

Elective on PTSD and mental health in Gulu, northern Uganda, December 2008–January 2009

Sir: I chose a psychiatry elective because of my interest in Uganda. There is a high rate of post-traumatic stress disorder (PTSD) among the Acholi people in the north, following the 1986–2006 guerrilla war between the Ugandan government and the rebel Lord's Resistance Army (LRA).

The LRA is infamous for using child soldiers (during the conflict, 30 000–60 000 children were abducted, making up over 90% of LRA troops) and committing atrocities against civilians. Villages were attacked, their inhabitants killed, beaten and raped; crops and stores were stolen and roads made impassable. In an attempt to gain control, the Ugandan government moved over 90% of the population of the north into camps for internally displaced persons; by 2005 these contained 2 million people. Unable to farm, the Acholi became dependent on the World Food Programme.

PTSD is found both in former child soldiers and civilian victims. Gulu town, once at the centre of the conflict, is now at the heart of regeneration. I worked with three organisations there:

- Gulu Regional Referral Hospital Mental Health Unit, the main psychiatric centre in the north, which runs outreach and daily out-patient clinics
- The Peter C. Alderman Foundation, an American non-governmental organisation (NGO) which specialises in rehabilitating victims of trauma, and which works closely with Gulu Hospital
- the African Centre for Treatment and Rehabilitation of Trauma Victims (ACTV), staff from which spend up to 4 days at a time in the field addressing all aspects of victims' lives.

Psychiatry is very paternalistic in Uganda, but PTSD management seems an exception, focusing on talking therapies, involving the patient in treatment. Medication is used in most cases, primarily antidepressants (usually amitriptyline), often with an antipsychotic (haloperidol). Almost universally, patients I spoke to had seen a benefit from therapy, especially meeting others who shared their experiences. But the further people are from Gulu town, the harder it is for them to access help.

The ACTV works effectively using a multidisciplinary approach. It has discussions led by social workers and drama projects which recall and deal with the trauma of the past. A clinical officer manages medication and a staff physiotherapist deals with stress-related musculoskeletal pain. Lawyers and social workers offer advice on everything from domestic violence to the land wrangles which resulted when families returned from camps to find strangers occupying their land. All aspects of patients' problems are covered.

Although there were fewer hands-on opportunities for me than there might have been in a medical elective, all the teams involved me fully. I found my psychiatry elective an excellent way to develop the brief grounding I had as a student – and by visiting a low-income country I learned a way of practising using limited resources. The 'Western' way of treating patients simply is not possible (for instance following guidelines produced by the National Institute for Health and Clinical Excellence).

A place as traumatised as northern Uganda will not heal overnight; but hope remains as long as victims of trauma have someone to talk to – even though, as one ACTV social worker told me – 'sometimes the best you can do is listen to their stories and say "I'm sorry"'.
 Emily Sherley
 Student Associate of the RCPsych

'Legal highs' – a health warning that does not appear on the wrapper

Sir: There are an increasing number of substances appearing on the recreational drug scenes in Europe, North America, Oceania and Japan (International Narcotics Control Board, 2011). In 2009 for example, 24 new psychoactive substances were notified in Europe, compared with 13 in 2008, including synthetic cannabinoids, tryptamines, phenethylamines and synthetic cathinones, according to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA & Europol, 2009).

Many are synthesised by chemists who modify the structure of existing psychoactive substances controlled by United Nations conventions so that they remain legal. These new generations of 'designer drugs' are marketed as 'legal highs', and sold in 'head shops' and increasingly over the internet as 'research chemicals'. Purity levels are very high; they are laboratory manufactured and sold, for example, as 'synthetic cocaine'. Thus, the products appear to potential consumers as both legal and safe.

Such assumptions are dangerous. If sold under a 'brand name', the contents and active ingredients are not listed; consumers do not know what they are taking. Even if a substance is advertised using its chemical name, is extremely pure and is chemically related to drugs with known desired psychoactive properties, there is no guarantee that it does not have potential adverse or even toxic effects. Adverse effects reported by users in recent years include psychiatric conditions such as psychoses, depression, anxiety, paranoia and suicidal ideation. Physiological effects similar to those experienced by overdosing on amphetamines, cocaine and ecstasy have been reported by attendees at emergency departments. Sometimes, these complications have resulted in fatalities (Ghodse *et al*, 2010).

Such occurrences led to risk assessments being conducted at national level in many countries, resulting in substances being controlled. For example, the Council of Europe on 2 December 2010, following a formal risk assessment (EMCDDA, 2010), adopted a Decision submitting mephedrone to control measures (Council of Europe, 2010). Following new controls, some chemists further manipulated the molecules of these chemicals so that they complied with the law.

New psychoactive substances are appearing at an increasingly faster rate than hitherto. Users are exposed to all types of unknown risks, as research and analyses have not been undertaken. Branded products may contain different active ingredients than when first marketed. For instance, initially,