

tries. Along with the natural growth of foreign and foreign-born populations, new influxes due to either labour recruitment, family reunification or request for political asylum are playing an important role. It is clear that as the demography of most countries in Europe continue to shift, therapists will increasingly work with clients who have backgrounds and cultural expectations highly dissimilar to their own.

The importance of preserving and fostering the health of immigrant communities has only been recently acknowledged. As of today, many receiving countries have limited information on the health status of their immigrant populations; evidence is increasing, however, that individuals from ethnic minority groups have worse mental health status.

On the political level, it is clear that the health and health care delivery to non-native ethnic groups need to be considered in the frame of both national immigration policies and health system structure, because both factors could greatly influence entitlement and access to health services. An important issue is if immigrant communities are allowed to participate in the political discussions about the mental health care system and whether or not they can organize their own ethnopsychiatric system.

On the institutional level, the health status of immigrants can be attributed to various barriers to access to mental health care (financial, linguistic, cultural); lack of training of health professionals; racism and lack of attention to the needs of ethnic communities within the health system. The benefits and risks of engaging allochthonous care providers will be discussed.

At the individual level, the eurocentric basis of educational programs may equip students for work with middle class white people and highly acculturated immigrants, but most are not trained to conduct accurate clinical assessments of more culturally diverse clients. The benefits of systematic introduction of anthropological knowledge in euro-mental health education, and modification of eurocentric forms of treatment will be discussed, and alternatives suggested.

PSYCHOPATHOLOGY AND MIGRATION: AN EPIDEMIOLOGICAL STUDY

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Objectives: There have been many reports of increased incidence of psychiatric disorders in ethnic minority groups from the Caribbean and North Africa living in Northern European countries. Little is known about psychiatric morbidity associated with migration within Europe. **Method:** The administrative incidence for all psychiatric disorders were determined for Italian individuals living in a defined area in Southern Switzerland. In this area, Italians constitute around one-fifth of the total population. **Results:** Preliminary results indicate that, over the period 1991–1992, the raw administrative incidence rates were nearly twice as high for the Italian group, as compared to the Swiss group (including a small group of immigrants from other countries): 136.3 per 100,000 person-years in the Italian group, and 79.6 per 100,000 person-years in the Swiss group (rate ratio: 1.7, 95% confidence interval: 1.4–2.1). **Conclusions:** The findings suggest a substantially increased risk for psychiatric morbidity in the Italian population living in Southern Switzerland. Further investigations should shed light on which of several possible explanations for this finding is most likely: i) differences in socio-demographic composition of the source populations, ii) a selective increase in a particular diagnostic group, such as psychosis or alcohol-related pathology, iii) differences in the pathway to care.

EVIDENCE FOR PSYCHOSIS OF GOOD PROGNOSIS IN PEOPLE OF CARIBBEAN ORIGIN LIVING IN THE UK

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Cross cultural studies have shown that the prognosis of psychotic disorders is better in non-industrialised countries. Some researchers have questioned whether the reported increased incidence of psychosis in people of Caribbean origin living in the UK may be due to an excess of such good prognosis illness.

The objective of this study was to compare the course and outcome of psychotic illness in a group of Caribbean people resident in the United Kingdom and a group of white British patients.

A cohort of 113 patients with psychosis, admitted consecutively to two south London Hospitals, was followed up over an average of four years.

Multiple sources of information were used including relatives, general practitioners, family members, spouses, hospital and hostel staff and case notes.

The black Caribbean group spent more time in a recovered state during the follow-up period (adjusted odds ratio 5.0 95% confidence interval 1.7–14.5) and were less likely to have a continuous illness (0.3; 0.1–0.9).

There were no differences in hospital use. These findings persisted after adjustment for possible confounding variables such as age of onset, childhood social class, DSM diagnosis, sex and length of illness.

We conclude that black Caribbean patients have a better outcome after psychotic illness than do white patients and the high incidence of psychosis in this group may be due, at least in part, to an excess of good prognosis illness.

The presence of environmental precipitants, "life events", predicts better prognosis. The better prognosis shown here may be due to a higher prevalence of illness with social precipitants.

REFUGEE MENTAL HEALTH IN EUROPE: AN OVERVIEW OF EPIDEMIOLOGY AND TREATMENT INTERVENTIONS

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In this paper, we will discuss recent trends in numbers of refugees in Europe. The advantages and disadvantages of different models for psychosocial interventions in refugees with mental health problems will be considered. Suggestions will be made about future research on psychosocial interventions for adult refugees, concentrating on further development of effective and efficient treatment for those who have developed serious and physical symptoms as a result of extreme stressors.

HIGH INCIDENCE OF SCHIZOPHRENIA IN SURINAMESE AND ANTILLEAN IMMIGRANTS TO HOLLAND

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Introduction: Reports of a high incidence of schizophrenia in Afro-Caribbeans in the UK are a matter of much debate. In recent decades many immigrants from Surinam and The Netherlands Antilles have settled in Holland. More than one third of the Surinamese-born population now lives in Holland. We compared the risk of a first discharge for schizophrenia (ICD-9) for young (15–39 yrs) immigrants from Surinam and the Antilles to that for their native-born peers in the period 1983–92.