Guest editorial
1 The need to reform mental health legislation in Commonwealth countries
Soumitra Pathare, Laura Shields, Jaya Sagade and Renuka Nardodkar

Thematic papers. Strategic developments in the delivery of psychiatric services worldwide
3 Introduction
David Skuse
3 Mental health: strengthening health and development opportunities in the WHO African Region
Carina Ferreira-Borges
6 Mental health in Latin America and the Caribbean
Jorge J Rodriguez
8 Together to make a difference in mental health in the Western Pacific Region
Xiangdong Wang

Mental health law profiles
10 Introduction
George Ikkos
11 Mental health law in Greece
A. Dratsinis, C. Tsepelas and L. Lykouras
12 Mental health law in Turkey: legislation pending
Esra Caglar and Musaffer Kaser

Research paper
15 Teaching psychiatry to undergraduate medical students in Somalia
Lauren Gavaghan, Peter Hughes, Khalid Saeed and Susannah Whitwell

Special papers
18 Community mental health services in Al Ain Hospital, United Arab Emirates
Amir Mufaddel, Mouna Al Saboussi, Yahya Takriti, Badr Dawoud, Nora Cansino, Habib Belhaj and Nasser Al Hekmani
20 Addressing the mental health needs of a rapidly growing megacity: the new Lagos Mental Health Initiative
Olufemi Oluwalaye, Olufemi Olugbile and Ayodele Coker

News and notes
23
Correspondence
24
Forthcoming international events
25
Forthcoming international events

13–15 March 2014
V International Congress of Medicine and Women’s Mental Health
Medellín, Colombia
Website: http://www.medical-events.com/vmhm14/

14 March 2014
American Association for Geriatric Psychiatry, Annual Meeting
Orlando, USA
Website: http://www.confereencalendars.com/psi/psy/6htm

14–15 March 2014
21st International Symposium About Current Issues and Controversies in Psychiatry
Barcelona, Catalunya, Spain

18–21 March 2014
16th Annual Conference of The International Society for Bipolar Disorders
Seoul, South Korea
Website: http://www.medical-events.co

19–21 March 2014
3rd Neurological Biomarkers
San Diego, California, USA
Website: http://www.cibe.org/conference

22–25 March 2014
4th Global Conference: Trauma: Theory and Practice
Prague, Czech Republic
Website: http://www.inter-disciplinary.net/idl-the-international-workshop-idl-for-papers/

27 March 2014
ACP2014 – The 4th Asian Conference on Psychology and the Behavioral Sciences Osaka, Japan
Website: http://www.confereencalendars.com/psi/psy/6htm

4 April 2014
5th Global Symposium for Psychology Professionals
Los Angeles, USA
Website: http://www.confereencalendars.com/psi/psy/6htm

8 April 2014
16th International Neurosciences Winter Conference
Sbolden, Austria
Website: http://www.confereencalendars.com/psi/psy/6htm

15–17 April 2014
10th International Conference on Psychiatric Psychotherapy Models: Biological and Psychological Perspectives
Jeddah, Saudi Arabia

23–25 April 2014
STEM Call Summit 2014
Cambridge, Massachusetts, USA
Website: http://www.gtcbio.com/conference

28 April 2014
International Society for Affective Disorders Congress
Berlin, Germany
Website: http://www.confereencalendars.com/psi/psy/6htm

28–30 April 2014
International Society for Affective Disorders Congress
Berlin, Germany
Website: http://www.ivsdconference.com/

13–16 May 2014
19th International Conference of the Association of Psychology and Psychiatry for Adults and Children (APACP)
Recent Advances in Neuropsychiatric, Psychologcal and Social Sciences Athens, Greece
Website: http://www.appaci.gr/displayITM1.asp?ITMID=18&LANG=EN

21–24 May 2014
17th EPA Section Epidemiology and Social Psychiatry Meeting: ‘Disease Burden and Disease Driver’
Ulm Neu-Ulm, Germany
Website: http://www.epa2014ulm.eu

Contents of the African Journal of Psychiatry (affiliated journal) Volume 16 Number 6 November 2013

Editorial
387 Improving mental health systems in Africa

EUSARNA
401 Report from First EUSARNA Colloquium, February 2013 D. Baldwin, M. Nowak

Scientific letters
410 Homemade heroin substitute causing hallucinations T. I. Leemon

Original articles
414 The prevalence of metabolic syndrome and its associated factors in long-term patients in a specialist psychiatric hospital in South Africa K. Maonganye, M. Mohapi, C. Kruger, P. Rivended
424 The accuracy of interpreting key psychiatric terms by ad hoc interpreters at a South African psychiatric hospital J. Hogan, S. Kthat, B. Chiulu, P. Biorgno, J. Jocka
430 Post traumatic stress disorder and resilience in veterans who served in the South African border war M. A. Connolly, O. Orkolu, U. Stansberry, S. Olayemi
437 Understanding cohort differences in appraisals of reconstruction priorities of mental health systems in post-conflict Liberia D. A. King, C. P. Corbin, B. L. Harris, S. D’Souza, R. Boyd, E. K. Wang, D. C. Henderson
456 Mild cognitive impairment and dementia in a heterogeneous elderly population: prevalence and risk profile S. Ramial, J. Chipp, B. J. Pillay, A. J. Bhigee

Movie review
467 Lincoln, Steven Spielberg F. P. Visser

South African Depression and Anxiety Group
470 Getting back to basics – raising stress literacy: the first step on the path to improving mental health – a South African study: patients as partners R. Hawkey

International Psychiatry Volume 11 Number 1 February 2014

Journals affiliated to International Psychiatry

African Journal of Psychiatry
Arab Journal of Psychiatry

Mission of International Psychiatry
The journal is intended primarily as a platform for authors from low- and middle-income countries, sometimes writing in partnership with colleagues elsewhere. Submissions from authors from International Divisions of the Royal College of Psychiatrists are particularly encouraged.

Editorial board
Michel Botbol France
Nick Bouras UK
Rakesh Chadda India
Santosh Chaturvedi India
George Christodoulou Greece
John Cox UK
Anna Datta Ireland
Olwule Farmayemi UK
Christopher Hawley UK
Peter Hughes UK
George Ikchos UK
Eleni Palidouza UK
Rachel Jenkins UK
Stephen Kelsey UK
Marinos Kyrokolou UK
Nasser Loza Egypt (Assistant Editor)
M. Almol Mokhdum UK
Amil Motlik UK
Donald Miliken Canada
Ghulam Reza Mir-Sepassi Iran
R. N. Mohan UK
Hollen Najyan UK
David Niditer Kenya
Seán O’Domhnaill Ireland
Olufemi Olugbile Nigeria

The views presented in this publication do not necessarily reflect those of the Royal College of Psychiatrists, and the publishers are not responsible for any error of omission or fact.

The Royal College of Psychiatrists is a charity incorporated in England and Wales (228856) and in Scotland (SC038369).

The journal is intended primarily as a platform for authors from low- and middle-income countries, sometimes writing in partnership with colleagues elsewhere. Submissions from authors from International Divisions of the Royal College of Psychiatrists are particularly encouraged.

The views presented in this publication do not necessarily reflect those of the Royal College of Psychiatrists, and the publishers are not responsible for any error of omission or fact.

The journal is intended primarily as a platform for authors from low- and middle-income countries, sometimes writing in partnership with colleagues elsewhere. Submissions from authors from International Divisions of the Royal College of Psychiatrists are particularly encouraged.

The views presented in this publication do not necessarily reflect those of the Royal College of Psychiatrists, and the publishers are not responsible for any error of omission or fact.

The journal is intended primarily as a platform for authors from low- and middle-income countries, sometimes writing in partnership with colleagues elsewhere. Submissions from authors from International Divisions of the Royal College of Psychiatrists are particularly encouraged.
The need to reform mental health legislation in Commonwealth countries

Soumitra Pathare1,2 MD, Laura Shields2,3 MSc, Jaya Sagade1,2 PhD and Renuka Nardodkar1,2 MSc

The outdated nature of many mental health laws is also illustrated through the terminology employed. Our review found the word ‘lunatic’ used in laws in 12 countries, ‘insane’ in 11, ‘idiot’ in ten, ‘imbecile’ in two and ‘mentally defective’ in two. Overall, 21 laws in Commonwealth countries (47%) use one of these terms, reinforcing the incapability of PWMI and thus reinforcing stigma.

Rights and services

Ensuring the right to health means mental healthcare is equated with physical healthcare, access to mental healthcare is specified in legislation and community-based care is mandated within law (in line with Article 19 of the CRPD). Our review found only 5 (11%) of the 45 Commonwealth mental health laws equated physical and mental health, and 11 (24%) had some provision for promoting community-based care. However, the broad thrust of these 11 laws was towards institutional environment and regulation. Arguably, community-based care and deinstitutionalisation are matters of broader health policy and not legislation; however, mental health laws themselves may be a barrier to enacting and implementing such policies.

Many PWMI receiving treatment are either unaware of their rights or not in a position to ask about their rights. Thus, a provision in legislation mandating health authorities to inform service users of their rights will help them to exercise those rights. Our review highlighted this deficiency, as the mental health laws of only 13 Commonwealth countries (29%) give patients the right to be informed of their rights while receiving care.

The transition from guardianship to supported decision-making

Under Article 12 of the CRPD, which is reaffirmed by Article 13, PWMI have the right to recognition as persons before the law and are entitled to equal benefit and protection of the law. Article 12 has been celebrated worldwide by disability activists as representing a ‘paradigm shift’ in our perception of PWMI. However, professionals and service providers have been less enthusiastic, primarily owing to concerns about the decision-making capacity of PWMI. The transition from guardianship to supported decision-making is mandated within law and deinstitutionalisation is a matter of broader health policy and not legislation; however, mental health laws themselves may be a barrier to enacting and implementing such policies.

Traditionally, concern about capacity led to the inclusion of guardianship provisions in mental health legislation – we found that 24 Commonwealth countries (53%) had guardianship provisions in their mental health legislation; of these, 7 (29%) allowed only limited guardianship (restricted to property matters), while 14 (58%) had provisions for both limited and plenary (full) guardianship.

Plenary guardianship conflicts with obligations under the CRPD, as it does not allow PWMI to retain decision-making abilities, rendering them...
found laws in only 24 countries (53%) mandate restrictive care. The majority of laws specified that persons admission and treatment are the preferred alternative towards voluntary care. Our review found that 32 restrictive care orders, contrary to the requirements of Article 12. Currently, all Commonwealth laws allow involuntary admission and treatment for PWMI. We found laws in only 24 countries (53%) mandate that the mental disorder be of a specified severity to allow involuntary admission; in the remaining countries, there is no such requirement. Often, laws allow involuntary admission only if there is a serious risk of harm to self or others, or a likelihood of serious deterioration in the patient’s condition if treatment is not provided. This was the case in 31 Commonwealth countries (69%). Amendment of these provisions may be necessary to comply with the CRPD. In fact, the UN High Commissioner for Human Rights goes as far as to say that any form of involuntary admission or non-consensual treatment is considered non-compliant with the CRPD and provisions relating to involuntary admission and treatment should be removed from all mental health legislation (Mendez, 2013).

Moving forward

Although there is substantial encouragement from regional, national and international actors to reform mental health legislation, as well as the shifting discourse on rights, many mental health laws still espouse guardianship, institutionalisation and protectionism as opposed to models of supported decision-making, community-based care and entitlement. The key goals of mental health legislation should be to facilitate better access to and the quality of mental healthcare, and to promote the rights to social inclusion of PWMI. A number of countries are currently reforming their legislation, the result of which may be more progressive mental health law. While legislation by itself cannot improve the situation in the absence of well designed and implemented policies and services, it is a necessary and important step. Future work in this area should look at subsidiary legislation, which may have important provisions for rights protection, and explore civil, political and economic laws, as well as social and cultural rights for PWMI. The Commonwealth should provide technical and financial support, in particular for those countries with limited resources.

References


non-persons before the law, contrary to Article 12. Limited and partial guardianship are preferred over plenary guardianship, as PWMI then retain some decision-making abilities, although, ideally, provisions for supported decision-making would be in place in legislation, in line with Article 12.

While the notion of supported decision-making is a relatively new concept and it would be premature to evaluate its implementation in legislation across Commonwealth countries, some (e.g. Australia, Canada, Scotland) have replaced guardianship provisions in mental health legislation with supported decision-making provisions, largely through separate capacity legislation. These countries could share lessons learned on transitioning to supported decision-making models with more resource-scarce Commonwealth states. Supported decision-making can be tailored to fit a country’s legislative framework and resources, and can even make use of existing community resources (e.g. peer support to become ‘supporters’). This more adaptive approach counters the argument that these rights for PWMI are particularly problematic in low- and middle-income countries, primarily due to fragmented public health systems and resource scarcity, based on a presumption that supported decision-making will be resource intensive. This is not necessarily true: Kumar et al (2013) showed it was feasible in India for PWMI to write a psychiatric advance directive (PAD; one form of supported decision-making), despite active symptoms, and to engage carers in the PAD process with little in the way of additional resources.

There are also major procedural problems with existing guardianship provisions in mental health legislation. Of the 24 countries with such provision, only 3 (13%) had legislation that gives the person who is the subject of the guardianship application the right to appear before a court at the guardianship hearing and to be represented there. In addition, 16 countries (67%) had no provisions for appealing to a higher court against a guardianship order; nor did 19 (79%) countries provide for regular time-bound review of guardianship orders, contrary to the requirements of Article 13(1) of the CRPD.

Involuntary admission and least restrictive care

The last few decades have seen a movement towards voluntary care. Our review found that 32 countries (71%) had provisions for voluntary admission; however, few had laws stating that voluntary admission and treatment are the preferred alternatives. The majority of laws specified that persons voluntarily admitted to a mental health facility can be treated only after informed consent is obtained. Currently, all Commonwealth laws allow involuntary admission and treatment for PWMI. We found laws in only 24 countries (53%) mandate that the mental disorder be of a specified severity to allow involuntary admission; in the remaining countries, there is no such requirement. Often,
Strategic developments in the delivery of psychiatric services worldwide

David Skuse

We are delighted to have a trio of papers from senior staff members of the World Health Organization (WHO) on the strategic development plans for psychiatric services in the African Region, in Latin America and the Caribbean, and in the Western Pacific. We are truly privileged to publish these valuable documents, which reflect the current state of the WHO’s attempts to improve psychiatric services worldwide.

Dr Carina Ferreira-Borges reports from Africa, and draws attention to the WHO’s Comprehensive Mental Health Action Plan for 2013–20. This emphasises the importance of delivering care in the community and of considering the notion of recovery. Despite the emphasis in the plan on moving away from a purely medical model to a socially responsive model of care for people with mental health problems, there has been little movement in this direction in Africa. Unfortunately, in most African states, mental health has a low priority. It is considered to be a ‘small problem’ compared with the burden of communicable diseases, an attitude fostered by the big donors from the West.

Dr Jorge Rodriguez reflects on the possibilities of delivering the objectives of the WHO’s Comprehensive Mental Health Action Plan in Latin America and the Caribbean. He points out that the small proportion of the health budget of countries in the region that is spent on mental health is targeted largely at mental hospitals. Only two-thirds of countries in the region have a national mental health plan. There are considerable constraints and difficulties to overcome before 2020.

Finally, Dr Xiangdong Wang reports from the Western Pacific. He draws our attention to the very high rate of suicide in this region: an astonishing one in three of all suicides globally takes place here. Encouraging news is adduced. There is recognition among health ministers that the disasters associated with the region in recent years have increased the burden of mental health problems, and that effective action is urgently required. It is gratifying to read about the initiatives that are taking root in the region, including a strategy to manage the high suicide rate and the pending transformation of mental healthcare delivery.

Mental health: strengthening health and development opportunities in the WHO African Region

Carina Ferreira-Borges

Despite the efforts of the World Health Organization (WHO) to put mental health at the core of the health and development agendas, the underdevelopment of services in Africa is widespread. The adoption of the WHO’s Comprehensive Mental Health Action Plan 2013–20 at the 66th World Health Assembly in May 2013 provides an opportunity to reshape policy. In the African Region, mental health generally appears to be of low interest and people with mental health conditions are not prioritised. This article describes factors that contribute to this low level of interest and recommends collective action to prioritise mental health on the public health and social development agendas. It is also a call to all stakeholders to increase financial investment and bring mental health out of the shadows.

Research has shown that addressing mental health has a positive impact not only on the overall burden of diseases but also on human development, including economic growth and poverty and conflict reduction. The World Health Organization (WHO) has played an active role in
putting mental health at the core of health and development agendas. This has been reflected in important global initiatives, such as the World Health Report dedicated to mental health (WHO, 2001), the 2010 WHO report Mental Health and Development, and the 2013–20 Mental Health Action Plan recently approved by the World Health Assembly (WHO, 2013). Several other initiatives, including the WHO MIND project and the Mental Health Gap Action Programme (mhGAP) have also been launched by the WHO in an attempt to increase political commitment and the capacity of member states to address mental health (WHO, 2008). Ongoing projects and initiatives have provided a better assessment of the key components of national mental health systems and so help to improve planning (WHO, 2009).

Yet, despite all the evidence showing some improvements, reforming mental health systems has not been easy in the African Region. Mental illness is not receiving from government authorities and donors the visibility, commitment and resources that are warranted by the magnitude of the burden. In the African Region, neuropsychiatric conditions make a substantial independent contribution to the burden of disease, accounting, in 2004, for 5% of the total burden of disease in Africa (WHO, 2004), and the overall economic costs are very high. The financial and human resources available for mental healthcare in Africa are insufficient to address the problem effectively. Seventy per cent of African countries spend less than 1% of their small health budgets on mental health (WHO, 2005) and most of that is consumed by large psychiatric institutions, contrary to growing evidence for cost-effective community-based interventions (Patel et al., 2007). In the region, there is 1 psychiatrist per 2.5 million people, 1 psychiatric nurse per 500,000 people and 1 psychologist per 2 million people, while the world median numbers are 1.3 psychiatrists per 100,000 population, 5.8 nurses per 100,000 population and 1 psychologist per 300,000 population (WHO, 2011).

An evaluation of the Regional Strategy for Mental Health 2000–10, covering 34 countries (WHO Regional Office for Africa, 2000; Lund et al., 2010), revealed a marginal increase in the proportion of African countries with a national mental health policy and mental health laws, as well as a critical shortage of financial and human resources. Although efforts are being made, the underdevelopment of mental health services in Africa is widespread. Many reasons can be advanced to explain why countries are responding in such a way to mental health problems. A study developed under the Mental Health and Poverty Project (MHaPP) in four countries of the African Region (Fisher et al., 2007; Bird et al., 2011) looked at factors affecting the low priority given to mental health and grouped them into three categories adopted from the Hall model (Hall et al., 1975). This model looks at the setting of health priorities and argues that a policy issue comes onto the policy agenda only when the issue and its possible solution are ranked high in terms of their legitimacy, feasibility and support. In a simple way, this would mean that for mental health to be prioritised in countries’ policy agendas there would need to be a ‘perceived social obligation’ to do something to resolve the problem, a ‘perceived feasibility of implementation of a response’ (translated into the availability of theoretical and technical knowledge, human and financial resources and infrastructure) and ‘perceived support’ (translated into public support for government action, for mental health and for the proposed solutions).

Based on this study, in order to analyse the situation in the region, we have examined each of these criteria against regional findings.

**Legitimacy or perceived social obligation to act**

The results from the MHaPP study showed that there was a limited appreciation of the prevalence of mental illness among decision makers in the four participating countries (Ghana, South Africa, Uganda and Zambia). Several factors contributing to this situation were identified in the evaluation report, and were summarised as country-specific focal points. There was a low level of research activity at the country level due to lack of capacity, resources and funding, and lack of routine data collection. A low level of reporting from health management information systems definitely contributes to the ‘invisibility’ of the problem in the African Region. Mental health is considered a ‘small’ problem, especially when compared with many communicable diseases. The latter are extremely well documented and receive highvisibility from high-profile donors. In contrast, mental health is not allocated enough financial or human resources.

Data were collected in seven countries in the African Region using the WHO Assessment Instrument for Mental Health Systems. This found that in these countries, between February 2005 and February 2008, the level of government mental health spending per capita was a median of US$0.01 while the median level of mental health spending per capita in the other reporting countries in regions outside Africa was US$0.30 (WHO, 2009). Such a low level of investment affects key components of each country’s mental health system. It implies a very low level of service delivery and availability of drugs and human resources, and very limited capacity and information systems.

**Perceived feasibility of implementation of a response**

Results from the MHaPP study showed that the chronicity of mental illness, the lack of appropriate response to treatment and the lack of any tangible evaluation of treatments signal to decision makers that provision for mental health management is a waste of resources. This evaluation of the regional strategy showed that it is generally believed that mental illness is more of a spiritual illness, or is attributable to supernatural causes. Either way, the
implication is that it is not appropriately addressed by the health system. Such misconceptions, together with the poor responses to treatment or lack of data on treatment outcomes, strengthen the view of governments that mental disorders are either untreated or that they are expensive to treat.

The current situation reveals limitations regarding current knowledge about mental health and the methods of treatment that are potentially available. It reflects cultural and social values that are not supportive of political actions favouring appropriate responses to the problem of mental disorders (prevention, treatment, rehabilitation). Mental health services remain centralised and institution-based in most countries of the region, thus consuming a lot of resources and reinforcing myths. Because of prejudicial views about mental illness, evidence of treatment impact on the outcomes of mental disorders is difficult to access. Organisational change, through decentralisation, has been advanced as an important way of improving the performance of mental health systems. There is no clear guidance, or examples of how mental healthcare can be integrated into general healthcare. There is evidence that services can be made accessible, affordable, acceptable and available, with patients being treated in their own communities rather than hospitalised far from home (WHO & WONCA, 2008). However, the response to mental health problems in the countries surveyed tends to reinforce negative views of mental health services.

Perceived support for action

The general public's interest in the well-being of people with mental disorders is low, in marked contrast to attitudes to communicable diseases. This lack of concern is associated with a lack of funding. There is no support for mental health from big donors to global health (and to initiatives in the African Region), such as the US government, the Bill and Melinda Gates Foundation and the Global Fund, or from development partners and other agencies. That lack of interest is a barrier to progress. In a region where donor funding plays an important role in health systems and where vertical programmes are aimed at specific diseases, especially communicable diseases, developing appropriate services and providing appropriate resources are real challenges. It is striking that there are few user groups, non-governmental organisations (NGOs) or other professional associations that strongly advocate for mental health, and that deficiency contributes to low support in general.

The lack of political commitment and the low prioritisation of mental health in the allocation of resources at all levels perpetuate the slow development and implementation of mental health policies, programmes and legislation. Data from the 2010 evaluation (Lund et al, 2010) revealed that the proportion of countries with mental health policies has marginally increased, from 48% to 50%, over the past few years. Although some countries do have draft policies in place, these remain inactive, as they still need to be ratified by government. Legislation faces the same constraint; only 25% of countries reporting have reformed their mental health legislation.

Discussion

The findings are largely consistent with other published studies on barriers to improved mental health (Saraceno et al, 2007; Lund et al, 2010; Bird et al, 2011). Despite efforts and some improvements, mental health continues to be left out of planning and prioritisation exercises both by governments and by other health and development stakeholders in the African Region. Competing health priorities, stigma, barriers to the implementation of policy, financial and human resource constraints and poor service delivery are both the cause and the result of this situation. Behind them lies a limited appreciation of the importance of mental health as a contributor to the overall burden of disease and poverty. This lack of appreciation has led to low levels of support for the provision of services and high levels of discrimination. People with mental disorders are seen as having a hopeless disease for which treatment represents a waste of resources, because it is largely ineffective. Alternatively, they are considered to be possessed by spirits and therefore are not ill.

On the other hand, there are some positive initiatives, developed by NGOs or by emerging users’ networks for people with mental disorders, showing that change can occur and care for mental disorders can be improved (Katontoka, 2007, Basic Needs, 2012; CBM, 2013). But these are contributions that affect only a small part of the population, and they do not impact on health policy decision-making. They do not bring about the changes that are necessary for a truly public health approach to improving mental health. The recently approved 2013–20 Mental Health Action Plan is a renewed opportunity for collective action to push mental health forward on government agendas. It should help those who wish to place it on public health and social development priority agendas through coordinated and strong advocacy. It is also a call to all stakeholders to increase the priority of mental health and to call for greater financial investment, and therefore to bring mental health out of the shadows.

Conclusion

It needs to be recognised that, for many different reasons, addressing mental health in the WHO African Region represents an immense challenge. Governments play a pivotal role in bringing mental health onto the public health and social development priority agendas, but will be able to do so only if other stakeholders such as multilateral and bilateral agencies, including development agencies, donors, mental health and public health practitioners, researchers and civil society and consumers, actively support mental health intervention.
STRATEGIC DEVELOPMENTS IN THE DELIVERY OF PSYCHIATRIC SERVICES WORLDWIDE

Mental health in Latin America and the Caribbean

Jorge J. Rodriguez MD PhD

Mental illnesses are a growing health problem and reducing the treatment gap in Latin America and the Caribbean is a great challenge. Evaluations conducted by the Pan American Health Organization (PAHO) and World Health Organization (WHO) have shown that the responsiveness of health services is still limited. Nonetheless, from an evaluation of how mental health reform has progressed in the region following the historical benchmark of the Caracas Declaration (1990), it is clear that – despite the limitations, shortcomings and challenges – significant progress has been made in most countries. This paper briefly reviews this progress.

Mental illnesses are a growing health problem in the Americas, as in the rest of the world. In 1990, mental and neurological disorders accounted for 8.8% of the total burden of disease in Latin America and the Caribbean (LA&C), estimated in terms of disability-adjusted life-years (DALYs). This proportion had more than doubled, to 21%, by 2006 (PAHO, 2009; Rodriguez et al, 2009a,b).

A review of the most relevant epidemiological studies of mental disorders conducted in LA&C showed that, in recent years, the estimated average prevalence rates in the adult population (measured during the preceding year) has been 1.0% for non-affective psychoses, 4.9% for major depression and 5.7% for alcohol misuse or dependence. It also revealed that more than a third of people with non-affective psychosis, over half of those with non-affective psychosis, and about three-quarters of those with depression and about three-quarters of those who were dependent on or misused alcohol had not received any medical treatment, from either the population who are most vulnerable, for whom services are scarce (PAHO, 2009; Rodriguez et al, 2009a,b).

In practical terms, this means that only a minority of people who need mental healthcare actually receive it. To this situation must be added the fact that mental illnesses produce a high degree of disability, and they particularly affect those in the population who are most vulnerable, for whom services are scarce (PAHO, 2009; Rodriguez et al, 2009a,b).
Reducing this treatment gap is one of the great challenges facing health systems on our continent.

The response of programmes and services

Evaluations of mental health systems, conducted by the Pan American Health Organization (PAHO) and World Health Organization (WHO) in LAC, showed that despite the magnitude of the burden of mental disorders, the responsiveness of health services is still limited. Here are some facts about the availability of resources and the current situation of the programmes and mental health services in LAC.

The proportion of the budget spent on mental health, as an average in those evaluated countries in the region, is less than 2.0% and 67% of that budget allocation goes to mental hospitals. For example, in six Central American countries and in the Dominican Republic the review found that just 1.6% of the health budget is allocated to mental health. Of that small proportion, no less than 75% is allocated to mental hospitals. This illustrates the need not only to increase financial resources for mental health services, but also to update the way in which these systems operate, with a shift to out-patient, community services linked to primary healthcare services (WHO, 2011; PAHO, 2012).

Of all the countries in the region, 66% have a national mental health plan in place, of which 71% were formulated or updated after 2004. Also, 56% of countries reported having enacted mental health legislation, although in many cases it needs to be updated and adjusted to new technical and human rights standards. The PAHO has identified that in terms of policies, plans and legislation, the crucial challenge is to achieve real and effective implementation.

Thirty-eight per cent of the countries have training programmes in mental health for primary care physicians, and a similar proportion have guidelines or protocols for the care of people with mental disorders at the primary care level. The median number of psychiatric beds per 100,000 population is 2.6, and these are distributed in mental hospitals (45%), general hospitals (22%) and residential facilities or 'other' (33%).

Fifty-two per cent of LAC countries have reported having at least one association of or for users of mental health services, and 60% have an organisation for families. This involvement of user groups is an important contributor to the promotion of social participation and particularly of stakeholders in the formulation and implementation of mental health plans.

A final comment

The development of mental healthcare in LAC countries has faced various constraints and difficulties in recent years. In response to this situation, a conference on the restructuring of psychiatric care in Latin America was held in Caracas, Venezuela, in November 1990. This culminated in the adoption of a continental initiative and launched the Caracas Declaration, a document that made history. The Caracas Declaration emphasised that conventional care, focusing on the mental hospital, did not allow the achievement of the objectives of modern mental healthcare – a community, decentralised, participatory and comprehensive approach to care, motivated by evidence-based prevention (PAHO, 2009; Rodriguez, 2009).

Following the historical benchmark of the 1990 Caracas Declaration, it is clear that – despite the limitations, shortcomings and challenges – significant progress has been made in most LAC countries in the reform of services and the protection of the human rights of people with mental disorders. Almost all now have better laws, national plans and a vision of a community model of mental healthcare linked to primary care and integrated service networks. Similarly, there is greater awareness, on the part of both governments and society, of the challenges of mental disorders, and of the treatment gap that still exists in the provision of services, as well as of the stigma that surrounds people with these conditions.

In October 2008, the WHO launched a programme of action to bridge the gaps in mental health. This aimed to scale up care for mental, neurological and substance use disorders (through the Mental Health Gap Action Programme, mhGAP; WHO, 2008), based on the best available scientific evidence.

In 2009, the PAHO Directing Council adopted – with the consensus of participating governments – the Strategy and Plan of Action on Mental Health (PAHO, 2009), a milestone that marks the way for the next 10 years. The Directing Council acknowledged there was a significant burden of need in terms of mental disorders and substance misuse and that a large proportion of sick people do not receive any treatment. The Council emphasised that there is no comprehensive physical health without mental health.

Subsequently, the regional mental health conference ‘20 years after the Declaration of Caracas,’ held in Panama in October 2010, issued a final statement clearly stating an objective for the region: ‘A continent without asylums by 2020.’ This was emphasised in the book Mental Health in the Community, which was launched at the conference (PAHO, 2010).

Technical cooperation in the PAHO is based on the Regional Strategy (Rodríguez, 2009) and mhGAP (WHO, 2008) and currently focuses on five areas:

- the formulation and implementation of national plans and mental health laws
- mental health promotion and mental disorder prevention, with an emphasis on the psychosocial development of children
- the organisation of mental health services in a network linked to primary care (with definition of priority conditions and implementation of interventions)
strengthening human resources
• strengthening the capacity to produce, evaluate and use information about mental health.

Primary healthcare has become a key component of a comprehensive mental health strategy, with the aim of reducing the huge treatment gap between need and delivery for mental health problems in the region. Most people with mental disorders cannot access care, and others who do not need access to specialised care are subject to overmedicalisation of their suffering, which can be counterproductive. We are aware that most people would benefit from comprehensive assistance provided by a community health team and a good social support network, and that is what we are struggling to achieve within the next few years.

References


STRATEGIC DEVELOPMENTS IN THE DELIVERY OF PSYCHIATRIC SERVICES WORLDWIDE
Together to make a difference in mental health in the Western Pacific Region
Xiangdong Wang

Mental disorders are among the leading causes of disease burden in the Western Pacific Region of the World Health Organization (WHO). Networking and partnership have been identified as the major components of key strategies to address challenges in meeting mental health needs in the region. This article provides a brief review of relevant initiatives collaboratively developed by the WHO, member states in the region and other partners.

Mental disorders are among the leading causes of disease burden worldwide. Depressive disorders alone are responsible for 5.73% of the global burden of disease in the Western Pacific Region of the World Health Organization (WHO). About a third of all suicides in the world are reported from the region. At the population level, there are common factors that have a negative impact on mental health in many member states. These include disaster proneness, rapid population ageing and dramatic changes in social norms and values that have accompanied globalisation and substantial socioeconomic development. It has been a consensus of health ministers that mental health issues, if not addressed appropriately and immediately, will continue to grow. They will have an adverse effect on the health of people in the region and on overall socioeconomic development as well.
The Committee for the Western Pacific Region, at its 52nd session in September 2001, endorsed the Regional Strategy for Mental Health (WHO Regional Office for the Western Pacific, 2002). Over the past decade, encouraging progress has been achieved in specific areas identified by the Regional Strategy. These include: advocacy; policy and legislation; service provision; mental health promotion; development of a research culture and capacity, and suicide prevention. The following account provides a brief review of initiatives that aim to foster development, and the strengthening and sustaining of networks and partnerships that aim to support services for mental health in the region.

**WHO Pacific Islands Mental Health Network (PIMHNet)**

At a meeting of ministers for health for the Pacific Island countries (PICs), held in March 2005 in Apia, Samoa, the idea of a mental health network was discussed as a means of overcoming geographical and resource constraints in the field of mental health. Following extensive consultations, and after successful bidding for funds from the New Zealand Aid Programme (with the objective of establishing and operating a network) the WHO Pacific Islands Mental Health Network (PIMHNet) was officially launched during the health ministers’ meeting at Port Vila, Vanuatu 2007 (Hughes, 2009). There are now 19 countries participating in the network.

Through the PIMHNet, most PICs have developed or drafted a national mental health policy or plan. Various training initiatives have been established. Training is now provided to address former human resource constraints, including a 1-year postgraduate diploma in mental health established at Fiji National University, fellowship programmes on community mental health and depression provided by WHO collaborating centres in Australia and the Republic of Korea, technical support visits to countries by mental health professionals, and national workshops. Health and legal professionals from various PICs have received support to study mental health legislation. The relocation of the PIMHNet secretariat to the WHO South Pacific Division of Pacific Technical Support in 2011 brought better opportunities for networking and the provision of timely technical support to PICs due to the central location of the office in Suva, Fiji.

**Partnership for suicide prevention**

The WHO START (Suicide Trends in At-Risk Countries and Territories) project was launched in March 2006 with support from the Australian Institute for Suicide Research and Prevention, which is a WHO Collaborating Centre for Research and Training in Suicide Prevention. Originally a regional project, START was recently extended to all areas of the world. The START project was specifically developed to increase awareness about the prevalence of suicide. It aimed to provide a low-cost intervention for those who have engaged in suicidal behaviours; and to ascertain information on the presence of both risk and protective factors for suicidal behaviours. The project seeks to build capacity in low-income contexts by creating partnerships with researchers in areas of the world with established suicide research and prevention activities (De Leo et al, 2015). Participating countries are supported through training and other academic events, including country support missions by WHO consultants, to establish baselines, to monitor suicidal behaviours and to implement prevention strategies.

Recognising the unique role of engaging media attention to promote suicide prevention, the WHO initiated a project entitled Media and the Prevention of Suicide (MAPS). The project includes: a systematic review of literature related to the evaluation of media-centred suicide prevention interventions; identifying and forging links with partner organisations and technical advisors in the media, and the government and non-governmental sectors; and developing resources to facilitate consultations and discussions, most importantly with media professionals. Eight consultation meetings with various media were organised in China, Hong Kong (China), Japan, Korea, the Philippines and Vietnam. Through a participatory and consultative approach, the media community now contributes to the development of media-based suicide prevention programmes.

**Promotion of integrated mental health services and care**

Integrated high-quality services contribute not only to the early recognition and treatment of mental health problems but also to the improvement of health outcomes and well-being in general, providing support to various clinical and community populations.

In accordance with resolutions WPR/RC54.R2 and WPR/RC55.R1, the Regional Office for the Western Pacific has embarked on the People at the Centre of Care Initiative as a biregional effort with the Regional Office for South-East Asia to pursue a more people-centred and rights-based approach to healthcare. The WHO’s governing body in the Western Pacific Region in 2007 endorsed the resolution People-Centred Health Care: A Policy Framework. The need to harmonise mind and body and the need to meet the psychosocial needs of health service users in all settings were highlighted in the resolution. There is also a related policy framework. Subsequently, the Regional Office launched a popular publication entitled People at the Centre of Health Care: Harmonizing Mind and Body, People and Systems (WHO Regional Office for the Western Pacific, 2007a,b).

Natural disasters and other emergency situations cause significant psychological and social suffering in affected populations. Since 2003, the WHO has been working closely with China, Japan, Mongolia and the Philippines to improve and integrate mental health services, and to provide psychosocial support, for disaster preparedness,
response and rehabilitation. Disasters provide a unique opportunity for public and policy makers to recognise and address the broader mental health and psychosocial needs of community and health workers and humanitarian workers. A WHO regional forum on disaster-related mental health, hosted by the Institute of Mental Health at Peking University, was recently organised in Beijing. The main purpose of the forum was to address post-disaster mental health needs and to promote an integrated multidisciplinary approach to provide protection and promotion of psychosocial well-being for disaster-affected populations, including disaster responders.

Continuous efforts are being made in the region to link mental health with other health programmes, such as those relating to non-communicable diseases, maternal health, child and adolescent health, ageing, ‘healthy city and healthy islands’ initiatives, and health system development. More efforts are needed to ensure that mental health issues are incorporated into general health policies and plans. There should be a review and monitoring mechanism to determine whether mental health issues are being addressed by all the health system building blocks: service delivery, health workforce, information, medicines, financing and governance.

In May 2013, the 66th World Health Assembly adopted a resolution on the Global Comprehensive Mental Health Action Plan 2013–20. To support implementation of a global plan with a view to addressing the unique challenges faced by member states in the region, the WHO will work with those states in the following ways. It will monitor, analyse and disseminate information on regional trends, examine the consequences and risk factors associated with suicide and mental disorders, and help to develop national policies, as well as support legislation and programmes that contribute to global targets. There will be unique challenges in member states, but the framework aims to support multidisciplinary and multi-sectoral programmes to improve the ability of health and social systems in member states to prevent and manage suicide and mental disorders, and to strengthen regional and subregional networks and partnerships.

References
WHO Regional Office for the Western Pacific (2007a) People-Centred Health Care: A Policy Framework. WHO Regional Office for the Western Pacific.
WHO Regional Office for the Western Pacific (2007b) People at the Centre of Health Care: Harmonising Mind and Body, People and Systems. WHO Regional Office for the Western Pacific.

Mental health law profiles
George Ikkos

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

The Eastern Mediterranean has a profoundly rich but troubled history. The histories of Greece and Turkey have been closely entwined over many centuries. Both have undergone major social changes, with the economic development of Turkey being a particularly welcome phenomenon in the past 10–20 years, while Greece, after a period of unprecedented growth and prosperity, is currently undergoing a destructive economic crisis, with adverse consequences for mental health and increasing rates of suicide.

On the evidence of the two papers published here, social and economic development in these countries has been associated with initiatives in law to safeguard the rights of people with a mental illness, with Greece having adopted relevant legislation to conform with United Nations and European Union standards, and Turkey, a nation aspiring to join the European Union, being on the brink of doing so. However, the routine use of emergency orders and the lack of due process in practice in Greece, even in times of plenty, are both worrying and reprehensible, and the hope must be that in both Greece and Turkey safeguards to ensure implementation of the spirit of the law will be seen as a priority and be put in place, and resources allocated to make this possible, irrespective of economic conditions.
Like all European countries, Greece has developed its national legislation based on the principles of equality and the right of representation, but there is no separate, specific mental health law in Greece. This paper describes the law for involuntary psychiatric admission. The law concerning criminal and civil responsibility and the law relating to individuals with addictions committing drug-related crimes are also outlined.

Involuntary admission
In Greece, involuntary admissions are regulated by Law 2071/92, which in 1992 replaced the previous legislation governing involuntary psychiatric hospitalisation. This change was necessary in order to bring Greek legislation into line with the legal prerequisites for joining the European Union. When the law was introduced it was recognised as an important, albeit belated, step towards acknowledging and securing the rights of people with mental illness. The law recognised, for instance, for the first time in Greece their right to appeal against involuntary hospitalisation.

In particular, Law 2071 describes two procedures to be followed for involuntary admissions: ‘normal’ and ‘emergency’. The ‘normal’ procedure requires two separate psychiatric assessments by ‘approved’ psychiatrists to be completed before admission. In fact, the ‘normal’ procedure is almost never used (Douzenis et al., 2012).

The emergency procedure
The ‘emergency’ procedure by-passes the initial psychiatric assessments; instead, the relatives requesting the admission are put in direct contact with a public prosecutor (there are a number of these officials, one of whom will be on duty on any particular day). The individual for whom a relative has requested a psychiatric assessment for involuntary admission is escorted by the police to the psychiatric emergency department (for this purpose, one such department is nominated to be on call on any particular day). Alternatively, in the absence of the ‘nearest relative’, the procedure for involuntary admission is instigated ex officio, where the public prosecutor makes the application and orders the police to take the individual for assessment. The public prosecutor gives this order in writing after being alerted by the police or a member of the public (e.g. a neighbour). Only in cases of grave emergency can the public prosecutor order the police verbally.

Once people due to be assessed arrive in the psychiatric unit on call, they are examined by two qualified psychiatrists. The mental health assessment needs to establish: that they suffer from a mental illness and are unable to look after themselves; and that they refuse treatment because of lack of insight. Furthermore, the examining psychiatrists need to be convinced that if the mental disorder remains untreated, then the patient’s life or the lives of others might be at risk. If the psychiatrists establish that these prerequisites for involuntary admission are present, then, after the appropriate forms are completed (which are returned to the public prosecutor), the individual is admitted involuntarily. The public prosecutor then brings the case before a court within 10 days (Douzenis et al., 2013). The individual examined and deemed to be suffering from a psychiatric disorder can appear in that court and argue against involuntary admission, with legal representation.

The maximum time for involuntary admission is 6 months. The public prosecutor requests medical reports after 3 months and again at the end of the 6 months (in the rare instances when a patient is not discharged earlier).

After patients are involuntarily admitted they can be discharged whenever the responsible medical officer decides that the criteria for involuntary admission are no longer met. Involuntarily-in-patient treatment lasts on average 4–6 weeks (Douzenis & Lykouras, 2008). No one can be treated involuntarily in the community. Involuntary ‘admission’ in fact means involuntary treatment during the period of hospitalisation.

Mental capacity
Penal code
The law accepts that there are instances when a mental disorder may impair the individual’s ability to differentiate between right and wrong and interfere with free will. Offenders with a mental disorder should primarily be considered as ill and therefore exempt from punishment.

Article 34 of the Greek Penal Code states:

A criminal act is not attributable to the perpetrator if because of a disturbance of his mental functions, or a disturbance of conscience, he did not possess the ability to acknowledge the wrongfulness of this act or to act according to this knowledge.

If the court accepts that this is the case, the perpetrator is considered not guilty of the crime, that is, ‘not guilty by reason of insanity’, and is admitted to a psychiatric hospital for ‘the protection of others and treatment’ (Article 69).

If the ability ‘to acknowledge the wrongfulness of the act’ is not totally absent but only reduced, there is diminished responsibility for the criminal act and thus a reduced punishment (Article 36).
Civil Code
According to Article 128 of the Greek Civil Code, all adults (i.e. those aged over 18 years) are considered legally responsible (e.g. are able to sign legal documents). A person arguing that someone is incapacitous has to prove the incapacity and not vice versa. Articles 129 and 130 clarify the concept of diminished capacity. Individuals may have the right to decide some of their own affairs under certain circumstances. The ability of someone to make a will is closely connected with the above (Androulakis, 1986).

Legislation on substance misuse and offending behaviour
The current legislation on substance misuse (Law 3459/2006, called the Code of Laws on Narcotics) introduced the concept of ‘decriminalisation’ for individuals dependent on illegal substances. This legislative reform aims to encourage treatment initiation and reduce prison sentences for individuals with addictions (mainly heroin addiction) who commit petty offences (Kotsalis et al, 2007).

If a court accepts that defendants are addicted, then they can receive a reduced sentence, as indicated above for persons with a mental illness. Defendants making such a claim as part of their defence have to be examined by a psychiatrist and receive a psychiatric report confirming the presence or absence of addiction (according to the DSM-IV-TR criteria). This can be difficult to achieve since the psychiatrist is not called immediately after the arrest.

Discussion
Although in theory the law safeguards human rights, in practice a lack of resources makes its application problematic. For instance, the ombudsman (a citizens’ advocate for civil rights) in Greece, in a special report published in 2007, indicated that mental health professionals are not acting according to the legal prerequisites (Department of Health and Social Welfare, 2007). The medical reports often contain no clear record of an assessment of a patient’s ability to decide on healthcare and the stock phrase ‘the prerequisites for law 2071 are met’ is often used. Additionally, it was not certain that patients were being properly informed about their right of legal appeal. More disturbingly, though, the ombudsman discovered that no court decision was recorded for 84% of the cases of involuntary admission and that for the majority of cases the rule that there should be a maximum 10-day wait for a court decision had not been met. These findings indicate that the legal system is treating involuntary admissions without due process. New ways of approaching the right of appeal, including the ‘Greek equivalent’ of mental health review tribunals, have been suggested by the Greek Forensic Psychiatry Association. It is more than 20 years since the introduction of Law 2071, and it now needs to be updated and redrafted.

References

Mental health law in Turkey: legislation pending
Ersin Caglar1 MD MRCPsych and Muzaffer Kaser2 MD MPhil

In Turkey, mental health professionals, together with patients and carers, have been involved in the drafting of the Mental Health Bill which is presently under consideration by Parliament. While the Mental Health Law is pending, various pieces of legislation are being used for different types of involuntary admission. The prospective Mental Health Law is of paramount importance for doctors, patients and families.

The Mental Health Law in Turkey is still at the proposal stage and has not yet been enacted (Psychiatric Association of Turkey, 2007). This has significant repercussions. Various groups, including clinicians, patients and carers, are affected and take on major responsibilities to compensate for the lack of specific mental health legislation. Currently, clinical practice is heavily influenced by cultural factors, such as carers’ attitudes towards people who are mentally ill and the family’s
resources. However, there is nonetheless a legal framework to compensate for the lack of specific mental health legislation. The Ministry of Health (2011) has a mental health action plan that prioritises finalisation of the Mental Health Law. The proposal is still pending discussion in Parliament.

Turkey has a long history of providing mental health treatment in in-patient settings. As early as 500 years ago, at the time of the Ottoman Empire, mental illness was recognised as a physical ailment and physicians treated patients in therapeutic settings using holistic approaches that included music therapy. Several mental health institutions were established in the early 19th century. The first regional psychiatric state hospital was set up after the foundation of the Republic of Turkey in 1923. Currently, university, state, military and private hospitals provide in-patient psychiatric treatment.

In Turkey, family members are the main providers of care and are usually the legal guardians of patients with mental illness. Most people with severe mental illnesses live with their families and the number of homeless patients with schizophrenia is lower in Turkey than in other European countries. On the other hand, family-related factors have a large influence on the course of treatment and admission rates of patients with schizophrenia in Turkey. Thus, patients from families who are less functional are likely to be admitted more often (Taktak et al, 2000).

The proposed Mental Health Law
The Psychiatric Association of Turkey began work on draft legislation in 1998 and the first proposal was released in 2006, after a specialist task force was appointed (Psychiatric Association of Turkey, 2007). The task force had representation from 15 professional organisations, including the Psychiatric Association of Turkey, the Turkish Medical Association and numerous charities formed by patients and carers. The proposed Bill supports not only patients’ rights to treatment but also clinical governance in mental health settings. The Bill defines voluntary and involuntary admissions, how an independent psychiatrist is to be involved in decision-making, how the courts should be informed of long-term involuntary admissions and patient care after discharge. It has been regarded as an unusual but valuable opportunity that a new law is being created afresh (Arikan et al, 2007).

Current practice
In current practice, the family should consent to the involuntary admission if the patient lacks capacity at the time of assessment. This also means that the family can either refuse admission or discharge the patient by withdrawing consent, against medical advice. This system places clinicians, patients, carers and the general public in a vulnerable position. The question of whose responsibility it is when things go wrong is an important one. There are examples, albeit few, of unfavourable and at times tragic results. Patients can be left untreated. Clinicians also suffer from not being able to provide optimum treatment and the carers have to take on overwhelming responsibilities.

While specific legislation for involuntary admissions is still lacking, psychiatric units are making use of an article in the Turkish Criminal Code (Ministry of Health, 2011). Article 432 sets out the requirements for involuntary admission: the patient must have a mental illness and pose a danger to the public. The same article covers infectious diseases, intellectual disability and alcohol or drug misuse or vagrancy. It further states that patients should be discharged as soon as they are fit. The article has not been prepared for or tailored to the needs of people who are mentally ill, their well-being or rights; rather, the focus is on the ‘safety of the public’ (Sercan, 2007).

Until 2008, Article 432 had been rarely used by the legal authorities or mental health professionals. Since then, with the support of the Mental Health Law initiatives taken by the Psychiatric Association of Turkey and also with the support of several clinical directors of psychiatric state hospitals who contacted their local courts, this piece of legislation began to be used within routine clinical practice. Currently, psychiatric state hospitals and most of the university hospitals use Article 432. If the judge decides that a patient meets the criteria set out in the Civil Code, then permission is given and Article 432 is used for involuntary admission. However, there are still ongoing difficulties, such as delays in court decisions, problems with the appeal procedure and communication problems with regard to discharge. Although the active use of Article 432 in psychiatric practice has effectively established a legal framework and thereby reduced the uncertainties for psychiatrists, patients and carers, it can be regarded only as a subsidiary regulation until the Mental Health Law is passed.

Other forms of involuntary admission, particularly for patients who are involved in criminal acts, are regulated by the Turkish Criminal Law. The Criminal Court can decide on a compulsory admission of a patient who has a history of offending. This is only for up to 3 weeks, as part of an assessment process of criminal responsibility (Criminal Procedure Law, Article 74). If the forensic psychiatric assessment concludes that the patient does not have criminal responsibility due to a mental illness, the patient does not receive a conviction and is instead compulsorily admitted to a psychiatric ward. The relevant article of the Turkish Criminal Law (Article 57) also defines discharge processes and the frequency and the reporting of compulsory follow-up visits following discharge (Sercan, 2007). The Mental Health Law is expected to be compliant with the relevant articles of Turkish Criminal Law, although further amendments might be required when the Mental Health Law is debated in Parliament (Psychiatric Association of Turkey, 2007).

Consent should be obtained from parents for
the admission of anyone under 18 years of age. When there are no parents involved in the care of the child, as in the case of children living in children’s homes or foster homes, social services have legal responsibility and should give consent. Under the Child Protection Law, a child is entitled to safeguarding, to receive healthcare, to adequate shelter and to an education. This law is used in the best interests of the child to enable the child to receive adequate treatment, including in-patient and out-patient psychiatric care when necessary.

Turkey provides an example of how different pieces of legislations can be used for involuntary admissions while the proposed Mental Health Law is pending discussion in Parliament. In the meantime, mental health professionals in conjunction with patients and carers continue to campaign for the Mental Health Law.

References
Teaching psychiatry to undergraduate medical students in Somalia

Lauren Gavaghan,1 Peter Hughes,2 Khalid Saeed3 and Susannah Whitwell4

This paper describes a pilot project in which (for the first time, worldwide) psychiatry was taught to undergraduate medical students in Somalia using an evidence-based intervention – the World Health Organization’s Mental Health Gap Action Programme Intervention Guide.

In the Eastern Mediterranean Region (EMRO) of the World Health Organization (WHO), which spans from Morocco to Pakistan and which includes Somalia, 2.8% of training for medical doctors and 3.4% of training for nurses is devoted to psychiatry and other subjects related to mental health. These are rates similar to those for the rest of the world. Across the region, as in the rest of the world, 6.11 nurses and 3.28 doctors per 100 000 population per year are trained in mental health. Compared with nurses and non-psychiatric doctors, few psychiatrists, psychologists and social workers specialise each year (WHO, 2011). It is therefore unlikely that mental healthcare will be accessible or available to the vast majority of the populations in need if the current reliance on in-service training is continued. Somalia is an impoverished area. The health service, including mental health services, has low capacity. There are three in-patient units in the country, minimal community services and limited psychiatric medications, with services located only in the main towns (WHO, 2006).

The WHO launched the Mental Health Gap Action Programme (mhGAP) with the aim of closing the gap between need and services available for mental, neurological and substance use disorders in low- and middle-income countries. Although these disorders account for 14% of the global burden of disease, up to 75% of people in low-income countries do not have access to appropriate treatment (WHO, 2008).

The Mental Health Gap Intervention Guide (mhGAP-IG) was developed as a technical tool. It is an evidence-based, peer-reviewed manual to guide health practitioners through the assessment and management of mental health conditions at a primary-care level (Barbui et al, 2010; WHO, 2010).

Training non-specialists in mental healthcare is vital, due to the lack of mental health professionals in a region like Somalia, but also due to wider issues. The WHO emphasises the integration of mental health into primary care as the most viable way to close the existing treatment gap in mental health. Wider advantages of this approach include better holistic care, wider accessibility of services, less stigma and therefore better acceptability, and ultimately the production of better health outcomes at lower cost (WHO & World Organization of Family Doctors, 2008).

This report describes the experience gained through the King’s–THET Somaliland Partnership (KTSP) (Leather et al, 2006) of incorporating the mhGAP-IG into undergraduate medical student teaching at Amoud University, Borama and Hargeisa University, Hargeisa, in the Somaliland region of Somalia in May 2012 and May 2013. This was the first time worldwide that the mhGAP-IG has been utilised in this way in medical undergraduate teaching. The objectives of this pilot were to incorporate the mhGAP-IG into Somaliland medical student undergraduate psychiatry training as an additional resource to aid understanding of the assessment and management of mental disorders and to further develop and evaluate this teaching using the mhGAP-IG.

Methods

The basic psychiatry teaching course offered to medical students by KTSP in collaboration with local partners is an annual intensive 9-day programme. In 2012, it ran 15–24 May and was held at Amoud University, Borama. In 2013, it ran 6–15 May and was held at Hargeisa Group Hospital, Hargeisa. Students in their penultimate year of medical school attended from both the Universities of Amoud and Hargeisa. Thirty-six medical students and one nursing student took part in 2012, and 52 medical students in 2013. The mhGAP-IG was incorporated into the curriculum primarily to explore the management of conditions and to familiarise students with the manual.

The teaching was delivered using different techniques, including lectures and more interactive methods already piloted in this environment with good effect on knowledge and attitudes (Syed Sheriff et al, 2010). The mhGAP-IG was used in its current format. Each student received a copy of the manual and the teaching was added to the existing lecture-based teaching. Role-play and case-based discussions were used, with the mhGAP-IG as the basis to guide learning. Aetiology of disorders was covered separately from the mhGAP-IG, as it is primarily a tool for assessment, diagnosis and management.

There was a need to adapt teaching using the mhGAP-IG to ensure relevance to the Somaliland context. For example, because of the widespread use of khat in Somalia and its effects on mental health, discussion of this issue was warranted. Not all medications are available in the country, such...
Table 1

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Mean score (out of 25)</th>
<th>Range</th>
<th>Change (negative)</th>
</tr>
</thead>
<tbody>
<tr>
<td>mhGAP pre-test score</td>
<td>14.8 (59%)</td>
<td>28–84 %</td>
<td>–</td>
</tr>
<tr>
<td>mhGAP post-test score</td>
<td>21.2 (85%)</td>
<td>68–100 %</td>
<td>2 negative out of 48 (4%)</td>
</tr>
</tbody>
</table>

Fig. 1
Survey of the use of the mhGAP-IG in medical student undergraduate psychiatry teaching in Somaliland (2012)

Fig. 2
Survey of the use of the mhGAP-IG in medical student undergraduate psychiatry teaching in Somaliland (2013)

as lithium and medications for behavioural disorders, and this required consideration.

Following the course, a short satisfaction survey was conducted to evaluate participants’ views of the mhGAP and its inclusion in teaching. Participants were asked to answer five questions relating to their experience of the mhGAP-IG training:

- Did you understand the mhGAP?
- Was it useful?
- Does it apply to Somaliland?
- Was it easy to use?
- Would you use it again?

Answers to each of the five questions were ranked on a five-point Likert scale, ranging from ‘not at all’ to ‘excellent’.

Improvements in mhGAP-based knowledge were quantified in 2013, although they were not tested during the initial pilot in 2012. A draft of the WHO mhGAP Monitoring and Evaluation Toolkit’s Pre- and Post-Test for the mhGAP Base Course (WHO, 2013) was piloted in May 2013, to test students’ knowledge immediately before and after the 2 weeks of training. This included 25 multiple-choice questions directly related to mhGAP-IG information. The KTSP course evaluation also includes pre- and post-course questionnaires of attitudes towards mental illness and these, along with the mhGAP knowledge test, have informed further development of the mhGAP training.

Results
Thirty-three of the 36 medical students responded to the survey in 2012 (Fig. 1). Fifty-one out of the 52 students responded in 2013 (Fig. 2). Ability to understand the mhGAP-IG in 2012 was rated as mostly ‘good’ or ‘excellent’ (36% and 39% respectively). In 2013, this proportion had risen substantially, with 75% of students ranking their understanding as ‘excellent’ and 24% as ‘good’. In terms of its usefulness, in 2012, 82% of students felt it to be good or excellent, compared with 94% of students in 2013. Importantly, in relation to its relevance to Somaliland from the viewpoint of the medical students, in 2012 42% rated it ‘excellent’ and approximately 40% rated it to be either ‘good’ or ‘medium’. In 2013, 49% of students ranked its appropriateness to Somaliland ‘excellent’ and 24% ‘good’. Nearly half of the students rated the mhGAP-IG ‘excellent’ in terms of its ease of use in 2012, with this proportion increasing to 69% in 2013, and nearly a quarter rated it ‘good’ in 2012 (18% in 2013). The majority of students were keen to use mhGAP-IG again, with 73% rating it ‘excellent’ in 2012 (78% in 2013) and 18% rating it as ‘good’ (16% in 2013).

To demonstrate changes in knowledge, the mhGAP pre- and post-test was completed by the medical students immediately before the course (with most of them having an online copy of the mhGAP-IG in advance) and at the end of the 2-week course. Of the 52 students, 48 completed the post-course test.
The test results showed objective improvements in knowledge, with the range of results increasing from 28–84% pre-course to 68–100% post-course. Only two students scored less in their post-test than in their pre-test (Table 1).

Discussion and conclusions
The incorporation of the mhGAP-IG into medical undergraduate teaching in Somaliland was received well during training in 2012 and 2013. There was increased understanding of the mhGAP-IG after the second period of training, both as subjectively perceived by medical students and as objectively shown by improvements on the post-course mhGAP-IG knowledge tests. This may have been due to improved methods of delivering the training the second time, with more interactive methods used to demonstrate use of the manual and each student having access to an individual copy of the mhGAP-IG.

The risk of social desirability bias may be a limitation of this type of study, although the fact that a few students reported that they did not find the mhGAP wholly useful suggests this bias was not substantial.

It is neither feasible, nor sustainable, to rely wholly on specialists to deliver mental health care to patients and this is highly relevant in the Somaliland region of Somalia, where mental health services are very limited.

We feel it important and timely to roll out the inclusion of the mhGAP-IG into both the medical and nursing undergraduate curriculums, so that those specialising in other fields may have at least an evidence-based grounding in the management of mental and substance use disorders.

The aim will be to continue this training and to supervise those in the country who are able to lead the teaching, in order to ensure sustainability. This would include monitoring of the incorporation of the mhGAP-IG and measuring future changes in skills rather than simply knowledge, which alone is insufficient to improve mental healthcare at a wider level.

References


Community mental health services in Al Ain Hospital, United Arab Emirates

Amir Mufaddel,1 Mouza Al Sabousi,2 Yahya Takriti,3 Badr Dawoud,4 Nora Coroza,5 Habib Belhaj5 and Nasser Al Hekmani6

This paper evaluates a model of community mental health service (CMHS) in Al Ain in the United Arab Emirates. The hospital records were reviewed and the total number of patient admissions and duration of in-patient care before and after enrolment in the CMHS were documented. Patient satisfaction with the CMHS was assessed using a questionnaire. The total number of admissions and the number of days that the patient spent in hospital per year were significantly reduced by the CMHS. Patients had high satisfaction rates with the information and advice they received, with their relationships with CMHS workers, with their access to mental health services and with their drug treatment.

Major changes have occurred in methods of delivering psychiatric care, particularly for those with severe and persistent mental illness such as schizophrenia, bipolar mood disorder and treatment-resistant depression. The trend is now directed towards community psychiatric services. Before the deinstitutionalisation movement, the majority of patients with severe mental illness spent most of their lives in psychiatric hospitals (Rosen et al, 2007).

Models for the delivery of community psychiatric services can be broadly divided into three types:

- standard case management
- rehabilitation-oriented community care
- intensive comprehensive care (assertive community treatment and intensive case management).

Countries adopt their own model according to population needs, health service structure and available resources (Hadley et al, 1997; Kim et al, 1998; Rosen et al, 2007; Ranasinghe Mendis & Hanwella, 2010; Flannery et al, 2011).

A Cochrane systematic review concluded that home treatment teams reduce days spent in hospital, particularly if the visits are regular and the teams have responsibility for both social care and healthcare. However, the review commented that most of the research evidence comes from the USA and the UK (Catty et al, 2002; see also Burns, 2007).

The current paper evaluates a community mental health service (CMHS) in Al Ain in the United Arab Emirates (UAE), and is offered as a comparison with studies done in other parts of the world. Such research can be useful for planning psychiatric services. The CMHS in Al Ain provides: psychiatric, physical and social assessment; assessment of activities of daily living; home administration of medication and medication supplies; social intervention; long-term follow-up; support and psychoeducation for patients and families; and community outreach involving repeated attempts to maintain contact with non-compliant and uncooperative patients and families.

The CMHS team at Al Ain Hospital consists of psychiatrists, community psychiatric nurses, a psychologist, a social worker and an occupational therapist. The team covers the Al Ain area. Al Ain is the second largest city in Abu Dhabi and has a population of around 570,000 (2010). The population covered by the service is mainly local citizens. The CMHS is continuously expanding, in terms of both patient number and organisation. It started in 1994, when it had 20 patients. The team now serves around 140 patients through 160 visits every month. An assessment of patient outcomes was a prerequisite for further development of the service.

The CMHS at Al Ain Hospital is guided by a comprehensive policy concerning the roles of the different team members, referral and admission, discharge, psychiatric assessment and doctors’ case management, CMHS patient referral to hospital services, claim management, emergency action plans, transportation plans, management of patient records, medical waste, medication management, and patients’ rights and responsibilities.

Methods

This descriptive study aimed to assess the outcome of Al Ain Hospital’s CMHS. Hospital records were reviewed to obtain: demographic data; psychiatric and medical diagnoses; and duration of illness. Total numbers of admissions and duration of in-patient care before and after enrolment in the CMHS were documented. Frequency of admission and duration of hospital care (per year) were calculated for each patient. Patient satisfaction with the CMHS was assessed using a questionnaire modified from the user version of the Customizers’ and Users’ Expectations of Health Services Questionnaire – Users (CUES-U), which has eight questions (four assessing quality of life and four assessing satisfaction with the CMHS), with three available responses (‘satisfied’, ‘not satisfied’ or ‘unsure’). We used only the four questions assessing patient
satisfaction with: information and advice offered by CMHS team members; access to the mental health service; relationships with CMHS team workers; and drug treatment.

Results

The characteristics of the 123 patients included in this study are shown in Table 1. About 60% had had symptoms for more than 10 years. The majority of patients were diagnosed with schizophrenia (32.5%). Other diagnoses are listed in Table 1.

The total number of admissions per year was significantly reduced, from 62 to 15, by enrolment in the CMHS (t = 6.171, d.f. = 122, P < 0.0001). Similarly, the mean number of days spent in hospital per patient per year was reduced from 9.8 to 1.3, which was highly significant (t = 5.678, d.f. = 122, P < 0.0001). About 15% of patients spent more than 20 days a year in hospital before they were enrolled in the CMHS, compared with less than 2% after enrolment. Table 2 compares the frequency and duration of hospital admissions before and after enrolment in the CMHS.

Patients’ responses to the questionnaire indicated high satisfaction with the CMHS: 95.4% of patients were highly satisfied with the information and advice, 90.1% with their relationships with CMHS workers, 83.5% with the access to the mental health service, and 91.2% with their drug treatment.

Discussion

Measures for the evaluation of services can cover a wide range of outcomes, including symptom control, social functioning and community stability, quality of life and risk reduction. However, the outcome most frequently reported is hospitalisation (Burns, 2007). This study has shown a significant reduction in the frequency and duration of hospitalisation after our patients started regular CMHS visits. This finding could be explained by the fact that CMHS patients are more likely to adhere to the treatment regime; also, relapse or worsening of the mental disorder was more likely to be detected earlier by the CMHS team, which results in early intervention (including admission, if indicated).

The total number of admissions per year was significantly reduced, from 62 to 15, by enrolment in the CMHS (t = 6.171, d.f. = 122, P < 0.0001). Similarly, the mean number of days spent in hospital per patient per year was reduced from 9.8 to 1.3, which was highly significant (t = 5.678, d.f. = 122, P < 0.0001). About 15% of patients spent more than 20 days a year in hospital before they were enrolled in the CMHS, compared with less than 2% after enrolment. Table 2 compares the frequency and duration of hospital admissions before and after enrolment in the CMHS.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>40</td>
<td>32.5</td>
</tr>
<tr>
<td>Schizoaffective disorder</td>
<td>14</td>
<td>11.4</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>13</td>
<td>10.6</td>
</tr>
<tr>
<td>Major depression</td>
<td>24</td>
<td>19.5</td>
</tr>
<tr>
<td>Dementia</td>
<td>9</td>
<td>7.3</td>
</tr>
<tr>
<td>Intellectual disability</td>
<td>24</td>
<td>19.5</td>
</tr>
<tr>
<td>Pervasive developmental disorder</td>
<td>6</td>
<td>4.9</td>
</tr>
<tr>
<td>Unspecified psychosis</td>
<td>5</td>
<td>4.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Duration of illness (years)</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5</td>
<td>24</td>
<td>19.5</td>
</tr>
<tr>
<td>5–9</td>
<td>25</td>
<td>20.3</td>
</tr>
<tr>
<td>10–14</td>
<td>35</td>
<td>28.5</td>
</tr>
<tr>
<td>15 and more</td>
<td>39</td>
<td>31.7</td>
</tr>
</tbody>
</table>

Table 2

Frequency and duration of hospital admissions for the 123 patients before and after enrolment in the community mental health services (CMHS)

<table>
<thead>
<tr>
<th></th>
<th>Total/ Mean</th>
<th>s.d.</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total number of admissions per year</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Before CMHS</td>
<td>62</td>
<td>0.50</td>
<td>0.77</td>
</tr>
<tr>
<td>After CMHS</td>
<td>15</td>
<td>0.12</td>
<td>0.42</td>
</tr>
<tr>
<td><strong>Total duration of hospital stay (days/year)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Before CMHS</td>
<td>1211</td>
<td>9.84</td>
<td>18.03</td>
</tr>
<tr>
<td>After CMHS</td>
<td>166</td>
<td>1.35</td>
<td>5.73</td>
</tr>
</tbody>
</table>
of acceptance of treatment, reduction of hospital admissions, maintaining care, reducing death by suicide and reducing costs. However, Simmonds et al. (2001) found no significant differences in patient psychopathology between CMHT management and standard care.

Despite the advantages of the CMHS in reducing in-patient hospital care and patients’ satisfaction with the service shown in our study, collaboration between the CMHS team and other mental health services is needed for crisis and relapse interventions, as many psychiatric illnesses are characterised by frequent relapses. In recent years, there has been a debate between those who support the provision of mental health treatment and care in hospital, and those who support primarily, or even exclusively, the provision of community care. This dichotomy could be replaced by an approach that integrates community services with modern hospital care (Thorncroft & Tansella, 2004).

This study is limited by the fact that it examined only one CMHS team, and the findings cannot be generalised to the whole country.

Conclusion
The effectiveness of the Al Ain Hospital CMHS in minimising the need for hospitalisation as well as the length of stay for the enrolled patients has been demonstrated. Patients were highly satisfied with the CMHS. Further research is needed to assess the continued effectiveness of this service, assessing different outcome measures. Evaluations of CMHS in other regions are needed.

References


Addressing the mental health needs of a rapidly growing megacity: the new Lagos Mental Health Initiative

Olufemi Oluwatayo,1 Olufemi Olugbile2 and Ayodele Coker3

The Lagos State Government of Nigeria recently launched its Mental Health Policy and Work Plan aimed at addressing the mental health needs of Lagos, one of the world’s fastest-growing megacities, and its nearby communities. This paper discusses the contextual basis of this initiative, its components and the challenges faced so far. It argues that urban centres deserve attention in the current push towards investing in mental health services in low- and middle-income countries.

There has recently been concerted global action to address the poor state of mental health services in low- and middle-income countries (Eaton et al., 2011) but the efforts seem to be based mainly in rural settings (WHO, 2011). The focus on rural areas mirrors past efforts, based on the assumption that access to mental health services in urban areas is better than in rural areas. In Nigeria, however, access is generally poor, regardless of location (Gureje et al., 2006) and a recent study from São Paulo indicated that the prevalence of

1Consultant Psychiatrist, Wells Road Centre, Nottinghamshire Healthcare NHS Trust, Nottingham, UK, and Mental Health Advisor, Lagos State Ministry of Health, Ikeja, Lagos, Nigeria, email Olufemi@dokctors.org.uk
2Consultant Psychiatrist and Permanent Secretary, Ministry of Health, Ikeja, Lagos, Nigeria
3Consultant Psychiatrist and Senior Lecturer, Department of Psychiatry, Lagos State University Teaching Hospital, Ikeja, Lagos, Nigeria
mental disorders is high in that city (Andrade et al., 2012), suggesting that there is a need to direct investment also to urban centres.

Lagos, the former capital of Nigeria, is estimated to have a population of 15 million and is recognised as the fastest-growing megacity in the world (United Nations, 2012). Lagos and its nearby communities constitute one of Nigeria’s 36 states. Its mental health service provision is patchy and inadequate (Olugbile et al., 2008).

In order to comprehensively address the mental health needs of Lagosians, in October 2011 the State Government launched a Mental Health Policy and began implementing a Mental Health Work Plan. We review the Plan in terms of the progress and challenges in its implementation after 1 year.

Mental health promotion

The Plan aims to prevent mental ill health. It includes:

• *The appointment of a mental health desk officer at the Ministry of Health.* As the coordinator of the programme, he/she will be responsible for its running. Tasks include reaching out to stakeholders, setting up a mental health programme team, organising and chairing the team’s meetings, planning and budgeting, organising training and facilitating the release of funds for the implementation of programmes.

• *Setting up a mental health programme team.* To be headed by the desk officer, it will have representatives from stakeholders and relevant ministries, non-governmental organisations (NGOs) and professionals. The team will meet regularly to review the programme and ensure its implementation.

• *Public enlightenment to improve the public perception of mental illness, combat stigma and encourage treatment.* This includes organising seminars and activities for members of the public, especially women and children, about mental disorders, as well as media activities involving local celebrities.

• *Mental health programme for children.* This will incorporate school mental health activities and care in juvenile correction homes, including organising training for teachers to improve their awareness of mental disorders in children and setting up a counselling service for schools.

• *Establishing trauma and disaster counselling services.* Accidents are frequent on Lagos roads; injuries from commercial motorcycles (locally called okada) are particularly common. Victims of road accidents and disasters are to be offered psychological support and debriefing by trained counsellors, including paramedics and volunteers accessible through a helpline.

• *Motor Park Safety Programme.* This will involve a team from across the relevant ministries and agencies educating drivers about road safety, traffic laws, and the dangers of alcohol and illicit drug use in general and in driving.

• *Reduction of workplace stress.* A programme on stress management is to be rolled out for civil servants. It will include training counsellors, establishing a counselling helpline and organising regular seminars for staff.

• *Coordinate activities of NGOs operating in mental health.* A register of these organisations will be opened and operated as part of the programme, to help coordinate their activities.

• *Suicide prevention.* Education and enlightenment of the public on the relationship between mental health and suicide will be included in educational programmes.

Primary care and access to services

The first point of contact of Lagosians with health services is usually through private hospitals, primary care centres and general hospitals (Olugbile et al., 2008). For reasons ranging from lack of awareness of the presence of a mental illness, to beliefs concerning supernatural causes of illnesses that require traditional or spiritual interventions, to fears about affordability, sufferers often present late or fail to attend altogether. For those who are able to access services, recognition of their conditions and the interventions offered vary, with no clear standard and process for referral to specialist treatment.

There are three action plans:

• *Training of primary healthcare (PHC) workers.* Mental health training, support and supervision of PHC staff using the resource materials from the Mental Health Gap Action Programme (mhGAP) (WHO, 2011) will be undertaken.

• *Full integration of mental health into primary care.* This will involve using available resources to improve access to basic psychotropic medications, establishing systems for supervising PHC workers and monitoring their work, to collect data for research purposes.

• *Work with private hospitals.* The programme aims to improve the ability of private hospital clinicians to manage mental disorders by organising regular training for them using the mhGAP in order to support them and standardise their interventions and referral to secondary care.

Secondary and tertiary care

This part of the programme aims to improve access to specialist mental healthcare. In Lagos, the Federal Government operates a 476-bed neuropsychiatric hospital and a small academic psychiatric department at the University of Lagos Teaching Hospital. The Lagos State Government operates an academic psychiatric department and a 12-bed facility at Lagos State University Teaching Hospital. There are some basic psychiatric services and undesignated admission beds at three of the state’s 25 general hospitals. In addition, the Lagos
State Government has a 500-bed vocational rehabilitation centre at Majidun, mainly for vagrant homeless people with a mental illness. There are also some private and military psychiatric facilities.

The existing services will be complemented by:

- **Majidun Rehabilitation and Treatment Centre.** A redevelopment plan will be put in place to transform the Majidun Rehabilitation Centre to a psychiatric hospital to provide specialist tertiary mental health services, including rehabilitation beds. Access will be on referral from secondary care and statutory agencies.

- **Improving services at three general hospitals.** Secondary care ‘psychiatric hubs’ will be established in three general hospitals in the three senatorial political districts of the state. They will provide emergency services, out-patient clinics, acute-admission beds and outreach teams and take referrals from primary care and private hospitals.

- **Working in partnership with stakeholders in the field.** NGOs and private providers will be partnered to coordinate their services and ensure that appropriate standards are met.

- **Training and research collaboration.** There will be collaboration with the federal institutions in research and training. The educational curriculum of the state’s schools for training of primary care workers, nurses and medical students will be reviewed to address inadequacies in the mental health component.

**Progress on implementation 1 year on**

One year on from launching of the Lagos State Mental Health Policy, the implementation of the Mental Health Work plan had been slow.

The mental health desk officer and team were in place and functional, with various activities being implemented. Regular public lectures to create awareness, combat stigma and fight the scourge of drug misuse were taking place. A register of NGOs was in place and clinicians in private hospitals were being trained. Some private sector resources, including those from the pharmaceutical industry, were being mobilised to participate in activities.

The Motor Park Safety Programme had been a success as it coincided with the implementation of new traffic laws in the state.

A research team from the state’s teaching hospital recently got a Canadian grant for the implementation of mental health services at primary care level using the mhGAP. A study of the prevalence of mental disorder among youths at four of the state’s juvenile correction homes was being carried out, with the aim of providing appropriate interventions and educating staff.

The trauma and disaster counselling service played a role in a recent disaster when a plane crashed into a slum area in a Lagos suburb, with several fatalities, both on the ground and in the plane. Within 1 week, brief one-to-one counselling was provided to some family members of the be-reaved, witnesses of the crash and injured ground survivors who accepted the offer.

The initial task of agreeing a redesign plan between the Ministry of Social Welfare and Health for the Majidun redevelopment plan had been completed construction work was about to commence.

The reasons for the slow implementation of the programme have ranged from bureaucratic delays in approving budgets and lack of adequate human resources to general logistical problems.

**Conclusion**

The mental health challenges facing Lagos, the world’s fastest-growing megacity, and its nearby communities are enormous. The city has some unique challenges that require novel services, including some of the ones initiated in this programme. Because of its large population, interventions in Lagos are likely to affect more people, thus our view is that the current push for investment in low- and middle-income countries should include urban centres. The Lagos State Government is showing political will and committing resources to mental healthcare. It has created an enabling environment for partnerships and investment in the sector. Opportunities abound going forward to engage in this process and tackle the challenges.

**References**


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

**Bursary for psychiatrists from developing countries**
The Faculty of the Psychiatry of Intellectual Disability has an annual bursary to enable a psychiatrist from a low- or middle-income country to attend the Faculty Annual Residential Meeting (usually held in October). The deadline for this round is 31 May 2014. See http://www.rcpsych.ac.uk/workingpsychiatry/faculties/intellectualdisability/aboutthefaculty/prizes,bursariesandlectures.aspx#devbur

**Fundraising Trek to Burma, February 2014**
The College Volunteer Scheme links up projects and services in low- and middle-income countries with members of the College who want to volunteer their time and expertise. The volunteer fund allows the College to support these volunteers by paying for some of their associated costs. In order to raise more funds for the Volunteer Scheme, the College is running a fundraising trek to Burma in February 2014. Those who undertake this trek will be fundraising for the Scheme. You can find out more about the work of the Volunteer Scheme, and make a donation to it, on the College website: http://www.charitychoice.co.uk/royal-college-psychiatrists-5207/events/trek-burma-february-2014

**Medical Training Initiative**
In November 2013 the College was granted approval to become a sponsor for the UK Government’s Medical Training Initiative (MTI). The scheme allows senior psychiatric trainees from outside the European Union (EU) to come to the UK to train for a maximum of 24 months before returning to their own country. The first International Fellows will start their placements in August 2014. For more information about the scheme please contact the International Liaison Manager, Elen Cook: ecook@rcpsych.ac.uk

**European Association of Mental Health in Intellectual Disability**
The bi-annual meeting of the European Association of Mental Health in Intellectual Disability (EAMHID) took place in Lisbon in September 2013. The following were nominated onto the Board of EAMHID from the UK: The Baroness Prof. Sheila Hollins; Dr Roger Banks; and Dr Ken Courtenay.

The next EAMHID conference will take place in Florence, Italy, in July 2015.

**Diaspora meetings and conferences**
There has been a number of conferences by diaspora groups as well as the Academy of Royal Medical Colleges Diaspora conference on 25 November 2013.

November saw the launch of ‘Turning the World Upside Down’ – a discussion of four groundbreaking interventions that are improving mental health in low- and middle-income countries and that could transform mental health in the UK.

We value feedback and contributions for news and notes. We also welcome any comments on current international issues in mental health.

---

**Contents of the Arab Journal of Psychiatry**
(affiliated journal)
Volume 24 Number 2 2013

### Schizophrenia papers

**85** Could infection effect cognitive function in schizophrenia? One Egyptian center study
M. Adel El-Hadidy, W. Elemshaty, W. Othman

**93** Self-reported quality of life for people with schizophrenia in a psychiatric outpatient department in Saudi Arabia
A. Ashowkan, J. Curtis, Y. White

**102** Quality of life among caregivers of patients with schizophrenia in Erbil, Iraq
R. S. Piro, T. A. Rahim

### Palestine papers

**109** Resilience and psychological problems among Palestinian victims of community violence
A. Anwar, A. A. Mousa Thabet

**117** Violent behavior among adolescents: findings from the national survey of Palestinian school children
K. Khayat Dajani, Z. Abdeen, R. Qasrawi

**124** Prevalence and risk factors for smoking among Palestinian adolescents: findings from the national study of Palestinian school children
K. Khayat Dajani, Z. Abdeen, R. Qasrawi

### Original papers

**133** Comorbid physical and psychiatric disorders among elderly patients: a study at an outpatient clinic in Saudi Arabia
M. Amr, T. Tawfik Amin, U. Al-Saeed

**142** Attitude of primary healthcare physicians to mental illness in Bahrain
S. H. Meer, C. A. Kamel, A. Ismail, E. Kamel

**148** Burnout and personality among Egyptian residents

**161** Enzymatic studies in autism spectrum disorder from a psychiatric research unit in Mosul, Iraq

### Country reports

**170** Mental health in the Kurdistan region of Iraq
Z. Al-Salihy and T. A. Rahim

**174** Mental health in Palestine
S. Jabr, M. Morse, W. El Sarraj, B. Awdi
Hubris syndrome and the Arab spring: shared ideology or folie partagée?

Sir: In his paper ‘Psychiatry and politicians’, Russell (2011) provided an excellent review of the ‘hubris syndrome’, as expounded by Owen & Davidson (2009). Diagnostic criteria for the syndrome are included in Lord Owen’s eponymous book (2012). In this letter, we propose that developments in the Arab Spring demonstrate how the syndrome may be exhibited not only by a person in power, but also by his or her followers.

The hubris syndrome is characterised by exaggerated pride, overwhelming self-confidence and contempt for others. It often involves an overestimation of one’s own competence and capabilities, which results in the leader’s misinterpretation of reality. This can result in the leader making swift, unwise and risk-laden decisions, decisions which are to the detriment of the people whom the leader is meant to serve. Hubristic behaviour may be a product of the environment in which the leader operates. However, the self-generating element of the behaviour cannot be underestimated; it means that the leader is gripped by something which is no longer driven by outside factors but comes from within that individual.

Owen & Davidson (2009) suggest that the hubris arises from a personality change which is associated with the individual’s possession of power. The condition postdates the acquisition of power and remits after the power is lost. The longer political leaders are in power, the more likely it is that they develop the condition.

The Arab Spring is the media term for the revolutionary wave of demonstrations and protests (both non-violent and violent), riots and civil wars in the Arab world that began in Tunisia in December 2010. To date, rulers have been forced from power in Tunisia, Egypt, Libya and Yemen; civil uprisings have erupted in Bahrain and civil war has engulfed Syria for the past 2 years. In all these countries, a common feature appears to exist: all the deposed rulers in the Arab Spring appear to fulfil the proposed diagnostic criteria for hubris syndrome as described by Lord Owen. They have been replaced by ‘democratically’ elected leaders with strong religious ideology. However, within a few weeks in office, the symptoms of hubris syndrome were in evidence in all of the newly elected leaders, perhaps even sooner than Lord Owen (2012) postulated.

These elected leaders appear to have crossed the dividing line between decisive leadership on the one hand and hubristic leadership on the other, with the accompanying loss of trust of the people who elected them. Moreover, the syndrome appears to have rapidly spread beyond the leaders themselves, and to have infected the ruling parties, the wider governments and their supporters. These groups now also appear to exhibit identical hubristic behaviour.

The prevailing collective hubristic behaviour in each of these countries has led to deep social divisions, civil unrest, mindless violence and loss of lives and liberty. Political opponents, liberals, intellectuals and minorities have been regarded as the enemy (nemesis) (Owen, 2012). The leaders and their followers appear to have developed an extraordinary mindset that fits the classic dynamic of hubris opposing nemesis with a vengeful desire to confront, defeat, humiliate and punish an adversary who may be accused of hubris (Owen, 2012).

It may therefore be plausible that the hubristic behaviour of a leader – based on beliefs or intoxication of power, and induced or acquired in circumstances of religious fanaticism and political power – may expand into a collective form affecting the leader’s supporters in a manner not dissimilar to folie partagée, where followers share and act on such beliefs, albeit not of equal strength (Enoch & Ball, 2001).

Salwa Khalil1 and Emad Salib2

1Consultant Psychiatrist, Hallam Street Hospital, West Bromwich, UK; 2Retired Consultant Psychiatrist, London, UK

Forthcoming international events

11–13 March 2014
V International Congress of Medicine and Women’s Mental Health
Medellin, Colombia
Website: http://www.medical-events.com

14 March 2014
American Association for Geriatric Psychiatry, Annual Meeting
Orlando, USA
Website: http://www.conferecelerts.com/psychiatry.htm

14–15 March 2014
21st International Symposium About Current Issues and Controversies in Psychiatry
Barcelona, Catalunya, Spain

18–21 March 2014
16th Annual Conference of The International Society for Bipolar Disorders Seoul, South Korea
Website: http://www.medical-events.co

21–24 March 2014
International Society for Affective Disorders Congress
Berlin, Germany
Website: http://www.isadconference.com/

25–27 April 2014
Stem Cell Summit 2014
Cambridge, Massachusetts, USA
Website: http://www.gtcbio.com/conference

28 April 2014
International Society for Affective Disorders Congress
Berlin, Germany
Website: http://www.isadconference.com/

28–30 April 2014
International Society for Affective Disorders Congress
Berlin, Germany
Website: http://www.isadconference.com/

30–31 March 2014
International Conference of the Association of Psychology and Psychiatry for Adults and Children (APAPC): Recent Advances in Neuropsychiatric, Psycholgical and Social Sciences Athens, Greece
Website: http://www.apapc.gr/displayTM11.asp?TMID=1&LANG=EN

21–24 May 2014
19th International Conference of the Association of Psychology and Psychiatry for Adults and Children (APAPC): Recent Advances in Neuropsychiatric, Psycholgical and Social Sciences Athens, Greece
Website: http://www.apapc.gr/displayTM11.asp?TMID=1&LANG=EN

Contents of the African Journal of Psychiatry (affiliated journal)
Volume 16 Number 6 November 2013

Editorial
387 Improving mental health systems in Africa

EUSARNAD
401 Report from First EUSARNAD Colloquium, February 2013

D. Baldivis, M. Novak

Scientific letters
411 Mineral hormone substitute causing hallucinations
T. I. Lemo

413 Sodium valporate for the treatment of mania in a patient with Charcot-Marie-Tooth disease: scientific letter
S. Kumar Kar, A. K. Panda, A. Kumbir, O. Prakash

Original articles
414 The prevalence of metabolic syndrome and its associated factors in long-term patients in a specialist psychiatric hospital in South Africa
K. Maaganyite, M. Mahata, C. Kragar, P. Rixivela

424 The accuracy of interpreting key psychiatric terms by ad hoc interpreters at a South African psychiatric hospital
S. Hagan, S. Kilian, B. Chiliza, P. Bisogno, J. Joska

430 Post traumatic stress disorder and resilience in veterans who served in the South African border war
M. A. Connolly, O. Onah, U. Samaniw, S. Olayni

437 Understanding cohort differences in appraisals of reconstruction priorities of mental health systems in post-conflict Liberia
D. A. King, C. F. C. Bobo, B. L. Harris, S. Daronio, R. Rossell, E. K. Wang, D. C. Henderson

445 Screening a heterogeneous elderly South African population for cognitive impairment: the utility and performance of the Mini-Mental State Examination, Six Dim Screener, Subjective Memory Rating Scale and Detoxification Cognitive Observer
S. Ranjit, J. Chpps, A. B. Bhugra, B. J. Patel

456 Mild cognitive impairment and dementia in a heterogeneous elderly population: prevalence and risk profile
S. Ranjit, J. Chpps, B. J. Patel, A. B. Bhugra

Movie review
467 Lincoln, Steven Spielberg
P. F. Visser

South African Depression and Anxiety Group
470 Getting back to basics: raising stress literacy: the first step on the path to improving biopsychosocial mental health – a South African study: patients as partners R. Hoekse

Volume 11 Number 1 February 2014
ISSN 1759-3676

Journals affiliated to International Psychiatry
African Journal of Psychiatry
Arab Journal of Psychiatry

Mission of International Psychiatry
The journal is intended primarily as a platform for authors from low and middle-income countries, sometimes writing in partnership with colleagues elsewhere. Submission from authors from International Divisions of the Royal College of Psychiatrists are particularly encouraged.

Editorial board

Michel Board
France
Nick Bouras
UK (Section Editor – Special papers)
Katy Briffs
UK
Jorge Calderon
Chile
Rakesh Chadda
India
Santosh Chaturvedi
India
George Christodoulou
Greece
John Cox
UK (Assistant Editor)
Anna Datta
India
Owolale Famuyiwa
UK
Christopher Hawley
UK
Peter Hughes
UK (Section Editor – News and notes)
George Ikos
UK (Section Editor – Guest editors; Mental health law profiles)
Rachel Jenkins
UK (Section Editor – Research papers)
Stephen Kelsey
Austria
Marinos Kyriakopoulou
UK
Nasser Loza
Egypt (Assistant Editor)
M. Aimal Mokhdum
Switzerland (Assistant Editor)
Amit Mokld
UK (Section Editor – Correspondence)
Donald Miliken
Canada
Gholam Reza Mirmisapossi
Iran
R. N. Mohan
UK
Helmie Najmin
UK
David Nidet
Korea
Sean D’Oornhall
Ireland
Okunfer Ogubale
Nigeria
Eleni Paladzou
UK
Vikram Patel
India
Sundraogaran Ragappal
India
Mohamed Omar Salem
United Arab Emirates
Shefali Saxena
Switzerland (Assistant Editor)
Fabrizio Schifano
UK (Section Editor – Country profiles)

Subscriptions
International Psychiatry is published four times a year.
For subscriptions non members of the College should contact:
Publications Subscriptions Department, Maney Publishing, Suite 1C, Joseph’s Well, Hanover Walk, Leeds LS1 5AB, UK. tel. (+44) 0113 243 2800; fax (+44) 0113 386 8178; email subscriptions@maney.co.uk
For subscriptions in North America please contact: Maney Publishing North America, 875 Massachusetts Ave., 7th Floor, Cambridge, MA 02139, USA. tel. 864 297 5154 (toll free); fax 617 354 6875; email subscriptions@maney.co.uk
Annual subscription rates for joint issues for 2014 (four issues, post free) are £28.00 (US$50.00). Single issues are £8.00 (US$15.00) post free.
Design © The Royal College of Psychiatrists 2014.

The views presented in this publication do not necessarily reflect those of The Royal College of Psychiatrists, and the publishers are not responsible for any errors or omissions.

International Psychiatry is a refereed journal published in England and Wales (228636) and in Scotland (SC320849).

International Psychiatry was originally published as (and substituted) the Bulletin of the Board of International Affairs of the Royal College of Psychiatrists. Printed in the UK by Hong Ling Limited at the Donmak Press, Disseltrust 1105.


Notice to contributors
International Psychiatry publishes original research, country profiles, mental health law profiles and thematic overview, dealing with mental health policy, promotion and legislation, the administration and management of mental health services, and training in psychiatry around the world. Correspondence as well as items for the news and notes columns will also be considered for publication. The journal is an open platform for work that is generally underrepresented in the literature, expressly not reviews or opinion pieces from low and middle-income countries.

Manuscripts for publication must be submitted online at http://submit.ip.rcpsych.org (general enquiries may be addressed to gp@rcpsych.org.uk). Research papers and special articles printed in the journal may be no longer than 1500 words; at the Editor’s discretion, longer versions of papers that have been successfully peer reviewed may be linked to the online version of the journal in manuscript form. Correspondence should be no longer than 500 words. The Manual of Laboratory and Diagnostic Tests, a financial resource of referencing should be used. Manuscripts accepted for publication are copy-edited to improve readability and to ensure conformity with house style. Authors whose first language is not English are encouraged to contribute, our copy-editor will make any necessary corrections, in consultation with the authors. Contributions are accepted for publication on the condition that the substance has not been published or submitted elsewhere. Once a paper is accepted for publication, all its authors are responsible for disclosing any potential conflict of interest. Completion of the form developed by the International Committee of Medical Journal Editors for this purpose (http://www.icmje.org/ ethics-document/icmje-conflict.pdf) is mandatory.

About our peer review process
All articles included in this journal have been peer reviewed to ensure that their content, length and structure are appropriate for the journal. Research papers and special papers are reviewed by a minimum of two peer reviewers. All papers will be accepted for publication, but our peer-review process is intended to assist our authors in producing articles for worldwide dissemination. Wherever possible, our expert panel of reviewers will help authors to improve their papers to maximize their impact when published.

Open access
Online access to International Psychiatry is unrestricted; use of its content is governed by an Open Access License Agreement.

The publishers.
All rights reserved. No part of this publication may by reproduced or reprinted, or in any electronic, mechanical or other means, new or known hereunder excepted, including photocopying and recording, or in any information storage or retrieval system, without permission in writing from the publishers.
Guest editorial
1
The need to reform mental health legislation in Commonwealth countries
Soumitra Pathare, Laura Shields, Jaya Sagade and Renuka Nardodkar

Thematic papers. Strategic developments in the delivery of psychiatric services worldwide
3
Introduction
David Skuse
3
Mental health: strengthening health and development opportunities in the WHO African Region
Carina Ferreira-Borges
6
Mental health in Latin America and the Caribbean
Jorge J Rodriguez
8
Together to make a difference in mental health in the Western Pacific Region
Xiangdong Wang

Mental health law profiles
10
Introduction
George Ikkos
11
Mental health law in Greece
A. Douzenis, C. Tsopelas and L. Lykouras
12
Mental health law in Turkey: legislation pending
Eesa Gaglar and Muazafker Kaser

Research paper
15
Teaching psychiatry to undergraduate medical students in Somalia
Lauren Gavaghan, Peter Hughes, Khalid Saeed and Susannah Whitwell

Special papers
18
Community mental health services in Al Ain Hospital, United Arab Emirates
Amir Mufaddel, Mouza Al Sabousi, Yahya Takriti, Badr Dawoud, Nora Cassra, Habib Belhaj and Nasser Al Hekmani
20
Addressing the mental health needs of a rapidly growing megacity: the new Lagos Mental Health Initiative
Olufemi Oludayo, Olufemi Olugbile and Ayodele Coker

News and notes
23
Correspondence
24
Forthcoming international events
25