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Volume 12
Number 4
November 2015

BJPsych International (Print)
ISSN 2056-4740

BJPsych International (Online)
ISSN 2058-6264

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Volume 12
Number 4
November 2015

BJPsych International (Print)
ISSN 2056-4740

BJPsych International (Online)
ISSN 2058-6264

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

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

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

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

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

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Social sciences and medical humanities: the new focus of psychiatry

Dinesh Bhugra¹ and Antonio Ventriglio²

¹Professor of Mental Health and Cultural Diversity, Institute of Psychiatry, King's College London, London, UK, email dinesh.bhugra@kcl.ac.uk

²Honorary Researcher, Department of Clinical and Experimental Medicine, University of Foggia, Foggia, Italy, email a.ventriglio@libero.it

The clinical practice of psychiatry should incorporate a biopsychosocial model of illness, acknowledging both cultural and social influences on the patient's experience. Medical humanities include a number of academic disciplines that complement the clinical practice of psychiatry. The medical profession, including psychiatry, has a social responsibility to study the psychosocial context within which people become ill and have to be treated. Although the biopsychosocial model of illness has strong theoretical foundations, its application in clinical practice is limited. A new approach would be to restructure medical student teaching to include medical humanities in the first year, and to share such education with other professions.

Psychiatry is the branch of medicine which deals with the aetiology, diagnosis, management and prevention of mental illness, mental disorders and emotional and behavioural disorders. The basis of diagnosing and managing psychiatric illness is in using the biopsychosocial model. The medical model is often a reductionist one, arguing that medicine can only be biological, whereas all medicine arguably is social (Bhugra, 2014). Social factors may be determinant in triggering psychiatric disorders and should be considered for therapeutic intervention in order to improve patients' well-being. Moreover, social and cultural factors affect our cognitive schema as well our child-rearing patterns. The understanding and expression of emotional distress is extremely culturally influenced. Thus, medical students, and especially psychiatry trainees, need to have a broad training. The integration of psychiatry and medical humanities, in particular, may improve the understanding of mental illness and support more effective interventions.

Current conceptual models in psychiatry

Although the biopsychosocial model has been well theorised and accepted, its application in clinical practice remains uncertain and heterogeneous (Engel, 1980).

In fact, psychiatry, like the rest of medicine, largely adopts the *disease* model. Disease is defined literally as *dis-ease*, illustrated by pathology, and its social impact on functioning is defined as *illness*. Having made this distinction, Eisenberg (1977a) suggested that while doctors are interested in disease, patients are interested in illness. In a later article, Eisenberg (1980) reminded us that when

persons become ill, they become patients; when they become well, they revert to being persons again. These are related to social decision points in help-seeking rather than boundaries determined by shifting biological equilibria.

Social stress can influence host resistance. Becoming well is not simply a matter of cure of the disease process which made the person ill. However, often medicine, including psychiatry, focuses on disease and reduction of symptoms. We all know patients who, in spite of their symptoms (representing disease), continue to function well, and others whose symptoms have been eliminated but whose functioning remains a problem. Disease and illness do not always have a clear one-to-one relationship. Similar levels of pathology in different individuals elicit different responses to the symptoms as well as to therapeutic interventions. This clearly suggests that the biological model offers limited understanding of the functional aspects of psychiatric syndromes, which seem to be more influenced by social, environmental, educational and socioeconomic factors than by symptoms.

The discrepancy between the viewpoints of patients and their clinicians is strongly influenced by a number of factors on both sides of the equation. For example, the psychiatrist may see something simply as being caused by medical factors, whereas the patient may see it as being caused by supernatural factors. Such discrepancies will have a negative influence on therapeutic engagement and alliance. Furthermore, patients may be interested in regaining full functioning in spite of their symptoms (which they could well live with if they can function), whereas psychiatrists may be more focused on symptom reduction, as our training often emphasises. A newer model should consider that the cognitive distance between the patient and the psychiatrist may be unbridgeable. The emphasis on the aetiology, symptoms and healing process may greatly impoverish any therapeutic interaction, resulting in poorer adherence to therapy. Also, new technology and investigations, increasingly influencing clinicians' evaluations, should be integrated with cultural and socioeconomic determinants in an appropriate contextual manner.

What can medical humanities contribute?

Fenton & Charsley (2000) point out that sociology and epidemiology are 'incommensurate games'. Kleinman *et al* (1978) highlighted that cultural patterns of disease and sickness influence social

systems and, in return, are influenced by the very same social systems. Similarly, as mentioned above, cultures dictate child-rearing patterns and influence child development and development of cognitive schema. The new focus of modern psychiatry should be the integration of qualitative and quantitative aspects of research and practice. Biomedicine should integrate traditional approaches aimed at dealing with the person and the illness.

In fact, the new approach should comprise cultural and social constructions, as both influence the understanding of illness, explanatory models and pathways to care, as well as patients' expectations. Eisenberg (1977b) suggests that all human diseases reflect the outcome of an interaction between biology and social organisation, with culture as a mediator. Social environments affect cultural attitudes to illness experiences, as well as engagement in the therapeutic process.

Moreover, in rather old studies from the USA, it was shown that 70–90% of all illness episodes are treated in personal, folk or social sectors (Zola, 1972). There is little to suggest that this may have changed dramatically in recent times.

Integration of medicine and humanities: a new focus for psychiatry and psychiatrists

The medical profession has an ethical obligation to provide equity of access to all, that is, across all ages and social classes. However, in order to deliver physically and emotionally accessible services to all, those responsible must take into account local cultural and social factors and needs.

Medical humanities include a number of academic disciplines (Greaves & Evans, 2000) that complement the clinical practice of psychiatry, which should, though, still be seen as a natural science (Rutherford & Hellerstein, 2008). As Hankir & Zaman (2013) point out, the health humanities have a role to play and can be beneficial for both service providers and service users. Understanding cultural and illness narratives can bring them together, to produce better outcomes and higher levels of patient satisfaction.

Fathalla (2000) argues that medicine has lost its pastoral role – providing care to the anxious patient – because it has developed too much of a technical orientation, which has led to a reduction in levels of social consciousness on the part of doctors. It is not, though, a question either of technical orientation *or* social consciousness, but both. The medical profession, including psychiatry, has a social responsibility to study the psychosocial context within which people are ill and have to be treated. Anderson *et al* (2005) remind us that social and economic conditions affect health, disease and the practice of medicine, and the health of the whole population is a social concern. Rosen (1974) emphasises that society needs to promote health through both individual and social means. Storington & Holmes (2006) add a dimension

to the doctor–patient relationship: the culture of medicine itself. This culture, too, is strongly influenced by external social factors and social determinants of health.

Conclusion

Psychiatry is an extremely competitive field. We select students but then expect them to give up their competitive nature and work in teams. A revolutionary idea would be to restructure undergraduate training by sharing the learning of medical humanities in the first year with other professions. This will help trainees to understand what the local social context in which they will be practising is likely to be, and so improve the quality of services. It is conceded that one limitation of such integration of medical humanities within psychiatric training might be the enlargement of the gap between psychiatry and the other medical disciplines, when psychiatry is still seen as a branch of medicine that lacks the backing of scientific evidence. This stigmatising view needs to be discouraged by further evidence and clinical application of the biopsychosocial model.

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Stigma in Latin America

Jorge Calderon

Head of Liaison Psychiatry Unit,
Associate Professor, Department
of Psychiatry, Pontificia
Universidad Católica de Chile,
Santiago, Chile, email jcaldep@
gmail.com

Despite the fact there has been difficulty in developing a theory of stigma that is specific to patients with mental disorders, a multidisciplinary effort has been made to understand its impact (Smith, 2002). The key element in the social origins of stigma is the perception of difference, in particular societal concerns that people with mental disorders, who often have communication problems, harbour undesirable traits such as potential violence and other unpredictable behaviours (Byrne, 2000). In order for us to overcome barriers to the implementation of effective stigma-reduction programmes, we need to understand more about the public's misperceptions of mental illness, including the origins of prejudice and discrimination.

In industrialised societies, the impact of education and the media has led in recent years to an increasingly widespread understanding of mental illness as a medical problem. However, it is unfortunate that despite this enlightenment, many in society continue to be suspicious of, and even rejecting of, people with mental illness. Consequently, educational campaigns directed at ensuring their inclusion, which seek to influence wider cultural contexts, become relevant (Pescosolido *et al*, 2013). To date, most research into stigma and mental illness has been carried out in North America and Europe and has focused upon schizophrenia.

In much of Latin America there has been a widely implemented switch away from an asylum model of psychiatric care to community-based services in recent years. In a number of countries, that change has been accompanied by new mental health legislation, which has centred on patients' rights. In this issue of *BJPsych International*, we

present a series of papers that reflect on the origins and management of stigma towards psychiatric patients in the region. Acuña *et al* inform us that in Latin America and the Caribbean, mental and neurological disorders account between them for over 20% of the total burden of disease, but resources are scarce and the treatment gap between resources for mental and physical disorders in many countries is substantial. Different ways of reducing this gap and fighting stigma are suggested.

The adoption of resolutions regarding universal access to health and universal health coverage by members of the Pan American Health Organization may help to increase the provision of resources for psychiatric care and encourage its integration with primary healthcare. As described by Dahl *et al* in their report from Brazil, novel interventions such as peer support groups implemented by peer support workers and community mental health groups may help to modify patients' narratives about their illness and overcome stigma.

Finally, Agrest and colleagues describe a corpus of new studies on stigma which is beginning to shed light on the similarities and differences between the characteristics of societal stigma towards people with mental illness in Argentina and those found in North America and Europe.

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Stigma and psychiatric care in Latin America: its inclusion on the universal health coverage agenda

Cecilia Acuña,¹ Rafael Sepúlveda² and Osvaldo Salgado³

¹Advisor, Health Systems and Services, Pan American Health Organization/World Health Organization, Ecuador, email acunamar@paho.org

²Chief, Mental Health Department, Ministry of Health, Chile

³Director, South Metropolitan Health Area, Ministry of Health, Chile

In 2014, the Pan American Health Organization (PAHO) approved Resolution CP53.R14, which aimed to provide a framework for universal access to health and universal health coverage. It sets the stage for the inclusion of psychiatric practice within the provision of universal healthcare and highlights the fight

against stigma. We propose to concentrate our efforts on changing the model of medical management. To that end, we are promoting the inclusion of mental health patients within the daily routine of primary care centres, thus allowing them to interact with other users of health services on a regular basis.

Background

One of the key aims of Resolution CD53.R14 ('Strategy for Universal Access to Health and Universal Health Coverage'), which was agreed in September 2014 by all member states at the 53rd Directive Council of the Pan American Health Organization (PAHO), concerns the provision of universal access to people-centred health services in the Americas region. The resolution urges participating countries to move towards providing universal access to comprehensive, high-quality and progressively expanded health services that are consistent with broad population health needs, system capacities and the national context. It emphasises that there are unmet and undifferentiated population requirements from such a system, as well as specific needs of groups who are particularly vulnerable. The resolution recognises the importance of defining and implementing actions to improve the organisation and management of health services through the development of healthcare models that focus on the diverse needs of people and communities. There is an unfulfilled demand to improve response capacity at the primary level of care, through the development of integrated health services networks.

At that same meeting, PAHO member states approved Resolution CD53.8, 'Plan of Action on Mental Health'. Based on information gathered from the World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS) (PAHO, 2013), the Plan of Action's background document reports that in Latin America and the Caribbean, mental and neurological disorders account for 22.2% of the total burden of disease, measured in disability-adjusted life-years (DALYs). Resources allocated by countries to tackle the burden of disease related to mental health problems are insufficient and inequitably distributed. This treatment gap in the provision of resources is, in many countries, more than 70%. Although the document acknowledges that there are key factors that account for the relative neglect of mental health as a priority for investment – including stigma, social exclusion and discrimination against patients with psychiatric conditions – no specific actions to tackle stigma are included in the Plan of Action.

The World Health Organization (WHO, 2013) has highlighted the widespread human rights violations and discrimination experienced by people with mental disorders. It calls for a human rights perspective to respond to the global burden of mental disorders. Its *Mental Health Action Plan 2013–2020* proposes that the formulation of strategies for mental health promotion, with the aim of preventing mental disorders across the life course, should focus on antidiscrimination laws and should encourage information campaigns (WHO, 2013). There should be an effort to redress the stigmatisation and human rights violations associated with mental disorders. The *Action Plan* requests the WHO secretariat to provide technical support to assist in the implementation

of evidence-based best practices for reducing stigmatisation and discrimination, and to promote human rights, but it does not identify the best practices by which these goals might be achieved. This is an important omission.

Positioning psychiatric care and stigma on the universal health coverage agenda

The concept of universal health coverage received strong support in the unanimous adoption of Resolution 67/L.36 'Global Health and Foreign Policy' by the United Nations General Assembly in December 2012. It urges governments to move towards ensuring all people fall within the healthcare framework and to work on the determinants of better healthcare provision within the sectors of mental and physical disorder. It thus sets a political agenda for positioning psychiatric care within universal health coverage, and encourages the development of strategies to eliminate stigma as a barrier that prevents patients from accessing the care they need. Accordingly, it is now of critical importance to identify the best strategies by which to implement this resolution.

At the 29th Congress of the International Academy of Rights and Mental Health (Paris, July 2005), Acuña & Bolis proposed specific strategies to ensure that stigma is included on the political and health agenda. These include:

- highlighting the role that stigma plays as a barrier, impeding access to healthcare
- providing information to people with mental health problems about the facilities available to them, and advocating for the rights of people with mental illness
- educating and training health workers at the primary care level
- encouraging community leaders to address the health needs of people with mental illness
- strengthening legal mechanisms so that people with mental health difficulties can exercise their rights, especially in relation to healthcare.

Some of these strategies are also included in the PAHO's Plan of Action on Mental Health, as well as in the WHO's *Mental Health Action Plan 2013–2020*.

Changing the model of care

So that we can make progress on the goal of eliminating stigma as a barrier to access, best practices and specific actions must be identified. In addition to those ideas proposed by Acuña & Bolis, other strategies also could be adopted. For example, it is now widely accepted that community-based models of care, with a focus on promoting recovery, should replace psychiatric hospitals and allow the social reintegration of patients, as suggested by PAHO Resolution CD53.R14. Our own proposal is based on the work of Lopez *et al* (2008); we would like to see the exposure of mental health patients to other users of health services at the primary care level, and the inclusion of psychiatric patients in the day-to-day routine of their

community health centres. If this idea is implemented, other patients and users of health services will have the opportunity to meet and interact with people who have psychiatric disorders. By these means we hope to reduce the prejudicial attitudes that stigmatise people who are psychiatrically ill as dangerous and threatening. It will help to ensure they are regarded in future simply as members of the community, just like everyone else.

Conclusion

The adoption of resolutions regarding universal access to health and universal health coverage by PAHO and WHO member states as well as by the United Nations General Assembly provides a unique window of opportunity for us to promote the universality of psychiatric care. It can assist in our fight against the stigma that psychiatric patients currently experience in so many regions

of the world. But to eliminate stigma, we need to identify and to implement specific evidence-based strategies. Changing the model of medical care, with a focus on integrating psychiatric care into the everyday practice of primary healthcare and promoting exposure of psychiatric patients to other users of health services, should be a centrepiece of those strategies.

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Stigma and recovery in the narratives of peer support workers in Rio de Janeiro, Brazil

Catarina Magalhães Dahl,¹ Flavia Mitkiewicz de Souza,² Giovanni Marcos Lovisi³ and Maria Tavares Cavalcanti⁴

¹Psychologist and PhD Student, Institute of Psychiatry, Federal University of Rio de Janeiro, Brazil, email catdahl@hotmail.com

²Psychologist and PhD Student, Institute of Psychiatry, Federal University of Rio de Janeiro, Brazil

³Associate Professor of Collective Health, Institute of Collective Health Studies, Federal University Rio de Janeiro, Brazil

⁴Associate Professor of Psychiatry and Director, Institute of Psychiatry, Federal University of Rio de Janeiro, Brazil

Acknowledgements: We would like to acknowledge the National Institute of Mental Health (NIMH) grant no. 1 U19 MH095718-01 and the National Council for Scientific and Technological Development (CNPq grant no. 470217/2012-0) for financial support. We also wish to acknowledge all RedeAmericas' partners and, last but not least, the peer support workers and mental health users who directly or indirectly contributed to this work.

Stigma attaching to mental illness has been considered a major challenge to public policies, to the provision of care and to the well-being of people who live with the experience of mental illness worldwide. Here we discuss narratives from peer support workers which we obtained during the assessment of a new psychosocial intervention programme in Rio de Janeiro. We used a range of focus groups, in-depth interviews and clinical supervision notes to derive these narratives, which covered topics such as the peer support workers' perceptions of family and social views, their sense of self and the experience of being stigmatised. We conclude that stigma appears to be a barrier to recovery. Peer support work for people with severe mental illness is a strategy that may help them to overcome stigma and discrimination. Fostering mutuality and hope in the context of peer support helps affected individuals to make sense of their being in the world and can facilitate their recovery.

Background

Stigma presents a challenge to public policies, to the provision of care and to persons worldwide

who live with the experience of mental illness (Saraceno *et al*, 2007; Sartorius, 2007). Characterised by negative thoughts and attitudes, stigma results from lack of knowledge (ignorance), prejudicial attitudes and discriminatory behaviour (Thornicroft *et al*, 2007). The experience of stigma decreases self-esteem, which in turn reinforces negative attitudes and increases the risk of social exclusion (Sartorius, 2007). Stigmatisation is a devastating experience that negatively impacts upon self-identity and creates a barrier to recovery, to accessing health services, to getting a job and to education and housing. Whereas an important step to recovery is accepting one's illness, on the other hand, the label of a psychiatric diagnosis can lead to internalisation of stigma and a sense of hopelessness (Davidson, 2003; Farkas & Anthony, 2010).

In the last decade, the need to tackle stigma has been included in both global and local mental health policies and research agendas (Saraceno *et al*, 2007). Psychosocial interventions that include peer support work give positive results in reducing stigma among persons with mental illness and professionals (Farkas & Anthony, 2010). Peer support work is based on the principles of mutuality and hope. It is also based on the belief that persons with mental illness who have gone through difficult situations, and have overcome them, can be

helpful to others who have similarly experienced such situations. It aims to encourage affected individuals to think positively about their future and about their prospects for recovery (Davidson *et al.*, 2012; Stastny, 2012). Personal narratives, which are a component of peer support work, have an important role in overcoming stigma (Jenkins & Carpenter-Song, 2008).

In Brazil, there have been recent improvements in the care of people with mental illness that were engendered by legislation passed in 2001. There are new psychosocial care centres (centros de atenção psicossocial, CAPS) across the country, strategic services that provide mental healthcare and promote the social inclusion of people with severe mental illness (Ministério da Saúde, 2011, p. 106). In 2008, Brazil ratified the United Nations Convention on the Rights of Persons with Disabilities, banning any kind of discrimination against persons with mental illnesses. Yet, despite all this, stigma is still a challenge in the country (Spadini & Souza, 2006; Saraceno *et al.*, 2007).

Clinical experience reveals that stigma and prejudice are still prevalent aspects of perceptions and social representations of mental illness, from the perspective of users, families and professionals (Spadini & Souza, 2006; Moreira & Melo, 2008; Vicente *et al.*, 2013). Vicente *et al.* (2013) investigated family members' perceptions of mental illness in southern Brazil. They found that a lack of understanding makes it difficult for people to accept mental illness in family members or in the community. Stigma negatively influences relationships within families and between families and society, and can even lead to interpersonal and institutional violence. Moreira & Melo (2008) analysed the lived experience of stigma among in-patients with mental illness in Fortaleza (a city in north-eastern Brazil). They described a feeling of uselessness and powerlessness, reflecting the internalisation of stigma and a negative self-perception. People with severe mental illness tend to try to disguise their mental health problems because they fear negative reactions from others. In a review of Brazilian publications about societal attitudes to mental illness, Spadini & Souza (2006) emphasise that a lack of awareness of the problem reinforces prejudice.

Peer support work for severe mental illness

Here we report on the analysis of narratives we obtained from peer support workers, focusing on the issues of recovery and stigma, in the city of Rio de Janeiro. During 2014 and 2015 we carried out a project entitled RedeAmericas (RA), which was designed to build capacity among young researchers and lay workers for a novel intervention service, and to assess the effectiveness of that psychosocial intervention through a randomised clinical trial. We called the intervention 'critical time intervention – task shifting' (CTI-TS). It was delivered jointly by a peer support worker and a community mental health worker to CAPS users.

This was the first time peer support work had been used in Latin America (concurrently in Chile) (Susser, 2012). Because it represented a novel approach to formal mental healthcare and utilised a workforce in Brazil (Stastny, 2012), we decided to obtain, and to analyse qualitatively, narratives from peer support workers about their experience of delivering care and how it interacted with their recovery process.

Ten potential peer support workers, aged between 25 and 54 years, were initially nominated by CAPS, and after participation in a short course organised by the research team, assistants were selected to work on the CTI-TS trial, providing they met the following criteria: a history of mental illness, a minimum of 8 years of education, and their own participation in active treatment. Four peer support workers were selected and were expected to dedicate 20 hours each week to undertaking the following activities: accompanying designated patients in their daily lives; attending clinical supervision sessions; and completing records regarding interventions. There was on-the-job training. We used audio-recordings of focus groups, in-depth interviews and clinical supervision notes to gather information about the work that had been done with clients. We codified their narratives and organised them into broad categories.

Our work was approved by a local ethics committee and all participants gave informed consent. Participants' names in this paper are fictitious.

Sense of self: from embodied stigma to recovery

From the perspective of the peer support workers we had appointed and trained, their family is the foundation of their world, although they remarked that prejudice begins at home ('the biggest prejudice is within the family'). Grace (54 years of age, female and married) stated that her family life is 'turbulent'. She said she was often abused by her husband, who said 'that I'm too ugly, that I'm the worst of everything' and that she herself thought the members of the research team were 'crazy' for having selected her as a peer support worker. She asked us, 'How come you could believe in us? Nobody believes in us; everybody fears us.' Grace believed she was not a person, after hearing such harsh remarks from her husband, because he often called her an 'animal':

I was an animal ... now I'm not an animal anymore. I used to think I had no brain, nor body ... that's why I never understood geography, because I never understood the map. So, just now I got to find out what a map is ... before, I never understood about it. Look, I don't know if I've really lived during the past 40 years. I guess I hadn't really lived. I didn't live! I think I started to live 3 years ago. I have started to live now! Now I am getting a life!

Grace reconstructed her sense of self by recognising that she does have a physical presence, and came to accept that it was possible to be experienced as a distinct and valued being. Dance classes and peer support work helped her to make sense of herself and aided her recovery:

I never could imagine that [dance classes] were so important. I discovered that my life wasn't a prison anymore. Like now, you are teaching me how to walk ... I am another person, today I am walking differently.

Grace particularly valued supervision meetings and told us she believed her function as a peer support worker was 'to help, to be able to explain my experience in overcoming my difficulties to other people'.

According to another peer support worker, Leo (33 years of age, male and single), his family gave him support, despite the fact that 'people from outside do not understand us'. For many of the peer support workers, their family and social relations could be supportive but, paradoxically, they could also be a source of discrimination and stigma, and that sense of stigma was often internalised. From Leo's perspective, he 'became a teacher' out of his own experience:

I realised that I can help other people ... so this job is helping me a lot; now I know how to approach people, how to express myself properly.

In another example, a former service user, Michael (43 years of age, male and single), when asked about his new role as a peer support worker, explained:

What I've understood about peer support work is that we help people who in Brazilian society's eyes should be given nothing.

In terms of the work he was doing with people who were experiencing severe mental illness, he explained that 'we try to rescue their sense of citizenship, their sense of inner love, their self-esteem'.

Sammy (29 years old, female and single) told us that being a peer support worker, having 'gone through difficulties oneself', offered an opportunity 'to share those experiences with people, to know that one can take pills and despite that one can have a normal life'.

Conclusion

In the narratives presented here, stigma clearly influences self-esteem and self-confidence, and can present a barrier to recovery (Davidson, 2003). Our peer support scheme offers an important strategy that can help to overcome stigma and discrimination, because it gives peer support workers a new role within a social milieu. We must, however, bear in mind that family and social relations also play a central role in helping to overcome stigma, even though they themselves present a potential source of discrimination and negative attitudes (Thornicroft *et al*, 2007) that can lead to symbolic violence (Vicente *et al*, 2013). Prejudice and negative beliefs – expressed in words such as 'ugly', 'crazy', 'animal' – were used in peer support workers' discourse when talking about society's attitude towards them. Internalised stigma can be conceptualised as a dialogical game between the ideas of being 'normal' and 'crazy', as noted in Grace's narrative: 'there's no problem in calling

me crazy, because I cannot be normal ... because I think nobody is normal'.

Participants incorporated the main principles of mutuality and hope. Peer support work helped them to make sense of themselves, by recognising their embodied experience and enabling them to think in different ways about their being-in-the-world; they became their own educators in this role. We are confident that peer support work is, possibly, a light on the path that will overcome stigma.

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Mental illness stigma research in Argentina

Martin Agrest,¹ Franco Mascayano,² Sara Elena Ardila-Gómez,³ Ariel Abeldaño,⁴ Ruth Fernandez,⁵ Norma Geffner,⁶ Eduardo Adrian Leiderman,⁷ Ezra S. Susser,⁸ Eliecer Valencia,⁹ Lawrence Hsin Yang,¹⁰ Virginia Zalazar¹¹ and Gustavo Lipovetzky¹²

¹Senior Researcher, Proyecto Suma, NGO, Buenos Aires, Argentina, email magrest66@gmail.com

²Associate Researcher, School of Public Health, Faculty of Medicine, University of Chile

³Postdoctoral Fellow, Scientific and Technical Research National Council (CONICET), Universidad Nacional de Lanus, Buenos Aires, Argentina

⁴Postdoctoral Scholar, Scientific and Technical Research National Council of Argentina (CONICET), School of Public Health, Faculty of Medicine, Universidad Nacional de Cordoba, Argentina

⁵Professor, School of Public Health, Faculty of Medicine, Universidad Nacional de Cordoba, Argentina

⁶Clinical Psychologist, Proyecto Suma, NGO, Buenos Aires, Argentina

⁷Associate Researcher, Proyecto Suma, NGO, Buenos Aires, Argentina

⁸Professor of Epidemiology and Psychiatry, Mailman School of Public Health, Columbia University, New York, USA

⁹Lecturer, Department of Epidemiology, Columbia University, New York, USA

¹⁰Associate Professor, Department of Epidemiology, Columbia University, New York, USA

¹¹Research Fellow, Proyecto Suma, NGO, Buenos Aires, Argentina

¹²General Director, Proyecto Suma, NGO, Buenos Aires, Argentina

Conflict of interest statement: The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Acknowledgments: The research reported in this publication was supported by the National Institute of Mental Health under award U19MH095718, Proyecto Suma – NGO, and the National Council of Scientific and Technical Research of Argentina. The content is solely the responsibility of the authors.

Studies regarding stigma towards mental illness in Argentina blossomed after the first National Mental Health Law was passed in 2010. Methodological limitations and contradictory results regarding community perceptions of stigma hinder comparisons across domestic and international contexts but some lessons may still be gleaned. We examine this research and derive recommendations for future research and actions to reduce stigma. These include tackling culture-specific aspects of stigma, increasing education of the general population, making more community-based services available and exposing mental health professionals to people with mental illness who are on community paths to recovery.

Stigma is a well known obstacle in the recovery of people living with severe mental illness. Stereotypes, prejudice, discrimination and a desire for greater social distance are common among the general public, as well as among health and even mental health workers. Although stigma exists worldwide (and has done so throughout history), its effects vary, depending (as with all social processes) on the cultural context in which it appears. It affects coping strategies, disclosure and help-seeking, and has many other profound effects at the personal, familial and community levels (Mascayano *et al.*, 2015). Examining stigma in local contexts in Argentina may lead to better research design and better national policies, and convey important lessons for other countries as well.

We make use of a recent historic transformation in Argentina – the 2010 National Mental Health Law – to examine ramifications of the new orientation towards providing mental health services in the community. We review research published after implementation of the law, examining articles addressing the stigma of mental illness in Argentina. We analyse the methods and outcomes reported in these articles to draw conclusions for future research and policy regarding the current transformation of the local mental health system.

Stigma research in Argentina in context

Argentina has recently been categorised as a high-income country. Of its population of some 42 million, less than 10% live in rural areas. Regarding mental healthcare, from 2001 to 2010, Argentina

was gradually transitioning from hospital-based to community-based care. According to the National Health Department, the number of beds in public psychiatric hospitals dropped during those years by 51% (from 21 000 to 10 691), but still represented 89% of the total 11 532 in-patient beds available for people with mental illness. That is, a mere 7% were located in general hospitals and 4% in community care centres (Dirección Nacional de Salud, 2010).

Accelerating this transformation to community-based care was the enactment of a human rights-centred National Mental Health Law, passed in 2010, which fully adopts the social model of disability and follows the 2006 United Nations Convention on the Rights of Persons with Disabilities. The law explicitly grants protection from discrimination, despite not mentioning the term ‘stigma’, by declaring that ‘everybody has the right not to be discriminated against because of a current or previous mental health condition’. Complementary to this statement, the more recent National Mental Health Plan (2013) declares that ‘stigma is the first aim and problem to be addressed’.

Given this milestone, it is no wonder that there has been more research into stigma in the past 5 years than was done in the previous 45 years. Our focus in this paper is on how stigma has been investigated, and its implications for Argentina’s ongoing transformation to community mental health.

Research regarding stigma in Argentina since 2010

A literature search was conducted using PubMed, PsycINFO Database, Scielo, Bireme and Lilacs, with the terms ‘stigma’, ‘mental illness’ and ‘Argentina’, for publications appearing up to April 2015. We narrowed the selection to empirical studies using quantitative or qualitative methods that focused explicitly on stigma towards mental illness, and found eight papers that were published after 2010 (Table 1).

Regarding methodology, all the quantitative studies were cross-sectional, mostly located in the Buenos Aires metropolitan area, and none of them recruited representative samples. Only one study solely used a qualitative approach and two others used mixed methods. These studies included a range of respondents: community members, service users, psychology and other students,

Table 1

Overview of selected Argentinian studies of stigma

Study	Number in sample (population sample was drawn from)	Aims	Methods and instruments (quantitative or qualitative study)
Public stigma			
Leiderman <i>et al</i> (2011)	1254 (members of the general community population)	To assess the knowledge, social distance and perception of social discrimination towards persons with schizophrenia in the general adult population of Buenos Aires, Argentina	Interviewer-assisted questionnaire divided into five sections (three of them original); section 4 assessed social distance towards people with schizophrenia with a modified version of the Bogardus Social Distance Scale; section 5 addressed the perception of social stigmatisation through Link's Discrimination–Devaluation scale. Convenience sampling was used. (Quantitative)
Digiuni <i>et al</i> (2013)	462 (psychology degree students in Argentina, the UK and the USA)	To examine the relationship between clinical psychology students' perception of the social stigma attached to receiving therapy and their attitudes to seeking therapy	Students completed measures of demographic characteristics, the Attitudes Toward Seeking Professional Psychological Help Scale – Short Form, and the Social Stigma Scale for Receiving Psychological Help, and other variables associated with therapy-seeking. (Quantitative)
Ardila-Gómez <i>et al</i> (2015)	236 (neighbours and equivalent non-neighbours in the general population)	To analyse the effects of community life on people with mental illness in the neighbourhoods in which they live, in Buenos Aires, Argentina	A non-standardised questionnaire blindly administered to randomly selected neighbours ($n = 117$) of group homes of a discharge programme and an equivalent control area ($n = 119$). (Quantitative and qualitative)
Consumer stigma			
Vazquez <i>et al</i> (2011)	241 (people with bipolar disorder in Argentina, Brazil and Colombia)	To investigate the association between self-rated stigma and functioning in patients with bipolar disorder in Latin America	Functioning Assessment Short Test (FAST) and Inventory of Stigmatising Experiences (ISE). (Quantitative)
Mileva <i>et al</i> (2013)	392 (people with bipolar disorder in Argentina and Canada)	To adapt the Inventory of Stigmatizing Experiences (ISE) and to evaluate its basic psychometric properties among Argentinian people with bipolar disorder	The Stigma Experiences Scale (SES) and the Stigma Impact Scale (SIS) were administered to patients with bipolar I and bipolar II disorder in Argentina ($n = 178$) and Canada ($n = 214$). (Quantitative)
Saldivia <i>et al</i> (2014)	164 (people with schizophrenia and related psychoses – service users)	To develop a cross-cultural measure of the stigma perceived by people with schizophrenia	Items for the scale were developed from qualitative group interviews with people with schizophrenia in six countries (18 from Argentina). The scale was then applied in face-to-face interviews. (Quantitative and qualitative)
Institutional stigma			
Druetta <i>et al</i> (2013)	517 (mental health practitioners)	To determine general demographics, attitudes and social distance of mental health workers in relation to people with schizophrenia	27 questions in six sections; last section was an adaptation of Link's Social Distance Scale. (Quantitative)
Multiple types of stigma			
Wagner <i>et al</i> (2011)	303 (service users and carers in Argentina, Brazil, England, Chile, Venezuela, Spain)	To analyse the opinion of people with schizophrenia in long-term care and their (informal and formal) carers regarding mental healthcare within different contexts and cultures	Eight focus groups were conducted in each country. The data were analysed with the aid of the Qualitative Solutions and Research/Non-numerical Unstructured Data Indexing program (QSR NUD*IST 4.0). (Qualitative)

carers and mental health practitioners. They addressed public stigma, perceived and self-stigma, and institutional or structural stigma. People with substance misuse disorders had not been targeted for research, despite some evidence that this group is the most stigmatised population (Ardila-Gómez *et al*, 2015).

Findings are organised in terms of their implications for implementation of community mental health services in Argentina.

Public stigma

The general population reported a low social distance from people with schizophrenia, with 80% of a local sample endorsing less than one-third of the maximum possible 'social distance' score. Still, one in four people surveyed declared that they would feel disturbed about working with a person with schizophrenia (Leiderman *et al*, 2011). People living in close proximity to former in-patients showed less discriminatory attitudes to people with mental illness than non-neighbours, thus suggesting that personal contact yields better acceptance of people with mental illness (Ardila-Gómez *et al*, 2015).

However, this finding was somewhat disputed by Leiderman *et al*, whose study showed that those who were familiar with people with schizophrenia did not show significantly less social distance than the general population. Overall, while there remains strong resistance to accepting people with mental illness, people may benefit from everyday contact with those with mental illness living in the community, as investigated in other contexts by Corrigan *et al* (2007).

Consumer/self-stigma

Regarding consumer/self-stigma, a mix of findings emerge. Self-stigma appears to lead to negative psychological outcomes, as an association was found between perceived stigma, social functioning and severity of affective symptoms (Vazquez *et al*, 2011), with stigma affecting quality of life and self-esteem (Mileva *et al* 2013).

With regard to characterising levels of self-stigma in Argentina, the results are contradictory. On the one hand, Digiuni *et al* found that Argentinian psychology students, compared with UK and US samples, would expect lower levels of perceived

social stigma if they had received psychological treatment. Another study found that people with bipolar disorder reported fewer stigma experiences in Argentina than in Canada (Mileva *et al*, 2013). A third study reported that people with schizophrenia had few perceptions of discriminatory attitudes in custodial institutions (Wagner *et al*, 2011). However, another study found that people with schizophrenia in Argentina fared worst or near-worst on four dimensions of perceived stigma (informal networks, socio-institutional, health professional and self-stigma) in a comparison with five other countries (Saldivia *et al*, 2014). Thus, while the absolute level of self-stigma experienced in Argentina by varying types of consumers (except for those with schizophrenia) may be reported to be somewhat less than in other areas of the world, it is nevertheless associated with negative psychological outcomes – as in other countries.

Institutional (or structural) stigma

Mental health practitioners held significant discriminatory attitudes (Druetta *et al*, 2013; Saldivia *et al*, 2014) and those with more work experience showed greater social distance desire than younger ones. Thus, reducing stigma by providing more traditional clinical services would be ineffective in Argentina. Scarcity of community-based services was hypothesised to contribute to these more stigmatising attitudes among clinicians (Wagner *et al*, 2011; Saldivia *et al*, 2014).

Conclusions

As Argentina is moving towards community-based treatments, studies regarding stigma are proliferating and may help to overcome barriers in the full implementation of the National Mental Health Law. As an initial conclusion based on the above studies, while increased education efforts may help to reduce stigma in the general population, increased contact in collaborative situations that take place in the community rather than in clinical settings, in addition to interacting with consumers at different stages of recovery, might facilitate stigma reduction among practitioners.

Methodologically, most of the samples in the studies examined were non-representative in nature; moreover, the studies focused solely on attitudes. Emphasising the study of real-life experiences of discrimination (Thornicroft, 2006) and the use of representative population samples would increase confidence in research findings and provide a methodologically rigorous way to track stigma change as more community mental health services are implemented.

Another important gap we found is that the identification and measurement of culture-specific aspects of stigma are limited. Little information exists regarding how stigma is embodied in different Argentinian subgroups or locations distant from Buenos Aires, or regarding how important cultural values (e.g. strong family bonds) might protect people with mental illness in Argentina. These culture-specific aspects of stigma could be

examined with systematic research using stigma-specific frameworks (Mascayano *et al*, 2015).

It is our hope that a broad collaborative task-force made up of academic researchers, mental health service staff, users, policy-makers, journalists and non-governmental organisations (NGOs) can bring forth new studies and a national campaign on stigma more sensitive to local idiosyncrasies, respectful of experiences from diverse perspectives and stakeholders, and grounded in the best empirical science.

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Mental health law profiles

George Ikkos

Consultant Psychiatrist in Liaison
Psychiatry, Royal National
Orthopaedic Hospital, London,
UK, email ikkos@doctors.org.uk

The Caracas Declaration, referred to in both of this issue's mental health law profiles on Bolivia and Colombia, and agreed by all national governments in the Latin American region in 1990, has set clear aspirations and extracted explicit signed commitments. Materialisation of these, however, has been distinctly patchy. On the evidence of the paper by Anne Aboaja and colleagues, Bolivia offers an alarming example of promises failing to materialise. This is particularly disappointing, because rights and service deficits remain largely unchanged despite a stable and popular government and a tripling of the size of the economy in the decade to 2014. Irrespective of future politics and economics, people with mental illness and their families have a right to expect early improvement and to hope that such wider social developments as have occurred in Bolivia will create a favourable climate in which to address mental health issues.

Both Bolivia and Colombia face major problems with substance misuse and domestic violence. In addition, Colombia faces the legacy of violent armed conflict that has repeatedly placed it at the top of relevant international tables. According to

the report by Roberto Chaskel and colleagues, the suffering engendered by such violence, especially against women, seems to have spurred much research-informed progressive legislation tailored to the particular needs of the Colombian population. This is coupled with commitment to service provision in the area of mental health, particularly trauma-related mental health problems.

In their paper the Colombian authors lay emphasis on the importance of service provision (e.g. mandatory provision of 30 individual and 30 group sessions for all patients and unlimited sessions for victims of violence) and report less on the protection of liberty in relation to compulsory detention (e.g. they do not specify whether patients have a right of appeal and under what conditions). In part perhaps this reflects that 'institutionalisation is the rare exception' and lack of resources and services remains the paramount issue in that country. This, however, is cold comfort for the patient who is at risk or who has been detained in violation of fundamental human rights. Such rights are universal and their violation a contravention of the Caracas Declaration.

Mental health law in Bolivia

Anne Aboaja,¹ Guillermo Rivera Arroyo² and Liz Grant³

¹Consultant Psychiatrist (Forensic) and Global Health Researcher, University of Edinburgh, UK, email anne.aboaja@ed.ac.uk

²Tenured Professor of Abnormal Psychology and Consultant Psychiatrist, Universidad Privada de Santa Cruz de la Sierra, Bolivia

³Director of the Global Health Academy and Assistant Principal Global Health, University of Edinburgh, UK

Bolivia's mental health plan is not currently embedded in mental health legislation or a legal framework, though in 2014 legislative change was proposed that would begin to provide protection and support for the hospital admission, treatment and care of people with mental disorders in Bolivia. Properly resourced, regulated and rights-based mental health practice is still required. Mental healthcare in the primary care setting should be prioritised, and safeguards are needed for the autonomy of all patients, including all those in vulnerable and cared-for groups, including those in prisons.

Bolivia is a lower-middle-income country in South America surrounded by four middle-income countries (Peru, Brazil, Paraguay, Argentina) and one high-income country (Chile) (World Bank, 2015). Despite the lack of large-scale psychiatric

prevalence studies in Bolivia, there is some evidence to suggest that mental disorders are common. A cross-sectional study showed that nearly one in two women is a victim of violence perpetrated by an intimate partner and that this is associated with symptoms of depression (Meekers *et al*, 2013). According to a review published by Jaen-Varas *et al* (2014), alcohol addiction has a clear impact on psychiatric admissions, domestic violence and road traffic accidents in Bolivia. A study using the World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS) tool examined the reasons for admission to psychiatric centres and showed that just over one-quarter of patients were admitted for psychotic illnesses, a similar proportion for substance misuse problems and a slightly lower proportion for affective or neurotic disorders (Caetano, 2008). There are, though, no data available on the prevalence of mental disorder in the general

Table 1

Articles in Bolivia's Constitution relevant to mental health

Article	Provisions
35	I. The state at all levels protects the right to health, promoting political policies oriented to improving quality of life, collective well-being and the population's free access to health services
37	The state has the inescapable obligation to guarantee and uphold the right to health, which constitutes a supreme role and financial responsibility. Health promotion and disease prevention will be prioritised
41	The state shall guarantee the population access to medicines
70	Everyone who has a disability enjoys the right to be protected by his or her family and by the state
71	I. The state shall take affirmative action to promote the effective integration of persons with disability into the productive, economic, political, social and cultural field, without any discrimination II. The state will create conditions for the development of the individual potential of persons with disabilities
72	The state shall guarantee persons with disabilities the integral services of prevention and rehabilitation and other benefits established in law
73	I. Everyone deprived in any way of liberty shall be treated with the respect due to human dignity

population or in prisons which might be used to inform policy and shape legislation.

A promising but unsuccessful start to mental health legislation

Although Bolivia was one of the first South American countries to have a written mental health plan (Bolis, 2002), in the past two decades fewer changes than expected have been made in the development of psychiatric services. In contrast, many other Latin American countries have made important progress in order to meet their commitments under the 1990 Caracas Declaration, which was agreed by all the health ministers of the Americas (de Almeida & Horvitz-Lennon, 2010). This landmark declaration aimed to ensure mental healthcare legislation will protect the human and civil rights of people with mental illnesses and will lead to the reform of mental health services based on scientific evidence. The main objectives of the latest (2009) Bolivian mental health plan, revised for 2009–15, were to embed mental health services within primary care and to promote and develop community mental health services (World Health Organization, 2011). Compared with other South American countries, however, following the Caracas Declaration Bolivia has seen a minimal reduction in deinstitutionalisation as measured by a reduction in the number of psychiatric beds (Mundt *et al.*, 2015). Moreover, the mental health plan does not address care provision or regulation of patients admitted to hospital involuntarily. Furthermore, the absence of sufficient funds for its implementation has meant that the goals have not been achieved. According to local stakeholders, other reasons for this include the lack of importance given to mental health by society and by health authorities and the stigma associated with mental disorders (CBM, 2010).

International influences on mental health legislation and human rights

In the 21st century many South American countries have embraced a new era characterised by the integration of international recommendations into national legislation and policy, and the

creation of mechanisms for monitoring human rights in mental health services. While Bolivia has been slower than neighbouring countries to adopt similar changes, new laws have been passed, such as Law 4034, which promotes housing for people with dementia, while the General Law for People with Disability offers benefits to people with intellectual disability and major mental disorders (Ortiz-Antelo *et al.*, 2009; Montaña-Viaña *et al.*, 2012). Furthermore, Bolivia's new (2008) Constitution promises to protect the right to health (Bolivia, 2008; and see Table 1). Civil legislation defines how, on the basis of a medical assessment, a person can be deemed mentally incapacitous and be made subject to power of attorney.

The Bolivian government has signed both the 1969 American Convention on Human Rights and the 2006 United Nations Convention on the Rights of Persons with Disabilities, in which the definition of disabilities includes those associated with mental and intellectual impairment (Gable *et al.*, 2005). Since 2007, the United Nations High Commissioner for Human Rights has played a formal role in monitoring, reporting and advising on the human rights situation in Bolivia (United Nations, 2014). The Office of the High Commissioner has made a number of recommendations for the improvement of human rights to government ministers. However, the current remit of the Office does not extend to monitoring the human rights of patients admitted to psychiatric hospitals, and the 2009 mental health plan fails to address ethical practice and matters concerning the protection of human rights of people with mental disorders.

Constitutionally, people can be admitted to psychiatric hospitals involuntarily (Camisón Yagüe, 2012). However, there are no formal mechanisms for a detained patient to appeal against hospital detention and there is no responsible, independent body which actively monitors unlawful hospital detention and the use of coercive practices of administering treatment to patients in hospitals or in the community or the use of mechanical restraint. Legislation pertaining to mental health in Bolivia remains weak in offering actual protection and equality to these people, who are likely to

encounter stigma, who may not always have insight into their health and social needs, and who may disagree with medical opinion regarding hospital admission and treatment (Gable *et al.*, 2005). In the absence of national mental health legislation and the effective implementation of a national mental health plan, region-specific mental health guidelines have been published (Cocarico *et al.*, 2014).

Forensic psychiatry and legislation

Forensic psychiatry, which intersects many branches of law, is not a recognised subspecialty in Bolivia at present. Systems for diverting those with mental disorders in the criminal justice system towards mental health services have not been established. There are no legal means by which prisoners in Bolivia with serious mental disorders can be transferred to a psychiatric hospital in order to receive appropriate treatment and care (Caetano, 2008). At a national level, no formal agreement has yet been made between the prison system and mental health services. Although the 2009 national mental health plan set out to meet the needs of vulnerable populations such as women, children and those with addiction problems, prisoners were not identified in the plan as requiring a targeted mental health intervention (Camacho-Rivera, 2009). It is therefore not surprising that prison mental healthcare remains underdeveloped in Bolivia.

Current legislation in Bolivia permits children up to the age of 6 to reside in prisons with detained parents, although prisons are ill-equipped for children of any age. Children above this age have been reported living inside adult prisons with detained parents and the Bolivian government has set goals to address this problem. Globally, there is a paucity of literature on the immediate mental health needs of children of detained parents and on the longer-term mental health effects of residence in an adult prison during childhood. It is reported that pre-trial prisoners (who are at higher risk of mental disorder than post-trial prisoners) represent 83% of the total prison population and that prisons can reach 256% occupancy rates – another potential risk factor for mental disorder (International Centre for Prison Studies, 2014). There is scope for legislation and policy to address these two mental health risk factors, which have been reported by the High Commissioner for Human Rights (United Nations, 2014). The development of adequate prison mental healthcare is therefore particularly important in Bolivia but currently, if available at all, it is provided on an *ad hoc* or voluntary basis (Caetano, 2008; Garcia, 2011).

Future opportunities

Bolivia has shown a commitment to improving mental healthcare through a series of mental health plans revised over the past decade. Although there is no specific mental health legislation, currently the mental health needs of the population are considered to some extent in human rights and disability legislation. New strategic guidelines for

mental health have been developed for 2014–19 (WHO & PAHO, 2014). The move towards de-institutionalisation is likely to contribute to reducing the risk of coercive treatment for patients with mental disorders and the risk of inappropriate deprivation of liberty by patients detained either voluntarily or involuntarily. In August 2014 Bolivian stakeholders and the WHO regional office developed a proposal for mental health legislation which has been presented to the government for consideration (World Health Organization & Pan American Health Organization, 2014).

An increase in the amount of epidemiological data on the mental health needs of the general and prison population is essential in order to inform the development of future mental health policies in Bolivia. Further research and audit are required into the actual practices of hospital admission and treatment. The Office of the High Commissioner for Human Rights in Bolivia could widen its remit to monitor the human rights of hospital patients and prisoners with mental disorders. Lastly, the implementation of any mental health plan and serious discussions about mental health legislation will require greater financial support from the government in order to achieve lasting improvements in the population's mental health.

Conclusions

The intentions of the current mental health plan and existing general disability legislation are good. They consider global recommendations, promote inclusive healthcare and incorporate modern practices such as community-based care. However, they may prove only partially effective due to the lack of local epidemiological evidence and of sufficient financial and workforce resources. In the absence of specific mental health legislation outlining the conditions and processes for admitting and treating people with mental disorders, it will be necessary to reinterpret existing legislation. Whether Bolivia judiciously opts for new mental health legislation or chooses to operate within existing legal frameworks, there is a need for adequate ring-fencing of mental health funding within the national health budget to support the full implementation of any modern mental health plan which seeks to integrate mental health into primary care, to safeguard patient autonomy, improve access to psychiatric assessment and treatment, and to respect the principles of human rights in mental health and social care practice.

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Mental health law in Colombia

Roberto Chaskel,¹ James M. Shultz,² Silvia L. Gaviria,³ Eliana Taborda,⁴ Roland Vanegas,⁵ Natalia Muñoz García,⁶ Luis Jorge Hernández Flórez⁷ and Zelde Espinel⁸

¹Head, Child and Adolescent Psychiatry, Fundación Santa Fe de Bogotá, Hospital Militar Central, Universidad El Bosque, Universidad de los Andes, Bogotá, Colombia, email rchaskel@gmail.com

²Director, Center for Disaster and Extreme Event Preparedness (DEEP Center), University of Miami Miller School of Medicine, Miami, Florida, USA

³Head, Department of Psychiatry, Universidad CES, Medellín, Colombia

⁴Psychiatry Faculty, Department of Psychiatry, Universidad CES, Medellín, Colombia

⁵Psychiatry Faculty, Universidad Pontificia Bolivariana, Medellín, Colombia

⁶Graduate Student, Master of Psychology Program, Universidad de los Andes, Bogotá DC, Colombia

⁷Associate Professor, School of Medicine, Universidad de los Andes, Bogotá DC, Colombia

⁸Resident Psychiatrist, Department of Psychiatry and Behavioral Sciences, University of Miami Miller School of Medicine, Miami, Florida, USA

Mental health law in Colombia has evolved over the past 50 years, in concert with worldwide recognition and prioritisation of mental healthcare. Laws and policies have become increasingly sophisticated to accommodate the ongoing transformations throughout Colombia's healthcare system and improvements in mental health screening, treatment and supportive care. Mental health law and policy development have been informed by epidemiological data on patterns of mental disorders in Colombia. Colombia is distinguished by the fact that its mental health laws and policies have been formulated during a 60-year period of continuous armed conflict. The mental health of Colombian citizens has been affected by population-wide exposure to violence and, accordingly, the mental health laws that have been enacted reflect this feature of the Colombian experience.

Historical perspective

In Colombia, the latter half of the 20th century was marked by a growing awareness of the importance

of mental health and the need for mental health services based on public education and advocacy from the Colombian Psychiatric Association, the Colombian Psychological Association, a variety of non-governmental organisations and information dissemination via a broad spectrum of media channels.

During the 1960s, the Colombian Ministry of Health established a small section of mental health that, for decades, was staffed by one or two individuals. Only since 2004 has the Ministry expanded mental health to division status, focusing on diagnosis and design of services. However, the Ministry has encountered barriers to the provision and implementation of mental health services due to competing priorities.

During the 1990s, developments in Colombia coincided with hemispheric shifts in healthcare delivery. The 1990 Declaration of Caracas paved the way for adoption of the primary healthcare model promoted by the World Health Organization (WHO). In 1991, the WHO released its 25 Principles for the Protection of Persons with Mental Illness (United Nations General Assembly, 1991). In the same year, Colombia redrafted the

national Constitution and mental health issues were subsumed under provisions for persons with disabilities. Law 100 reconfigured the social security system to provide national healthcare coverage in a manner more favourable to mental healthcare delivery. Moreover, a 1992 resolution specified the rights of persons with mental illness and these were amplified in the national health policy of 1995. Despite the progressive language, the legislation was not matched by sufficient funding and much of the public health infrastructure collapsed.

A national mental health policy promulgated in 1998 expanded the purview beyond the traditional focus on mental illness. Operating within the context of social security reform, the policy encompassed prevention, screening and mental health services. Additionally, it focused on improved access, coverage and quality of services, while strengthening the network of service providers. Once again, meagre funding for this initiative curtailed its diffusion.

Colombia's 2003 national mental health survey was conducted as a collaboration between the Colombian Ministry of Health, the WHO and Harvard University (Posada *et al*, 2004; Ministerio de la Protección Social, 2005). The survey provided an epidemiological profile (including prevalence estimates for common mental disorders) and explored the interconnections among mental health indicators, socioeconomic status, physical health, social environment and measures of vulnerability. National survey results were cited when transforming the national mental health policy into guidance for action. The resulting document asserted that national mental health policy should focus on decreasing the burden of mental health conditions in the population and the concomitant consequences for social development (Ministerio de la Protección Social, 2009). The strategy document recommended strengthening the capacities of the state and the provider institutions to deal with the challenges of mental health service delivery within the structure of the national health system. As an offshoot, in 2004, the Ministry of Health developed a planning guide for use by local health departments for integrating mental health into their operations. The Colombian Psychiatric Association drafted a proposal for restructuring the mental health system and conducting systematic research in 2006.

Mental healthcare services

Synergisms between the judicial and health systems have greatly accelerated the process for mental health intervention in recent years. From a patients' rights perspective, the Obligatory Plan of Health, released in 2011, specifies that the national health system must provide each patient with 30 individual or group psychotherapy sessions, regardless of the patient's stage of illness, and unlimited sessions for victims of armed conflict.

Electroconvulsive therapy (ECT) is an accepted treatment modality but may be prescribed only

if psychopharmacological and psychotherapeutic treatments are ineffective.

Regarding in-patient care, in academic settings the average length of stay is 12 days, while in state institutions the average stay is 30 days. Institutionalisation is the rare exception; most patients with chronic and persistent mental illness live with their families and are cared for within the community. Admissions to mental health facilities require the signed consent of the patient, a family member, a guardian or a designated employee of the judicial system, depending upon the situation (compulsory, judicial or emergency admission).

Female victims of physical, sexual or emotional abuse have the right to access psychological or psychiatric services and to be hospitalised when necessary in accordance with medical criteria. Psychiatric emergency services must be available and include a minimum 24-hour mandatory observation period for persons who are deemed to pose a risk of harm to self or others. In this case, the patient has the right to be hospitalised for a maximum of 90 days.

Mental health and addictions are considered in tandem. Definitions of common mental disorders treat addictions. Institutions are equipped to treat persons with addictions and dual diagnoses. The Ministry of Health released a national policy for decreasing drug demand and drug misuse in 2007, in response to observed patterns of increasing illicit drug use. In 2011, the National Observatory on Mental Health was created at Universidad CES to conduct systematic surveillance of national patterns of mental disorders and substance use. In 2014, the Ministries of Health and Justice combined forces to launch the Colombian National Drug Observatory. Data generated from research conducted by these observatories are intended to provide informational support for mental health and drug policy decisions.

The intersection of mental health law and population exposure to violence: Law 1448 (Victims and Land Restitution)

Mental health law in Colombia is related to the context of population-wide exposure to trauma and loss stemming from 60 years of armed insurgency, high rates of homicide (Pan American Health Organization, 2012), pervasive gender-based violence (Pan American Health Organization & Centers for Disease Control and Prevention, 2013) and community violence associated with drug trafficking, gang activities and criminal bands ('BACRIM') (Médecins Sans Frontières, 2006, 2010; Pan American Health Organization, 2012; Pan American Health Organization & Centers for Disease Control and Prevention, 2013; Shultz *et al*, 2014a,b).

The landmark Law 1448, 'The Law of the Victims and Land Restitution', was enacted in 2011 to provide comprehensive support for 'victims of armed conflict' (Ministry of Justice and Law, 2012). Victims who are eligible for services include those who have been affected by combat,

terrorist acts, improvised explosive devices, landmines, massacres, homicides, kidnapping, forced disappearance, assaults, gender-based violence, torture and internal displacement (Acción Social, 2011). Globally, Colombia consistently ranks first or second in numbers of internally displaced persons (Shultz *et al.*, 2014a,b). Moreover, Colombia has the highest tally of victims of kidnapping (Centro Nacional de Memoria Histórica & Cifras y Conceptos, 2013).

Law 1448 is not mental health legislation *per se* but includes provisions for psychotherapies and both ambulatory and in-patient treatment. Health promotion and prevention programmes must dedicate 10% of their budgets to mental health. The Law creates a protocol for comprehensive healthcare based on a psychosocial approach that assesses the needs of the victim in relation to the victimising event and the consequences for the victim population. The Ministry of Health serves as the administrative home, but service delivery occurs at the municipal level. A special victims administrative unit, operationalised under the name PAPSIVI (Programa de Atención Psicosocial y Salud Integral a las Víctimas del Conflicto Armado), oversees the coordination of medical, mental health, social and legal services. The psychosocial care 'pathway' includes active outreach to victims, creation of a psychosocial profile, development of a care plan, provision of care, referrals for specialty medical and psychological/psychiatric care as needed, and ongoing client surveillance. Multidisciplinary mobile outreach teams are used to deliver the PAPSIVI services to the households of victims.

Mental health is a right in Colombia

Law 1616, enacted 21 January 2013, establishes mental health as a fundamental right. The Colombian state is charged with ensuring the promotion of mental health and the prevention of mental illness; and providing for the diagnosis, treatment and rehabilitation of mental disorders. Law 1616 and Resolution 5521, enacted 29 December 2013, specify the state's responsibilities to promote mental health and prevent the occurrence of mental disorders through interventions that mitigate risk factors for psychopathology. Emphasis is placed on the early detection of psychological risk and protective factors, and actions that positively influence mental health.

Concluding comments

Colombia's mental health laws and policies have become increasingly comprehensive over recent decades. As happens worldwide, in practice, the finely crafted language of the laws does not guarantee that the intended outcomes are rapidly and equitably realised. However, to address the pervasive population-wide exposure to trauma, loss and violence, Colombian mental health laws have been generating far-reaching and innovative programmes. Grounded on science and evidence-based clinical practice, and scrupulously

evaluated, the results of Colombia's approach of converting mental health policy into practice (such as PAPSIVI) will be well documented.

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Roberto Chaskel,¹ Silvia L. Gaviria,² Zelde Espinel,³ Eliana Taborda,⁴
Roland Vanegas⁵ and James M. Shultz⁶

¹Head, Child and Adolescent Psychiatry, Fundación Santa Fe de Bogotá, Hospital Militar Central, Universidad El Bosque, Universidad de Los Andes, Bogota, Colombia, email rchaskel@gmail.com

²Head, Department of Psychiatry, Universidad CES, Medellín, Colombia

³Resident Psychiatrist, Department of Psychiatry and Behavioral Sciences, University of Miami Miller School of Medicine, Miami, Florida, USA

⁴Psychiatry Faculty, Department of Psychiatry, Universidad CES, Medellín, Colombia

⁵Psychiatry Faculty, Universidad Pontificia Bolivariana, Medellín, Colombia

⁶Director, Center for Disaster and Extreme Event Preparedness (DEEP Center), University of Miami Miller School of Medicine, Miami, Florida, USA

A hallmark of Colombia is population-wide exposure to violence. To understand the realities of mental health in Colombia requires attention to the historical context of 60 years of unrelenting armed conflict overlaid upon high rates of homicide, gang activity and prevalent gender-based and intra-familial violence. The number of patients affected by trauma is extremely large, and the population burden of alcohol misuse and illicit drug use is significant. These patterns have brought the subspecialties of trauma and addiction psychiatry to the forefront, and highlight the need for novel treatments that integrate psychotherapeutic and psychopharmacological modalities.

Colombia: sociodemographic profile

The Republic of Colombia occupies the north-west corner of the South American continent, bordered by Venezuela, Brazil, Peru and Ecuador. Colombia's remarkable ecological diversity includes three ranges of towering Andes mountains, the expansive Eastern Plains, the large Amazonian basin, and extended coastlines along the Caribbean Sea and the northern Pacific Ocean, separated by the isthmus of Panama. The three largest cities, Bogotá (the nation's capital), Medellín and Cali, are situated along the Eastern, Central and Western Andes ranges, respectively. Colombia's 45.8 million citizens (51.4% women, 75% urban, 80% Catholic religion, 93.6% literacy, 9.2% unemployed) are distributed among the nation's 32 'departments'. While Spanish is the predominant language and most citizens are of Spanish or Spanish and 'mixed race' origin, there are remnants of indigenous cultures (64 native American languages are spoken) and of Afro-Colombian populations.

In 2013, Colombia's gross domestic product (GDP) of \$526 billion put the country 29th in the world. In 2012, Colombia ranked 91 among 187 countries on the Human Development Index, with a designation of 'high human development'. Citizens are categorised into six socioeconomic 'strata'. However, Colombia is among the nations in the western hemisphere with the greatest socioeconomic disparities (Gini index of 55.9) and corresponding inequalities in access to essential services, including healthcare.

Epidemiology of mental disorders

The epidemiological profile of mental health derives from several nationally representative surveys. The most recent, the 2003 National Survey of Mental Health in Colombia (Posada-Villa *et al*, 2004), indicated that two in five Colombian citizens

(40.1% of respondents) met DSM-IV criteria for 'any mental disorder' at some point in their life. Past-year prevalence was 16.0% and past-month prevalence was 7.4%. Lifetime prevalence rates were 19.3% for anxiety disorder (women, 21.8%; men, 16.0%), 15.0% for affective disorder (women, 17.5%; men, 11.7%), and 10.6% for substance misuse disorder (women, 2.6%; men, 20.8%). Consistent with the gender disparities observed for lifetime prevalence rates, major depression was the most common psychiatric diagnosis for women and alcohol misuse was the most common problem for men. Survey results confirmed the early onset of mental disorders and, coupled with the chronicity of these diagnoses, findings suggest that many Colombians suffer from mental disorders lifelong. The 2003 profile revealed that only one in ten persons with a diagnosed mental disorder was receiving care, highlighting challenges for access and utilisation of mental health services.

Distinguishing features of mental health needs in Colombia

Armed insurgency

Colombia has experienced one of the most protracted internal armed conflicts in the world, dating from bipartisan political violence in the 1940s that led to the rise of leftist guerrillas in the 1950s. Both guerrilla and right-wing paramilitary forces, fuelled by income from drug trafficking, have carried out massacres and targeted assassinations that have triggered forced migration. Armed groups have engaged in kidnapping (39000 victims with extortion between 1970 and 2010), forced recruitment of youth and gender-based violence. Government figures estimate the casualty toll at 220000 conflict-associated deaths between 1958 and 2012, of which 81.5% were civilian (non-combatant) deaths.

The recent bilateral peace negotiations between the Colombian government and the largest guerrilla faction have shifted the nation into a 'partial post-conflict' phase and initiated the process of social reconciliation. The three main parties involved are victims of armed conflict, ex-combatants and the civilian population. Issues of relevance to mental health include: citizen security; demobilisation and reintegration of members of armed groups; and property restitution for internally displaced persons (IDPs). Even as the process evolves, clashes continue unabated between the Colombian military and armed outlaw groups (guerrilla, narco-paramilitary, criminal bands).

Following the passage of the Victims' Law in 2011, the Colombian government has created economic, legal, public health, medical, psychosocial

and mental health programmes for millions of persons officially designated as 'victims of armed conflict', an umbrella term that includes citizens affected by death, destruction, dispossession of lands, disappearance and displacement – all the casualties of the prolonged war.

Internal displacement

Among the categories of 'victims of armed conflict', Colombia has the largest population of conflict-affected IDPs in the world (Shultz *et al*, 2014a,b). Estimated at 5.7 million in 2013, Colombia's IDP population accounts for 19% of the worldwide total and 95% of IDPs in the entire western hemisphere. Nationally, one in eight Colombian residents are currently IDPs. Most displacement is 'rural to urban' and, once displaced, most Colombian IDPs are displaced for life. Throughout the trajectory of displacement – the phases of initial threat, forced expulsion, migration, early transition and long-term resettlement – IDPs face the stressors of physical and economic survival in unfamiliar places and vulnerable circumstances. These exposures elevate risks for common mental disorders (depression, anxiety, post-traumatic stress) as well as somatic complaints and substance misuse.

Conflict-related versus non-conflict-related violence

Studies have begun to examine the mental health impacts of violence in Colombia. Bell *et al* (2012) differentiated exposures to conflict-related and non-conflict-related violence, and found higher rates of anxiety disorders in the former and higher rates of substance misuse and aggression in the latter. However, it is not always possible to isolate the conflict and non-conflict effects; for example, conflict-displaced persons may relocate to urban settings where they are newly endangered by gang violence in the community, their children are bullied in school, employment opportunities are restricted to the 'informal sector' and partner abuse takes place within the household.

Family-based and gender-based violence

Most violence suffered by women and girls occurs in the home at the hands of male household members and intimate partners. Nationwide, one in five women living with a partner reports physical abuse and one in ten reports sexual abuse. As another variation of gender-based violence, in armed conflict zones, young girls have been forcibly recruited or kidnapped by armed groups and forced to work as fighters, informants, guides, messengers and conjugal partners to the group leaders, or sex slaves.

Substance misuse in the context of Colombia's role in international drug trafficking

From the supply side, Colombia is the primary cocaine source for drug markets worldwide. With recent crop diversification, the opium poppy is now cultivated and Colombia has rapidly become one of two primary source nations for heroin entering the USA.

From the demand side, the 2003 National Survey of Mental Health found that 10.6% of respondents met criteria for any substance use disorder (alcohol and drug use combined). Alcohol is the most common substance of misuse and drinking starts on average at age 14. The national lifetime prevalence rate of alcohol misuse, 6.7%, displays a pronounced gender disparity (one in ten men, one in 80 women). Survey data documented a significant association between substance misuse and the presence of depression and other psychiatric illnesses.

Psychiatric diagnosis, disability and suicide

An estimated 18% of persons with a psychiatric diagnosis qualify as having a disability. The lifetime prevalence of suicide attempt is 4.9% and the national suicide rate, 4.4 suicides/100 000 citizens in 2011, is one of the highest in the world – and rising in post-conflict populations.

Psychiatric training and services

Healthcare financing

Colombia's expenditures for healthcare, equivalent to 7.6% of the GDP, fund a two-tiered system that has attempted to achieve nearly universal coverage (Yepes Lujan, 2012). The contributory health insurance system for employers and their formally contracted employees covers healthcare provided by 22 'EPSs' (akin to health maintenance organisations) for 44% of the Colombian population. The remainder, including those who are poor or unemployed, receive 'subsidised' healthcare paid for by taxes and other deductions from workers' pay. There are gross disparities between the coverage and care provided within the two systems and Colombia's healthcare faces a grave crisis due to widespread corruption and regulatory failures (Yepes Lujan, 2012). A mechanism has been put in place to allow persons to sue for delivery of proper medical care but, in practice, this is crippling the system.

Mental health needs and care access

The number of psychiatric beds has decreased over the past decade, leading to overcrowding. About 75% of psychiatric beds are in public hospitals. In contrast, the military facilities are well equipped; however, many soldiers with post-traumatic stress disorder (PTSD) go untreated following their discharge and return to their rural communities.

Mental health workforce

About 900 psychiatrists (including 45 child psychiatrists) and 1500 psychologists are tasked with delivering mental healthcare in specialty medical centres, general hospitals and psychiatric facilities. Ninety per cent of psychiatrists are concentrated within Colombia's ten largest cities. Specialisation in psychiatry requires a 3-year residency programme (residents pay for their tuition and receive no compensation) based in 11 medical schools nationwide; currently about 100 resident physicians are in training. Psychiatric

training focuses on psychodynamic therapies and pharmacotherapy, with the recent addition of training in cognitive-behavioural and systemic therapies.

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International employment schemes for people with mental health problems

Bob Grove

Senior Policy Adviser, Mental Health Europe, Brussels, email doctorbobgrove@aol.com

It has been recognised that work is a positive factor for mental health since the days of Galen (2nd century CE). It was central to the theories and practice of William Tuke at the Retreat in York (founded 1796) and has continued in different forms as a therapy and/or a form of rehabilitation ever since. These forms can be usefully divided into four main categories: sheltered work, vocational training, transitional employment (or work experience) and supported employment. These broad categories have been adapted to different cultures and economic circumstances across the world. There are advantages and disadvantages to all forms, but the burgeoning research literature of the past 20 years does show that when it comes to finding people paid work in the open labour market, supported employment is markedly more successful than other methods.

The four main categories of employment schemes – sheltered work, vocational training, transitional employment (or work experience) and supported employment – have been adapted to different cultures and economic circumstances across the world, though if such schemes exist in low- and middle-income countries they tend not to appear in the literature. Paid employment is not always prioritised but increasingly this is what service users say they aspire to and in this article 'employment' is taken to mean work which is paid at the going rate for the job. Therefore, the extent to which these models lead to paid employment is considered a primary outcome. There are advantages and disadvantages to all forms – none is the complete answer for everyone who wants a job, but the burgeoning research literature of the past 20 years does show that when it comes to finding people paid work in the open labour market, supported employment is

markedly more successful than other methods. For the purposes of this brief article I have excluded discussion of volunteering – an important and valued activity in its own right but not necessarily a methodology for employment integration.

Sheltered work

Sheltered work – work in specially constructed protected environments – is slowly (and painfully) disappearing from modern mental health services across the world, along with other forms of institutional care. The reasons for this decline are manifold: the changing aspirations of mental health service users; poor-quality, repetitive work often with little or no pay; segregation from the workaday world; very low rates of transition to the open labour market; and cost. The end of sheltered workshops is painful because, as with other institutions, those who work in them (including the staff) become dependent on them. Thus, decisions are postponed until the work dries up and the costs become so huge that they are completely unsustainable.

Newer forms of sheltered work – social firms, social cooperatives – have minimised many of the disadvantages of the sheltered workshop. Beginning with the social integration (type B) cooperatives (Thomas, 2004) formed at the time of the reforms inspired by Franco Basaglia in Italy in the 1970s, large numbers of small and medium-sized enterprises whose main aim is to create employment for people with disabilities and those who are disadvantaged have sprung up across Europe, North America (where they are called 'affirmative enterprises') and elsewhere (Warner & Mandiberg, 2006). Ideally, these enterprises compete for business with other firms in the open market, pay workers the rate for the job, provide good working conditions and achieve high levels of worker participation. They are popular in places

with unemployment problems and high levels of stigma against people with mental illness. Greece, for instance, has made social cooperatives a key part of the structural reform of mental health services. Apart from Italy, the largest, most numerous and most economically successful social firms are in Germany. Elsewhere, the numbers are small, although there are some outstanding examples in the UK and North America. The disadvantages are mostly to do with the difficulties of running any kind of business, scalability and poor permeability with the open labour market.

Vocational training

The idea of preparing people for work by providing them with vocational skills (train, then place) sounds like common sense. However, in practice the way such training is usually organised gives poor results when it comes to finding paid work. The reasons are not hard to find and with today's fast-changing labour market there is arguably even less justification for basic, generic training schemes. The problems begin with deciding what people should be trained for. Unless specifically commissioned by an employer, basic training schemes tend to opt for work that is no longer available or is now being carried out to a level which can only be achieved through industry standard training. Basic, generic training in information technology skills, woodworking, catering and so on have never been sufficient as a basis on which to offer jobs and nowadays the technological requirements of most workplaces have made specialised training essential. This means that, to be accepted, would-be workers have to compete for places on courses from which only the most accomplished will actually be employed. This does not, or at least should not, rule out people with mental health problems but the route to such a job would require the kind of intensive support that only individual supported employment services could provide. The unfortunate consequence is that people get stuck on a training roundabout, accumulating certificates in basic skills – which many enjoy and value – but never getting actual jobs.

One way out of the training trap may be to design modern forms of flexible, supported apprenticeship which have jobs at the end for all who can stay the course. However, it is important to note that schemes for people with mental health problems must fit with the ways in which entry into employment is organised at local and national levels. Only 5% of employers in the UK offer apprenticeships of any kind, compared with around a quarter of employers in Germany, Austria and Australia. In Germany, two-thirds of people under 25 have completed an apprenticeship qualification and there is a subsidy for employers who provide extra support for people with disabilities.

Transitional employment (or work experience)

Transitional employment is a way of working which is specific to the International Clubhouse

Movement. It is based on the idea that people can prepare psychologically and socially for paid work by taking on a temporary job, which if successful gives them the confidence and discipline to apply for more permanent jobs. Nowadays the International Clubhouse standards specify supported, individually designed employment opportunities as a part of what is on offer, which arguably fall under the same broad heading as other forms of supported employment. In their pure form, placements in transitional employment are found and owned by the local clubhouse, which enters into a relationship with a local employer in which the clubhouse guarantees to get the work done, no matter who does it. The clubhouse then offers the job to a member for a limited period (6–9 months at most), who will be paid the rate for the job. If the post-holder becomes unwell, then another member (or a member of staff) will step in to fulfil the contract. Jobs are usually part-time and entry-level.

The theory of transitional employment as a bridge to permanent employment holds good as long as the member is able to cope with the loss of a job to which he or she has become attached and then plucks up the courage to take on a new job and new set of work relationships. Advocates of supported employment (discussed below) would argue that if the individual wants a job, it is probably best to go for it directly, thus obviating the need for a difficult transition. Clubhouse advocates argue that for some people this relatively risk-free form of employment commitment is a necessary stepping stone to the open labour market. There are over 300 clubhouses worldwide in 28 countries, with most situated in the USA. Numbers reach double figures in Canada, Korea, China and Finland, with other significant clusters in Sweden, Denmark and Japan.

In one randomised controlled trial (RCT) involving 120 participants, directly comparing clubhouse-supported employment with that practised in ACT (assertive community treatment) the clubhouse version performed as well or better in terms of employment outcomes (Macias *et al.*, 2006).

Supported employment

Supported employment reverses the proposition behind vocational training – it is *place then train* not *train then place*. Adapted originally from the 'job coach' model of supported employment for people with intellectual disabilities, the form of supported employment known as individual placement and support (IPS) is the most researched model of employment scheme in the mental health field. Much of the research has been undertaken in the USA, where the methodology was developed (Bond *et al.*, 2008), but there have been trials in Europe and Australia, including a multicentre study (EQOLISE) across six European countries (Burns *et al.*, 2008) and a Cochrane review (Crowther *et al.*, 2001). With one exception (Heslin *et al.*, 2011) almost 20 RCTs have shown IPS to be superior to a range of alternative methods (including all those discussed above) in terms of employment

outcomes, however these are measured. The EQOLISE study used as controls the best available alternative methods and showed IPS to be superior in each country. It also showed that the intervention group had a lower dropout rate and fewer hospital admissions than the controls, thus countering the suggestion that the rigours of open employment might be harmful to health.

International comparisons show that the advantages of IPS in terms of employment outcomes (Bond *et al.*, 2012) and cost-effectiveness (Knapp *et al.*, 2013) are maintained across different countries. However, absolute rates of employment do not match those achieved in the USA, and despite the strength of the evidence base IPS is still not widely implemented. This has been attributed to differing client and clinician attitudes, different organisational contexts and low-fidelity implementation (Boardman & Rinaldi, 2013).

Individual placement and support is a manualised methodology using a fidelity scale with 24 items based on eight basic principles:

- It aims to get people into competitive employment.
- It is open to all those who want to work.
- It tries to find jobs consistent with people's preferences.
- It works quickly.
- It brings employment specialists into clinical teams.
- Employment specialists develop relationships with employers, based upon a person's work preferences.
- It provides time-unlimited, individualised support for the person and the employer.
- Benefits counselling is included.

The higher the fidelity, the better are the outcomes, but it is highly skilled work and both individual employment specialists and employment support teams operate in a culture of continuous review and learning. Having said all of which, IPS does not work for everyone entering the programme. Employment rates range from 40% to 80%, depending on local conditions, the skills

of the practitioners and the degree of fidelity to the model. However, it is clearly the best model the mental health field has to offer thus far to service users who want paid, competitive employment and it is increasingly recognised, even in countries where other methods are deeply embedded, that it should be one of the options available.

Conclusion

There is sufficient evidence to say that IPS is the most effective technology so far devised for enabling people with mental health problems to gain competitive employment and it should be available to everyone with this aspiration, no matter where they live.

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BJPsych International Volume 12 Research Supplement, May 2015

The Research Supplement is freely available online at http://www.rcpsych.ac.uk/pdf/PUBNS_InterV12n2_Supp.pdf. Topics include: a psychiatric liaison service in Rawalpindi, Pakistan; the effect of aerobic exercise in the maintenance treatment of depression; scaling up mental healthcare in the Republic of Niger; evaluation of undergraduate psychiatry teaching in Malawi; hospital doctors' management of psychological problems at a Nigerian tertiary health institution; the WHO mhGAP Intervention Guide; implementing the NICE guidelines for schizophrenia in Lagos, Nigeria; and mental health research in the Arab world.

Rapid tranquillisation: a global perspective

Pallavi Nadkarni,¹ Mahesh Jayaram,² Shailesh Nadkarni,³ Ranga Rattehalli⁴ and Clive E. Adams⁵

¹Assistant Professor, Department of Psychiatry, Queen's University, Kingston, Ontario, Canada, email nadkarnp@kgh.kari.net (at the time of the project, she was a ST4 trainee with Leeds Partnerships Foundation NHS Trust)

²Senior Lecturer, Department of Psychiatry, University of Melbourne, Australia

³Vice-President, National Research Corporation Canada, Markham, Ontario, Canada

⁴Consultant Psychiatrist, Newsam Centre, Seacroft Hospital, Leeds, UK

⁵Professor of Psychiatry, University of Nottingham, UK

Violence and aggression among patients suffering from mental health problems undoubtedly pose a challenge to healthcare professionals, families and carers. Aggressive behaviours affect all aspects of clinical care. The goal of professionals is to ensure safety while effectively managing behavioural emergencies. 'Rapid tranquillisation' implies prescribing pharmacological agents to manage these behaviours. This article highlights changing prescription trends. Appraisal of global guidelines suggests that factors other than scientific evidence dictate their evolution. High-quality randomised controlled trials are needed to develop a global guideline.

The management of violence and aggression

Violence and aggression among patients suffering from mental health problems undoubtedly pose a challenge to healthcare professionals. Families and carers find it difficult to cope and often are victims of the aggression. In-patient admission units may present a volatile environment where the surroundings can trigger or amplify such behaviours. The goal of healthcare professionals is to ensure safety while effectively managing behavioural emergencies.

Psychosis, concomitant physical illness and substance misuse or personality traits are frequently cited as aetiological factors leading to violence or aggression. In about 10% of these patients this may further escalate, leading to assaultive behaviour. Aggressive behaviours affect all aspects of clinical care. Apart from physical and psychological consequences, violent behaviour has considerable financial implications in terms of staff injuries and absenteeism (Hunter & Carmel, 1992). A press release (National Health Service, 2005) stated that there were 43 301 incidents of physical assaults against National Health Service staff working in mental health settings in 2004/05 across England.

Over the years, various interventions have been tried to manage violence and aggressive presentations. Blood-letting gained popularity after Paracelsus stated, 'Retention of toxic materials in the blood can lead to insanity'. Therapeutic bleeding was a panacea in ancient Egypt and Western cultures up to the late 1800s. Enemas and purgatives followed suit as an extension of this theory. Fasting and prayer were also used. Subsequently, the therapeutic effects of hypnotics were discovered and somnifacients were advocated.

More recently, guidelines advocate various non-pharmacological interventions, such as de-escalation, before medications are used. They also recommend a holistic assessment replete with all relevant physical and laboratory investigations before the institution of pharmacotherapy (Expert Consensus Panel, 2005).

Rapid tranquillisation

It can sometimes be impossible to conduct a thorough physical examination of a violent patient. To ensure the safety of everyone involved, rapid tranquillisation of aggressive or violent patients may be unavoidable in these situations. Tranquillisation means calming without sedation. It is the use of psychotropic medication to control agitated, threatening or destructive psychotic behaviour, and is defined by the National Institute for Health and Care Excellence (NICE) as:

the use of medication to calm/lightly sedate the service user, reduce the risk to self and/or others and achieve an optimal reduction in agitation and aggression, thereby allowing a thorough psychiatric evaluation to take place, and allowing comprehension and response to spoken messages throughout the intervention. (NICE, 2005)

It is used when appropriate psychological and behavioural approaches have failed to de-escalate disturbed behaviour and is therefore essentially a last resort.

Historically, two strategies have been used for rapid tranquillisation:

- high-potency antipsychotic drugs, with an anxiolytic (benzodiazepine) or other drug for sedation
- low-potency antipsychotic drugs with both sedative and antipsychotic effects.

The procedure involves administering low doses of antipsychotic medication every 30–60 minutes with the specific goal of decreasing violence. A concurrent sedative medication often has the advantage of allowing a lower dose of antipsychotic, and therefore is associated with a decreased incidence of extrapyramidal side-effects. A lack of consensus among psychiatrists on the best medications to use for rapid tranquillisation highlights the need to have standardised guidelines which would enable some degree of uniformity in practice, although they would still remain only a guide and use would have to be tailored to individual patient needs, circumstances and available resources.

Interest has been rekindled in the topic by the inquiries into the deaths of patients Orville

Blackwood in 1991 and David 'Rocky' Bennett in 1998 in the UK, both Afro-Caribbean males who died while in seclusion. They had always instilled a fear of violence in the nursing staff who had perhaps perceived them as 'big, black and dangerous'. The inquiry committees alerted psychiatrists to be wary of institutional bias against ethnic minorities owing to failure of Euro-centric psychiatry to appreciate cultural differences.

The need for consensus and better guidelines

A strong evidence base does not underpin rapid tranquillisation. Recommendations have therefore been based partly on research data and partly on clinical experience. One point of criticism is that studies have not included participants who were unable to consent.

The TREC Collaborative Group (2003) produced compelling evidence. Despite the robust methodology, the findings have not been incorporated into most guidelines. The 'zero tolerance' campaign of the UK National Health Service (NHS) has added another dimension to this issue. Most NHS trusts operate their own policies for rapid tranquillisation and emergency treatments.

There is no international consensus on the most effective treatment. Guidelines are statements of consensus and differ on which drugs to use. Clinical practice guidelines have been defined as 'systematically developed statements of recommendation for patient management to assist practitioner and patient decisions about appropriate health care for specific situations' (Institute of Medicine, 1990).

Clinician preference surveys also show variation. Antipsychotics and/or benzodiazepines are generally preferred as they can swiftly and safely calm patients. Given the scale of the problem there is a need to have a high-quality survey of clinician preferences and to critically examine the available evidence from guidelines recommending interventions for rapid tranquillisation.

Appraisal of existing guidelines

We identified seven national guidelines on rapid tranquillisation from five English-speaking countries: the UK, the USA, Canada, Australia and New Zealand (Nadkarni *et al*, 2014). Methodological quality was studied using the Appraisal of Guidelines Research and Evaluation (AGREE) instrument (AGREE Collaboration, 2003). All guidelines scored well on the domain of scope and purpose. The NICE guidelines consistently scored well on all domains with the exception of editorial independence. Surprisingly, the various guidelines lack uniformity in their recommendations. To cite examples, the guidelines from the Royal Australian and New Zealand College of Psychiatrists (RANZP) recommend benzodiazepines as the sole first-line option (McGorry, 2004). The NICE (2005) guidelines recommend using lorazepam only in cases of non-psychotic behavioural disturbance. The guidelines produced by the American

Psychiatric Association (APA, 2004) and those produced by the Canadian Psychiatric Association (CPA, 2005) recommend antipsychotics as the first line. The APA guidelines equate haloperidol with the atypical antipsychotics, whereas the CPA guidelines strictly recommend second-generation antipsychotics. The guidelines from the Royal Australian and New Zealand College of Psychiatrists (McGorry, 2004) recommend zuclopenthixol even in drug-naïve patients, to avoid repeated injections (unlike the NICE and CPA guidelines).

Clinician surveys and changing trends

A search of the literature published between 1992 and 2005 revealed eight clinician practice surveys and two clinician preference surveys on rapid tranquillisation (Nadkarni *et al*, 2014). In 1994 most clinicians (68%) opted for sedation as the desired outcome, while expecting it to be quick (Cunnane, 1994). In another survey, in 25% of incidents of aggression and violence patients received repeat doses of psychotropic agents within an hour of administration of the first agent (Pilowsky *et al*, 1992). Studies have found that higher initial doses do not lead to more rapid symptom resolution and are therefore unjustified for routine use (Huf *et al*, 2002). This was reflected in a local survey we conducted in an NHS hospital in 2009 (Nadkarni *et al*, 2014). From a total sample of 95 doctors, 60 (63%) responded, of whom 51 (54%) completed the questionnaires (nine were unable to complete the questionnaires owing to lack of experience, inadequate information or leaving employment). Of the respondents, 18% were consultants. As the drug of first choice, 45% would opt for lorazepam; other choices were olanzapine (33%), haloperidol (12%), haloperidol plus lorazepam (6%) and haloperidol plus promethazine (2%). The doses were within the range recommended by *British National Formulary* and choices conformed with the NICE guidelines. Preferences for monotherapy and the oral route (78%) were in contrast to the older surveys; 92% aimed to achieve a calming effect without sedation, which was in keeping with the NICE guidelines.

Final comments

Clinician preferences have changed over time as recommendations from guidelines are incorporated in daily practice. This reflects the use of evidence-based medicine. What needs to be seen is how sound and unanimous this evidence is. It appears that the desired outcome and side-effects dictate the choice of the agent used for rapid tranquillisation. While a sedated patient might be the best solution in a busy, resource-stretched country such as Brazil, a calm patient is ideal in a higher-income country with adequate resources such as the USA or the UK. This may explain why guidelines differ in their choice of agents for rapid tranquillisation, although they access the same evidence pool. Despite there being a good-quality evidence base in the form of randomised controlled trials favouring promethazine (TREC Collaborative Group, 2003), it has not been licensed in the

UK for use in rapid tranquillisation. This may be the result of these trials being conducted in a different country. Organisational and cultural differences between countries can lead to legitimate variations in recommendations. It is evident that treatments used for rapid tranquillisation still do not have a clear evidence base and uncertainty is still prevalent.

This work now raises a question: is current practice ethical in the UK, without the support of evidence from a well-designed randomised controlled trial? A local survey conducted in 2010 highlighted high conformity with NICE guidelines. However, it is evident that cultural and personal factors influence the recommendations – not scientific evidence alone. Hence we conclude that high-quality randomised controlled trials with large samples are urgently needed. This will generate more evidence for the development of a global guideline rather than clinician preferences dictating their course. We can then hope to envisage evidence-based and ethical clinical practice in the near future.

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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)



World Suicide Prevention Day

In 2003, 10 September was designated World Suicide Prevention Day (WSPD), an annual event aiming to raise awareness and prompt action. The International Association for Suicide Prevention (IASP), the World Health Organization (WHO) and the World Federation for Mental Health (WFMH) collaborate to host WSPD. Suicide is a major social and public health issue! Nearly 1 million people around the world kill themselves every year. Every 40 seconds one person somewhere in the world puts an end to his or her life. Suicide is a global phenomenon. The highest rates are among those aged 70 or over, although globally suicide is the second leading cause of death among those 15–29 years old.

In September 2014 the WHO published its first 'World Suicide Report', *Preventing Suicide: A Global Imperative*, according to which 75% of suicides are in low- and middle-income countries. The WHO Director-General, Dr Chan, noted 'This report is a call for action to address a large public health problem which has been shrouded in taboo for far too long'.

The onset of these activities dates back to the 1990s, when concern about the high rates of suicide led some countries to approach the United Nations

(UN) and the WHO for help in designing national plans to tackle this problem in a cost-effective way. The UN, supported by the WHO, responded by issuing in 1996 the influential document 'Prevention of suicide: guidelines for the formulation and implementation of national strategies'. At that time only Finland had a government-sponsored initiative to develop a national framework and programme for suicide prevention, but within 15 years more than 25 low-, middle- and high-income countries had a strategy. In 2008, the WHO identified suicide as a priority condition in the Mental Health Gap Action Programme (mhGAP), designed to scale up care for mental, neurological and substance use disorders and particularly aimed at middle- and low-income countries. Research attention worldwide also turned to the prevention of suicide. WHO member states made a commitment to work towards a 10% reduction of suicide rates by the year 2020. Time will show!

A dream turned into a nightmare

Continuing with the theme of suicide, the same September 2014 WHO report states that 'while mental health problems play a role, which varies across different contexts, other factors, such as cultural and socio-economic status, are

also particularly influential'. An example of how socioeconomic status can influence suicide rates is the dramatic rise of suicides in Greece during the ongoing recession in the past few years. Branas and colleagues, examining national data from the Hellenic Statistical Authority over a period of 30 years, assembled monthly counts of all suicides, and found that select austerity-related events in Greece corresponded to statistically significant increases in suicides. January 2002, a time of optimism which saw the launch of the euro in Greece, marked an abrupt but temporary decrease in male suicides. There was then a marked and sustained increase in male suicides in October 2008, when the Greek recession began. In April 2012 there was an abrupt but temporary increase, which, according to the authors, followed a public suicide in response to austerity conditions. Suicide rates in women also showed an abrupt and sustained increase from May 2011 and there was a dramatic increase of 35.8% in women and 18.5% in men after the passage of the new austerity measures.

Although not able to claim cause and effect, the authors demonstrate a good correlation between austerity and suicide increase as well as prosperity and suicide decrease. The authors warn those in power who consider future austerity measures to give greater weight to the unintended mental health consequences as well as to the public messaging of these policies and related events.

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A global health risk framework (GHRF)

The outbreak of ebola in West Africa highlighted the shortcomings of the current global health system, claim the authors of an article in the *New England Journal of Medicine*. An independent, multinational Commission on a Global Health Risk Framework for the Future has now been established to recommend a more effective global architecture for mitigating the threat of epidemic infectious disease. The Commission will be guided by a sound evidence base and will rigorously analyse options for improving governance, finance, health system resilience, and research and development for global health security. It will aim to foster trust, internationally, with various levels of government, civil society, academia and industry, and to keep the framework from being influenced by politics or the interests of any one country or organisation. The Commission's work will be overseen by an international group. The authors of the article are leading this: Dr Dzau is the chair and Dr Rodin the vice-chair of the International Oversight Group of the Global Health Risk Framework.

This initiative will look into ways of reforming or empowering the WHO and the UN systems so that they respond more effectively to public health emergencies. These could include the development of mechanisms for mobilising a global health workforce, strong regional networks that share

information to coordinate responses, and possibly creating national command centres. To ensure cooperation and global support and effects well beyond the health sphere, they plan to feature the Commission's work at major events of the UN, the World Health Assembly and the G7 and G20 groups of countries. They recognise that, ultimately, world leaders' actions will determine international preparedness for future pandemics and medical disasters.

Dzau, V. J. & Rodin, J. (2015) Creating a global health risk framework. *New England Journal of Medicine*, 373, 991–993.

What if there were a pill that made us more compassionate?

As the refugee influx into Europe accelerates and the drowning of men, women and children continues, the attitudes of many of those at the receiving end are hardening. What if there were a pill to make us more compassionate? Scientists claim there may be. Giving a drug that changes the neurochemical balance of the prefrontal cortex is associated with greater willingness to engage in pro-social behaviours such as ensuring resources are divided more equally.

In a double-blind study, 35 participants, including 18 women, received tolcapone, a drug used in the treatment of Parkinson's disease (it prolongs the effects of dopamine associated with reward and motivation in the prefrontal cortex), or placebo. They were asked to take a simple economic test, which involved dividing money between themselves and an anonymous recipient. When receiving tolcapone, the participants divided the money in a fairer and more egalitarian way than when they received placebo.

The authors suggest that fair-mindedness is not a stable personality trait and it can be affected by targeting specific neurochemical pathways in the brain. Consequently, studying basic scientific questions about human nature might provide insights into the diagnosis and treatment of social dysfunctions.

Sáez, I., Zhu, L., Set, E., et al (2015) Dopamine modulates egalitarian behavior in humans. *Current Biology*, doi: 10.1016/j.cub.2015.01.071

Forthcoming international events

6–10 July 2016

World Psychiatric Association International Congress: Integrating Clinical, Community, and Public Health in Psychiatry

Istanbul, Turkey

Website: <http://www.wpaistanbul2016.org>

18–22 November 2016

World Psychiatric Association International Congress: Psychiatry: Integrative Care for the Community

Cape Town, South Africa

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