One main obstacle to being open to these questions is the pressure on epidemiologists, managers, and academics to collect data in a vertical fashion. Yet violence cannot be seen as detached from infectious disease, maternal mortality, drug addiction, or unemployment. The Family Health Strategy, cited in most of the Series papers, has been a vehicle by which many vertical actions have already been integrated, and the results have been well studied. What readers really need to know are the obstacles to going further in this regard.

The outcome of The Lancet’s Series is a collection of excellent health data empty of relevant messages for taking decisions around health-policy organisation. There is a need to understand health in Brazil in terms of the best answers to health service problems.

We declare that we have no conflicts of interest.

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In his World Report, Justin McCurry succinctly highlights the difficulties facing the surviving victims of the earthquake and super-tsunami in northeastern Japan on March 11. However, he misrepresents existing mental health-care provision in two respects.

First, his statement that “Japan’s health system is ill prepared to address long-term mental health problems triggered by the disaster” does not accurately reflect the situation. Although existing provision is not perfect, valuable lessons about post-disaster mental health have been learned since the two previous major disasters at Kobe in 1995 and Niigata in 2006. In 2001, the National Center of Neurology and Psychiatry issued national guidelines for post-disaster mental health, and several thousand caregivers have been trained in traumatic stress counselling over the past few years. The directors of most mental health centres have attended lecture courses in post-disaster mental health care. As a result, responses to the present disaster were very rapid, allowing prompt scheduling and dispatch of mental health-care teams to the devastated areas.

Second, we were concerned about the inclusion of comments from Stephen McDonald of Save the Children on the fear expressed by a child he had interviewed, and the assertion that lack of counselling in the early phase can lead to subsequent mental and behavioural problems. There is no evidence for this statement. As recommended in

Post-disaster mental health care in Japan

International guidelines and principles for the promotion of psychosocial wellbeing and the prevention or treatment of mental health problems in humanitarian settings are often ignored, and Justin McCurry’s World Report on Japan (March 26, p 1061) is an example.

McCurry does not seem to have sought input from relevant mental health authorities within Japan, and instead cites “experts” as stating that “thousands of victims will be in need of long-term trauma counselling” and that “children who have been caught up in disasters can develop behavioural and mental health problems unless they receive counselling at an early stage”.

Such statements are not consistent with guidelines or published data and thus send inaccurate messages. Guidelines recommend that children are best helped by reinforcing supportive family and community structures, and by restoring routines and culturally accepted activities; only a minority of children and adults will need specialised mental health services.2–4

Japan has considerable experience and expertise in the field of mental health and psychosocial support. The Ministry of Health, Labor and Welfare quickly mobilised human resources and guidance including from the Japanese Society of Psychiatry and Neurology and the League of Psychiatric Departments of Universities. Japanese response and support systems (including mental health care) for this disaster will be reported soon elsewhere.

We are keen to learn from international experiences and appreciate the support from international actors. However, as the Inter-Agency Standing Committee guidelines note, responses must be coordinated, evidence-based, culturally informed, and build on existing capacities.

We declare that we have no conflicts of interest.

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the guidelines produced by the UK’s National Institute for Health and Clinical Excellence, human suffering should not be too readily medicalised, and resilience should be respected. There is a possibility that early and temporary counselling focused on traumatic memory or fear could generate harmful effects, and there is no evidence for its efficacy in preventing the symptoms of traumatic stress.4,5

McCurry’s concern for the plight of the disaster victims is, of course, well intentioned, but we believe that a better balanced and more comprehensive picture of mental health care in Japan would have been conveyed if opinions had been sought from Japanese health-care professionals.

We declare that we have no conflicts of interest.

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Support for senior management at Great Ormond Street Hospital

The anonymous letter you published online on July 1 does not, we believe, reflect the majority view of the senior staff at Great Ormond Street Hospital, London, UK. We have seen no evidence of bullying of staff who have raised concerns about clinical risk with management. It is regrettable that patient safety issues are being used as a political weapon, and that this will cause anxiety for our patients and their families.

We all support the Chief Executive and senior management of Great Ormond Street Hospital. For the full list of signatories, see webappendix.

Jon Goldin, on behalf of 107 consultants and 52 other senior staff members
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1 Anon. GOSH consultants express alarm. Lancet 2011; 378: 123.