provincial control. Each province has a public health sector that gives free cover. Its resources are limited.

The national social security system is financed by contributions from employers and workers. However, people who are unemployed are not covered by this. Private insurance plans, taken out independently by individuals, cover more than 12% of the population, mainly in urban areas. Pensioners and people with a disability receive cover provided by the

federal state, financed in a similar way to the social security contributions system, but through contributions from the state and state pensions. Disability allowances are paid by this federal system.

Local councils and provincial governments provide the large psychiatric hospitals. These are poorly resourced and most of the workforce are underpaid or work voluntarily. The four largest hospitals in Buenos Aires, with a total of 2221 beds, have been threatened with closure, but no plans have been made for patients' relocation. Despite developments in social assistance provision in recent years (e.g. the introduction of the 'Head of Household Programme' in 2002), national housing and welfare policies in Argentina remain of a less established and comprehensive nature than those that exist in many European countries, including the UK.

Argentina has a total of 20 945 general psychiatric ward beds (10 864 public sector and 10 081 private). The number of private beds has increased notably since 2001, unlike the number in the public system. There are 186 private hospitals and 45 private institutions for people with addiction problems. The majority of private facilities are in the main cities.

Community services also exist. There are 533 out-patient mental health facilities available in the 10 provinces surveyed, of which 28 are for children and adolescents. There are 65 day hospitals in the 10 provinces, of which only 4 are for children and adolescents. The province of Buenos Aires has 60 units, with a total of 244 short-term beds. Several provinces have mental health services without in-patient beds. This difference illustrates the geographical inequalities that exist, with large urban areas containing the highest concentration of resources.

In summary, treatment within the public sector still relies on a model based on the psychiatric hospital, at least for severe mental disorders. Three provinces (Neuquén, Rio Negro and San Luis) conducted a successful process of deinstitutionalisation during the 1990s. However, their combined populations constitute just 4.03% of the total national population. In these areas, following deinstitutionalisation, the private sector advanced, opening facilities for those patients who needed admission. This puts the model itself into question in terms of public health considerations.

Psychiatric training

The main system for postgraduate training is through the medical residence programme, which lasts 3–4 years for those taking it full time. There are about 450 vacancies nationwide. Another system is through part-time work in an approved service, but it is not paid and so has more vacancies than the former. Further routes into the specialty are university postgraduate training, which lasts 3 years, and the training organised by the Association of Argentinean Psychiatrists. The latter has also run a programme for recertification since the 1990s. Although it is not mandatory, it has been very successful, drawing a wide attendance to its annual meeting, and also generating a training network for the more distant provinces and rural areas.

There are no examinations to qualify for the Certificate of Specialist in Psychiatry. The Ministry of Health awards this certificate to professionals who have worked a total of 5 years in the specialty (either part time or full time).

Mental health training in primary care is poor. Some programmes for physicians receive a strong input from the pharmaceutical industry. The Health Ministry runs almost no regular professional training programmes for physicians and nurses working in primary healthcare. A training programme for over 8000 family and community physicians, implemented in 2008 by the Ministry of Health, has no mental health content. The first author of this article did deliver training for family doctors at the 2010 National Psychiatric Congress, based on a 'stepped care' model for the detection and treatment of mental disorder in primary care, but much still needs to be done in this field.

Workforce issues

There are 13.25 psychiatrists per 100 000 inhabitants. They are located mainly in Buenos Aires and the other urban centres. Prominent inequalities still exist with respect to the rural areas, many of them having no access to specialist services, or indeed mental health professionals at all.

Data for Argentina suggest a lack of nurses when compared with doctors, with a ratio of about one nurse to ten doctors (in all medical specialties). In the ten provinces surveyed by the WHO (2011) there were 12.91 psychiatric nurses per 100 000 inhabitants. Data for other provinces are still lacking or unreliable, due to the exclusion of the private sector in the data. It is also worth mentioning that the operational definition of a 'nurse' varies from province to province. The profession of community psychiatric nurse does not exist as in the UK. There is a surplus of psychologists (172 per 100 000 inhabitants, compared with 9 in the UK and 31.1 in the USA, for example). There are 11 social workers per 100 000 inhabitants, but they do not usually form a part of mental health teams. Child and adolescent psychiatry is still understaffed, with only 295 registered specialists in this area.

It should be noted, however, that there can be substantial differences across countries in the training and practice of the above categories of professional. An example is how the roles undertaken by Argentine psychologists are far wider than those undertaken by British clinical psychologists. In Argentina 'clinical psychologist' is a graduate post that requires no mandatory clinical training before registration, while in the UK the job is highly regulated and specialised, requiring doctoral training that includes both research and supervised clinical practice. In Argentina psychologists often do work that would be carried out by a variety of other professions in the UK, such as specialist nurses and social workers, or generic mental health workers. Moreover, many of the specialist skills offered by a clinical psychologist in the UK do not form part of mandatory training in Argentina (e.g. psychometric evaluation). It is important to observe that, while the data suggest an excess of specialised psychological input, it is more likely that psychoanalytic input is over-represented and other (evidence-based) aspects of such input are lacking.

It remains unclear whether, in Argentina, psychologists are filling some of the gaps in service provision created by the shortage of professionals such as specialist nurses and social workers. More research is needed to obtain a better understanding of the skills mix on offer.

Main research areas

There has been insufficient epidemiological research. This explains the lack of reliable information that would be expected of current evidence-based mental health approaches. Funding for medical research through the National Council for Scientific and Technical Investigations is almost nonexistent. Under these conditions, research in the biomedical areas is restricted to the pharmaceutical industry.

In contrast, within Buenos Aires a psychoanalytical tradition, dating back to the 1940s, has developed. It is at present considered the 'most psychoanalysed city' in the world. Two psychoanalytical societies are affiliated with the International Psychoanalytical Association. Psychoanalysis has exerted a powerful influence on the mental health system, and still constitutes a very important part of the psychiatric curriculum.

Human rights

There are several laws that regulate compulsory admission to hospital, the status of people under guardianship (including property) and periodical review of those patients compulsorily admitted. Again, these regulations vary across the provinces.

Progress has been made in relation to the traumatic sequelae of the so-called 'dirty war' (1976–83). Mental health professionals have been organised to assist with the restitution of children abducted by the military. Several non-governmental organisations are widely involved with the subject of human rights and the prominent socioeconomic inequalities in health. There is still much work to be done in this area, particularly in relation to housing. With the presence of a stable democratic government, it is very much hoped that the necessary changes will soon be implemented.

Sources

Adaszko, D. & Salvia, A. (2010) *Poverty and Deprivation Conditions in the Great Urban Centers*. Catholic University of Argentina.

Alperin, M. N. P. (2009) The impact of Argentina's social assistance program plan *jefes y jefas de hogar* on structural poverty. *Estudios Economicos*, **20** (número extraordinario), 49–81.

Ceriani, L., Obiols, M., Michaelewicz, A., *et al* (2009) Obstáculos para el desarrollo de políticas transformadoras en salud mental: el caso de la ley 25.421. [Obstacles against the development of policies and the implementation of improvements in mental health: the case of law 25.421.] *Investigaciones en Psicología*, **14**, 7–19.

Cia, A., Cordoba, R. N. & Abib Adad, M. (2010) Current clinical advances and future perspectives of the psychiatry/mental health field in Latin America. *International Review of Psychiatry*, **22**, 340–346.

Garay, C. J. & Korman, G. P. (2008) Clinical guidelines in mental health: situation in Argentina. *Vertex*, **19**, 491–495.

Hollander, N. C. (1989) Psychoanalysis confronts the politics of repression: the case of Argentina. *Social Science and Medicine*, **28**, 751–758.

Lupu, N. &. Stokes, S. (2010) Democracy, interrupted: regime change and partisanship in twentieth-century Argentina. *Electoral Studies*, **29**, 91–104.

Ohman, L. (2009) The reform in the Central Psychiatric Unit. *Vertex*, **20**, 51–61.

Pellegrini, J. (2004) Social crisis, human rights and public hospital. *Vertex*, **15**, 147–155.

Penchaszadeh, V. B. (1992) Abduction of children of political dissidents in Argentina and the role of human genetics in their restitution. *Journal of Public Health Policy*, **13**, 291–305.

Saxena, S., Sharan, P., Garrido, M., *et al* (2006) World Health Organization's Mental Health Atlas 2005: implications for policy development. *World Psychiatry*, **5**, 179–184.

Toro Martinez, E. (2008) Substance use disorder. Forensic issues in Argentina. *Vertex*, **19**, 537–542.

Torricelli, F. & Barcala, A. (2004) Epidemiology and mental health: an impossible analysis in Buenos Aires city. *Vertex*, **15**, 10–19.

World Health Organization (2005) *Mental Health Atlas 2005*. WHO.

World Health Organization (2011) *Mental Health System in 10 Argentine Provinces: Jujuy, Salta, Tucuman, Corrientes, Catamarca, Mendoza, San Juan, Chubut, Rio Negro, and Tierra del Fuego. Results of an Assessment by the WHO–AIMS*. WHO (in press).

Yanco, D. & Roma, V. (2007) Mental health internships in Buenos Aires. *Vertex*, **18**, 179–186.

COUNTRY PROFILE

Mental health in Botswana

Paul Sidandi[1] MRCPsych, Philip Opondo[2] MMed Psych and Sebonetse Tidimane[3] RN FNP

[1]Senior Consultant Psychiatrist, [2]Consultant Psychiatrist, [3]Nursing Superintendent, Jubilee Psychiatric Unit, Nyangabgwe Hospital, Francistown, Botswana, email paul.sidandi@yahoo.com

Botswana is a landlocked country located in southern Africa. More than two-thirds of it (70%) is covered by the Kalahari Desert, known locally as the Kgalagadi. The majority (82%) of the nearly 2 million population live in the eastern part, along the railway line from Lobatse in the south-east to Francistown in the north-east, and the rest in the central part, including the Okavango River delta.

Botswana is about the size of Kenya, France or the State of Texas and is thinly populated. The surface area is 581 730 km² (363 581 square miles). This poses a challenge in the provision of health services in general and psychiatric services in particular. About 45% of the population is under 15 years of age. Over 50% are settled in urban areas. The four main centres are: the capital city, Gaborone (population 250 000), in the south-east; the second city, Francistown (105 000), in the north; Lobatse (60 000); and Selebi-Phikwe (50 000).

It is a multiparty democracy that became independent from Britain in 1966. It has achieved the status of a middle-income country with P12.18 billion (US$1.2 billion) in its annual development budget and P27.14 billion (US$4.17 billion) in its recurrent budget. Its national income per capita (PPP international $) in 2009 was $13 310. Total expenditure on health per capita was $1341 and total expenditure on health as a

proportion of gross domestic product was 10.3%. Around 80% of the health budget is provided by the government.

The ongoing global economic difficulties have led to the postponement of most development projects. The economy is closely linked with South Africa. As one of the poorest countries before independence, Botswana depended on migrant mine labour remittances from that country. The health of ex-miners was a public health issue at the time and some still receive compensation for lung diseases. Unemployment is high at 18% and this remains a social problem.

Health services

The government health services are divided into a two-tier system, one tier based in health facilities and the other in the community. The facility-based services are organised in a pyramidal structure, with referral hospitals at the apex. There are three national referral hospitals, one of which is a psychiatric hospital. At the bottom of the pyramid are mobile stops, health posts and clinics which are manned by nursing staff and grouped into clusters with a doctor. Community-based clinics, which were previously under the Ministry of Local Government, are now run by district health management teams under the Ministry of Health.

The country has 3816 hospital beds. In January 2010, a second 200-bed private hospital was opened in Gaborone. The teaching hospital will add 400 beds when it opens in 2014. There are 390 psychiatric beds, constituting 10% of the total. HIV accounts for 18% of the admissions at Sbrana Psychiatric Hospital. The 2009 Botswana AIDS Impact Survey III reported a national HIV prevalence rate of 17.6%.

Role of religious practices

Botswana is mainly a Christian country, with the majority belonging to the main denominations. However, there are a growing number of spiritual, apostolic and revival charismatic churches and many still follow indigenous religious practices. There are a number of converts to Islam. Some patients visit churches for prayer, holy water and laying on of hands.

Policy on traditional medicine

The traditional healers are represented by the Botswana Dingaka Association. The Ministry of Health has adopted a policy of recognising them and promoting good working relations between them and modern scientific practice. Many patients combine the use of traditional medicine with hospital-based treatment and spiritual healers. Traditional healers are consulted mostly for the management of problems arising from psychological and cultural factors.

Mental health services

The 300-bed Sbrana Psychiatric Hospital in Lobatse has four psychiatrists. It opened in 2009 to replace the 180-bed Lobatse Mental Hospital, which had been in existence from 1938. Sbrana Psychiatric Hospital is a stand-alone fully serviced hospital with teaching and forensic facilities and separate child, adolescent and psychogeriatric wards, a mother and baby unit and an observation ward, as well as acute, chronic and rehabilitation wards. It has a day hospital, psychology, social work, occupational therapy and pharmacy services.

The Jubilee Psychiatric Unit, Nyangabgwe Hospital, has two psychiatrists. It opened in 1980, initially with four beds. The capacity had increased to 34 beds (22 male and 12 female) when the in-patient wing was closed in October 2010 to pave way for the establishment of an infectious diseases unit. The majority of in-patients were transferred to Sbrana Psychiatric Hospital in Lobatse. A few were transferred to Sekgoma Memorial Hospital Psychiatric Unit in Serowe Village (population just under 53 000), about 200 km away.

The Jubilee Psychiatric Unit now has only eight holding beds (five for males and three for females). Patients who need in-patient care for more than a day or two are transferred to the Sbrana Psychiatric Hospital, a distance of approximately 500 km. The Psychiatric Unit at Sekgoma Memorial Hospital will be improved in the interim to function as the referral centre for psychiatry in the northern part of the country, pending the construction of a 100-bed facility in Francistown when the economy improves.

The newly built Mahalapye, Sekgoma, Scottish Livingstone and Letsholathebe II Memorial Hospitals have psychiatric units with 20–30 beds each. Other hospitals, including Princess Marina Hospital, a national referral facility in Gaborone, offer out-patient psychiatric clinic services but have no in-patient beds.

Mental health services are provided by eight psychiatrists, as well as medical officers, psychologists, occupational therapists, social workers, psychiatric and general nurses. There are also about 100 community health nurses. Psychiatric nurses, who have to have the Diploma in Advanced Community Mental Health Nursing (see 'Training'), form the backbone of psychiatric care outside the referral hospitals. They carry out extensive outreach in their respective catchment areas. This complements the airborne and road-trip outreach clinics by the psychiatrists based in Francistown and Lobatse. The district and primary hospitals, including mine, mission and military hospitals, have one or more psychiatric nurses, who admit patients to the general wards and transfer only the unmanageable ones to Lobatse or Francistown.

In comparison with other African countries, Botswana appears to be better staffed but the geographical spread means the workforce is overstretched. For example, Botswana has the same area as Kenya, which has a population 20 times greater, with 67 psychiatrists.

Psychiatric association

As there are only eight psychiatrists, including two in private practice (one general and one child psychiatrist) in Gaborone, there is no Botswana Psychiatric Association affiliated to the World Psychiatric Association. The Botswana Association for Psychosocial Rehabilitation (BAPR), which runs a day-care centre in Lobatse, is the only non-governmental organisation functioning in the community in this field. It is affiliated to the World Association for Psychosocial Rehabilitation and groups together professionals, families, consumers and policy makers.

Unpublished reports indicate that stigma contributes to only a few health workers opting to take psychiatry and psychiatric nursing as a discipline for specialisation.

Training

The Institute of Health Services, Lobatse campus, runs an 18-month Diploma in Advanced Community Mental Health Nursing course. The University of Botswana opened its School of Medicine in August 2009 with the intake of the first MBBS undergraduates. It is on schedule to establish a 400-bed academic hospital in Gaborone. Psychiatry will be offered as a modular course for the undergraduates and will be allocated one month of study on the postgraduate course in family medicine (see http://www.ub.bw).

Mental health disorders

According to the annual reports of the Lobatse Mental Hospital and Jubilee Psychiatric Unit for the years 2005–08, the five conditions most commonly presenting in the in-patient unit were:
1 schizophrenia
2 depressive disorders
3 alcohol use disorders
4 bipolar affective disorders
5 epilepsy.
In the out-patient unit they were:
1 schizophrenia
2 cannabis-induced disorders
3 depressive disorders
4 alcohol use disorders
5 epilepsy.

Mental health legislation

The current law was enacted in 1971 (5 years after independence) and is due to be reviewed and updated.

Mental health policy

The July 2003 Botswana National Policy on Mental Health provides a framework for the incorporation of the objectives of the mental health programme into the existing general health services. The aim of the policy is to provide access to services, to enable every individual to have the benefit of good mental health and thus allow them to make an optimal contribution to personal, community and national development.

The future of mental health services

As in the USA (Bernstein *et al*, 2010), although society's perception of individuals with mental illness has improved, stigma is still significant in Botswana. With the opening of Sbrana Psychiatric Hospital, there is hope that the facility will be accredited along with other major general hospitals by the Council for Health Service Accreditation of Southern Africa (COHSASA) as meeting international standards.

Sources

Bernstein, C. A., Hershfield, B. & Cohen, D. C. (2010) Psychiatry in the USA: an overview. *International Psychiatry*, **7**, 90–92.

World Health Organization (2009) *World Health Statistics*. WHO. At http://www.who.int/countries/bw/en (accessed January 2011).

Criteria for compulsory admission in some European countries

A. Carballedo[1] and M. Doyle[2]

[1]Senior Registrar in Psychiatry, Cheeverstown House, Dublin, Ireland, email carbala@tcd.ie;
[2]Registrar in Psychiatry, St James Hospital, Dublin, Ireland

Compulsory admission to mental health facilities is a controversial topic, as it impinges on personal liberty and the right to choose, and it carries the risk of abuse for political, social and other reasons (Gostin, 2000). However, involuntary admission can prevent harm to self and others, and assist people in attaining their right to health, which, due to their mental disorder, they are unable to manage voluntarily. Since the 1950s and 1960s, the delivery of mental health has shifted from a paternalistic emphasis on the need to treat those who are not able to look after themselves, to the rights of patients who have a mental illness. The Principles for the Protection of Persons with Mental Illness ('the MI Principles') adopted by the United Nations in 1991 play an important role in raising awareness about the human rights of people with mental health problems. They provide guidance on areas such as the procedures for involuntary admission to mental health facilities and standards of care (Knapp *et al*, 2007). Legal frameworks for involuntary placement of those who are mentally ill have been reformed in many European countries. Most regulate compulsory admission and treatment by special mental health laws. Only Greece, Spain, Italy and those member states of the European Union (EU) that joined in 2004 and 2007 have no separate laws (Dressing & Salize, 2004).

Increasing rates of compulsory admission have been reported by some authors (e.g. Darsow-Schutte & Muller, 2001). However, comparison of the time series of compulsory admission quotas during the past decade reveals a slightly more homogeneous pattern, with more or less stable quotas in most countries (Salize & Dressing, 2004). Some countries have made the focus of commitment laws the protection of society at large from people who are mentally ill, but this has led to a public perception of those with mental disorders as dangerous and thus contributes to their stigmatisation, when in fact more recent studies do not show a marked difference in the danger presented by those who are mentally ill and the general population (Swanson et al, 1990). Studies conclude though that in routine clinical practice the characteristics of compulsory admission are rather stable, irrespective of the various criteria for commitment. This suggests that decision-making procedures across the world rely on similar objective and 'good faith' criteria for involuntary placement (Appelbaum, 1997). It is important also to consider that the availability of alternatives that are more acceptable to patients might contribute to increasing or reducing the rates of compulsory admission in different countries.

Overviews of national approaches are scarce. There is a lack of sound studies in the field and statistics on compulsory admissions are rarely published internationally (Riecher-Rossler & Rossler, 1993). Consequently, the European Commission funded in 2000 a study that gathered and analysed information on the differences and similarities of legal frameworks for the involuntary placement or treatment patients presenting with a mental illness across the EU member states, and the outcome in terms of involuntary admission rates to psychiatric facilities. Our paper aims to give a brief overview of compulsory admission data from official sources across some European countries through a review of the literature published to date in relation to this issue.

Different criteria for different countries

The Salize report in 2004 (Salize & Dressing, 2004) highlighted that frequencies of compulsory admissions vary remarkably among countries in Europe. This finding was not surprising given the large differences in the relevant legal instruments, but it was astonishing given the much smaller differences in psychiatric morbidity. The authors of the Salize report concluded that involuntary admissions were a result of a complex set of still poorly understood legal, political, economic and social factors. A more recent European research initiative, the EUNOMIA project in 2005 (Kallert et al, 2005), carried out in 12 countries (Bulgaria, Czech Republic, England, Germany, Greece, Italy, Israel, Lithuania, Poland, Slovak Republic, Spain, Sweden), included the objective of providing detailed information on the basis of involuntary psychiatric admission.

To define clear conditions that have to be met when persons who are mentally ill should be involuntarily placed is crucial for preventing abuse. Although the laws of all countries studied stipulate a confirmed mental disorder as a major condition for detention, additional criteria are heterogeneous. Threatened or actual danger to oneself or to others is the most common additional criterion, but is not a prerequisite in Italy, Spain or Sweden, or in England, Wales or Scotland. Some other countries such as Denmark, Finland, Greece, Ireland and Portugal do stipulate as further criteria the need for treatment and danger. The other countries we considered in the review had as a further criterion danger on its own. Some countries emphasise a lack of insight on the part of the patient, additionally. No significant correlation could be identified with compulsory admission quotas or rates when comparing countries applying the 'danger' or 'need for treatment' criterion (Dressing & Salize, 2004). Dangerousness is an additional criterion for involuntary psychiatric admission in Lithuania, Bulgaria, the Czech Republic, the Slovak Republic and Poland (Kallert et al, 2005) (Table 1).

In most countries studied, the final decision on involuntary placement is made by a non-medical authority, either a representative of the legal system (judge, prosecutor, mayor) or another agency independent of the medical system. In the remaining member states the decision is left to psychiatrists or other healthcare professionals (Table 1). However, it is important to mention that in all countries, thorough assessments are performed by psychiatrists as soon as a patient is admitted to a psychiatric facility (Dressing & Salize, 2004; Kallert et al, 2005). According to the laws of six European countries, notification or inclusion in the procedure of a legal representative of the patient (e.g. advocate, counsellor or social worker) is mandatory. Countries with obligatory inclusion of a legal representative showed significantly lower compulsory admission quotas and a trend towards lower compulsory admission rates (Salize & Dressing, 2004).

Across Europe, the legally stipulated period of time that may elapse between psychiatric assessment and the actual start of an involuntary placement ranges from 24 hours (in Luxemburg, Spain, Sweden, The Netherlands, Ireland, Bulgaria, Czech Republic and Slovak Republic) to 10 days (in Belgium). Emergency procedures for short-term placement are defined separately in some countries and are usually applied at night, weekends, or whenever immediate action is deemed necessary. Short-term detention usually is permitted from 24 to 72 hours (except in Belgium, where it is up to 10 days). There are also large differences with regard to the maximum length of a compulsory admission order. Only Denmark, France, Portugal and Spain do not define a maximum duration for initial involuntary placement. For the rest of the countries we have considered in the review, initial placements may vary from 7 days to 2 years (e.g. 7 days in Italy, 14 days in Luxembourg, 4 weeks in Sweden, 21 days in Ireland and up to 6 months in the UK). Other countries have lengthy initial placements, such as Austria, Bulgaria, the Slovak Republic and the Czech Republic, with 3 months; Poland, with 6 months; and Belgium and Germany, with up to 2 years. Reapproval or reassessment procedures are established in all countries studied (Salize & Dressing, 2004; Kallert et al, 2005). For clarification see Table 1.

The demographic characteristics of detained patients

Research studies suggest that the largest group admitted involuntarily are people with severe and chronic mental disorders such as schizophrenia or other psychoses; they account for 30–50% of all involuntary placements in states

Table 1

Country	Essential legal criteria for detention (additional to mental disorder)	Deciding authority for detention order	Mandatory inclusion of patient counsel	Detention for assessment	Maximum length of initial placement
[1]Austria	Danger	Non-medical	Yes	48 hours	3 months
[1]Belgium	Danger	Non-medical	Yes	10 days	40 days to 2 years
[1]Denmark	Danger or need for treatment	Medical	Yes	Not separately defined	Not defined
[1]Finland	Danger or need for treatment	Medical	No	Not separately defined	9 months
[1]France	Danger	Non-medical	No	48 hours	Not defined
[1]Germany	Danger	Non-medical	No	24 hours to 3 days	6 weeks to 2 years
[1]Greece	Danger or need for treatment	Non-medical	No	48 hours	6 months
[1]Ireland	Danger or need for treatment	Medical	Yes	Not separately defined	21 days
[1]Italy	Need for treatment	Non-medical	No	48 hours	7 days
[1]Luxembourg	Danger	Medical	No	24 hours	14 days
[1]Netherlands	Danger	Non-medical	Yes	24 hours	3 weeks to 12 months
[1]Portugal	Danger or need for treatment	Non-medical	Yes	48 hours	Not defined
[1]Spain	Need for treatment	Non-medical	No	24 hours	Not defined
[1]Sweden	Need for treatment	Medical	No	24 hours	4 weeks
[1]UK	Need for treatment	Non-medical and medical	No	72 hours	28 days to 6 months
[2]Bulgaria	Danger	Non-medical	No	24 to 48 hours	34 days to 3 months
[2]Czech Republic	Danger	Non-medical	No	24 hours	3 months
[2]Lithuania	Danger	Non-medical	No	48 hours	1 month
[2]Slovak Republic	Danger	Non-medical	No	24 hours	3 months
[2]Poland	Danger	Non-medical	No	48 hours	10 days to 6 months

[1] Salize & Dressing (2004).
[2] EUNOMIA project (Kallert *et al*, 2005).

that provided diagnostic data. The proportions of groups with other diagnoses, such as dementia, affective disorders or substance misuse, differ remarkably.

Information about the sociodemographic characteristics of involuntarily admitted patients is as scarce as information on psychopathological background. There seems to be an overrepresentation of male patients, which might serve as a rough indicator that danger is the prime consideration in involuntary placement, since men with mental illness reportedly are more likely than women to show dangerous behaviour (Salize & Dressing, 2004). Several studies have confirmed that involuntary admission is more frequent among patients with an immigrant background than among the general population (Tolmac & Hodes, 2004; Ali *et al*, 2007; Torrissen, 2007). In a 3-year prospective study in Norway looking at the characteristics of voluntary and involuntary psychiatric admissions of immigrants, Iversen *et al* (2011) concluded that involuntarily admitted immigrants more often have a diagnosis of schizophrenia and psychotic disorders than immigrant patients who are voluntarily admitted. However, for a valid comparison, the proportion of compulsorily admitted males should have been tested against the proportion of total admissions of males to psychiatric in-patient care in each country. Unfortunately, these data are not available.

Conclusions

Legal regulations as well as routine procedures for detaining people who are mentally ill differ considerably across Europe. Specification of the various national regulations presents an opportunity to harmonise national laws. However, there is limited evidence on which to recommend best practice, and this constitutes a major obstacle to any mutual European action. International epidemiological research in this field is needed for an evaluation of the effectiveness of different approaches. Diverse legal traditions, general attitudes towards people who are mentally ill, and the structure and the quality of mental healthcare systems or administrative procedures must be considered along with other factors when analysing outcomes from the different legal frameworks. It will be an important task to adapt legal frameworks in all countries, balancing patients' rights and interests against their need for and right to treatment.

The substantive and procedural safeguards suggested by the case law of the European Court of Human Rights (ECHR) will need to be addressed when drafting legislation providing for the detention of individuals on the grounds of mental disorder (Knapp *et al*, 2007). The MI Principles of the United Nations provide for the detention of individuals with a 'mental illness' in mental health facilities, and set out the conditions for detention, review of the decision and relevant procedural safeguards. On the other hand, commentators have raised concerns about the level of protection offered by the MI Principles regarding detention (UN Secretary-General, 2003) and a review of the Principles has been suggested. Internationally standardised and annually updated involuntary placement rates on a national level are fundamental to the evaluation of national as well as Europe-wide policies.

An important limitation of the present paper is that it does not include data from all European countries.

References

Ali, S., Dearman, S. P. & McWilliam, C. (2007) Are Asians at greater risk of compulsory psychiatric admission than Caucasians in the acute general adult setting? *Medicine, Science, and the Law*, **47**, 311–314.

Appelbaum, P. S. (1997) Almost a revolution: an international perspective on the law of involuntary commitment. *Journal of the American Academy of Psychiatry and the Law*, 25, 135–147.

Darsow-Schutte, K. I. & Muller, P. (2001) Number of hospitalizations according to German 'PsychKG' legislation has doubled in 10 years. *Psychiatrische Praxis*, 28, 226–229.

Dressing, H. & Salize, H. J. (2004) Compulsory admission of mentally ill patients in European Union member states. *Social Psychiatry and Psychiatric Epidemiology*, 39, 797–803.

Gostin, L. O. (2000) Human rights of persons with mental disabilities. The European Convention on Human Rights. *International Journal of Law and Psychiatry*, 23, 125–59.

Iversen, V. C., Berg, J. E., Smavik, R., *et al* (2011) Clinical differences between immigrants voluntarily and involuntarily admitted to acute psychiatric units: a 3-year prospective study. *Journal of Psychiatric and Mental Health Nursing* (in press).

Kallert, T. W., Glockner, M., Onchev, G., *et al* (2005) The EUNOMIA project on coercion in psychiatry: study design and preliminary data. *World Psychiatry*, 4, 168–172.

Knapp, M., McDaid, D., Mossialos, E., *et al* (2007) *Mental Health Policy and Practice*. European Observatory on Health Systems and Policies Series. Open University Press.

Riecher-Rossler, A. & Rossler, W. (1993) Compulsory admission of psychiatric patients – an international comparison. *Acta Psychiatrica Scandinavica*, 87, 231–236.

Salize, H. J. & Dressing, H. (2004) Epidemiology of involuntary placement of mentally ill people across the European Union. *British Journal of Psychiatry*, 184, 163–168.

Swanson, J. W., Holzer, C. E., 3rd, Ganju, V. K., *et al* (1990) Violence and psychiatric disorder in the community: evidence from the Epidemiologic Catchment Area surveys. *Hospital and Community Psychiatry*, 41, 761–770.

Tolmac, J. & Hodes, M. (2004) Ethnic variation among adolescent psychiatric in-patients with psychotic disorders. *British Journal of Psychiatry*, 184, 428–431.

Torrissen, T. (2007) Tvangsinnleggelser i en akuttpsykiatrisk post. [Involuntary admissions to an acute psychiatric ward.] *Tidsskrift for den Norske legeforening*, 127, 2086–2089.

UN Secretary-General (2003) Progress of efforts to ensure the full recognition and enjoyment of the human rights of persons with disabilities – report of the Secretary-General (A/58/181). Available at http://www.un.org/disabilities/default.asp?id=148 (accessed June 2011).

ORIGINAL PAPER

Naturalistic study of crisis referrals to an Irish community adult mental health service

Tunde Apantaku-Olajide[1] MBBS, Bobby P. Smyth[2] MRCPsych and Pat Gibbons[3] MRCPsych

[1]Registrar in Addiction Psychiatry, Youth Drug and Alcohol Service (YoDA), Dublin, Ireland, email tunde.apantaku@hse.ie;
[2]Consultant Child and Adolescent Psychiatrist in Substance Use, HSE Addiction Services, Cherry Orchard Hospital, Dublin, Ireland;
[3]Consultant in General Adult Psychiatry, Naas General Hospital, Kildare, Ireland

There is no agreed definition of a mental health crisis; however, a useful one is 'a situation where mental health has deteriorated to an extent that the user is likely to be at risk of harm to self or others and is in need of urgent intensive specialist support and treatment' (Minghella *et al*, 1998). Community-based care is the primary model of specialist mental healthcare in Ireland (Government of Ireland, 2006*a*). When clinically indicated, a patient with mental health crisis is referred to the community mental health team (CMHT) for an urgent assessment.

Most data available on the relationships between patients' explanatory variables, crisis referrals and urgent demands in mental healthcare are from international studies, which have highlighted the relevance of acute psychosis, marked affective symptoms, risk to self or others, and lack of social support (Abas *et al*, 2003; Johnson *et al*, 2005; Cotton *et al*, 2007). Although urgent referrals are for people in crisis, the crisis may be psychosocial in nature (Spurrell *et al*, 2003). Therefore, understanding mental health crisis and patients' explanatory variables within a sociocultural context is necessary for a more targeted referral system that offers optimal interventions and the appropriate use of services.

The study reported here explored the demographic and clinical characteristics of patients referred to an Irish CMHT and sought to identify the key differences between crisis and scheduled referrals.

Method

This was a retrospective analysis of the clinical records of all people who attended a CMHT within the 12 months 1 January–31 December 2008. This CMHT provides services to a well-defined catchment area in the North Kildare area of Ireland, a suburban and rural population of approximately 35 000 (Government of Ireland, 2006*b*). The team receives referrals from 22 general practices, other CMHTs and a local general hospital emergency department. The team provides home-based assessments and treatment of acute mental illness, together with out-patient care, day hospital and in-patient care at the local general hospital where necessary.

A standard form is used for all referrals made to the team. This requires the referrer to indicate the perceived urgency of assessment. The completed form is faxed to the mental health centre office. In addition, the referrer is required to alert the home care team to crisis referrals using a designated mobile telephone number during office hours. Crisis referrals are reviewed by telephone with the referrer and an appointment offered depending on the degree of urgency as determined by the referrer, with same-day assessments available during weekday working hours. The waiting period for routine referrals is usually 7–14 days.

Demographic data collected included age, gender and marital status, past psychiatric illness and source of referral.

Clinical data were extracted from FACE Version 5 of the Core Assessment and Outcomes Package for Mental Health Services (Clifford, 1999). This scale is routinely completed at initial assessment. The recorded clinical data were dichotomised. Two independent groups of patients were generated from this sample. One group comprised crisis referrals; these were all patients for whom the referral source indicated 'urgent assessment'. The second group comprised the scheduled referrals, where the referral source suggested 'routine assessment', and it served as a control.

All data analyses were performed using PASW Statistics 18 (SPSS Inc., 2009). The demographic and clinical data of the two groups of patients were investigated for statistical differences, using the two-sided Fisher exact test. As this was an exploratory study, we opted not to employ a Bonferroni correction for multiple testing and left the *P*-value at 0.05. To control for possible confounding factors, multivariate analysis was performed using the 'enter method' logistic regression model to identify variables independently associated with crisis referral. Variables were selected for entry into the regression equation based upon the results of the univariate analysis, with all variables that had a *P*-value less than 0.1 being entered.

Results

During the study period, 234 persons were referred to the service. Of these, 31 (13.2%) (crisis referral, 13; scheduled referral, 18) did not attend; they were not different from the attenders on the sociodemographic characteristics and so were excluded from analysis. Of those who attended, 150 patients (73.9%) had a complete set of FACE data; they did not differ on the sociodemographic characteristics of interest from patients with missing data.

The demographic and clinical characteristics of the two groups are presented in Table 1. The mean (s.d.) age of all attenders was 37.8 (15.3) years; the age range was 16–88. The crisis referral group comprised 100 people (49.3% of the total sample), of mean age 36.4 (15.1) years, with an age range of 16–83.

On univariate analysis, recent suicidal behaviours, polysubstance use, and emergency department referral source were significantly associated with crisis referral (Table 1). Multivariate analysis indicated that polysubstance use was significantly predictive of crisis referral and memory problems were associated with routine referral (Table 2).

Discussion

In this study, almost half (49%) of the referrals were crisis referrals, mostly from general practitioners (74%) or the emergency department (21%). Mainly two categories of patients present to emergency departments in Ireland: self-referrals and general practitioner referrals out of office hours. Their subsequent re-referrals to the CMHT for follow-up indicate that the level of crisis was manageable in the community (Hatfield *et al*, 2000). In the present study, the proportion of people with overt psychosis and immediate risk/safety concerns was considerably less than in a UK study (Johnson *et al*, 2005). The crisis referrals in our study were differentiated by recent suicidality, polysubstance use and referral via the emergency department. However, when the confounding effects of other variables were controlled for via logistic regression, only polysubstance use remained statistically significant. We also found evidence to suggest that patients presenting with memory difficulties were less likely to be referred as a crisis; this is understandable, given the potentially chronic nature of memory complaints (Neu *et al*, 2009).

Our findings may be explained by the limitation of crisis assessment to weekday working hours; most crisis presentations occur out of office hours, when the 'at risk' patient is likely to be admitted (Cotton *et al*, 2007). It is somewhat surprising that we did not detect greater differences in symptom profile between crisis and routine referrals. In particular, one might expect evidence of a more robust association between core psychiatric symptoms, risk behaviour (i.e. suicidality, self-harm and risk to others) and categorisation as a crisis referral.

Clinical implications

Our study raises two issues: the level of need for urgent assessments in community care; and the adequacy of weekday working hours provision for crisis assessments. More importantly, polysubstance use and suicidality were common among the crisis referrals; although the management of primary substance misuse is not within the remit of the CMHT, if there is any psychiatric comorbidity then the care is a responsibility of the CMHT (Government of Ireland, 2006*a*). Therefore, we are emphasising the need to enhance the skills of CMHTs in managing addiction issues and the provision of more ready access to specialist addiction services, as this patient group seems particularly likely to present in crisis.

Study limitations

This study had several limitations that need to be taken into account when considering the implications of the findings. First, the study recruited patients from one CMHT in a predominantly suburban population and lacked clinical data on 26% of the attenders; therefore, the findings may not apply to patients in other CMHTs, geographical locations, or socioeconomic settings in Ireland. Second, this is an exploratory study employing multiple testing without advanced hypotheses and therefore runs the risk of a type 1 statistical error. While the logistic regression analysis controlled for confounding, it remains possible that some of the variables entered into the final regression equation were selected based upon chance associations. Third, the dichotomised data cannot capture important distinctions in the severity of symptoms or risk behaviours. Finally, we did not examine data on presentations to the emergency department out of hours and hospital admissions, because this was outside the scope of the present study.

Research implications

We suggest the need in future studies for more information on presentations to the emergency department out of hours and hospital admissions; this would help quantify the impact of available services and inform future service developments. Further research should also investigate the relationships between symptom severity, the level of patient care and onward referral pathways.

Table 1 Demographic and clinical characteristics

Characteristic	Proportions of patients (%)			Fisher test significance (2-sided)
	All attendees	Crisis referrals	Scheduled referrals	
Age (years)				
16–19	17/203 (8.4)	10/100 (10)	7/103 (6.8)	0.40
20–44	122/203 (60.1)	62/100 (62)	60/103 (58.3)	0.41
45–64	53/203 (26.1)	23/100 (23)	30/103 (29.1)	Ref.
≥65	11/203 (5.4)	5/100 (5)	6/103 (5.8)	1.00
Gender				
Male	93/203 (45.8)	49/100 (49)	44/103 (42.7)	0.4
Female	110/203 (54.2)	51/100 (51)	59/103 (57.3)	Ref.
Marital status				
Single	107/203 (52.7)	54/100 (54)	53/103 (51.5)	1.00
Married	77/203 (37.9)	39/100 (39)	38/103 (36.9)	Ref.
Separated/widowed	19/203 (9.4)	7/100 (7)	12/103 (11.7)	0.2
Source of referral				
General practices	158/203 (77.8)	74/100 (74)	84/103 (81.6)	0.2
Emergency department	28/203 (13.8)	21/100 (21.0)	7/103 (6.8)	0.005
Other community mental health teams	17/203 (8.4)	5/100 (5.0)	12/103 (11.7)	Ref.
Past psychiatric illness	121/203 (59.6)	58/100 (58)	63/103 (61.2)	0.67
Primary diagnostic categories				
F00–09 (organic, including symptomatic, mental disorders)	4/203 (2.0)	2/100 (2)	2/103 (1.9)	0.99
F10–19 (mental and behavioural disorders due to psychoactive substance use)	20/203 (9.9)	13/100 (13)	7/103 (6.8)	0.26
F20–29 (schizophrenia, schizotypal and delusional disorders)	19/203 (9.4)	13/100 (13)	6/103 (5.8)	0.24
F30–39 (mood [affective] disorders)	67/203 (33.0)	26/100 (26)	41/103 (39.8)	1.00
F40–49 (neurotic, stress-related and somatoform disorders)	50/203 (24.6)	23/100 (23)	27/103 (26.2)	1.00
F60–69 (disorders of adult personality and behaviours)	33/203 (16.3)	19/100 (19)	14/103 (13.6)	0.47
Nil evident psychiatric disorder	10/203 (4.9)	4/100 (4)	6/103 (5.8)	Ref.
Indicators of psychiatric morbidity				
Psychotic features				
Thought disturbance	9/150 (6.0)	5/77 (6.5)	4/73 (5.5)	1.00
Delusions	7/150 (4.7)	6/77 (7.8)	1/73 (1.4)	0.12
Hallucinations	4/150 (2.7)	3/77 (3.9)	1/73 (1.4)	0.62
Odd behaviours	6/150 (4.0)	5/77 (6.5)	1/73 (1.4)	0.21
Affective features				
Overactivity	12/150 (8.0)	6/77 (7.8)	6/73 (8.2)	1.00
Expansive mood	7/150 (4.7)	2/77 (2.6)	5/73 (6.8)	0.27
Anhedonia	96/150 (64.0)	49/77 (63.6)	47/73 (64.4)	1.00
Insomnia	77/150 (51.3)	56/77 (72.7)	44/73 (60.3)	0.07
Depressed mood	109/150 (72.7)	55/77 (71.4)	54/73 (74.0)	0.86
Neurotic features				
Obsessions	31/150 (20.7)	14/77 (18.2)	17/73 (23.3)	0.55
Anxiety	112/150 (74.7)	57/77 (74.0)	55/73 (75.3)	1.00
Somatisations	27/150 (18.0)	10/77 (13.0)	17/73 (23.3)	0.14
Dissociation	4/150 (2.7)	4/77 (5.2)	0/73 (0.0)	0.12
Cognitive deficits				
Memory	47/150 (31.3)	19/77 (24.7)	28/73 (38.4)	0.08
Attention/concentration	62/150 (41.3)	28/77 (36.4)	34/73 (46.5)	0.25
Polysubstance use	39/150 (26.0)	28/77 (36.4)	11/73 (15.1)	0.005
Risk/safety concerns				
Harm to others	10/150 (6.7)	4/77 (5.2)	6/73 (8.2)	0.53
Aggression	31/150 (20.7)	18/77 (23.4)	13/73 (17.8)	0.42
Suicidal behaviours	34/150 (22.7)	24/77 (31.2)	10/73 (13.7)	0.01
Self-harm	15/150 (10.0)	10/77 (13.0)	5/73 (6.8)	0.28
Self-neglect	30/150 (20.0)	18/77 (23.4)	12/73 (16.4)	0.31
Lack of a social support network	43/150 (28.7)	20/77 (26.0)	23/73 (31.5)	0.48

Ref. indicates the reference category where indicated.

Table 2 Results of multivariate analysis for crisis referrals

Variable	Odds ratio for crisis referrals	95% confidence interval		*P*-value
		Lower	Upper	
Emergency department referrals	3.0	1.0	9.4	0.06
Suicidal behaviours	2.0	0.8	4.8	0.14
Polysubstance use	3.2	1.3	7.6	0.009
Memory difficulties	0.4	0.2	1.0	0.04
Insomnia	2.0	0.9	4.2	0.07

Conclusions

Crisis referrals to this CMHT have similar symptom profiles to scheduled referrals; however, patients with substance use problems are more likely to present in crisis. Therefore, there is a need to enhance the CMHT's management of addiction issues and provide ready access to specialist addiction services. Finally, the study suggests that it is inappropriate to restrict crisis assessments to weekday office hours.

References

Abas, M., Vanderpyl, J., Prou, T. L., *et al* (2003) Psychiatric hospitalization: reasons for admission and alternatives to admission in South Auckland, New Zealand. *Australian and New Zealand Journal of Psychiatry*, **37**, 620–625.

Clifford, P. I. (1999) The FACE recording and measurement system: a scientific approach to person-based information. *Bulletin of the Menninger Clinic*, **63**, 305–331.

Cotton, M. A., Johnson, S., Bindman, J., *et al* (2007) An investigation of factors associated with psychiatric hospital admission despite the presence of crisis resolution teams. *BMC Psychiatry*, **7**, 52.

Government of Ireland (2006*a*) *A Vision for Change. Report of the Expert Group on Mental Health Policy*. Stationery Office.

Government of Ireland (2006*b*) *Census Report*. Central Statistics Office.

Hatfield, B., Spurrell, M. & Perry, A. (2000) Emergency referrals to an acute psychiatric service: demographic, social and clinical characteristics and comparisons with those receiving continuing services. *Journal of Mental Health*, **9**, 305–317.

Johnson, S., Nolan, F., Pilling, S., *et al* (2005) Randomised controlled trial of acute mental health care by a crisis resolution team: the North Islington Crisis Study. *BMJ*, **331**, 599–602.

Minghella, E., Ford, R. & Freeman, T. (1998) *Open All Hours: 24-Hour Response for People with Mental Health Emergencies*. Sainsbury Centre for Mental Health.

Neu, D., Minner, P., Le Bon, O., *et al* (2009) Significance of fatigue and insomnia complaints in the psychiatric emergency room. *European Neuropsychopharmacology*, **19**, S243–S244.

SPSS Inc. (2009) *PASW Statistics* (18.0). SPSS Inc.

Spurrell, M., Hatfield, B. & Perry, A. (2003) Characteristics of patients presenting for emergency psychiatric assessment at an English hospital. *Psychiatric Services*, **54**, 240–245.

Challenges for psychiatry in the 21st century

Dinesh Bhugra PhD FRCPsych

Professor of Mental Health and Cultural Diversity, Health Service & Population Research Department, Institute of Psychiatry, King's College London, UK, email Dinesh.bhugra@kcl.ac.uk

Psychiatrists manage ambiguity in diagnosis as well as management of patients with psychiatric disorders and contain anxiety experienced by patients and their families as well as that of the teams. The changes in societies and cultures in the past few decades have produced changes in their expectations of their doctors, including psychiatrists. In some high-income countries, patients are better informed about their conditions and treatments than they were before. This availability of knowledge has led to a levelling in the relationship between patient and doctor.

In this paper I highlight some of the challenges psychiatry as a profession and psychiatrists as clinicians face in the early part of the 21st century. These challenges can be divided into broad categories of social, biological and psychological factors. Social factors include globalisation and urbanisation as a result of increasing industrialisation in several countries across the globe. Biological factors include pharmacogenomics as a result of gene mapping and newer pharmacological agents. Psychological factors include computer-based therapies and stigma against patients and the profession itself.

Globalisation, urbanisation and industrialisation

Globalisation describes better communications and ease of movement of people, materials and products. The process of globalisation influences not only market forces but the political and social functioning of societies as well (see Gupta & Bhugra, 2009; Bhugra & Gupta, 2011). Countries can be broadly divided into: those which provide raw materials for production; those which manufacture goods; and those which are largely consumers. The movement of professionals has similar pathways. Countries may produce healthcare professionals at a lower cost but then lose them to countries which pay higher salaries, leading to serious brain drain.

Within low- and middle-income countries, increased industrialisation will lead to increased urbanisation as it did in high-income countries centuries ago. This process may cause fragmentation of families, a reduction in social support and an increase in demand for healthcare services. Furthermore, after internal migration, individuals may find that their aspirations in a number of areas are not met, which lowers self-esteem.

These factors in turn will cause changes in cultural beliefs, attitudes and values such as deculturation, affecting the individual's functioning. As a majority of the world's population is likely to reside in urban areas in the next three decades, clinicians need to be aware of the potential needs that these populations may have.

Pharmacogenomics

With new means of identifying pathology such as gene mapping, it is likely that, in due course, there will be specific medications tailored to individuals. Mrazek (2010, p. 3) defines psychiatric pharmacogenomics as the study of how gene variations influence the response of a patient to psychotropic medication. An understanding of the structural gene variants may allow drug side-effects to be minimised and genetic testing may allow the creation of bespoke

medications for individuals. However, there are a number of key ethical and technical issues: appropriate consent, voluntary or compulsory testing, confidentiality of medical information and reliability of these tests (Mrazek, 2010, p. 231).

Talking therapies without therapists

With many behavioural and cognitive–behavioural therapies available on computer, with clear algorithms and steps for home work, will psychotherapists and therapists be required? Patients prefer their psychiatrists to have good communication skills (Bhugra & Gupta, 2010). Medicine and doctoring are about caring and curing and the human and humane touch with people who are suffering. Psychotherapy is at the core of what we do – whether we are persuading patients to take their medication as prescribed, exploring their inner world and turmoil or helping modify their cognitive schema, psychiatry and psychiatrists have a major role to play.

Stigma

Stigma, discrimination and prejudice against mental illness and those with mental disorder remain a major challenge to psychiatry, although the fact that more celebrities, sports stars and film stars now talk in public about their experience of mental illness and mental distress may lead to a reduction in stigma.

❍ *Against patients*. The social and cultural contexts play a significant role in the development and understanding of stigma. In cultures where the locus of control of their illness is seen as external by patients (evil eye, bad deeds, etc.), the onus is likely to be taken away from the patient and stigma may be less. In societies where individuals are expected to look after themselves and their nuclear family, pressures to get better may well stigmatise patients and their illness.

❍ *Against psychiatrists*. Stigma and discrimination against psychiatrists, from a large number of sources, contribute to a sense of alienation from the medical profession as a whole. Stereotypes of psychiatrists being soft and of psychiatry as not being a science are common. These prejudices and discriminating behaviours have many consequences, including poor recruitment.

❍ *Consequences*. Stigma can cause delays in seeking help or complying with therapies. It has been shown that where doctors have better control of their own workload, rates of burnout are lower (Bhugra *et al*, 2008). Stigma against mental illness may translate into poor services and poor research funding as well. There is evidence that education may reduce stigma, which is a result of knowledge, attitudes and behaviour (see Evans-Lacko *et al*, 2010).

Solutions

These challenges can be managed using a number of strategies.

❍ *Leadership*. The first major step psychiatrists need to take is to become leaders in service planning, service delivery and evaluation of services. Medical training and an awareness of biopsychosocial models in making sense of aetiological factors make psychiatrists ideal leaders. Any leadership has to be in the cultural and social contexts. As leaders we should inspire, motivate, enable and empower others.

❍ *Anti-stigma*. There is no doubt that a lack of knowledge may contribute to negative attitudes, but increasing knowledge may not always change behaviour. However, concerted efforts in education will shift attitudes; such efforts should include not only working with local media but also personal contacts, particularly with patients and their carers.

❍ *Quality improvement*. In spite of limited resources, it is possible to focus on quality of services. This quality focus is not only on structures – physical environment – but also on processes, between patients and their psychiatrists. The task is to determine causes of problems and barriers in providing good services. But the quality has to be assessed in the context of local priorities and available resources. For psychiatrists, up-to-date knowledge and clinical skills remain critical in ascertaining and delivering quality.

❍ *Prevention and health promotion.* A considerable proportion of adult mental illness starts before people reach their mid-20s. Various risk factors (e.g. domestic violence, sexual or physical abuse, alcohol misuse) have been identified, especially in Black and minority ethnic individuals, gay, lesbian, transgender and bisexual individuals and in prisoners. A number of strategies can be used to reduce the development of psychiatric disorders. Similarly, early intervention in psychoses, addictions and dementia should enable a reduction in psychiatric and physical morbidity.

Conclusions

At the beginning of the second decade of the 21st century, new challenges are emerging which psychiatrists need to get to grips with. It is inevitable that some changes will occur at a faster speed than others. It is in the best interests of patients and society at large that psychiatrists and patients work together to deal with the challenges proffered by stigma, newer treatments and health promotion.

References

Bhugra, D. & Gupta, S. (2010) Patient expectations from psychiatrists. In *Professionalism in Mental Healthcare: Experts, Expertise and Expectations* (ed. D. Bhugra & A. Malik), pp. 92–100. Cambridge University Press.

Bhugra, D. & Gupta, S. (2011) Globalisation: internal borders and external boundaries. In *Migration and Mental Health* (ed. D. Bhugra & S. Gupta), pp. 56–67. Cambridge University Press.

Bhugra, D., Bhui, K. S. & Ram Gupta, K. (2008) Burnout and stress among doctors and dentists in North India. *International Journal of Culture and Mental Health*, 1, 24–29.

Evans-Lacko, S., London, J., Little, K., *et al* (2010) Evaluation of a brief anti-stigma campaign in Cambridge: do short-term campaigns work? *BMC Public Health*, 10, 339.

Gupta, S. & Bhugra, D. (2009) Globalization, economic factors and prevalence of psychiatric disorders. *International Journal of Mental Health*, 38, 53–65.

Mrazek, D. A. (2010) *Psychiatric Pharmacogenomics*. Oxford University Press.

Elections to the International Narcotics Control Board

Congratulations to Professor Hamid Ghodse, who, on 2 May 2011, was elected President of the Bureau of the International Narcotics Control Board (INCB).

The Board also elected Raymond Yans as First Vice-President, Rajat Ray as Second Vice-President of the Board and Chairperson of the Standing Committee on Estimates, and Sri Suryawati as Rapporteur.

Twenty-one years of old age psychiatry

It has been 21 years since old age psychiatry was recognised by the Department of Health as a specialty in its own right. Old age services were started in some parts of the UK as early as 1958. It received status as a Section of the Royal College of Psychiatrists in 1978 and as a Faculty in 1988.

In order to combat the growing public health problem of substance misuse in older people, the Faculty, along with the Faculty of Addictions, has produced a document entitled *Our Invisible Addicts*. The report examines the nature and extent of the problem, and makes key recommendations for service delivery, staff training and public policy. It is available at http://www.rcpsych.ac.uk/files/pdfversion/CR165.pdf

Volunteer project in Sudan

In May and June 2011 seven volunteers from the Royal College of Psychiatrists travelled to Sudan for one or two weeks at a time to offer mental health training to family practitioners as part of a programme being run by the World Health Organization (WHO), the Federal Ministry of Health in Sudan and the Royal College of Psychiatrists. Training was based on the WHO mhGAP materials and a report from the event will be published on the College's website in

due course (http://www.rcpsych.ac.uk/members/international affairsunit.aspx).

New Special Interest Group

In June 2011 the Volunteer and International Psychiatry Special Interest Group was formed. This new Special Interest Group hopes to promote volunteer work internationally and expand the population of people interested in this work. The Special Interest Group will also promote appropriate training materials for volunteers overseas and will have a fundraising role in order to support this goal. Members of the College can join this new Special Interest Group via the members area of the College website (http://www.rcpsych.ac.uk/member.aspx) or by contacting the College's Membership Office on 0207 235 2351 ext. 6280 or 6281. Non-College members wishing to join should email Dr Peter Hughes at dppmh@hotmail.com

UN General Assembly on NCDs

The UN is holding a summit on non-communicable diseases (NCDs – cancers, cardiovascular diseases, chronic respiratory diseases and diabetes) in New York in September 2011. The aim of the summit is to agree on a global strategy to address NCDs. The omission of mental health conditions from the NCDs being considered has prompted a great deal of lobbying by non-governmental organisations and health associations.

New Chair of the BMA

Congratulations to Baroness Professor Sheila Hollins, who has been elected as the new President of the British Medical Association. Baroness Hollins will succeed Sir Michael Marmot in 2012.

Training in child and adolescent psychiatry in Europe

Sir: We write as the current and past chairs of the Child and Adolescent Psychiatry (CAP) working group of the European Federation of Psychiatric Trainees (EFPT) to highlight the work of our organisation. The EFPT is an independent federation of psychiatric trainee associations and a European forum for psychiatric trainees

in all branches of psychiatry in Europe. It aims to facilitate the exchange of ideas, improve training and develop national trainee organisations for psychiatrists, and it brings together trainees in more than 32 countries.

Delegates meet at an international forum annually, and work on projects relating to psychiatric training throughout the year. The EFPT acknowledges that CAP and adult psychiatry are two separate, though closely linked, specialties. We therefore recommend that a CAP trainee as well as a general psychiatry trainee attend each forum where

possible. A CAP working group meets at the EFPT annual forum to discuss issues of relevance to CAP trainees, to facilitate the exchange of ideas and experiences. The group also produces training recommendations. Existing recommendations are that a minimum of 5 years of postgraduate training is required, 4 of which should be pure CAP experience. The group recommends that CAP trainees should gain experience both within a broad range of age groups and across varying settings of care. It also recommends that for the remaining training period, trainees should have the opportunity to gain basic clinical experience in related specialties, including adult psychiatry and paediatrics.

The CAP working group at the EFPT forum 2009 recognised the variation in training, and that we were in a good position as a representative body to collate this information. In many member countries, trainees experience difficulty accessing training. To learn more about this, we surveyed trainees to gain insights into current training (2009–10), recording training information for countries across our membership. In 2010–11 this international survey was expanded significantly to cover all aspects of training in detail. To date, our surveys have demonstrated a number of disparities in a number of areas, including perceived training quality and structure, access to supervision, psychotherapy and research.

The aims of recording and sharing information on training are to improve international understanding of training in CAP, and to alert trainees and trainers to areas where further work is required to improve training. We are highlighting the results of these surveys by exchanging information with other psychiatry organisations such as the UEMS (European Union of Medical Specialties), ESCAP (European Society of Child and Adolescent Psychiatry) and EPA (European Psychiatric Association). The EFPT has long-standing links with these organisations, and we welcome increasing trainee involvement in their structures.

The EFPT CAP working group intends to expand these initiatives, by annually recording information on training throughout Europe. Development of our training database is crucial to this. Thus we hope to add depth to current understanding of training in subsequent years through the goodwill of participating CAP trainees in Europe.

Meinou Simmons[1] and Elizabeth Barrett[2]

[1]Cambridge, UK, EFPT CAP Secretary 2010–11,
email meinou.simmons@gmail.com;
[2]Dublin, Ireland, EFPT CAP Secretary 2009–10

A new child and adolescent mental health service in low-income countries

Sir: Mental disorders of children and adolescents represent a key area of concern from demographic and epidemiological perspectives and in relation to the burden of disease (World Health Organization, 2003). About 35–45% of the population in low-income countries are under the age of 18 years; among them 20% are suffering from a diagnosable mental illness (World Health Organization, 2000). We need to find a way to bridge the gap between need and service provision in these communities.

In low-income countries, children and adolescents are subject to a large diversity of conditions – poverty, malnutrition, infectious diseases and illiteracy – which affect their physical and psychological well-being. Conversely, some factors tend to make people more resilient, such as a supportive traditional society, a high degree of cohesiveness within the family, a stable and supportive environment, affirmative learning and teaching experiences, and parental authority. Low-income countries have a small number of psychiatrists and few child and adolescent psychiatrists. To deal with this situation, we need to adopt a less resource-driven model, one that involves 'specialist workers' more (parents, teachers, child health staff, general practitioners, social workers, counsellors, volunteers). The allied professionals and the 'potential workforce' have to be trained. Active collaboration between health, social and educational agencies and the active involvement of the private sector are required.

A standard model for delivering a child and adolescent mental health service (CAMHS) will consist of primary (primary health centres and community teams), secondary (general hospitals and clinics) and tertiary levels (specialist hospitals and clinics). At the primary level it will be delivered to out-patients and the community through general physicians, primary health workers, health counsellors, teachers, trained child mental health workers and trained parents. At the secondary level the care will be delivered to in-patients, the clients of specialist clinics, out-patients and community members through non-specialist and specialist services, such as trained general practitioners, paediatricians, neurologists, general psychiatrists, psychologists/behavioural scientists, social workers and so on, via clinic and outreach platforms. At the tertiary level the service will be delivered to in-patient, out-patient and specialist clinics through child and adolescent psychiatrists and clinical psychologists, child and adolescent psychiatric social workers, and psychiatric nurses specialising in child and adolescent psychiatry.

For proper implementation we need short- and medium-term training courses for postgraduate doctors, trainers and the 'potential workforce'. Also, we need outreach facilities at primary health centres, as well as outreach clinics and specialist clinics at secondary and tertiary levels. Integration with the existing health service will be done by training the current workforce and by providing support from trained specialists. Outreach clinics will support local primary care physicians, but also the primary care physicians will refer patients to the secondary and tertiary centres. Multidisciplinary teams will be formed at secondary and tertiary levels that will perform specific duties and will coordinate with other members of the health service.

Mohammad S. I. Mullick[1] and Noor Ahmed Giasuddin[2]

[1]Professor of Child and Adolescent Psychiatry, and Chairman, Department of Psychiatry, Bangabandhu Sheikh Mujib Medical University, Dhaka, Bangladesh, email msimullick@gmail.com; [2]Assistant Professor, Department of Psychiatry, Faridpur Medical College, Faridpur, Bangladesh

World Health Organization (2000) *The World Health Report 2000: Health Systems: Improving Performance*. WHO.

World Health Organization (2003) *Caring for Children and Adolescents with Mental Disorders: Setting WHO Directions*. WHO.

Forthcoming international events

24–28 August 2011
WCP 2011 – World Congress of
Psychotherapy
Sydney, Australia
Organiser: World Council for Psychotherapy
Email: wcp2011@arinex.com.au
Website: http://www.wcp2011.org

1 September–3 September 2011
Joint Congress of the European Association
for Mental Health in Intellectual Disabilities
& the IASSID SIRG for Challenging
Behaviour & Mental Health
Manchester, UK
Organiser: British Psychological Society
Contact: Samantha Smith/Reshma Oza
Website: http://www.mhid2011congress.co.uk

2 September–4 September 2011
14th ICPP: Ethics, Experience and Evidence –
Integration of Perspectives in Psychiatry
Gothenburg, Sweden
Organiser: Swedish Association for Philosophy
and Psychiatry
Contact: Helge Malmgren
Website: http://www.phil.gu.se/sffp/sffp_eng.
html

7–10 September 2011
14th Conference of the International
Society for Neuroimaging in Psychiatry
Heidelberg, Germany
Organiser: ISNIP/ISBET/ECNS
Website: http://isnip2011.unitt.de

13–17 September 2011
26th World Congress of International
Association for Suicide Prevention
Beijing, China
Contact: Ms Ye Rong
Website: http://www.iaspchina.org

18–22 September 2011
World Psychiatry 2011: Our Heritage and
Our Future
Buenos Aires, Argentina
Organiser: World Psychiatric Association
Website: http://wpa-argentina2011.com.ar

24–25 September 2011
EUFAMI 5th European Congress:
Community Care – A Blessing or a Curse?
Basel, Switzerland
Email: ritag@eufami.org
Website: http://www.eufami.org

5–8 October 2011
II International Congress of Dual Disorders:
Addictive Behaviours and Other Mental
Disorders
Barcelona, Spain
Organiser: Spanish Society of Dual Disorders
Email: secretariat@cipd2011.com
Website: http://www.patologiadual.es/cipd2011

12–14 October 2011
American Psychotherapy Association
Executive Summit
Branson, Missouri, USA
Contact: Jessica Campbell
Website: http://www.americanpsychotherapy.
com/conference

16–18 October 2011
6th International Conference on Psychiatry
Dhaka, Bangladesh
Contact: Prof. Md. Golam Rabbani
Website: http://www.bap.org.bd

17–21 October 2011
World Federation for Mental Health
Conference
Cape Town, South Africa
Contact: Natalie Kensley
Website: http://www.wmhc2011.com

19–22 October 2011
7th European Congress on Violence in
Clinical Psychiatry
Prague, Czech Republic
Organiser: European Violence in Psychiatry
Research Group
Email: info@oudconsultancy.nl
Website: http://www.oudconsultancy.nl/
MAILING/Prague

25–27 October 2011
International Conference on Global Health
and Public Health Education
Hong Kong
Organiser: School of Public Health and Primary
Care, CUHK
Email: cuhksphpc2011@cuhk.edu.hk
Website: http://www.sphpc.cuhk.edu.hk/
conference2011

5–6 November 2011
The Fifth International Congress of the
Asian Society Against Dementia
Hong Kong, China
Organiser: Chinese Dementia Research
Association, Asian Society Against Dementia
and Hong Kong College of Psychiatrists
Contact: Ms Sabrina Hung
Website: http://www.asad2011.org.hk/

15–17 November 2011
ISAD 2012: Affective Disorder – Mind, Body
and Society
London, UK
Organisers: International Society for Affective
Disorders
Website: https://www.isad.org.uk/conference.asp

15–17 November 2011
2nd Bergen Conference on the Treatment of
Psychopathy
Bergen, Norway
Organiser: Haukeland University Hospital and
Greater Manchester West Mental Health NHS
Foundation
Contact: Steffen Stamn
Website: http://www.bctp.no

Contents of the *African Journal of Psychiatry* (affiliated journal)

Volume 14, Number 2, May 2011