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

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less than a year: two of these patients have organic brain syndromes and two are schizophrenic. We have no access to a mental hospital or similar long-stay facility but one patient from the district has been in a private hospital for over a year and another has been transferred from a special hospital to a mental hospital in a neighbouring county.

Follow-up of all discharges[1] has shown that, over a six year period, 17 patients have had continuous stays lasting more than a year (seven organic, five affective and five schizophrenic). Of these three are dead, two were transferred to the dementia unit and others have been resettled at home, in hostels or private nursing homes in circumstances which seem adequate and appropriate.

These figures are substantially lower than those quoted by Dr Haslam but comparable with the 20 patients from a population of 230,000 accumulated over 11 years meeting criteria for admission to a Manchester Hospital Hostel[2] Obviously further investigation is required to establish whether the service is indeed meeting patients' needs and whether a substantial number drift out of contact. With regard to the latter point we have continuing contact through community and day services with 75% of our discharged patients diagnosed as schizophrenic.

This pattern has emerged from a small industrial town and its environs in which 90% of the population live within four miles of the hospital. We also have the advantage of a wide range of resources planned under the Worcester Development Project (rehabilitation hostel, day hospital, day centre, community nurses and mental health social workers). One should be cautious about extrapolating conclusions to different catchment areas, particularly large cities. Nevertheless we are concerned that unwarranted pessimism about the possibility of community care may result in perpetuating the existence of large out-moded institutions, locking up large amounts of money and resources which urgently need diversion to progressive psychiatric services.

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Human volunteers in pharmacological experiments

DEAR SIRS

An interesting debate has started in the Republic of Ireland as to the question of healthy human volunteers being used in pharmacological experiments. I would like to put forward a few points.

(1) Subjects should be fully informed of all the known side-effects in language which he can understand and which is free from unintelligible jargon.

(2) The subjects' motives should be carefully assessed before being admitted to the study—the chance of personal gain should in my opinion exclude the subject.

(3) All evidence, and results of such experiments should be available for scrutiny by the subjects or their representative for ten years after the research is complete.

It may be of interest to your readers to know that a medical student at one famous London teaching hospital was involved in just such experiments, and due to pressure being applied he had no option but to repeat the procedure without being given the opportunity to reveal the side-effects of the drug given in the first experiment.

He subsequently failed his finals repeatedly, was admitted to hospital himself five times, and was on medication for almost 18 years. Whether this was the only factor in his illness is not known, for sure. However, it underlines the point that pharmacological experiments can be extremely dangerous not only for the researcher, but for the subject. I would put in a plea for stronger safeguards in the future.

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Peer group counselling – appeal for help

DEAR SIRS

At the beginning of May an interesting and useful initiative will be getting off the ground in the Greater London area. For the past six months a group of young people has been undergoing training in peer group counselling – and another group in problem solving – in the field of drug misuse. In May they will be ready to start working together in teams of two under the auspices of the Association for Prevention of Addiction (APA).

However, the psychiatric registrar who was going to conduct the supervision group has had to withdraw for family reasons and we are left with this gap. It is of first importance that someone – a psychiatrist or a psychotherapist – takes this group regularly every week because it will be necessary to keep the counsellors on course and the advisers supported in the difficult area.

I am appealing for someone used to group work to come forward and do this vital job. The APA teams themselves will be working voluntarily, with only their expenses being paid, out of their wish to do their best for society.

Although they are young and inexperienced their training will have gone a long way towards preparing them for working with drug takers, problem drug misusers, their families and friends. But there are bound to be occasions when they will be uncertain whether the interventions they have made during a session with a client have been the most likely to advance the process or even been appropriate.

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