

2nd Annual International Mental Health (IMH) at the IOP

Wednesday 31st August 2005

- 09:15 Welcome
George Szmukler - Institute of Psychiatry
Shekhar Saxena – World Health Organisation
- 09:30 Keynote Speaker
Sir Andy Haines – London School of Hygiene and Tropical Medicine: Prospects for the attainment of UN Millennium Development Goals and the potential contributions of improved mental health
- 10:30 – 11:00 Tea
- 11:00 – 12:30 Plenary Session 1 – MDG/HIV/AIDS
Melvyn Freeman – South Africa: The mental Health Consequences of the HIV/AIDS epidemic in Africa – page 11
Sylvia Kaaya – Tanzania: Mental Health and its Relevance to Prevention and Treatment page 11
Frances Cowan – Zimbabwe: Community Interventions for Primary Prevention page 11
- 12:30 – 13:30 Lunch
- 13:30 – 14:30 Plenary Session 2 – MDG/Mental Health and Child Health
Atif Rahman – Pakistan: Maternal Depression and Infant Growth and Development - page 12
Anthony Costello: Maternal Interventions to Prevent Infant Mortality – The Nepal Experience – page 13
- 14:30 – 15:00 Plenary Session 3 – Achieving the MDGs – intersectoral approaches
Joseph Mbatia – The Government Sector – page 13
- 15:00 – 15:30 Tea
- 15:30 – 16:00 **Chris Underhill** - The NGO sector
- 16:00 – 17:10 Commentaries and Panel discussion
- 17:30 – 18:30 Invited Guest Lecturer
Professor Norman Sartorius: Millennium Development Goals: Risks, Gains and Tasks for Mental Health Programmes – page 14
- 18:30 Reception/Dinner

Thursday 1st September 2005 – Themed Research Presentations

SUMMARY PROGRAMME

	ROOM A	ROOM B	ROOM C
1st morning 09:00-10:30	Session: Child and Adolescents I	Session: Stigma	Workshop: Mental Health Service Development
TEA 10:30-11:00	POSTER EXIBITION		
2nd morning 11:00-12:30	Session: Eastern Europe	Session: Africa Mental Health Initiatives	Session: Cross-cultural research
LUNCH 12:30-13:30			
1st afternoon 13:30-15:00	Session: Psychosis	Session: Epidemiology	Workshop: Getting started in research
TEA 15:00-15:30	POSTER EXIBITION		
2nd afternoon 15:30-17:30	Session: Violence	Session: Responses to war and natural disaster	Session: Policy

MORNING

09:00 – 12:30

PARALELL SESSIONS – ROOM A

1. Child and Adolescent I

09:00 – 10:30

Chair: **Professor Robert Goodman**

Damanjit Sandhu: Psycho-social Predictors of Identity Formation in Adolescence – page 17

Priya Anaokar: Promoting Child Mental Health Through Preventive Interventions – page 17

Marilynn McDonald: Engaging socially excluded parents into multi-family groups: a values-and-evidence-based approach to preventing mental health problems – page 18

Anula Damanyanthi Nikapota: Training in child mental health – an international perspective – page 19

10:30 – 11:00 Coffee Break

2. Eastern Europe

11:00 – 12:30

Chair: **Robin Jacoby**

Vesna Jordanova: Pathways to care in Eastern Europe – page 22

Simon Surguladze: Insight into psychosis and availability of therapeutic environment: Georgian experience – page 22

Katarzyna Kucharska-Pietura: Cognitive and emotional dysfunction in schizophrenia. Evidence for progressive deficit? – page 23

Rudolf Uher: Au pairs and eating disorders in the new Europe – page 23

12:30 – 13:30 Lunch

PARALLEL SESSIONS – ROOM B

1. Stigma

09:00 – 10:30

Chair: **Professor Graham Thornicroft**

Chombe Gondwe: HIV/AIDS in Africa – page 19

Lisa Davies: Disquiet, dismay and disrepute: contemporary stigma and ignorance about employees with depression in some modern Australian workplaces – page 20

Chris Papadopoulos: Stigma Towards People with Mental Health Problems: An Individualism-Collectivism Cross-Cultural Comparison – page 20

Joanne Kim: What Peer-Run Mental health Organizations Teach us about the Barriers and Influences for Recovery and Reintegration – page 21

10:30 – 11:00 Coffee Break

2. Africa Mental Health Initiatives

11:00 – 12:30

Chair

Dr Sylvia Kaaya

Julia Eaton: The Effect of Training Village-based Health Workers in Mental Health Awareness on Utilisation of Community Psychiatric Services – page 24

Marian Muller: Effectiveness of one week training in mental health for primary care health workers in rural Tanzania – page 24

Oludotun Olugbemi: Mental health: less apparent but not less important – page 25

Paul Moore: Mental health and Human Rights in Africa – page 25

12:30 – 13:30

Lunch

PARALLEL SESSIONS and WORKSHOPS – ROOM C

1. Workshop

09:00 – 10:30

Convenor Shekhar Saxena: Mental health service development – page 21

10:30 – 11:00

Coffee Break

2. Parallel Session – Cross Cultural Research

11:00 – 12:30

Chair:

Dr Vikram Patel

Nasir Warfa: A cross-national comparison of social factors, life events and common mental health problems among Somali refugees in Minneapolis (USA) and London (UK): A quantitative study – page 26

Mohamed I. El-Wafi: Cultural Issues in Mental Health Practice in Lybia Arab Jamahiriya – page 27

Hyong Jin Cho: A cross-cultural comparison of chronic fatigue and chronic fatigue syndrome between Brazil and the United Kingdom – page 27

Anita Puri Singh: Simhastha: A community mass syndrome (CMS) – page 28

12:30 – 13:30

Lunch

AFTERNOON

13:30 – 17:30

PARALLEL SESSIONS – ROOM A

1. Psychosis

13:30 – 15:00

Chair: **Professor Robin Murray**

Geraldo Busatto: Population-based studies of first-episode psychosis in Brazil: structural brain abnormalities and relationship with duration of untreated symptoms – page 29

KS Jacob: Insight in people with psychosis – page 29

Pauv Bunthoeun: Psychological treatment of schizophrenia in Cambodia – page 30

15:00 – 15:30 Tea

2. Violence

15:30 – 17:30

Chair: **Professor KS Jacob**

Jay S. Sweifach: A culture Sensitive approach to recovery: Domestic Violence in the Orthodox Jewish Home – page 33

Jair Mari: The Cultural Construction of Depression among Women Living under Violence and Poverty in a Community in the Outskirt of Sao Paulo – page 33

Isabel Bordin: Familiry Mental Health Problems and Violence as Correlates of Severe Physical Punishment of Poor Children – page 35

Cleusa Ferri: The Impact of Violence on Maternal and Newborn Health: a Survey of Adolescent Mothers in Sao Paulo, Brazil – page 35

Muhammed Lafta: Domestic Violence among females employees of Iraqi Ministry of Health – page 36

PARALLEL SESSIONS - ROOM B

1. Epidemiology

13:30 – 15:00

Chair: **Dr Jair Mari**

Kaniz Gausia: Validation of the Bangla version of the Edinburgh Postnatal Depression Scale for Bangladeshi sample – page 30

Renata Sousa: Disablement and Common Mental Disorders Among Adults in Great Britain – a secondary analysis of the 2000 ONS Survey in Great Britain – page 31

Henrikje Klasen: Poverty and Child Psychopathology – using Dutch longitudinal epidemiological data to contribute to the debate – page 32

Omar Moghraby: Mental Health and Risky Behaviour in adolescents - cross-sectional study in Durban, South Africa page 32

15:00 – 15:30 Tea

2. Responses to War and Natural Disaster

15:30 – 17:30

Chair: **Dr Athula Sumathipala**

Anthony T. Ng: Disaster Response and Staff Wellness – A public Health Approach – page 36

Ravi Samuel Dhanaraj: Psychological Rehabilitation for Tsunami affected Area in Chennai – India – page 37

Ernest Hunter: Disasters big and small: opportunities for system change – page 38

Laila Farhood: Posttraumatic Stress Disorder, Anxiety and Depression among civilian population in South Lebanon – page 38

Helen Herrman: Is mental health promotion relevant to countries in conflict? – page 39

Lynne Jones: Integrating mental health into primary health care in war and disaster affected communities – page 39

PARALLEL SESSION and WORKSHOP - ROOM C

1. Workshop

13:30 – 15:00 **Martin Prince and Vikram Patel**
Getting started in research – page 33

15:00 – 15:30 Tea

2. Parallel Session – Policy

15:30 – 17:30

Chair: **Professor Rachel Jenkins**

Stuart Marchant: The role of mental health legislation in the development of international mental healthcare – page 40

Celia Jane Briar: Public policies to improve the mental health of working mothers – page 41

Nicole Jayne Highet: Managing depression and related disorders in the workplace: a national response across Australia – page 41

Helen Keleher: Evidence for effectiveness of mental health promotion – page 42

Friday 2nd September 2005 – Plenary sessions and Parallel sessions

MORNING

09:00 – 12:30

PLENARY SESSION:

Mental Health NGOs

- 09:00 – 09:30 **Jane Gilbert:** UK NGOs and International Mental Health: an explanatory review – page 15
- 09:30 – 10:00 **Shoba Raja:** Mental Health And Development: A Powerful Evidence Base Across Borders – page 14
- 10:00 – 10:30 Panel discussion
- 10:30 – 11:00 Tea

PARALLEL SESSION – ROOM A

1. Child and Adolescence II

11:00 – 12:30

Chair: **Dr Anula Nikapota**

Ia Shekriladze: Permanency – A Precondition for Children’s Healthy Development – page 42

Cristiane Silvestre de Paula: Prevalence of mental health problems in children and adolescents from the outskirts of Sao Paulo city: estimating service need and capacity – page 43

Eunice Nakamura: Child depression in Greater Sao Paulo, as a particular stance of the doctor-family-of-patient relationship, in an ethnological approach – page 44

Metin Donma: Could children’s reactions to paediatric examination be related to socioeconomic status, which may affect mental health? – page 44

PARALLEL SESSION – ROOM B

1. Africa Mental Health – Research and Policy

11:00 – 12:30

Chair: **Professor Melvyn Freeman**

Kwabena Otoo Siaw: Measures to improve Mental Health in Africa: Ghanaian Perspective – page 45

Ursula Mary Read: An ethnographic study of living with mental illness in Ghana – page 45

Souci Frissa: A population-based study of the outcome of major depression in a sub-Saharan African country – page 46

Bushra Habbani: NGO – a question of quality – page 46

PARALLEL SESSION – ROOM C

1. Depression

11:00 – 12:30

Chair: **Professor Helen Herrman**

Orkide Donma: Trace elements: Could they be a possible solution to reduce mortality from suicide in depressed subjects? – page 47

Erico Costa: Is GDS-30 better than GHQ-12 to screening depression in the elderly in the community? The Bambui Health Ageing Study (BHAS) – page 48

Kari Kvaal: Anxiety and depression disorders among elderly Norwegians – page 48

Nicole Jayne Highet: The development and workings of beyondblue, the national depression initiative and its engagement with consumers and carers – page 49

Nicole Jayne Highet: Improving depression literacy in Australia, has this changed over time and how? – page 50

12:30 – 13:30

Lunch

AFTERNOON

13:30 – 18:30

PLENARY SESSION – closing

Responding to major disasters – the experience of the Asian Tsunami

13:30 – 14:30 **Shekhar Saxena – World Health Organisation – page 15**

14:30 – 15:00 Tea

15:00 – 15:30 **Athula Sumatipala-Advisor to Sri Lanka Government**

15:30 – 16:00 **Hiranthi da Silva – Director of Mental Health, Sri Lanka**

16:00 – 16:30 **Chintha Munasinghe and Neil Fernando – Basic Needs Sri Lanka**

16:30 – 17:20 Panel discussion

17:20 **Closing session: Prize Awards**

PLENARY ABSTRACTS

Mental Health and HIV/AIDS in Africa

Professor Melvyn Freeman – South Africa

This presentation examines relationships between HIV/AIDS and mental health and the impacts of the pandemic on various infected and affected people eg people living with HIV/AIDS, carers, children left vulnerable and orphaned and on society as a whole. It will be argued that the cumulative impacts in countries with high HIV prevalence levels is likely to be greater than the sum of the parts – though the introduction of anti-retroviral (ART) medication has the potential to substantially improve this situation. Nonetheless with ART many more people will be living with HIV and this too will create new challenges in mental health treatment and care. The presentation will then describe a WHO intervention to integrate mental health into the “3 by 5” initiative (to get 3 million people on ART by 2005). By including mental health in this programme it is intended that both mental and physical health can be improved ie directly and through raised levels of adherence to ART.

Mental health and its relevance to prevention and treatment of HIV/AIDS

Dr Sylvia Kaaya – Tanzania

There is increasing evidence for need for comprehensive strategies, including access to mental health services, for the prevention and treatment of HIV/AIDS. This presentation focuses on the challenges of providing mental health services for persons with HIV/AIDS in developing countries.

The relevance of mental health services for the promotion of healthy sexuality development, prevention of HIV/AIDS transmission risks, adjusting to HIV positive serostatus and adhering to health promoting practices in persons living with HIV/AIDS are discussed; drawing many examples from the situation in Tanzania. The implications for operational research are briefly touched upon.

Regai Dzive Shiri Project – a community randomised trial of an adolescent reproductive health intervention

Dr Frances M Cowan, Centre for Sexual Health and HIV Research, University College London.

The Regai Dzive Shiri Project is a community randomised trial of an adolescent reproductive health intervention being run in 30 rural communities in three provinces in Zimbabwe. The intervention comprises i) a youth programme ii) a clinic programme and iii) a community based programme aimed at parents. The impact of the intervention will be measured in a cohort of adolescents (Form 2 pupils) who will be followed for 4 years. 15 communities have been randomly selected to receive the intervention early. In 15 communities implementation will be deferred until 2007.

Randomisation was conducted using a restricted randomisation procedure, which ensured balance between early and deferred intervention communities in terms of the district, the distance a community was from a tarred road and the number of pupils enrolled. In each community five community advisory board members have been recruited and trained.

A cohort of 6791 students (3270 girls and 3521 boys; average age 15.2years) were recruited from 82 secondary schools, in 30 communities, was enrolled in 2003. This comprised 87% of those eligible for inclusion. Each participant had a dried blood sample tested for HIV-1 antibodies and completed baseline questionnaire collecting socio-demographic, knowledge, attitude and behaviour information.

Analysis of the baseline data established an overall prevalence of HIV of 0.75% (95% CI: 0.56-0.99). HIV prevalence among boys was 0.57% and among girls 0.95%. Age, education, other demo characteristics Factors associated found to be associated with HIV. 35% (95% CI: 33.9-36.2%) of the RDS cohort are orphans and over 25% of these orphans have lost both parents. Orphaned participants are at increased risk of HIV compared to non-orphans (Age-adjusted OR=3.4; 95% CI: 1.9-6.1) and make up the majority of the HIV infected participants.

In addition, a social scientist team is conducting ongoing research to complement the quantitative results including process evaluation of the intervention, a substudy to examine the evolution of sexual behaviour in young people which will look specifically at the broad context of vulnerability to HIV and a substudy to develop valid tools for measuring behaviour in this setting.

Maternal depression and infant growth and development

Dr Atif Rahman - Wellcome Research Career Development Fellow in Tropical Medicine/University of Manchester/Institute of Psychiatry/ Rawalpindi - Pakistan

Depression is the fourth leading cause of disease burden and the largest cause of non-fatal burden, accounting for almost 12% of all total years lived with disability worldwide. Women of child-bearing age in developing countries are twice as likely to suffer from depression compared to men.

Maternal depression has important direct and indirect bearings on Millennium Development Goals (MDGs) – maternal health; strategies for dealing with poverty alleviation; and issues of gender equality and empowerment. In addition, recent evidence provides compelling evidence that maternal depression in the antenatal and postnatal period leads to poorer growth and higher morbidity from diarrhoea in infants, thus directly influencing child health and nutrition.

Findings from a follow-up study of 320 mothers and infants in Rawalpindi, Pakistan show that infants of antenatally depressed mothers are more likely to have low birthweight than controls (Relative risk 1.9; 95% CI 1.3 – 2.9). The association becomes stronger in the postnatal period, relative risk for being underweight (weight-for-age z-score < -2SD) is 4.0 (95%CI 2.1-7.7) at 6 months and 2.6 (95% CI 1.7-4.1) at 12 months, while the risks for stunting (length-for-age z-score < -2SD) is 4.4 (95%CI 1.7-11.4) at 6 months and 2.5 (95% CI 1.6-4.0) at 12 months. Relative risk for ≥5 diarrhoeal episodes per year is 2.4 (95% CI 1.7-3.3).

Early treatment of antenatal and postnatal depression could benefit not only mothers' mental health but also infants' physical health and development. Strategies for intervention are discussed and one such activity, the 'Thinking Healthy Programme', being carried out in Rawalpindi, Pakistan, is described.

Maternal interventions to reduce infant mortality - the Nepal experience

Professor Anthony Costello - Institute of Child Health, University College London
- UK

Neonatal deaths in developing countries make the largest contribution to global mortality in children younger than 5 years. 90% of deliveries in the poorest quintile of households happen at home. We postulated that a community-based participatory intervention could significantly reduce neonatal mortality rates.

We pair-matched 42 geopolitical clusters in Makwanpur district, Nepal, selected 12 pairs randomly, and randomly assigned one of each pair to intervention or control. In each intervention cluster (average population 7000), a female facilitator convened nine women's group meetings every month. The facilitator supported groups through an action-learning cycle in which they identified local perinatal problems and formulated strategies to address them. We monitored birth outcomes in a cohort of 28931 women, of whom 8% joined the groups. The primary outcome was neonatal mortality rate. Other outcomes included stillbirths and maternal deaths, uptake of antenatal and delivery services, home care practices, infant morbidity, and health-care seeking.

The neonatal mortality rate was 26·2 per 1000 in intervention clusters compared with 36·9 per 1000 in controls (adjusted odds ratio 0·70 [95% CI 0·53-0·94]). The maternal mortality ratio was 69 per 100000 in intervention clusters compared with 341 per 100000 in control clusters (0·22 [0·05-0·90]). Women in intervention clusters were more likely to have antenatal care, institutional delivery, trained birth attendance, and hygienic care than were controls. The cost of the intervention was \$US 0.75 per capita.

Birth outcomes in a poor rural population improved greatly through a low cost, potentially sustainable and scalable, participatory intervention with women's groups. This approach is being replicated in Bangladesh, India and Malawi, with evaluation of other health outcomes such as malaria and mother-to-child transmission of HIV, and might also be evaluated to reduce post-natal depression and poor infant growth. The presentation will speculate on why and how the intervention may have worked.

Mental Health and the Millennium Development Goals - Government Approaches

Joseph Mbatia - Tanzania

In Tanzania, the MDGs are implemented through a National Strategy for Growth and Reduction of Poverty (NSGRP). The National strategy for Growth and

Reduction of Poverty is a 5 years plan 2005/06 – 2009/10. The end point of this strategy coincides with the end of two thirds of the way towards the MDGs (2015).

The NSGRP is linked to debt relief. Debt relief and other resources are to be channeled into priority sectors of education, health, water, agriculture, rural roads, judiciary and land. Spending on these areas is expected to impact on poverty reduction. Poverty is multidimensional in nature and recent analytic evidence shows that poverty and inequality are high in Tanzania. To reduce poverty much more resources are required and the roles of all key sectors clearly defined. The NSGRP adopts “outcomes approach which counts on the contribution of all sectors towards growth and poverty reduction. The approach stresses cross sector collaboration, inter sector linkages and synergies. The strategy is dependent on increased commitment of domestic stakeholders and increased assistance from development partners.

Millennium Development Goals: Risks, Gains and Tasks for Mental Health Programmes

Professor Norman Sartorius, MD, PhD, Geneva, Switzerland

The achievement of the Millennium Development Goals (MDG) could improve mental health of the world’s population. The process of achieving them however holds also risks for progress in the field of mental health. The lecture will list some of the gains and some of the risks and suggest action that the mental health programmes should undertake to draw maximum benefit from the striving to reach the MDG. The lecture will also propose additional goals that might be of equal urgency for socioeconomic development as the MDG

Mental Health And Development: A Powerful Evidence Base Across Borders

Shoba Raja - Programme Manager Policy and Research Programme, India

In pursuance of the Millennium Development Goals (MDGs) in health, the WHO commission on Macroeconomics and Health has come up with ten major recommendations. These emphasise ways of generating evidence of health related epidemiology, priorities of poor people, outcomes, financing mechanisms economics, highlighting the paucity of information in the health sector in developing countries.

Mental illness is being recognised as one of the leading burdens of disease globally affecting twice as many poor people as rich. BasicNeeds’ operations in Africa and South Asia reveal that mental illness is widespread in poor communities where the majority remain untreated for many years resulting in loss of family productivity and income, exacerbating their poverty and impacting the economy. Yet there is little hands-on information available about their situation. Governments in Africa and Asia have given themselves the mandate of fighting poverty to meet the MDGs. But people with mental illness have been left out of this fight. There is no one to inform governments realistically about MH policy or practice needs. Yet these governments ARE attempting a paradigm shift in mental health practice from - medico-institutional settings to community interventions. However these initiatives have remained ineffective mainly because

there is very little research evidence available from developing countries that can inform policy makers in policy formulations and resource allocations.

BasicNeeds programmes reach out to 17,173 mentally ill people. Through partnerships with NGOs and importantly with ministries of health, BasicNeeds' operations demonstrate a model that addresses needs of large numbers of people, in communities, needing mental health services. A key factor is that ongoing research captures, in action, evidence of policy and practice blending into a coherent whole. MH policy makers, influencers, implementers, and importantly 'users', are part of implementation and its evidence gathering processes.

UK NGOs and International Mental Health: An Exploratory Review

Jane Gilbert – Independent Clinical Psychologist

Following the first IMH conference last year, it was recognised that the extent and nature of UK NGO involvement in international mental health is not well known, and there have been few opportunities to share best practice and identify priorities. It was thus decided that an exploratory review of mental health and UK based international NGOs would be undertaken.

Semi-structured interviews were carried out with respondents from 19 UK based international NGOs. Topics included, inter alia, areas of operation, examples of programmes, methods of evaluation, funding, and future priorities.

This paper outlines some of the major issues raised by respondents. Areas of controversy are highlighted, conclusions drawn, and recommendations for future directions are put forward.

Responding to major disasters – the experience of the Asian Tsunami

Dr Shekhar Saxena (WHO Department of Mental Health and Substance Use)
Dr Hiranthi de Silva (Sri Lankan Government Director of Mental Health)
Dr Athula Sumatipala (Sri Lankan Psychiatrist/ UK Sri Lanka Trauma Group)
Chintha Munasinghe and Dr Neil Fernando (Basic Needs Sri Lanka)

The magnitude 9.0 (Richter Scale) earthquake that struck the area off the western coast of Sumatra on 26 December, at 7:59 am local time, triggered massive tidal waves that destroyed the lives of people in coastal areas in all countries around the Indian Ocean rim – from Indonesia to Somalia. The latest estimated death toll from the tsunami is 286,000 and 1.6 million people have been displaced. In Sri Lanka alone, 800,000 people have lost their homes. The scale of the disaster stunned the international community and prompted a huge relief effort involving governments, international aid agencies and locally based NGOs and civil society. In the aftermath of the disaster, the immediate needs of survivors were for search and rescue services, fresh water, shelter and medical attention.

The mental health needs of survivors is a crucial aspect of the rehabilitation phase. Families throughout the Tsunami affected areas have experienced severe trauma; family members have died or are still missing, homes

and possessions have been destroyed and livelihoods decimated. An initial rapid assessment carried out by the World Health Organization in Sri Lanka, the Maldives and Indonesia, found that 5-10% of the affected population may develop stress related disorders as a result of the disaster. Up to 100,000 people may require mental health interventions. The WHO has pointed out that post-traumatic stress disorder per se is relatively rare. The majority of excess psychological morbidity attributable to the tsunami will be the 'common mental disorders'; depression, anxiety, somatisation and alcohol use disorders. More seriously suicide is a potential issue because Sri Lanka has a high suicide rate.

These disorders are generally poorly managed in developing countries, which have very limited mental health care resources. In Sri Lanka, for example, with a population of 19 million, there are 30 psychiatrists, 346 mental nurses, 13 social workers and only 4 psychologists working in mental health. They have a key role to play in advocacy, policymaking, planning, and training, but the bulk of the frontline work will fall upon primary health care and other community agencies, including the education and non-governmental sectors.

In this plenary session:

Dr Shekhar Saxena (WHO Mental Health and Substance Use), Dr Hiranthi de Silva (Sri Lankan Government Director of Mental Health), Dr Athula Sumatipala (Sri Lankan Psychiatrist/ UK Sri Lanka Trauma Group), Chintha Munasinghe and Dr Neil Fernando (Basic Needs Sri Lanka) report on the immediate aftermath, and longer term mental health and psychosocial consequences of the tsunami. We will hear of the considerable efforts to plan and implement a coherent and sustained multi-sectoral response in Sri Lanka that would meet the needs of the affected communities. A national mental health policy has been developed. The policy sets out a vision for development of community mental health services and the closure of 3 psychiatric hospitals in Colombo. The policy has been subject to public consultation and a revised version and implementation plan have now gone forward to Parliament.

PARALLEL SESSION ABSTRACTS

1st September - ROOM A – 09:00 – 10:30 - Child and Adolescents I

Psycho-social Predictors of Identity Formation in Adolescence

Dr Damanjit Sandhu – Punjabi University, Patiala – India

Identity formation is an important psychosocial challenge of adolescence, which, when dealt effectively with, results in well-being, whereas, identity diffusion is associated with various indices of maladjustment. However, factors leading to identity formation have been less investigated in Indian culture, which is traditionally collectivistic. Moreover, being autonomous has often been confused with rebellion. The aim of this research was to understand the psychosocial variables which predict identity achievement, moratorium, foreclosure, and diffusion in adolescents. For this purpose, 600 Indian adolescents (300 boys & 300 girls) of age-range 13 to 21 years, belonging to various schools and colleges of city Amritsar (India) were administered:

- (1) Objective Measure of Ego Identity Status – 2 (Bennion & Adams, 1986)
- (2) Emotional Autonomy Scale (Steinberg & Silverberg, 1986)
- (3) Family Environment Scale (Moos & Moos, 1986)
- (4) PGI Well Being Scale (Verma et al., 1986)
- (5) California Psychological Inventory (Gough, 1975)
- (6) Torrance Tests of Creative Thinking, Figural Form A (Torrance, 1966).
- (7) Standard Progressive Matrices (Raven, 1975).

Discriminant analyses was applied. It revealed that variables predicting high identity achievement, high moratorium, low diffusion, and low foreclosure are emotional autonomy, family environments characterized by cohesion, positive interpersonal relationships, encouragement for personal growth and organization, personality patterns of interpersonal/ intrapersonal maturity, character, achievement potential and superior interest modes, well being, and cognitive patterns that reflect creativity and clarity in thought. However lower identity achievement, higher diffusion, and lower moratorium in adolescents is predicted by family conflict and ideational fluency.

Promoting Child Mental Through Preventive Interventions

Mrs Priya Anaokar – Tata Institute of Social Sciences, Mumbai – India

There is increasing evidence on the growing mental health needs of children, with emphasis on a preventive approach with families to address these needs. The last decade has seen the growth of preventive initiatives in India. However, efforts are scattered and little data exists on the nature and outcomes of such interventions. This paper presents the findings of a study undertaken as part of a doctoral thesis aimed to explore the scene of preventive interventions with families, to promote child mental health in urban India.

The study uses an exploratory, multiple case-study design conducted in two phases. Through in-depth documentation of the interventions, the study attempts to gather data on mental health conceptualizations, protective factors being enhanced and perceptions of planners, implementers and participants.

Drawing on emergent themes, within and across interventions, the findings are discussed within an exploratory framework, devoid of any conclusive generalizations. The study observed that a fast changing urban environment, with stress on achievement and academic excellence is perceived as a risk factor to mental health. Families are being involved as targets as well as resources for intervening, with family communication being enhanced as a protective factor. The study reflects the movement of interventions to a community based approach, with parental initiative and empowerment emerging as core concepts.

The study recommends strengthening and interlinking interventions in the various contexts of the child's environments, utilization of indigenous resources supported by evidence-based practice to make intervention research an integral part of the policy agenda.

Engaging socially excluded parents into multi-family groups: a values-and-evidence-based approach to preventing mental health problems in children

Dr Marilyn McDonald – University of Wisconsin-Madison – USA

Two separately conducted randomized controlled trials of community based multi-family support groups suggest significant outcomes at one and/or two year follow-up by teacher's reports of children's mental health indicators. One study was conducted using matched pair design in collaboration with three rural Native American tribes, of 5-7 year old children (N=100 families). The second involved randomization of whole 2nd grade classrooms in a major urban setting, with Mexican immigrant children (N=150 families). Both studies, using different designs and conducted by independent research groups showed reduced aggression/Externalizing, increased social skills and improved academic performance on standardized instruments, and favored the multi-family group intervention over the control or comparison condition.

In both cases, the families were socially excluded from the dominant European-American culture in the US. Several strategies were used to engage and retain involvement in the group sessions. 1) Shared governance: parents worked alongside mental health and other professionals. 2) Cultural representation: if 50% of the families were from any specific cultural or language group, so were 50% of the team. 3) Experiential learning: the focus was on empowering parents within their own family unit, rather than acting as experts and presenting lectures on mental health or giving handouts; 4) Relationship building: laughter and open communication takes place in parent child dyads, parent-parent dyads, and family groups. 5) Repetition: each week for 8 weeks the structured routines are repeated; within the repeated routines, families experience new and positive ways of being with one another.

Evidence based multi-family groups have implications for countries in which there are insufficient resources to provide one to one interventions, for marginalized minorities in countries in which the professionals are primarily from one dominant culture, and for those committed to enhancing local community strengths by investing in parents to become grassroots leaders, rather than increasing dependency upon mental health professionals.

Training in child mental health – an international perspective

Dr Anula Damayanthi Nikapota – Michael Rutter Centre – IOP

Child and adolescent mental health has an evidence base which largely derives from research and service development in Europe and North America. Recent years has seen an expansion in training of professionals internationally at specialist and primary care level to meet generic service needs as well as specific needs arising from conflict and disaster.

Issues that arise include identification of risk and an understanding of the ways in which risk may be defined in different sociocultural contexts. A particular issue relates to the role of poverty and risk. Cultural beliefs may also determine perception of disorder and the ways in which children manifest distress.

A crucial aspect for discussion and debate relates to what is valid and should be taught and what may be inherently biased towards a Western model and hence be culture inappropriate. Other issues relate to what may be feasible and appropriate in terms of service provision.

The author will draw on the experience of teaching internationally and from the outcomes of the international courses based at the Institute of Psychiatry

ROOM B - 09:00-10:30 - Stigma

HIV/AIDS in Africa

Mr Chombe Gondwe

The HIV/AIDS epidemic has several derogatory names in vernacular among them *kanayaka* (meaning the red light is on- implying that one is HIV positive.) *moving coffins*, *kalaye noko* (say bye to your mother) all of these names show how HIV is feared and how people living with it are often treated like walking zombies to be avoided. Such stigmatized and dehumanizing labels lead People Living With HIV/AIDS (PLWHA) to experience severe discrimination at almost every turn of their lives.

Discrimination is denial and abuse of human rights. The need to protect and promote the human rights of PLWHA has been widely accepted as the means of eradicating discrimination. There is need to move away from a culture of stigma and discrimination to a culture of rights if the pandemic is to be successfully fought. Discrimination increases vulnerability to infection and women and vulnerable groups are particularly at risk of infection-largely because of unequal status in society.

Stigma is a complex issue to address, however there may be a way out. Governments should now realize the importance of signing and enacting the United Nations General Assembly Special Session on HIV/AIDS (UNGASS declaration), which commits Countries to eliminate all forms of discrimination against people living with HIV/AIDS and members of vulnerable groups.

Disquiet, dismay and disrepute; contemporary stigma and ignorance about employees with depression in some modern Australian workplaces

Ms Lisa Davies – University of South Australia - Australia

An increasing concern about the impact of depression on the Australian workforce has emerged. Hickie (2001) stated that depression is affecting over 800,000 Australians every year and is associated with a loss of over six million working days annually. Given this assertion, both the social and the economic implications are significant. However, it emerges that despite increasing media attention and associated dissemination of information about depression, some people are undereducated about it.

Some employees in the deregulated sector of Information Technology in South Australia, a microcosm of the modern workforce, exemplify this lack of relevant knowledge. Workers and employers alike stigmatise depression, leading to denial of its validity or existence; this in turn leads to the perpetration of discriminatory behaviours and allied human rights violations against sufferers.

When interviewed about their accessibility to work based education about depression and to ask their opinions regarding the merit of such education, many people with personnel responsibilities in both International and local organisations in that sector, described education about depression as not work related, not of interest to engineers and too expensive. The pragmatism with which employees are treated is justified by personnel staff who cite the restraints associated with the demands of economic rationalism. In so doing, they utilise stigmatising language which further reflects a generalised ignorance about depression.

The perpetration of such perceptions in modern organisations in this Millennium further highlights the need for work-based education which will negate pervasive workplace disenfranchising beliefs and practices about people with depression.

Stigma towards people with mental health problems: an individualism-collectivism cross-cultural comparison

Mr Chris Papadopoulos – Middlesex University – United Kingdom

There has been much work on investigating the vast array of psychological differences that exist between cultures (Hofstede 1980, 1991; Triandis 1985, 1995, 2001; Berry 1996). One of the main paradigms in understanding cross-cultural differences is that of the collectivism-individualism dimension (Triandis 1985, Hofstede 1991).

In 'collectivist' cultures, people are described as being interdependent with their in-groups (family, community, tribe etc), give priority to the goals of their in-groups, shape behaviour primarily on the basis of in-group norms, and behave in a communal way. People from 'individualistic' cultures are described as being autonomous and independent from their in-groups and give priority to their personal goals than to their in-group goals.

I wish to examine whether, how and why stigmatisation towards people with mental health problems differs in collectivist and individualistic cultures. The issue of stigma around mental illness is important for prevention, early detection and community treatment of psychiatric disorders (Malla and Shaw, 1987). I will also explore whether and how acculturation affects the individualism-collectivism hypothesis with regard to this particular social phenomenon.

My main aim, however, is to use the findings of this study to further our understanding of the way culture influences stigmatisation to people with mental health problems, so that health-care professionals are more culturally sensitive and competent when working with both patients and their families.

What Peer-Rub Mental Health Organizations Teach us about the Barriers and Influences for Recovery and Reintegration

Ms Joanne Kim – Dartmouth College – United States of America

This paper explores the American consumer/survivor/ex-patient movement and their relation to modern mental health advocacy and recent anti-psychiatry ideologies. For three months, I conducted ethnographic fieldwork at two consumer-run mental health organizations that were drastically different in terms of membership, location, ideology, and effectiveness.

The Ruby Rogers Center, a self-governed offshoot of the Mental Patients Liberation Front, helped members avoid hospitalizations, homelessness, and crime, but furthered their segregation and did not necessarily encourage members to seek employment and behave in ways deemed socially appropriate. The Cole Center, affiliated with McLean Hospital and Manic-Depressive/Depressive Association, featured a unique skillbuilding approach that seemed more accessible and serviceable to motivated middle to upper class users with depression and bipolar disorder.

Utilizing interviews and participant observation, I compared the worklife of these self-help treatment/advocacy groups and their efficacy in helping members recover and reintegrate into the outside community. The study's results observed class, race, and experiential factors that influenced perceptions and outcomes with mental illness and specific service interactions that perpetuated dependence, helplessness, victimology, and isolation and impeded the recovery and reintegration.

Also examined are organizational strategies for endorsing independence, resilience, perseverance, individual accountability, social skills, employment motivation, positive mindset, and self-reliance.

ROOM C – 09:00 – 10:30 - Workshop

Mental Health Service Development

Shekhar Saxena - WHO

Are you involved in, or interested in the development of responsive and effective services for people with mental health problems? The aim of this participatory workshop is:

- 1) to allow participants to share experiences,
- 2) to seek to identify challenges and obstacles, and how they might be overcome
- 3) to identify aspects of good practice
- 4) to consider the generalisability (and/ or culture specificity) of models of care

Dr Saxena will set the scene for the workshop by describing the WHO AIMS project - Strengthening Mental Health Services in Resource Poor

Settings. This programme is working in 18 countries in Latin America, India, China, Africa and the middle East

ROOM A – 11:00-12:30 – Eastern Europe

Pathways to care in Eastern Europe

Dr Vesna Jordanova – Institute of Psychiatry, London - UK

The E-EPSI group (Eastern European Psychiatric Scientific Initiative) is a recently formed group of psychiatrists who are aiming to obtain evidence about mental health services in Eastern Europe and make suggestions concerning their improvement based on it. There has been almost no mental health service research in the region. A pathways study is a useful starting point, can be completed quickly and requires few resources.

To gain a better understanding of prior care seeking and treatment of new patients seen at mental health services.

A collaborative study was carried out in eight centres: Belgrade in Serbia-Montenegro, Bucharest, Iasi and Tg Mures in Romania, Sofia in Bulgaria, Strumica in Macedonia, Tirana in Albania and Zagreb in Croatia. All patients that were newly referred to the psychiatric services and agreed to participate were interviewed until the target of 50 patients were recruited in each centre. The Pathways Encounter Form was used. Pathways Diagrams were drawn showing the main routes of care seeking in each centre.

Patterns of care seeking, durations and previous treatments were compared within ICD-10 diagnostic groups.

Diagnostic composition of patients varies according to the organization of the services. General practitioners have a limited role as 'gatekeeper' in centres in Albania, Croatia, Macedonia, Romania and Serbia-Montenegro, and rarely prescribed treatment for mental disorders, except sedatives.

Findings highlight areas that require further attention if aspirations for community-oriented mental health care are to be realized, particularly the integration of mental health care into primary care.

Insight into psychosis and availability of therapeutic environment: Georgian experience

Dr Simon Surguladze – Institute of Psychiatry, London - UK

We report the results of the study comprising a) small-scale epidemiological survey of all patients admitted to two psychiatric hospitals in Tbilisi, Georgia during three consecutive months, with the follow-up three months after their discharge; b) survey, examining psychiatrists' views on different aspects of treatment regimes and carer-patient relationships.

The sample was 113 patients with schizophrenia (62 male, 51 female), mean age 41. Methods includes SANS, SAPS, Life Satisfaction Scale (MANSA), Schedule for Assessment of Insight (SAI).

Psychopathological states improved from admission to discharge and then stabilised in three months time. The level of insight improved from the time of admission to the discharge and returned to the baseline level in three months after discharge. Compliance with medication was strongly correlated with insight.

The questionnaire assessing therapist-patient relationship was administered to 89 psychiatrists working at psychiatric services in Tbilisi. The results were compared to those obtained from 54 psychiatrists working in London.

The analysis showed that Georgian specialists over-emphasized the biological nature of the psychosis, ignoring social and psychological aspects of the management of the disorder. They considered their patients as mostly lacking insight and undervalued an option of reasoning with the patients.

There was a deterioration in adherence to medication in patients assessed 3 months after discharge. On the other hand, the specialists were not prepared to provide for psychological support which could improve the adherence. These two aspects of the current psychiatric care may be interdependent, i.e., poor of compliance could follow the deficit in psychological treatment available in Tbilisi.

Cognitive and emotional dysfunction in schizophrenia – evidence for progressive deficit?

Dr Katarzyna Kucharska-Pietura – University of Lublin, Poland/Whitchurch Hospital, Cardiff - UK

In schizophrenia relatively little is known about the global aspects of social cognition and association between deficits in emotion perception and social neurocognitive functioning.

We aimed to examine the nature of both emotional and cognitive impairments in schizophrenic patients at early and late stages of illness and healthy controls. The goals of the study was: 1) to determine the extent and nature of such deficits in patients with schizophrenia, 2) to determine the relation of such deficits to patients' age, sex, education, current mood, duration of illness, severity of psychopathology, and medication dose, 3) to clarify whether patients' deficiency in the perception of affect is due to impairments of emotional processes or whether it reflects a more generalised cognitive dysfunction.

In our work the following methods were used: SANS, SAPS, Beck Depression Inventory, Test of Everyday Attention, Facial Emotion Recognition Test, Visual Object and Space Perception Test, Facial Memory Recognition Test, and “Reading the mind in the eyes” Test.

Chronic schizophrenic patients were significantly more impaired compared with other groups on the both emotional and cognitive tasks. They showed the deficits in the perception of facial affect, selective attention, attentional switching, object and spatial perception, and level of empathy.

Our findings indicate both emotional and cognitive deficits in schizophrenia process which seem to be trait features of the disorder and increase with illness duration.

Au pairs and eating disorders in the new Europe

Dr Rudolf Uher – Institute of Psychiatry, London - UK

In girls and women at vulnerable age, events including separation from the family or culture of origin may contribute to the development of eating disorders. Thousands of girls in their late teens and early twenties leave the Czech Republic every year to work as au pairs abroad, the UK being the prime destination. Clinicians in the Czech Republic have reported on high proportion of female patients, who have developed an eating disorder in relation to their stay abroad.

To explore the link between sojourn abroad and the development of eating disorders we are conducting two related pilot studies. First, in a retrospective study, we explore the migration history in relation to the time of onset in a sample of women treated for eating disorders in the Czech Republic; to date, questionnaire data have been collected from 50 patients. Second, in an explorative qualitative study, we conduct in-depth interviews with (a) women with eating disorder and history of stay abroad, (b) women with eating disorders without a history of stay abroad and (c) with women currently working in the UK as au pairs; so far 12 interviews have been conducted.

While the retrospective questionnaire study aims to estimate the degree and temporal characteristic of the association, the qualitative interview study is designed to detect the nature of association and the key factors in the separation and acculturation experience. Preliminary results will be presented and feasibility of a longitudinal study will be discussed.

ROOM B – 11:00-12:30 – Africa and Mental Health Initiatives

The effect of training village-based health workers in mental health in mental health awareness or utilisation of community psychiatric services

Dr Julian Eaton – Federal Neuro-Psychiatric Hospital, Enugu State – Nigeria

Nigeria is a country which, like many others in Sub-Saharan Africa, has a grossly under-met psychiatric need. The country has a population of around 130 million, and there are estimated to be less than 100 Consultant Psychiatrists. In order for some of these needs to be addressed, an accessible community-based psychiatric service has been established in South-East Nigeria as a partnership between Government Primary Health Care Departments and a small NGO (Amaudo Itumbauzo Community Psychiatric Programme).

Even when services were established, uptake of the services was low. In order to raise the profile of the Programme, and to increase awareness of mental illness and its treatability, a Mental Health Awareness Campaign, funded by Comic relief UK was carried out over three years. The main method used was to train Village-based Health Workers to recognise and refer cases in their communities to the clinics at the Primary Health Centre.

This paper charts the effect that this had on service utilisation in the states where the campaign was carried out. We found statistically significant 3-to-4-fold increased use of community psychiatric services and conclude that a Mental Health Awareness Campaign is an essential task in establishing services where knowledge about mental health is low.

Effectiveness of one week training in mental health for primary care health workers in rural Tanzania

Dr Marian Muller – Mental health Association Tanzania – Tanzania

Four out of the ten most disabling conditions in the world are mental illnesses, with depression as number one. Like many countries, Tanzania has chosen to integrate mental health care in the primary care services. This approach has proven to be most cost-effective. Over recent years first line health

workers have been trained during a one week course in the diagnosis and treatment of common serious health problems.

A study was carried out to assess the effectiveness of this one week training course, focusing on depression. The General Health Questionnaire-12 (GHQ) was used to indicate the prevalence of depression among primary care setting visitors. The ability of the primary care workers to diagnose depression before and after the training was assessed.

Because the Kiswahili version of the GHQ was not yet validated, 3 different cut off points (≥ 2 , ≥ 3 and ≥ 4) were considered. Of primary care setting patients 49 % had a score ≥ 2 , 32 % a score ≥ 3 and 25% had a score ≥ 4 on the GHQ. Being older, having a lower level of education and having a lower income were positively associated with a higher score on the GHQ. Before the training the health workers identified 1% of the patients with a positive score on the QHQ-12, after a one week training they were able to diagnose 25% of the patients with a positive score on the GHQ. The training made thus a significant difference in the ability of primary care workers to diagnose common mental disorders.

Mental health: less apparent but no less important

Mr. Oludotun Olugbemi – World Hope Foundation, Lagos – Nigeria

Most relief programs focus only on physical health and psychological trauma, leaving the majority of mental health needs unmet. Mental illness affects every community worldwide. In fact, neuropsychiatric disorders are the most common non-infectious health problem. Nevertheless, mental health care has not been prioritized in humanitarian emergencies and relief. Although some relief agencies have established short-term trauma counseling programs, serious mental disorders such as psychoses and mental retardation have been generally ignored. One reason is that such conditions, although common, are less visibly apparent than starvation, physical injury or communicable disease. Another is that those suffering are often unable to articulate their needs, while their families, fearful of the stigma, tend to hide them away.

In addition, varying cultural understandings of mental illness can hinder the provision of services. Many communities in developing countries recognize the most severe psychological disturbances, but often attribute them to spiritual or magical causes and seek traditional solutions. These are often ineffective, particularly in the context of a refugee camp, where normal family and social support is unavailable.

The fact that many developing countries have almost no national capacity to treat severe mental disorders further complicates matters. Sierra Leone, for example, has only one psychiatrist to serve a population of almost six million. Likewise, Chad has just one for a population of more than nine million.

Mental Health and Human Rights in Africa

Mr. Paul Moore – Mind in Barnet Advocacy Service, London – UK

Although the African Commission on Human and People's Rights is the youngest of the three regional human rights systems, it has some very unique features. A crucial one is that according to the African Charter on Human Rights,

the regional human rights treaty, individuals can issue communications against governments, and the individual need not reside in Africa or be a victim of the alleged violation. This paper will analyse the case of Purohit and Moore/ The Gambia 241/2001 16th Activity Report Documents of the African Commission 2002-2003 page 62.

This case is very significant for the following reasons:

- (1) It is the only mental health case that the commission have decided on its merits.
- (2) The applicant was not a victim or a NGO nor a resident of Africa.
- (3) The Commission found that there was no need to exhaust local remedies if the victims lacked the financial means to do so.
- (4) The right against discrimination on grounds of mental health had been violated.
- (5) The right to equal treatment had been violated.
- (6) The right to dignity and against torture and inhuman and degrading treatment had been violated
- (7) The right of psychiatric patients to vote in elections had been violated.
- (8) The right to the best attainable mental health had been violated.

Unfortunately the commission found that the right against arbitrary arrest and detention had not been violated. This part of the decision is currently subject to revision.

The paper will also address the question of what does this decision tell us about the treatment of the human rights of mental health service users in Africa, and will the setting up of the soon to be established African Court on Human Rights have any impact in this area?

ROOM C – 11:00-12:30 – Cross-cultural research

A cross-national comparison of social factors, life events and common mental health problems among Somali refugees in Minneapolis (USA) and London (UK): a quantitative study

Mr Nasir Warfa – Queen Mary's School of Medicine & Dentistry – UK

Since the collapse of the Somali state in 1991, around two million Somalis have fled to other Africa countries, North America, Australasia and Europe (UNHCR 2000). However, international studies comparing the determinants of psychological distress among Somali refugees across these host nations have been scant. This cross-national study was carried out with 189 Somali refugees living in London and Minneapolis. The **objective** was to estimate and compare the prevalence of and risk factors for mental disorders in Somali refugees living in London and Minneapolis. We used the MINI International Neuropsychiatric Interview to assess ICD-10 and DSM-IV diagnoses of mental disorders including major depression, PTSD and suicidality.

21%, 11% and 7% of the participants met diagnostic criteria for major depression, PTSD and suicidality respectively. The prevalence of depression and

all mental disorders was higher in the London than the Minneapolis participants (26.6% vs 6.5%; $\chi^2 = 4.49$, $p < 0.034$; and for all mental disorders: 35.7% vs 13%; $\chi^2 = 8.455$, $p < 0.004$). Family separation, educational background, unemployment status and detention at the point of entry were associated with psychiatric disorders. The risk of having any mental disorder, adjusted for age and gender, was four times higher amongst Somali refugees in London than in Minneapolis.

Social and healthcare providers ought to consider arranging interventions for Somali refugees affected by mental health problems.

Cultural issues in mental health practice in Lybia Arab Jamahiriya

Dr Mohamed El-Wafi – Al Razi Hospital (Girgarish), Tripoli – Lybia

Libya is a developing country with moderate access to mental health services and substance abuse rehabilitation. It was not until the 1970s that mental health was separated from mainstream health services in the form of two main hospitals – Al Razi Hospital, Tripoli and Al Hawri Hospital, Benghazi. These hospitals service the entire country providing inpatient, outpatient, emergency and substance abuse rehabilitation – although private services have been on the increase in recent years.

Mental health in Libya is highly stigmatized by cultural taboos that often obstruct proper diagnosis and treatment, particularly with respect to women. Although in recent years mental health issues have become slightly less marginalized there are still strong tendencies to view such illnesses as shameful.

They are kept within the family and any treatment is usually done so in secret. Mental health illnesses have long been considered as rooted in the spiritual realm and a spiritual leader or 'sheikh' is often the first point of contact when a person exhibits signs of mental illness. A spiritual healer will often be called upon to "heal" or exorcise demons or "jinn" from the patient by reading prayers and passages of the Qur'an. This process might take up to years before a medical doctor or particularly mental health practitioner is called upon to intervene and investigate organic causes and administer medication/counseling.

Research for this presentation will be based on limited statistical information obtained from government health offices and the UN World Health Organization country office. Anecdotal references will be made based on first hand practice in the mental health and substance abuse rehabilitation fields in Tripoli Libya since 2001.

A cross-cultural comparison of chronic fatigue and chronic fatigue syndrome between Brazil and the United Kingdom

Dr Hyong Jin Cho – IOP

Chronic fatigue syndrome (CFS) as a severe illness with physical causes seems to be a unique phenomenon in the West. Several cognitive-behavioural factors are believed to perpetuate CFS: somatic attribution of cause, fear of exercise, avoidance as coping strategy and focusing on bodily symptoms. These perpetuating factors seem to be influenced by several sociocultural factors uniquely observed in the West—e.g. awareness of CFS among the population,

media coverage, litigation and overemphasis on a biomedical model of health care. Brazil is a country where CFS is practically unknown and the above-mentioned sociocultural factors are far scarcer than in the UK.

The hypothesis are: 1) The perpetuating factors of fatigue are less prevalent among Brazilian patients with chronic fatigue (CF: a subsyndromal counterpart to CFS) than their British counterparts. 2) Brazilian patients with CF are less disabled.

A cross-sectional survey at primary care level is being conducted in São Paulo and London. Consecutive attendees to general practices, aged 18-45 years, are being screened with the Chalder Fatigue Questionnaire and GHQ-12. All patients with CF will answer the questionnaires on the perpetuating factors and disability. They will also undergo application of the CFS case definitions and a psychiatric interview. We screened 3930 attendees and interviewed 580 CF patients in Brazil. The survey in the UK is in progress and we anticipate that we will have preliminary results of this cross-cultural comparison by the occasion of the present conference, August 2005.

Simhastha: A Community Mass Syndrome – Promoter of Mental Health?

Dr Anita Puti Singh - Govt.M.L.B. Girls Post Graduation College Bhopal – India

Community mass syndrome has been described as a normal behaviour in which hundreds to millions of people from a community are motivated towards a certain type of behavior with one or more than one common goal(P.Singh Anita). What is the explanation for CMS? Is this an opportunity for Catharsis? Does group conformity enhance mental health? Examples of CMS are deeply embedded within many cultures worldwide. The feast of fools was a very popular medieval celebration for Roman Catholics. Every year, on Jan 1st, people participated in a wild carnival where Christian morals, otherwise strictly followed, were abandoned. The behavior was similar to the ancient orgiastic rites by which people worshiped the Greek God Dionysus. Since 1531 every year in the celebration of Lady Guadalupe million of people gather in Mexico for Mass, cultural festivals, religious discussions, music, dance, parties, fun and relaxation. In India on the auspicious occasion of Simhastha, Sadhus and Sanyaasins as well as pilgrims and devotees assemble in millions.

A study was conducted at Ujjain SIMHASTHA, one of the biggest mass celebrations to find out the psychodynamics behind human behaviour in CMS and promoters of mental health. Sample consisted of 300(150 male and 150 female) from rural and urban areas. The results indicate key aspects of the community mass syndrome and attributions which enhance mental health on such mass occasion. Further research is required to understand Community Mass Syndrome, and to discover how other mass occasions all over the world play their role in enhancing mental health.

ROOM A – 13:30-15:00 - Psychosis

Population-based studies of first-episode psychosis in Brazil: structural brain abnormalities and relationship with duration of untreated symptoms

Dr Geraldo Busatto – Faculdade de Medicina da Universidade de São Paulo – Brazil

Many magnetic resonance imaging (MRI) studies have suggested that the diagnosis of schizophrenia is associated with structural abnormalities in the brain, but sample sizes have frequently been modest and the findings obtained have not always been consistent. Moreover, brain volumetric measurements may be confounded by long exposure to antipsychotic drugs.

Recently, population-based MRI studies of large groups of first-onset functional psychosis have been reported, but none of these have been carried out in developing countries. We report here findings from a structural MRI study of first-contact psychosis in Sao Paulo, Brazil. Patients with a psychotic illness (ICD10 F20-29&F30-39) (n=80) from a defined geographical area of São Paulo were compared to asymptomatic subjects from the same districts (n=50).

Structural MRI data was obtained using a 1.5T system, and between-group gray matter differences were investigated on a voxel-by-voxel basis. Voxel clusters of significantly ($p<0.001$) decreased gray matter in the psychosis group were detected in separate, small foci located in prefrontal and temporal cortical regions (all $<0.5\text{cm}^3$).

Gray matter reductions in fronto-temporal regions were greater in patients with a longer duration of untreated psychotic symptoms ($p<0.001$). These results indicate that structural brain abnormalities in first-contact psychosis in São Paulo are subtle, and provide support to the notion that a longer duration of untreated psychosis is associated with more severe abnormalities in the brain.

The latter finding may have important implications to health policies in Brazil, where the still underdeveloped mental health resources do not guarantee early treatment access to sufferers from psychiatric disorders.

Insight in people with psychosis

Professor KS Jacob – Christian Medical Collge, Vellore – India

The assessment of insight is a part of the routine clinical examination for people with mental illness. However, such assessment is based on the current definitions of insight which rely on western notions of health and illness.

Mental illnesses are considered medical diseases and a failure to subscribe to such a point of view often result in a diagnosis of absence of insight. Alternative local and culture explanations for mental illness are discounted. Non-western beliefs are excluded from being standards even in parts of the non-western world.

This paper discusses the recent findings of explanatory models of people with a variety of physical diseases in Vellore, India. It also summaries the results of studies on insight in schizophrenia, which examined explanatory models of illness among patients, relatives and the general population, in Vellore.

The findings support the following broad conclusions (i) many people with schizophrenia, their families and members of the community simultaneously hold multiple, often contradictory beliefs about causation and treatment. (ii) patients and their relatives simultaneously seek diverse medical and non-medical

interventions (iii) patients and their relatives hold beliefs which did not necessarily result in corresponding actions.

The authors suggest an alternative conceptualization of insight and propose awareness, attribution and actions as the components to assess insight. They argue for the fact that the assessment of insight should be against the local cultural standards rather than universal yardsticks.

Psychological treatment of schizophrenia in Cambodia

Dr Pauv Bunthoeun – Preah Bat Norodom Sihanouk Hospital, Phnom Penh – Cambodia

After 1979, there was no mental health structure in Cambodia. Most of the patient, especially psychotic patients, have been seen by the traditional healer. They treated them by using very harmful way to expel the spirit such as force the patients to drink the pollute water, beaten or burning body, shooting near the patient's head etc...Sometime they bring the patient to pagoda to see the monk. Very few patients were coming to the hospital to see GPs. In 1994, under cooperation between Cambodian Ministry of Health and The Oslo University, a postgraduate training has been established in Phnom Penh. Until 1998 there were 10 Cambodian psychiatrists were graduated.

We started to see patients since the beginning of training program, 5 to 10 patients coming to the hospital a day to find the treatment after he/she defeat from seeing by traditional healer.

Gradually the number of patients increased, right now around 150 to 200 patients seeking the treatment in our clinic. Fortunately, we just having the psychiatric in patient clinic in the hospital, we had 10 beds to reserve for the emergency or the difficult cases. Beside of giving medicines ,it is very important to provide the psychiatric education to families, to relatives , about how to take care the patients and let them understand well the serious symptoms of the patients

ROOM B – 13:30-15:00 - Epidemiology

Validation of the Bangla version of the Edinburgh Postnatal Depression Scale for Bangladeshi sample

Dr Kaniz Gausia – Centre for Health and Population Research, Dhaka, Bangladesh – India

Postnatal depression (PND) is a common mood disorder occurring in women following childbirth. Worldwide, 10-15% of women experience this treatable health problem. However, it appears that there is scarce information on PND for Bangladesh. The internationally accepted screening tool, i.e. the Edinburgh Postnatal Depression Scale (EPDS) for PND, is available but a Bangla version was yet to be developed and validated in Bangladesh.

A multi disciplinary research consultative group was formed to develop an appropriate Bangla version of EPDS scale. An agreed Bangla version of EPDS scale was administered to the women attending an immunization clinic to vaccinate their child. A purposive sample of 100 women at 6-8 weeks postpartum

were included in the study. A trained field research assistant introduced a brief socio-demographic questionnaire along with Bangla EPDS. A clinical psychiatrist examined all women following the structured clinical interviews (SCID) for a DSM-IV diagnosis for depression. The validity of Bangla EPDS was tested. Cronbach's alpha, sensitivity, specificity, PPV, NPV and ROC curve analysis were performed.

Nine women (9%) out of 100 were found to be depressed. The internal consistency of the EPDS Bangla version was tested using Cronbach's alpha coefficient (0.8363) and Guttman split-half coefficient (0.8566). The best cut-off score of the Bangla version of EPDS was 10 with the sensitivity of 88.9 %, specificity of 86.8 %, PPV 40% and NPV 98.8%.

The developed Bangla version of EPDS is a valid and reliable screening tool for identifying PND in Bangladesh.

Disablement and Common Mental Disorders among Adults in Great Britain – a secondary analysis of the 2000 ONS Survey in Great Britain

Ms Renata Sousa – Institute of Psychiatry, London - UK

Mental health disorders are prevalent, disabling and cause an important burden among those who have been suffering from any of these conditions, for this reason mental health conditions are becoming an important public health subject. An association between psychiatric illness and disability has been shown in several studies, but this association can differ according to age groups, and other factors such as gender and socio-economic status.

This study is a secondary analysis of the data set provided by the Psychiatric Morbidity Survey carried out in 2000 in private households in Great Britain. The aim of our analysis are: to describe variation in prevalence of common mental disorders (CMD) by physical health status in a nationally representative UK sample, and to quantify the association between measured physical health status (impairment, disability and handicap) and CMD with a range of adult age groups.

Univariate and multivariate analysis were carried out to describe prevalence rates of CMD and disablement, and to analyze the association between them. Logistic regression was used to control for confounding and Wald Test was used to test if age is an interaction mediating the association between disablement and CMD. From our analysis was possible to maintain the hypothesis that disablement is highly associated with CMD independent of confounders or bias. After test for interaction was also possible to conclude that age was not an effect modifier in the association between disablement and CMD.

We are not able to speculate about cause and effect. However, the present study sustains the strong association between disablement and CMD that other studies also found.

Poverty and Child Psychopathology – using Dutch longitudinal epidemiological data to contribute to the debate

Dr Henrikje Klasen – Erasmus University, Rotterdam – Netherlands/IOP

The strong association between poverty and mental disorder produced two dominant theories. The *social causation theory* assumes that the experience and stress of poverty itself predisposes to mental illness while the *social selection theory* assumes that individuals with mental disorder tend to drift into or stay in poverty.

We use a Dutch longitudinal sample of child psychopathology to examine both socio-economic status (SES) linked *differential incidence* as well as SES linked *differential prevalence*. The cumulative prevalence hypothesis suggests that low SES cases do not improve to the same extent as high SES cases once they develop a disorder. From an epidemiological standpoint this would result in differential cumulative prevalence rates by SES as new cases occur and old cases do not recover.

Childhood psychopathology and SES were examined in a nationally representative sample of 787 children (age 4-10 at time 1) followed over 8 years at 2 yearly intervals. Multivariate analysis of covariance was used to test differential rates of psychopathology over time for the different SES levels, while chi-square analysis was used to test differential incidence, cumulative prevalence and recovery rates. Results showed clinical elevations for the lowest SES group on different symptom scales. Both differential incidence as well as differential cumulative prevalence contribute to these elevations. Recovery rates differed by SES for some types of psychopathology. (Full details of the analyses will be available at the time of the conference).

We discuss social, economic and biological factors that might explain the results. These include SES linked disparities in access to care, uptake of treatment and treatment response.

Mental Health and risky behaviour in adolescents - cross-sectional study in Durban, South Africa

Dr Omar Moghraby, Institute of Psychiatry, London - UK

The problems associated with contracting HIV, and consequently AIDS, in sub-Saharan Africa are none more apparent than in the youth of Kwa Zulu Natal province, South Africa. A HIV prevalence of 14%, despite active Government endorsed initiatives, is an obvious cause for concern. In this analysis of a Urban School youth risk behaviour survey, the impact of poor mental health, specifically depression, is investigated as a possible independent risk factor for risky behaviour (the main outcome was unsafe sex) and as a modifier of the effect of knowledge and education upon behaviour.

A cross-sectional study of adolescents aged 14-19 from schools in the Durban Metropolitan area (South Africa). A modified version of Centre for Disease Control's Youth Risk Behaviour surveillance system was administered to 27 schools yielding a sample of 6067. The self-completed questionnaire included sections on Depression symptoms, alcohol and drug use and HIV knowledge.

Multivariate Poisson regression was used. 10.9% of adolescents reported having had unprotected sex. Suggested depression (based on DSM-IV criteria) was strongly associated with a risk of having unprotected sex (PR 1.51, $p < 0.001$ CI=1.24-1.83) after adjusting for possible confounders (age, gender, grade, race and socio-economic status). The general absence of associations between HIV knowledge (on subjective or objective measures), and reported exposure to education messages suggests a complex relationship between health promotion activities and prevention. There was some evidence that poor mental health impacted negatively upon any beneficial impact of education and knowledge. Poor mental health is a risk factor for partaking in risk behaviour. It may also impair the efficacy of health promotion activities.

ROOM C – 13:30-15:00 - Workshop

Getting Started in Research

Professor Martin Prince and Dr Vikram Patel – Institute of Psychiatry and London School of Hygiene and Tropical Medicine

This workshop seeks to identify opportunities and challenges for research in low resource settings. We will have brief presentations on the following areas:

- Research funding schemes in the UK
- Research funding in developing countries
- Institutional research resources in developing countries:
- the NGO model for action research
- International research networks

This will be followed by contributions from participants (with a rapporteur) around key themes, e.g. accessing funding; setting up collaborations; setting the research agenda. each with 15 minutes for discussion, and a final ten minutes for bringing together the consensus.

ROOM A – 15:30-17:30 - Violence

A culture sensitive approach to recovery: domestic violence in the orthodox Jewish home

Dr Jay S. Sweifach – Yeshiva University – Wurzweiler of Social Work – USA

This presentation highlights the value sensitive approach as a viable therapeutic technique which has generated positive results in working with orthodox women. The value sensitive approach uses ethno-cultural-religious factors as part of the therapeutic process. Outcomes of this approach have been positive in addressing the unique needs of Orthodox Jews and other religiously traditional women who are victims of domestic violence. Implications and issues for educators and practitioners will be presented.

The Orthodox Jewish community has struggled to address domestic violence. Acknowledging the problem involves dealing with the stigma surrounding it, a task which challenges the emotional and religious fiber of a

community which considers each person a treasured gift. Given this backdrop, an abused orthodox woman may have to contend with a number of issues:

- (1) The inability to understand that she is being abused, in light of religious explanations and excuses by the abuser.
- (2) Confronting the stigma. The difficulty is compounded for Orthodox women who not only struggle with the physical and emotional abuse, but simultaneously face a legacy of disbelief, skepticism and recrimination from the community, built on the myth that domestic violence does not exist in Jewish households.
- (3) Finding help that appreciates her unique religious principles. Many therapists focus on purely therapeutic techniques and do not use the client's religious values as a source of strength.

This presentation differs from previous scholarly pursuits. Although previous efforts explore and examine the complex multi-dimensional aspects of domestic violence, relatively few bridge the gap between theory and practice; those that do apply theory, do not address direct practice with abuse victims.

The cultural construction of depression among women living under violence and poverty in a community in the outskirts of São Paulo

Dr Jair Mari – Federal University of São Paulo (UNIFESP) – Brazil

Depression is an important issue of public health for women.

To understand motives and reasons underlying the idioms of depression of women diagnosed with the disorder, and what think psychiatrists who follow them.

A qualitative study was carried out: ethnographic observation and in-depth interviews. The participants were 16 lower class women who live in Embu, diagnosed with depression (F33- ICD-10), patients of a primary care service and 4 psychiatrists. Embu, at metropolitan area of São Paulo, is a very poor city with slums, poor housing and faulty health. It is one of the most violent cities in Brazil.

Interviews with psychiatrists (4) showed that depression is a term already assimilated to common sense. They consider it as a difficulty to distinguish between sadness and depression in their female patients, who complain about life (family, unemployment and violence) and frequently ask for antidepressants and tranquilizers.

All of the women interviewees identify the origin of the disease on a past event such as: death of a son, violent episodes, e.g., guns shot in the neighbourhood, children involved with drug dealers, imprisonment of a son, unemployment, aggression by the companion. Violence is a common issue in their lives.

Interviews with women showed that depression is the idiom to express many feelings, such as their unhappiness in a context of poverty and misery. Dialogue between psychiatrists and their patients must improve as to render evident how depressive women do articulate particular meanings, and specific notions, heavily burdened by their daily extreme poverty context.

Family Mental Health Problems and Violence as correlates of Severe Physical Punishment of Poor Children

Dr Isabel Bordin – Universidade Federal de São Paulo – Escola Paulista de Medicina – Brazil

The objectives of the study were to determine the prevalence of severe physical punishment of children by mother/father, and to examine family mental health problems and violence as potential correlates.

A Cross-sectional study. The Brazilian study is part of WorldSAFE (World Studies of Abuse in Family Environments) that involved researchers from six countries. The setting was an urban poor community near São Paulo city. The participants were 811 mothers (aged 15-49 years) of children under 18 (probabilistic sample of 24 clusters based on census units, including all eligible households; attrition rate=17.8%). Severe physical punishment of children by mother/father: hit with an object such as a stick, broom, cane, or belt; kick; choke by putting hand or something else around neck; smother with hand/pillow; burn/scald/brand; beat or shake if age <2 years. Correlates: Child (mental health); Mother (mental health, childhood experience of harsh physical punishment, victim of lifetime severe physical marital violence); Mother's husband/partner (getting drunk in the past 12 months). Standardized instruments: WorldSAFE Core Questionnaire, Self-Report Questionnaire, Child Behavior Checklist/CBCL 4-18 years.

Outcome prevalence=19.6%. Three variables were associated to outcome: child behavior problems in the clinical/borderline range [OR=2.0 (CI 95%: 1.3-3.1), p=.003]; mother history of harsh physical punishment [OR=1.6 (CI 95%: 1.1-2.2), p=.01]; severe marital violence [OR=2.5 (CI 95%: 1.7-3.7), p<.001].

Severe physical punishment of children is frequent in the studied community. Child mental health status and marital violence must be addressed when dealing with child abuse. In addition, suffering physical abuse in childhood increases the risk of victims becoming perpetrators in the next generation.

The impact of violence on maternal and newborn health: a survey of adolescent mothers in São Paulo, Brazil

Dr Cleusa Ferri – IOP

Studies in developed countries show significant associations between violence and poor maternal health during pregnancy, particularly mental illness and low birth weight. The evidence base on the effect of violence on maternal and newborn health from the developing world is fragmentary.

Violence was assessed using the Californian Peri-natal Assessment among 930 consecutive pregnant teenagers admitted for delivery in a public hospital in Sao Paulo. Maternal health outcomes focused on obstetric outcomes and mental illness measured using the Composite International Diagnostic Interview (CIDI). Apgar scores of newborns were estimated and their weight measured. 21.9% of mothers reported lifetime violence. The risk for lifetime violence was significantly elevated for less educated women. Lifetime violence was strongly associated with Common Mental Disorders (OR adjusted for maternal age and education=3.49, 95%CI=2.50-4.89). Two per cent of the participants reported experiencing violence during the pregnancy and this was found to be strongly associated with both

Common Mental Disorders (adjusted OR=4.32, 95%CI=1.70-10.97) and low birth weight (OR adjusted for maternal age, education, gestational age, alcohol intake during pregnancy, smoking during pregnancy, medical problems, and common mental disorders=3.46, 95% CI=1.10-10.86).

Lifetime time violence is commonly reported by pregnant adolescents and has a strong, independent, adverse effect on their mental health. Violence during pregnancy is less common, but has an even stronger effect on the mother's mental health and, in addition, on the birth-weight of their babies. The mental health and fetal growth of mothers who have been exposed to violence during pregnancy should be closely monitored and appropriate interventions provided.

Domestic Violence among females employees of Iraqi Ministry of Health

Dr Muhammed Lafta - AL-Rashad Mental Teaching Hospital, Baghdad – Iraqi

Domestic violence (DV) occurs in all countries, irrespective of social ,economic ,religious or cultural group. Women are usually the common victims of DV .No national survey, or any other database, is available to illustrate the size of the DV in Iraq.

From September to November 2004 , a self-rated questionnaire asking about DV was delivered by hand in enclosed envelopes to 500 female employees working in the offices of the Iraqi Ministry of Health. Only 325 (65%) females completed the questionnaires .Those respondents were 163 (50 %) married &142 (44%) single. Their age was between 20-55 y. (mean was 31 y.) . From the 325 women of respondents ,105 (32 %) were victims of DV .The rate was more among the wives (36%) &then the singles (26%). The DV was increased as the women got older in this study. The educated women were more prone to DV as 75% of them had college or university degrees. Husbands were the highest assaultive groups (82%) for the wives, while brothers (51%) were the commonest for the single women. Most of the victims were insulted regularly & about 12% of them got aggressive physical assault.

DV is an important public health problem which is still not estimated in Iraq. National survey should be done. To help the victims, involvement of many sectors working together at community, national &international levels, is very essential.

ROOM B – 15:30-17:30 – Responses to War and Natural Disaster

Disaster Response and Staff Wellness – A Public Health Approach

Dr Anthony T. Ng – Reich, Ng & Associates – USA

The mental health consequences of disasters, humanitarian crises and other public health emergencies on first responders and humanitarian workers have been well documented over the years. They include Post Traumatic Stress

Disorder, Major Depression, Generalized Anxiety Disorders, and Substance Abuse.

Awareness of these psychological issues on such populations have been increasing in the aftermath of events such as the September 11th attacks on the United States, the Madrid bombing, the SARS outbreak and the more recent Asian tsunamis disaster. However, as the mental health community assume a greater role as part of the public health response to these events, mental health clinicians are also at increased risk to adverse psychological distress from secondary traumatization. Research into the post disaster psychological consequences of this care provider population remains scarce however.

In this presentation, the risks of psychological and behavioural distress on individuals and in particular mental health clinicians will be identified.

The presentation will highlight the public health risks to mental health clinicians in disasters and humanitarian crises. Strategies to address these psychological concerns from a public health perspective will be identified. Additionally, specific strategies will be identified for both clinicians working in such extreme environments as well as organizations to promote staff wellness.

Psychological Rehabilitation for Tsunami affected Area in Chennai, India

Mr Ravi Samuel Dhanaraj – Medical Centre Taramai, T.S. Srinivasan Centre for Clinical Neurosciences, Tamil Nadu – India

Tsunami lasted for less than 3 minutes but affected the coastal areas of Tamil Nadu left 7951 dead, 8,90,000 affected and over 5,00,000 lost their homes. In the initial phase all the relief work and counselling were concentrated on places where there was loss of lives. Many areas faced the disaster of the same magnitude but luckily there were no loss of lives nevertheless people were psychologically affected but no services were offered to them.

On request from community leaders from a community of 200 families in the coastal areas, a rehabilitation team consisting of Psychiatric Social Workers and Psychologist were formed. After one month of the disaster the team went house by house and met all the members of the family to assess the psychological problems.

It was observed that children developed anxiety disorders and behavioural problems like clinging, school avoidance, and preventing family members from going near the sea. School avoidance was found in children who had problems with their education and had avoidance behaviour prior to the disaster. Men had depressive features due loss of property, inability to go for fishing and loss of income. Young girls developed chronic physical illness and were sick of continuously sick and were mostly in bed. Eighty per cent of the women had sleep disturbances and were hyper vigilant during nighttime. Women who slipped into clinical depression were those who already had multiple problems prior to the disaster. The presentation will be about the community based psychiatric rehabilitation like emotional support, counselling and relaxation therapy done by the team and the outcome of the rehabilitation.

Disasters big and small: opportunities for system change

Professor Ernest Hunter – University of Queensland/Queensland Health – Australia

In the aftermath of the Boxing Day tsunami an enormous range of governmental and ngo psychosocial interventions were undertaken across affected populations. This was the case in Aceh where there was, initially, considerable interest in investments in the mental health sector where the issue was not 'rebuilding' but building a system which had, to that point, been concentrated in one institutional facility serving a population of 4.5million. However, over the ensuing months, as the land dried out, so did enthusiasm for investment in this sector.

This speaker, whose usual occupation is working with Aboriginal and Torres Strait Islander patients in remote Australia, will reflect on this process and the opportunities available for investment in a setting where (nationally) mental health is given a low priority, and the problems of rapid and potentially unsustainable system investment. Immediately after returning to Australia the speaker coordinated the social/mental health response to a plane crash involving victims from a remote Aboriginal and Torres Strait Islander community.

The presentation will include reflections on lessons learned in the experiences to the disaster in Aceh for the local response to the tragedy in Cape York, and to the wider arena of the disaster of Indigenous health and mental health generally.

Posttraumatic Stress Disorder, Anxiety and Depression among civilian population in South Lebanon

Professor Laila Farhood – American University of Beirut – Lebanon

Over 20 years, until May 2000, the south of Lebanon was under occupation. During this time the residents of the area were exposed to several different events that have the potential to cause psychiatric distress, especially Posttraumatic Stress Disorder (PTSD). The consequences of the occupation on the mental health of the population in the area has until now not been studied.

The first purpose of this study was to investigate the prevalence of PTSD symptoms among residents of the formerly occupied region. Prevalence of symptoms for depression, anxiety, somatisation and social dysfunction were assessed as well. The second purpose was to investigate whether symptom development can be predicted by the amount of exposure to traumatic events. The third purpose of the study was to see if life-style and socio-economic factors mediate the impact of traumatic events on symptom development. The method of the study was to conduct structured interviews among the general population from two adjacent towns in the south of Lebanon. The area has been subjected to several war-related events since the beginning of the Israeli occupation more than two decades ago. The sample consisted of 250 randomly selected persons. Traumatic events and symptoms of PTSD were measured by the Harvard Trauma Questionnaire whereas symptoms for somatisation, anxiety,

social dysfunction and depression were assessed by the 28 item General Health Questionnaire. The interviews were done at the participants' homes.

Almost all persons in the sample had witnessed or experienced a traumatic event. 29% had developed PTSD. Exposure to traumatic events was strongly correlated with symptoms of PTSD, ($r = .491$; $p < .0001$). Exposure was also correlated with general psychiatric morbidity ($r = .247$; $p < .0001$). Some lifestyle variables, such as social support, could explain part of the remaining variance when introduced into a multiple regression analysis together with exposure. Exposure to traumatic events, however, remained the single most important predictor for PTSD symptoms.

Is mental health promotion relevant to countries in conflict?

Professor Helen Herrman – University of Melbourne – Australia

Freedom from discrimination and violence is one of the main social determinants of good mental health, along with social inclusion and economic participation. Conversely, conflict and violence are linked with poor mental and physical health, including depression and substance abuse. Conflict and poor mental health are both related to poverty and social disadvantage.

Mental health has been invisible to people around the world. Yet the salience of mental health and the need for its measurement and improvement are becoming clearer to many communities. A new report from the World Health Organization has been released: *Promoting Mental Health: Concepts, Emerging Evidence, Practice*. Evidence at varying levels demonstrates the effectiveness of policies, programs and initiatives for improving the mental health of populations. The scope for promoting mental health is identified by analogy with health promotion successes in other areas such as heart health.

The relevance of health promotion to world conflict is evident in the World Psychiatric Association's (WPA) position statement on economic globalisation and mental health. The statement recognises the need to raise awareness that the effects of globalization will be optimal only when improvements in health including mental health become central objectives of national and international economic policies.

Integrating mental health into primary health care in war and disaster affected communities

Dr Lynne Jones – International Medical Corps/Cambridge University

There is a growing consensus that a proportion of the population caught up in complex emergencies suffers from psychiatric disorders that warrant some form of clinical intervention. International Medical Corps has addressed this problem by integrating mental health services into existing primary health care programmes.

This paper contrasts programmes established in Kailahun district of Sierra Leone, two years after a 15 year civil war ended in 2002; and Aceh province,

Indonesia which was devastated by the Tsunami in December 2004. In the aftermath of these disasters, both national governments are committed to introducing community mental health services.

Integration consists of: identifying appropriate health professionals to receive specialized mental health training, liaising with indigenous healers to understand cultural expressions of mental distress and help seeking behaviour, establishing mental health referral clinics attached to primary health care centres; training PHC providers in front line management of common mental disorders; and community education programmes.

Clinical audit shows that different contexts produce different patient populations. The most common presenting problems in Kailahun were epilepsy, psychosis, depression and substance abuse. In Aceh, the most common problems are bereavement; anxiety; sleep problems and low mood. However a third have problems that predate the Tsunami, the most common presentation being "crazy". Other detailed findings will be presented.

Issues confronting service providers include difficult access, poor security, fragmented social networks; disrupted systems of indigenous care, stigmatization, difficulties in sustaining adequate supplies of psychotropic medication, setting up mechanisms for referral and ensuring the sustainability of the service. Para-professionals can be trained to provide specialised mental health in primary health care settings. INGOs have a role to play in piloting such schemes in collaboration with local ministries of health.

ROOM C – 15:30-17:30 - Policy

The role of mental health legislation in the development of international mental healthcare

Mr Stuart Marchant – Bevan Brittan LLP, Birmingham – UK

Mental health legislation should codify and consolidate the fundamental principles, values, goals, and objectives of mental health policy. Such legislation is essential to guarantee that the dignity of patients is preserved and that their fundamental human rights are protected. (The World Health Report 2001).

The goal of mental health legislation should be to facilitate ethical and effective care and treatment for people suffering from mental disorder by means which are compliant with basic human rights principles. Domestic priorities should coincide with this goal, but as this is not always the case sometimes the tension between the two can hamper service development. In addition, resource difficulties, including capacity and funding, can prevent proper access to psychiatric services and treatments with detrimental consequences.

The World Health Organisation, the World Bank and NGOs have an important role to play in assisting all countries, but particularly developing countries, implement and modernise mental health policies and legislation to tackle stigma and encourage modern methods of treating and rehabilitating people with mental disorder. Mental health legislation should enable professionals in caring for patients using modern, increasingly community-focussed, models with fuller involvement of carers and relatives, provided that the

rights of individuals to engage or refuse treatment other than in accordance with carefully monitored rules are protected.

As well as a driver for enabling and protecting fundamental human rights principles, mental health policy and legislative reform can also act as drivers for regeneration and social inclusion, which reflect the objectives of the millennium development goals of having a healthier and fairer domestic and global society.

Public policies to improve the mental health of working mothers

Dr Celia Jane Briar – Massey University, Palmerston North – New Zealand

Mothers at home are known to be particularly likely to suffer from depression. Although the rise in mothers' employment has to a degree combated this problem, women combining paid work with unpaid care-giving responsibilities are particularly likely to suffer from stress-related disorders resulting from multiple roles.

In addition, mothers are particularly likely to be employed in high demand/low control jobs, which are known to result in poorer mental and physical health outcomes. Working mothers have lower pay and status than women without children or men. Both low pay and inequalities at work are also known to result in greater morbidity.

Women are known to be far more likely to seek professional help for depression and stress than men. This situation affects not only the well being of the women themselves but also their children, partners, co-workers, employers and communities. This paper assesses the supports that work the best for easing the pressures on mothers worldwide. From here it outlines kinds of public policies that will be needed to address this issue and to meet the United Nations goals of improving health and empowering women by 2015.

Managing depression and related disorders in the workplace: a national response across Australia

Dr Nicole Jayne Highet – Beyondblue – Australia

In Australia over six million full work days are lost every year due to depression. Lack of awareness and understanding about depression and related disorders in the workplace can result in prolonged absenteeism, reduced productivity, with additional implications for health and safety.

In response to this, *beyondblue; the national depression initiative* has developed and extensively evaluated a workplace-based program. The program was developed in response to the significant personal, social and economic costs of depression to organisations, together with the fact that management strategies currently used within the workplace are likely to exacerbate the problem, prolong absenteeism and reduce the likelihood of the employee returning to work.

The *beyondblue* workplace program provides managers and staff with key information and hands-on strategies to ensure that depression, anxiety and related substance misuse are identified early, and appropriately managed within

the workplace. The *beyondblue* program has been implemented to over 8,000 employees from a range of large and small organisations across Australia with impressive qualitative and quantitative outcome data.

This presentation will highlight the key features of this program, and demonstrate its impact on increasing awareness and understanding about depression and related disorders, and importantly changing attitudes and improving managers and colleagues to ensure effective and efficient management of depression in a workplace environment.

Evidence for effectiveness of mental health promotion

Professor Helen Keleher – Deakin University, Melbourne – Australia

Mental health promotion is usually understood in terms of early intervention and prevention of mental disorders, primarily focused at individuals but there is an emerging interest in the mental health promotion for communities and populations. This paper reports on the framing of mental health promotion evidence from a determinants of health perspective, in a Mental Health Promotion Evidence Resource that considers mental health as dependent on the creation of supportive social, economic and environmental conditions.

The review of evidence used a conceptual framework based on upstream determinants of mental health: social connectedness and social inclusion, freedom from discrimination and violence, and economic and social participation.

The search strategy was complex, and highlighted particular challenges in identifying good quality mental health promotion evidence to guide mental health promotion programs and policy development. As a relatively new field of interest, mental health promotion is a poorly indexed concept, and there is also a paucity of peer-reviewed evidence about the effectiveness of mental health promotion interventions. This was further complicated by our upstream mental health promotion focus.

Nonetheless, we found that the emergent paradigm of mental health promotion has advanced with greater strength of evidence to justify its place in contemporary health promotion theory and practice. There remains a great need for stronger project evaluations and policy analysis against relevant criteria, and there is a need for indicator sets for mental health and wellbeing, as well as innovative evaluation methodologies to systematically measure outcomes particularly in relation to organisational change, partnerships and intersectoral activity.

2nd September - ROOM A - 11:00-12:30 - Child and Adolescents II

Permanency – A Precondition for Children’s Healthy Development

Ms Ia Shekrladze – Kidsave – USA

All societies – developed and developing - face the problem of children left without parental care. Policy attempts to find solutions may vary from country to country. However, it is internationally acknowledged that institutionalization and absence of proper parental care create common challenges in children’s development that share marked similarities regardless of where children may

come from. It is also universally recognized that successful parenting is a primary key to the mental health of the next generation.

Kidsave – a nongovernmental organization committed to end institutionalization of children - implements Family Visit Model in Russia, Kazakhstan, and the US. The model considers moving children from institutions/foster homes to family-like settings so that they are able to connect with at least one caring adult. Family Visit Model places the child with a local prescreened and trained family/adult for summer/weekend whose role is to provide the child with the experience of family life and advocate to find the child a permanent family or long-term connection. The visit itself often starts the permanency process, motivating families to either adopt, mentor or help the child find a family.

While the model does not claim to be flawless, the results are promising - more than 1,000 children have found permanent families as a result of participation in family visits. The success of the model, however, highly depends on the stigma associated with orphans and adoption, predominant in given society. Combination of solid social marketing campaign with programs aiming at placing orphans into permanent family-based care holds the greatest promise for success.

Prevalence of mental health problem in children and adolescents from the outskirts of São Paulo city: Estimating service need and capacity

Ms Cristiane Silvestre de Paula – Universidade Federal de São Paulo, Escola Paulista de Medicina – Brazil

The objectives of the present study were: a) To estimate the prevalence of mental health problems in children and adolescents (MHPCA), with and without considering global impairment (GI), in a low-income urban community of a town in the outskirts of São Paulo city; b) To estimate the annual mental health public service delivery capacity; c) To relate the service need to capacity.

The study design was cross-sectional. Probabilistic sample of clusters, including all eligible households in each selected cluster (Jardim Santo Eduardo, Embu-SP). Participants: 479 children and adolescents (aged 6-17 years; attrition rate: 18.3%). Measurement: (1) Clinical level MHPCA in the Child Behavior Checklist and/or Youth Self-Report total problem scale; (2) GI: Positive score on the Brief Impairment Scale (total score >15.5); (3) Service capacity: total number of cases assisted annually by psychologists/psychiatrists in the following sectors: health, education, juvenile justice, child welfare.

MHPCA prevalence: 24.6% (20.7-28.5) without considering GI; 7.3% (5.0-9.6) considering GI (impaired cases). Current annual service capacity would only provide care for 14.0% of the impaired cases; approximately seven years would be necessary for all to be treated.

MHPCA are frequent in the studied community, with rates compatible to the poor populations from Latin America/Caribbean. The current structure of Embu's public service system is not prepared to treat impaired cases in a timely fashion. This study data may be used as a resource for better planning public health actions in child and adolescent mental health.

Child depression in greater São Paulo as a particular stance of the doctor-family-of patient relationship in an ethnological approach

Dr Eunice Nakamura – Universidade Federal de São Paulo, Escola Paulista de Medicina – Brazil

The concept of child depression has 2 opposed sets of meanings, one medical, the other popular. What are these meanings, and how can they influence medical and parental treating actions?

The sample was lower middle class residents of the Greater Sao Paulo area (17.5 mi), who seek help for their children (6-12 yrs) at the public, free, Hospital das Clinicas child psychiatry service.

The method was a qualitative. In-depth semi-structured interviews with psychiatrists (8), and depressed children parents (9) were made, analysed and interpreted. Ethnographic observation at the depressed children homes, and at the hospital, was made.

Together, doctors and parents form the 2 opposed sides of an operational cultural concept of child depression. Psychiatrists get prompt positive reactions from the children through the use of rapid acting drugs; parents obtain relief for their concern for an odd behaving child at home. This barely spoken and shallow arrangement between doctors and parents becomes stable and satisfactory, to both sides.

Bonded together by their respectively professional and familial necessity, doctors and parents have created stereotypes for the disease that form a stable system to recognizing and satisfactorily coping with depressed children, within this particular poorer urban cultural context

Could children's reactions to paediatric physical examination be related to socioeconomic status, which may affect mental health?

Dr Metin Donma – Istanbul University – Turkey

Socioeconomic status is one of the factors, which may influence mental health, behaviour and interaction patterns. A new observational rating scale was developed and introduced to assess the quality of paediatrician -child interaction in a psychological context in terms of income inequality. Children's anxious reactions examined by the paediatrician to a paediatric physical examination observed for 2022 children aged 0-6 years were classified based on the criteria elaborated in "DOPPERS", DONMA Scoring Table. DOPPERS evolved out of clinical observations and descriptions of child behaviour, disturbance and/or dysfunction, and after a period of pilot work, the main five subscales were eventually chosen. Each is composed of five different subscales. The ratings were made on a 5-point scale. The reliability and validity of the DOPPERS were tested. The responses (the behaviours and movements) of the children with and without fear of feeling pain prior to physical examination rather than the reactions to pain itself were examined. Also the effects of some physical characteristics of the children as well as socioeconomic status of the family on the reactions of the children during paediatric physical examination were evaluated on the basis of this recently developed scale. The relationship between the reaction intensity and age distribution was significant. However, no significant difference was found between male/female ratios of each of the five reaction groups in this study. A significant relationship between low socioeconomic status and more intense reactions was detected. Low

income may affect mental health through the promotion of abnormal behaviour and psychosocial characteristics.

ROOM B – 11:00-12:30 – Africa Mental Health – Research and Policy

Measures to improve mental health in Africa: Ghanaian perspective

Mr. Kwabena Otoo Siaw – Centre for Human Health Care (Youth Life Care-Ghana), Ghana

Diseases, poverty and unemployment in African communities affect individual mental state. These conditions must be controlled to improve individual mental health. The study was to identify effective measures to help improve the mental health of the populace.

Seven communities were selected from each region in Ghana for the study. Interviews and questionnaires were used. News and magazines from other African countries were also used. Majority of the populace, are unemployed therefore resulting to the use of drugs for no apparent reasons. Cost of providing mental health management, care and treatment service remains high for most families. Mental health service is poor because of few mental health facilities in the country. There are insufficient governments and non-governmental structures to provide intensive education and community sensitization programs on mental health. Stigma attached to mental problems makes it difficult to provide services to the infected and affected families.

Africa leaders should advocate helping bring down the cost of providing mental health services and focus on creating employment opportunities to improve the populace living standards. Governments should allocate funds from national budget and debt relief to support the mental health services. International donors, example, World Bank and United Nations should increasingly focusing on mental health management services in Africa as their commitment to scaling up the global mental health improvement to achieve the 191 UN member countries objective set by 2015. Mental health programs should be incorporated in institutions to increase the knowledge levels.

An ethnographic study of living with mental illness in Ghana

Ms Ursula Mary Reads – University College London, London – UK

Studies by WHO have suggested that the prognosis for people diagnosed with schizophrenia may be better in 'developing' countries. This has been hypothesised to be due to greater family support, more opportunities to resume work and family responsibilities and to therapeutic approaches which include consideration of spiritual and social difficulties.

Nonetheless other studies have contested these results, indicating that stigma, disability and social exclusion remain serious difficulties for those with a diagnosis of schizophrenia in the developing world, often despite the presence of traditional family networks. Despite calls for research to elucidate the sociocultural factors which might impact on the experience of mental illness in

developing countries, such research, which calls for a qualitative ethnographic approach, has been limited.

This study with outpatients in Ghana utilises such an approach to explore the impact of mental disorder on the daily life of the individual and their family utilising a phenomenological approach to explore the intersubjective 'life-world' of the person who has received a diagnosis of schizophrenia.

This paper will consider the impact of mental illness on the person's ability to participate in culturally defined roles in the family and wider community and how local kinship organisation and household management, for example extended family networks, and patterns of employment impact on the person's recovery. It will also explore how 'recovery' should be defined within mental health research and critique the use of normative measures in the measurement of outcomes, arguing that health as much as illness is contextually and culturally defined.

A population-based study of the outcome of major depression in a sub-Saharan African country

Dr Souci Frissa – Institute of Psychiatry, London - UK

The outcome and impact of major depression in developing countries where most people do not receive treatment is not clear. The aim of this study is to describe the outcome of major depression and compare the disability and patterns of service use among different outcome groups in an Ethiopian rural community. We carried out a case cohort study nested within a population-based survey of 68,000 participants using CIDI.

Three hundred participants were randomly selected each from those with current major depression and those with no lifetime history. These were re-interviewed after 2-4 years to ascertain current diagnosis (CIDI), psychological symptoms (SRQ-20), disability (WHODAS II), and use of health services. The maintenance rate for major depression was 26%. Age and sex standardised mortality ratio was 355 (95%CI 197-639). The number of disability days, WHODAS-II total and domain specific scores at follow up were significantly higher in the persistently depressed compared with either the completely recovered or the never depressed.

Those who had recovered completely had similar levels of disability and service use to the never depressed, whilst the partially recovered resembled the persistently depressed. Two-thirds of persistently depressed had not sought any help. Major depression was strongly associated with mortality. Disability resolves with clinical recovery. Those with residual symptoms remain disabled. Help seeking was unusual even with persistent major depression.

NGO – a questions for quality

Dr Bushra Habbani – Khartoum Teaching Hospital, Khartoum – Sudam

The new world order brought about great changes in the world political and economic dynamics. New concepts have been introduced, old formulae had been abundant, if we take that any change in people lives is stressful event from the out set of psychobiological dimensions, thus huge changes require great degree of psychosocial readiness. Governments of world, especially developing countries cannot face this challenge on their own due to their limited degree of

flexibility. UN organizations are not implementers themselves hence their role remains advisory and technical. Thus the NGOs remain best option to raise to this challenge by virtue of their democratic set up, their organizational constitution, their official recognition ,their capacity to recruit personnel ,ability to raise funds ,flexibility to re set their priorities and reshape their programs .All these properties plus their capacity to work right at the top official level and deep down at the grass roots.Sudan has been a conflict zone for the last fifty years, with subsequent deterioration in almost all services especially health. Mental health falling to bottom of government agenda, causing great frustration to mental health working personnel.

Numbers of NGOs were formed to meet the challenge at different health sectors. I worked for the last seven years as government employed psychiatrist and a leader of NGO working on mental health issues; My experience shows ((there is a need to improve the quality of NGO standards on technical, financial, education and training specification and articulations, research and evaluations, liaison and networking .All in a comprehensive programme under a national and international forum.)

ROOM C – 11:00-12:30 - Depression

Trace elements: could they be a possible solution to reduce mortality from suicide in depressed subjects?

Dr Orkide Donma – Istanbul University – Turkey

Maternal depression and child adjustment problems are intrinsically intertwined and impose significant burden to society. Suicidal behaviour is closely related to depressive disorders. Both depression and suicidal behaviour have firm biological basis e.g. abnormalities in the metabolism of serotonin and norepinephrine. Metals are involved in synthesis, breakdown and complex formation of these compounds.

Lithium usually considered specific to reduce suicide risk, has bcl-2's neurotrophic effect, increases N-acetyl- aspartate in the brain. Zinc may affect brain contents of serotonin and norepinephrine by inhibiting MAO-A activity. The alteration in zinc interaction with NMDA receptors may be involved in psychopathology underlying suicidal attempts. Serotonin and dopamine are capable of leading oxidative DNA breakage in the presence of copper.

There is a selenium specific increased neural activity of dopaminergic pathways. Changes in the serotonergic system occur due to aluminium exposure. Manganese increases neuropsychiatric symptoms. The effect of serotonin is blocked by nickel. Cadmium inhibits the activity of dopamine, norepinephrine and serotonin. Lead can cause changes in catecholaminergic functions. Arsenic exposure resulted in mood and memory disturbances.

All human thoughts and emotions are neurophysiological processes. The role of metals in the human response to stressful events is emphasised. The knowledge of the neurobiology and genetics of normal and pathological behaviour is growing. Future development of trace element research will expand the research potential for examining the nature-nurture relationship. Better understanding of the participation of metals in the related metabolic pathways,

their interactions and cumulative effects will help to improve health and also the effects of treatment.

Is GDS-30 better than GHQ-12 to screening depression in the elderly in the community? The Bambui Health Ageing Study (BHAS)

Dr Erico Costa – Nucleo de Estudos em Saude Publica e Envelhecimento (FIOCRUZ)/Universidade Federal de Minas Gerais – Brazil/IOP

A two-phase diagnostic survey is commonly applied in epidemiological research in psychiatry. The *Geriatric Depression Scale* (GDS) and *General Health Questionnaire* (GHQ) are two of the most popular screening scales.

Phase I: 392 subjects aged ≥ 75 years from study area were screened. Phase II: Half of those scoring ≥ 11 in GDS and ≥ 4 in GHQ, and 20% of others, participated (n=126) for detailed evaluation according to ICD-10 assessed by SCAN. The internal consistencies were good (α : GDS=0,87, *classical*-GHQ=0,82, Likert=0,86, c-GHQ=0,81). The optimal cut-off point of GDS-30 was 14/15 with 73% sensitivity and 65% specificity, whereas 4/5, 15/16 and 5/6 for *classical* GHQ, Likert and c-GHQ respectively with sensitivity (66%-75%) and specificity(57%-62%). Receiver operating characteristic curve analysis against SCAN indicated moderate screening potential (AUROC: GDS=0.76; *classical* GHQ= 0.74; Likert=0.76; c-GHQ=0.73), with no clear differences and bias by disability and self-reported health.

In this Brazilian population based study of elderly ≥ 75 years the performance of both were insufficiently predictive of SCAN ICD10 diagnosis to recommend their use as efficient screening measures. Despite its theoretical advantages, the GDS performed no better than the GHQ12, and was biased in similar ways.

Anxiety and depression disorders among elderly in Norwegians

Dr Kari Kvaal – Oslo University College – Norway/IOP

Prevalence of anxiety and depressive disorders based upon symptom scales varies between populations. Item content in the factor structure varies between populations, so fresh factor analysis must be undertaken to investigate the construct and determine whether the structure is the same in the particular population

The aim was to compare prevalence of anxiety and depressive disorders using the constructs as defined by the scale developers and those based on factor-analysis.

The study design was a cross-sectional study

The Norwegian Health Survey 1995 is a random population study which sampled citizens not living in institutions or homes for the elderly. The response rate was 78%. Records came from participants aged 60-79 years (N=1377). Outcome was the 25-item version of the Hopkins Symptom Checklist (HSCL), designed to tap anxiety and depressive symptoms. Interviewees filled in a

questionnaire measuring symptoms occurring during the last fortnight. All HSCL items have score range 1-4 where 1 reflects no and 4 very much. Factor analyses were based upon polychoric correlations.

The mean HSCL item score in this sample was 1.2 and 5.1 % scored above a caseness level of 1.75 on the mean item score. Prevalence of caseness on Depressive items was 4.6%, on the Anxiety items was 6.4%, and mixed anxiety depressive disorder was 2.9%.

A four-factor model was needed to explain the HSCL items adequately, and according to their item content they were named Somatic, Suicidal ideation, Depressive and Anxiety symptoms. These correlated significantly with shared variance in the range 0.6-0.7. Using these items for the factors, the prevalence of depressive disorder was 7.5%, anxiety disorder was 8.5% and mixed anxiety-depressive disorder was 3.2%.

Using the original published cut-off compared with the cut-off given by factor-analyses in the population gives different prevalence rates in anxiety and depressive disorders.

The development and workings of beyondblue, the national depression initiative and its engagement with consumers and carers

Dr Nicole Jayne Hightet – Beyondblue – Australia

Beyondblue; the national depression initiative, is a bipartisan, national organisation established in 2002, to address depression in Australia. Initially funded (35 million Aus) *beyondblue* has recently been refunded for a further five year term. In this presentation the work and achievements to date will be viewed across beyondblue's five priority areas:

Community awareness and destigmatisation: overviews a range of strategies including community service announcements, media training and liaison and working with high profile people. *beyondblue* has also monitored changes in depression literacy and community attitudes over time, and outcomes from this will be detailed.

Consumer and Carer: Includes conducting extensive research with consumers and carers into the lived experience of persons living with mental illness. Key achievements in advocacy include rewriting guidelines around insurance to reduce discrimination for those with a history of depressive/anxiety disorders.

Prevention and early intervention: programs across the lifespan include a national postnatal depression screening program, schools based initiatives, programs within the workplace, and prevention of depression in the elderly.

Primary Care Reform: included the provision of training and healthcare reform to ensure public access to adequate psychological and medical healthcare for the treatment and management of depression and related disorders in the community.

Targeted Research: across all program areas has revealed important implications for future areas of extension and policy reform.

This presentation will provide an overview of the workings and achievements of beyondblue to date and key directions for the future, including the expansion and application of key program outcomes overseas.

Improving depression literacy in Australia, has this changed over time and how?

Dr Nicole Jayne Highet – Beyondblue – Australia

Beyondblue; the national depression initiative is committed to improving awareness and understanding about depression and related disorders in the community, and reducing the stigma surrounding these illness and those who suffer from them. Over the past four years a range of strategies have been employed including community service announcements, public forums, training of media health professionals and promotion of the lived experience of illness by both high profile and ordinary Australians.

In order to evaluate the impact and changes in literacy over time, beyondblue has developed a national survey, “the beyondblue depression monitor”. The instrument monitors community awareness, knowledge, attitudes and behaviours with respect to the perception, management and treatment of depression in Australia, and is currently been replicated abroad.

This presentation will detail results from the national surveys conducted in 2001 (N=900), 2002 (N=2000) and 2004/05. Key findings from initial surveys indicated that Australians do not view depression as a major health problem, have limited understanding about the illness, effective treatments, and its prevalence is generally underestimated. There was also clear evidence that there is significant stigma, and a lack of understanding and willingness to assist someone who may experience depression. Since this time there as been significant activity in the community, and the replication of the beyondblue depression monitor in October 2004/05 has revealed a number of significant changes in depression literacy in the community over this time, and highlights key factors which are likely to have contributed to this.

POSTER ABSTRACTS

Study of depression frequency in the students of Urmia Medical Sciences – University of Iran

Mr Nader Aghakhani – Urmia University of Medical Sciences – Iran

A depressive disorder is an illness that involves the body, mood, thoughts and behaviors. The first step in defeating depression is recognizing it. It is normal to have some signs of depression some of the time. But five or more symptoms for two weeks or longer or noticeable changes in usual functioning is all factors that should be evaluated by a health or mental health professionals. The economic cost for this disorder is high, but the cost in human suffering cannot be estimated.

Our research is a descriptive study to evaluate depression frequency in students of Urmia university of Medical Sciences in Iran. 700 students were given a standardized beck questionnaire. 628 of them answered to it. 52.6 % a had degree of depression, 4 % a had severe depression. The finding indicates that there are no significant relationship between depression with married or single students: Its severity was high in the students whose mother was dead and in non – native students, too. Its frequency has no significant relationship with age, rank of birth and duration of education, but there is a significant relationship between depression and the bad marks in their lessons.

Depression in our university is very prevalent, which can affect the quality of education and social behavior of the students. Students should be encouraged to seek professional help and offered emotional support. They mustn't give in to negative thinking. They must take an active role in getting better and they must be good to themselves, when they are getting well.

A tale of two cities: primary care and depression – What can GP's and service users in London and Melbourne tell us about what works in two different health care systems?

Ms Eugenia Cronin – Institute of Psychiatry – London

Starfield¹ developed criteria describing health system and primary care characteristics to rate primary care in 13 countries. These criteria differentiate the organisation and funding of primary care in Australia and the UK. Depression represents a significant burden of disease in both countries and there is evidence that organisational factors may hinder primary care for depression.

This study seeks to identify GP and service user perceptions of:

1. Health system policies shaping primary care mental health;
2. Application of these health system policies;
3. Effect on optimum primary care for mild to moderate depression.

Primary research is in the form of a two-round Delphi questionnaire using a panel of GPs and service users in each country, followed by additional research, if necessary, to explain divergent views. The questionnaire consists of 45 statements (15 from earlier Starfield research) and three questions to score for each, using a 9 point Likert scale.

Participants have been identified as follows: GPs with/without formal role in mental health in London and Melbourne; and service users/carers in London and Melbourne. Measures of mental illness need and deprivation have been used to ensure a good mix of socioeconomic settings are represented. The study is restricted to urban areas only.

Rounds 1 and 2 from the UK will be available. There are differences in participants' perceptions of policy versus application of policy, and differences in GPs' and service users' views about policy, reality and value of particular system features for management of this condition.

U.S Public Mental Health Systems: Breaking the Impasse in the Treatment of Oppressed Groups

Dr Jaimie Page – University of Texas at Arlington – USA

This paper focuses on oppressed mental health consumers in the United States. While recognizing the uniqueness of individuals, it is critical that the universal community mental health field understands the commonalities between those groups, and begins to incorporate that understanding into new strategies that can help address and end oppression. Highlights of those commonalities are that oppressed groups are underrepresented in mental health treatment and overrepresented in institutions. They experience various forms and manifestations of stress, historical loss, discrimination, isolation, and may experience poverty and other serious social problems. Mental health issues may be experienced, described, and approached in ways that are incongruent with traditional approaches to care.

Traditional Western approaches to mental health care and research are frequently irrelevant, inappropriate, and entrenched in values associated with the very system that seeks to oppress them. The mental health field should do more to help turn the tide of oppression, beginning with a better understanding of both the overt and subtle facets of oppression and by eradicating it through sufficient housing, health care, and income. Aggressive, appropriate attention to oppression in education, research, and professional publications will also help break the impasse in service delivery, as will promoting service non-traditional technologies that respect, incorporate, and build upon existing cultures and worldviews.

Particular attention is given in this paper to the very poor and homeless, people of color, immigrants, lesbian/gay/bisexual/transgendered (LGBT), and multiple layers of oppression. Specific strategies to break the impasse are provided (56 references).

The effect of exercise during gestation on postpartum depressive – like behaviours in rats

Dr Ziba Farajzadekan – Isfahan University of Medical Sciences - Iran

Several studies have reported that exercise alleviates the symptoms of depression and elevates mood states and quality of life. Exercise effects are due to alteration in β_1 and β_2 adrenoceptor population, increasing transcription of BDNF (brain-derived neurotrophic factor) gene, modulating body metabolism and increasing slow wave sleep. Although the positive effect of exercise on depression is repeatedly confirmed, little is yet known about the effectiveness of physical exercise during gestation on postpartum depression (PPD).

In our study on the effect of exercise during gestation on postpartum depressive-like behaviors, twenty female Wistar rats were randomly divided in two groups. Rats of the first group were exercised by running on a motorized treadmill at 5.5 m/min for 30 min/day on 10-17 days of gestation. And the second was the control group. FST (Forced Swim Test) was used to assess postpartum depressive-like behaviors. On postnatal days 3 and 4 dams were placed in swim tank and observed behaviors in FST (struggling, swimming and immobility time and diving number) were assessed as depression symptoms and compared by independent samples t-test. Findings showed that exercise decreased immobility time ($p < 0.001$) and increased struggling time and number of diving significantly ($p < 0.05$). There was not any significant difference for swimming time between two groups ($p > 0.05$). Results of this study imply that exercise during gestation alleviates PPD-like behaviors in rats.

Social isolation and microfinance NGO membership among women in Rural Bangladesh

Dr Joanna Maselko – Harvard School of Public Health – USA

Social isolation and lack of social supports are significant risk factors for the development of common mental disorders. Social isolation may be especially detrimental for mental health in developing countries where lack of formal institutions necessitates reliance on informal networks for access to various kinds of resources. Previous research has pointed to positive social

externalities of microfinance NGO involvement in lower income countries, yet the potential impact of participation in NGO programs in reducing social isolation is not fully understood.

In this study, we use data from a 2002 survey of 1,190 rural women in Bangladesh residing in six villages to examine the association between microfinance NGO membership (Grameen Bank and BRAC) and social isolation among these women. Twenty-one percent of women reported that they did not have a single confidante to whom they could go to for emotional support or in times of crisis. Women who have never belonged to an NGO were over twice as likely to report not having a single confidante (OR: 2.11, 95% Confidence Interval: 1.56-2.86) when compared with women who are currently members or have belonged in the past. This association was not explained by differences in age, education, income or other factors associated with social isolation and NGO membership.

Given the higher risk for mental health problems due to poverty and gender inequality in lower income countries, participation in NGOs may have a potentially positive impact on the mental health of women through reducing social isolation.

Study of hygienic life style and nutrition behaviour based on Rogers' Client-Centered Theory in Iranian students

Dr Ali Asgari/Professor Mahmoud Ghazi-Tabatabaie – Tehran University – Iran

The purpose of the study was to assess the mediating effect of conception of phenomenal or perceptual field on the relationship between self-concept and nutrition behavior based on Rogers' personality client-centered theory. Previous studies have failed to take account of mediating role of perceptual field in the study of such relationship. As Rogers suggested self-concept is not a direct determinant and organizer of behavior, but it is determined through and by perceptual field that considered in this study as perception and knowledge about health.

Undergraduate students (n = 505) selected through random cluster sampling were measured with the hygienic life style questionnaire adapted by Smith and Maurere (2000). Structural equation modeling was used to analyze the data. The results showed that the path coefficient self-concept over perception of health was 0.37 (p < 0.01). But the same value for nutrition behavior was -0.02. The path coefficient of perception of health over nutrition behavior was 1.3 (p < 0.01). Fit indexes were $\chi^2 = 8.88$ (p = 0.431, df = 1), GFI = 0.99 and AGFI = 0.98. RMR value was 0.022.

As observed, the perception about health as a mediating variable indicating the importance of the perceptual field in design and implementation of any educational and clinical intervention with regard to nutrition behavior.

Evaluation of the Threshold Assessment Grid (TAG) as a means of improving access from primary to secondary mental health services

Ms Mairi Stewart – Institute of Psychiatry – London

There is little consensus over how severe mental illness is specifically defined by different primary and secondary mental health services. This lack of clarity is problematic and can lead to inequalities in access to services due to the lack of a reliable and consistent means of prioritising the most severely mentally ill. To assist services in identifying and prioritising adults with mental illness the Threshold Assessment Grid (TAG) was developed. TAG is a 7-tick, one page standardised assessment that previous research has been found a valid and reliable tool.

The current study seeks to evaluate the implementation and use of the Threshold Assessment Grid (TAG) as a means of improving the referral process between primary and secondary adult mental health services. It is hoped that referrals from General Practitioners that are accompanied by a completed Threshold Assessment Grid (TAG) will contain the information required by Community Mental Health Teams & other Mental Health Services to assist them in the identification and prioritisation of the most severely mentally ill to facilitate access to treatment. As well as, improve agreement between General Practitioners and Mental Health Services on the appropriateness of referrals to secondary mental health services

Interestingly, this study is a multi-site clustered randomised controlled trial that is taking place across the Croydon Borough in London, as well as part of Manchester - covering a total population of over 500000. The study is due to end in June 2005.

Earthquake Impact and suicide phenomenon in Adolescent: a descriptive study in Nantou, Taiwan

Dr Chin-Hung Chen – Institute of Psychiatry – London

Suicide is currently the third leading cause of mortality among adolescents in Taiwan, but here were few reports of the prevalence of suicide ideation and attempted suicide in Taiwanese adolescents. After Taiwan 1999 earthquake, suicide problem emerged as an important public health issue due to the huge devastation of the disaster. Data from a school-based cross-sectional study were used to investigate the prevalence rate of suicide idea and attempted suicide in adolescent in Nantou area, the epicenter of the earthquake. The associations between age, gender, damaged level caused by earthquake, family support, physical assault victimization and suicide problem were also examined. A middle school sample of 6345 students from four schools in Nantou area was assessed with self-reported questionnaire in February, 2004. Data analyses were conducted by frequency description and multiple logistic regression.

24.8% reported having suicide ideation and 3.9% having attempted suicide during the preceding 12 months. 38% got influence by Earthquake. 21.3% and 15.7% reported the experience of being physically assaulted at school and home respectively. Factors associated with suicide ideation are female, school and domestic physical assault victimization, house damage and parents' unemployment due to earthquake, poor family support. Factors associated with attempted suicide are female, domestic physical assault victimization, parents' unemployment due to earthquake, poor family support and suicide idea which is the most associated. The prevalence of suicide ideation and attempt among adolescents in Taiwan earthquake area are prominent. The impact due to earthquake are associated with suicide idea and attempted suicide, even 4.5 years after earthquake.

The association of drinking and socio-economic position in a changing world: evidence from a developing country birth cohort

Dr Alexandre Ferraro – Federal University of Sao Paulo – Brazil

Recent population transition together with an expansion of alcoholic beverage industries within developing societies are changing traditional risk factors for hazardous drinking. Little is known about how the effect of socio-economic position (SEP) has modified. The objective was to analyse the association of SEP and drinking pattern among adolescents today and among their parents 16 years ago.

The sample included all males born in 1982 in Pelotas, southern Brazil, were contacted in 2000 when they were legally required to enlist in the Army at 18 years of age. Of the 2,890 subjects presumed alive, 2,250 participated in the study. Data about family income, paternal education and drinking in 1984 were used. Information about adolescent education and alcohol consumption was collected.

For adolescents, last week drinking and binge drinking was more prevalent among those who come from a wealthy background. Higher education was associated with non-hazardous drinking. Among the fathers, data collected 16 years before showed drinking associated with deprivation. The multivariate analysis confirmed that wealth is a risk factor for last week drinking and binge drinking in adolescence – OR=1.84 (1.31-2.58) and 3.04 (2.14-4.32), respectively – and that education is a protective factor. Fathers from this same wealth stratum had an OR=0.25 (0.07-0.91) for regular drinking.

There is a contrast in the association between hazardous drinking with SEP. Among adolescents higher drinking rates are linked to wealth, with a modulating effect of education. Among fathers drinking was apparently associated with deprivation. Possible explanations could be a cohort-effect or an interaction with age.

Macrominerals and Trace-Elements in Preeclampsia, a risk factor for schizophrenia

Dr Metin Donma – Suleymaniye Maternity and Children's Education and Research Hospital – Turkey

Eclampsia and pre-eclampsia are the leading causes of convulsions, coma and death for pregnant women and their fetuses. Pre-eclampsia, a serious complication of pregnancy is one of the birth complications that play a significant role in the development of schizophrenia. Alterations in metals may play important roles in the pathogenesis of both pre-eclampsia and schizophrenia. The aim of this study was to assess the concentrations of metals and introduce some elemental ratios for diagnostic purposes in order to clarify the altered mineral levels in pre-eclamptic toxemia and evaluate them in association with the mineral profile of schizophrenia.

A total of 90 individuals; 30 non-pregnant, 30 pregnant healthy women, and 30 patients with pre-eclamptic toxemia were included into the scope of the study. Serum calcium(Ca), magnesium(Mg), phosphorus(P), iron(Fe), copper(Cu) and zinc(Zn) concentrations were determined by the spectrophotometric and AAS methods, respectively.

In pre-eclampsia, decreased Mg($p \leq 0.01$), and increased P($p \leq 0.05$) levels were detected in comparison with those of healthy pregnancy group. Slightly higher Fe and Cu values concomitant with extremely low Zn values($p \leq 0.01$) may be suggested as the expected profile in pre-eclamptic toxemia. Five ratios, significantly increased Ca/Mg($p \leq 0.05$), Ca/Zn($p \leq 0.001$), Mg/Zn($p \leq 0.01$) and decreased Mg/Cu($p \leq 0.01$), Zn/Cu($p \leq 0.001$) in pre-eclampsia may be suggested as the parameters available for clinical diagnosis. This profile is consistent with the metal profile reported for schizophrenic patients.

Measurement of macrominerals and trace elements may be useful for the early diagnosis of a pre-eclamptic condition as well as taking preventive measures against the development of schizophrenia, which will certainly affect the child's well-being.

Cultural Issues and Stress Management: Group Approach

Mehdi Safari – Tabriz University of Medical Sciences – Iran

A human is complex and always had interaction with environment . Stress is a prevalent problem that involves people, but proper behaviour with stress forces to us. Nursing students are as health main members and prior to remove client stressors, must to enabled confronting with stressors. Group education causes to improvement of communities, self-concept and problem solving skills.

The aim of this Quasi-experimental study was to determine and compare effect of group education on stress and life experiences. In this study female student (n=9) were selected by convenience and purposive sampling. The instrument for gathering data was a questionnaire. Adaptation methods have educated during 8 sessions (stress awareness, relaxation methods, Interpersonal relationship skills, time management) . The results of study showed that group education had effect on reduction of stress (Wilcoxon test , $t=5.19$, $p < 0.005$), life experiences ($t=6.6$, $p < 0.005$) .

Nurses should to learned to methods of stress management for their life and client education. Educational groups provides one away for reduce stress and improve quality of life.

HIV-Risk Behaviours and Knowledge about of AIDS among Inpatient Psychiatric

Fatemeh Eskandari – Tabriz University of Medical Sciences – Iran

AIDS is a problem throughout the world and 95 percent of people infected population lives in developing countries. The aim of the research was to determine HIV-risk behaviour and knowledge about HIV-AIDS among inpatient psychiatric wards teaching hospitals in Tehran city.

230 patients of psychiatric ward were selected based on Quota sampling. 33.9 percent patients reported using substances in the last 10 years and 9.1 percent injected drugs and 76.2 percent of IV drug users shared a needle with other. 19.6 percent of patients had the history of sexual abuse. 27.8 percent had sex with multiple partners and 16.1 percent known to be same sex. 26.5 percent of patients reported sexual intercourse with IV drug users. 37.9 percent of sexually active patients had sex after or while using drugs and alcohol. Among demographic characteristics, gender ($p < 0.001$), occupational status ($p < 0.004$), living situation ($p < 0.05$) was significantly associated with drug and alcohol abuse, so that males, workers and people with lived in institutions reported a higher rate of drug and alcohol abuse. Gender($p < 0.001$) and number of hospitalization

($p < 0.007$) showed significant association with IV drug use, as, males and patients with more than six admissions in hospital had higher rate of IV drug use.

General levels of knowledge about AIDS, routes of transmission, prevention were all very limited. Older patients, patients with basic education, housewives, people who lived in institution, patients with more than eight year illness and people with more than six psychiatric admissions had a lower score on the AIDS-knowledge test. This study concluded by recommending that sexual history taking, HIV education and risk-reduction counseling become an integral component of the care of adults with a people with mental disorders.

Fertility and Fecundity Rates of Patients with Schizophrenia in Cuiabá, Brazil

Dr Jair Mari – Federal University of Sao Paulo/Federal University of Mato Grosso – Brazil

The aim of this study was to estimate fertility and fecundity rates from a representative sample of patients with schizophrenia from Cuiabá, Brazil.

All patients attending mental health outpatient services, in a period of three months, received a semi-standardized questionnaire related to parenthood, and diagnoses were confirmed by means of a DSM-IV checklist. Data from the general population of Cuiabá were collected from the census of Brazil, 2000.

488 patients completed the questionnaires: 260 (53%) were females with a mean age of 41.6 (SD=11.6) years old. 288 (59.3%) patients were ever married, and 293 (60%) were parents, being identified 982 children, with a mean of 3.35 children per parent. Multivariate analyses were performed and gender and marital status were significant predictors to fertility and fecundity. The fertility rate for female patients (78%) and the fecundity rate (3.4) were both higher than that estimated for the general population (69.4%, and 3.2 respectively).

Many patients with schizophrenia desire or will become parents in their lives. Nonetheless, parenthood can be a difficult task for these individuals because of the disease and its social barriers. Mental health services to deal with these specific needs of patients with schizophrenia are inexistent in Brazil, where the fate of these children remains unknowns.

Perceptions of depression among women in a poor community in Sao Paulo, Brazil

Dr Jair Mari – Federal University of Sao Paulo - Brazil

Depression is one of the most important disorders in the global burden of diseases, being deeply influenced by social and cultural context.

The aim of this study is to identify concepts of depression among women diagnosed with the disorder under treatment in a primary care unit, located in a deprived area in the outskirts of São Paulo. Qualitative study based on anthropology methods and techniques: ethnographic observation and in-depth interviews. 16 lower class women diagnosed with depression (F33- ICD-10), from a primary care unit, Jardim Santo Eduardo, were selected for participation.

This study was conducted in Embu, in the outskirts of São Paulo, a city comprised with slums, and faulty health. There are no leisure areas and most of the adult inhabitants are unemployed. It is reported as one of the most violent cities in Brazil.

For women, depression is deeply reported to their violent and unequal daily life. To be “depressed” in this community has two meanings: 1) “Authentic depression”: when women have suffered (loss of a son by violence, for instance) this suffering is recognised as a true feeling by community and they are supported by family and community. 2) “False depression”: although women have suffered (problems of relationship with partner, aggression from partner, for instance), this suffering is not recognised as legitimate by community. Women are blamed by their behaviour and community doesn't support their distress. In this sense depression can be viewed as a moral problem and not a disease.

The label “depression” has clear social inspiration, showing how this community also recognises the disease as a moral expression.

Parental Child-Rearing Behaviours in a Brazilian Urban Poor Community: Brazilsafe findings

Dr Isabel Bordin – Federal University of Sao Paulo – Brazil

The objective of this study was to verify the influence of child age and gender on different parental child-rearing behaviours and on severe physical punishment.

The BrazilSAFE (Brazilian Studies of Abuse in Family Environments) is a cross-sectional study, part of WorldSAFE (World Studies of Abuse in Family Environments) that involved researchers from six countries. The setting was an urban poor community near Sao Paulo city. The population was 813 mothers (aged 15-49 years) of children under 18 (probabilistic sample of 24 clusters based on census units, including all eligible households; attrition rate=17.6%). 28 child-rearing behaviours from mother/father in the past 12 months were investigated using a WorldSAFE copyrighted checklist. Child severe physical punishment defined as: hit with an object such as a stick, broom, cane, or belt; kick; choke by putting hand or something else around neck; smother with hand/pillow; burn/scald/brand; beat or shake (if age <2 years).

Logistic regression models were used to examine the effect of age and gender on parental behaviours. Younger age was associated to shout/yell/scream, twist ear, pinch, and spank buttocks with hand. Older age influenced seven parental behaviours: call names, curse, refuse to speak, threaten to kick the child out of the house, slap face/back head, hit head with knuckles, and hit body parts other than buttocks with an object. Boys were twice more likely to suffer severe physical punishment than girls [OR=2,0(1.4-2.8), $p<.001$].

Parental behaviours used for child rearing vary according to child age and gender. Boys are at greater risk for severe physical punishment in the studied community.

Does physical activity relieve depressive symptoms?

Ms Chia Yi Jenny Wu – Institute of Psychiatry, London – UK

Physical activity may play an important role in the improvement of depression in general, and it can also have similar efficacy to psychotherapy as well as providing no significant contraindication to the use of medication. Studies of older adults with depression have been limited, but physical activity appears beneficial to this population. Under the circumstances that only a handful of studies look at the effect of physical activity on depressive symptoms among elderly people in Taiwan, the proposed study aims to explore the relations of physical activity and depressive symptoms using representative community elderly samples.

One hundred elderly people were randomly selected from the administrative list of older adults aged over 65 from a catchment area in the capital city of Taiwan. The results indicated that the point prevalence for depression was 7%. Bivariate analysis found that the level of physical activity and depressive symptoms are significantly associated ($r=-0.42$, $p<0.001$). Perceived health status is correlated with both physical activity and depressive symptoms and may be a confounding factor. The study concluded that higher physical activity level among Taiwanese elderly people may serve as a protective factor in minimizing depressive symptoms. The more physical activity the elderly maintains, the less symptoms of depression she/he presents. More controlled, experimental and/or longitudinal studies to address the benefits of exercise or regular physical activity on mental health are required to clarify their causal relationship

Professional NGO collaboration in setting up Child Psychiatry Services: a low cost effective model

Dr Arun Kishore N.R – Medical College, Kerala – India

Kerala is the southernmost state in India. It has unique features of being the most literate State, having good health care indices, an upwardly mobile populace, and high levels of morbidity. Education of children is an important preoccupation of parents. This state has 231 Psychiatrists, 32 Clinical psychologists, fewer Psychiatric Social Workers and Psychiatric Nurses. There is one full time and 3 part time Child and Adolescent Psychiatrists.

With good obstetric care, infant mortality is low. There is a proportionate increase in the softer spectrum of Developmental Disabilities such as Speech and Language disorder and the

Specific Developmental Disorders of Scholastic Skills. The state has scarce resources to manage these children. School teachers are often overworked and have little time to devote to children who have difficulties in learning.

In this background, the joint venture of a Child Psychiatrist and a Voluntary organization (Association for Learning Disabilities India) has made tremendous changes in the services available to children who have problems in learning. This association has helped to create awareness, train teachers, special educators and empower caregivers in rendering services to these children throughout the State. After experimenting with various models over 11 years, a low cost feasible model has been developed. The core of this model is training caregivers in remediation of Learning problems in Children as well as addressing caregiver distress.

This paper describes the process through which this model was developed.

Neighbourhood socio-economic deprivation and delayed recovery from severe mental disorder: a multicultural study from New Zealand

Dr Melaine Abas – Institute of Psychiatry, London – UK

It is not clear whether greater socio-economic deprivation is associated with delayed recovery from severe mental disorder.

A representative sample of adults (n=322) requiring inpatient psychiatric admission living in a defined geographic area in South Auckland, New Zealand were followed from admission to discharge. 34% self-identified as Maori, 11% Pacific Islander, 40% European and 15% Asian. Deprivation, as an individual attribute, was measured using the New Zealand index of deprivation for small areas (NZDep96). Length of stay was used as a proxy for delayed recovery.

The mean admission length was 21 days for those from the most deprived areas, compared with 12 days for the least deprived areas. After adjusting for ethnicity, marital status, diagnosis, chronicity, psychiatric symptom severity, physical disability, consultant psychiatrist and involuntary admission, length of stay for those living in areas ranked as most deprived was still 7 days greater than for those living in areas ranked as least deprived (LR test $\chi^2(2df) = 6.09$, $p = 0.048$).

Greater deprivation is associated with delayed psychiatric recovery (as measured by greater length of stay), even after taking account of key confounding variables. Individual deprivation and deprivation of neighbourhood of residence should be assessed routinely in clinical practice and the information used to facilitate discharge planning and optimise management and access to community care. Neighbourhood deprivation should be taken into account when comparing the performance of local services and when allocating resources.

What is the contribution of breast feeding to maternal mental health? Is it important?

Dr Orkide Donma – Istanbul University – Turkey

Postpartum depression is a serious, common, and treatable condition that often goes unrecognized. Postpartum depression among women has been shown to have adverse consequences among mothers and infants. However little is known about the relationship between breastfeeding and depressive symptoms.

Compared with not breastfeeding, breastfeeding is associated with increased parasympathetic nervous system modulation, greater vascular stress response, lower perceived stress levels, and fewer depressive symptoms. Breastfeeding exclusively is associated with an attenuated initial sympathetic cardiac nervous system response to some laboratory stressors. Bottle-feeding is associated with increased sympathetic and decreased parasympathetic cardiac control. The act of breastfeeding is associated with decreased neuroendocrine response to stressors and decreased negative mood. Finally, breastfeeding is associated with enhanced physical and mental health compared with non-breastfeeding.

Breastfeeding is negatively associated with perceived stress. Mental health benefits include reduced response to stress and promotion of maternal behaviour and bonding. Breastfeeding revealed negative associations for psychological illnesses. Frequency of bottle-feeding is positively associated with perceived stress.

Maternal mental health status deserve attention as modifiable factors in promoting breastfeeding continuation. Attention should also be paid to maternal mental health status not only for the health benefits to mothers but also as a potentially modifiable factor in promoting breastfeeding continuation. Understanding the relationship of depressive symptoms and breastfeeding patterns may help community health nurses provide interventions and support that enhance breastfeeding exclusivity, duration, and promote maternal mental health. Paediatricians, obstetricians, midwives, and community health workers should be encouraged to consider maternal mental health as well as physical health.

Factors hindering mental health promotion in Ghana

Mr Kwabena Otoo Siaw – Centre for Human Health Care (Youth Life Care – Ghana) – Ghana

The roles of Non-Governmental and Governmental institutions towards mental health promotion and improvement in Ghana are under performance. This predicament has created problems in the mental health sector. The aim is to identify major factors hindering mental health promotion and improvement in Ghana and find possible solutions

Mental health services, Non-governmental organisations and individuals were randomly selected for the study through questionnaire and personal interactions. There are inadequate mental health facilities and professionals in the country. The few professionals have left for greener pasture elsewhere due to poor remuneration. The stigma attached, makes it more difficult for individuals with mental problems and affected families to be more open. Most families and institutions do not welcome individuals with mental problems even after rehabilitation. Cultural, social and traditional issues attached, people do not associate themselves with persons with mental problems as such hinders mental health improvement and promotion in Ghana and world at a large. Roles of Non-governmental organisations towards mental health promotion and improvement are hindered due to lack of funds and other resources.

Government should increase mental health facilities in Ghana and provide good conditions of services to mental health service providers.

The government should co-operate with international donors and provide material and financial support to Non-governmental institutions for mental health programs planning and implementation. There should be frequent mass education about mental health to eradicate the stigma and other social and cultural misconception attached.

Understanding child/youth emotional and behavioral concerns and use of mental health services in three Brazilian primary care settings (Sao Paulo, Rio de Janeiro and Fortaleza)

Ms Cristiane Silvestre de Paula – Federal University of Sao Paulo – Brazil

The objective was to develop new knowledge to improve mental health assistance at primary care settings for low-income children and youths in three Brazilian sites; through investigating how primary care sites can better detect/refer/treat children with mental health problems (MHP).

Design: Qualitative study based on focus groups and interviews with parents, youths and primary-care providers at two clinics from each of the three sites. Participants: 143 participants from 18 focus groups and 8 interviews. Sites: three Brazilian urban poor communities (São Paulo, Rio de Janeiro and Fortaleza).

Results: a) general problems: poverty, violence, lack of services and/or difficulty getting access to them (according to participants: “it seems like people aren’t even people when they live here”); b) some professionals from primary care (especially from reception), often hear/orient/give counsel, seeking to help solve MHP; however, this intervention is based on common sense and takes place without any previous training; c) according to psychologists/psychiatrists, most of their child/youths patient’s problems are more related to family counseling than specific mental health treatment; d) according to providers, all professionals should be trained to identify MHP, counsel youths, support and know where to refer them; e) all agree that there is a need to implant services for youths in the community with professionals serving as reliable references for them.

Participants refer a strident lack of resources to treat child/youths MHP. Providers should be trained to better identify and deal with these problems. Counseling programs for parents could be a useful resource.

Dementia care in resource limited settings: the role of dementia clinics

Dr Shaji K.S – Medical College, Kerala – India

There is an increasing need for dementia care services in the developing world. We need to consider starting specialised services for people with dementia , at least in the major general hospitals. This paper describes our experience in developing such a service at Thrissur, in the South Indian state of Kerala . The aim was to set up a suitable model for out patient dementia care, based on principles of palliative care.

DSM IV criteria were used for the diagnosis of dementia. Assessments included Mini Mental State Examination (MMSE), Neuropsychiatric Inventory (NPI), Everyday Activities Scale of India (EASI), and Clinical Dementia Rating scale (CDR).

During the study period from April 2002 to February 2004, we assessed 202 subjects There were 137 patients who met the DSM IV criteria for dementia. One-fourth of these patients had vascular dementia. Use of standard assessments made clinical evaluation easier for the clinicians. This clinic provided opportunities for training both undergraduate and postgraduate medical students. We were able to train many researchers in the use of tools used in dementia research. The feed back from the caregivers and their families was encouraging.

Dementia clinics can be set up in general hospitals using existing resources. This will provide training opportunities for clinicians and researchers. The caregivers seem to benefit most. Though clinic based, such services are capable of providing support to home based care.

Investigating the Mental Health of Older Bangladeshis in Tower Hamlets, London: a pilot study

Dr Pamina R. Mitter – Institute of Psychiatry, London – UK

In Tower Hamlets, London Bangladeshi migrants are often underprivileged with poor English skills. The mental health needs of older Bangladeshis may not be met as they predominantly present to secondary services at a late stage of their illness.

The aims were to establish the acceptability and feasibility of using a research interview in this population. To gain qualitative information on the mental health needs of older Bangladeshis.

A research interview was piloted in 8 service users and carers. Bangladeshis over the age of 50 and their families were recruited for interview by leafleting and door-knocking in randomised census output areas. In collaboration with the charity *Age Concern* qualitative data was sought from service users and local community groups.

After amendments the interview took less than an hour and included the 12-item EURO-D depression screen, the 6-item Cognitive Impairment test, the CSI-D informant interview and an amended Client Services Receipt Inventory. 550 randomised households were targeted in the community. 13 households included an older Bangladeshi, of which 5 wished to participate in the research. There were difficulties in accessing secondary services and a general lack of knowledge about mental illness in the community.

We have developed a culturally acceptable and feasible method of establishing the level of cognitive impairment and depressive symptoms and service use in this community.

There is a local need for a bi-lingual outreach educator to inform older Bangladeshis and their families about mental health issues and *Age Concern* are currently seeking funding for this post.

Sexual Violence in Married Women aged 15 and older Residence of Tehran City, 2003

Mrs. Massomeh Alimohammadian – Tehran University of Medical Sciences – Iran

Sexual violence is a serious public health problem affecting millions of women each year worldwide. It is driven by many factors operating in a range of social, cultural, and economic contexts. Sexual violence can profoundly affect the physical, emotional, mental and social well-being of victims.

This cross sectional study estimates the prevalence of sexual violence; its contributing factors, and associated effects on women's mental health. Data's from 1189 married women, aged 15 and older resident families in city of Tehran indicate that 10% women reported experiences of sexual violence by their husbands which among them 91% had psycho emotional distress and 53% had physical distress. Data's about women's mental health status indicate that overall 32% women were suspicious with psychological disorders such as depression and anxiety. The chance of mental disorders was 4.8 times higher in women who experience sexual violence comparing to those who did not (OR = 4.8 CI: 95% 2.98, 7.72).

Main contributing factors to sexual violence are women's age and educational status, chronic physical and mental diseases in victims and their husbands, husband's job, educational status, suspicious, and addiction, and having multiple children specially 5-12 years old in family. Most of victims feel unhappy and unsatisfied in their marriage life. The results of this study along with the other data's on this important hidden public health issue indicate that to combat sexual violence should focus on education and raising awareness, including educational programs for health care providers, in schools, and other settings that address gender relations, sexual coercion, and skills for building healthy relationships.

Social Exclusion and Mental Illness. A Case Study of Cambodia

Mr Laurent Chapuis - Consultant for Social Policy and Institutional Strengthening with Cambodian Ministry of Social Affairs, Veterans and Youth Rehabilitation Children in Need of Special Protection UNICEF CAMBODIA

This study examines the life experience of people with common mental health disorders in developing countries using a social exclusion framework and a case study in Cambodia. It first explores mental illness in relation with health, poverty, education, gender, age, environmental change and social relations. Life stories from members of NGO supported self-help groups addressing emotional and economic needs then provide contextual insights on how extremely poor people with mental disorders access different capitals in rural Cambodia. This work subsequently unravels relations between individual, family, civil society, market and state, and underlines how these mediate access to resources and rights.

The findings confirm the circularity of disadvantage experienced by mentally ill people. They also stress the value of the concept of social exclusion in understanding and explaining the experience of mentally ill people by pointing at the role of market failure and un-enforced social rights in the discrimination experienced by mentally ill people, and by revealing relational and trans-generational dimensions in the exclusion encountered.

This understanding of mental illness suggests a holistic approach to mental health promotion. Responding to mental distress in a development context involves a synthesis between Western and indigenous healing practices. In parallel, the promotion of self-help groups to enhance people with mental disorders self-esteem and to improve their access to resources and rights demands to reconcile seemingly opposed solidarity and economic logics. These questions advocate in favour of a contextual approach addressing mentally ill people's specific needs while promoting their participation into the wider community.

Diabetes, ethnicity, and common mental disorder; Findings from the UK National Psychiatric Morbidity Survey

Dr Jay Das-Munshi, Institute of Psychiatry, London – UK

The objectives were to determine prevalence rates of common mental disorder in a national sample of people with diabetes, and to analyse the effects of age, gender, social class and ethnicity on such associations.

Analysis of data on 8550 individuals, drawn from the 2000 United Kingdom National Psychiatric Morbidity Survey (UK NPMS). 249 individuals identified themselves as suffering from diabetes; diagnosis was confirmed against prescribed medications. Measures used included the Clinical Interview Schedule-Revised.

People with diabetes were 60% more likely than the rest of the population to screen positive for common mental disorder, much of this association was accounted for by sub-syndromal mixed anxiety and depressive disorder. This association persisted when age, gender, ethnicity, and socioeconomic status were adjusted for, but lessened when disability was included. People who had diabetes and described themselves as of African Caribbean, West Indian, or 'Other' ethnicity were 5 times more likely than others, to screen positive for common mental disorder.

People with diabetes are more likely to suffer from common mental disorder. This association may be mediated by disability. The findings also suggest that the experience of living with diabetes amongst specific minority ethnic groups predisposes to an increased risk of common mental disorder. This is a significant finding as diabetes is known to be more prevalent amongst certain ethnic groups, having an important impact with respect to disease prognosis and progression, and potential differential access to services.

Achieving Culture-Fair Child and Family Assessment: Meeting the Needs through a Research-Informed-Practice (RIP) approach.

Professor Dr Smadar Celestin-Westreich - Dept. Developmental Psychology, Vrije Universiteit Brussels

Despite its multicultural reality, socio-cultural specificities remain insufficiently addressed in European child and family assessment. This need especially applies to children's psychosocial assessment, in which psychometrically sound, developmentally adequate methods are sparse.

This paper 1) identifies unmet needs regarding culture-fair child and family assessment, 2) formulates suggestions for operationalisation through a RIP (Research-Informed-Practice) approach. Data from an ongoing European study into culturally diverse children's family experiences illustrate this approach.

Achieving culture-fair informal and formal child and family assessment requires differential, yet complimentary practices. Informal assessment requires cultural competence development through: a) acknowledgment of sociocultural specificities in families' psychosocial experiences, b) constructing a knowledge-basis of these experiences, c) training abilities in recognizing and dealing herewith. Culture-fair formal assessment, in turn, requires that families' socio-cultural diversity be reflected in psychometrically adequate instruments by investigating whether a) test-taking procedures are culture-sensitive and bias-free, b) test content and construct validity are free from cultural bias, and c) normative data sufficiently represent diverse population segments. More organised efforts are still needed to meet such requirements through systematic implementation into assessment training and psychometric test development.

In our study, 100 children from Belgian and French North-African, African and Creole families provided insights into differential effects of gender, sibling-rank, and family composition on their family experiences as expressed on the 'Animal Family Drawing test' and 'Family Relation Test'. Moreover, intercultural along with socio-economic effects underscore the need to validate socio-cultural variations when attempting to understand children's psychosocial development and possible difficulties herein. The RIP approach further discusses systematic implementation of these insights into the outlined components of informal and formal child and family assessment practice.

All Equal? Fostering Fair Mental Health Services for Disadvantaged Youth and their Families through Evidence-Based Protocol Implementation in France.

Dr Leon-Patrice Celestin - Hospital Poissy-Saint-Germain-en-Laye - France

France's specific egalitarian orientation has limited focus so far on socio-cultural identificatory processes in mental health services. Paradoxically, this firm egalitarian context may have contributed in its own way to under-recognition of socio-economic and cultural disparities among disadvantaged youth.

This paper aims to 1) identify prevalence and sources of stigma in mental health services, 2) provide guidelines for advancing fair practices. One trimester of youth referrals and follow-up was systematically examined, with data being drawn from a mental health service deserving a large, socially mixed western-Paris region.

Eighteen youth (aged 11 to 17 years) were clearly identified as presenting a (family) developmental history of misdiagnosis. Misdiagnoses consisted chiefly of depression, hypomania, mania and posttraumatic stress being mislabelled as psychotic manifestations. Ensuing inadequacy of services leading to current referral thus appeared to result from a poor understanding of socio-cultural variations in manifestations of psychosocial distress and/or psychopathology. Moreover, more subtle forms of socio-cultural stigma expressed in longer treatments, higher symptom resistance levels and multiple referrals can be linked to an identified lack of staffing and personnel training in socio-economically disadvantaged service delivery sections. Interestingly, cumulative effects may occur through patients' own reluctance to address socio-cultural issues in a context that values fading hereof. The implementation of a research-guided, evidence-based protocol is further presented and discussed as an effective means of a) systematically gathering valid and reliable mental health data that allow identification of relevant risk and resiliency factors, b) providing leads for adequate treatment implementation, c) facilitating patient - service provider communication on potentially sensitive issues and d) personnel training.

The effect of massage therapy during Labour on pain and anxiety

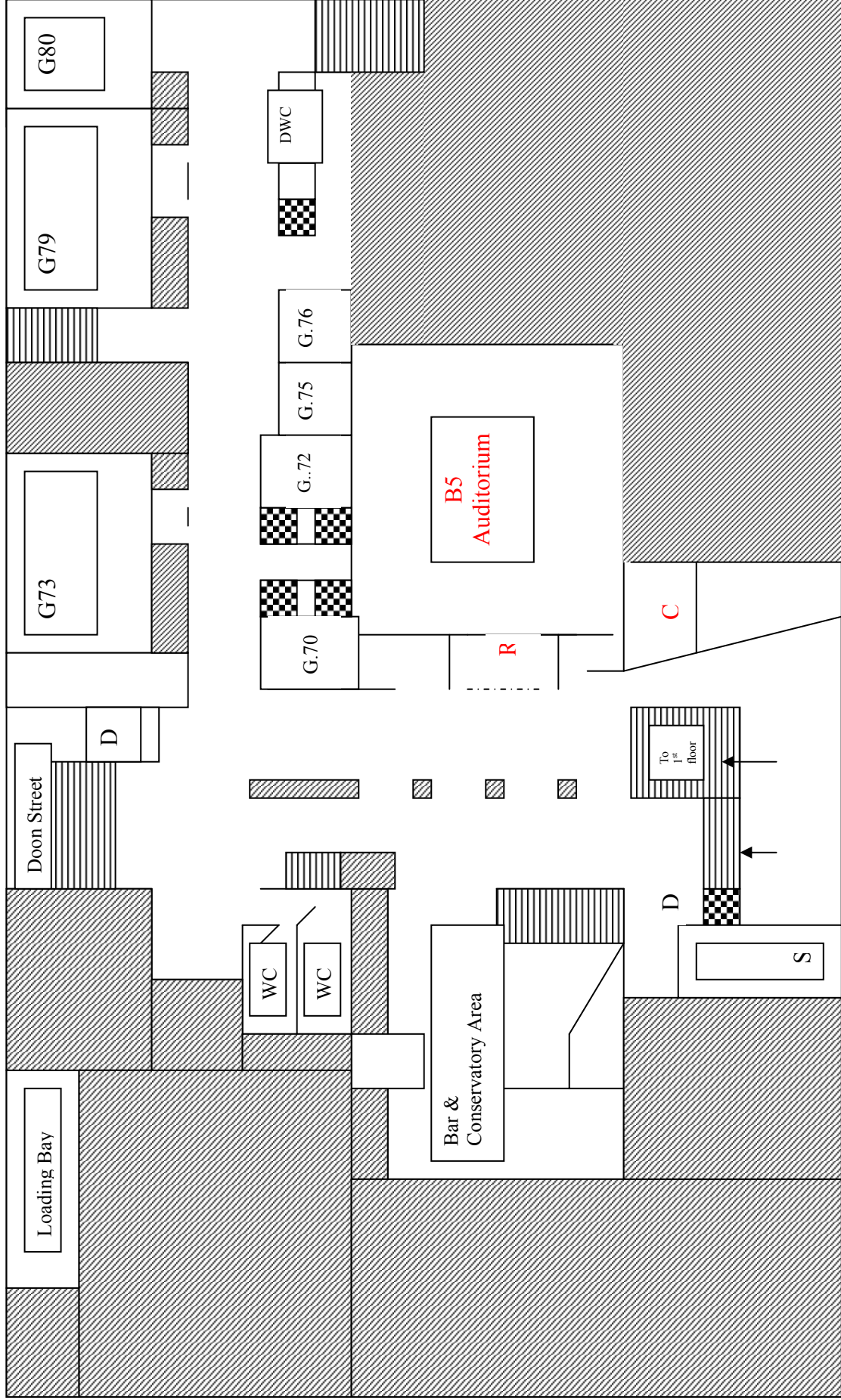
Mr Nahid Khodakarami - Shahid Beheshti Medical University – Iran

Labour pain is the most severe pain that the majority of women experience during their lifetime (1) in nulliparous it is more severe and durable which could cause unpleasant psychological effects, phobia, anxiety and non-confidence. Coping with pain in labour is recognized as being of crucial importance to women preparing for childbirth and there is now widespread interest in the use of massage as a form of reassurance by gentle touch or as a method of pain and anxiety relief in labour.

This research was a semi experienced clinical experimentation which had one stage and two groups. The study community were The women that address for delivery in mahdieh teaching Hospital. In-depth interviews with the pregnant women have been completed and key themes are being identified: Confidence, anxiety,, relaxation and comfort.

When interviewed, the mentioned that using the massage program helped them feel more confident in the whole of the labour process and in their own ability . Using the program appeared to have made an impact on anxiety, which was expressed in varying ways: increased confidence, comfort, relaxation, preparing for the birth .

We found that the massage may help to nurture and cultivation a belief in the woman's ability to birth her baby quite spontaneously, without anxiety. There is a powerful feeling of satisfaction when a mother manages her own labour with support and encouragement, culminating in a responsive baby, able to continue the physiological process of adaptation to the outside world. The use of massage not only makes labour a pleasant procedure but also can reduce number of elective caesarean section arising from the phobia of labour pain and labour's side effects on mother and baby



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