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GUEST EDITORIAL

Placebo effects: a new paradigm and relevance to psychiatry

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Systematic evaluations show that placebo treatments can have large effects, sometimes larger than those of 'evidence-based treatments'. This is the 'efficacy paradox'. The neurobiology of placebo effects is being mapped out. Placebo effects are no less real or, in some illnesses, clinically important than the effects of direct biomechanical or pharmacological interventions. The technical model of medicine seeks impersonal technologies that can be applied independently of context and person. This approach has had spectacular success in the treatment of *disease* but meaning, cultural context, interpersonal effects, personal preferences and values are enormously important in the treatment of *illness*. The study of placebo reveals aspects of the biology of interpersonal relationships and the social environment. The evidence demonstrates that interpersonal healing (sometimes called placebo) in illness is just as real, scientific and biological as technological healing. This is a paradigm shift.

Paradigm shifts occur, according to Thomas Kuhn, when scientists encounter anomalies that cannot be explained by the existing, accepted paradigm within which scientific progress has hitherto been made.

Placebo effects have been a scientific curiosity for years, but tainted by associations with quackery and dishonesty. Recently, research on placebo effects has greatly increased. In June 2011 the Royal Society devoted a themed issue of its *Philosophical Transactions* to the placebo, which presented current understanding of psychobiological mechanisms, anomalies in placebo research, and how to harness placebo effects in clinical practice (Meissner *et al*, 2011).

Placebo effects may be simplistically defined as those accruing from taking dummy pills or inactive treatments. In placebo-controlled randomised controlled trials (PCRCTs) placebo is defined negatively, as those non-specific (typically non-pharmacological) effects to be subtracted from the treatment arm, to reveal the specific (typically pharmacological) effect. Here, placebo is 'noise' obscuring the 'signal' of 'real' treatment. Recently, placebo effects have been defined positively as the specific effects arising from caregiving.

Systematic evaluations reveal that placebo treatments can have large effects, sometimes larger than the effects of properly evaluated 'evidence-based treatments'. This is the 'efficacy paradox' (Kaptchuk *et al*, 2010). The neurobiology of placebo effects (nuclei, pathways, neurotransmitters, peptides and hormones) is being mapped out. There is evidence for various psychological mechanisms, including classical conditioning, evaluative conditioning, expectation (including the expectations of professionals), the quantity of care and attention received from professionals, and the quality of the therapeutic relationship or alliance (Meissner *et al*, 2011). Placebo effects are no less real or, in some illnesses, clinically important than the effects of direct biomechanical or pharmacological interventions.

Meta-analyses of PCRCTs demonstrate greater placebo responses for subjective symptoms, but far less for objectively measured physical parameters. Improvements also occur in no-treatment groups. This distinguishes *technological healing* (interventions acting directly on physical processes in the body, working even in unconscious patients), *interpersonal healing* (requiring a conscious patient to engage with symbolic interventions that influence perception, meaning and subjective experience) and *natural healing* (natural history of a disease, the body's natural responses to disease, and regression to the mean) (Miller *et al*, 2009). Healing rituals occur in all human societies. The biological substrate and instinctual underpinning of interpersonal healing are likely to be rooted in the evolution by natural selection of mammalian attachment instincts and related grooming (bonding) behaviours. The investigation of placebo effects and mechanisms has emerged as a way of studying the 'healing situation'.

The technological model of medicine seeks impersonal means of cure that can be applied independently of context and person. The PCRCT is a central tool of technological medicine. It developed precisely to control for interpersonal healing effects and individual and contextual factors. This approach has had spectacular success in the treatment of *disease* (the objective anatomico-pathophysiology). However, meaning, cultural context, interpersonal effects, personal preferences and values are enormously important in the treatment of *illness* (the phenomenological subjective experience), particularly psychiatric conditions (Miller *et al*, 2009).

The size of a placebo effect is highly dependent on the conditions of treatment, specifically the person's active participation, beliefs, preferences and the quality of relationships with clinicians. Lidstone *et al* (2010) manipulated the expectation of patients with Parkinson's disease that they

were receiving placebo and found that significant dopamine release occurred when the declared probability of receiving active medication was 75%, but not at lower probabilities. Manipulating treating clinicians' beliefs in the efficacy of treatment also leads to significant differences in patient outcomes.

Some drugs may exert their effect by amplifying placebo responses. Benedetti *et al* (1995) showed that the cholecystokinin antagonist proglumide was more effective in reducing postoperative pain than placebo, which was more effective than no treatment (cholecystokinin opposes endogenous opiate pathways). However, when proglumide was given covertly it had no effect. The authors concluded that proglumide has no direct effect on pain pathways, but instead potentiates a placebo-activated endogenous opiate system, and therefore is effective only when combined with the placebo mechanisms inherent in the clinical encounter. Similar studies using covert administration of drugs indicate a far larger role for placebo effects than has hitherto been recognised (Benedetti *et al*, 2003). The finding that some drugs exert effects by acting on pathways that are activated in placebo responses, if replicated, further complicates the simple 'placebo *v.* specific effect' dichotomy.

Understanding the evolution of primary emotional systems reveals that the critical determinants of affects, psychiatric disorders and placebo effects are interpersonal relationships and the social environment. Recognition of the importance of relationships has focused interest on the 'art of medicine' and the informal psychotherapeutic processes that occur between skilled empathic clinicians and their patients, which can help patients to achieve more successful ways of coping with illness, disease and life's other challenges. Psychotherapy can be seen as a pure form of the doctor–patient relationship, stripped of pharmacological effects. It has been argued that psychotherapy is analogous to a chemotherapy placebo, or even that psychotherapy is only placebo. However, this is derogatory to both psychotherapy and placebo. What does the psychotherapy literature reveal about interpersonal processes leading to therapeutic change? Different *bona fide* short-term psychotherapies, be they psychoanalytic, behavioural, cognitive, humanistic, or integrative, have globally comparable outcomes across a range of conditions, with effect sizes in the region of 0.85. This is the 'equivalence paradox'. Claims for the effectiveness of specific techniques have been largely explained by strong biases in investigator allegiance. Psychotherapy process research reveals that specific techniques account for very little of the variance in outcome, far less than the so-called 'non-specific' effects of being in therapy. Non-specific factors can be conceptualised in various ways but generally include: the therapeutic alliance (consistently accounting for most of the variance in outcome), patient factors (such as engagement), therapeutic focus (having a specific focus leads to better outcome), expectation of a good outcome (clinicians' and patients' expectations of success tend to be self-fulfilling), and patient and therapist characteristics (Messer & Wampold, 2002).

In the pharmacological treatment of depression three-quarters of the effects of antidepressants are achieved by placebo. Up to one-quarter of improvements may be due to natural history and half to 'true' placebo effects (Kirsch & Sapirstein, 1998). Placebo effects may be smaller and pharmacological effects proportionately larger as severity increases (Kirsch *et al*, 2008). McKay *et al* (2006) reanalysed data from the US National Institute of Mental Health's Treatment of Depression Collaborative Research Program and showed that the contribution of the therapeutic alliance outweighed the modality of treatment, whether cognitive–behavioural therapy (CBT), interpersonal therapy (IPT), imipramine or placebo. Individual psychiatrist effects accounted for more variance in outcome than did the difference between taking imipramine or placebo (9.1% *v.* 3.4% of variance in score on the Beck Depression Inventory). The most effective psychiatrists were responsible for the largest clinical improvements irrespective of whether their patients were taking placebo or medication. The most effective psychiatrists had better outcomes with placebo than the least effective psychiatrists had with antidepressants.

Placebo responses are less well studied in schizophrenia, but may be similar to those in depression (Kinon *et al*, 2011). However, rates of dismissive and unresolved attachment in schizophrenia are at least double those in depression; this complicates relationships with clinicians and therefore interpersonal healing (Dozier *et al*, 1999).

Further support for the importance of interpersonal healing comes from the mental health recovery movement, which has highlighted the importance of hope, validation, supportive relationships, engagement, coping skills and meaning. These factors are central to both placebo and psychotherapy.

Prescribing evidence-based treatments and simply expecting the technology to work while failing to establish therapeutic relationships profoundly limits clinical effectiveness. In the absence of long-term research on placebo effects, evidence from psychotherapy process research suggests that relationship factors promote therapeutic change. The ability to form therapeutic relationships should be promoted in the training of psychiatrists. A range of strategies may be required, including: training in communication skills, reflective practice (Balint groups and work discussion groups) and conducting psychotherapeutic treatments under supervision.

The study of placebo reveals aspects of the biology of interpersonal relationships and the social environment. The evidence demonstrates that interpersonal healing (sometimes called placebo) in illness is just as real, scientific and biological as technological healing. This is a paradigm shift.

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Recovery

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The concept of 'recovery' as applied to severe mental illness has fostered a cultural change in attitudes to the long-term outcome of conditions such as schizophrenia. 'Recovery' has a specific meaning in this context. It refers to the possibility that even in the presence of a chronic psychiatric disorder there is hope for a life that has value. The affected individual can still make a contribution to society; he or she can expect to live independently and with dignity. The term implies that our traditional medical model of illness lacks the longer-term perspective on how patients might learn to cope with their condition.

We present three themed articles on 'recovery' as applied to mental healthcare. Two of those articles review the concept of recovery and its historical antecedents. The third concerns the specific case of schizophrenia and reviews surprising findings about the prognosis of the condition in different countries and cultures.

We start with an authoritative account of the origins of the 'recovery movement' in the USA, from Anthony Ahmed and colleagues. Back in the early 1970s grave concern was being expressed by patients, their families and some professionals about the management of severe mental illness and the role played at that time by lifelong institutional care, which was then prevalent in the USA and many other high-income countries. As a reaction against this management strategy there was a push for greater patient participation in decision-making. This was the start of the focus on 'recovery'. It involved the establishment of advocacy for those who wished to leave institutional care and make a future for themselves within rather than outside the community at large. Such a movement challenged societal stigma about those with impaired mental health.

Ahmed and colleagues discuss the development of the 'recovery theme' of psychiatric illness in the USA, where it appears to have been most enthusiastically supported. In their view, in the UK we are lagging behind. On the other hand, Jed Boardman and Geoff Shepherd are optimistic about the changes that we are beginning to see here. They discuss in outline the Implementing Recovery – Organisational Change project, which is a national strategy that aims to help organisations in the UK become more supportive of recovery.

Finally, Aleksandar Janca and Sivasankaran Balaratnasingam take a historical perspective on cross-national comparisons of prognosis in schizophrenia. Since the pioneering projects devised by John Wing in collaboration with the World Health Organization, 40 years ago, evidence has been accumulating that indicates there are major international differences in the prevalence and the prognosis of schizophrenia. Here, the surprising and controversial accounts of better 'recovery' from the condition in countries that have rudimentary mental health services, than in the psychiatrist-led, medication-oriented, hospital environments of the Western world, are debated.

RECOVERY

International efforts at implementing and advancing the recovery model

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For almost a century the medical model has been the overarching framework for mental healthcare but since the 1980s it has been challenged by a consumer/survivor movement. Central to this revolution is the recovery model, which suggests that mental illness is only one of many facets of the life of an individual with mental illness, and that a full, meaningful life is possible despite illness (Anthony, 1993). The medical model emphasises the role of symptomatic improvements and functional status, and considers recovery as an 'outcome' or 'end state', at which point symptoms are remitted and community functioning is restored. In contrast, the recovery model underscores hope, empowerment, the self-management of illness and some aspects of community functioning, such as social support and role functioning, which operate in a non-linear fashion throughout the recovery journey.

The advent of recovery was partly driven by dissatisfaction with the traditional medical model, which many consumers, family members, advocates and practitioners have viewed as fostering a gloomy picture of clinical outcomes in severe mental illnesses. The recovery model was historically fuelled by consumers'/survivors' views that traditional systems fostered disability, alienation, oppression and marginalisation (Jacobson & Curtis, 2000). In contrast, the recovery model promises self-determination, shared decision-making, community involvement, advocacy, decreasing stigma and discrimination, and a more hopeful picture of outcomes for individuals with psychiatric illnesses.

Although recovery has begun to permeate mental healthcare systems, there has been little effort to compare and contrast recovery-oriented systems cross-nationally. The current article is a snapshot of systems transformations and the implementation of recovery across countries. The recovery model has wielded its influence in mental health systems in North America, Europe, New Zealand, Australia and Japan. Efforts at transforming national systems to recovery-oriented approaches have generally followed examples set in the USA. In some cases individual countries have incorporated unique elements into the recovery model. A full review of the international advancements of recovery would have been overly lengthy; thus, we chose to focus on countries that have experienced the most remarkable systems transformation. We begin with the USA and contrast efforts there with advances in the UK and New Zealand.

Systems transformation in the USA

Systems transformation in North America has been driven by consumer voices and political movements that sought to address glaring needs in the delivery of mental health services. In the USA, the recovery model received a substantial boost with the publication of the US Surgeon General's report on mental health and the activities of the New Freedom Commission (Hogan, 2003). The Surgeon General's report made recommendations consistent with recovery, including requiring recovery-based treatment practices, shared decision-making, self-help services, advocacy and consumer-led programmes. The Commission task force was charged by executive order to evaluate mental healthcare in the USA and offer recommendations. In its final report, the task force recommended a transformation of the nation's mental healthcare system to a recovery-oriented approach, focused on decreasing stigma, building resilience and coping, and fostering partnerships between consumers, families and practitioners. Since its political mandate, state legislatures and mental health systems have adopted a 'recovery vision' in service delivery. Further, mental health organisations have endorsed the recovery approach, including the American Psychiatric Association, the American Psychological Association, the Veterans Affairs Healthcare System, and the United States Psychiatric Rehabilitation Association (USPRA).

Some US states – Arizona, Georgia, Pennsylvania and Washington – have incorporated peer support into their reimbursable services, and Georgia and Arizona have even developed credentialing processes for peer specialists. As the recovery model evolved in the USA, it became heavily influenced by psychosocial rehabilitation, due to the contributions of service providers who viewed recovery as consistent with their practice (O'Hagan, 2004). Self-help programmes for psychiatric illnesses, including the Family to Family Programs of the National Alliance of the Mentally Ill (NAMI), have emerged in the USA and are recognised as useful adjuncts to traditional treatments. The consumer movement maintains its political roots in the activities of advocacy organisations, including NAMI, the National Mental Health Association (NMHA)

and the State Protection and Advocacy Centers. The activities of these organisations include disseminating information about mental illness and recovery as part of efforts to decrease the stigma attached to mental illness.

Systems transformation in the UK

The recovery model has also made headway into care systems in Europe, most notably in the UK, although it remains in its infancy compared with efforts in North America and New Zealand. The Department of Health's National Service Framework for Mental Health has established standards for service systems in the UK that are consistent with recovery, including consumer and family involvement, non-discrimination and choices that promote independence. The introduction of the recovery approach in the UK has led to actions in the jurisdictions. The Scottish government established the National Programme for Improving Mental Health and Well-Being, which had the aims of disseminating information about mental health, fostering recovery in people who have experienced psychiatric illnesses, and eliminating stigma and discrimination due to mental illness. The National Institute for Mental Health in England (2005) has established 12 principles of recovery-based care that parallel the guidelines of the US-based Substance Abuse and Mental Health Services Administration (SAMHSA) for recovery-oriented care. These principles relate to self-management, community integration and responsiveness, and emphasise people's strengths and wellness.

A number of recovery-based self-management programmes have emerged in the UK, and these serve as the psychiatric equivalents of the 'expert patient' initiatives for chronic medical conditions. These include: the Hearing Voices Network; the Safe, Holistic, Integrated Recovery Environment (SHIRE); and the TIDAL model (Davidson, 2005). Similar to efforts in North America, self-help and peer/mutual support programmes are currently being incorporated into the mental health system in the UK. These involve organisations such as Rethink Mental Illness (formerly the National Schizophrenia Fellowship), Together for Mental Well-Being, Clients and Professionals in Training and Learning (CAPITAL), Peer2Peer, and Borough-Wide User Forum (BWUF). Unlike in the USA, accredited peer support training and certification are provided by only a few organisations, such as Reading Resource, and the Nottingham University/Making Waves collaboration.

Systems transformation in New Zealand

The recovery movement appeared early in New Zealand (O'Hagan, 2004). The New Zealand government established a Mental Health Commission in 1996 to offer recommendations for a National Mental Health Strategy and to oversee its implementation. The Commission produced the *Blueprint for Mental Health Services in New Zealand* (Mental Health Commission New Zealand, 1998), which included recommendations for transforming the mental healthcare service into a recovery-oriented system. Its recommendations emphasised curbing or reversing the effects of the discrimination experienced by minority groups. In contrast to the recovery model in Europe and North America, which viewed recovery as an individual process, the New Zealand view underscored the role of social processes that may be associated with recovery, such as ending stigma and discrimination, and increased connectedness with cultural groups (O'Hagan, 2004).

The individual and society rather than the individual alone are responsible for promoting recovery. Thus, systems transformation in New Zealand, as reflected in the *Blueprint*, has focused on promoting the recovery of cultural and social groups such as the Maori and Pacific people, cultural sensitivity, citizenship, ending stigma and discrimination, ensuring that services are readily available to minority groups, and accommodating the views of service users on mental illness and coping.

Systems transformation in New Zealand has also extended to how mental health providers are trained. In 2001, the Mental Health Commission published its 'recovery competencies'. The document required that mental health training be transformed. New Zealand appears to be ahead of other countries with regard to requiring recovery-based mental health education. Although there have been efforts at recovery education in the USA (e.g. Peebles *et al*, 2009), recovery education is not currently mandated at the national level. In New Zealand, as in the USA, peer support programmes have emerged, for example Mind and Body Learning and Development, and the New Zealand Bipolar Network.

Conclusions

The recovery model has made headway into service systems in the USA, the UK and New Zealand through the influence of consumer voices and political mandates. A full review of all service systems implementing recovery is beyond the scope of this article, but we have reviewed steps that have been taken in a few countries. Whereas the UK adopted the American conception of recovery, New Zealand's brand of systems transformation has additionally focused on transformation of the community context in which recovery occurs, by addressing stigma and discrimination. It has also chosen to depart from an exclusively individualistic notion of recovery in favour of one that incorporates collectivist attitudes and behaviours as part of recovery. Although other countries not reviewed here, such as Ireland, the Netherlands, Italy and Australia, have also embarked on forms of systems transformation, the recovery approach has yet to be formally implemented in most nations. The adoption of that approach in care systems in Asian, African and Middle Eastern nations would be of particular interest, given the sociological aspects of

the experience of psychiatric symptoms (Harrison *et al*, 2001). It may be that sociological context will be just as crucial to the adoption and advancement of recovery and subsequent systems transformation in those nations.

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RECOVERY

Implementing recovery in mental health services

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The ideas of 'recovery' arise from the experiences of people with mental health problems. The recovery approach emerged in the North American civil rights and consumer and survivor movements from the 1970s onwards. It is concerned with social justice, individual rights, citizenship, equality, freedom from prejudice and discrimination. In this paper we discuss a project in England that has examined how mental health services may be transformed to be more supportive of recovery and the implications that this has for professional practice.

The ideas that are subsumed under the heading of 'recovery' are not new: they have their roots in the history of psychiatry (Davidson *et al*, 2010). Their recent history specifically reflects the intellectual output and lived experience of people with mental health problems, particularly psychoses. The contemporary roots of recovery ideas also lie in the civil rights and consumer and survivor movements that emerged in North America from the 1970s onwards. In this, people were declaring that their symptoms and incapacities need not permanently impede their achievement of personally valued life goals, and not only did mental health services need to change to recognise the legitimacy of these objectives, but also a social transformation was necessary to deal with the stigma and exclusion that are still commonly experienced by people with mental health problems in most societies (Frese *et al*, 2009).

What is recovery?

Recovery can be seen as a set of ideas and principles derived from the experiences of people with mental health problems and is associated with a movement calling for social justice, individual rights, citizenship, equality, freedom from prejudice and discrimination. When we talk about 'recovery' nowadays we are not necessarily talking about 'clinical recovery' (symptom reduction) but rather the process of helping people to live a life 'beyond illness' – that is, the recovery of a meaningful life, with or without symptoms. This is usually known as 'personal' or 'social' recovery (Slade, 2009).

Analysis of the accounts of people who have direct experience of mental health problems suggests that three concepts are central to recovery (Repper & Perkins, 2003; Shepherd *et al*, 2008). These are: *hope* (sustaining motivation and supporting expectations of an individually fulfilled life), *agency* (recovering a sense of personal control) and *opportunity* (using circumstances to gain

personally valued goals). Recovery is, then, seen as a journey, a process through which people attempt to increase their sense of hope, agency and opportunity. Hence, people speak about being 'in recovery', rather than 'recovered'. The challenge for services and practitioners is then to think about their contributions to these processes. Are they supporting them, or getting in the way?

Recovery and mental health policy – national and international perspectives

In recent years, the principles of recovery have influenced mental health policy in several English-speaking countries, including the UK, Ireland, the USA, Canada, Australia and New Zealand, and there are many good examples of recovery-oriented services and practices. However, we know that the implementation of complex policies in mental health is challenging and the results are often rather patchy: so it is with recovery.

In England, the objectives of recovery are now well established in mental health policy. Thus, a 2011 strategy document from the Department of Health (*No Health Without Mental Health*) contains six key objectives, one of which is that 'More people with mental health problems will recover' (p. 7). It goes on to state what this means:

> More people who develop mental health problems will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live.

In addition, all the major professional organisations in England and Wales (nursing, psychology, occupational therapy, social work) have voiced their support for recovery ideas, including, notably, the Royal College of Psychiatrists (Royal College of Psychiatrists *et al*, 2007).

In England, we have closed our large mental hospitals and have developed a much clearer structure for community services. But we still need to improve the content and quality of these services and the experience of those who use and work in them. For these challenges, the ideas of recovery can provide the guiding principles.

Box 1 Ten key organisational challenges

1. Changing the nature of day-to-day interactions and the quality of experience
2. Delivering comprehensive, user-led education and training programmes
3. Establishing a 'recovery education centre' to drive the programmes forward
4. Ensuring organisational commitment, creating the 'culture'. Leadership
5. Increasing 'personalisation' and choice
6. Transforming the workforce (training and deployment of peer professionals)
7. Changing the way we approach risk assessment and management
8. Redefining user involvement to achieve true partnership working
9. Supporting staff in their recovery journey
10. Increasing opportunities for building a life 'beyond illness' (e.g. 'individual placement and support')

Source: Sainsbury Centre for Mental Health (2009).

Taking a recovery perspective – the organisational challenges

The ideas of recovery arise from the experiences of people who have used mental health services. These ideas do not constitute a 'theory' of mental illness, nor are they a new form of 'treatment'. Clinicians and the mental health services cannot make people 'recover'. They can only try to support their recovery in a positive way. So, what does this mean for the practice of clinicians, as well as for the structure and the culture of mental health services? How can they become more 'recovery oriented'?

At the Centre for Mental Health in London (an independent, not-for-profit, research and consultancy centre) we have been developing a framework to address this question. Through consultation with stakeholders (clinicians, managers, service users, carers, commissioners etc.) and a thorough review of the literature, we have produced a list of key challenges that mental health services have to face in order to make their services more recovery oriented (see Box 1). Behind these challenges is the proposition that the ideas of recovery must go right through the organisation, influencing it at every level. Thus, there needs to be a fundamental change in the quality of day-to-day interactions. Every interaction, by every member of staff, should confirm recovery principles and promote recovery values. Training of both staff and service users is central to this. Fundamentally, the training should be co-produced between professional staff and service users and this will require a cadre of trained and supported service users to act as peer trainers. We suggest the creation of a 'recovery education centre', jointly run by staff and service users, in each mental health provider organisation within the National Health Service (NHS) to support these developments.

However, training will not be sufficient on its own. We know from studies of attempts to embed recovery principles into services that, in addition to training, we need to take into account the management and supervision of staff, the quality of leadership and the organisational culture within which this training is delivered (Whitley *et al*, 2009). Recovery values need to be embedded into every management process: recruitment, supervision, management and appraisal, and the development and implementation of operational policies. This means support and leadership from the top of the organisation as well as developments from the 'bottom up'.

Important policies may also need to change. For example, risk assessment and management need to become more open, transparent and co-produced. The 'involvement' of service users should be redefined to reflect a much greater emphasis on 'partnership' working, and consideration should be given to the employment of a

much greater proportion of appropriately trained and supported 'peer support workers' (Repper & Carter, 2011).

Staff also need to be supported in *their* recovery journeys; their 'lived experience' should be valued, as should the contribution that this can make to their professional roles.

Finally, the organisation needs to increase its partnerships with non-mental health agencies (housing, education, employment, leisure) to support the social inclusion of service users.

The Implementing Recovery – Organisational Change (ImROC) project

We are now engaged in a major national project, Implementing Recovery – Organisational Change (ImROC), aimed at helping organisations become more supportive of recovery. It has been devised to support the Department of Health's 'No Health Without Mental Health' strategy, with its emphasis on supporting recovery for individuals, and is jointly funded by the Department of Health and by contributions from participating sites.

The project is aimed at helping mental health organisations to develop in a more recovery-oriented way using the ten key challenges listed in Box 1. An organisation is asked to identify which challenges it wishes initially to work on and it is then set specific targets for changing in this direction (Shepherd *et al*, 2010). Once the goals are agreed, the process of change is implemented and progress is monitored. The goals may then need to be adjusted. New goals are set and the cycle repeated. This form of internal audit loop (the 'plan–do–study–act' cycle) has been recommended as the most effective process for producing sustained organisational change (Iles & Sutherland, 2001).

The project began on 1 April 2011 and over 30 English NHS mental health trusts applied. Twenty-nine were eventually accepted and they were assigned to one of three categories: 'demonstration' sites ($n = 6$), which are already well advanced; 'pilot' sites ($n = 6$), which were those that seemed most likely to benefit from intensive help; and 'network' sites ($n = 17$), which have joined a learning network with the other sites and attend regular, themed 'learning sets'.

All the pilot sites have now identified their key challenges and are working through them. The major developments are around the joint training of staff and service users (training is jointly delivered and jointly received), support for team leaders and key clinicians, review of key policies and work with the trust boards (most senior managers). Many sites are also preparing to train and support a new cohort of peer support workers.

International relevance

As indicated above, interest in developing mental health services to support recovery is already common in the English-speaking world and many European nations are also moving in this direction. However, there has been less interest in middle- and low-income countries. This is a little surprising given the importance of informal supportive networks in many such countries and the relatively low cost of the 'technology' associated with developing a recovery orientation (e.g. joint training, partnership working with local user groups, peer support workers and the establishment of local recovery education centres).

There are, however, some signs of progress. For example, the East London NHS Foundation Trust has an established link with Butabika hospital in Kampala, Uganda, which promotes training and development (Baillie *et al*, 2009). This link has facilitated the development of Heartsounds, a local service user organisation whose membership includes 55 service users, 10 professionals, more than 25 well-wishers from the community and over 300 online members. In collaboration with Heartsounds we are planning to provide core training in the recovery approach to a Kampala community recovery team and service user leaders, and then to begin a training programme for peer support workers. These are exciting developments and it will be fascinating to see how they progress.

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RECOVERY

Schizophrenia across the world: outcome and recovery

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The International Pilot Study of Schizophrenia (IPSS) was a seminal, ground-breaking study that revealed important information regarding schizophrenia on a global scale. Perhaps the most interesting and controversial finding was that for all outcome variables considered, patients suffering from schizophrenia in Nigeria and India ('developing countries') tended to 'recover' better than patients in the other six sites. However, in recent times, this finding has been repeatedly challenged. The renewed debate led to a vigorous rebuttal by some of the original IPSS study authors. In an increasingly globalised world, the IPSS stands as a reminder of the importance of the cultural determinants of recovery from schizophrenia.

The Word Health Organization (WHO) was ratified as an agency of the United Nations on 7 April 1948, which is commemorated annually as World Health Day. The charter of the WHO states that the

> enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. (WHO, 2011a)

The WHO describes itself as:

> the directing and coordinating authority for health within the United Nations system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends. (WHO, 2011b)

In this respect, the WHO has developed a mental health programme with a cross-cultural agenda furthering the generation, translation and dissemination of knowledge across the world.

An expert committee on the epidemiology of mental disorders met in 1960 and recommended that the WHO undertake research which would allow standardisation of psychiatric patients across cultures and carry out comparative studies on mental disorders in different cultures (WHO, 1960). This led to the launch of the International Pilot Study of Schizophrenia (IPSS) some years later. This was a seminal, ground-breaking study that revealed vital information regarding schizophrenia on a global scale. There had been a dearth of cross-national information on the presentation, clinical course and outcome of schizophrenia in different settings. The IPSS aimed to illuminate many unanswered questions in schizophrenia research from a global perspective, including the following.

- Does schizophrenia exist in different parts of the world? If so, how and to what extent?
- What are the commonalities and differences in the presentation of schizophrenia across cultures? What may explain any areas of divergence?
- What are the variations in clinical course and outcome of schizophrenia across the world? What may explain any such variation?

Furthermore, this study was the first to tackle the significant methodological and logistical hurdles involved in developing standardised research instruments and procedures, and training research workers from different theoretical backgrounds and widely separated countries with different cultures, socioeconomic and political conditions, to use them to make comparable observations. Further issues of standardisation and coordination of multicentre data collection, transmission and analysis were also addressed. No previous study had made such bold attempts and little was known about the characteristics and clinical course of schizophrenia across cultures and settings (WHO, 1979).

The IPSS used a comparative prospective design, where patients with psychotic illnesses were selected from nine countries across the 'developing' and 'developed' world (Colombia, China, Czech Republic, Denmark, India, Nigeria, Russia, the UK and the USA). Case finding for the study began on 1 April 1968 and a total of 1202 patients who equally represented the nine countries received intensive evaluation using eight previously standardised instruments (including the Present State Examination), resulting in the accumulation of some 1600 data items. All centres participated in 2- and 5-year follow-up studies and three of the sites (Colombia, Nigeria and India) followed up their original cohorts after 26 years.

The results of this novel and unique international study were interesting, informative and unexpected. From a methodological point of view, they did affirm that large-scale cross-cultural investigation of psychiatric disorders was possible, that transculturally applicable instruments for research can be produced and sufficient training can be provided to international researchers from diverse settings and contexts to enable comparable

observations to be made. Although they confirmed the presence of chronic psychotic disorders across cultures, they also highlighted striking and surprising differences in outcome at different centres. The rates of schizophrenia were found to be similar across different countries. Stressful life events were also similar across countries. The suicide rate was as high in schizophrenia as it was in the IPSS subsample of people with depression. Perhaps the most interesting and controversial finding was that, for all outcome variables considered, patients with schizophrenia in Nigeria and India ('developing countries') tended, on average, to have better outcomes than patients with the same condition in the other sites. There was no specific character of the individual patient, environment or disorder that could be considered in isolation to have affected this outcome (Harrison *et al*, 2007).

The finding from the IPSS that patients in developing countries on the whole have better outcomes than those in developed countries has been repeatedly challenged. Cohen *et al* (2008) conducted a literature review of 23 longitudinal studies of schizophrenia outcome in 11 middle- and low-income countries and observed a heterogeneous picture, one neither favouring these countries nor showing any specific pattern indicative of positive outcome. Some of the reports included in their review pointed out that large numbers of symptomatic individuals with schizophrenia were found in rural areas of countries such as China, where 77.9% were assessed at 2-year follow-up as experiencing either 'continued marked symptoms' or 'further deterioration of illness' (Ran *et al*, 2001).

Cohen *et al* (2008) also considered that individuals tended to change over time and their presentation tended to approach the 'intermediate' category, from an initial 'best' or 'worst' category. They also appeared to have high levels of social disability across developing countries, with lower levels of marriage and higher unemployment.

It was further contended by Cohen *et al* (2008) that treatment with psychotropic medication was associated with a better prognosis, in contrast to the findings of the IPSS, where the ultimate outcome appeared not to be associated with psychotropic medication treatment *per se*, but with a variety of other factors. For example, Cohen *et al* pointed out that, in China, lack of treatment of any kind and duration of untreated psychosis greater than 1 year were associated with poor clinical status and the patients at 2-year follow-up who had gone without treatment were, on average, assessed as having a poor clinical status. They also suggested that excess mortality due to suicide in low- and middle-income countries had not been taken into account, thus giving the impression of a favourable prognosis. They speculate that withdrawals or attrition due to premature mortality may not have been considered in the IPSS measure of final outcome, giving further weight to the impression of a more favourable prognosis in developing countries. They conclude by urging caution regarding the making of broad assumptions about the outcome of schizophrenia based on country of origin, and suggest a picture of complexity that defies such generalisation.

This led to a renewed debate on the subject. There was a vigorous rebuttal from some of the IPSS study authors (Jablensky & Sartorius, 2008). They pointed out that a second epidemiological study was launched in 1980 by the WHO to review the findings of the IPSS. Titled Determinants of Outcome of Severe Mental Disorders (DOSMeD), it was designed to be more representative, with 1379 participants from 12 international centres who were rigorously assessed using standardised instruments, unified design and stringent methods (Jablensky *et al*, 1992). The DOSMeD study used incident first-episode cohorts and made an attempt to overcome selection bias by recruiting people from non-medical centres, such as primary care, police/prisons, traditional healers and religious shrines (notably, 28% of the cases in India and Nigeria were recruited through such 'alternative' care sources). Less than 10% had been prescribed antipsychotics prior to entry into study and 86% had been experiencing first-episode psychosis lasting under 12 months. The cohort was followed up at 1 year, 2 years and 15 years. This study showed complete clinical remission to be significantly more common in developing countries (37%) than in developed countries (15.5%), although the proportions of people with continuous unremitting illness (11.1% and 17.4%) did not differ significantly across the two types of setting. Patients in developing countries experienced significantly longer periods of unimpaired functioning in the community even though only 16% of them were on continuous antipsychotic medication (compared with 61% in the developed countries). Across all centres, the best predictors ($P < 0.001$) of outcome were type of onset (insidious *v.* acute) and type of setting (developed *v.* developing country), followed by marital status ($P < 0.01$), gender ($P < 0.05$), social isolation ($P < 0.05$) and drug misuse ($P < 0.05$).

Regardless of the comments and criticisms of the methodology and limitations of the IPSS, it truly was a ground-breaking study and a quantum leap in epidemiological and cross-cultural psychiatric research. It paved the way for other rigorous studies in the area and informed practice and thinking. It highlighted the influence of culture and social support on the trajectory of chronic psychotic disorders and thereby spawned interest in this field of research. Respected experts in the field have described this as 'arguably the single most important finding' in cross-cultural research into mental illness (Lin & Kleinman, 1988). As a forerunner of other cross-cultural studies, it achieved its stated aims in establishing the existence of schizophrenia across cultures, probing determinants of its variation across cultures and establishing standardised, comparable research tools in a global field. In an increasingly globalised world with changing social fabric, the IPSS stands as a reminder of the importance of cultural determinants of recovery from schizophrenia.

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Mental health in Bhutan

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The Kingdom of Bhutan lies in the folds of the eastern Himalayas, sandwiched between India to the south and China to the north. It has a total area of 38 394 km², which is roughly the size of Switzerland, and a population of a little over 700 000 (Royal Government of Bhutan, 2002). It is a mountainous country, except for a small flat strip in the southern foothills. The official language is Dzongha, but English is widely spoken. English is the medium of instruction from pre-primary level onwards. In 1999 Bhutan allowed viewing of television and use of the internet, as a step towards modernisation. In the early 20th century, Bhutan came into contact with the British Empire; Bhutan maintains strong bilateral relations with India. *Business Week* magazine in 2006 rated Bhutan the happiest country in Asia and the eighth happiest in the world, based on a global survey. Bhutan is in fact the only country where happiness is measured in the form of an index, 'Gross National Happiness'. The main religion practised in the country is Buddhism, with Hinduism as the second most prevalent. The capital and largest city is Thimphu. In 2007, Bhutan made the transition from absolute monarchy to constitutional monarchy, and held its first general election in 2008. Bhutan is a member of the United Nations and of the South Asian Association for Regional Cooperation (SAARC); it hosted the 16th SAARC summit in April 2010.

Health indicators

According to the Bhutan Ministry of Health (2010a), life expectancy is 65.5 years; further health indicators include the following:

- the infant mortality rate (per 1000 live births) is 40.10
- the mortality rate among under-5s is 61.50 per 1000 live births
- 83% of the population have access to safe drinking water
- the incidence rate of diabetes is 38 per 10 000
- the incidence rate of cancer is 17 per 10 000
- the incidence rate of hypertension is 310 per 10 000.

Healthcare system

Modern healthcare started in the early 1960s; prior to that, the use of traditional methods of healing was very popular. Since then, the primary healthcare system has been progressing.

The health human resources, according to the 2010 *Annual Health Bulletin* (Ministry of Health, 2010a), include the following national totals:

- doctors (MB BS/specialists) 176
- nurses 556
- nursing assistants 92
- health workers 505

- assistant clinical officers 45
- *drungtshos* (doctor practising traditional medicine) 41
- *sowa menpas* (trained in traditional medicine) 52
- pharmacists 12.

Medical education

There are no medical colleges in Bhutan; students go on a government scholarship to nearby countries such as India, Bangladesh, Sri Lanka, Thailand and Myanmar. In recent years some wealthier parents have paid for their children to undertake medical education abroad. After graduation students are expected to come back to Bhutan and work for at least 2 years before moving on to complete their postgraduate education. Postgraduate degrees take 2–5 years, depending on specialty and the requirements of the country where doctors complete their postgraduate training.

Psychiatric services

The Mental Health Programme was launched in 1997. A psychiatrist from Burma was then hired for the first time to work at the national referral hospital in Thimphu; at that time there were no Bhutanese mental health workers. As the first doctor to undertake postgraduate studies in psychiatry (in Sri Lanka) had not yet completed his course, a general nurse midwife was sent for a 1-year diploma course in psychiatric nursing to the National Institute of Mental Health and Neurosciences in Bangalore, India. He then came back from training and headed the National Mental Health Programme, under the Department of Public Health, as the programme officer.

The first Bhutanese psychiatrist qualified in 1999 from Sri Lanka. He implemented a range of programmes to train health workers across the country, who, consequently, can now manage patients with common mental disorders (e.g. depression, anxiety, psychosis, alcohol use disorder).

At the national referral hospital, there were no separate wards for psychiatric patients until 2003 and patients were mostly admitted to medical wards. In 2003, a portion of an old boys' hostel at the Royal Institute of Health Sciences was converted into an eight-bed in-patient unit. Currently, there are 20 beds available; half of them are primarily used for detoxification of people with alcohol and drug addiction.

At present, there are only two psychiatrists for the whole nation and only three trained mental health nurses. There are no psychiatric social workers, psychologists, counsellors or any other type of mental health workers (Nirola, 2010).

Since July 1999, all new psychiatric cases have been formally registered and up to December 2008 a total of 2846 new cases had been treated. Of these patients, 19.2% were diagnosed with anxiety disorders, 29.3% with depression and 9.7% with psychotic/bipolar disorders (Ministry of Health, 2010b).

In 2002, a community-based pilot survey on the prevalence of severe mental disorders was carried out in three districts of Bhutan with a sample population of 45000. The survey identified 273 cases of severe illness: 83 alcohol dependence, 69 epilepsy, 49 depression, 39 intellectual disability, 17 psychosis and 16 suicidal cases (Whangmo & Whangmo, 2009).

Mental health services are funded from the overall health budget, of which they receive only about 10%.

There is no mental health law.

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Bursary to attend the Faculty of the Psychiatry of Learning Disability's annual residential meeting

The College's Faculty of the Psychiatry of Learning Disability will establish an annual bursary to enable a psychiatrist from a low- or middle-income country (LMIC) to attend the Faculty's annual residential meeting (ARM), usually held in October. The recipient will give an oral or poster presentation, or deliver a workshop at the ARM. The bursary will cover the cost of economy-class travel, accommodation during the ARM, registration and attendance at the conference dinner, up to a maximum of £1500. Psychiatrists living and working in LMIC who intend to present at the Faculty ARM and wish to apply for the bursary should submit an abstract, a brief CV and a letter stating what financial help is required, as well as a 500-word article on mental health and people with intellectual disabilities in the psychiatrist's own country.

For further details see http://www.rcpsych.ac.uk/specialties/faculties/learningdisability/aboutthefaculty/prizesandbursaries.aspx#devbur

RESEARCH PAPER

Retention factors affecting migrant psychiatrists from low- and middle-income countries

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A major barrier to the large treatment gap in mental healthcare in low- and middle-income countries is the shortage of psychiatrists, partly caused by a brain drain. This qualitative study aimed to gain an in-depth understanding of the motivations and experiences of migrant psychiatrists in order to address retention factors. We interviewed a convenience sample of 11 psychiatrists from Afghanistan, Iraq, South Asia and Africa. Interviews were semi-structured and based on questions about the participants' reasons for emigrating, their expectations and experiences of the move, their views of psychiatry as a profession in their country of origin and whether any incentives would persuade them to return. Prevention of emigration appears to be far more effective than encouraging expatriates to return; an improvement in training and job opportunities could have a drastic impact on retention. Almost all the psychiatrists interviewed intended to contribute to training and raising the profile of psychiatry in their country of origin, and therefore their emigration may have long-term benefits. It could potentially break the cycle between lack of understanding, lack of demand for mental health services and lack of training. It should therefore be an ethical obligation of UK employers to offer migrant psychiatrists time and support to facilitate these contributions.

There is a large treatment gap in mental healthcare in low- and middle-income countries due to the scarcity of mental health services (Kohn *et al*, 2004). However, improvements to services are hindered by a shortage of mental health specialists (Saraceno *et al*, 2007). A brain drain has resulted in estimations that over half of psychiatrists trained in low- and middle-income countries now work abroad. Furthermore, the UK is one of the main recipients, employing over 2500 psychiatrists who trained overseas (Jenkins *et al*, 2010), despite having about 40 psychiatrists per million population, while India has only about 4 and parts of sub-Saharan Africa have less than 1 per million (World Health Organization, 2001). Although a number of alternative strategies are being developed to overcome shortages, such as training primary care staff or lay people to deliver community-based care (Goldberg & Gater, 1996; Chatterjee *et al*, 2011), psychiatrists remain necessary in order to provide specialist services and supervision. It is therefore important to understand the motivations and experiences of migrant psychiatrists in order to address retention factors and thereby improve mental health services. Research in the form of questionnaires has explored the topic previously (Gureje *et al*, 2009); the present qualitative study aimed to gain a more in-depth understanding of the complex and sensitive issues.

Method

We interviewed a convenience sample of 11 psychiatrists (5 women, 6 men) from Afghanistan, Bangladesh, India, Iraq, Nigeria (although the participant had trained in Cuba), Pakistan and South Africa. Two participants had moved to the UK after starting their psychiatry training, while the remainder began their specialty training in the UK. Participants were currently employed in psychiatry and were drawn from across Yorkshire (although many had previously worked in different regions of the UK). Interviews were conducted in the workplace of the participant and lasted 25–40 minutes. Audio recordings were made which were then transcribed, coded and grouped into emergent themes. Interviews were semi-structured and based on questions about the participants' reasons for emigrating, their expectations and experiences of the move, their views of psychiatry as a profession in their country of origin and whether any incentives would persuade them to return there. After the initial interviews, subsequent questions were adapted based on the emerging themes.

Approval for the research was granted by the Newcastle & North Tyneside 2 Research Ethics Committee and all respondents provided written informed consent before their interview.

Results

Emigration to the UK

Five participants moved to the UK due to family circumstances; five cited the quality of training and career structure and opportunities as their main reasons. Participants from India mentioned the lack of subspecialty training, while a number of participants from South Asia stated that despite the shortage of psychiatrists throughout the country, the unequal distribution between cities and rural areas meant it was often extremely difficult to get a job or training position. Many of those interviewed believed that the differences in culture and lifestyle between different parts of their country of origin

were greater than between the UK and the areas in which they had trained or been raised. Consequently, they felt more comfortable moving to the UK than working in a rural area. However, one participant from South Africa stated that although there were countless incentives to remain, such as family, weather, lifestyle and good-quality training, a basic desire to travel motivated both this particular psychiatrist to work abroad as well as a number of classmates.

All participants began to consider the possibility of emigrating only after graduating. The idea therefore appears not to be deep-rooted, making it easier to address. However, most participants found the first few years a struggle, since they were required to move to the UK before they could complete conversion examinations and find a job. One psychiatrist commented, 'When I arrived I first had to live in East Ham, quite a deprived area … there were ten doctors in one house with three in each bedroom, it was quite a shock' (participant 2, India). Another said, 'You were constantly counting money … you had no computer or internet and so you had to decide whether to spend the little you had in an internet cafe or risk waiting another day but then missing out on jobs' (participant 5, India). One psychiatrist pointed out that the effort required to move made it understandable that many would be reluctant to leave.

A couple of psychiatrists found alternative routes into the UK. One gained sponsorship through the British Council, which allowed her to bypass the conversion examinations, while another was able to sign up to an agency in South Africa which arranged a job in the private sector and organised the contract, visa and flights.

A number of psychiatrists stated that their interest in the specialty developed only while in the UK, since placements where they trained were limited to extreme cases, often due to a lack of comprehensive services. One participant commented, 'It was all hospital-based … it was 8 weeks of ECT … if that was what everybody saw at medical school I wouldn't think a lot of people would be keen on going into psychiatry' (participant 8, Cuba). Another psychiatrist had prepared for civil service examinations after graduating in India since he felt unable to practise in a corrupt environment. This participant considered continuing to practise medicine only after emigrating to the UK. Consequently, if these participants contribute to psychiatry in their country of origin, this may be more beneficial to the specialty than if they had not emigrated.

Methods of contribution

Many participants had become settled after their move to the UK and cited family circumstances as a reason not to return. A number felt that they were better able to help patients because they had experienced working in an environment with greater availability of resources and more hospital infrastructure. Many also enjoyed working in a diverse setting and felt that the high proportion of international psychiatrists made the specialty more broad-minded. Out of the psychiatrists from politically stable countries, only three felt that returning to their country of origin was a possibility, but they pointed out that they would need to complete their training in the UK for it to be recognised abroad. One participant from Bangladesh had made definite plans to return, for a number of reasons, including altruism, opportunities available and family and friends. However, this psychiatrist considered the ability to 'take a risk' and return a luxury that many of his colleagues could not afford, due to factors such as financial responsibility.

When asked about other ways of contributing to the specialty, one psychiatrist commented, 'What I know of psychiatry in South Africa … really proves that … in-reach is not needed; in fact, it would be big-headed … to go there' (participant 2, South Africa). However, almost all other participants felt they would like to contribute. Although many recognised that at present mental health is a low priority, while the focus is on basic needs, they felt the large mental health burden should not be ignored. Two psychiatrists, from Nigeria and India, believed a top-down approach and an end to corruption were necessary before anything could be done personally. Those from Iraq and Afghanistan also felt it was difficult to translate their desire into action because colleagues and family in their home countries had been kidnapped or killed. However, a participant from Afghanistan still felt that improvements could be made using the internet and by sending books. Most participants were able to identify particular areas of psychiatry that they would like to introduce to their country of origin; these included risk assessments, critical appraisals and psychotherapy. Participants from South Asia appeared to feel most able to contribute. A number often travelled back and gave presentations and lectures, discussed ideas and formed collaborations while there. These were initially informal visits but had now become organised more formally through psychiatric societies and alumni groups. Participants felt limited in making these contributions by leave restrictions; however, they felt that sharing ideas was very valuable to both countries and a major positive aspect of emigration.

Prospects for psychiatry

Although a few psychiatrists from Nigeria, Afghanistan, India and Iraq were pessimistic about the prospects for an improvement in psychiatry due to ongoing factors such as corruption and political instability, almost all psychiatrists from South Asia felt more positive. One psychiatrist commented, 'The direction in which healthcare is going in this country, it's not inviting … whereas talking to psychiatrists in Bangladesh you see the scope for expanding is almost infinite…. In the UK at the moment all you hear about is shrinking, how you're going to get less and how you're going to have to do more' (participant 9, Bangladesh). After a number

of international initiatives, both the government and the private sector in Bangladesh have become keen to invest in the specialty. A psychiatrist from India mentioned the possibility of a reverse brain drain due to changes in the visa process making migration to the UK more difficult, improvements in postgraduate training and increases in salary. However, this psychiatrist acknowledged that the caveat to growth and improvement was unequal distribution.

Conclusion

Although relatively few participants were involved in the study, theoretical saturation was achieved. It could be that different issues might arise in other regions, although it does not seem likely that these findings could be influenced by geographical context.

For low- and middle-income countries to retain psychiatrists, prevention of emigration appears to be far more effective than encouraging expatriates to return. Since there are a number of inherent incentives for psychiatrists to remain in their own country, and the idea to emigrate generally starts to develop only after graduation, an improvement in training and job opportunities could have a drastic impact on retention. Although in a number of countries this is complex and reliant on numerous external factors, this study highlighted many positive findings. Almost all psychiatrists intended to contribute to psychiatric training and raising the profile of psychiatry in their country of origin, and therefore their emigration may have long-term benefits. It could even help break the cycle between a lack of understanding, lack of demand for mental health services and a lack of training. Consequently, emigration could encourage funding to train allied mental health specialists, to build psychiatric hospitals and to campaign to raise public awareness of mental health. It should therefore be an ethical obligation of UK employers to facilitate this approach further through formal contractual agreements offering migrant psychiatrists time and support to continue to contribute.

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Psychological support and recovery in the aftermath of natural disaster

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Natural disasters can result in a range of mental health outcomes among the affected population. Appropriate mental health interventions are required to promote recovery. In the aftermath of the 2009 bushfires in Victoria, Australia, a collaboration of trauma experts, the Australian and Victorian state governments and health professional associations developed an evidence-informed three-level framework outlining recommended levels of care. The framework was underpinned by an education and training agenda for mental health professionals. This framework has been successfully applied after further natural disasters in Australia. This paper outlines the steps included in each of the levels.

Disasters involving widespread loss of life and property may result in a range of mental health outcomes among the affected population (Norris *et al*, 2002). A proportion will show a 'resistant' trajectory of recovery, reporting few or no clinically significant symptoms, while a small minority will develop persistent diagnosable psychiatric conditions. Between these extremes, a large group of survivors are likely to develop mild to moderate clinically significant symptoms (Galea *et al*, 2002; Norris *et al*, 2002). It is incumbent upon response agencies to ensure, for reasons of both economic impact and human suffering, that appropriate mental health interventions are provided to promote psychological recovery for this significant proportion of disaster survivors.

In the aftermath of serious and widespread bushfires in Victoria, Australia, in 2009, the Australian and Victorian state governments met with experts in psychological trauma, as well as health professional associations, to develop an evidence-informed framework outlining recommended levels of care, underpinned by an education and training agenda. This framework was applied after subsequent disasters in Australia, such as the floods and cyclone in Queensland in 2011.

The framework identified three levels of response. Level 1 is consistent with current models of psychological first aid (PFA) (Brymer *et al*, 2006); it is targeted at the whole affected population and is designed to enhance the use of adaptive support and recovery strategies. Level 2 involves an intervention called Skills for Psychological Recovery (SPR) (Berkowitz *et al*, 2009), designed for delivery by primary care and allied health providers treating survivors with persisting mild to moderate distress and functional impairment. Level 3 focuses on treatment for the minority of survivors who develop a diagnosable psychiatric disorder.

Level 1: psychological first aid (PFA)

Although most people affected by disasters are likely to experience distress, the majority will recover using their existing coping strategies and social supports. Importantly, there is international expert consensus that, in the first couple of weeks after a traumatic event, the routine use of structured interventions, such as psychological debriefing, is not recommended (Forbes *et al*, 2010a). While survivors who wish to discuss their experiences should be supported in doing so, practitioners should be mindful of the survivor's capacity to tolerate distress and the potential adverse effects of excessive ventilation in those who are very distressed or have dissociative symptoms.

Instead, PFA (Brymer *et al*, 2006), an evidence-informed approach to assisting people in the immediate aftermath of disaster, is now internationally recognised as the recommended intervention. The PFA model is based on five empirically supported principles to guide post-disaster interventions (Hobfall *et al*, 2007): promoting a sense of safety; promoting calming; promoting a sense of self- and community efficacy; promoting connectedness; and instilling hope.

Psychological first aid is provided in a step-wise manner tailored to individual need. It has eight components (Box 1) and is designed to reduce initial distress and to foster short- and long-term adaptive functioning. It is typically delivered by generalist health and disaster response workers, with support from mental health professionals (Allen *et al*, 2010). A detailed manual to guide PFA is available from the website of the US National Center for PTSD (http://www.ptsd.va.gov).

In large-scale disasters, early interventions should include a focus on community development. These activities are designed to unite the community and reduce the risk of damaging splits occurring in the emotionally charged aftermath of the disaster. They may include sports events, fetes and barbeques, newsletters and community meetings. They may also include the identification of, and support for, people in the community who are likely regularly to come into contact with the affected population (e.g. hairdressers, bar staff, sports coaches, bank tellers, receptionists).

Box 1 The eight components of psychological first aid (PFA)

1 Initiating contact and engaging with an affected person in a non-intrusive, compassionate and helpful manner
2 Providing immediate and ongoing safety and both physical and emotional comfort
3 If necessary, stabilising survivors who are overwhelmed and distraught
4 Gathering information to determine immediate needs and concerns and to tailor PFA interventions
5 Providing practical assistance in helping the survivor address immediate needs and concerns
6 Connecting the survivor with social supports by helping to structure opportunities for brief or ongoing contacts with primary support persons and/or community helping services
7 Providing information on coping, including education about stress reactions and coping (often in a written format)
8 Linking the survivor with collaborative services and providing information about those that may be needed in the future

Level 2: Skills for Psychological Recovery (SPR)

Clinical experience and research data suggest that a significant number of people will continue to experience distress despite their best attempts to cope and the receipt of PFA-type support. For many, these difficulties are limited to mild to moderate distress and include worry, sadness, insomnia, anger, decreased ability to function at work, school or home, or other psychological issues. This level of distress or dysfunction can often be fuelled by practical issues arising from bereavement, the destruction of property and other possessions, relocation and rebuilding. For these intermediate difficulties, training in SPR (Berkowitz *et al*, 2009) is provided.

Skills for Psychological Recovery has a strong focus on structured skills development and is provided by health practitioners or general counsellors. It was developed by the US National Center for PTSD and the National Child Traumatic Stress Network in the aftermath of Hurricane Katrina and was tested in Australia in the aftermath of the 2009 Victorian bushfires. Several hundred health and welfare providers across the state were trained in SPR. It focuses on an evidence-based set of interventions that include a brief needs assessment, problem-solving, activities scheduling, helpful thinking, social support facilitation, and distress management. Where indicated, survivors are also assisted in beginning to address issues of loss. These interventions are provided over one to five sessions in a flexible manner tailored to need. Delivery is not restricted to a 'consulting

room'. Indeed, the fact that SPR can be provided in any setting (including community facilities such as church halls, schools and club rooms) makes it an ideal model when there has been widespread destruction.

Data from the implementation of SPR following the Victorian bushfires indicated that health providers from varying disciplines and paradigms perceived it as a useful intervention for disaster survivors with moderate levels of mental health difficulties (Forbes *et al*, 2010b).

Level 3: psychological interventions for medium-term and long-term problems

Despite the fact that the majority of those affected will recover without long-term mental health issues, a significant minority will continue to experience distress and functional impairment. In such cases, more formal assessment and intervention should be considered. Mental health problems following trauma and disaster may include depression, anxiety disorders (including post-traumatic stress disorder), complicated grief and substance misuse. These disorders may be newly developed in the aftermath of a disaster or exacerbations of existing conditions or vulnerability. An intensive training programme was developed and rolled out for mental health practitioners across Victoria to equip them to provide evidence-based cognitive–behavioural treatments targeted at these post-disaster psychiatric disorders (Forbes *et al*, 2009).

Pharmacological treatments for traumatic stress disorders are not normally recommended as a first-line intervention: preference is given to trauma-focused therapy unless psychological treatment is unavailable or the distress cannot be managed by psychological means alone. Where medication is considered for post-traumatic stress disorder, depression or other anxiety disorders, selective serotonin reuptake inhibitors are usually the first choice. Specific training for psychiatrists, with an emphasis on pharmacotherapy, was provided following the bushfires.

Conclusion

Mental health practitioners have a great deal to offer in assisting individuals, groups and communities to recover from disaster and trauma. Our first responsibility should not be to intervene but, rather, to support the normal recovery process and naturally occurring networks. For those who do not have a normal recovery, however, it is incumbent upon us to provide the best available treatment. Evidence-based interventions for common post-traumatic mental health conditions have a demonstrable track record of efficacy for the majority of those affected.

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Professor Dinesh Bhugra, past President of the Royal College of Psychiatrists, awarded CBE in the New Year Honours List

Professor Dinesh Bhugra, past President of the College and President Elect of the World Psychiatric Association (WPA), was awarded CBE (the second highest civilian honour) by HM The Queen for services to psychiatry in the 2012 New Year Honours List. Professor Sue Bailey, President of the College, extended her congratulations. Professor Bhugra has been active within the College throughout his career, and was President from July 2008 until June 2011, previously having been Dean from 2003. In 2009 Professor Bhugra founded the RCPsych Awards to recognise and reward excellence in psychiatry and mental health. In 2011 Professor Bhugra became President Elect of the WPA. This recent honour not only recognises the major positive impact that Professor Bhugra has made in the field of mental health, but gives a voice to the one in four of us who will suffer from mental health problems over their lifetime.

RESEARCH PAPER

The traditional belief system in relation to mental health and psychiatric services in Sudan

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The authors express their gratitude to all those with mental disorders in the traditional healers' centres and their families and relatives who answered our research questions. They were our essential guides and teachers for the better understanding of traditional healing and mental illness. We would also like to thank the traditional healers and their assisting therapists for welcoming the research teams.

Traditional healers' centres may constitute community resources for people with a mental illness. Many low-income countries are seeking to integrate mental health into their mainstream health services and primary healthcare, so as to decrease the duration of untreated illness. Traditional healers can help to meet these needs. A series of four studies has been conducted in central Sudan. In-patients with mental disorders undergoing treatment with traditional healers were recruited, as well as some of the healers themselves. The resulting observations should help practitioners trained in Western psychiatry to better understand traditional healing as an alternative healthcare system. The results should contribute to current debates on whether or not traditional healers in Africa should be officially recognised as healthcare providers. They should also deepen social scientists' understanding of the role of culture in mental health and help policy makers to improve mental health services.

Traditional healers' centres may constitute community resources for people with a mental illness in a culture where they are recognised and valued. Traditional healers often have high credibility and deep respect among the population. They are knowledgeable about local treatment options, as well as about the physical, emotional and spiritual lives of the people they serve, and are able to influence their behaviour. Therefore, it is imperative to consider traditional healers as partners in an expanded response to mental disorder, and to maximise the contribution they can make in meeting the needs of those who require some form of mental health service (Anderson & Kaleeba, 2002, p. 5).

A series of four studies has been conducted in central Sudan (see Sorketti, 2008, 2009; Sorketti & Habil, 2009; Sorketti *et al*, 2010; Sorketti *et al*, 2011), with the following aims:

- to delineate the sociodemographic characteristics of people with mental disorders who seek treatment from traditional healers
- to record their clinical presentations and diagnoses
- to establish the outcomes afforded by traditional approaches to the treatment of people with psychosis
- to generate a profile of traditional healers
- to investigate the knowledge, beliefs, attitudes and practices of the wider Sudanese community in relation to people with mental disorders, traditional healing and formal psychiatric services.

The resulting observations should help practitioners trained in Western psychiatry to better understand traditional healing as an alternative healthcare system, one that is used by a large section of the Sudanese population – as is the case in other African countries, and elsewhere. The results should contribute to current debates on whether or not traditional healers in Africa should be officially recognised as healthcare providers. They should also deepen social scientists' understanding of the role of culture in mental health. The data may help policy makers to improve mental health services.

Method

We used both qualitative and quantitative research methods for the four studies, which were conducted in selected traditional healers' centres in central Sudan. In-patients with mental disorders undergoing treatment in these centres and the traditional healers themselves were recruited. The sample size was calculated using the Kish–Leslie formula for a descriptive study.

Both qualitative and quantitative research methods were used. These included focus group discussion, in-depth interviews with key informants and healers, structured questionnaires (for interviews with both patients and traditional healers), the Mini International Neuropsychiatric Interview (MINI, to elicit the diagnosis) and the Positive and Negative Syndrome Scale (PANSS, to assess those with a psychosis, at both admission and discharge from the centres).

Ethical approval was obtained before the start of the study and informed consent was obtained from all participants.

Results

We interviewed more than 400 patients receiving treatment at traditional healers' centres and were able to follow-up 129 patients with psychotic disorders from admission until discharge from the centres, to study the outcomes of the interventions.

We were able to interview 28 traditional healers to assess their concepts, attitudes and practices in relation to mental disorder.

Focus group discussions were held with the relatives and families of patients treated in these centres.

Discussion

We need to modify community concepts, attitudes and practices concerning mental health and the care of people who have a mental illness, to raise public awareness and to decrease the stigma of mental illness and enhance utilisation of services.

It is vital to establish channels of collaboration and common understanding between traditional healers and mental health professionals in those countries where the majority of people with mental illness consult traditional healers first. Traditional healers are in a position to help in the early detection of mental illness; in turn, early management will lead to better outcomes. Collaboration with psychiatrists will help to eliminate some potentially harmful methods of practice by the traditional healers, such as misdiagnosis, isolating patients in an unhealthy, non-hygienic environment, depriving patients of nutritional food, and beating patients. Collaboration can help to improve community awareness and decrease the stigma of mental illness. Use should be made of traditional healers' centres as community rehabilitation facilities for people with mental illness.

If the education of traditional healers can be improved, they may gain a better understanding of mental illness and the benefits of modern medication. This could be achieved through seminars, programmes and workshops to raise awareness of new psychiatric treatments.

It was evident from the studies that traditional healing can produce some improvement in the signs and symptoms of patients, even those with psychotic disorders, but, despite this, the approaches used by traditional healers do raise ethical and human rights issues, which need to be addressed.

We need to ensure community involvement in both the delivery and the utilisation of mental health services. Many low-income countries are seeking to integrate mental health services into mainstream general health services and primary healthcare, so as to decrease the duration of untreated mental illness, through early community detection. Collaboration with traditional healers would be of enormous strategic benefit in this regard.

More research is needed into traditional healing and mental health in Sudan, especially community needs and demands; to this end, the establishment of a specialist research institute for mental health and traditional healing in low- and middle-income countries would be of great advantage.

Although the researchers did their best to make the studies as comprehensive as possible, there were of course some limitations.

- Some harmful and even abusive practices are used by traditional healers in these centres, such as depriving patients of food. The researchers were only observers but were able to advise patients and their families to think about modern psychiatric treatment, and provided addresses of local mental health services.
- Psychiatrists' opinions about traditional healing practices and collaboration were not ascertained.
- For patients with a psychosis, consent to participate was obtained from a close relative.
- We were prohibited from taking photographs and making tape recordings.
- Transportation was often a difficulty for the research team because many of the centres were in remote villages.

We need to bring what was happening in these centres to the attention of our psychiatric colleagues and indeed of mental health professionals more widely, as well as to the attention of mental health service providers, decision-makers in the Ministry of Health, government officials and human rights organisations. Collaboration will help to improve the situation and put an end to some of the harmful practices we found. The current situation is most probably due to the shortage and high cost of formal mental health services, but also to the long experience in Sudan of war, internal conflict, political instability, poverty and lack of education.

Much work has to be done in order to convince patients' families and to work closely with the traditional healers to educate them (not to fight them) about mental illness and the value and effects of modern psychiatric treatment. There is at present a gap between psychiatrists, mental health professionals and people with mental disorders. This is true of many low-income countries. Psychiatrists and other service providers need to make more effort to reach those patients who require modern psychiatric management.

There is a lack of appropriate legislation to regulate traditional healers in Sudan (as in many other countries). Such legislation is urgently needed.

While it is important to know what role cultural and social factors play in determining the health-seeking behaviours of people with mental disorders and their relatives, it is imperative that researchers investigate what is going on in these centres from a cultural point of view, and that they do not judge them.

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RESEARCH PAPER

Evaluation of an Urdu version of the Impact of Event Scale – Revised

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In the aftermath of the major earthquake that hit Pakistan in 2005, there appeared to be a paucity of psychometric tools validated in Urdu. It was decided to translate the Impact of Event Scale – Revised (IES-R) so as to obtain an internationally validated and recognised psychometric tool for use in research into post-traumatic stress disorder. The resulting Urdu and English versions of the IES-R were compared for linguistic, conceptual and scale equivalence. The Urdu version of the IES-R (UIES-R) can be used for clinical, psychological trauma populations in Pakistan with evidence of good reliability and satisfactory validity. In trauma research in Pakistan the UIES-R will be an extremely useful psychometric tool.

We would like to thank: D. Weiss for permission to use the IES-R and GL Assessment for permission to use the GHQ-28; EMDR Europe HAP Project Pakistan for providing financial resources for the project; EMDR trainees for assisting in the Urdu translation; the Medical School, Abbottabad, Pakistan, for allowing data collection to take place; and the School's students for their invaluable participation.

On 8 October 2005 a devastating earthquake measuring 7.6 on the Richter scale struck northern Pakistan. In response to this natural disaster, in March 2007 a research project was launched at Ayub Medical College, Abbottabad, the city closest to the epicentre of the earthquake. In undertaking the research, it was important to utilise psychometric instruments that would enable an effective comparison to be made between psychological trauma populations in Pakistan and elsewhere, including higher-income countries.

The Impact of Event Scale – Revised (IES-R) is probably the most widely used self-report measure in the field of traumatic stress (Weiss & Marmar, 1997). The purpose of the research was to generate and to then validate an Urdu version of the IES-R (the UIES-R). Many of the scales used in cross-cultural research have been developed in high-income countries and later translated from English. Whether, and to what extent, the translated instruments perform the same function across cultures has often been debated (Cheung, 2004) but few quantitative studies have tackled the issue. Mumford *et al* (1991) advocated the use of a multi-stage method of evaluating translations, and they reported satisfactory results with an Urdu version of the Hospital Anxiety and Depression Scale. Riaz & Reza (1998) reported the development of an Urdu version of the General Health Questionnaire (GHQ-28) utilising a similar method.

Method

Translation

The IES-R scale was professionally translated from English into Urdu by an internationally recognised translation service. This became the first version of the UIES-R. The second stage was to embark upon an independent back-translation of the UIES-R, as recommended by the World Health Organization (Power *et al*, 1999). In light of this back-translation, slight changes were made, thus creating version 2 of the UIES-R. The third stage involved the back-translation of version 2. This became the final version of the UIES-R, used for the purpose of the evaluation study.

Evaluation

Following a similar method adopted by Mumford *et al* (1991), the equivalence of the Urdu and English versions of the IES-R was evaluated in terms of their linguistic, conceptual and scale equivalence. Linguistic equivalence, or the extent to which the translation is a literal one, was determined by administering both language versions of the questionnaire to a sample of bilingual people and calculating the mean difference scores (Urdu minus English) for each item; the expectation is that the mean score on each UIES-R item would not be statistically different to the corresponding English item score. Conceptual equivalence, or the extent to which the translation captures the meaning of the original, was determined by calculating correlation coefficients between each item and its corresponding subscale score, the expectation being that the items would correlate similarly for the Urdu and English versions. Scale equivalence, or the extent to which the Urdu and English versions of the IES-R identify the same individuals as high scorers, was determined by classifying each participant as having a high or a low score on the two versions of the questionnaire and calculating the concordance rate.

Reliability analyses were based on a comparison of the alpha coefficients for the original and translated versions of the IES-R.

Convergent validity was assessed by correlations between scores on each of the instrument's three subscales and the total score, for both the Urdu and English versions.

Study sample

Recruitment for the evaluation took place at the Medical School in Abbottabad, and involved 118 participants, who were all trainee doctors (an opportunity sample). Ethical approval was granted through Ayub Medical College, Abbottabad. Participation was entirely voluntary. No initial mental health screening took place for any of the participants. The only inclusion criterion was that participants were fluent in both Urdu and English.

The trainee doctors were given details of when and where data collection was scheduled to take place. After an initial explanation regarding the purpose and nature of the research, each participant was randomised in such a way that half the sample completed the Urdu version of the IES-R first, then the English version, while the other half completed the two versions in the reverse order.

Results

Linguistic equivalence

Table 1 shows the mean differences (Urdu minus English) for each of the 22 items of the IES-R, the subscale scores and total score. Paired-sample *t*-tests showed that statistically significant differences ($P < 0.05$) were found with two items (18 and 19), with English scores higher than the Urdu scores. There were no statistically significant differences in the three subscale scores, or in the total score.

Table 1

Mean differences (Urdu minus English) for each of the 22 items of the Impact of Event Scale – Revised, the subscale scores and total score

Item	Mean (s.d.) score in Urdu	Mean (s.d.) score in English	Mean (s.d.) of differences	*P*
Avoidance subscale				
5	1.98 (1.468)	1.88 (1.483)	0.10 (0.854)	0.253
7	1.28 (1.590)	1.26 (1.482)	0.02 (0.995)	0.846
8	1.80 (1.509)	1.90 (1.467)	–0.10 (0.849)	0.253
11	1.95 (1.576)	1.99 (1.546)	–0.04 (0.792)	0.625
12	1.03 (1.161)	1.06 (1.180)	–0.03 (0.733)	0.693
13	0.92 (1.238)	1.02 (1.271)	–0.10 (0.687)	0.158
17	2.10 (1.546)	2.00 (1.535)	0.10 (1.110)	0.343
22	1.74 (1.494)	1.81 (1.415)	–0.07 (0.654)	0.240
Subscore	1.61 (0.952)	1.62 (0.933)	–0.01 (0.360)	0.748
Intrusion subscale				
1	1.68 (1.398)	1.59 (1.344)	0.08 (0.649)	0.181
2	0.77 (1.098)	0.84 (1.105)	–0.07 (0.442)	0.127
3	1.59 (1.492)	1.62 (1.457)	–0.03 (0.660)	0.657
6	1.42 (1.421)	1.40 (1.412)	0.03 (0.822)	0.724
9	2.17 (1.495)	2.21 (1.530)	–0.05 (0.757)	0.525
14	0.83 (1.089)	0.94 (1.061)	–0.10 (0.842)	0.212
16	1.47 (1.423)	1.48 (1.320)	–0.01 (0.795)	0.903
20	1.11 (1.430)	1.11 (1.389)	0.00 (0.801)	1.000
Subscore	1.38 (0.860)	1.40 (0.830)	–0.01 (0.302)	0.671
Hyperarousal subscale				
4	1.28 (1.431)	1.14 (1.332)	0.13 (0.789)	0.085
10	1.83 (1.626)	1.79 (1.585)	0.04 (0.919)	0.672
15	0.92 (1.348)	1.06 (1.440)	–0.14 (0.768)	0.075
18	1.00 (1.242)	1.18 (1.337)	–0.18 (0.871)	0.036*
19	0.68 (1.156)	0.86 (1.297)	–0.18 (0.731)	0.013*
21	1.80 (1.489)	1.76 (1.471)	0.04 (0.767)	0.614
Subscore	1.24 (0.953)	1.31 (0.966)	–0.07 (0.442)	0.101
Total	31.00 (17.753)	31.23 (17.950)	–0.23 (5.530)	0.666

Table 2

Internal consistency data for the Urdu and English versions of the Impact of Event Scale – Revised

	Urdu version	English version
Avoidance subscale	0.812	0.805
Intrusion subscale	0.787	0.778
Hyperarousal subscale	0.777	0.776
Total score	0.916	0.912

Conceptual equivalence

All correlation coefficients reached a high level of statistical significance ($P < 0.001$). The ranges of the item–subscale correlation coefficients for the Urdu (0.39–0.85) and English (0.37–0.84) versions of the IES-R were comparable. For 17 of 22 items, the difference between the pair of correlation coefficients was 0.05 or less, and no differences exceeded 0.1.

Scale equivalence

The Pearson's correlation coefficients were high (0.89–0.95) and highly statistically significant ($P < 0.001$) when comparing the English and Urdu versions of the three subscales of the IES-R and the total scores.

Reliability

Table 2 shows the internal consistency data for each of the subscales of the Urdu and English versions of the IES-R, in addition to that of the instrument as a whole. The magnitude of the alpha coefficients was of the same order for both versions of the questionnaire and indicated acceptable levels of internal consistency.

Convergent validity

Spearman rank order correlations were calculated between each of the three subscales and the total scores for the Urdu and English versions. All correlation coefficients reached statistical significance ($P \leq 0.002$). The ranges of the coefficients for the Urdu (–0.31 to –0.53) and English (–0.29 to –0.62) versions of the IES-R were comparable. For the majority of the comparisons, the difference between the pairs of correlation coefficients was 0.05 or less, and in no case did this difference exceed 0.1.

Discussion

The results of the present study are consistent with previous findings with regard to the IES-R and suggest that this Urdu translation of the IES-R compares favourably with the original English version.

The IES-R is not a specific diagnostic measure for post-traumatic stress disorder (PTSD). This is because it is extremely difficult to assess criterion A for the DSM-IV diagnosis: that the person experienced or witnessed a traumatic event that involved actual or threatened death or serious injury, and the person's response involved intense fear or helplessness. What was extremely significant about the sample population used for this study is that all the medical students were either directly from the earthquake zone or were certainly indirectly affected by the earthquake. The inclusion of the hyperarousal element within the IES-R does better synchronise with the DSM-IV PTSD criterion and therefore better encapsulates the psychological impact of traumatic events. However, there is always the need to explore further the cultural idiosyncrasies of psychological trauma. More empirical and clinical work is needed in this area. What makes the results of the present research so significant is that the UIES-R was evaluated with a distinct trauma population. However, a justifiable limitation of the research was not being able to clarify more specifically the research participants' experiences of criterion A. Being able to have done so would have greatly enhanced the contextual findings and enabled a more idiosyncratic, subjective interpretation of the Pakistan earthquake of 2005. This may to some degree affect the degrees of variance of the measures, which in turn may relate to the independence of the subscales. However, the number of research participants involved potentially limits this.

In conclusion, the Urdu version of the IES-R can be used for clinical populations in Pakistan with evidence of good reliability and satisfactory validity. In research in Pakistan the UIES-R will be an extremely useful tool. Its validation will enable researchers to compare Pakistani psychological trauma research data with existing data in the international academic literature. Bhui *et al* (2000) have suggested that even within a broad ethnic group, expressions of distress may vary between different subgroups and may change as a result of acculturation. Much more research is therefore needed on the use of the UIES-R within the various Pakistani subcultures.

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Contributions to the 'News and notes' column should be sent to ip@rcpsych.ac.uk

UK Division of the Hellenic Psychiatric Association

The Hellenic Psychiatric Association (http://www.psych.gr) has established a UK Division. The officers are:

- Chair, G. Ikkos
- Honorary Secretary, D. Paschos
- Academic Secretary, E. Palazidou
- Trainee Lead, N. Christodoulou.

Membership of the UK Division is open to all specialists and trainees in psychiatry registered in the UK and interested in Hellenic psychiatry, irrespective of ethnic origin.

The UK Division has held meetings on mental health services in the UK and Greece: 'Perspective on Service Development' and 'Development, Innovation, and Governance'. The programme of forthcoming academic activities includes 'Focus on Bipolar Disorder' (confirmed speakers to include Professor Craddock, Cardiff University) and 'Psychiatry and Emotion: Neuroscience, History and Culture' (jointly with the Royal Society of Medicine, confirmed speakers to include Professor Chaniotis, Institute of Advanced Studies, Princeton University, and co-organiser, and Professor Randolph Nesse, University of Michigan). It has been proposed to hold study tours in Greece and Cyprus and other centres of Hellenic medicine.

For more information email gikkos@hotmail.com or drpaschos@hotmail.com

BIPA 'train the trainer' programme

The British Indian Psychiatric Association (BIPA), a diaspora network of psychiatrists of Indian origin is currently involved in an International Health Link Project, led by the chair of BIPA, Dr Subodh Dave.

India has only 0.4 psychiatrists per 100 000 population, compared with 14 per 100 000 in the UK. While there are no short-term solutions to increasing capacity in psychiatry, improving medical students' ability to recognise and manage psychiatric illnesses offers a sustainable solution in the long term. Recognising the local focus on didactic teaching and a minimal summative assessment, the joint UK–India faculty felt a critical need for a psychiatric curriculum focused on skills, outcomes and attitudes.

The Association's five-strong faculty designed and delivered a 4-day 'train the trainer' programme to a core faculty, Mumbai (India) in January 2012 and is due to follow this up with post-course online mentoring and support. The

new teaching techniques will be compared with the older methods through a randomised controlled study.

Contact details: Subodh.dave@derbyshcft.nhs.uk

2011 BPPA/BAPA conference, 'State of the Art Psychopharmacology'

The 10th annual British Pakistani Psychiatric Association (BPPA) conference was held with the British Arab Psychiatric Association (BAPA) on 19 and 20 November 2011 in Solihull, UK. Key-note addresses were provided by a variety of academic and clinical experts, including: Dr Fiona Gaughran, Dr Gordon Bates, Professor Chitra Mohan, Professor Malcolm Larder, Dr Peter Haddad and Dr Claire Royston. Topics covered included psychopharmacology across the breadth of psychiatric specialties. Conference attendees also benefited from an address by Professor Sue Bailey, the President of the Royal College of Psychiatrists, on her vision for the future. The key message from the conference was the need to use medications based upon the risk/benefit ratio, taking into account the ever-evolving evidence base.

The 11th BPPA conference, in 2012, has provisionally been set for 17–18 November 2012. For further information on the BPPA, please visit http://www.bppauk.org or email bppa@btinternet.com

Global Health Alerts: Why mental health matters to global health

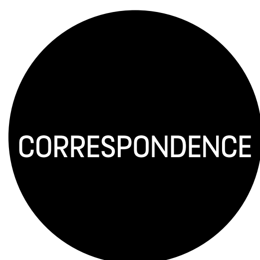
Friday 9 March 2012, from 6.30 p.m., at the Royal Society of Medicine (RSM), 1 Wimpole Street, London W1G 0AE

The Global Health Alerts is a series of free evening events organised by and held at the RSM. This series of talks aims to allow RSM members and non-members to engage in global health and learn about its past, current and future challenges. Well-respected speakers or organisations are invited to address controversial issues.

Professor Vikram Patel will address arguably the most neglected and stigmatised of all the causes of human suffering around the globe. The lecture will demonstrate not only why addressing health conditions affecting the brain is central to global health and development, but also that things are now beginning to change for the better and there are clear directions in which we need to be going.

Vikram Patel is Professor of International Mental Health and Wellcome Trust Senior Research Fellow in Clinical Science at the London School of Hygiene and Tropical Medicine, where he is joint director of the School's Centre for Global Mental Health.

Following a chaired discussion, delegates will be invited to a networking reception.



Correspondence should be sent to ip@rcpsych.ac.uk

Religious and spiritual dimensions of healthcare

Sir: John Cox challenges readers of *International Psychiatry*, the academic community, policy planners at the World Health Organization and national governments 'to fill in these glaring conceptual and practical gaps in research, education and clinical work – and to reconsider the religious and spiritual dimensions of healthcare' (Cox, 2011). This may seem daunting, but it is worth noting that much groundwork has already been done, for example in the work and publications of the Royal College of Psychiatrists' Spirituality and Psychiatry Special Interest Group (SIG). There are examples in Cook *et al* (2009), and in numerous other publications to be found on the College's SIG web pages (http://www.rcpsych.ac.uk/college/specialinterestgroups/spirituality.aspx).

I would also humbly draw your attention to a recent account of a comprehensive 'psycho-spiritual' paradigm, *The Psychology of Spirituality* (Culliford, 2011). Based in part on the work of James Fowler (1981), this book seeks to shed light on human existence and development at personal, interpersonal, sociocultural and spiritual levels. The paradigm described could readily be adapted for both research and teaching (Culliford, 2009).

Its relevance to medicine and psychiatry is that a key element of the new, holistic paradigm concerns the potential for people to grow through adversity and it reasserts the value of healing (making people whole), as distinct from simply removing or suppressing symptoms.

As well as informing clinical work, the paradigm also points meaningfully towards the benefits of sharing people's suffering and attempting (whether successfully or not) to restore them to health. It offers something of an explanation, then, of the vocational aspects of becoming a healthcare professional, and suggests ways of developing skills to enhance professional competence.

These may be thought of as 'spiritual' skills (including, for example, developing emotional resilience, having the courage to witness and endure distress while sustaining an attitude of hope), and they are by no means bounded by the work setting, some of them being of equal value in the family environment and in everyday life.

Larry Culliford

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Governance, choice and the global market for mental health

Sir: In their guest editorial for the August issue of *International Psychiatry*, Philip Sugarman and Andrew Kakabadse (2011) make interesting observations on how to improve state healthcare through patient choice, and how to develop an attractive alternative to monopolised state provision. Understandably, their focus was on mental health. They point out that the independent sector has, in the UK, increasingly invested in mental healthcare homes and hospitals.

The sector I work in – secure care and highly specialised treatment for people with intellectual disabilities, many of whom have forensic backgrounds – has perhaps recorded one of the largest growth rates of independent-sector role provision and expertise in recent years.

The *13th Biennial Report* of the Mental Health Act Commission (2009) revealed that, in 1998, of individuals with an intellectual disability detained in hospitals, 15% were within the independent sector. This had grown to 46% of individuals (545 of 1184) by 2008. Moreover, in 2007/8 a total of 67 section 37 hospital orders were made (restricted and unrestricted), and 42 of these individuals were placed within the independent sector.

Collectively, the UK independent sector has immense knowledge of how best to provide tailor-made and highly specialist care to this complex patient group, and offers this expertise internationally.

However, as Sugarman and Kakabadse note, there are political 'tensions' between public and private UK providers which stifle collaboration and debate over what services best meet patient needs. These tensions have, in turn, led to the independent sector being consulted only at a superficial level about the development of services for this patient group. I believe we must continue to emphasise the message that, for both mental healthcare and intellectual disability, independent care is funded from the National Health Service (NHS) or Social Services, not by the individual receiving care. The independent sector works in clinical partnership with the NHS. This cooperative relationship represents an important component of market diversity.

Actively promoting this message will both help defuse political tensions and enable the public to understand more clearly how the independent sector can provide effective and high-quality services which are both overseen by the NHS and free to the individual at the point of service delivery.

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Forthcoming international events

2–4 March 2012
Oman's First Psychiatric Conference
Organiser: Department of Behavioral Medicine, Muscat, Oman & Arabian Gulf Psychiatric Association (AGPA)
Email: drhamed@hotmail.com
Website: http://web.squ.edu.om/med/psyconf

14–17 March 2012
5th Biennial Conference of the International Society for Bipolar Disorders
Istanbul, Turkey
Website: http://www.isbd2012.org

19–20 March 2012
2nd Malawi Mental Health Research and Practice Development Conference
Email: robstewart@mac.com

14–18 April 2012
3rd Biennial Schizophrenia International Research Society Conference
Florence, Italy
Website: http://www.schizophreniaconference.org

17–19 April 2012
8th International Conference on Psychiatric Comorbidity Within Psychiatric Disorders and Medical Illnesses
Jeddah, Saudi Arabia
Organiser: Saudi German Hospital (SGH), Saudi Psychiatric Association and Motmaenna Psychiatric Centre and Egyptian Psychiatric Association
Website: http://jed.sghgroup.com.sa/

17–21 April 2012
13th World Congress of the World Association for Infant Mental Health
Cape Town, South Africa
Website: http://waimh-capetown2012.co.za/

30 May–1 June 2012
International Symposium on Controversies in Psychiatry
Cancun, Quintana Roo, Mexico
Organiser: Anfitriones nacionales
Website: http://www.controversiasmexico.org

4–6 June 2012
Together Against Stigma: Changing the way we see mental illness, 5th International Conference
Ottawa, Ontario, Canada
Organiser: Mental Health Commission of Canada and the World Psychiatric Association Scientific Section on Stigma and Mental Illness
Website: http://togetheragainststigma2012.ca

16–18 July 2012
7th International Conference on Child and Adolescent Psychopathology
London, UK
Organiser: Centre for Applied Research and Assessment in Child and Adolescent Wellbeing (CARACAW), Department of Psychology, Roehampton University
Website: http://estore.roehampton.ac.uk

7 –11 September 2012
International Psychogeriatric Association International Meeting 2012
Cairns, Queensland, Australia
Website: http://www.ipa2012cairns.com/

17–21 October 2012
WPA International Congress 2012
Prague Congress Centre (PCC), Czech Republic
Organiser: World Psychiatric Association
Website: http://www.wpaic2012.org/en/welcome

8–11 November 2012
International Conference on Clinical Practice in Alzheimer Disease (CPAD)
Budapest, Hungary
Organiser: Paragon-Conventions
Website: http://www.cpadconference.com/

29 June–3 July 2013
XXI World Congress of Social Psychiatry. The bio-psycho-social model: the future of psychiatry
Lisbon, Portugal
Website: http://www.wasp2013.com

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