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GUEST EDITORIAL

Mental health impact of the war on drugs

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Further to the publication by the London School of Economics and Political Science of the report *Ending the Drug Wars*, this editorial focuses on the mental health impact of the 'war on drugs' and on the need to end such policies in favour of evidence-based interventions to manage drug dependence as a health condition.

Last year, the London School of Economics and Political Science (LSE) published a report, *Ending the Drug Wars*, which stated:

> the pursuit of a militarised and enforcement-led global 'war on drugs' strategy has produced enormous negative outcomes and collateral damage, including mass incarceration in the US, highly repressive policies in Asia, vast corruption and political destabilisation in Afghanistan and West Africa, immense violence in Latin America, an HIV epidemic in Russia, an acute global shortage of pain medication and the propagation of systematic human rights abuses around the world. (LSE Expert Group on the Economics of Drug Policy, 2014: p. 3)

The report claims that 'it is time to end the "war on drugs" and massively redirect resources towards effective evidence-based policies underpinned by rigorous economic analysis' (p. 3). Throughout the report it is clear that the public health, safety and economic burden of the war on drugs has been grave and not cost-effective in terms of return on investment. Its toll on health has been particularly evident in the area of mental health, especially for prisoners incarcerated for drug-related crimes and after their release into the community.

In 2011, nearly half (48%) of inmates in US federal prisons were serving time for drug offences (Carson & Sabol, 2012). Latin America is equally immersed in a drug-related prison epidemic. Harsher criminal penalties underlie the increase in the prison population. The number of women incarcerated in the region nearly doubled between 2006 and 2011, from 40 000 to 74 000, and drug crimes were the first or second most frequent reason for their incarceration (Giacomello, 2014). Of a total of 9 million prisoners in the world, approximately 40% are held on charges related to drugs.

Within prisons, mental health challenges are distinctly more prevalent and result in a substantial health burden for inmates and society. Compared with the general population, prison inmates experience poorer physical and mental health and social well-being, including both acute and long-standing physical and mental illness and disability, sexual health problems, suicide, self-harm, physical, psychological and sexual violence, lower life expectancy and breakdowns in family and other relationships, as well as drug, alcohol and tobacco dependency (Barry *et al*, 2010). In the USA, more than half of the approximately 2.2 million prison and jail inmates at the end of 2010 experienced a mental health problem (Glaze, 2011): 44–64% had mental health issues and 74–76% had substance misuse issues (James & Glaze, 2006). In Europe, a systematic review of 62 surveys of about 23 000 prisoners from 12 countries confirmed that up to 65% of prisoners have a mental health disorder, which may range from personality disorder (42–65%), to major depression (10–12%) to psychotic illnesses (4%, including schizophrenia, manic episodes and delusional disorder). Prisoners are several times more likely to have psychosis and major depression and about ten times more likely to have antisocial personality disorder than the general population (Fazel & Danesh, 2002). Those disorders represent a serious risk factor for suicide, which is the leading cause of death among those who are imprisoned and accounts for around one-third of all prison deaths. In Europe, the risk of suicide among prisoners (10.5 per 10 000 in prison) is estimated to be seven times that of the general population (Rabe, 2012); in the USA, suicide was the most frequent reason for the 4150 deaths among inmates in 2010 (Noonan, 2012).

Time in prison is plagued by violence. Both men and women with mental disorders are disproportionately represented among victims of physical violence inside prison. Rates of physical victimisation for men with any mental disorder were higher than those of men with no mental disorder, by a factor of 1.6 for inmate-on-inmate incidents and a factor of 1.2 for staff-on-inmate victimisation. Female inmates with mental disorder were 1.7 times more likely to report being physically victimised by another inmate than did their counterparts with no mental disorder (Blitz *et al*, 2008).

This situation is exacerbated for inmates who use drugs. Data from the USA, Canada and Australia show that the prevalence of drug use among prisoners prior to incarceration is substantially above the level in the general population. In studies carried out in Europe since 2000, estimates of the prevalence of injecting illicit drugs while in prison range from 2% to 31% (EMCDDA, 2012). This is particularly critical for users who switch drugs inside prisons due to lack of availability of their drug of choice. Additionally, the high prevalence of HIV and hepatitis C infection among prisoners and pre-trial detainees, combined with

overcrowding and substandard living conditions, sometimes amounting to inhuman or degrading treatment in violation of international law, make prisons and other detention centres a high-risk environment for transmission. Ultimately, this contributes to epidemics in the communities to which prisoners return upon their release (Jurgens *et al*, 2011).

After release, prisoners do not have an easier time. Release from prison has been associated with increased health burden, including mortality from all causes and, in particular, from drug overdose. A review of drug-related deaths that occurred shortly after release from prison in Europe, Australia and the USA showed that six out of ten deaths in the first 12 weeks after release were drug-related (Merrall *et al*, 2010). This risk does not appear to have decreased in the last 20 years (World Health Organization Regional Office for Europe, 2010). It is experienced by an increasing population of drug users whom the 'war on drugs' has sent to prison rather than to appropriate care and treatment.

The principles underpinning that 'war' (militarisation, control, imprisonment) continue to undermine the impact of repeated calls to shift the emphasis from law enforcement, punishment and interdiction towards public health, prevention, harm reduction and treatment-oriented policies. This shift could save lives, ease the burden of mental ill-health and communicable diseases on healthcare systems and deliver sustainable savings in healthcare and social welfare (Room & Reuter, 2012). The 'war on drugs' principles feed the fear of relinquishing strict control over people who use drugs, resulting in their incarceration, which maintains them in the same vicious cycle, rather than assisting them to access continuing care and treatment for their dependence.

In spite of a substantial body of evidence demonstrating the benefits of evidence-based, drug-related health services in the prison setting and the community, such services remain underfunded, unavailable or inadequate to meet an increasing need. Thus, a major opportunity to improve public health within prisons and beyond, save on critical resources and maximise public good (Strang *et al*, 2012) is sacrificed on the altar of misconceptions and moral pseudo-dilemmas.

There is now, though, renewed interest in sweeping reform to end the persistent criminalisation of drug users – including developing programmes of general amnesty for the prisoners of drug wars. The Europe Union's Drugs Strategy 2013–20 (European Council, 2012) calls on member states to increase the use of effective alternatives to the incarceration of drug-using offenders. At a time when treatment for people using drugs is of immense value in terms of personal and public health, social welfare and economics, it is critical to recognise that drug policy, like any policy, must be defined, applied and evaluated against measurable goals and results, and not determined by fear, ideology, intentions or short-term politics.

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GUEST EDITORIAL

Reconciliation and psychosocial understanding

John, Lord Alderdice

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'Reconciliation' generally means the development of good relations where they have never truly existed before. This paper refers principally to the example of Northern Ireland and the Irish peace process. Psychiatrists should examine what really contributes to 'large group' reconciliation, as the absence of the psychiatric perspective would be a serious loss in the search for post-conflict well-being at the communal level.

In struggling with the concept of 'reconciliation' I am reminded of Aubrey Lewis on hysteria. It is hard to define, and one may even be sceptical about its existence, but 'it is unlikely to be killed so long as [we] find it useful, if not indispensable' (Lewis, 1975). Similarly, despite objective and reasonable scepticism about the role of psychiatry or even the possibility of achieving reconciliation between communities long caught in historic feuds, and without even a clear definition of exactly what we mean, as Lewis said of hysteria, so it is true of reconciliation, whatever the critique: 'It tends to outlive its obituarists'.

In individual relationships 'reconciliation' is sometimes defined as 'the restoration of friendly relations'; however, when applied to communal relationships, it generally means the development of good relations where they have never truly existed before – South Africa, Australia and Northern Ireland are the three examples addressed in the thematic papers in this issue.

Some have suggested that the word 'conciliation' is more accurate but more important than the etymological problem is the challenge of finding a definition that is truly satisfactory. How does one set down criteria that define when reconciliation has occurred? We know when reconciliation has not occurred and, as with hysteria, most people have a sense that they would recognise reconciliation if they saw it, but setting down the criteria for reconciliation and how it may be achieved is very challenging, because it is about the complexity of relationships between communities, or 'large groups'.

Let me use the example I know best, that of Northern Ireland and the Irish peace process, which has been ongoing in recent decades.

When the civil rights marches of the late 1960s broke down into serious rioting, it was not only because of the problems of anti-Catholic discrimination in Northern Ireland at the time, but came out of a long history of unhappy relations between Britain and Ireland since at least the Anglo-Norman invasion of 1169. Britain hoped it had sorted the problem with the 1922 partition settlement, but the substantial Catholic minority in Northern Ireland felt isolated and alienated, and in the absence of reconciliation the relative tranquillity broke down in the late 1960s. During the ensuing 30-year conflict, out of a population of 1.5 million, more than 3500 were killed, over 100 000 suffered physical injury, and there were hundreds of thousands of other victims too.

A unionist/nationalist power-sharing initiative in 1973 collapsed after only 6 months and – despite efforts by civil society, the women's peace movement, high levels of security intervention and regular political initiatives – the violence continued to wreak havoc for a generation.

The United Kingdom and the Republic of Ireland joined the European Economic Community on the same day in 1973. From that time, government ministers and officials met regularly, cooperation developed, respect grew and the resulting 1985 Anglo-Irish Agreement led to unprecedented cooperation and improved relations between the two governments. But the IRA campaign continued and loyalist paramilitaries, feeling betrayed by Britain, took revenge through sectarian killings. After 6 more years of diplomatic activity, political representatives of the two sides in Northern Ireland came round the table, but it took another 5 years and two ceasefires to bring the parties associated with the paramilitaries into the talks.

The painstaking procedural discussion of the pre-negotiation period ('talks about talks') slowly edged the partisans towards the table, not by addressing the substantive issues, but by exploring the problems of three sets of disturbed relationships – between Protestant unionists and Catholic nationalists within Northern Ireland; between Northern Ireland and the Republic of Ireland; and between Britain and Ireland. The process was constructed in three strands addressing these three sets of relationships. This focus on 'relationships between large groups' was a major step forward in international thinking about resolving violent political conflict.

The wider international community, particularly the USA and the European Union (EU), provided economic assistance, encouragement and, in the case of the USA, expertise and mediation. Northern Ireland politicians visited other peace processes, most notably in South Africa, and aid was targeted to enable the divided community to take shared responsibility for its own governance and economy.

Senator George Mitchell, the chairman of the multi-party talks that led to the 1998 Belfast

Agreement (also known as the Good Friday Agreement), was conscientiously therapeutic in his approach, listening patiently to everyone involved and developing trust over many months. The gradual building of respectful behaviour, finding devices to break through deadlock, the imaginative use of different formats and careful deadlines were just a few of the skills he demonstrated. The EU provided a model of post-war conflict resolution with its cross-border cooperation mirrored in the Ministerial Council that now brings ministers together from Northern Ireland and the Republic of Ireland on agriculture, economic development, environment, tourism and transport. The British and Irish governments continue to meet regularly and the protection of human rights central to the EU is a fundamental feature of the Belfast Agreement.

All these components – the critical part played by influential external relationships, a preparatory period of pre-negotiation engagement, the difficult but necessary inclusion of all elements of the relationships, patient, imaginative and skilful engagement with the conflicts, the sustained commitment over a long period of time, an element of creativity in the context of an embedded commitment to the rights and freedoms of all elements of those involved – reflect vital aspects of a psychotherapeutic approach to internal conflicts with individuals as well as conflict resolution in a divided community, but they are not themselves sufficient for success.

Until people in any conflict begin to turn away from violence as a means of solving problems they will not be prepared to accept the price of peace. Only a community weary of war is prepared to accept an outcome which is less than their ideal. Rebuilding 'the rule of law', with demilitarisation, decommissioning of illegal weapons, resettlement of paramilitary prisoners and reform of policing and the criminal justice system, was both difficult and contentious.

There were also the challenges of addressing rights, responsibilities, and respect for minorities at the core of the conflict. More than merely accepting international legal norms, this required specific political protections and involved negotiating mutual vetoes and complex formulae with guarantees for both sides in the new Northern Ireland Assembly.

One might imagine that having achieved such an all-encompassing agreement approved by overwhelming majorities in referendums on both sides of the Irish border, reconciliation would be merely a matter of time and implementation. The upcoming generation do not wake up to daily news of the bombings and shootings that destroyed lives, property and relationships; our political structures are based on principles of power-sharing and parity of esteem; the police are more representative and accountable; robust protections are in place for human rights; and Britain and Ireland have new sets of political relationships. However, 17 years on from the Good Friday Agreement, disagreements on flags, parades and how to deal with the painful legacy of the past, as well as the problems elected leaders have in finding workable compromises on current socioeconomic questions, show that there is 'unfinished business', particularly in respect of reconciliation, however undefined.

While good relationships need the stability of structures and boundaries, reconciled communities require more than the observance of rules and laws. There must also be a spirit of generosity and respect. Rules and rights can provide the context for a conflict to be stopped, but only a culture of mutual respect can truly put it to the past. What is preventing reconciliation in Northern Ireland?

Committed, as I am, to applying psychological understandings from work with individuals in my psychotherapy clinic to the problems of a community in conflict that I faced as leader of the Alliance Party, I appreciate that there is not a simple read-across from individual psychology to what Vamik Volkan (2013) calls 'large-group psychology' and that good relations between individuals (unless they have special communal representative roles) do not overcome communal conflict. However, I have found that at the different systemic levels there are common fundamentals of the human condition and, as I have described elsewhere (Alderdice, 2010), understanding them was central to my work in the Irish peace process and other long-standing violent political conflicts.

A huge package of political and socioeconomic measures have been agreed and implemented in Northern Ireland, but still there has not been reconciliation. Could a kind of community 'psychotherapy assessment' help us understand the remaining obstacles to reconciliation? We brought together a representative group of leading members of political parties, paramilitaries, police, religious figures, civil society and victims in Northern Ireland, for an exploration facilitated by some colleagues who work at applying the principles of individual and group psychology to political processes.[1] What emerged?

As individuals, our personality is made up of our genetic structure and those experiences which continue to affect us even when our situation changes. People brought up without enough food learn to eat as much as possible any time they have the chance. If life changes and they have food and to spare, they often continue to eat according to the old pattern, resulting in overweight and poor health. The same behaviour that helped them survive comes to threaten their well-being, and they continue with it even when the external

1. I was joined for the residential session at Corrymeela in Northern Ireland in June 2013 by colleagues from the International Dialogue Initiative (IDI; http://www.internationaldialogueinitiative.com): Vamik Volkan (President of the IDI), Robi Friedman (President of the International Group Analytic Society), Jerry Fromm (President of the International Society for the Psychoanalytic Study of Organizations) and Ford Rowan (Chairman of the US National Center for Critical Incident Analysis).

circumstances change and it becomes harmful. I have seen this particular problem with Aboriginal people in Australia, where a whole community has stuck with old ways of thinking and 'being' when their world has changed, and the result has been disastrous for their physical and mental health.

Our new structures in Northern Ireland came about by negotiation and the people voted for a future based on fairness and parity of esteem, but although the structures have changed, communities still see things in the old ways. Listening in our 'diagnostic group' to the different communal representatives speak, it seemed to us that an element of the identity or culture of the Protestant/unionist/loyalist community still involves a sense of 'dominance' – a disposition to think and act as though they ought still to be in charge, so there is no sense of a need to negotiate accommodations with nationalists over flags and parades. There is a fear that if they are not dominant, their circumstances will reverse and they will be dominated by the Catholic/nationalist/republican community; however, the underlying problem seems more to do with this dominance element of their identity/culture not changing to accommodate the new reality. If the Protestant/unionist/loyalist identity is to incorporate parity of esteem and develop a sense of self-confidence there needs to be a change in their culture. Flags and traditional parades are indications of culture, but 'culture' itself is the way of 'being-in-the world' of that group.

In the Catholic/nationalist/republican community, generations of being dominated created an identity, or way of 'being-in-the-world', characterised by a sense of victimhood. Despite parity of esteem in political, legal, social and economic opportunities, that community still looks through the lens of victimhood, rather than realising they are joint authors of a shared destiny.

This analysis of residual cultures/identities of 'anxious dominance' and a 'sense of victimhood' implies that the 'unfinished business' of reconciliation will not be resolved by more political deals, economic development, action plans or the mere passage of time. The shadow of the past hangs heavy, and it will require a change in the way-of-being of the groups. If it is difficult for us as individuals to change our way-of-being, it is no less a challenge for large groups.

I am now engaged with colleagues in Northern Ireland in developing psychosocially informed community interventions to help our divided community engage with the process of necessary change,[2] including the initiative by Sinn Fein to engage in what they have called 'uncomfortable conversations' with unionists/loyalists and those within their own nationalist/republican community (Alderdice, 2015). The implication is that we need to address the 'unfinished business' by finding new ways of relating and being that we could recognise as 'reconciliation', challenging the traditional narratives and attitudes within our own communities and moving away from elements of our current cultures and identities to new shared ways of 'being-in-community'.

Many liberally minded people inside and outside government have tried in the past to reassure communities that they do not have to change their culture and that all cultures can be celebrated, and should be; indeed, it enriches a community when the symbols and artefacts of different backgrounds, traditions and culture can be valued and displayed appropriately. However, if there is not a largely shared way of being-in-the-world (a shared communal culture), then fractures and fissures are inevitable. Culture and identity involve many things we quite properly want to preserve; however, they also emblematise divisive historic attitudes and ways of behaving that we need to leave behind because they are no longer appropriate to the reality of our shared communal lives and can be harmful in the present and for the future. Transforming our identities will not happen without effort, hence the need for these 'uncomfortable conversations' and other community interventions.

How do these experiences in Northern Ireland relate to the work described in the thematic papers on South Africa and Australia, and indeed other conflicts?

Bernard Janse van Rensburg similarly describes 'unfinished business' from the South African Truth and Reconciliation Commission and asks the question whether psychiatrists should be concerned with not only dealing with the consequences of conflicts on individuals in the past (rehabilitation and restoring), but also with preventing future violations. As he says, that would clearly require a significant shift in the traditional scope of psychiatric practice, but if psychiatrists do not contribute, how will such preventive work be informed? Addressing communal memory and trying to achieve communal reconciliation following the trauma, stress and loss of conflicts and human rights abuses requires 'large group' interventions, such as ceremony, ritual and the establishment of facilities like the Freedom Park in Pretoria, with its sacred ceremonial space, garden of remembrance, Wall of Names and what he calls cleansing and healing ceremonies – indeed, he rightly calls these 'strategic interventions in the quest for symbolic reparation of the nation'. Surely it is a form of 'public health psychiatry' to examine and assess interventions such as truth telling, forgiveness, remorse, restitution, justice, remembrance, restorative action and transcendence, which may contribute to reconciliation.

Undoubtedly psychiatrists should not examine what really contributes to large group reconciliation on their own. I have found myself working increasingly with anthropologists, political scientists, theologians and artists, but the absence of the psychiatric perspective would be a serious loss in

2. This has required the establishment of the Centre for Democracy and Peace Building (http://www.democracyandpeace.org) to provide an institutional base for the work.

the search for post-conflict well-being at the communal level.

Jason Lee describes the enormous commitment evidenced by the 2014–16 Aboriginal and Torres Strait Islander Reconciliation Action Plan developed by our psychiatrist colleagues in Australia and New Zealand. They have taken seriously the responsibility of the community of psychiatrists to contribute to the wider community of citizens. I have seen for myself the disproportionately poor physical and mental health, and inequity of opportunity, of the Australian Aboriginal community. What struck me was that the expenditure of huge resources and the genuine commitment and investment in legal and political changes and social policies and projects have seen limited measurable improvement and indeed in some cases the situation is worse (Alderdice, 2014).

Initiatives by the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and others in Australia are most commendable and not just in working harder at the problem. There are also questions that require psychosocial exploration. Why is the situation of the Maori people in New Zealand so different? Of course there is no easy simple answer; however, the fact that they do not see themselves as a defeated people, and the ways in which New Zealanders as a whole seem to have integrated their historic identities into a shared culture, seem crucial.[3] I have been struck by how some of those who are most enthusiastic to help Aboriginal people want to conserve an approach to life that may doom Aboriginal people to continuing misery and untimely deaths. It seems to me that not just resources but a process of psychosocial engagement is required with a preparedness to change perspectives on both sides, if the long-term problems of the historically disturbed relationships between the Indigenous peoples and the majority community in Australia are to result in reconciliation, and the RANZCP clearly has the understanding and commitment to make a major contribution.

It seems appropriate to end with Lee's quotation from Pitjantjatjara elder Nganyinytja, 'Reconciliation means bringing two cultures together: *maru munu piranpa tjun-gurin-ganyi*, Black and White coming together.' These wise words of an Aboriginal elder seem to urge us beyond conservation of the past, and on to change our separate communal ways of 'being-in-the world', if we are to build 'reconciliation' together.

3. I am grateful to Professor Stuart Twemlow for drawing this contrast to my attention and I was subsequently able to observe and confirm these cultural developments in New Zealand.

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THEMATIC PAPER

Reconciliation and conflict resolution

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The three thematic papers in this issue, and the guest editorial by John, Lord Alderice, speak for themselves and pointedly and poignantly show how psychiatrists cannot abdicate from the challenge of reconciliation and conflict resolution, whether this is within families, across ethnic or political divides or in the aftermath of war. The understanding of group dynamics, the mechanisms of projective identification, the splitting/scapegoating of the unfamiliar 'other', as well as the known vagaries of the unconscious are pertinent to any serious attempts to resolve conflict. These understandings, when combined with humanitarian energy and a vision for peace, can bring about positive change and reconciliation, whether in South Africa, Australia, Northern Ireland, or elsewhere in the world.

For example, the World Psychiatric Association, at its best, can not only speak out against the political abuse of psychiatry, but also bring together psychiatrists and their professional organisations on opposite sides of conflict. Members of the Royal College of Psychiatrists may also reconsider establishing a special interest group on conflict resolution, or reinstate the core experience of group work, or explore the extent to which religious belief may cause conflict as well as bring comfort to victims of oppression.

This writer is reminded of the sheer persistence of Nathaniel Minton, who worked tirelessly for understanding and resolution of the Palestine–Israel conflict (see Clein, 2013), and of the dogged determinism of Alex Poteliakhoff, who, with other colleagues, founded the Medical Association for Prevention of War in 1981 and, aged 97, is working on a plan for tackling global disharmony through an international Truth and Reconciliation Commission brokered by the United Nations (Watts, 2015). I am also reminded of the imaginative and

innovative writings of my brother Murray Cox (forensic psychotherapist and Shakespeare scholar), whose edited book *Remorse and Reparation* was published posthumously (Cox, 1999). It included a discussion of Shakespearean language about guilt and remorse, an analysis of Kierkegaard's psychological and theological thinking, and chapters on novel aspects of forensic psychiatry.

The three thematic papers that follow shine a ray of hope on what is otherwise a gloomy political landscape at present. This writer recalls celebrating Victory in Europe (VE) day in 1945 – but, at the time, none of us knew of the ethnic cleansing of thousands of German-speaking civilians that would occur in Eastern Europe as a consequence of the post-war agreements between the Western powers and Stalin (de Zayas, 1977: pp. xxv, 54).

These papers and these people will remind the reader that psychiatry and medicine as a whole is an interpersonal discipline that is *sans frontières*. Benjamin Britten used the poetry of Wilfred Owen for his *War Requiem* (1962), including Owen's 'Strange meeting', written in 1918, which features the line:

> I am the enemy you killed, my friend.

The music does not shirk the dark shadows and can enlighten us, as well as promote reconciliation.

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THEMATIC PAPER

Committing to reconciling our differences: development of the Royal Australian and New Zealand College of Psychiatrists' Reconciliation Action Plan

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Declaration of interest: the author was chair of the Royal Australian and New Zealand College of Psychiatrists' Aboriginal and Torres Strait Islander Mental Health Committee at the time of the development of the Reconciliation Action Plan and at the time of the writing of this article.

Aboriginal and Torres Strait Islander Australians continue to experience disproportionately poor physical and mental health, and inequity of opportunity. Australia's Reconciliation Action Plan programme provides a framework and support for organisations to demonstrate leadership through public commitment to actions. The Royal Australian and New Zealand College of Psychiatrists developed its own Reconciliation Action Plan through a consultative process, and hopes to lead and promote reconciliation as a peak medical body.

Background

Aboriginal and Torres Strait Islander people are the Indigenous populations of Australia. Archaeological evidence suggests that human colonisation of the continent dates as far back as 68 000 years (Thorne *et al*, 1999). Indigenous Australians were hunter-gatherer societies, deeply spiritual, whose wisdom and cultural knowledge were transmitted through stories and rituals involving songs, dance and art. Prior to colonial settlement in 1788, the population, an estimated 750 000 people, spoke several hundred different languages (Australian Bureau of Statistics, 2008).

The impact of European settlement was rapid and devastating. War, disease and dispossession changed living conditions and caused a rapid decline in population, to a low of 93 000 in 1900 (Australian Bureau of Statistics, 2002). Longitudinally, the sequelae and continuing impact of historical and trans-generational trauma have resulted in many Indigenous youths engaging in dysfunctional behaviours, from crime and violent behaviours through to substance misuse and self-harm (Atkinson, 2002). This maelstrom of cumulative trauma contextualises the sub-optimal social and emotional well-being, and indeed the mental ill-health, experienced by many Aboriginal and Torres Strait Islander people.

Social, economic and environmental factors have a pivotal role in cumulatively increasing the lifetime risk of an individual experiencing physical and mental ill-health. Indigenous Australians experience higher rates of incarceration, unemployment, household overcrowding and domestic violence. Their life expectancy is 10.6 and 9.5 years less than male and female non-Indigenous Australians (Australian Government, 2015). Addressing these disadvantages requires engagement from individuals, communities and all levels of government, with multi-sectorial and multi-systemic interventions. Australia's journey of reconciliation with its Indigenous people has been slow to gain momentum, with the most significant milestones arguably being the 1967 referendum (to include Indigenous Australians in the census and

allow the Commonwealth to make laws for them), the 1992 Mabo native title decision (the High Court found that *terra nullius* – the notion that the land belonged to no one – should not have applied to Australia), and the 2008 'stolen generations' national apology (for past mistreatment, particularly children forcibly removed from families).

Despite significant recent commitment and investment in social policies and projects, progress in ensuring Indigenous Australians have equal opportunity to participate in society has been limited. The 2015 *Closing the Gap* report showed encouraging signs in Indigenous child mortality and child and youth participation in education, but little improvement in life expectancy, employment and literacy (Australian Government, 2015). The sixth *Overcoming Indigenous Disadvantage* report, comparing 2004–05 and 2011–12 rates, found no significant change in alcohol and drug misuse and harm, while the proportion of Aboriginal and Torres Strait Islander adults reporting high levels of psychological distress increased from 27% to 30%, and hospitalisations for self-harm by 48% (Australian Government, 2014).

While measurable outcomes serve as focal targets, cultural identity and recognition by and respect from others are no less important in the efforts to help Aboriginal and Torres Strait Islander people to their rightful place in Australian history and contemporary society. Cultural factors, despite being severely damaged by European colonisation, helped Aboriginal and Torres Strait Islander people survive generations of trauma and disadvantage, and continue to protect them from racism and marginalisation (Zubrick *et al*, 2014). One current such activity is the push for recognition of Aboriginal and Torres Strait Islander people in the Australian Constitution.

Reconciliation then is about improving the relationship between Aboriginal and Torres Strait Islander people and the rest of the Australian population, through addressing inequity of opportunity, enhancing recognition of cultural identity and building respect.

In the words of Pitjantjatjara elder Nganyinytja, 'Reconciliation means bringing two cultures together: *maru munu piranpa tjun-gurin-ganyi*, Black and White coming together' (Nganyinytja, 2010).

Reconciliation Australia's Reconciliation Action Plan (RAP) programme

Reconciliation Australia is an independent national not-for-profit organisation. It launched its RAP programme in 2006 to support organisations to develop business plans that target change within their spheres of influence to address social determinants of health and contribute to the national 'Closing the Gap' targets of Indigenous life expectancy, employment and high-school completion rates. The programme grew from eight organisations in 2006 to more than 600 in 2014 (Reconciliation Australia, 2014).

Reconciliation action plans promote commitments to actions under the three pillars of building relationships, showing respect and improving opportunities. Four types of RAP are available, depending on the organisation's experience in reconciliation, preference for engaging innovative or stretch targets, and track record of proven results.

In 2012, Reconciliation Australia demonstrated the effectiveness of the programme by reporting on several key findings: 45% of RAP employees agree that Aboriginal and Torres Strait Islander peoples hold a special place as the First Australians, compared with 21% of the general population; 77% of RAP employees are proud of Aboriginal and Torres Strait Islander cultures, compared with 51% of the general population; and 86% of RAP employees have taken action in support of reconciliation, compared with 50% of the general population (Reconciliation Australia, 2012). Furthermore, as of September 2013, RAP organisations employed 25 755 Aboriginal and Torres Strait Islander peoples and purchased A$81 million worth of goods and services from accredited Aboriginal and Torres Strait Islander organisations.

Organisations engaged in the RAP programme have ranged from private companies to small businesses, government agencies to local councils, and peak bodies to schools and universities, and have included peak medical bodies, including the Royal Australian and New Zealand College of Psychiatrists (RANZCP; see http://www.ranzcp.org/About-us/About-the-College/Reconciliation-Action-Plan.aspx).

Development of the RANZCP RAP

One of the core values of the RANZCP is improved health outcomes and access to mental health services for Indigenous populations. It has therefore proactively developed internal mechanisms and external opportunities for meaningful consultation and collaborative partnerships with Indigenous stakeholders.

In 1997, the RANZCP established the Aboriginal and Torres Strait Islander Mental Health Committee (ATSIMHC) in Australia and the Te Kaunihera mo nga Kaupapa Hauora Maori Committee in New Zealand. Each committee aims to work with respective Indigenous peoples and organisations: to promote the mental health of their communities; to reduce the impact of mental disorders on individuals, families and the community; to ensure optimal and complementary recognition and application of the expertise of people and organisations involved in mental healthcare delivery to the communities; and to assure the rights of Indigenous peoples with mental disorders.

The ATSIMHC is composed of Aboriginal and Torres Strait Islander community members and psychiatrists working in Indigenous mental health. It enables the RANZCP and the mainstream of mental health providers to hear Aboriginal and Torres Strait Islander concerns in the areas of social and emotional well-being and mental health. Its roles within and on behalf of the RANZCP

include: advocating on relevant issues at a national level; advising the RANZCP; supporting the establishment of collaborative relationships; advocating for and supporting Aboriginal and Torres Strait Islander mental health workers, doctors and medical students; and promoting public understanding.

Aside from the establishment of the ATSIMHC, the RANZCP has developed and maintained position statements on Aboriginal and Torres Strait Islander mental health workers, and the recognition of Indigenous people in the Australian Constitution, and 'stolen generations'; it has also produced an ethical guideline on Aboriginal and Torres Strait Islander mental health.

The RANZCP, led by its board, embraced the development of a RAP as an opportunity to contribute to and support the reconciliation process. The RAP was developed in consultation with the ATSIMHC, with targeted input and feedback sought from its Aboriginal and Torres Strait Islander membership. All RANZCP members were invited to contribute. Key stakeholder groups were consulted, including the Australian Indigenous Doctors Association and Reconciliation Australia. The RAP was launched at the RANZCP annual congress in May 2014, in the presence of Dr Tom Calma, co-chair of Reconciliation Australia.

The key to the RANZCP's successful development of a comprehensive and meaningful RAP is its long-standing interest in Indigenous health. The ATSIMHC, with its expertise and established relationships, provided appropriate advice and leadership. The actions committed to in the RAP represented work that was already underway, as well as aspirational goals, both practical and, as importantly, symbolic (Subašic & Reynolds, 2009). An action under 'Respect' for supporting Fellows and trainees to enhance their cultural competency has recently been completed with the development of a series of e-learning modules on Indigenous mental health. An approach to an action under 'Relationships' to develop new partnerships and engage local communities has been to hold the ATSIMHC's meetings at different Aboriginal or Torres Strait Islander health services across Australia. Aspirational goals include an action under 'Opportunities' to support the recruitment and retention of Aboriginal and Torres Strait Islander psychiatrists and trainees, for which affirmative action is being considered. Moving forwards, a RAP steering group is being formed to oversee the RANZCP's progress towards its RAP goals. Significantly, the steering group will include two ATSIMHC community members, enabling culturally appropriate input at every point of the RAP process.

Conclusion

Aboriginal and Torres Strait Islander Australians have suffered tremendous losses as a legacy of colonial settlement. Reconciliation cannot change the past, but can begin to heal those wounds and provide a vehicle for correcting the inequities that persist and, in some instances, continue to worsen. Reconciliation Australia's RAP programme provides a framework for organisations to contribute to meaningful change, and join the growing body of leadership in Australia to promote reconciliation. The RANZCP has developed its RAP through a multi-tiered consultation process, with Aboriginal and Torres Strait Islander involvement at every level. The challenge ahead will be to transform words into actions, and to celebrate and build on those successes as we continue on this journey of reconciliation.

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THEMATIC PAPER

Reconciliation and psychiatry in South Africa

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Although psychiatrists did not form part of the structures of the South African Truth and Reconciliation Commission (TRC), the Society of Psychiatrists of South Africa (SPSA) at the time did make a submission. Since then, the local association of psychiatrists has been reconstituted as the South African Society of Psychiatrists (SASOP). Psychiatry and psychiatrists may have to extend their activities beyond rehabilitation and restoration, to include endeavours to prevent future violations of human rights.

Truth and reconciliation in South Africa

The South African Truth and Reconciliation Commission (TRC) undertook its work from 1996 to 1998 with the mandate to recommend measures 'to prevent future violations of human rights' and in relation 'to rehabilitating and restoring the human and civil dignity of victims'. The chair, Archbishop Emeritus Desmond Tutu, submitted his report in October 1998:

> It is not and cannot be the whole story; but it provides a perspective on the truth about a past that is more extensive and more complex than any one commission, in two and a half years, could hope to capture. (TRC, 1998: vol. 1, ch. 1, p. 1)

Local authors reported extensively at the time on the experiences and meaning of the process (Krog, 1998), followed by others (Du Bois & Du Bois-Pedain, 2009). The addendum to this paper outlines some of the further work done since.

In April 2006, a follow-up congress, 'The TRC: Ten Years On', was organised by the Institute for Justice and Reconciliation, funded by Danish and Flemish donors. It reviewed the TRC's unfinished business at the time (Villa-Vicencio & Du Toit, 2006). Four areas of unfinished business received attention: (1) government decisions regarding the prosecution of those who either were denied amnesty or refused to apply for it; (2) reparations for those found by the TRC to be victims of gross violations of human rights; (3) access to the TRC archives; and (4) national reconciliation.

In terms of the prosecution and reparation that affected the South African medical fraternity in particular, it is surely the death of Steve Biko[1] and the position of the Medical Association of South Africa (MASA) during apartheid that should be recalled (Rubenstein & London, 2001), as well as the case of the physician Wouter Basson, former head of the apartheid chemical and biological weapons programme ('Project Coast'). While Basson was acquitted in 2002 of criminal charges, and appeals to this ruling were dismissed by the Supreme Court of Appeal and the Constitutional Court in 2005, the Health Professions Council of South Africa (HPCSA) in December 2013 found him guilty of unethical conduct (*Mail & Guardian*, 2013). His sentencing procedure started in November 2014, but was postponed to 2015.

In terms of the unfinished business of national reconciliation, it can be noted that the death of Nelson Mandela in December 2013 afforded an opportunity for informal review and contemplation of our progress as a nation on this road 20 years later, with a fairly general realisation that reconciliation, transformation and integration have not been completed, or, in some instances, not even been undertaken yet.

Psychiatry's previous participation

While no psychiatrists were included in the different activities of the TRC, the then Society of Psychiatrists of South Africa (SPSA) did submit a formal report (available from the author on request; see also TRC, 1998: vol. 4, ch. 5, p. 142). The report provided an overview of the history of the SPSA since its formation in the early 1950s and alluded to visits and/or reports by the World Health Organization (WHO, 1977, 1981), American Psychiatric Association (APA, 1979), American Association for the Advancement of Science (AAAS, 1990), Royal College of Psychiatrists (RCPsych, 1983), as well as to the SPSA's reply to the World Psychiatric Association (WPA) in response to calls for its expulsion (Jablensky, 1978). The SPSA subsequently established a Human Rights Subcommittee in 1986, while its TRC submission pointed to several statements, resolutions and press releases issued from 1986 to 1989 and in 1995.

Emsley (2001) reported on the state of psychiatry and mental healthcare in South Africa at the time, and Stein *et al* (2008) published findings on the relation between psychiatric status and forgiveness

1. Steve Biko, a medical doctor, anti-apartheid activist and founder of the Black Consciousness Movement, was arrested and interrogated in Port Elizabeth in August 1977 by South African Security Police, which included torture and beatings resulting in a coma. On 11 September he was transported in the back of a vehicle on a 1100 km journey to Pretoria, where he died in prison on 12 September 1977.

among survivors of human rights abuses, and on the impact of the TRC on psychological distress and forgiveness (Kaminer *et al*, 2001). Stein's group was also responsible for the first, and to date only, large-scale population-based study of common mental health disorders in the country, the South African Stress and Health (SASH) study (Heeringa *et al*, 2009), which was recently quoted by a local media report that highlighted the ongoing generally poor state of mental healthcare in South Africa (*Sunday Times*, 2014). The SASH study formed part of the WHO's World Mental Health initiative and was placed within the historical context of early post-apartheid South Africa, where communities were sharply divided (and indeed still are).

Truth and reconciliation elsewhere

As described in the thematic paper by Jason Lee in this issue, a recent encouraging example of a body of psychiatrists involving themselves actively with a local process of reconciliation is the innovative initiative of the Royal Australian and New Zealand College of Psychiatrists on reconciliation with the Aboriginal and Torres Strait Islander people (RANZCP, 2011, 2014). Its 2014–16 Action Plan, with measurable outcomes, includes: building relationships; respect and value for culture and history; and providing opportunities for trainees and members to engage and build cultural competency skills. It must also be noted that the WPA Action Plan for 2014–17 includes refugees and asylum seekers in prioritised action to promote the mental health of the most vulnerable of population groups (Bhugra, 2014).

Psychiatry's required participation

It can be noted that the local association of psychiatrists has, since the conclusion of the TRC's activities, been reconstituted in its entirety. Since 2008 it has existed as the South African Society of Psychiatrists (SASOP), with a current memorandum of incorporation as a non-profit, membership-driven, private company and, as such, is not cast in any way as a statutory body of the state. The SASOP has adopted objectives such as to promote and uphold the principles of human rights, dignity and ethics in the practice of psychiatry, and to oppose unfair discrimination in the field of psychiatry. It has around 600 members, of a total of about 700 psychiatrists serving a population of some 50 million. There are currently also several South African psychiatrists in other countries, such as the UK, Australia and Canada.

Considering the above and the original mandate of the TRC it seems important that current involvement in reconciliation should go beyond dealing only with the consequences of conflicts after many years and much destruction (rehabilitation and restoring), to actively seeking 'to prevent future violations of human rights'. This may require a significant shift in psychiatry's current thinking, to move beyond its traditional scope of biological practice and intervening only in terms of neurochemical and subsequent clinical results of stress- and trauma-related anxiety, mood or substance disorders. Psychiatry may have to consider pre-emptive social interventions and involvement in social issues and political conflicts, in order to avert the devastating results of already escalated conflicts. Should psychiatry and psychiatrists involve themselves in military conflict management and resolution, as in Ukraine, Syria, Iraq and Afghanistan? Should they involve themselves in the pervasive reality of international human trafficking (United Nations, 2014)? Or in resisting abusive legislation regarding homosexuality in Uganda (Ugandan Government, 2009)?

Many national associations like the SASOP, however, are, constitutionally, small, voluntary, non-profit, private enterprises that, at best, have achieved some strategic space to offer comments and statements as non-governmental organisations. Although the SASOP has created divisions and task teams to engage in the protection of human rights and prevention of stigma and discrimination, its challenge will remain to position itself more strategically and to adopt a broader social role than it has so far occupied, despite the discourse becoming progressively less psychiatric and more social-political (Robertson & Walter, 2011).

Conclusion

The South African experience (the SPSA during the 1970s and 1980s) seems to suggest that the review of national psychiatric associations in countries where conflicts with potential human rights abuses may occur should probably be ongoing. Such scrutiny may be the role of the WPA and of collective bodies of associations, such as the European Psychiatric Association (EPA), the Asian Federation of Psychiatric Associations (AFPA) or a future African association of psychiatric associations. The aim should be not only to strengthen and assist national associations to formulate position statements, strategies and actions, but also to engage them on their own positions and actions regarding such challenging local scenarios.

In this regard it can be noted that the SASOP will be co-hosting a WPA International Congress in Cape Town in November 2016, which should be an opportunity to address what aspects of reconciliation, transformation and integration of our communities and of our clinical practice have not been completed or, in some instances, not even undertaken yet. The theme of the Congress will be 'Psychiatry: Integrative Care for the Community' and it will explore concepts, controversies and consequences of psychiatry's responsibility and accountability to society in terms of its scope of practice and of what can be considered psychiatry's social contract.[2]

2. 'Transformation also includes reconciliation and creating a nation united in the rich diversity of communities previously forced apart.' Nelson Mandela, State of the Nation Address, South African Parliament, 10 February 1999.

Addendum

Memory and reconciliation

One response to enduring trauma, stress and loss incurred from conflicts and human rights abuses is its processing through ceremony, rituals and commemoration. The Freedom Park in Pretoria was established in 2002 as an expression and direct continuation of the processes of the TRC (http://www.freedompark.co.za). The site now includes a sacred ceremonial space in a garden of remembrance, a museum and exhibition space, and a Wall of Names of victims of the main eight South African conflicts over past centuries – the pre-colonial wars, slavery, genocide, wars of resistance, the South African (Anglo-Boer) War and the First and Second World Wars and the liberation struggle. Following the notion of Chidester (2006), the site has been promoted to use African cleansing and healing ceremonies described by the Freedom Park Trust as 'strategic interventions in the quest for symbolic reparation of the nation'. The site is also required and expected to restore indigenous African forms of spirituality – the Freedom Park Trust says 'to follow [the nation's] liberation also from colonial spirituality', which was mainly religious and Christian in nature (Freedom Park Trust, undated).

Another public institution that can be cited in this regard is the inclusion of 16 December in the South African public holiday calendar as national Reconciliation Day.

Reconciliation components

Literature and TRC documentation allude to several components of reconciliation, such as: truth telling; forgiveness; remorse; restitution; justice; memory and remembrance; as well as restorative action and transcendence through spiritual/religious or other means. These components eventually form part of history and even subsequent myth making, while all these have to find crucial expression in different art forms, whether in writing, visual arts, dance or music. Allais (2008a) considered the role and meaning of forgiveness in a philosophical sense. She also developed an account of forgiveness which allows that the TRC did not require forgiveness for its process to work, but that victims who offered forgiveness for atrocities were not making a moral mistake, even if they did this in the absence of repentance of the wrongdoer (Allais, 2008b). These philosophical contributions demonstrate how academic disciplines, including psychiatry, can and should include components of reconciliation in their scope of attention and practice.

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THEMATIC PAPER

Reconciliation in Northern Ireland: the value of inter-group contact

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Northern Ireland is still riven by segregation, caught between peace and reconciliation. Extensive survey research shows that inter-group contact has a key role to play in achieving reconciliation, whether through generic contact, cross-group friends (most effective) or indirect. Segregation is most profound in education. The new Shared Education Programme (SEP), which provides children with the opportunity to study with and meet pupils from the other community, has demonstrated benefits. The Northern Ireland Assembly's support for SEP is based on sound psychological principles and robust research evidence.

> We must never forget those who have died or been injured, and their families. But we can best honour them through a fresh start, in which we firmly dedicate ourselves to the achievement of reconciliation, tolerance, and mutual trust. (Article 2 of the Belfast [Good Friday] Agreement, signed 10 April 1998)

The Belfast Agreement of 1998 marked the beginning of a comparatively peaceful period in Northern Ireland's troubled history after three decades of sectarian violence between groups associated with the main Catholic and Protestant communities. After 1969, over 3600 people were killed in 'The Troubles', and more than half of the population knows someone injured or killed as a direct result of sectarianism. In the 17 years since the signing of the Belfast Agreement, violent conflict has reduced significantly and life in the region has gained a normalcy that could not have been imagined during the worst years of the conflict. However, although the killing has largely ceased, Northern Ireland remains a deeply divided society and nowhere is this more apparent than in education. Northern Ireland still has to move beyond 'peace' (or the absence of war) to 'reconciliation' (when members of previously hostile groups come to mutual acceptance based on trust and respect). Emphasis has long been placed on promoting inter-group contact between Catholics and Protestants. We highlight the importance of this mixing, which has a demonstrable impact on attitudes, trust and even forgiveness. We then focus specifically on mixing in educational settings, which we see as fundamental for reconciliation.

Inter-group contact

We first explore the evidence in support of the prejudice-reducing effects of direct, face-to-face inter-group contact, and then turn to extended contact (an indirect form of contact). We consider the impact of contact on outgroup *attitudes*, *trust* and *forgiveness*.

Direct contact

Given that extensive segregation still pervades all aspects of Northern Irish society (Hewstone *et al*, 2005), positive contact with members of the other community should provide a means of reducing inter-group anxiety (anxiety about mixing with the outgroup), overcoming stereotypes and promoting more positive outgroup attitudes. We have demonstrated this in numerous studies, using both cross-sectional and longitudinal survey designs, with both university students and members of the general public as respondents (e.g. Paolini *et al*, 2004; Tausch *et al*, 2010). We have also shown longitudinally, using a large sample of respondents drawn at random from four areas of Belfast, that those who have more cross-group friendships at baseline will be more likely to trust outgroup members 1 year later than will those with fewer or no such friendships (Kenworthy *et al*, 2015); there was no evidence that those high in initial trust were more likely to seek cross-group friendships.

If generic contact can reduce prejudice, then it is unsurprising that having cross-group friends is particularly effective. Paolini *et al* (2004) found that having cross-group friends was associated with reduced inter-group anxiety in samples of both students (study 1) and adults in the general population (study 2); contact exerted its effect on attitudes, in part, via reduced anxiety. Kenworthy *et al* (2015) also showed that cross-group friendship in a large random sample predicted inter-group emotions and trust via more intimate self-disclosure (sharing personal information about oneself).

Our research has also shown that inter-group contact is associated with greater forgiveness, even among respondents from a national sample who had personally been affected by inter-group violence (Voci *et al*, 2015), and that forgiveness is negatively related to mild psychiatric morbidity (Myers *et al*, 2009).

Extended contact

Direct (face-to-face) contact can improve inter-group relations only if people have the opportunity to engage in it. If people do not live in the same neighbourhood, attend the same school, or occupy the same workplace as outgroup members, they are unlikely to come into contact with them, let alone develop friendships with them – hence the value of extended contact, an indirect form of contact that refers to the knowledge that an individual has

of an ingroup member's direct contact with outgroup members (here, whether a Catholic knows fellow Catholics who have Protestant friends, or vice versa). Paolini *et al* (2004) asked their participants to report the number of ingroup friends they had who had cross-group friends. Extended cross-group friendship was associated with lower levels of outgroup prejudice (controlling for direct contact), a relationship that was due to a significant reduction in inter-group anxiety.

It might be thought that cross-group friendships will be relatively rare, thus limiting the potential for extended contact. However, Tausch *et al* (2011) examined the effects of extended contact via different types of ingroup contacts (neighbours, work colleagues, friends and family members). As expected, extended contact via more intimate ingroup relationships (i.e. friends and family) was more strongly related to outgroup trust than was extended contact via less intimate ingroup relations (i.e. neighbours and work colleagues). But we also found that within each level of intimacy, extended contact was related to outgroup trust only at high levels of rated closeness to ingroup contacts.

Finally, we have found that the negative relationship between extended cross-group friendship and prejudice is consistently stronger for participants with few direct cross-group friends or who live in segregated rather than mixed neighbourhoods (Christ *et al*, 2010). Christ *et al* found that extended contact at baseline increased participants' inclination to help outgroup members 1 year later, and this effect of extended contact was amplified for participants who had little experience of direct contact with outgroup members.

Education

We cannot identify school segregation as a cause of sectarianism, but the mere fact of separate education allows prejudice and stereotypes to flourish. While both communities appear to support this school system, in surveys the majority of the population claim they would support integrated education or would, at least, like to see some mixing between pupils from different schools. How is this best done?

Segregated versus integrated education

It is estimated that around 94% of primary and post-primary pupils from the main Catholic and Protestant communities are educated in schools that are predominantly 'own' religion. Dating back to the late 1970s, and until recently, the only schools-based means of promoting contact has been via integrated schools (of which there are today 62, across primary and secondary sectors, accounting for around 5% of overall provision). Research has typically found that integrated education promotes more harmonious relations (Stringer *et al*, 2009). But do schools have to be specially designed integrated schools to promote reconciliation, or does simply attending a standard state school that has, by chance rather than design, become mixed do some good?

We have begun to answer this question with a 5-year longitudinal survey of children attending Catholic, Protestant or integrated schools (Hughes *et al*, 2013). So far, we have reported only on the data from wave 1, based on 51 schools that agreed to take part, and a final sample of 3565 students (2422 Catholics, mean age 12.36 years; 1143 Protestants, mean age 12.34 years). We found, first, that children attending integrated schools generally had more contact and warmer outgroup attitudes than children in Protestant and Catholic schools. In addition, children attending Protestant schools scored higher on measures of contact and attitude than children attending Catholic schools. In exploring possible reasons for these results, we found that the mix of the student body seems to be the most important factor in promoting more positive cross-group relations, rather than the specific type of school attended. Future analyses with additional waves of data will provide a more rigorous analysis of whether attitudes change over time and, if so, how.

Shared education

Launched in 2007, the Shared Education Programme (SEP) seeks to offer Catholic and Protestant pupils from the different school sectors the opportunity for sustained, curriculum-based contact that can help bring about a more cohesive society (Hughes *et al*, 2012) (see http://www.schoolsworkingtogether.co.uk).

Rather than emphasising reconciliation objectives, SEP encourages participating schools to devise projects that target other shared educational priorities. In practice, this often means that collaborating schools will agree to offer non-compulsory subject choices at one or other school, and that all children wishing to take these subjects for national exam-based courses will attend the relevant school for classes. As SEP does not require structural change in the school system, it has the advantage of appealing to parents who wish to educate their children within a particular faith tradition, but may also want their children to have some experience of mixing with the other community. SEP offers an alternative for those who are happy for their children to mix with others at school but who also cherish and want to protect a uniquely separate school type.

Within SEP, contact occurs over repeated occasions, across a school year, and provides an experience of direct contact for those involved, and an indirect contact experience for those who themselves do not participate but who have friends who do. Does it work? Hughes *et al* (2012) reported an initial evaluation of the impact of participation in SEP based on 577 students from 14 schools in Northern Ireland between the ages of 12 and 18 (264 Catholics, 313 Protestants; 162 participants involved in SEP, 415 students not). We measured whether a range of outcomes (outgroup attitudes, positive action tendencies and outgroup trust) were affected via, first, inter-group contact (cross-group friendships) and, second, inter-group anxiety. We

found that being in a school that is involved in SEP promoted more positive outgroup orientations by increasing outgroup friendships and reducing inter-group anxiety. These results remained significant even after controlling for respondents' religious community, age, gender and whether or not they were involved in other collaborative activities.

Conclusion

Inter-group contact has a key role to play in promoting reconciliation in Northern Ireland. This contact will be most effective in the form of close friendships with members of the other community, but indirect forms of contact are also effective. Segregation in education will sustain division in society unless interventions such as SEP become widespread, providing each child with the opportunity to meet pupils from the other community. The Northern Ireland Assembly has now passed a motion in support of prioritising shared education (Northern Ireland Executive, 2011). This policy is based on sound psychological principles and robust research evidence.

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MENTAL HEALTH LAW PROFILES

Mental health law profiles

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The states of Iran and the United Arab Emirates (UAE), both rich in natural resources, face each other across the Persian Gulf and come closest geographically at the highly strategic straits of Hormuz. Iran enjoys an exceptionally rich historical heritage, as one of the earliest centres of civilisation and political authority in the world and including having been the seat of power of two empires that were the largest in their times. The Abbasid Caliphate in particular reigned strong at the centre during the golden age of Arab science (Al-Khalili, 2012). Today, Iran is an Islamic Republic. UAE is a young federation of seven absolute hereditary monarchies.

As the authors of the two mental health law profiles in this issue report, in both Iran and the UAE recognition of the human rights of people with mental illness remain inadequately defined and protected in law. Gender differences in mental health in the Middle East (Ghuloum, 2013) highlight the need for the law to protect women with suspected or confirmed mental health problems from unfair and harmful approaches to evaluation and management due to patriarchal prejudices. This is something that the dependence on families for decision-making and care may make difficult at times. In Iran, where in addition to civil and criminal courts there are revolutionary and special clerical courts, it must be ensured that patients' rights are protected across the whole range of courts. The fact that the vast majority of the resident population in the UAE are immigrant workers (Zahid, 2014) underscores the need for specific attention to be paid to their needs in mental health legislation as well as service provision. International anxiety is particularly high at present about the health of immigrants in the member states of the Gulf Cooperation Council.

It is encouraging that in both Iran and the UAE efforts are being made to create mental health law in the light of international norms. Such laws, however, need to safeguard patients' access to a range of legitimate professional perspectives on mental illness, not limited to that of doctors. The family and police are no substitute for social work, psychology, occupational therapy and nursing inputs during the application of the law. This is particularly the case when considering or reviewing compulsory detention and the application of intrusive treatments such as electroconvulsive therapy. To create adequate safeguards, the voices of mental health services users themselves must be heard as well. The two papers published here do not provide full assurance in relation to such requirements, although the ongoing process of drafting and enacting legislation should provide opportunities to ensure that legitimate expectations are met. Any deficit in meeting such legitimate expectations would be a cause of concern to the international psychiatric community.

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MENTAL HEALTH LAW PROFILE

Development of mental health law in Iran: work in progress

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A brief account of the three stages of development of a new mental health law in Iran is given. At each stage, the expert opinions of mental health professionals and lawyers interested in the rights of psychiatric patients were obtained. The final draft of the law consists of six sections and 50 articles. It has been submitted for ratification by Parliament.

At present, Iran has no laws that specifically address mental health. However, the civil law, the Islamic penal code, a jurisdiction act, a set of safeguarding measures from 1960, family protection law and a law permitting payment of wages to psychiatric patients do help to protect different aspects of the rights of psychiatric patients (Hojjati-Ashrafi, 1990; Jafarzadeh, 1996; Asgharzadeh-Amin & Shahmohammadi, 2004). Also, under the existing laws, the care of patients who are considered to have a mental health disability, as with people who have a physical disability, is the responsibility of the state's Welfare Organisation. In these laws, terms such as 'insanity', 'idiot', 'insane' and 'senile' are used. These terms do not have clear scientific definitions and there is no agreement among authorities in the field regarding their precise use (Tofighi, 1996).

Currently, there are some 7500 psychiatric beds scattered throughout the country. There are about 1300 psychiatrists and 5000 psychologists in Iran. There are in addition social workers, psychiatric nurses and related specialists. Due to the absence of a mental health law, the rights of psychiatric patients have been disregarded. Violation of their rights becomes more evident at the time of involuntary hospitalisation. Fortunately, the expansion of mental health services has raised public and official awareness of patients' rights and the need to develop mental health law.

Drafting the mental health law

In 2003, based on a suggestion from the Ministry of Health, a special committee of university professors was formed to draft the mental health law at Tehran Psychiatric Institute (the authors prefer 'Tehran, Institute of Psychiatry', but this has been much less used internationally).

The committee first reviewed the literature regarding mental health laws in both Western and Islamic countries (Segal, 1989; Mane & Gandevia, 1993; Wall *et al*, 1999; World Health Organization, 2006a,b, 2008). Then, based on the cultural considerations and existing legislation, and taking into account the recommendations of the World Health Organization (2003a,b) regarding the development of mental health legislation, a draft law was prepared. In order to obtain expert and stakeholder opinion, the draft was sent to 35 organisations, research centres, scientific associations, psychiatric

and clinical psychology departments, private hospitals in the city of Tehran, and one non-governmental organisation (the Iranian Society for Supporting Patients with Schizophrenia), and their suggestions were received.

In the following three stages, the draft was modified and the final document was prepared.

Stage I: national workshop

The initial draft, along with the comments and suggestions of the experts and stakeholders, was presented in a 2-day workshop, which was attended by more than 50 professionals, including psychiatrists, clinical psychologists, psychosocial workers, authorities in the field, university professors, and officials from the Ministry of Health. At the end of the second day, after extensive review, the final draft was prepared.

Stage II: review by a joint committee

In the second stage, the next draft was given to a joint committee of three representatives of the initial committee and three lawyers familiar with mental health issues in order to rewrite it as a legislative document, so that it could be presented to Parliament. The committee rewrote the draft as a legal Act. This demanding work took 47 sessions of 4 hours each.

The document was then sent to a number of lawyers, mental health professionals, judicial and legal officials. Afterwards, the comments and suggestions were reviewed at another national workshop attended by lawyers, mental health experts and a number of relevant authorities, and modifications were made if they were endorsed by the majority.

This version of the draft Act comprised 10 sections and 112 articles. It was sent to the Ministry of Health.

Stage III: Ministry of Health review

The Ministry authorities indicated that the draft should be condensed in order to facilitate its ratification by Parliament. This was done in several sessions with representatives of the law office of the Ministry and a number of the members of the joint committee. However, the original content of the draft was preserved.

This final draft of the Act comprises one introductory article and six sections with a further 49 articles in total.

Content of the law

Section 1. Definitions

In this section, all of the terms and phrases used in the Mental Health Act are defined. This chapter contains one article and 18 clauses. As an example, the definition of 'severe mental disorder' is:

> A state which is manifested by a transient or persistent severe destruction of most mental functions of the individual with at least one of the following symptoms or signs being present: delusions, hallucinations, severe formal thought disorder, severe mood disorder, severe cognitive disorder and behaviours which signify any of the above symptoms.

Section 2. Compulsory hospitalisation and treatment

In this section, the conditions and criteria for mandatory hospitalisation and treatment are addressed. For compulsory hospitalisation of an individual with severe mental illness, the presence of serious risks of harm to self or others together with signs of persistent and severe mental illness is required. For compulsory hospitalisation, the consensus of two psychiatrists is necessary. If compulsory hospitalisation is indicated, a forensic physician has to evaluate the patient within 1 week of hospitalisation and approve the continuation of compulsory hospitalisation for a maximum of 2 months. In Iran, forensic physicians are medical officers who specialise in the forensic aspects of medicine, and they are not responsible for the treatment of patients. The extension of subsequent 2-month periods of involuntary hospitalisation requires the same steps.

This section consists of 11 articles.

Section 3. Specific treatment techniques

In this section, compulsory community-based treatment, compulsory electroconvulsive therapy (ECT), physical restraint and physical isolation are addressed and the conditions and procedures for their implementation are described.

In order to protect the rights of patients, stringent restrictions have been imposed on such actions. For example, for administering involuntary ECT, recommendation by the treating psychiatrist, endorsement of another psychiatrist and confirmation by the psychiatric commission of the hospital is mandatory. That body comprises two psychiatrists appointed by the hospital superintendent and a forensic physician.

Physical restraint and seclusion can be done only with the approval of the treating psychiatrist and by specially trained and authorised staff. The maximum duration of seclusion for individuals under the age of 15 is 2 hours and for others is 4 hours. Such procedures can be repeated only once during each period of hospitalisation.

These measures are to be used strictly to prevent patients from harming themselves or others, interfering with a treatment programme or damaging property. Use of these procedures as a means of punishing the individual or because of staff shortage or insufficient resources is prohibited.

This section consists of seven articles.

Section 4. Prisoners (accused or convicted) with a mental disorder

This section concerns prisoners who have a history of any psychiatric illness or who develop a psychiatric illness during trial or while serving their sentences, or who on observation show bizarre behaviour indicating possible psychiatric illness.

The judicial officer has the responsibility of referring the individual to a forensic psychiatrist for evaluation. The forensic psychiatrist must then declare an expert opinion regarding the presence of current or previous mental disorder,

the person's criminal responsibility, the relation between the individual's psychiatric problem and the crime, the person's competency to stand trial, the possibility of deterioration of the individual's condition as a result of enforcement of the judgement, and the availability of psychiatric treatment and regular follow-up.

This section consists of six articles.

Section 5. Special groups

This section relates to children and adolescents, elderly people and those who are not capable of making decisions regarding their affairs. It has four articles.

Section 6. Other rules

In this section, the responsibilities of both the judiciary and the executive (including the Ministry of Health, the Welfare Organisation and insurance companies) to psychiatric patients are addressed. This section comprises 20 articles.

Discussion

The new draft Mental Health Act in Iran has been prepared in collaboration with the departments of psychiatry and clinical psychology of most medical schools in the country and the Iranian Psychiatric Association. Due to the practical nature of the law, one expects many of the current problems facing patients, carers and members of staff to be resolved after the Act is ratified.

The Bill is presently at the Ministry of Health, but is due to be submitted to Parliament. The next stage will be to educate and prepare guidelines for patients and carers. We hope we achieve our objectives in the near future.

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MENTAL HEALTH LAW PROFILE

Mental health law profile: the United Arab Emirates

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There are two federal laws in the UAE from 1981 that are specific to people with mental illnesses and disabilities. Efforts are presently being made to develop other laws addressing the protection of the vulnerable population, including women, children and the elderly. A new updated Mental Health Act is needed to keep in line with the UAE's major leaps achieved in healthcare.

The United Arab Emirates (UAE) was established on 2 December 1971 as a federation of seven emirate states (Abu Dhabi, Dubai, Sharjah, Ajman, Umm al-Qaiwain, Fujairah and Ras al-Khaimah). The constitution of the UAE defines the division of powers between the federal and the local authorities. The highest authority in the country is the Supreme Council of the Federation, which consists of the rulers of all seven emirates. The Council elected the first President of the Federation (the late Sheikh Zayed Al Nahyan). In 1981 the President signed one federal law relating to mental illness (Federal Law 28) and another relating to mental disability (Federal Law 29). These laws (together with related professional codes of conduct) remain the principal legislation specific to mental health. Regulations were later developed with relevance to mental health as part of the general Medical Code of Ethics for health services. In 2008 an updated federal law on medical responsibility dealt with medical malpractice.

Federal mental health laws

Federal Law 28 (1981) concerning the detention and treatment of people with a mental disorder

This Law consists of 15 articles. It covers all aspects of involuntary detention in medical facilities. The ground for compulsion emphasises the presence of psychosis alone or in combination with any other mental disorder, intellectual disability or personality disorder, as long as it is 'accompanied by loss of contact with reality'. The legal age of consent to treatment was determined to be 18 years. The decision to detain a patient is made by a clinical evaluation board composed of the head of the psychiatry department and at least two specialist psychiatrists or neurologists (although it is no longer considered appropriate for neurologists to make decisions regarding the detention of psychiatric patients). Each psychiatric facility is expected to have its own board.

Article 3 describes mental capacity in lay language. It states that voluntary admission of adult patients with psychosis should follow their request, if they are in a state which allows them to express their will; if the age of consent has not been attained, voluntary admission shall be upon the request of the legal custodian.

Article 4 determines the grounds for compulsory detention. If it seems that a person has a psychosis and is likely to violate security or public order or cause serious bodily harm to self or another, detention shall be upon an order from the police or the judicial authority (a court). The patient's relatives may ask the authority to adopt detention procedures. Those eligible are specified as relatives of first degree or next of kin. In the event of their absence, the head of the tribe or his deputy or the police may initiate the procedure.

Article 5 indicates that in the event of compulsory detention the board must decide within 48 hours whether the patient's state genuinely requires his or her detention. The initial duration of detention must not exceed 1 week. If the board at its discretion after this period deems that the patient is not in a state that allows him or her to leave, it may extend this period, for 1 month at most, although the extension may be repeated. The authority has to be notified of every extension, and the patient's relatives or other party applying for the person's detention may oppose this extension. The board must give its decision within 72 hours and this decision is irrevocable.

Article 6 requires the psychiatric facility to notify the judicial authority of a patient's compulsory detention within 48 hours, in order to begin the process of dealing with the patient's assets.

Article 12 indicates that if his or her mental condition requires the patient to have special custody, the facility may resort to the assistance of the police to provide it.

Similar to other countries in the region, the family is typically the primary support network for patients (Ikkos, 2013) and is involved in decision-making about the continuation or discontinuation of involuntary procedures.

Federal Law 29 (1981) concerning the rights of people with mental disability

This elaborate law consists of nine articles that define disability and outline the guarantees for the rights of individuals with temporary and permanent disabilities. Its definition includes any person with reduced mental, interactive, educational or psychological capacity. It defines discrimination and guarantees the rights of people with disabilities to receive all the services they need. It requires awareness programmes to be run. It prohibits aggression against people with mental disabilities and arbitrary deprivation of their liberty and ensures legal assistance and protection of their medical records and related documents.

Article 7 ensures that people with mental disabilities have the right to freedom of speech and opinion through various means of communication, and to request, receive and transfer information on an equal footing with others. Article 8 ensures the protection of their medical records and personal affairs.

Article 9 requires the establishment of educational and training centres for care, training and rehabilitation in preparation for integration in society. It also provides programmes and training for families on the optimum methods to deal with relatives with a mental disability.

Laws under development with relevance to mental health

There are three important laws relating to mental health currently under development. The first is a federal law concerning mental health (in draft) which consists of 94 articles in 10 chapters. It covers definitions of mental illness, scope, objectives, rights of patients, confidentiality, types of admission, grounds for detention and treatment in a mental hospital. It identifies the balance between protecting the public and protecting the human rights of the patient. Relationships with the authorities (e.g. the police) and oversight responsibilities are covered in Chapter 6. In Chapter 7 the new law describes involuntary non-in-patient therapy (compulsory home-based or community-based treatment). Chapter 8 includes guidelines on the management of patients (including minors) with a mental illness. The family will continue to play a prominent role in treatment decisions but social workers will take on responsibilities in support of the family, which should ease the burden on relatives. The proposed law is consistent with recommendations from the World Health Organization's Eastern Mediterranean Region (Abou-Saleh, 2012).

The second proposed federal law is to protect elderly people and is designed to mainstream elderly care across the seven emirates and to address medical insurance, negligence and abuse.

The third is a child protection law, known as the 'Wadima Law', so named after an 8-year-old

Box 1. Provisions for mental health outside the specific legislation

- Constitutional guarantees of the promotion of human rights
- Federal Act 43 of 1992 for the right to healthcare for all citizens
- Constitutional article 19, concerning the rights of incarcerated persons to healthcare (1971)
- Federal Anti-Human Trafficking Act 51 of 2006 to combat human trafficking offences and various forms of exploitation of human beings, particularly women and children
- International Convention on the Elimination of All Forms of Racial Discrimination (1974)
- The Convention on the Rights of the Child (1997)
- The Convention on the Elimination of All Forms of Discrimination Against Women (2004)
- The Geneva Convention on international humanitarian law (1972)
- Cooperation agreement with UNICEF in 2005 to provide for the social and psychological rehabilitation, repatriation and local integration of child camel jockeys

Source: Working Group on the Universal Periodic Review (2008).

Emirati girl who died from abuse and torture suffered at the hands of her father and his partner, a crime that shocked Emirati society. In November 2012, the draft law was approved by the Cabinet. Its 72 articles cover all children's rights guaranteed by international conventions, the rules of Islamic law (Sharia) and the principles of the Emirati Constitution. It will ensure children's physical, ethical and psychological safety.

Other laws with provisions for mental health

The numerous constitutional guarantees of the promotion of human rights and guarantees in international treaties and programmes as they relate to the UAE are detailed in Box 1.

Discussion

The UAE's present mental health law regulates compulsory admissions to mental health facilities. However, there is currently no unified procedure for its consistent implementation. The language of the law needs to be updated to incorporate modern, internationally used terminology (e.g. the term 'legal guardian' instead of 'legal custodian', 'interpersonal' instead of 'interactive'). A new comprehensive draft Federal Mental Health Act is in its final review and approval stages. The hope is to produce consistent and sustainable changes in mental health practices throughout the UAE.

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SPECIAL PAPER

Mental health and psychosocial support for children in areas of armed conflict: call for a systems approach

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This paper focuses on the question of whether separate attention to children who have faced specific conflict-related events is justified, or whether the scarce resources for mental health should be spent on the development of services for children more broadly in low- and middle-income countries (where most contemporary armed conflicts are taking place). It is argued that a systems approach to mental health and psychosocial support for children is warranted.

Mental health problems affect 10–20% of children and adolescents worldwide (Kieling *et al*, 2011). Especially in low- and middle-income countries (LMICs), there is a substantial gap in the available resources to meet the mental health needs of children (Belfer, 2008). Among these LMICs, there are currently 23 countries where armed conflict results in grave acts committed against children (United Nations, 2014). Armed conflicts have a negative impact on the mental health and psychosocial well-being of individuals, including psychological distress and mental disorders, as well as negative impacts on the families and communities in which children grow up (Barenbaum *et al*, 2004).

In response, psychosocial and mental health interventions for children affected by armed conflict have been developed. Types of interventions vary widely, with respect to both aim (from promotion, prevention and treatment approaches) and modality (spanning creative and recreational group activities; dance and movement therapy; parental support; individual psychotherapy) (Jordans *et al*, 2009b). School-based interventions are most often represented in the literature

(Betancourt *et al*, 2013). Research on resilience in children and adolescents affected by armed conflict converges on the importance of supports across socio-ecological levels, of which parental support and parental monitoring are most consistently associated with desired mental health outcomes (Tol *et al*, 2013b). Recent years have seen a rise in the number of trials for interventions targeting young people in humanitarian settings, but the evidence base is still weak, with mixed results (Tol *et al*, 2011).

Given the range of potential stressors that children in areas of armed conflict in LMICs are exposed to, a pertinent question is whether separate attention to children who have faced specific conflict-related events is justified, or whether the scarce resources for mental health should be spent on the development of services for children more broadly in LMICs (where most contemporary armed conflicts are taking place). This paper focuses on this question, starting with giving arguments for and against such special attention.

Whether and how to target services

The most compelling and most straightforward reason to argue in favour for services specific to conflict-affected children concerns their increased risk of mental health problems as a result of the exposure to violence. Studies suggest there are higher prevalence rates of mental disorders among children exposed to conflict compared with the general population, including post-traumatic stress disorder, anxiety and depression (Kohrt *et al*, 2008; Attanayake *et al*, 2009). In addition, exposure to violence affects children's views of the world, their social networks and relationships, and family functioning (Stichick, 2001; Williams, 2006). Furthermore, one could argue that precisely because of the limited resources it is better to target a smaller at-risk group rather than watering down resources by spreading them over the entire population. This pragmatic argument is based on the notion that a well defined sub-population is easier to cover. In addition, because of the obvious urgency of needs, funding specifically for children affected by armed conflict is commonly more readily available. Finally, psychotherapies targeting traumatic stress are among the few in LMICs that have a relatively strong evidence base.

On the other hand, there are many groups vulnerable to higher rates of mental health problems (e.g. children in caregiver roles; children facing child abuse and neglect; trafficked children; children with chronic physical illnesses or disabilities). Instead of focused attention on one group, a population-wide mental healthcare system can encompass multiple vulnerable groups – rather than having them compete for the scarce resources. Also, the simple argument that mental health problems are present in any child population, regardless of the presence or absence of armed conflict, supports such a broad approach. An additional argument for broader targeting comes from epidemiological research. Recent studies with conflict-affected populations have shown the importance of chronic daily stressors for mental health that most children in all LMICs are exposed to (i.e. poverty, social exclusion, domestic violence), in addition to past exposure to specific conflict events (Betancourt *et al*, 2010; Miller & Rasmussen, 2010; Jordans *et al*, 2012). Such data further complicate tough questions on targeting.

Maybe the more appropriate question is how these two positions can be combined. A two-pronged approach that works towards a population-wide mental healthcare system, within which the special needs of conflict-affected children are explicitly addressed, may reconcile these positions. This principle, also called *proportionate universalism*, entails that actions to support mental health should be universal yet calibrated proportionally to the level of vulnerability, because an exclusive focus on the most vulnerable will fail to receive the support of the whole population. An exclusive focus on one group will also fail to reduce the magnitude of social determinants of mental ill-health, which are felt across a gradient of vulnerability (World Health Organization & Calouste Gulbenkian Foundation, 2014). This two-pronged approach should build on the evidence that *is* available, and combine a universal approach geared towards promoting resilience within families and communities (Tol *et al*, 2013b) with more targeted attention to families and individuals with specific vulnerabilities (Jordans *et al*, 2011).

A comprehensive systems-of-care approach

In addition to prevention, such systems should focus on community-based mental health treatments for a range of mental disorders. This is based on the widely advocated idea that the best way to provide population-wide mental health services in LMICs is by integrating them into non-specialised health settings. Evidence-based guidelines have been drawn up that cover a spectrum of psychological and pharmacological treatments (World Health Organization, 2010). Specific attention to violence-affected children can be embedded, for example by including psychological treatments with proven efficacy to deal with post-traumatic stress disorder (e.g. cognitive–behavioural therapy with a trauma focus, eye movement and desensitisation reprocessing) (Catani *et al*, 2009; Betancourt *et al*, 2013; Tol *et al*, 2013a), or by population-based community screening for at-risk children (Jordans *et al*, 2009a).

Merging such approaches into one service-delivery framework is critical in order to address both preventive and treatment needs in humanitarian settings (Inter-Agency Standing Committee, 2007). Promoting resilience at different ecological levels to address long-term damaged social fabric as a result of conflict can be best achieved by targeting locally identified risk and protective factors, at the family, peer-group and community levels (Tol *et al*, 2013b). Families may be particularly relevant for selective preventive interventions, such

as parenting support, whereas schools have been shown to be promising venues for mental health promotion and universal prevention (Barry *et al*, 2013), for example classroom management support for teachers. The integration of mental health within non-specialised healthcare is a possible strategy to make targeted interventions sustainable. Overall, prevention and treatment should take into account a life-course approach that responds to the risk and protective factors for the overall well-being of children in a way that is sensitive to their developmental stage. Armed conflict clearly poses additional stressors for children and their environment, necessitating adjustments at all parts of the spectrum, which include promoting a sense of safety, calming, a sense of self-efficacy and community efficacy, connectedness and hope (Hobfoll *et al*, 2007) (e.g. normalising daily life by re-initiating safe schooling, strengthening parent–child relations, stress management).

Feasibility and sustainability

The comprehensive systems-of-care approach we propose clearly raises questions with regard to feasibility and sustainability. Especially in post-conflict settings where systems are devastated and weak, the development and continuation of a system of care will be challenging. However, this lack of a care infrastructure also provides opportunities. Experience has shown that mental health reform is realistic as part of post-emergency recovery, because of the increased recognition of donors and governments of the importance of mental health in humanitarian settings. Initiatives to (re)build mental health services are successful when they address the broad mental health needs of the population rather than set up vertical programmes (World Health Organization, 2013). This entails that psychosocial and mental health programmes in conflict-affected countries, which are often brief and consist of single-intervention approaches funded outside of existing health and social systems, need to systematically integrate a longer-term perspective into their work and employ multi-level or stepped-care packages with entry points in community and non-specialised healthcare settings (Jordans *et al*, 2009b; Betancourt *et al*, 2013). The feasibility of a multi-layered care system for children has been demonstrated in several conflict-affected settings, with schools as the entry point (Jordans *et al*, 2011). At the healthcare level, task-sharing mental healthcare with primary healthcare workers appears a feasible strategy based on existing studies (van Ginneken *et al*, 2011), also in post-conflict settings (Mendenhall *et al*, 2014).

Calls to widen the focus of treatment to a broader group of mental disorders seem daunting. However, a promising direction in this regard is a trans-diagnostic modular approach, in which different components of evidence-based treatments for specific disorders are combined to cater for a variety of mental health problems (e.g. rather than only addressing post-traumatic stress disorder, especially given the very high comorbidity rates). These different components can subsequently be combined to form the building blocks of a larger care package.

Conclusion

Clearly, this paper is not a call to neglect the potentially devastating impact of ongoing political violence on children in areas of armed conflict. In contrast, we argue that a broader systems approach is better capable of addressing the variety of needs of *both* this group of children and other vulnerable groups in LMICs affected by armed conflict. With millions of children living in areas of war, continued attention to their plight and mental health needs has to continue, and subsequently be channelled to establishing a mental healthcare approach that has the ability to address specific psychosocial sequelae of conflict-affected children and families. This can be achieved within a multi-level system that promotes mental health, prevents mental ill-health and strengthens access to evidence-based treatments in the population at large.

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PANDORA'S BOX

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

BJPsych International – Research Supplement

Pandora is pleased to announce the publication of the first Research Supplement of *BJPsych International* (May 2015), which is available (as is every issue of the journal) for free download at http://www.rcpsych.ac.uk/publications/journals/ipinfo1.aspx.

The journal's mission is to address matters of practical relevance to patients' care with a focus (although not exclusively so) on the mental health needs of low- and middle-income countries as well as the socially excluded in higher-income countries. The Research Supplement covers a wide range of subjects, including service developments, undergraduate training, the use of guidelines from the National Institute for Health and Care Excellence and the World Health Organization's Mental Health Gap Action Programme (mhGAP) in various parts of the world, and an examination of research productivity in Arab countries.

Healthy gut fauna for healthy brain

Have you ever imagined that bacteria living in your gut could have 'conversations' with your brain? The gut microbiome and its role in the function of body and brain have been the focus of research in recent years. S. R. Dash's summary of the evidence on Medscape makes interesting reading. The gut microbiota are established at birth and alterations in their composition appear to play a role in a range of body and brain disorders. There is bidirectional communication between the gut and the brain, which can be direct or indirect, via the enteric nervous system, neurotransmitter modulation, endocrine and immunoinflammatory systems. The gut microbes have been implicated in conditions such as type 2 diabetes, cardiovascular disorders, multiple sclerosis, anxiety and depression. A healthy balanced diet and good lifestyle encouraging growth of the right bacteria, living in harmony in the gut, are the road to good physical and mental health!

S. R. Dash (2015) The microbiome and brain health: what's the connection? Medscape, 24 March.

Precision medicine comes to psychiatry!

Are you disillusioned with successive diagnostic classification systems based on symptom categories? Like other medical disciplines, psychiatry is calling out for 'precision medicine'. Cancer research has led the way, with molecular diagnosis leading to better-defined treatments and improved outcomes. Could this be achieved in psychiatry? Modern biology, in particular cognitive, affective and social neuroscience, are producing new insights and 'mental' disorders are soon to be recognised as 'brain' disorders caused by disruptions to neural, cognitive and behavioural systems.

The National Institute for Mental Health has launched a 'precision medicine for psychiatry' project, the Research Domain Criteria (RDoC) initiative, with the aim of rethinking research into psychopathology. This has gained momentum, with over 1000 papers in the last year and with similar initiatives emerging in Europe, such as the Roadmap for Mental Health Research funded by the European Commission and a call from the European Union's Innovative Medicines Initiative

to link clinical neuropsychiatry with quantitative neurobiology. This does not mean that drugs are the only answer to treatment. Targeted psychological treatments such as cognitive–behavioural therapy can use the brain's capacity for neuroplasticity to remedy or restore communications within neurocircuits in some psychiatric conditions.

Insel, T. R. & Bruce, N. C. (2015) Brain disorders? Precisely. *Science*, **348**, 499. doi: 10.1126/science.aab2358

Brain grey matter and blood groups

We know of some drugs such as lithium increasing brain grey matter but did you know that our own blood group, ABO type, has a major role to play? There is evidence that people with blood group AB have a higher incidence of cognitive deficits. This led researchers to examine possible differences in grey matter volumes between people with blood group O and those with other blood groups; none of the participants had cognitive impairment or neurodegeneration. They found that those with blood group O had larger volumes of grey matter in the posterior ventral portion of the cerebellum (areas responsible for sensorimotor information) as well as in the temporal and limbic regions, including the left hippocampus. These findings point to a neuroprotective role for the blood group O alleles and suggest that blood group types are relevant to the development of the nervous system as well as the ageing process.

De Marco, M. & Vepperi, A. (2015) 'O' blood type is associated with larger grey-matter volumes in the cerebellum. *Brain Research Bulletin*, **116**, 1–6. doi: 10.1016/j.brainresbull.2015.05.005

Mental illness and creativity – is there a link?

The connections between creativity and mental illness were made as far back as ancient Greece and Aristotle, and it has fascinated people for centuries. The authors of this study tried to examine this possible connection using scientific methods. They investigated whether common genetic variants that affect risk for schizophrenia and bipolar disorder also underlie advantageous cognitive traits. They used polygenic scores or cumulative genetic profiles from across the genome and generated separate polygenic risk scores for schizophrenia and bipolar disorder on non-Icelandic populations. They then tested the ability of polygenic scores to predict the corresponding disease in 86 292 people in Iceland and looked for an association between these polygenic scores and creativity. Creativity was defined as individuals belonging to national artistic societies of actors, dancers, musicians, visual artists and writers. Both the schizophrenia and bipolar disorder polygenic risk scores were associated with creativity. The authors conclude that creativity may increase the risk of psychiatric disorder. Nevertheless, in the absence of other important pathogenic factors it is unlikely that our talented artists or writers will experience mental illness.

Power, R. A., *et al* (2015) Polygenic scores for schizophrenia and bipolar disorder predict creativity. *Nature Neuroscience* (online). doi: 10.1038/nn.4040

Stranded and drowned in the Mediterranean – who cares?

Almost daily we hear of boats full of people capsizing on the way to Europe. Italy and Greece are constantly on the alert, fishing out desperate people from overcrowded boats reaching their waters. About 1500 people are thought to have perished in the Mediterranean between January and May 2015. The survivors face an uncertain future. European citizens are facing the biggest test of their humanity and sense of responsibility to the rest of the world. Many European countries need to reflect on their colonial past and more recent involvement in Africa and the Middle East and ponder over how they became so affluent and powerful. With power comes responsibility. Unfortunately, globalisation has failed to decrease the gap between the rich and the poor in the world. It seems to serve the economic interests of the powerful, with no real benefit to those who are weak. Is this a matter for doctors to consider? Pandora welcomes readers' views.

A beautiful mind

It is with great sadness that Pandora reports the death of the famous mathematician John Forbes Nash. His remarkable research has been applied to a number of important areas, including macroeconomics, arms control and political science. He shared the Nobel Prize in Economics in 1994 and was on his way from a ceremony in Oslo, where he had been awarded the 2015 Abel Prize, accompanied by his wife, Alicia de Larde Nash, when their taxi crashed, killing them both, on 23 May. John Nash became more widely known by the film *A Beautiful Mind*, which was based on his life and which portrayed him battling with delusions and hallucinations. However, psychiatric treatment enabled him to continue his high-calibre work despite his illness (schizophrenia). His life shows both doctors and patients that mental illness, even one as serious as schizophrenia, can be controlled (he was treated with powerful antipsychotic drugs) and its presence should not be an end to one's aspirations.

BJPsych International Volume 12 Research Supplement, May 2015

The research Supplement is freely available online at http://www.rcpsych.ac.uk/publications/journals/ipinfo1.aspx. It feature the following papers:

Development of a psychiatric liaison service in Rawalpindi, Pakistan
Ayesha Minhas, Keith G. Bender and Fareed A. Minhas

The effect of aerobic exercise in the maintenance treatment of depression
P. Majumder, I. Sharma, P. Vostanis and C. Bone

Scaling up mental healthcare in the Republic of Niger: priorities for and barriers to service improvement
Alison Hwong, Djibo Maiga Douma, Soumana Zamo and Julian Eaton

Evaluation of undergraduate psychiatry teaching in Malawi
Amy E. Lindsay and Stephen Byers

Hospital doctors' management of psychological problems at a Nigerian tertiary health institution
Baba A. Issa, Abdullahi D. Yussuf, Olatunji A. Abiodun and Ganiyu T. Olanrewaju

Mental health e-supervision for primary care doctors in Sudan using the WHO mhGAP Intervention Guide
Anne Aboaja, Puja Myles and Peter Hughes

The WHO mhGAP Intervention Guide for people with intellectual disability: the Sri Lankan experience
Rohit Gumber, Shweta Gangavati, Sabyasachi Bhaumik, Sherva Cooray, Kiran Purandare, Jayan Mendis and Chamila Abeywickrema

Acceptability and challenges of implementing the NICE guidelines for schizophrenia in Lagos, Nigeria
Adeniran Okewole, Mobolaji Dada, Adefemi Adeoye, Kehinde Lawal and Taiwo Oduguwa

Mental health research in the Arab world: an update
Elie G. Karam and Lynn A. Itani

Forthcoming international events

18–22 September 2016

International Association for Child & Adolescent Psychiatry and Allied Professions World Congress 2016

Calgary, Canada

Website http://www.iacapap2016.org/

The International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP) hosts its World Congress every two years. The mission of the 2016 Congress is to bring together children's mental health professionals to exchange and present scientific research and information for the betterment of child and adolescent mental health globally, nationally and regionally. In addition, the Canadian Academy of Child and Adolescent Psychiatry will hold its 36th annual conference jointly with IACAPAP 2016. The theme of the 2016 Congress is 'Fighting Stigma, Promoting Resiliency and Positive Mental Health'.

18–22 November 2016

World Psychiatric Association International Congress

Cape Town, South Africa

Website http://www.wpacapetown2016.org.za

The Congress theme, 'Psychiatry: Integrative Care for the Community', is intended to explore concepts, controversies and consequences of psychiatry's responsibility and accountability to society in terms of the scope of practice and of what can be considered as psychiatry's social contract. The key concepts will be: integration (how to integrate the developing scope of current psychiatric practice); environment (the more important questions on medicine and the medical profession being posed now, in the early 21st century, are about the best ways for doctors to contribute in a world which is changing exponentially); the scope of psychiatric practice; social contract (the series of reciprocal rights and duties, privileges and obligations); multiple stakeholders.