Volume 12
Number 1
February 2015
ISSN 2056-4740

BJPsych International

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RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

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Mission of *BJPsych International*

We address themes that have real practical relevance to supporting patients, with a particular, but not exclusive, focus on the needs of low- and middle-income countries as well as the mental health needs of the poor and socially excluded in more developed countries. Contributors who can provide examples of innovative practice, which could be emulated elsewhere at minimal cost, are especially welcome, as are papers on public mental health.

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Annual subscription rates for print issues for 2015 (four issues, post free) are £35.00 (US$63.00). Single issues are £10.00 (US$18.00), post free.

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The Royal College of Psychiatrists is a charity registered in England and Wales (228636) and in Scotland (SC038369).

From 2003 to 2013 *BJPsych International* was entitled *International Psychiatry* and until 2006 published as (and subtitled) the *Bulletin of the Board of International Affairs* of the Royal College of Psychiatrists. Printed in the UK by Henry Ling Limited at the Dorset Press, Dorchester DT1 1HD.

The paper used in this publication meets the minimum requirements for the American National Standard for Information Sciences – Permanence of Paper for Printed Library Materials, ANSI Z39.48-1984.

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BJPsych International publishes articles dealing with mental health policy, promotion and legislation, the administration and management of mental health services, and training in psychiatry around the world. The journal aims to be a platform for work that is generally underrepresented in the literature, especially psychiatry in low- and middle-income countries.

Manuscripts for publication must be submitted online at http://submit-ip.rcpsych.org (general enquiries may be addressed to ip@rcpsych.ac.uk).

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Readers are encouraged to contribute online at http://www.BJPsychInternationalblog.org

MISSION STATEMENT

BJPsych International: new name, new strategic focus

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With this issue of our journal we are beginning a new chapter in facilitating communication between psychiatrists throughout the world. *International Psychiatry* was established in 2003, as the *Bulletin of the Board of International Affairs* of the Royal College of Psychiatrists. It continues to be provided free of charge, both in paper and online, thanks to the generosity of the members of the Royal College of Psychiatrists. Our potential readership is enormous: over 15 000 members of the College receive the print edition regularly, and all issues can be downloaded from the College website. We need to address both the clinical interests and the needs of this diverse readership, and in so doing we will be redirecting the focus of the journal over the next few months and years. Publication of articles in the journal will remain cost free to contributors and rigorous refereeing will be sustained.

The time has come to review our strategic aims. Over the past decade, there has been a gradual evolution in content. We have focused increasingly on issues that have practical application in countries that do not have the resources to be adequately supporting psychiatric services.

First, we published accounts of the infrastructure of psychiatry provided worldwide in 'Country Profiles', a series that began with our first issue and emphasised diversity in mental health policies. We will continue with this policy and we have added an important section on international aspects of 'Mental Health Law', which is curated by George Ikkos, Deputy Editor.

Second, since the very first issue, we have reviewed diverse 'Themes', with a brief editorial and three papers that address the same topic from different perspectives. We intend to continue to address themes that have real practical relevance to supporting patients, with a particular, but not exclusive, focus on the needs of low- and middle-income countries as well as the mental health needs of the poor and socially excluded in high-income countries. Contributors who can provide examples of innovative practice, which could be emulated elsewhere at minimal cost, are especially welcome, as are papers on public mental health. Most articles in this thematic section are commissioned.

We receive a regular stream of uncommissioned articles, including some that concern original research findings. In future, we will not be publishing research articles of this type. The journal's identity will be focused on practical issues, rather than theory or scientific studies that have no immediate relevance to the delivery of clinical services. We will pass such submissions on to the *British Journal of Psychiatry*'s new online sister journal, *BJPsych Open*, for consideration for publication there. We will continue to accept uncommissioned 'Special Papers', on subject matter that does not necessarily fit within a theme, but which is consonant with our aims.

There was a pressing need to address our limited online presence, and we have done so principally in the form of a blog. As we will no longer be publishing a Correspondence column, we will arrange for submitted comments about published articles, and also other relevant material, to be placed in the blogosphere, at http://www.BJPsychInternationalblog.org. A new member of the Editorial Board, David Jimenez, will be managing it, along with a social media presence with the journal's new Facebook page (https://www.facebook.com/BJPsychInternational) as well as a Twitter account (https://twitter.com/BJPsychInt; @BJPsychInt). We will also be changing the face of 'News and Notes'. In a journal that is published quarterly, it was inevitable that most news was out of date by the time it appeared in print. Accordingly, a change of focus was needed. Eleni Palazidou will be managing the new commentary section of the journal, 'Pandora's Box', which will take as its theme important developments in psychiatric practice over the previous few months that have direct clinical relevance to the non-specialist.

Finally, we have reviewed membership of the Editorial Board. We are keen for Editors to be active ambassadors for the journal, and we have consulted with members over the past few months about their roles. We have assigned specific tasks to many members of the revised Board, who will, we hope and anticipate, be actively eliciting contributions to the journal from colleagues in their region of the world. An important innovation is the appointment of new regional Associate Editors, who will help ensure the increasing local importance of the journal to psychiatrists worldwide. We have a new Associate Editor, Daniel Maughan, with responsibility for 'Psychiatry and Sustainability', a subject that is of increasing importance to all psychiatrists.

We trust the changes we have introduced, in the relaunched and renamed *BJPsych International,* will be welcomed by our readership. We look forward to hearing your comments.

GUEST EDITORIAL

The importance of mental health in the Sustainable Development Goals

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Declaration of interest: The authors are members of the FundaMentalSDG initiative established to support the inclusion of a mental health target and indicators in the Sustainable Development Goals.

The United Nations' draft Sustainable Development Goals (SDGs) only briefly mention mental health. In the context of a growing burden of disease due to mental disorders and psychosocial disabilities, the inclusion of a clear mental health target and indicators in the SDGs will acknowledge the needs and rights of hundreds of millions of people. It will mobilise international funding and policy development, and support other SDGs; it will also strengthen mental health structures, governance and services in low- and middle-income countries. We argue that for a just, sustainable and inclusive post-2015 development agenda, it is vital that the United Nations includes a clear mental health target and indicators in the SDGs.

Mental disorders and psychosocial disability are among the greatest global health challenges and yet are largely ignored in international development strategies. One in four people experience a mental health problem in their lifetime, and most of them (85%) live in low- and middle-income countries (Wang *et al*, 2007). Millions of these people worldwide face stigma, discrimination and severe human rights abuses every day (Thornicroft, 2006).

Since 2000, the Millennium Development Goals (MDGs) have motivated nations and organisations to take action for development; however, they made no reference to mental illness. In his review of the MDGs, the Secretary-General of the United Nations (UN), Ban Ki-Moon, stated that more must be done to secure the well-being, dignity and rights of those at the margins (Ki-Moon, 2013). The UN's Post-2015 Development Agenda is intended to provide 'a life of dignity for all' and to improve health, including mental health (United Nations, 2013). While the MDGs have had some success in promoting basic development, we now need to tackle an issue that was left out: mental health. It is vital that the UN includes a clear mental health target and indicators in its new Sustainable Development Goals (SDGs), for the following reasons.

The case is clear

Mental disorders and psychosocial disabilities are globally under-financed, in both government spending and development aid. In most middle- and low-income countries, government investments in mental health services and human resources utterly fail to respond to the level of need (Saxena *et al*, 2007). This is why most people with mental disorders do not have access to effective treatment (World Health Organization, 2011). In low-income countries, this treatment gap is up to 98% for more severe illnesses (World Health Organization, 2008). This is a breach of the fundamental right to access healthcare, as set out in the Convention on the Rights of Persons with Disabilities.

Amina J. Mohammed, a special advisor to Ban Ki-Moon, stated that with the new SDGs the voices of people will be 'lifted up and brought to … attention' (Mohammed, 2013). Most people who suffer from mental disorders and psychosocial disabilities cannot raise their voice, either because they are figuratively 'locked in' by their mental illness or because they are literally locked in, in mental health institutions or prisons, or locked out by their societies. Making mental health a target in the SDGs will help to strengthen their fundamental rights and give these people a voice.

Referring to the core values of development

The Rio+20 Conference in 2012 reaffirmed the values of global development: freedom, peace and security. When aiming to support these values, we need to recognise that many people with mental illness remain vulnerable, either in our communities, because of exclusion from normal citizenship, or in hospitals, where their human rights are more likely to be violated, for example by degrading conditions, neglect or inhumane treatment.

Including a mental health target in the SDGs responds to one of the core ideas of development, to 'leave no one behind' (Ki-Moon, 2013). For the new SDGs to be inclusive, they must focus on the needs of the least privileged people. People with mental health problems are among the most marginalised communities in the world; up to now they have been largely overlooked by global development, as well as national policies. A clear mental health target will include these hundreds of millions of people in development, and strengthen their fundamental rights and freedoms.

Motivation and mobilisation

Including mental health in the SDGs will motivate and mobilise nations, organisations and donors to take action, and allocate resources, for mental health development. Global development budgets have increasingly provided for the need to address psychosocial disabilities. The World Health Organization, the European Union and several high-income donor governments have focused on

scaling up services for mental health in low- and middle-income countries.

Globally, the average yearly spending on mental health is currently less than US$2 per person, but in low-income countries it is less than 25 cents per person (World Health Organization, 2011). This is clearly insufficient to treat even basic mental disorders. A mental health target in the SDGs will help to mobilise internal and external investment for psychosocial disability treatment and services, and it will attract international donors to invest in mental health systems, services and projects.

Measurability and accountability

Including mental health in the SDGs will also motivate countries; it will give governments a clearer focus on inclusive health policy-making and support good governance. This requires the global use of a small set of agreed indicators of mental health system performance. The use of measurable indicators of change will also help governments attract international donor funds to strengthen their service provision.

We therefore need a mental health target and indicators in order to measure progress and hold ourselves to account. As Lynne Featherstone stressed when she was the UK's under-secretary of state for international development, hundreds of millions of people with disabilities currently 'simply don't count' (Jones, 2014) and will be left out if we do not record data. Monitoring average development is not enough: progress must be measured specifically for people with mental and psychosocial disabilities.

A clear target and indicators will help to define responsibilities and mechanisms to which nations and donors can commit. It will enable the global community to monitor progress and to hold nations and organisations to account for the delivery of mental health services and policies.

Currently, only about 60% of countries have a clear mental health policy and only 72% have a mental health plan (World Health Organization, 2011). Including mental health in the SDGs will encourage countries to develop a dedicated mental health policy, plan and legislation. Mental health legislation and governance make systems for people with mental disorders more reliable and accountable.

Economic growth

Mental disorders and psychosocial disabilities are big obstacles to social and economic progress. Mental and behavioural problems account for nearly a quarter (23%) of the global burden of disease (Whiteford *et al*, 2013). They are the biggest single cause of disability, more than cardiovascular diseases and cancer combined. In high-income countries, men with mental health problems die on average 20 years earlier and women with mental health problems 15 years earlier than the rest of the population; in low-income countries this mortality gap is likely to be even wider (Wahlbeck *et al*, 2011). This is a huge loss of the workforce – which is only one aspect of the excessive costs of untreated mental health conditions. The World Economic Forum has calculated the global cost of mental health conditions at US$2.5 trillion for 2010, and estimates the costs to rise to US$6.0 trillion by 2030 (Bloom *et al*, 2011). Societies' economic development is linked to the mental health condition of their people. Sustainable, inclusive and equitable growth can happen only when we include the quarter of the world's population who have experience of mental health problems.

Mental health has strong links with many of the thematic areas of the SDGs; for instance, it is critical to success in addressing poverty and economic development (World Health Organization, 2013). Armed conflict, violence, insecurity and injustice often have roots in social and economic deprivation and inequalities. Mental health is a key to social benefits, economic growth and equality.

Conclusion

FundaMentalSDG is a global initiative aiming to include a specific mental health target in the post-2015 development agenda; it has called on the UN to create the conditions in which people can realise their basic rights and fundamental freedoms (Thornicroft & Patel, 2014).

The UN plays a key role in securing the human rights of people with mental and psychosocial disabilities. It needs to include mental health in the new development agenda, to enhance both foreign and national investment and policy-making. Adding a clear mental health target and specific indicators to the SDGs will motivate international actors and mobilise funds, help to measure progress and success, and guarantee accountability; it will also contribute to global and regional economic growth. Overall, this will further the social and economic inclusion of people with mental and psychosocial disabilities, and it will promote access to basic mental healthcare, human rights and the foundations for a decent life.

Considering the urgent global situation, and the cross-cutting influence of mental health on the planned SDGs, including a mental health target in the SDGs, and thus making mental health integral to development, is a global imperative. Without including mental health in the SDGs, many hundreds of millions of people will be left behind in development, especially those who are least able to help themselves.

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International partnerships in psychiatry: introductory reflections from a seasoned sojourner

John Cox

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The three thematic papers in this launch issue of *BJPsych International* are intended to inform and motivate College members around the world to reflect on the challenges of bilateral links between high- and low-income countries, on the exhilaration of being a new sojourner in a new land – and on the diaspora searching for almost forgotten cultural roots in a home country. They all illustrate the way in which twinning structures between National Health Service trusts, universities and research councils have facilitated these exchanges of personnel between high- and low-income countries which have benefited, at least in the short term, both parties – and facilitated the professional development of both psychiatrists and other health professionals.

They illustrate also the excitement and creative challenge of being caught between two cultures and of how to arrange revalidation and registration in the UK when working abroad. Globalisation, immediate communication by Skype or email, and low-cost travel can give a false sense of the universalism of values and of mental illness attributions which, though consoling in the honeymoon phase of cultural adjustment, may be succeeded by greater awareness of cultural and language difference in the disenchantment phase. Reverse culture shock on return home after a prolonged stay abroad can further complicate revalidation and adjustment to the swiftly changing demands of the National Health Service (NHS).

Julian Eaton and his colleagues aptly describe at an individual level the benefits of their innovative overseas peer group for continuing professional development (CPD), which meets by Skype and provides opportunity to review specific clinical problems when resources are scarce, and mutual encouragement about directed reading in clinical or research domains and, importantly, how to overcome revalidation and appraisal problems.

Athula Sumathipala *et al* report on the massive contribution to Sri Lankan and UK psychiatry of bilateral partnership between health institutions and universities in the two countries, including an important twin register. There are five times as many Sri Lankan psychiatrists in the UK (250) as in Sri Lanka at the present time (50). The diaspora is crucial to these bilateral links.

The third paper, by Dave Baillie and colleagues, considers the benefits specifically of a multidisciplinary link between the East London Mental Health Trust and Butabika Hospital Kampala (where I held my first consultant post), in Uganda. This present initiative is sustained by the Ugandan diaspora in the UK. The paper describes the mutual benefits of training psychiatric support workers. The authors illustrate the way in which these experiences benefit staff in East London – although they do acknowledge that this can be challenging if the Trust cannot see beyond the local financial constraints or is unsupportive of meeting the needs of a low-income African country whose family values may not mesh with those of postmodern Britain. The British diaspora in East Africa – an element not considered in the papers – as well as the abilities of East African doctors and nursing

staff were each vital to the success of my 2-year academic contract and to my doctoral studies – as was the support of religious institutions.

International psychiatry remains at the heart of the College *raison d'être*. There are over 3000 Members and Fellows outside the UK, and over 30% of the consultant and training posts in the NHS are filled by graduates from non-UK medical schools. Three of the eight members of the current executive of the World Psychiatric Association (WPA) are distinguished College Fellows. Interestingly, in recently published books two other British-based international South Asian psychiatrists (Channi Kumar and Suman Fernando) are honoured, both of whom influenced me considerably, and both of whom were 'movers and shakers' of UK mental health services as well as of College opinion (Cox, 2014; Pariante *et al*, 2014).

International readers of this journal will of course draw their own conclusions from these three papers about the pros and cons of partnership arrangements. They remind me of the need for a strong international College board to focus on this vital international work, to support bilateral exchanges and to develop further its own initiatives, including the Volunteer Scheme, and to encourage and resource the International Divisions.

Hamid Ghodse, the founding Editor of this journal and founding chair of the board, was a brilliant ambassador for the College. The current WPA leadership, with a College past President as WPA President, provides a landmark that should help to reduce any tendency towards isolationism in British psychiatry, or a reluctance to recognise that multicultural, multifaith Britain benefits from a multicultural, multifaith mental health workforce. Opportunity for the College (one of the largest member societies of the WPA) to fulfil some of its international commitments within this umbrella, including the monitoring of ethical practice, is another consideration at the present time.

Perhaps *BJPsych International*, in its new format, can become even more of a forum for this renewed commitment to global psychiatry and particularly for assisting and motivating psychiatrists to work 'outside the box' and for a short or more prolonged period to work outside the NHS.

The three papers are a reminder that for psychiatrists planning to work abroad, transcultural psychiatry is 'good psychiatry', but this is so only if good psychiatry is, at its core, interpersonal and conceptually complex.

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Sustaining international careers: a peer group for psychiatrists working in global mental health

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Regular appraisal and revalidation are now a routine part of professional life for doctors in the UK. For British-trained psychiatrists working abroad (in either development/humanitarian or academic fields) this is a cause of insecurity, as most of the processes of revalidation are tailored to those working in the standard structures of the National Health Service. This article explores the degree to which a peer group for psychiatrists working abroad has achieved its aim of helping its members to fulfil their revalidation requirements. It gives recommendations for how those considering work abroad can maximise their chances of remaining recognised under the revalidation system.

Meeting the expectation for doctors to maintain their level of knowledge and clinical skills has become a routine part of professional medical life in the UK. Since 2012, the processes for appraisal and revalidation have been integrated into the work environment of hospitals and other medical work spaces in the UK, but this poses a problem for doctors not following standard careers within the National Health Service (NHS). Although there are some mechanisms for doctors without a designated professional body, for those who have chosen to live and work abroad, revalidation remains a significant challenge and can make returning to work in the UK bureaucratically difficult.

One group facing this problem are those who work in global mental health, either in the development/humanitarian field or in academic

The authors and members of the peer group gratefully acknowledge the ongoing support of Maudsley International and the South London and Maudsley NHS Foundation Trust, under the Support Personal Development Scheme (SPDS), in particular Dr Ranga Rao and Dr Michael Holland. The authors would like to thank all those who completed the survey.

institutions. In 2008, a group of psychiatrists who had received their specialty training in the UK (Members or Fellows of the Royal College of Psychiatrists) but were now working predominantly abroad established a peer group similar to those British-based doctors use for the purposes of continuing professional development (CPD). Peer supervision is a key tool in appraisal and revalidation, allowing mutual learning and evaluation, and the setting of common standards. This article reflects on how successful this group has been in supporting CPD and revalidation.

The group's aims and development

The aims of the group are:

- to provide an opportunity to share clinical and professional experience and knowledge on a regular basis
- for its members to remain updated with respect to CPD in the UK
- to fulfil the requirements for maintaining registration and revalidation.

When the peer group was started, the processes of registration and revalidation were themselves in development and the group hoped to provide a model for doctors overseas seeking to maintain professional recognition in the UK. In this process of exploring (and sometimes negotiating) how this could be done, the group has relied on the support of the South London and Maudsley (SLaM) NHS Foundation Trust in terms of facilitating links with the Royal College of Psychiatrists and the General Medical Council (GMC), and offering honorary appointments to those participating in the group, something that is essential in order to have an institutional framework for revalidation. Maudsley International, an organisation affiliated to SLaM, which aims to improve global mental health by sharing expertise, has hosted and helped coordinate the group since its inception.

Over the past 6 years, the group has convened every 3–4 months via Skype. The meetings, chaired on a rotating basis, aim to provide a forum for discussions around the discipline of global mental health, clinical case studies, and updates on registration and revalidation issues. Members also review each other's personal development plans and other evidence of maintenance of clinical skills. This has proved to be a challenge, as these requirements have changed with time, and it was necessary to communicate regularly with the regulatory bodies in the UK to ensure the correct standards were being followed. On occasions it was clear that there was no guidance available for those not in the standard revalidation process. Within these regular meetings, a supportive network naturally developed where advice was shared about a wider variety of issues than those in the original aims of the group.

Survey of group members

In the context of increasing interest in pursuing international careers in mental health, we decided to examine how well the peer group had fulfilled its initial aims. One of the main reasons why people might choose not to do international work is the risk of making a subsequent British medical career difficult. Documenting successful mechanisms for maintaining registration and validation in the UK would go some way to assuage these anxieties. We therefore circulated a questionnaire to group members to explore whether this had been achieved. The questionnaire (available online) was sent to all members. This is a small group and complex statistical or independent thematic analysis was not appropriate. Open narrative responses are reported here.

We also asked three senior psychiatrists in the UK who have supported the process (members of Maudsley International and SLaM) about their views and experiences, using a modified version of the same questionnaire.

Results

At the time of the survey, the group had eight members, seven of whom completed the questionnaire (Table 1). In addition, all three supporters responded.

Participation in and benefits of the group

Commitment and participation have been high. All but two of the respondents said that they had attended 'all' or 'almost all' of the meetings (the other two responded 'over 50%'). There was a consensus that the main aims of the group had been met. The only weak element was that members'

Table 1

Summary of peer group membership and characteristics of respondents

	Total group (*n* = 8)	Survey respondents (*n* = 7)
Female:male ratio	3:5	3:4
Type of work[a]	International development: 2 Humanitarian: 1 Research/academic: 5	International development: 3 Research/academic: 4
Countries where members work[b]	Australia, Ethiopia, India (x2), Malawi, Sri Lanka, Togo, UK	Australia, Ethiopia, India (x2), Malawi, Togo, UK
Conflict and disaster zones	Various	Various

[a]There is considerable overlap between research and implementation in global mental health, with most people doing a mix of both.
[b]Some members work in jobs that take them to many low-income countries, and two had recently returned to the UK but remained involved in international work. One member mainly worked on a short-term voluntary basis.

registration was not recognised as fully equivalent to that of colleagues in the UK, something beyond the control of the group. Common themes were a sense of support from a community of practice with shared experiences, mutual learning on issues related to global mental health, and advice and guidance for what are relatively unusual, but shared, career paths.

One member commented:

> [the group members] give me a network in which to bring up challenges of international work … [and] helped me feel validated and supported regarding [an] unusual career track.

One member who has subsequently returned to work in the UK found the fact that being able to show even this level of CPD and revalidation while abroad helped the transition back to professional life in the UK. Continued membership of the group by those now in the UK is an open question, with several choosing to continue to participate due to their interest in the field.

Members occasionally met each other in person, by chance, as part of their shared global mental health work, which served to strengthen the group.

Challenges

Survey responses indicated that there were three main challenges to the running of the group.

- The members of the peer group have very demanding jobs, with many of them travelling extensively for work. This, coupled with living in different time zones, made it difficult to find time to meet as often as would have been ideal. For example, extra meetings were needed to accommodate the number of clinical case reviews that is recommended for revalidation.
- The Skype platform, while ubiquitous and free, was not ideal for some settings where members lived (particularly sub-Saharan Africa). Online communication through platforms like Skype is illegal in some countries. Some individual members often dropped in and out of meetings due to poor internet connections.
- The group members clearly did not fit in with standard procedures established for UK-based doctors. For example, it was not clear what qualified as CPD and how this should be documented, how reappraisal could be done in an isolated low-income setting, or who should supervise revalidation. Advice and consensus helped overcome these uncertainties. Support from SLaM and Maudsley International allowed the fulfilment of some requirements, like senior colleague support for revalidation, that would not otherwise have been possible. This external reality has meant that while most members have been able to fulfil their revalidation needs to a far greater extent than if the group had not existed, there will continue to be challenges to having international careers recognised in the UK.

Comments from senior supporters of the group in the UK

The three supporters felt that they had learnt about the different experiences of working in the international and development settings in which members were based. They also all recognised and appreciated the support group members offered each other. One felt that, given the extensive research being carried out by the members, it would be useful to spend time reviewing recent publications related to global mental health.

One supporter said:

> It has raised my awareness of the practical, professional and clinical issues faced by colleagues working in the developing world.

Conclusion

Overall, the survey showed that a peer group can provide a valuable network, allowing the members to share and strengthen knowledge and expertise despite being geographically isolated. While there is some way to go, the group has proved to be one mechanism through which those choosing careers in global mental health can maintain professional recognition in the UK. For those considering working abroad, some simple steps may ease re-entry into work in a home country. These include:

- maintaining affiliation with medical registration bodies (the GMC in the UK) and ensuring proper registration in any host countries
- engaging with an institution to sponsor and provide a framework for CPD (in our case SLaM NHS Trust)
- following accredited CPD learning opportunities online (such as those provided by the Royal College of Psychiatrists)
- participating in peer-supported learning networks.

Advances in technology, including internet-based models of distance learning, can be adopted by professional groups for peer support and training, such as this peer group of psychiatrists working in global mental health.

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THEMATIC PAPER

Reflections on research and clinical collaborations between South Asia and the UK

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In this paper we describe the mutual benefits of the bi-directional flows of knowledge and skills from North–South/South–North linkages, on the basis of our personal experiences of clinical and research collaborations between the UK and South Asia.

The '10/90' gap refers to the enormous inequity in global healthcare and research: <10% of research funds are spent on the diseases that account for 90% of the global disease burden (Global Forum for Health Research, 2000; Razzouk *et al*, 2010). This inequity is reflected in a publication gap (Patel & Sumathipala, 2001; Sumathipala *et al*, 2004). Although the treatment gap for mental disorders in low- and middle-income countries (LMICs) is frequently highlighted (Prince *et al*, 2007), a recent report by the UK's Chief Medical Officer shows that the picture is not much different in high-income countries, with only 25% of those with mental health problems in the UK accessing mental health services (Chief Medical Officer, 2013).

Historically, the tendency has been to highlight the potential of the West (global North) in building the capacity in resource-poor settings of the East (global South). However, during more recent times there has been a paradigm shift in how these traditional relationships are viewed. In this paper we seek to elucidate North–South relationships by describing the mutual and interdependent benefits of the bi-directional flows of knowledge and skills from North–South/South–North linkages, using our personal experiences of clinical and research collaborations between the UK and South Asia.

Our collective experiences stem from several South Asia–UK collaborations, including:

- the sponsorship programme of the Royal College of Psychiatrists
- the Maudsley International continuing professional development (CPD) peer group
- the UK–Sri Lanka Trauma Group
- the partnership between the Institute for Research and Development (IRD) in Sri Lanka and the Institute of Psychiatry, Psychology and Neuroscience (IoPPN) in the UK
- the South Asian Hub for Advocacy, Research and Education in mental health (SHARE)
- the Programme for Improving Mental Health Care (PRIME).

Some of these programmes exclusively involve clinical training and service development, while others are research collaborations. The selected examples reflect our personal involvement and are not exhaustive.

International links and exchanges can be formal or informal, with the latter having a more individual-oriented approach. However, both types can lead to benefits. Our examples reflect links that have resulted in short- and long-term benefits for both the individuals and the institutions involved.

Clinical exchanges

The Maudsley International initiative (http://www.maudsleyinternational.com) is a formal clinical collaboration on the part of clinicians, managers and scientists, to provide consultancy, teaching and training services tailored to improve global mental health by mutual sharing of expertise among a diverse range of collaborators around the world. It includes experts at the South London and Maudsley NHS Foundation Trust and the IoPPN. This initiative has generated benefits globally, in terms of mutual learning and consolidation of expertise and a bi-directional transfer of a wealth of experience from diverse cultures and geographical locations.

The sponsorship programme led by the Royal College of Psychiatrists is designed to allow a small number of doctors to enter the UK from outside the European Union (EU) for up to 24 months, to benefit from training in the National Health Service (NHS) before returning to their home countries. Under this scheme, International Fellows are placed in training posts with NHS trusts.

Research exchanges

There are critical advantages of North–South collaborative partnerships in building research capacity (Siriwardhana *et al*, 2011). The collaborative research partnership between the IoPPN, King's College London, and the IRD in Sri Lanka is a classic example of a successful North–South initiative contributing to research capacity building (Siriwardhana *et al*, 2011). A.S. was an initiator of this programme in 1997, and C.S. is a beneficiary and a contributor to this continuing and developing partnership (Siriwardhana *et al*, 2011; Sumathipala *et al*, 2013). The IoPPN–IRD collaboration has

led to the establishment of one of the largest twin registries in a low-income country, several globally important research studies and several capacity-building programmes (Siriwardhana *et al*, 2011; Sumathipala *et al*, 2013).

Sangath (a non-governmental, not-for-profit organisation) in Goa, India, and the Human Development Research Foundation (HDRF) in Pakistan are other such organisations involved as key partners representing South Asia in two major international research capacity-building consortiums: SHARE and PRIME. SHARE, funded by the National Institute of Mental Health, is a collaboration between the London School of Hygiene and Tropical Medicine and the IoPPN in the UK, and a network of research institutions and non-governmental organisations (NGOs) across India, Afghanistan, Nepal, Bangladesh and Sri Lanka (see http://sangath.com/inside_page.php?nav_id=232). PRIME is a programme in Ethiopia, Uganda, South Africa, India and Nepal funded by the UK Department for International Development (DfID). It has a focus on health systems strengthening through working partnerships between academic researchers, NGOs and the World Health Organization (Lund *et al*, 2012).

Focused training courses can strengthen the research and leadership skills of mental health professionals in LMICs. The Leadership in Mental Health (LMH) course has been jointly offered by the London School of Hygiene and Tropical Medicine and Sangath for the past 6 years (see http://www.sangath.com/images/file/LMH2014_Sept%2012.pdf). A.N. has been involved in the 2-week course, which equips participants with research and leadership skills to develop and scale up interventions for people with mental disorders in low-resource settings, and to promote the human rights of people affected by mental disorders. Since its inception, the LMH has hosted more than 200 participants from around the world, including mental health practitioners, researchers, policy makers, persons affected by mental health problems and advocates from countries as diverse as Nepal, Norway, Mexico, the USA, Australia, Nigeria, Jordan, Canada and Afghanistan.

C.S. and A.S. have led the organisation of a 'Qualitative methods for health research' programme at IRD since 2011, aiming to develop capacity to conduct qualitative health research in Sri Lanka and the wider South Asian region. We have hosted 80 or so participants from Sri Lanka and other South Asian countries. This is a partnership between the IoPPN, King's College London, the Institute of Public Health, the University of Cambridge and Anglia Ruskin University in the UK and SHARE.

The balance of benefits

At a glance, the work described above may appear to benefit the Southern partners. However, is this an accurate assessment? In this section, we explore the balance of benefits in North–South partnerships, challenges in establishing productive exchanges and the role of reverse innovation.

It is beyond doubt that overseas recruitment schemes are golden opportunities for LMIC doctors to get work experience in the world's best healthcare systems. However, some perceive it as trying to fill jobs in specialties where there is a recruitment crunch. One of the major challenges faced by the LMICs is the 'brain drain' and experience suggests that very few LMIC doctors return to their home countries after the training scheme has ended, thus increasing local shortages of healthcare professionals (Patel, 2003). Patel (2003) has been highly critical of one NHS scheme, now discontinued, which effectively poached highly experienced specialists in a number of fields, including psychiatry. He accuses the NHS of opportunism, where it should have been providing opportunities. While we agree that there certainly is a case to answer, as the benefits of clinical exchanges tend to be unfairly weighted towards the North, does the blame for robbing the best brains from the South lie only with the North?

As stated by Patel, when he finished training in psychiatry in the UK he found that very few routes were available to facilitate his return to India to practise (Patel & Araya, 1992). The difficulties that doctors face when they attempt to return home have not been widely discussed. As many of those trained in the global North would testify, there is resistance from their colleagues in their home countries to integrating those returning. A.S. has very poignant personal experience related to this issue. A.N., too, has first-hand experience of the challenges and advantages of returning to his home country after training in the UK. The continued links with academic institutions in the UK allow him to access CPD and also to contribute to teaching activities in the UK. Such an arrangement does not come without its share of challenges but, if one is able to go through the initial barriers, a vastly productive work environment can be created.

The research collaborations described above help the LMICs by strengthening individual and institutional capacity. C.S. has benefited through the IoPPN–IRD research partnership, gaining fellowship funding from the Wellcome Trust as a result and completing a masters degree and a PhD at the IoPPN while conducting research in Sri Lanka. However, there have been challenges in being based at two locations, dealing with systems built on different hierarchical attitudes, and resistance encountered when promoting a globally oriented research culture.

Research collaborations are reciprocally advantageous, as the knowledge translation and exchange allow evidence generation in the LMICs which can enormously contribute to knowledge generation in the health systems of high-income countries. For example, increasing treatment coverage through delivery of mental healthcare using non-specialist health workers used in LMICs would be useful if replicated in high-income countries, especially in recent times of economic difficulties.

In our experience, international clinical and research exchange can make a significant contribution to mutual learning and the consolidation of expertise. It represents a bi-directional transfer of the knowledge and experience between the North and the South.

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Diaspora and peer support working: benefits of and challenges for the Butabika–East London Link

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The International Health Partnership ('the Link') between the East London NHS Foundation Trust and Butabika Hospital in Uganda was set up in 2005. It has facilitated staff exchanges and set up many workstreams (e.g. in child and adolescent psychiatry, nursing and psychology) and projects (e.g. a peer support worker project and a violence reduction programme). The Link has been collaborative and mutually beneficial. The authors describe benefits and challenges at individual and organisational levels. Notably, the Link has achieved a commitment to service user involvement and an increasingly central involvement of the Ugandan diaspora working in mental health in the UK.

International health partnerships (or Links) are formalised voluntary partnerships between UK health institutions and counterpart health institutions in low-income countries, intended for mutual benefit, through sharing of learning, experience and capacity building. Over 25 years, the Tropical Health and Education Trust (THET) has supported and built a partnership approach that aims to harness knowledge and technical expertise to strengthen health systems through the training of healthcare workers in low-income settings (THET, 2009). It is involved in the allocation of Department for International Development (DfID) funds to Links. Links are advocated as a vehicle for international development (Crisp, 2007) with potential benefits to individual health workers (Longstaff, 2012) as well as UK institutions (All Parliamentary Party Group on Global Health, 2013, 2014; Forrington *et al*, 2014).

The Butabika–East London Link (Baillie *et al*, 2009) was set up in 2005 between interested staff at an English mental health trust (East London NHS Foundation Trust, ELFT) and Butabika Hospital, the national referral and teaching psychiatric hospital in Uganda. Since then, 40 Ugandan staff have come to London for training and over 70 UK staff have visited Uganda, collaborating on a series of work-streams and projects (see Box 1). Exchange staff have included psychiatrists, nurses, occupational therapists, social workers, psychologists, pharmacists, service users and administrative staff.

Box 1. Selected achievements of the Butabika–East London Link

- *Peer support worker (PSW) training and development*. Twenty-eight PSWs have been trained to work alongside the community recovery team to deliver community-based peer support to service users discharged from Butabika Hospital (Baillie *et al*, 2013).
- *Development of the Ugandan Diaspora Health Foundation*. The Foundation supports the strengthening of Ugandan mental health services and promotes advocacy for mental health in the diaspora community (http://www.ugandadiasporahealthfoundation.org; see also Mulimira & Stoddard, 2014).
- *Service user involvement*. Three East London staff and three service users went to Uganda to advocate for service user involvement, which led to the development of an organisation led by service users (Heartsounds Uganda; http://heartsounds.ning.com), development of peer working, the Kampala Hearing Voices Group (Sentamu *et al*, 2012) and the Kampala Mental Health Film Club.
- *Child and adolescent activity* (Messant, 2009). This has included training in family therapy, children's accelerated trauma treatment and the development of a diploma in child and adolescent psychiatry, which is due to be taken over by Mbarara University as a diploma course.
- *The Management of Aggression and Potential Aggression (MAPA) project*. This involved 'train the trainers' training delivered to 12 Butabika staff. It was on de-escalation techniques and the safe management of aggression, and was rolled out to front-line nursing staff at Butabika. It led to a reduction in violence on the wards.
- *Training in psychological interventions for psychologists*. This has included cognitive–behavioural therapy (CBT) and trauma-focused CBT (d'Ardenne *et al*, 2009).
- *Training psychiatric clinical officers (PCOs)*. Training has been delivered in motivational interviewing, solution-focused therapy and trauma-focused CBT (see http://www.butabikaeastlondon.com; Hall *et al*, 2014).

The Link aims to be collaborative and mutually beneficial. In this article, we share some of the authors' reflections on the benefits and challenges to the UK of being involved in Link work.

Benefits to the individual

Engaging in the projects has resulted in beneficial outcomes for Ugandan staff, who have noted practical gains, such as opening email accounts and becoming more connected. Their knowledge and skills have been enhanced by observing healthcare in a different country and context, experiencing different types of supervision, learning new therapeutic approaches and interventions, and engaging with service user involvement.

Involvement in Link work promotes the development of increased confidence, better communication skills, problem-solving and presentation skills, and leadership and project management skills, competencies all listed in the Knowledge and Skills Framework (KSF) and the National Health Service (NHS) Leadership Framework (Longstaff, 2012). It provides an opportunity for NHS staff to reflect on core skills and personal practice, which forms a key part of the appraisal process for doctors in the UK (Royal College of Psychiatrists, 2010).

UK staff describe increased job satisfaction and motivation. They feel that they are able to make a difference and contribute at a local and national level.

Given limited resources, there is an opportunity and a need to be creative and innovative and to value the co-production of solutions with service users and Ugandan staff. The training of 28 service users to work as peer support workers (PSWs) alongside a small community rehabilitation team in Kampala (see Box 1) gave D.B. experience of a different relationship between professionals and service users. PSWs became friends and colleagues, as they worked together towards a common goal. The experience fostered hope and optimism about the potential of the PSWs. For the PSWs, it provided an empowering relationship that seemed more therapeutic than the usual doctor–patient relationship. All UK-based staff gained the confidence to be bolder in the implementation of peer working in the UK and are now leading initiatives in developing this in London teams.

For M.A., growing up in Uganda produced a pessimistic view about service users' capacity for recovery. Seeing the transformation of service users who were trained and worked as PSWs, and observing the change of a Ugandan psychiatrist's attitude to peer working, were powerful influences on changing her attitudes to recovery. Having the Ugandan lead PSW speak to staff and service users in East London was catalytic in allowing peer working to be accepted on a psychiatric intensive care unit and prompted a service user from the ward to train as a PSW.

Uganda diaspora staff describe learning about their culture and African mental health as well as developing an enhanced confidence in their dual identity and culture, describing themselves as becoming more Ugandan British than before.

Cultural awareness

We all believe that we have developed a deeper cultural awareness. Underlying this is a sense of a better understanding of global mental health, with the challenges of translating Western concepts of illness and treatment approaches to a different cultural context.

Being involved in diaspora work has helped M.M. to synthesise the experience of having two cultural backgrounds (being born in Uganda and being raised in the UK since adolescence). He has shared this insight with Ugandan service users in East London, and with first- and second-generation migrants to the UK. His understanding has enhanced his work as a nurse in East London, an ethnically diverse area with a significant migrant population.

Working with Ugandan families and colleagues in the PSW training and the Hearing Voices Group (see Box 1) has given experience of how collectivist cultures conceptualise and approach mental health problems. UK mental health training emphasises a biomedical understanding of mental illness, often sceptical of different explanatory models, and this is challenged through the experience of working in Uganda.

Working with service users in Uganda exposed to acute poverty, not tempered by a welfare safety net, provides a stark reminder of how challenging it is to deal with adversity in the face of significant economic hardship. This gave greater understanding of the realities faced by service users in the UK, who carry the burden of current austerity measures. It also demonstrated the importance of even modest earnings and having a role and status in enhancing recovery from mental health challenges. Despite the adversity faced by service users in Uganda, many have demonstrated huge resilience in their path to recovery. In the UK, we are not always sufficiently hopeful and positive about what our patients can achieve.

In Uganda, there is an impressively different approach to positive risk-taking, with less institutional risk aversion. This experience of a different approach to risk-taking can be both empowering and liberating.

Benefits to the organisation

Benefits to Ugandan services include: the development of specialist services; improved nurse–patient relationships; increased confidence in responding to aggression and violence; reduced patient-reported violence on wards; improved service user involvement in the planning and delivery of services; improved psychological competency for the psychiatric clinical officers; and the development of child and adolescent training around the country.

Involvement in NHS Links provides organisations with an opportunity to demonstrate corporate responsibility as well as a commitment to diversity and equality, something recognised in ELFT policy. The Link has produced a greater understanding of systems and the complexity of working in partnership, as well as an orientating principle of focusing on the service user. The development of a person-centred focus is an important counterbalance to the concerns about a lack of compassion in some UK services. The experience of working in the Link increases staff morale, which, in turn, may improve staff recruitment and retention.

Benefits to the NHS

Current challenges to NHS services include operating effectively in times of austerity, how to maintain quality and how to make better use of existing resources. Collaborating with other countries can provide opportunities for the NHS to learn how to be effective with fewer resources and to learn from examples of task shifting. The PSW project trained 28 service users, greatly increasing the capacity of the community team of four community psychiatric nurses: an important lesson for overworked and understaffed services in the UK.

Challenges to the individual

Working in a context where both financial and human resources are limited can be emotionally, professionally and ethically challenging. Cultural misunderstandings can weaken established trust and collaboration. There can be a mismatch of perceived good practice; for example, informal working relationships can facilitate rapport and engagement in Uganda while more formalised modes of working are more common in the UK. Link work can be demanding for NHS staff and its value may not be officially recognised and supported.

Challenges to the organisation

At times, it can be difficult to engage partners in initiating, maintaining and sustaining project activity, raising concerns about whether activity is truly collaborative. Project work is often donor driven. In this partnership, the main donor is the ELFT, with Butabika often needing to fit into the funder's objectives. In Uganda, where the need is enormous, all projects have been acknowledged to add value to psychiatric practice and to expose staff to innovation, but the risk is that the collaboration remains unequal.

The financial and human resource challenges at Butabika will mean that there will always be areas of practice that excite concern in East London partners, and we need to be aware that the threat of withholding or withdrawing support is an ineffective means of influence. There can be a lack of compassion and understanding of the extreme challenges facing Ugandan colleagues: with only single clinicians covering a whole ward or clinic, UK standards could never be achieved. UK staff pointing this out to Ugandan staff serves only to demoralise them further and to undermine their professionalism.

Conclusion

The Butabika–East London Link is notable for its commitment to service user involvement and the increasingly central involvement of the Ugandan diaspora. The experience of training and working with PSWs in Uganda has provided important lessons for the UK and harnessing diaspora energy has inspired the workforce. Involvement in Link activity provides benefits for those involved, particularly with regard to developing knowledge, skills, leadership and cultural awareness, as well as opportunities for institutional learning. There are also considerable challenges that need to be negotiated, but these can provide opportunities for learning and adapting within the NHS environment. Future collaborations will include the enhancement of peer training in Uganda and the development of staff resilience.

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Mental health law profiles

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Germany and Russia are giants of European civilisation (Figes, 2002; Watson, 2010). In the world of arts and letters the names of Beethoven and Goethe, Tchaikovsky and Dostoyevsky have universal appeal. Many others could be included. In the history of psychiatry, Kraepelin and Pavlov stand at the very foundations of modern psychopathology. Yet when one looks in these countries' histories, one also finds grave offences against those who are mentally ill and against psychiatry. Though this is far from particular to these countries, some of the offences that occurred there have unique significance for our professionalism (Ikkos, 2010).

After the First World War, in the midst of a universal economic crisis and in the context of humiliation and destitution resulting from the harsh insistence by victorious allies on the payment of reparations by defeated Germany, the psychiatrist and pathologist Alfred Hoche was instrumental in developing the ideology of 'life unworthy of life', which led to the designation of people with a mental illness or intellectual disability as 'useless eaters'. Starting in hospitals with the killing by paediatricians of children with severe disabilities in Leipzig in the early 1930s and supported by the gross practice of collaborating psychiatrists signing certificates condemning people with mental illness, intellectual disability and epilepsy to the gas chambers, this ultimately led to the systematic extermination of 100000 psychiatric patients in specially designated 'hospitals' in the early 1940s. The Nazi Holocaust started with people with an intellectual disability or mental illness (Friedlander, 1995) and the German psychiatric profession has apologised since.

In Russia, during the Soviet era, the offence was the use of psychiatry against political dissidents, rather than against people with a mental illness (Musto, 2009). Through the unfounded invention of 'sluggish schizophrenia' by the Soviet psychiatrist Andrei Snezhnevsky, political dissidents were detained as mentally ill and subjected to systematic torture through 'psychiatric treatment' such as electroconvulsive therapy and insulin infusions. Victims included psychiatrists, such as the brave dissident Anatoly Koryagin, who questioned the legitimacy of such practices and other injustices.

This history reminds us why the scientific grounding and ethical integrity of psychiatric diagnostic systems and of practising psychiatrists, conventions on human rights, mental health law and just health and social policies are of such importance for both our patients and the profession. On the evidence of the two papers presented here,

in different ways, both Germany and Russia have made much progress in erecting legal safeguards. However, the risks to our patients remain universal and ever-present in practice (Robertson & Walter, 2010; Bark, 2014; Mendes dos Santos *et al*, 2014; van Voren, 2014).

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Mental health law in Germany

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There is no national mental health law in Germany: the 16 German states are responsible for legislation concerning forced admissions, while the German Civil Code covers non-acute care, in particular for those not able to care for themselves. In forensic psychiatry, both federal and state laws apply. This article describes this situation and provides figures about detentions and other aspects of mental health law in Germany.

Relevant historical issues

Mental healthcare institutions developed in Germany in the late 19th century. Since the development of the 'welfare state' in the early 20th century, mental healthcare has been covered by health insurance, or the state for those who are not insured, although restrictions apply for some special services such as psychotherapy. The National Socialist era (1933–45) saw the forced sterilisation of people with a mental illness and the nationwide euthanasia programme ('T4 action'). After 1945, restructuring led to a strengthening of the German federal states and a weakening of the central legislature. The states became responsible for mental health legislation (*Psychisch Kranke-Gesetze*, abbreviated to PsychKG), other than:

- under the Federal Penal Code, or *Strafgesetzbuch* (StGB), detention following a criminal conviction, leading to forensic psychiatric care
- under the Federal Civil Code, or *Bürgerliches Gesetzbuch* (BGB), detention to avoid imminent self-harm due to a mental disorder.

With German reunification in 1990, the West German mental health regulations were introduced in the East German states and each of the former East German states introduced its own PsychKG. A recent update on the general developments in German mental healthcare and increasing mental healthcare utilisation was provided by Gaebel & Zielasek (2012).

Legislation controlling detention in hospitals and grounds for detention

There are three routes to involuntary detention in hospital due to a mental disorder.

- A court may determine that a person with a mental disorder or a substance misuse disorder found guilty of a crime (under the auspices of the Federal Penal Code) will be admitted to a forensic psychiatric treatment unit rather than sent to prison. Normally, such rulings are based on expert testimonies by psychiatrists. Mental healthcare for forensic psychiatric units is governed by state-specific laws. Detention usually lasts several years. If treatment is successful, the latter parts of the treatment process may occur in the community, accompanied by regular visits to an out-patient forensic service. In treatment-refractory cases, courts may order preventive detention following the period of forensic psychiatric detention. Currently, approximately 500 persons are imprisoned under this law (Steinböck, 2009; Basdekis-Jozsa *et al*, 2013).
- If a person with a chronic mental disorder, who already has a legal guardian (previously determined by a court following expert

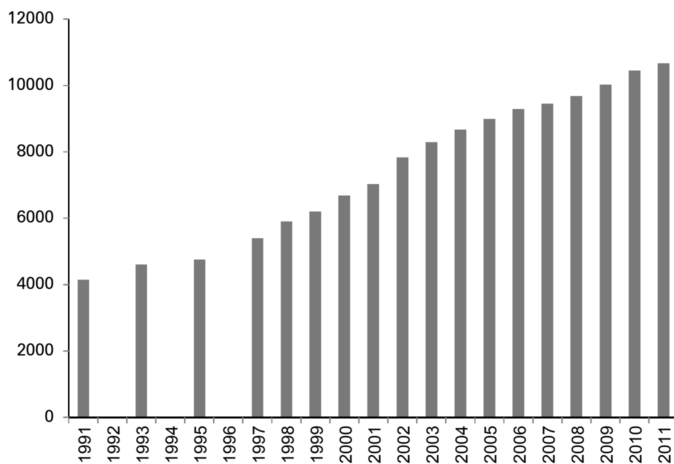

Fig. 1

Numbers of detained persons following court orders under the Federal Penal Code

Source of data: *Statistisches Bundesamt: Strafvollzugsstatistik. Im psychiatrischen Krankenhaus und in der Entziehungsanstalt aufgrund strafrechtlicher Anordnung Untergebrachte (Maßregelvollzug)*, 2013

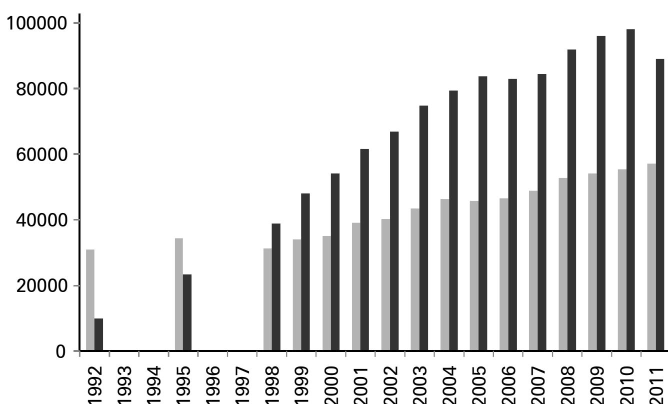

Fig. 2

Numbers of approved court rulings for admission to a psychiatric hospital (para. 1906 (1) BGB; lighter bars) and involuntary treatment or detention (para. 1906 (4) BGB; darker bars) under the Federal Civil Code, which involves participation of a legal custodian

Source of data: http://www.bundesanzeiger-verlag.de/fileadmin/BT-Prax/downloads/Statistik_Betreungszahlen/Betreuungsstatistik2011.pdf

psychiatric evidence), is becoming endangered by a deteriorating mental health condition, he or she may become subject to detention in a closed mental healthcare unit following a court order, under the auspices of the Federal Civil Code. In acute cases, the process can be shortened. Detention times, usually limited to 4–6 weeks, may be extended following a renewed court hearing. An expert psychiatric witness, not involved with the actual treatment, is required if a 12-week period is exceeded. Community treatment is not possible, since admission to a mental healthcare in-patient unit is necessary for this law to be applicable.

- In cases of acute mental illnesses or acute exacerbations of chronic mental illness, a person may be forcibly admitted to a closed mental healthcare service under state mental health laws. Two necessary conditions apply in general: the person must have a mental disorder and, due to the mental disorder, must be an acute danger to himself or herself or to the public. As this type of involuntary admission is governed by state mental health laws, there are considerable differences in the details of the regulation of the process. In general, either police or municipal authorities must rule that an acute psychiatric admission is necessary, a medical doctor must testify that a mental disorder is the cause, and within a very short time of the admission a regional or local court must confirm the rightfulness of the psychiatric admission, following expert psychiatric testimony. For example, in the state of Northrhine-Westphalia, a court order must be obtained on the day following the admission. Detention times may range from days to weeks. Community mental healthcare is not possible in these cases since the law applies only to cases in which there is acute danger.

Because the courts are involved in the process, the degree of adherence to these laws in Germany is probably very high. Medical doctors who do not follow these rules and admit or even treat patients against their will without obtaining the appropriate court permission would be subject to severe legal punishment. The states have visiting commissions composed of patients, medical doctors and administration officials which regularly visit mental hospitals to check that the legal procedures are adhered to.

Families do not play any formal role in the process, although they can apply for involuntary admission of a family member under the Federal Civil Code, or they can be installed as legal guardians by a court following state codes.

Danger, involuntary treatment and custodians

Where a person with a mental disorder represents an extreme and acute danger, the Federal Penal Code allows acute help to be provided by any person, including of course staff members of mental healthcare units. Indeed, a medical staff member who has recognised the acute danger but has not provided help may even be punished for neglect of professional duties, or claims may be made by any third parties which have been damaged. In such cases, forced detention or forced administration of medication may be necessary. Generally, if the need arises, the mental healthcare institution would then obtain a court ruling or initiate guardianship in order to continue with the detention. However, some state legislation (e.g. in Berlin) does not allow forced treatment in such situations, leaving forced detention without treatment as the only legal option. In forensic psychiatric units, forced treatment is usually given only in acute situations. Otherwise, a voluntary treatment plan is usually agreed with the patient, but if he or she declines any treatment, no forced treatment is allowed.

The same applies to patients involuntarily admitted to a mental hospital following rulings of a court under the Federal Civil Code. This requires

Table 1

Numbers of cases at court for detention orders (under para. 1906 of the Federal Civil Code) or due to acute involuntary admission to psychiatric hospitals under state mental health laws (PsychKG), 2000 and 2011

Year	Para. 1906 cases[a]	PsychKG cases[b]	Total admissions to psychiatric hospital[b]	Para. 1906 cases relative to all admissions to psychiatric hospital	PsychKG cases relative to all admissions to psychiatric hospital
2000	87 606	57 051	650 574	13.4 %	8.8 %
2011	146 190	78 147	800 122	18.3 %	9.8 %
Change	+67 %	+37 %	+23 %	+37 %	+11 %

[a]Figures from *Betreuungszahlen 2011*, pp. 28 and 29 (http://www.bundesanzeiger-verlag.de/fileadmin/BT-Prax/downloads/Statistik_Betreungszahlen/Betreuungsstatistik2011.pdf)

[b]Source of data: http://www.gbe-bund.de/oowa921-install/servlet/oowa/aw92/WS0100/_XWD_PROC?_XWD_102/3/XWD_CUBE.DRILL/_XWD_130/D.000/3722

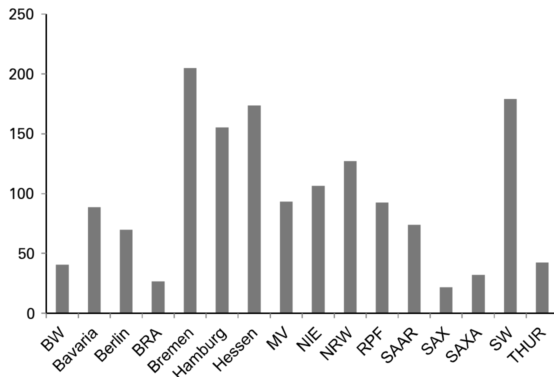

Fig. 3

Numbers of persons (per 100 000 population) admitted to mental health facilities following court orders under state mental health laws (PsychKG) in 2011

Abbreviations: BW = Baden-Württemberg; BRA = Brandenburg; MV = Mecklenburg-West Pommerania; NIE = Lower Saxony; NRW = North Rhine-Westphalia; RPF = Rhineland-Palatinate; SAAR = Saarland; SAX = Saxony; SAXA = Saxony-Anhalt; THUR = Thuringia.
Source of population data: http://www.statistik-portal.de/Statistik-Portal/de_jb01_jahrtab1.asp
Source of state PsychKG data: http://www.bundesanzeiger-verlag.de/fileadmin/BT-Prax/downloads/Statistik_Betreungszahlen/Betreuungsstatistik2011.pdf

the provision of a legal custodian and, until the summer of 2012, the custodian's agreement to treatment was sufficient. A legal controversy and ensuing uncertainties about the legal procedures for this substitution of patient permission by a custodian's permission arose in 2012 following rulings of the German Supreme Court. In early 2013, new legislation was introduced, so that now several factors need to be ascertained before a legal custodian can agree to any type of treatment: the person affected by the mental disorder must be admitted to a mental healthcare unit and be lacking the capacity to recognise or act according to the medical measures. These measures must be necessary to avoid imminent and considerable damage to the health of the affected person. Alternative measures must not be available and the benefit of the planned measure must exceed any potential danger due to the measure. Also, it must be documented that the affected person had been informed about these aspects in advance. In all cases, a special court ruling for the planned therapeutic measures must be obtained, which must be described in full detail, and the permission only of a legal custodian is not sufficient: expert psychiatric testimony is necessary. Usually, the time allowed for involuntary treatment is 2 weeks only. If longer treatment periods are necessary, new court rulings must be applied for.

The power to discharge and the right to appeal

Usually, the courts ordering forensic treatment or detention and treatment in general psychiatric units will set time limits for the respective legal measures, which may be extended following renewed expert testimony and court hearings. If a mental disorder subsides, the treating physicians may also initiate accelerated – usually immediate – termination of the legal detention or forced treatment measures by the responsible court. Any court rulings may be appealed by the patient.

Current issues

There are three major issues (Gaebel & Zielasek, 2012):

- the forced treatment of people with a mental illness who require, but refuse, treatment for somatic disorders
- the increasing number of mental health detentions, both criminal (Fig. 1) and civil (Fig. 2)
- the unpredictable consequences of new funding arrangements for mental hospitals.

When considering statistical findings, one must bear in mind that the admission rate to in-patient mental healthcare in Germany has increased considerably. Therefore, per capita population quotas must be viewed also in relation to per capita admission rates to in-patient mental healthcare. We calculated these figures for the numbers of cases admitted following court orders under state legislation (Fig. 3) (cases at court, not necessarily decided yet) and the German Civil Code (para. 1906, only court-decided cases) for 2000 and 2011 (Table 1).

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MENTAL HEALTH LAW PROFILE

Legal regulation of mental healthcare provision in Russia

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The article describes the changes that have taken place in the mental healthcare system in Russia since a new mental health law came into force. The focus is on involuntary hospitalisation and the guarantee of patients' rights.

In Russia, reforms to the mental healthcare system took place during the last decade of the 20th century, against a background of great social and economic change. Not only in psychiatry but throughout medicine, those reforms brought in democratisation, the principle of informed consent and a shift from a paternalistic to a partnership paradigm in healthcare. However, the same period saw the introduction of private mental health services and a system in which many psychiatric patients do not get adequate treatment. The reforms also had an impact on the continuity of care between in-patient and out-patient services. Regrettably, new legislation prohibited the use of placebo treatments, which had proved to be highly effective, for example with conversion disorders.

The legal regulation of mental healthcare and psychiatric care in the Russian Federation is principally through the Law on Mental Healthcare and Guarantees of the Citizens' Rights in the Course of Care Provision, although there are other federal laws and other provisions regulating government, federal agencies and citizens. That Law was developed in accordance with the principles recommended by the United Nations; it came into force on 1 January 1993. The Preamble states that mental health is of fundamental importance to every person. It underscores that a lack of specific legal regulation of mental healthcare can allow such 'care' to be used for non-medical purposes and can damage the person's health, dignity and rights, as well as the state's international reputation.

Diagnosis

Mental disorder is defined in line with ICD-10 (sections F00–F99) (World Health Organization, 1992). Only psychiatrists are permitted to diagnose mental disorder. Statements of medical doctors of other specialties are considered only preliminary. Non-medical professionals do not have the right to determine the presence of mental disorder. The law emphasises that admission to a mental institution should be used only for the purposes of treatment.

Consent

Treatment should generally be given with the patient's informed consent, defined as 'voluntary, competent permission of the patient to receive therapy', after receiving full and objective information about the procedure, its possible complications and any alternatives. If patients are unable to give informed consent, another person is generally authorised to give consent on their behalf (e.g. parents or legal guardians).

Involuntary hospitalisation

The criteria for involuntary hospitalisation are:

- the person exhibits dangerous behaviour to himself or herself, or others
- the person is helpless and cannot provide for his or her basic daily needs
- there is a danger of 'essential harm' to the mental health of the person if she or he is not in receipt of mental care.

The decision is made by a psychiatrist, who should document a detailed description of the person's mental condition. The necessary measures can be applied only by medical staff and should be thoroughly described and justified in special medical records. In the admission room the psychiatrist in charge should evaluate the mental status of the patient and check that the criteria for involuntary admission still apply. In the case of disagreement, the psychiatrist of the admission unit has the right to discharge the patient from compulsory treatment.

During the next 48 hours a commission of psychiatrists evaluates the involuntary patient and determines whether further detention is justified. The patient has the right to invite any specialist (a psychiatrist or psychologist) to participate in this process. If it is decided the hospitalisation is unjustified the patient is immediately dismissed, even if there are indications for voluntary treatment.

Where the involuntary hospitalisation is deemed justified, the mental institution should in the next 24 hours send an application to the local court together with the commission's conclusion and all the relevant documentation. The court has 5 days to consider the application. The patient has the right to be present in court; if the patient's mental condition does not allow this, the court sitting should take place in the mental hospital, which gives the judge opportunity to meet the patient personally.

In the next 10 days, the patient or the patient's representative as well as the head of the mental institution, or the organisation authorised to protect the rights of patients, have the right to appeal against the judge's decision to approve or decline the application for involuntary hospitalisation.

During the first 6 months, the need for involuntary treatment of the patient should be re-evaluated every month by the commission of psychiatrists. Thereafter, the re-evaluation should be done at least every 6 months. After 6 months of involuntary hospitalisation the commission sends the local court its decision on the need for continued involuntary in-patient treatment. Any further prolongation of treatment is approved by a judge annually.

Patients have the right: to ask questions concerning diagnostic procedures, treatment and dismissal; to make appeals without censorship in court or by executive authorities; and to meet alone with a lawyer or a representative of the state law bureau, or members of the clergy. There is an independent service that defends in-patients' rights. It accepts patient complaints and either resolves them with the head of the medical institution or refers them to the relevant court or executive authority.

Other forms of compulsory treatment

Under the Criminal Code of the Russian Federation, compulsory treatment can be given to patients with a mental illness who commit socially dangerous acts. Whether the mental disorder demands such treatment, care and observation is a decision made by a court. Treatment will be in a mental hospital if compulsory out-patient treatment is not possible. It will be in a general mental hospital unless the patient's condition (e.g involving extreme danger for himself or herself and others) needs constant intensive surveillance and so requires admission to a special mental hospital. The court makes the decision on the basis of an expert psychiatric commission's conclusion and all the other evidence. The commission explains the recommended treatment on the principle of necessity and adequacy for the prevention of socially dangerous acts. Individual treatment and rehabilitation procedures are suggested. Members of the commission should have a licence in forensic psychiatry.

On the basis of an evaluation of mental status, the type of mental disorder and violation of the law, the court makes a decision about the specific compulsory treatment and chooses the type of mental hospital to which the person should be sent for treatment. During the course of treatment the psychiatric commission should re-evaluate the mental condition of the patient every 6 months, undertake a re-evaluation of the mental condition of the patient and make a decision about further treatment.

Other legislative provisions

According to the Federal Law on Fundamentals of Healthcare of the Citizens in the Russian Federation, medical institutions of the subjects (i.e. states) of the Russian Federation in the sphere of mental healthcare are responsible for the development and implementation of measures of social support and medical care for persons with socially significant diseases (including mental disorders), as well as the provision of medications for this category of persons.

Persons with socially significant diseases are entitled to medical care and regular medical check-ups at relevant medical facilities (dispensaries). Article 16 of the Law on Mental Healthcare and the Guarantees of the Citizens' Rights in the Course of Care Provision lists the following mental health services and social support measures guaranteed by the state:

- emergency mental healthcare
- consultation for diagnostic, treatment, psychopreventive and rehabilitation services at in- and out-patient facilities
- all types of psychiatric examination establishing temporary disability
- social support and employment assistance for people with mental disorders
- resolution of custody-related problems
- legal consultations and other types of legal aid at mental and psychoneurological facilities
- social care and nursing for disabled and elderly persons with mental disorders
- the education of disabled persons and minors with mental disorders
- psychiatric aid in cases of natural disasters and catastrophic events.

To provide mental healthcare and social support for persons with mental disorders, the state:

- establishes all types of mental healthcare in- and out-patient facilities, located, if possible, close to the patient's place of residence
- arranges general and vocational education for minors with mental disorders.

The provision of mental healthcare is organised at both state and federal level: federal specialised medical facilities listed and approved by the government of the Russian Federation; and specialised medical facilities of the subjects of the Russian Federation.

Conclusion

We can say that legislative changes to the mental healthcare system have brought about the expansion of rights of persons suffering from mental disorders as well as new challenges for professionals dealing with lack of insight and non-compliance in their daily practice.

There remains much to be done to overcome prejudice against and stigmatisation (including self-stigmatisation) of psychiatric patients in society, and here legislative change can be only the first step on the long way to integration.

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SPECIAL PAPER

Participation of psychiatric nurses in public and private mental healthcare in Kenya

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Acknowledgements: Special thanks to Agnes Wangunjiri, chair of the mental health chapter of the National Nursing Alliance of Kenya, for her interest in and commitment to promoting research.

We studied the rate of participation of psychiatric nurses in mental healthcare in Kenya. A simple questionnaire was delivered to 50 nurses attending a mental health meeting of the National Nursing Alliance of Kenya in April 2012. Of the 40 nurses with psychiatric nursing qualifications, 19 worked specifically as psychiatric nurses; among those employed as general nurses, half their case-loads were mental health patients. Ten per cent of psychiatric nurses had run a private clinic (75% of them general clinics) and 15% were doing private locum work alongside salaried employment. Kenya would need to increase the number of psychiatric nurses 20-fold in order to achieve an internationally recommended ratio (for low-income countries) of 12 psychiatric nurses per 100 000. It appears psychiatric nurses are migrating internally to nursing positions in other areas of healthcare, aggravating the 'brain drain' in mental health.

A loss of psychiatric specialists in Africa is frequently attributed to outward migration to wealthier countries (Jenkins *et al*, 2010a; Padmanathan & Newell, 2012) and less attention is turned to migration internally, to other fields of health. Kenya's Ministry of Health estimates there are 500 practising psychiatric nurses nationally (Kiima & Jenkins, 2010); however, because of the shortfall of general nurses – estimated at 66 782 (Rakuom, 2010) – not all psychiatric nurses work in mental health. Psychiatric nurses in Kenya have prescribing rights and therefore can, and do, perform the functions of a psychiatrist and of a general doctor – as they do elsewhere in Africa (Chetty & Hoque, 2013).

Mental healthcare is designed to be delivered through trained primary care providers in outpatient settings in Kenya, as in higher-income countries. Reliance on psychiatric nurses to deliver specialist mental healthcare is greatest in rural provinces, where there averages one psychiatrist per 3–5 million (Kiima & Jenkins, 2010).

From a health systems perspective, it is essential to know the rate of participation of psychiatric nurses in mental healthcare, not only in public health services but also in private practice, since two-thirds (63%) of enrolled nurses are estimated to work in the private sector (Barnes *et al*, 2010). We therefore set out to establish the participation of psychiatric nurses in mental healthcare in Kenya (Kohn *et al*, 2004).

Method

A simple tool was designed and piloted for the study. The Mental Health Nursing Questionnaire, a 25-item multiple-choice numerical answer survey developed by the first author (available on request), was delivered to all psychiatric nurses attending the annual meeting of the mental health chapter of the National Nursing Alliance of Kenya (NNAK) in April 2012. The purpose of the tool was to determine the proportion of psychiatric nurses working in mental health and the rate of participation of psychiatric nurses in the private sector.

Membership of the NNAK mental health nursing chapter stood at approximately 80 nurses, 50 of whom attended the annual general meeting. The response rate was 100% (all 50 attendees). Ethical approval was given by Kenyatta National Hospital's Ethics and Research Committee (P450/10/2011).

Results

The mean age of the sample was 46 years (s.d. 6.5); 54% were female and 40% worked in Nairobi. Forty nurses had a psychiatric nursing qualification (33 a diploma and 7 a certificate), eight had none (two of whom did have a general nursing qualification and another two a midwifery qualification) and two did not respond (Fig. 1). A quarter of those with a psychiatric nursing qualification ($n = 10$) had at least one other nursing qualification: 12.5% ($n = 5$) in community health, 7.5% ($n = 3$) in midwifery and 5.0% ($n = 2$) in two or more specialties.

Half of those with psychiatric nursing qualifications ($n = 19$) worked specifically as mental health nurses, while the remainder of the sample were employed as general nurses ($n = 8$), as other specialist nurses ($n = 6$), in administration ($n = 5$) or as nursing teachers ($n = 2$) (Fig. 2). Among those employed as non-psychiatric clinical nurses, half (46%) their case-loads were mental health patients. The eight nurses without a psychiatric nursing qualification worked mostly as general nurses ($n = 5$), but also as administrators ($n = 2$) or teachers ($n = 1$).

Among the 47 psychiatric nurses in clinical practice, all but one held a public sector job (Table 1). Over two-thirds ($n = 27$) worked exclusively in the public sector, while over a quarter ($n = 11$) worked partly in the non-state sector. Those in non-state care worked for not-for-profit hospitals, for-profit facilities or a combination of providers.

Five nurses, including four with psychiatric nursing qualifications, reported ever having managed a private clinic and three currently did so. All private practice nurses also worked in the public sector.

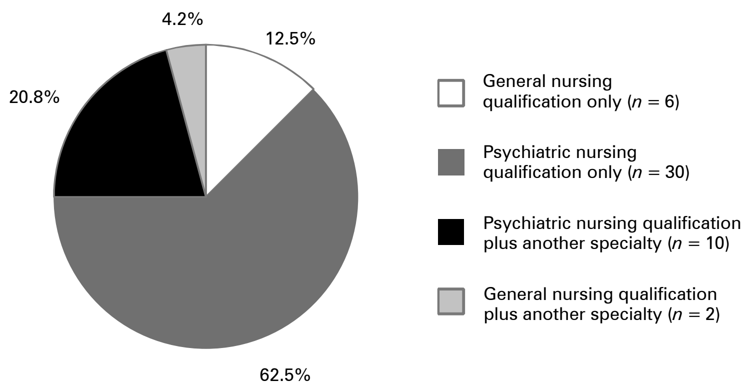

Fig. 1
Nursing qualifications held by the sample

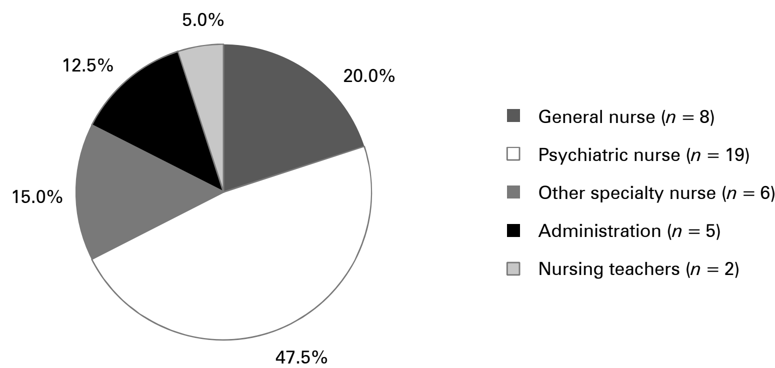

Fig. 2
Employment positions of those with psychiatric nursing qualifications

Private clinics operated on average 2 days (14 hours) per week. The majority ($n = 4$) operated general health clinics rather than mental health clinics. On average, five mental health patients were seen each week (range 3–10), representing a quarter of the patient case-load.

Outside of private clinics, psychiatric nurses also participated in private practice, doing locum work at for-profit hospitals or non-governmental organisations (NGOs). Seven reported doing private locum work in the previous month, largely ($n = 5$) in for-profit hospitals. Only one locum was employed for mental health services. The amount of time spent in locum work differed widely across respondents, from a minimum of a 0.5 day to a maximum of 9.5 days in the previous month.

Discussion

The study demonstrates one way in which the mental health treatment gap in Kenya is adversely affected by the overall health treatment gap, as rare skilled labour is being drawn away from the practice of psychiatry to other areas of health. We found that half of those with psychiatric nursing qualifications in Kenya are employed for functions other than delivery of mental healthcare – a finding consistent with previous estimates (Kiima & Jenkins, 2010). A contributing factor is that a quarter of those with psychiatric nursing qualifications also hold other specialty nursing qualifications, especially in community health and midwifery. It should also be noted that not all nurses who have worked in a mental health setting have psychiatric nursing qualifications, as was the case of 17% of our sample.

If the sample of nurses participating in this modest survey is representative, the results would imply that only 238 of the estimated 500 practising psychiatric nurses in Kenya work specifically with mental health patients, which amounts to a ratio of 0.62 psychiatric nurses per 100 000. Though low, this nonetheless amounts to higher than the average for low-income countries, which are estimated to have an overall mean of 0.42 (World Health Organization, 2011). Moreover, in response to the demand for mental health services, roughly half of the people on the case-loads of psychiatric nurses in general practice are patients with mental health needs. The training of a nurse is often known by colleagues, as a result of which a psychiatric nurse will commonly be referred psychiatric cases, even when employed for other functions.

Kakuma *et al* (2011) argue in *The Lancet* that the necessary ratio of specialist human resources to achieve desirable coverage for mental disorders in low-income countries is 22.3 health workers per 100 000 population: 6% psychiatrists, 54% nurses in mental health settings and 41% psychosocial care providers. This works out to a ratio of 12 mental health nurses per 100 000. To achieve that ratio, Kenya would need 4650 nurses working in mental health settings – 20 times the estimated number of psychiatric nurses practising full-time mental healthcare. Policy efforts to address this wide gap in human resources focus on two strategies: task-shifting counselling to lay health workers (Kakuma *et al*, 2011); and integrating mental health into

Table 1
Employment of those with psychiatric nursing qualifications

	Psychiatric nurse		Non-psychiatric, clinical		Non-clinical		Total	
	%	*n*	%	*n*	%	*n*	%	*n*
Sampled	100	19	100	14	100	7	100	40
Employed by the public sector	40	13	33	12	17	5	75	30
Employed by the public sector only	44	12	37	10	19	5	68	27
Participating in the non-state sector	64	7	36	4	0	0	28	11
Doing additional locum work	0	0	100	6	0	0	15	6
Private practice, ever	50	2	25	1	25	1	10	4

primary care by training clinical officers (Jenkins *et al*, 2010b, 2013). A stepped-care strategy also applied in settings with higher densities of specialised providers.

The findings from our survey point to a significant role played by psychiatric nurses in the private sector – through private out-patient practice, in-patient locum work and with NGOs. One nurse noted that the Ministry of Health has a policy prohibiting simultaneous work in public and private facilities, out of concern that private work compromises public work: 'If people work two jobs, they do it quietly.' Nonetheless, 14% of nurses reported doing locum work. A further 10% had managed a private practice and a quarter of their patients came seeking mental health services. Clinics run by psychiatric nurses tend to operate outside Nairobi, as the competition from private psychiatrists is high in the capital. The participation rate of psychiatric nurses in private practice was found to be lower than in other types of nursing (Barnes *et al*, 2010), though still significant.

A limitation of this study is the potential for sampling bias, as the sample represents only those attending the annual general conference on mental health. Those with psychiatric nursing qualifications who are no longer practising mental health would be less inclined to attend a mental health meeting. It is also possible that those in private practice would be less likely to attend the meeting, since there is a separate chapter of the NNAK for nurses in private practice. If this is the case, then our estimate of the shortfall of psychiatric nurses is conservative, as is our estimate of their participation in private practice. In addition, the questionnaire did not address wider intersectoral roles held by psychiatric nurses, including supervising primary care.

In conclusion, it appears that psychiatric nurses are migrating internally to nursing positions in other areas of healthcare, aggravating the existing 'brain drain' for mental health.

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SPECIAL PAPER

SUNDAR: mental health for all by all

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The research described in this article has been supported by the Wellcome Trust (V.P. is supported by a Wellcome Trust Senior Research Fellowship in Clinical Science); the National Institute for Mental Health; Autism Speaks; the Jamsetji Tata Trust; the WHO; the MacArthur Foundation; and UNFPA. The author is a founder of Sangath and a member of its Managing Committee.

This article describes the rationale and principles for the SUNDAR approach adopted by Sangath, an Indian non-governmental organisation: to use lay people, with appropriate training and supervision, to deliver psychosocial interventions for a range of mental health conditions. This approach has been evaluated in a number of randomised controlled trials and is now being scaled up. At the core of this innovation is revisiting the questions of *what* constitutes mental healthcare, *who* provides mental healthcare and *where* mental healthcare is provided. In doing so, SUNDAR offers a vision for a mental healthcare system which is empowering, inclusive, equitable and effective.

The rationale

Even by the most conservative prevalence estimates, about 50 million people are affected by mental health problems in India. In contrast to this high burden, the country has only approximately 5000 mental health professionals. It is obvious then that the strategies to address mental healthcare need to rely on alternative human resources if the country is to meet more than a tiny fraction of the needs of people affected by mental health problems. It is in this context that Sangath (http://www.sangath.com), an Indian non-governmental organisation (NGO) headquartered in the state of Goa and now working in several states around the country, began shaping its approach to using lay people to

deliver evidence-based psychosocial interventions for mental health problems. Inspired by similar approaches to 'task-sharing' interventions with lay and community-based workers in other areas of healthcare in India (for example, India's National Rural Health Mission contracts nearly a million such workers to deliver a range of maternal and child health interventions), Sangath adopted an approach which has now been replicated for use across a diverse range of mental health conditions.

The SUNDAR approach

Sangath's approach is characterised by several principles:

- designing interventions based on global evidence of effectiveness and local evidence of cultural acceptability
- systematically testing intervention delivery to ensure the feasibility of its use by lay health workers (who are referred to as 'counsellors') and its acceptability by patients and families
- involving diverse stakeholders, in particular people affected by the target mental health problems, in shaping the content and delivery of the intervention
- embedding the intervention in established healthcare platforms, most commonly those run by the government but also the private sector, which is widely utilised in India, to ensure scalability
- evaluating the effectiveness and cost-effectiveness of the intervention in randomised controlled trials in partnership with leading research institutions, notably the Centre for Global Mental Health in London (http://www.centreforglobalmentalhealth.org)
- disseminating the findings in a variety of ways, ranging from scientific papers to audio-video media (see for example https://vimeo.com/67216615)
- working closely with federal and state ministries of health to scale up the innovations.

Several lessons have emerged from these experiences, which have been coined with the acronym SUNDAR (which means 'attractive' in the Hindi language).

- First, we should **S**implify the messages we use to convey mental health issues, for example replacing psychiatric labels which can cause shame or misunderstanding with those which are contextually appropriate and widely understood.
- Second, we should **Un**pack our interventions into components which are easier to deliver and incorporate culturally sensitive strategies.
- Third, these unpacked interventions should be **D**elivered as close as possible to people's homes, typically their actual homes or the nearest primary healthcare centre or community facility.
- Fourth, we should recruit and train **A**vailable human resources from the local communities to deliver these interventions. This often refers to lay counsellors, but could also include parents and teachers in the case of childhood disorders.
- And finally, we should judiciously **R**e-allocate the scarce and expensive resource of mental health professionals to design and oversee mental healthcare programmes, and train, supervise and support community health agents.

This approach is built around a collaborative care framework, the most evidence-based delivery model for integrating mental health into routine healthcare platforms (Patel *et al*, 2013a), with four key human resources: the front-line lay counsellor; the person with a mental health problem and the family; the primary or general healthcare physician; and the mental health professional. SUNDAR is attractive not only because it enhances access to care using available human resources in an efficient way, but also because it empowers ordinary people to provide mental healthcare for others and, in so doing, promotes their own well-being (Shinde *et al*, 2013).

The evidence

Based on this approach, Sangath has completed research involving the systematic development of interventions and subsequent randomised controlled trials of interventions for three mental health problems – dementia, schizophrenia and common mental disorders – all of which have shown significant benefits in terms of clinical or social outcomes. The dementia trial (the Home Care Trial) (Dias *et al*, 2008) was the first such study from a low-income country and won Alzheimer Disease International's international prize for psychosocial interventions in 2010. The common mental disorders trial (the MANAS Trial) was the largest trial in psychiatry in low- and middle-income countries and the first to demonstrate the cost-effectiveness of task-sharing for mental healthcare (Patel *et al*, 2011; Buttorff *et al*, 2012). The schizophrenia trial demonstrated modest benefits in reducing disability levels in people with chronic illness (Chatterjee *et al*, 2014).

Six projects following the SUNDAR approach are currently in progress, for: the treatment of alcohol use disorders in primary care; the treatment of severe depression in primary care; the treatment of maternal depression in community settings by peers (i.e. other mothers); parent-mediated interventions for autism; school mental health promotion for young people; and the prevention of depression in late life.

The impact

This evidence has been used to scale up mental healthcare in rural communities in one of the poorest regions of the country through VISHRAM (Vidarbha Stress and Health Program), a partnership between Sangath, social development NGOs, the Ministry of Health and psychiatrists.

Promisingly, the new National Mental Health Programme of the Ministry of Health (government of India), which finances the country's District Mental Health Programme, citing this evidence, has mandated the establishment of a new cadre of community mental health worker attached to primary healthcare centres throughout this vast country. This evidence, consistent with similar evidence from other low- and middle-income countries on the effectiveness of psychosocial interventions delivered by lay health workers (van Ginneken *et al*, 2013), has led to this approach being one of the key recommendations of the World Innovation Summit in Health, in its report on mental health (Patel *et al*, 2013b). Examples of such innovations can be found on the recently launched Mental Health Innovations Network (http://mhinnovation.net/innovation/).

However, this research also points to some of the limits of this approach. For example, the evidence is restricted to a few mental health conditions, has not been evaluated for the critically important procedure of diagnosis and has not yet been scaled up significantly in any country. Thus, it is reassuring that these gaps in knowledge have led to a revolution in the field of global mental health research, with task-sharing among the leading research priorities in the Grand Challenges for Global Mental Health (Collins *et al*, 2011), which has leveraged more than US$50 million in the past 2 years to support more research and capacity building in this area.

There are a number of NGOs working in low-income countries to build skills among community-based workers to deliver psychosocial treatments for mental health problems, but few that are using robust, peer-reviewed scientific methods to evaluate the effect of these approaches and working closely with ministries of health to scale up these innovations. Sangath stands out as a rare example of an innovator committed to community empowerment, science and scaling up in low-resource settings. The impact of this evidence on the recognition of Sangath as one of India's leading mental health research institutions has been significant and a range of professionals from around the world participate in its annual 2-week Leadership in Mental Health course, held in November in Goa, to learn about these models of care.

The relevance for global mental health

The SUNDAR innovation of task-sharing of mental healthcare with lay people has enormous potential for low- and middle-income countries. While it would come as no surprise to learn that there are astonishingly large gaps in access to evidence-based care in these countries, the real puzzle is that large proportions of people do not access such care even in high-income countries. There are many explanations for this observation. At the heart of them all is the remoteness of mental healthcare from the communities it serves: the interventions are heavily medicalised; they do not engage sufficiently with harnessing personal and community resources; they are delivered in highly specialised and expensive settings; and they use language and concepts which alienate ordinary people. In all these respects, the SUNDAR approach may be instructive to rethinking mental healthcare globally.

At the core of this innovation is revisiting the questions of *what* constitutes mental healthcare, *who* provides mental healthcare and *where* mental healthcare is provided. SUNDAR uses appropriately trained and supervised lay workers, working in settings and at times convenient to patients (even *in* patients' homes and outside regular working hours). It offers a range of contextually appropriate interventions tailored to the needs of the individual and using familiar labels and concepts. SUNDAR is an approach with relevance to rethinking mental healthcare in all countries. By acting on the axiom that mental health is too important to be left to mental health professionals alone, SUNDAR seeks to achieve a paradigm shift by reframing so-called 'under-resourced' communities as 'richly resourced', for there is surely no community on earth which is not richly endowed with human beings who are capable of caring for those with mental health problems.

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PANDORA'S BOX

Pandora searches the world literature for evidence, news and other sources on matters of interest (doesn't shy away from controversy) to bring to the reader. She welcomes comments and suggestions (via ip@rcpsych.ac.uk)

Drug classification

Do you get frustrated trying to explain to patients or trainees the differences between first- and second-generation drugs or classical and atypical antipsychotics? How often have you found yourself trying to explain to a puzzled patient that, although it is an antipsychotic (e.g. quetiapine), the drug you are prescribing is the right choice for their bipolar depression; or that you are right in giving them a high-dose antidepressant for their obsessive–compulsive disorder? This may soon be a problem of the past. The first phase of a new psychotropic drug classification was launched at the 27th European College of Neuropsychopharmacology (ECNP) Congress in October 2014. This is the product of a 5-year collaboration between the ECNP and the American College of Neuropsychopharmacology (ACNP), the International College of Neuropsychopharmacology (CINP), the International Union of Basic and Clinical Pharmacology (IUPHAR) and the Asian College of Neuropsychopharmacology (AsCNP). The new Nomenclature Project, which uses terminology based on the pharmacology of the drugs rather than the symptoms they treat, aims to replace the outdated symptom-based classifications developed in the 1960s. The new classification consists of four axes: Axis 1 describes the pharmacological action (the target and mode of action), Axis 2 the indication, Axis 3 the efficacy and major side-effects and Axis 4 the neurobiology. In this first phase of implementation, a booklet, *Neuroscience-Based Nomenclature*, and a beta version app were released at the 27th ECNP Congress. These are available in English only at present, but there are plans to release them in other languages, including French, German, Spanish, Portuguese, Japanese and Chinese. Meetings are planned with key organisations such as the World Health Organization, the US Food and Drug Administration, the American Psychiatric Association and others. Is this going to make a difference in clinical practice? Does this appeal? Will it help improve clinical practice? More information is available and comments can be placed on the ECNP website.

Presentation at the 27th European Neuropsychopharmacology (ECNP) Congress, 19 October 2014; see also http://www.ecnp.eu/projects-initiatives/nomenclature.aspx

Age and neuroplasticity

We now live longer and are required to stay in employment for longer, but can our ageing brains cope? Do we have the same capacity to learn and do our neurons retain the flexibility to change? Is neuroplasticity still possible? It is established that our cerebral ventricular system enlarges with age, the grey matter shrinks and its capacity for plasticity decreases. But all is not lost! A study published in *Nature Communications*, a collaboration between scientists from Taiwan and the USA, compared the ability to learn and perform, using an abstract visual perception task over a period of a week, between a group of volunteers aged 65–80 and a younger group aged 19–32. They also scanned the subjects' brains during the test, using magnetic resonance imaging (to examine plasticity in the cortex) and diffusion tensor imaging (to examine plasticity in the white matter). The older group performed as well as the younger group on the test but while the young brain images showed more changes in the cortex, as expected, the older group's performance was associated with changes in the white brain matter. The conclusion is that although the ageing brain's plasticity in the cortex is impaired, older people are still able to learn (at least as far as this visual test demonstrates) because the brain capacity for plasticity shifts from the grey matter to the white matter, possibly by making neuronal signal transmission more efficient.

Nature Communications, 2014; 5: 5504
doi: 10.1038/ncomms6504

Stigma as a barrier

Did you think that stigma is a problem of less affluent and less informed societies? Some 60 million Americans experience mental illness in any given year but 40% of these will not receive care, according to a new report published in *Psychological Science in the Public Interest*, a journal of the Association for Psychological Science. The report specifically examines stigma as a significant barrier in seeking and receiving care. Without ignoring the role of public stigma, the authors go further in their analysis, implicating the institutional and public health systems' responsibility. They bring to attention the fact that both mental healthcare and mental health research are less well funded than physical medical care and medical research, an observation that also applies to the UK. The Carter Center Mental Health Program in the USA attaches a positive and optimistic statement to this report:

> Together, we can create robust systems and services all along the path of recovery and encourage early intervention and access to treatments without fear of labels or diminished opportunities. When that is achieved, we will know that our tireless efforts to eradicate stigma have been successful.

Psychological Science in the Public Interest, 2014; 15 (2): 37
doi: 10.1177/1529100614531398

Declaration on mental health in Africa

From the USA to the rest of the world and in particular Africa, where mental disorders, which account for a huge part of the burden of disease and disability, are allocated less than 1% of the meagre health budgets. In 2014, the 194 member states of the World Health Organization, including representatives from African countries, adopted the Comprehensive Mental Health Action Plan (MHAP) with the objective of advancing the mental health agenda in the world. African representatives, recognising this as a historic opportunity to improve the mental health and well-being of the continent's citizens, pledged to adopt this roadmap, to aim for parity of mental and physical health and to address stigma and the violation of human rights. They advocate the inclusion of mental

health in the post-2015 Sustainable Development Goals and the convening of a special United Nationas General Assembly High Level Meeting on Mental Health within 3 years.

Global Health Action, 2014
doi: 10.3402/gha.v7.24589

Rates of suicide and attempted suicide in Ethiopia

Most of the evidence on suicide originates from research in affluent countries; in low- and middle-income countries it is generally limited to patients attending psychiatric facilities, where selection bias is likely to be high. In a prospective study, 916 subjects with the diagnoses of major depression, bipolar disorder and schizophrenia were followed up annually for 10 years in a rural setting in Butajira, Ethiopia. High rates of attempted suicide were found in all three diagnostic groups. The cumulative risk of suicide attempts over the follow-up was 26.3% for major depression, 23.8% for bipolar I disorder and 13.1% for schizophrenia. The rates for depression are higher than the lifetime rates for suicide in clinic-based populations in high-income countries. The study's findings add to the literature reporting that although a treatable condition, depression remains not only a major cause of disability globally but also a major cause of mortality among those affected. The suicide methods most commonly found in this study were hanging, jumping from a height, drowning or using organophosphates, with understandably high rates of completed suicide at first attempt.

BMC Psychiatry, 2014, 14: 150
doi:10.1186/1471-244X-14-150

Leadership stress and hubris

A conference organised by the Daedalus Trust and the British Psychological Society held at the Royal Society of Medicine in November 2014 tackled the subject of leadership stress and hubris. The term *hubris* originated in ancient Greece, where it was used to describe a man's exaggerated sense of ability and power, nearing those of a deity, hence it was considered an insult (υβρις = insult) to the gods of Olympus and punishable by Nemesis. Hubris according to Lord Owen is 'exaggerated pride, overwhelming self-confidence and contempt for others'. Originally focused on politicians, hubristic behaviour is now recognised in any sphere of life in anybody who misuses power. The 'hubris syndrome' – overconfidence in one's own judgement – is considered to be an acquired personality change triggered by access to power. The presence of narcissistic traits, a sycophantic entourage and possibly some other as yet unidentified factors contribute to this. If you are interested in learning more about the hubris syndrome, check the Daedalus Trust website (http://www.daedalustrust.com).

Correction

The co-author was omitted from the guest editorial in the November 2014 issue of *International Psychiatry*: Mohammad Alsuwaidan, Assistant Professor, Department of Psychiatry, Health Sciences Center, Kuwait University, Kuwait, and Divisions of Brain Therapeutics and Philosophy, Humanities and Educational Scholarship, University of Toronto, Canada.

The correct citation is therefore:

Zahid, M. A. & Mohammad Alsuwaidan, M. (2014) The mental health needs of immigrant workers in Gulf countries. *International Psychiatry*, **11**, 79–81.

The online edition has been corrected post-publication, in deviation from print and in accordance with this correction.

Forthcoming international events

28–31 March 2015

EPA 2015 – 23rd European Congress of Psychiatry

Vienna, Austria

Website: http://www.epa-congress.org/

The 23rd European Congress of Psychiatry (EPA 2015) will facilitate learning, discussion and exchange among psychiatrists in Europe and around the globe. Guided by the motto 'Excellence in Psychiatry across Europe: Practice, Education, Research', EPA 2015 aims to showcase research and developments in European psychiatry, while providing opportunities for networking. The European Psychiatric Association is the main association representing psychiatry in Europe. EPA's activities address the interests of psychiatrists in academia, research and practice throughout all stages of career development.

29 June–2 July 2015

Royal College of Psychiatrists' International Congress 2015

Theme: Psychiatry at the Forefront of Science

ICC, Birmingham, UK

Website: http://www.rcpsych.ac.uk/traininpsychiatry/conferencestraining/internationalcongress2015.aspx

With a projected attendance of over 2000 delegates from more than 50 different countries, the International Congress of the Royal College of Psychiatrists is one of the biggest events in the annual mental health conference calendar. The Congress will have over 100 hours of academic programme. Presenters over the 3½ days of the conference will include academics, physicians, psychiatrists, patients, service users, family members, carers, psychologists, social scientists, policy makers and journalists within a programme that will include plenty of opportunities for networking and socialising.