resident in hospitals for extended periods and often against their will.

Clearly, these are thorny issues. However, mental health patients have the same right as any other patients to access to health promotion and to protection from the harmful effects of smoking. In this complex environment, the attitude of mental health professionals is likely to be of great importance and a recent survey revealed that mental health staff have significantly less positive attitudes towards providing smoking-related intervention to their service users than general medical staff (McNally *et al*, 2006). There is also some evidence that smoking-related attitudes differ across professional groups. For example, in one study doctors ranked smoking cessation as more important than nurses did (Braun *et al*, 2004). However, it appears that once smoke-free policies have been in place for some time, staff develop much more positive attitudes towards smoking cessation. This shift in opinion may flow from the fact that smoking bans have rarely been found to lead to increased aggression and adverse incidents and, in fact, have even had a positive effect on ward functioning in many cases (Lawn & Pols, 2005).

It is clearly important that patients with psychiatric disorders are not deprived of their right to a smoke-free environment because of unwarranted assumptions about what can and cannot be implemented within a hospital setting. Also, many mental health patients are now cared for in the community, where these arguments are irrelevant. It is therefore essential that psychiatrists exercise their duty of care and leadership in promoting smoking cessation at both individual patient level and within their institutions, to protect their patients from the serious consequences of smoking.

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THEMATIC PAPERS – INTRODUCTION

The mental health of refugees

David Skuse

Behavioural and Brain Sciences Unit, Institute of Child Health, London WC1 1EH, UK, email d.skuse@ich.ucl.ac.uk

Concerns about the fate of refugees, displaced because of war or famine and in some cases by genocide, are now expressed almost daily in news broadcasts and other media. This is a global problem, but currently there is a particular focus on the needs of Africa, and the terrible internal conflicts that are occurring in countries such as Sudan and Somalia. In our thematic section for this issue, we present three papers that express concern about the mental health of refugees.

In a series of polemical statements, Dr Njenga sets out the urgent challenges facing the international community. He discusses the former genocide in Rwanda and the scale of the conflict in Somalia, from which thousands of refugees are fleeing to Kenya, to escape a civil war between Islamists and warlords, thereby putting pressure on the fragile mental health infrastructure of that country. He mentions the high rates of post-traumatic stress disorder among refugees in Sudan. The failure of the world to take action to prevent the incipient genocide of the displaced peoples in Darfur has been described by President George Bush as putting the credibility of the United Nations at stake.

The suffering of the people of Sudan is the subject of the article by Drs Loza and Hasan, from Egypt. The south of Egypt borders Sudan, and many refugees have moved north. The number of displaced persons is so large that pressure is being put on the reception facilities in Egypt that are endeavouring to cope with them. Drs Loza and Hasan point out that not only do refugees have experiences of murder, rape and torture to come to terms with, psychologically, but also, in the foreign country to which they have escaped, they are likely to face racial discrimination and invariably

https://doi.org/10.1192/S1749367600005051 Published online by Cambridge University Press

will experience cultural dislocation. Both articles discuss the potentially beneficial role of traditional healers in assisting refugees. It would be interesting to learn more about the interface between traditional healing practices and psychiatric disorders associated with displacement and trauma. In this context, we need to be particularly vigilant about the needs of refugee children, whose development may have been harmed not only by their experiences but also by the associated famine and illness.

Finally, we have an article by Dr Mufti and colleagues concerning a chronic problem: refugees from the many years of conflict in Afghanistan who have moved across the border into Pakistan. The authors conducted a systematic study of refugee mental health in camps in Peshawar. They comment on the stress the large number of refugees has put on the fragile health service infrastructure in the host country, and they commend Pakistan for its positive response. The article reports a preliminary investigation that aimed to identify the prevalence of post-traumatic stress disorder. Rates were very high: indeed, most refugees seemed to be affected. This represents a similar story to that described in our papers on African refugees. There can be no doubt about the scale of the problem. Now, as psychiatrists who care about refugees within the international community, we should be working with our colleagues in the host countries to find the most efficient way of addressing it.

THEMATIC PAPER – THE MENTAL HEALTH OF REFUGEES

Refugee mental health challenges in Africa

Frank G. Njenga FRCPsych

President, African Association of Psychiatrists and Allied Professions, Upper Hill Medical Centre, 3rd Floor, Suite 3C, Ralph Bunche Road, PO Box 73749, Nairobi 00200, Kenya, email fnjenga@africaonline.co.ke

Nearly all low-income countries are either just themselves emerging from conflict or neighbour a country that has just emerged from one. According to the Office of the United Nations High Commissioner for Refugees (http://www.unhcr.org), of the 38 million uprooted people in 2003 worldwide, Africa played host to 13 million internally displaced persons and 3.5 million refugees.

The world's refugee burden is carried by the poorest countries. Significantly, of the 127 wars since the First World War, 125 have been fought in low-income countries, and 16 of the 20 poorest countries in the world have had a major conflict in the past 15 years. It is now accepted that, in Africa, conflict causes as many deaths as epidemic diseases. In addition, most of sub-Saharan Africa is listed by the World Bank as existing below the poverty line. It is therefore precisely these poor countries that have to share meagre resources with refugees and internally displaced persons. Given the link between psychological trauma, poverty and mental disorder, it is to be expected that refugee camps would have high rates of mental illness.

Other contributors to the challenge

Following political independence, many African countries enjoyed high levels of social and economic growth, before plunging into states of conflict, poor governance, corruption and, in some, total collapse of the central government authority – in the case Somalia for the past 13 years. In 1994, Rwanda experienced a genocide that lingers in the minds of all witnesses, African and non-African alike. Natural calamities such as droughts, famine, floods and earthquakes further contribute to high social morbidity. Terrorism has not spared the continent either (Njenga *et al*, 2004). Hitting the continent with increasing ferocity, mainly directed to women and the poorest, is HIV/AIDS, with current estimates showing 40 million infected. In some countries such as Botswana, the prevalence rates are up to 40% and life expectancy in some parts of Kenya have dropped from a high of 65 years before the pandemic to 38 years, in the process decimating the workforce, including that within the health services.

Mental health, poverty and special groups

It is now well established that poverty is an independent predictor of poor mental health (Holzer *et al*, 1986; Muntaner *et al*, 2004). It is also well established that particular groups in the population have higher rates of mental disorder, especially depression – for example, abused women, people living in extreme poverty such as slum dwellers, persons traumatised by conflict and war, migrants, and children and adolescents with disrupted nurturing, as well as indigenous groups. Of great significance is the fact that many of the well established vulnerabilities occur simultaneously in the same individuals.

Post-traumatic stress disorder in Africa

In the past few decades, the people of Africa have had many wars fought in their midst (Njenga *et al*, 2003). In a study from Rwanda, Pham *et al* (2004) found prevalence rates of post-traumatic stress disorder (PTSD) of 24.8%, 8 years after the 1994 genocide. Among the survivors of torture, this rose

https://doi.org/10.1192/S1749367600005051 Published online by Cambridge University Press