the committee's unbridled enthusiasm for community psychiatric nursing services:

> 'the Health Authority should expedite the expansion of the CPN Service in Harrow';
> 'an increase of two CPNs per year should be planned';
> '210 clients are currently supported by CPNs in Harrow. The service is clearly an important factor in the development of community services'.

The evidence on which these views were based is not stated and none of these recommendations or statements of opinion was placed in the context of other information about the management of patients within the unit. The 210 patients being supported by eight fulltime CPNs may be compared with the lists of over 200 patients that at least two consultants carry in their out-patient clinics. One might ask such questions as what type of patient is being seen in the two services? What is the overlap? What decisions are taken by the two services? What is the most cost effective way of preventing relapse and readmission? The HAS Committee recommendations ride roughshod over these issues. Community nursing services are good, psychiatrist-run outpatient clinics are bad.

Most distressing was the apparently complete lack of interest of the HAS team in serious clinical research. Such minor references to work at Northwick Park as appear in their report are mostly disparaging and it seemed that any appeal for evidence to substantiate particular opinions was regarded as a challenge to their right to issue authoritarian judgements on how a psychiatric service *must* be organised. We too protested individually and in considerable detail about aspects of the report, but these criticisms were brushed aside by the Director of the HAS.

The problem is one of excessive bureaucracy and centralisation. Because the remit of the HAS is so ill-defined and because the recommendations of the HAS have statutory force, power and influence over the psychiatric services have been concentrated in a few hands. Even if those involved were all well informed about the scope and limits of psychiatric knowledge this state of affairs would be undesirable.

In our opinion it would be much better that the HAS should be abolished than that it should continue in its present cumbersome and potentially destructive form. If it is to continue at all its remit should be restricted to identifying and correcting palpable psychiatric malpractices. It appears that this could be achieved with less contention, and considerably less expense, than is involved in the HAS system as it now operates.

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See page 145

British psychiatrists in Canada

DEAR SIRS

When I read G. M. Green's article about British psychiatrists in Canada (*Bulletin*, April 1985, **9**, 77–78) I thought it covered the topic well and was therefore surprised when I read Ishrat Ali's letter (*Bulletin*, December 1985, **9**, 251). Because of my interest in the subject, I thought it only fair to give you another opinion of the situation.

It should be pointed out to any psychiatrist considering a move to Canada that Health Delivery is a Provincial, not a Federal, responsibility in Canada and what can be offered by one Province may not be available in another.

If a psychiatrist intends to emigrate to Canada and have a non-restrictive practice, he will require the LMCC and the FRCP(C) within a given period. However without these qualifications restrictions on practice do not always place the psychiatrist in a hospital remote from big cities with the higher cost of living inferred by Ishrat Ali.

With respect to emigrating to the Province of Alberta, I would suggest any psychiatrist considering the move first to secure a locum contract and experience the change of life style and professional practice. To be able to secure a contract it would be necessary for the psychiatrist to obtain a special licence from the Alberta College of Physicians and Surgeons and this would enable him to work within the terms of the contract.

During the contract period he should obtain from the Canadian College of Physicians and Surgeons what additional training is required to obtain the Canadian qualifications and also discuss with the appropriate schools of medicine how these could be obtained. Then with all this information make a decision on whether or not to emigrate.

It is difficult to assess what financial gain the psychiatrists would experience. Not having lived in England for several years, I'm not aware of the cost of living, but from the comments of a locum psychiatrist at present working with us, the cost of living in this area is comparable to England and the Canadian fee schedule much more attractive.

Should any of your readers require further information, I would be pleased to provide relevant data with respect to the Province of Alberta.

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DEAR SIRS

I feel that Dr Ishrat Ali paints too gloomy a picture. For one accepted as fully trained the pay is now about twice the $70,000 (Canadian) that he gives. The work is rewarding in

that there is a much more abundant supply of nurses, social workers and psychologists (e.g. 390, 19 and 9 respectively for 400 patients) who will enthusiastically support any new enterprise. Agreed, distances are far by English standards, but highways are good and for us here the cities and universities of Edmonton and Calgary are one and two hours away by car. Food is cheap in relation to income; it is only three times city prices if it has to be flown in as in the far north where there is little psychiatric practice.

North American training is for private (i.e. office) practice, hence a low recruitment to the hospital of Canadian graduates. For those who decide on the hospital life work can be truly enjoyable and satisfying and off-duty the Canadian West has so much to offer recreationally. True, registration is now more difficult as so many overseas medical graduates have wished to come here and the former privileged position of those of us from the UK has been lost as discriminatory. Those wishing to apply will be warmly supported by those of us waiting to welcome them.

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Psychiatric problems in Afghan refugees

DEAR SIRS

It may be of interest to readers of the *Bulletin* to learn about the psychiatric implications of the war in Afghanistan. In the past seven years 3.5 million refugees have crossed the border from Afghanistan into Pakistan, with more than two-thirds of them settling in the North-West Frontier Province (NWFP). Because of this influx, considerable pressure has been put on all health services of the Province, including psychiatry. Since there are no formal psychiatric facilities in the refugee camps of towns other than Peshawar, the provincial capital, many Afghans make use of the clinics and hospital services in the capital. We have carried out a psychiatric field survey of 7000 Afghan refugees living in camps near Peshawar, and analysed the diagnostic pattern of 3000 patients who attended the outpatient clinic of the Post-graduate Medical Institute of Leady Reading Hospital over a two year period (1981–1983). We used standardised questionnaires to record age, sex, occupation, education, psychiatric symptoms, past treatment, and religious belief system. Duration and nature of exposure to combat were also recorded. This was accomplished through an initial screening by a social worker and followed by examination of the mental state by a psychiatrist.

The commonest syndrome was reactive depression in which vivid dreams, visual hallucinations and moderate to severe agitated depression were the predominant symptoms. These patients required some kind of treatment, usually antidepressants, rarely ECT. Neither these patients nor their close relatives had been involved in combat in the field. Most had been living in villages close to actual combat areas prior to migration. The main content of their visual hallucinations were 'Helicopter gunships firing at us' 'Aeroplanes', 'Red Russians with guns', and uniformed men attacking. The second most prominent group of the outpatient attendees and of the surveyed psychiatric population showed marked phobic neurosis, in many instances amounting to just short of panic. The main phrase used was 'fear of the unknown'.

Compared with the native Pakistani population of NWFP, as examined by the author in a separate survey of 1500 adults (900 urban, 600 rural), there were both similarities and differences:

Similarities

(1) In both groups a majority of patients sought treatment from traditional healers initially.
(2) The Pathans of both groups (a proud, militant tribal group of Pushtu-speaking people of NWFP and South-east Afghanistan) denied depression and felt ashamed about this word.
(3) Religious faith in Afghans and in the rural host population is very strong.

Differences

(1) There were significantly more psychiatric problems (30%) in refugees compared to the local population (14%).
(2) Reactive depressive psychosis was prominent in Afghan patients (35%) compared to the local population in whom depression was rare.
(3) Phobic anxiety was common (26%) in the refugee population and was mainly a female problem. In the local population this syndrome is rare.
(4) Refugees have a great understanding of the psychological nature of their symptoms while the local population present more somatic complaints in connection with mental illness. Thus, most Afghans relate their illness to psychosocial causes while the majority of the local population with similar problems believe they are physically ill.

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Psychiatric services and the community

DEAR SIRS

We were interested to see Dr M. T. Haslam (*Bulletin*, January 1986, **10**, 10) drawing attention to the accumulation of long-stay patients in psychiatric units, a problem obviously of increasing concern with the move to community care.

We have operated a community oriented psychiatric service in this district of approximately 100,000 population for over seven years, having for most of this time only one mixed admission ward of 30 beds to cope with all problems apart from senile dementia. Currently there are only four patients who have remained continuously on the Ward for over a year and none have remained over six months and