

# International psychiatry

Volume 11  
Number 2  
May 2014  
ISSN 1749-3676

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

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Annual subscription rates for print issues for 2014 (four issues, post free) are £28.00 (US\$50.00). Single issues are £8.00 (US\$14.40), post free.

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

*International Psychiatry* was originally published as (and subtitled) the *Bulletin of the Board of International Affairs* of the Royal College of Psychiatrists. Printed in the UK by Henry Ling Limited at the Dorset Press, Dorchester DT1 1HD.

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

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# What psychiatrists should know about environmental sustainability and what they should be doing about it

Daniel Maughan,<sup>1</sup> Helen Berry<sup>2</sup> and Phil Davison<sup>3</sup>

<sup>1</sup>Sustainability Fellow, Royal College of Psychiatrists, and Centre for Sustainable Healthcare, Oxford, UK, email daniel.maughan@sustainablehealthcare.org.uk

<sup>2</sup>Associate Dean Research and Professor of Psychiatric Epidemiology, Faculty of Health, University of Canberra, Australia

<sup>3</sup>Psychiatrist, Oxford Health NHS Foundation Trust, Oxford, UK

**The 2013 report from the Intergovernmental Panel on Climate Change has caused renewed concern among both clinicians and health policy makers. Climate change is continuing at an increasing rate. This guest editorial describes how climate change might affect global mental health and proposes three things that psychiatrists from every country could implement to respond appropriately to this urgent and severe global threat. These responses are mitigation and adaptation strategies for mental health services, and the integration of sustainability into training.**

Our planet is warming dangerously, a change that may represent the world's single biggest health threat (Chan, 2008). The Intergovernmental Panel on Climate Change (IPCC) has reported that the past three decades have been successively warmer than any preceding decade since 1850 and that this observed increase in global temperatures is very likely due to anthropogenic greenhouse gas (GHG) production (IPCC, 2013). The IPCC (2013) has forecast that global warming will continue to reduce crop productivity, to increase the risk of both floods and droughts, and to increase sea levels. Other impacts will include longer and hotter heat waves, and more cyclones and forest fires, with tropical forests increasingly lost to savannah. Water availability for human consumption and agriculture is also likely to reduce, and over 75 million people are projected to be exposed to increased water stress by 2020.

## Mental health effects of climate change

Attention has been given to the possible effects of climate change on global mental health (Berry *et al*, 2010). These effects are likely to be difficult to detect because, most often, mental health problems come at the end of a long and complex causal chain of events. For example, climate-induced displacement or conflicts arising due to scarcity of resources can expose people to traumatic events, or to loss of family, community and income-producing activity, provoking symptomatic responses (McMichael *et al*, 2010). Increasing drought can put pressure on the social and economic fabric of rural communities, with consequences for mental health (Berry *et al*, 2010).

There are, though, more straightforward links between climate change and mental health. Climate change increases the risk of acute weather-related

disasters, such as major fires, floods and cyclones, and these can have direct consequences for mental health (Morrissey & Reser, 2007; Stanke *et al*, 2012; Clemens *et al*, 2013). In addition, suicide rates have been noted to increase during periods of extreme temperature change (Page *et al*, 2007), as well as during periods of drought (Hanigan *et al*, 2012).

Australia is the canary in the world's climate change cage: it has the world's most variable climate, with frequent extreme weather conditions, and is already experiencing significant effects of climate change. It also has to accommodate the needs of people living in very remote locations, far from services and, sometimes, even from other people. As a result, Australia has taken the lead in considering the potential mental health effects of climate change and how best to prepare and respond. An Australian paper (Berry *et al*, 2010) categorised these possible impacts as shown in Table 1.

A paper in the *Lancet's* 'Global Health' series made the important claim that climate change is 'the biggest threat to global health in the 21st century' (Costello *et al*, 2009), yet, always the Cinderella issue in health, there was little substantive comment on mental health. Given that, by 2030, mental health problems will represent the world's leading burden of disease (Mathers *et al*, 2001), and given the extent of the climate change threat, a serious and coherent response is urgently needed from mental health services and the research community, including psychiatrists. Here, we suggest three areas for immediate focus:

- mitigating the effects of climate change
- preparing effective, achievable, adaptive strategies for mental health services
- equipping present and future psychiatrists with the knowledge and skills to manage the effects of climate change in their clinical settings.

## Mitigating the effects of climate change

Healthcare worldwide is big business, a business that consumes vast resources. For example, in Brazil, the healthcare sector has accounted for 10% of national energy consumption, while in England the National Health Service (NHS) is the largest single public-sector emitter of GHGs (Karliner & Geunther, 2011). The NHS has been encouraging clinicians to move beyond conventional service values focused on patients to incorporate a more global vision of health promotion (Karliner &

**Table 1**

Putative pathways between the effects of weather events and mental health problems

	Acute weather events (e.g. floods, hurricanes and fires)	Chronic weather events (e.g. more heat waves, droughts)
Direct effects on mental health	More frequent exposure to physical danger due to storms or floods leading to elevated rates of acute anxiety disorders	More frequent exposure to chronic stress (e.g. from long periods of extremes of heat or lack of clean water) leading to elevated rates of violence and aggression
Indirect effects on mental health	More frequent and more severe damage to homes and infrastructure, including community buildings (e.g. schools); physical injury to self or significant others; elevated rates of anxiety and mood disorders	More frequent and/or severe physical health impacts and damage to livelihoods and soft social infrastructure (disruption of networks, lack of time to socialise); elevated rates of chronic mood disorders and suicide

Adapted from Berry *et al* (2010).

Geunther, 2011). The World Health Organization (WHO) has a 'Health in the Green Economy' initiative, which focuses on reducing healthcare's climate footprint. Thailand is one country that has prioritised this initiative, creating a 'Green and Clean' hospitals programme that addresses energy and resource use (Astudillo, 2012).

While these top-down approaches are helpful, particularly in setting directions and an appropriate framework for action, engagement at a clinical level is necessary to produce more rapid results. There is evidence that the production and distribution of pharmaceuticals contribute about as much to healthcare's carbon footprint in England as does the total energy consumption of the NHS (NHS Sustainable Development Unit, 2013). Pharmaceuticals contribute around 20% of the total carbon footprint of mental health services, up to 50% of which may be wasted due to poor compliance with medication. A review of prescribing practice could therefore reduce the NHS mental health carbon footprint by up to 10% (NHS Sustainable Development Unit, 2013).

More importantly, as a profession, psychiatrists may be overprescribing, or prescribing in circumstances in which patients may recover equally as well with psychological therapies. There is good evidence for the effectiveness of behavioural activation in cognitive-behavioural therapy (CBT) for depressive disorders, an intervention with a potentially very small carbon footprint. Furthermore, some therapies can reduce relapse rates and therefore further decrease mental health services' carbon footprint by lessening the burden on services. Strong evidence is available that indicates mindfulness-based therapy is associated with a 44% reduction in depressive relapse risk compared with usual care for patients with three or more previous episodes (Williams & Kuyken, 2012). Clinicians could thus modify their routine practice to significantly reduce healthcare's environmental impact and even improve patient outcomes using treatment approaches that are more acceptable because they have fewer unwelcome side-effects.

The Centre for Sustainable Healthcare (Mortimer, 2010) proposes that clinical transformation is required because most of the carbon footprint of healthcare is related to clinical matters such as procurement, medical equipment and pharmaceuticals. It proposes that greater clinical focus is required on principles such as prevention,

patient empowerment, lean service delivery and use of low-carbon technologies.

One place to start implementing environmental sustainability principles would be secondary preventive measures. That is, mental health services could provide more options to help patients manage their own mental health. One such option could be web-based platforms that educate and empower patients by offering a range of evidence-based tools such as self-administered CBT, peer-to-peer support networks, educational packages and programmes for the self-monitoring of symptoms. Providing these opportunities would allow mental health services to be more strategic about where and when to intervene. Integrating mental health expertise into primary care settings facilitates the early detection and monitoring of mental illness. The integration of mental health services with primary care and the provision of specialist early intervention for psychosis should be a major focus.

### Adaptative strategies

Climate change will affect the *prevalence* of mental health conditions more than their *nature* (Berry *et al*, 2010). Healthcare services must prepare for potentially increased demands, especially in primary care settings, which receive the majority of initial presentations (Blashki *et al*, 2009).

A major effect of climate change on mental health will be through its effect of increasing health inequalities (Costello *et al*, 2009). It is well documented that inequalities are a major source of psychiatric morbidity (Marmot *et al*, 1997). Inequalities are likely to increase everywhere, but mostly (and most damagingly) in low-income countries and in countries particularly vulnerable to the effects of climate change (Berry *et al*, 2010). There are, however, very low levels of mental health service provision in most low-income countries, giving rise to the potential for a crisis in the availability of mental health services following acute weather events.

A first phase of development in adaptive strategies in low-income countries could be to better integrate mental health services into primary care. There is currently little integration between mental and physical health services (Horton, 2007), even though the majority of psychiatric patients first present in these settings. Introducing a mental health needs assessment at primary care

level could improve the identification of mental health conditions in these poorly resourced and vulnerable areas (Herrman, 2001). An example of this is a project in Kenya that trained primary care and community health workers to integrate mental health assessment into their routine work (Jenkins *et al*, 2010).

Principles of health system adaptation have been suggested: flexibility, robustness of services and strategic allocation of resources (Blashki *et al*, 2011). Mental health services will need to prioritise flexibility, as there remains substantial uncertainty about the specific nature, location and timing of climate change effects. Kyrgyzstan has implemented a national healthcare adaptation strategy (United Nations Development Programme, 2013) aimed at improving the flexibility of energy provision for services; it considers options for alternative energy sources following climate change effects.

Robustness refers to services' ability to moderate their capacity with changing needs. Acute weather events can have direct, immediate and sometimes widespread consequences that typically lead to spikes in demand for mental health services. At the same time, services must be able to downscale or relocate rapidly.

Other adaptive strategies could be implemented at a community level. It has been suggested that building community resilience ahead of weather-related disasters forms a crucial part of healthcare adaptation strategies (Berry, 2009). A qualitative study of Sudanese refugees found that religion and wider social support had positive effects on recovery after traumatic experiences (Schweitzer *et al*, 2007). Social capital, networks and support alongside supporting families and parents have been noted as important factors in community resilience in the face of environmental stress (Kirmayer *et al*, 2009). Social capital is enormously protective for mental health (Berry & Welsh, 2010) and is a resource that can also be mobilised before, during and in recovery from disasters (Berry, 2009).

Given the wide range of threats from climate change and the variety of supportive community structures, there is great scope for innovation when adapting healthcare services. More knowledge is needed, though, at a local level about how communities could adapt.

### Knowledge and skills

Psychiatrists could play a direct and influential role in designing health-related mitigation and adaptation strategies for climate change. For this reason, education and training in climate change and its likely impacts and responses are important. In Australia, learning objectives for medical students have been created that specifically focus on the health effects of climate change (Green *et al*, 2009). These could be adapted and expanded for continuing education. Sustainable healthcare learning objectives have also been created in the UK as a response to a request from the General Medical Council (Mortimer, 2013).

Educational programmes on the mental health effects of climate change could start during medical training. General concepts could be introduced at medical school through the use of either a problem-based or a case-based learning approach (Green *et al*, 2009). It needs to be realised that a healthy environment and ecosystem are crucial for maintaining health, and that healthcare services have responsibility not only for reducing their impacts on the environment, but also for ensuring that they are ready for the effects of climate change on health (Costello *et al*, 2013).

Developing an understanding of how a phenomenon as complex as climate change can have population-level mental health effects requires specialised psychiatric knowledge and an understanding of health and social policy. Box 1 lists specific learning objectives for postgraduate psychiatric trainees. At increasingly senior levels of practice, there will be broader educational aims, as well as advocacy of broader policy issues.

### Conclusions

The mental health effects of climate change are well documented, although evidence for causality is scarce. Psychiatrists can act to address these effects. The profession must develop both mitigation and adaptation strategies in response to these concerns. Psychiatrists also have a responsibility to equip future professionals with knowledge of the effects of climate change on mental health, and the likely impact on future generations of patients. Thinking sustainably in mental health demands a change from an *individual, illness* focus to a *community, health* focus. Decisions made now will affect the resilience of both mental health services and communities in dealing with the effects of climate change on mental health.

#### Box 1 Environmental sustainability learning objectives for postgraduate psychiatric training

- Understand the existing and potential mental health impacts of climate change in your country and internationally
- Understand the psychiatric sequelae for climate refugees
- Be aware of the mental health conditions that are likely to increase in prevalence following climate change (e.g. adjustment disorder)
- Be aware of characteristics that may make certain individuals or communities vulnerable to the mental health impacts of climate change
- Discuss how the duty of a psychiatrist to protect and promote health is shaped by the dependence of mental health on the local and global environment
- Demonstrate the knowledge and skills needed to improve the environmental sustainability of mental health systems

Adapted from Green *et al* (2009) and Mortimer (2013).

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THEMATIC  
PAPERS

# Training and education in mental health

David Skuse

Behavioural and Brain Sciences  
Unit, Institute of Child Health,  
London, UK, email d.skuse@  
ucl.ac.uk

The education of our colleagues around the world in the treatment and management of mental ill health is critically important, and the Royal College of Psychiatrists has a leadership role in promoting and supporting such training in many countries. Here we present contributions from three regions, South America, sub-Saharan Africa and the Western Pacific, in which UK involvement has played an important part in developing and

sustaining modern approaches to psychiatric care. First, David Jimenez and colleagues discuss SUD World Project, which is a charity devoted to building links between Latin America and Europe for that purpose. At the present time, the focus is on Peru and Ecuador, but there are plans to expand activities throughout the continent. As in so many other countries, not all of them classified as low or middle income, government support for mental

health rarely extends beyond paying lip service to its importance. SUD World Project is keen to develop a reciprocal exchange programme with trainees in the UK and Ireland.

Mark Roberts and his fellow contributors discuss the shocking fact that until recently only 2% of people with a mental illness in Ghana, one of the best-governed countries in the region, received assessment or treatment by health services. The Kintampo Project is a partnership between a UK National Health Service trust and the College of Health and Wellbeing in the Kintampo region, in central Ghana. Established in 2007, the project has concentrated on increasing the number of community mental health workers, and has almost doubled

this since 2011. Their training is supported by a UK team which aims to set up an infrastructure that will enable the development of local services to be self-sustaining within the next 3 years.

Finally, the contribution from Parameshvara Deva informs us about recent events in Fiji, where, despite periods of political instability, there remains a legacy of British administration in terms of its health services. It is gratifying to hear that a modest financial contribution from the Royal College of Psychiatrists has helped to establish a centre for psychiatric day-care services there. Yet it is disturbing to learn that so many local staff still hold views about people who are mentally ill that would not have seemed out of place a century ago.



## Mental health training and education in South America: SUD World Project

Christopher Symeon,<sup>1</sup> Dewi Pritchard,<sup>2</sup> Lucienne Aguirre<sup>3</sup> and David Jimenez<sup>4</sup>

<sup>1</sup>Specialty Registrar in Psychiatry, South London and Maudsley NHS Trust, London, UK, and SUD World Project

<sup>2</sup>Consultant, East London NHS Foundation Trust, London, UK, and SUD World Project

<sup>3</sup>Core Trainee, South West London and St George's NHS Trust, London, UK, and SUD World Project

<sup>4</sup>Specialty Registrar in Psychiatry, South London and Maudsley NHS Trust, London, UK, and SUD World Project, email [drdavidjimenezleiva@gmail.com](mailto:drdavidjimenezleiva@gmail.com)

**There is a clear interest in many countries in improving education, training and academic opportunities in mental health. The goal of SUD World Project is to create links between South America and Europe that will actively enhance education and training in mental health.**

SUD World Project is an international charity that is based in the UK and run by a team of volunteers who include doctors, psychologists and public health experts. The word *sud* – ‘south’ in Spanish – refers to the South American continent. SUD World Project’s focus is to build links between Latin America and Europe with the aim of collaboratively improving training and education for mental health professionals. The charity was set up in spring 2013.

South America has been changing rapidly since the continent moved from military dictatorships to democratic systems. There is economic growth and an expanding middle class. Interest in human rights and, as a result, in the treatment of psychiatric patients is high. The initial focus of our work has been on Peru and Ecuador, as SUD World Project had already established contacts in psychiatric centres there. We are working on a number of initiatives and, once our efforts have proved successful, we hope to replicate our model within other South American countries. We describe two of our projects here, one in Peru, the

other in Ecuador, after first providing some background to SUD World Project.

### Psychiatry in South America

Despite the high burden of psychiatric illness in South America, the majority of countries in the region devote less than 2% of their health budget to mental health. This has resulted in services that are extremely limited, with an estimated 3.3 psychiatric beds per 10000 inhabitants. Mental healthcare is usually restricted to urban areas, remaining inaccessible to much of the population in need (Alarcón, 2002). In addition, psychiatric services are mainly hospital based; there are few community resources. On the other hand, mental health law has been developing quickly, as countries have evolved from military dictatorships into modern democracies. Most of this progress took place in direct response to the Caracas Declaration, issued at the Regional Conference for the Restructuring of Psychiatric Care in Latin America, held in Caracas, Venezuela, in November 1990 (Levav *et al*, 1994).

Psychiatric trainees in lower-income countries often have lower levels of psychotherapy supervision, poor access to training tools such as visual aids and limited access to medical journals (World Health Organization, 2011a). In addition, they are subject to a heavy workload and those outside large urban centres have few academic opportunities. This has led to a situation in which there is

little availability of continuing professional development after training, and this is associated with early burnout.

### Research

There are deficiencies in mental and neurological health research in South America. The reasons for these deficiencies are multifactorial, but the lack of research is mainly due to a lack of provision and funding from government agencies. Fortunately, there is now a drive to increase the training in psychiatric research, as well as greater recognition of local research, which has led to publication and implementation of results (Fiestas *et al.*, 2008).

Research in South America happens mostly in urban centres. Any shift in the direction of delivery from hospital to community-based services presents a challenge to the academic community. Consequently, many academics have not wholeheartedly supported the shift to community services, as they are perceived to be less than ideal environments for research (Brazilian Ministry of Health, 2005). As our work develops, we hope to build links with European academic institutions involved in facilitating community-based research.

### Country profile: Peru

In Peru, neuropsychiatric disorders are estimated to contribute 21.8% of the burden of disease. There is a current mental health policy outlining the main priorities, including a shift of services and resources from mental hospitals to community mental health facilities, and integration of mental health services into primary care (World Health Organization, 2011b).

The key institute associated with psychiatric training in Peru is the Colegio Medico del Peru. This organisation has a structured syllabus for psychiatric trainees (called the Peruvian National Residency Syllabus, published by the Comité Nacional De Residentado Médico in May 2002).

Medical students in Peru spend 10% of their training hours on psychiatry and nurses have on average 6% of their curriculum dedicated to mental health. The Hospital Víctor Larco Herrera is the main teaching place and Hospital Hermilio Valdizán has a basic research department but it is mainly dedicated to qualitative studies.

### Country profile: Ecuador

In Ecuador, there are 8 mental health professionals per 100 000 habitants, of whom 2.1 are psychiatrists and 0.5 are psychiatric nurses (the remaining staff include social workers and psychologists). There are 24 523 physicians in Ecuador, but only 1.4% are psychiatrists, 44% of whom work for the public National Health Service.

The psychiatric training pathways in Ecuador are regulated by the different universities, especially in the cities of Quito and Guayaquil. There are six main universities that provide postgraduate training programmes in medicine, including psychiatry. Each university is linked to a different hospital. Each university provides its own syllabus,

which is evaluated and approved by the Ministry of Health. Psychiatric training takes 3–4 years. The Universidad Central del Ecuador, the biggest and oldest university, in Quito, has programmes in a wide variety of specialties, including psychiatry. The psychiatric training programme is not run every year because there is a minimum intake requirement of ten trainees; consequently, entry to training can be delayed until the minimum number is reached.

In Guayaquil, the Instituto de Neurociencias, the largest psychiatric hospital in Ecuador, provides care for 60% of the country's psychiatric patients. It has recently initiated a new postgraduate training programme, which is currently under evaluation by the Ministry of Education.

### Establishing exchange programmes

In 2003, in the first phase of SUD World Project, links were established with psychiatric centres in Peru and Ecuador, and members of the project visited teams there, including at the Hospital Víctor Larco Herrera, the Ministry of Health, ESALUD (in the private sector) and ALAMO (an association of service users and relatives).

The participating hospitals have expressed interest in developing a reciprocal exchange programme. We have now successfully facilitated the placement in Lima (Peru) of a trainee from Ireland with an interest in transcultural psychiatry. The programme will enable those placed in South America to explore and experience how the healthcare system functions in the host country. In particular, we are interested in learning about the experiences of people with a mental illness in a resource-poor service, and how spirituality and cultural traditions and social norms interplay with the presentation and management of psychiatric patients.

At a time when funding for mental health services is being cut in many countries, and efficiency of delivery is key, we are keen to learn how to offer a flexible and high-quality services in a low-resource environment. The aim of SUD World Project is to give professionals in the host countries the opportunity to learn about the UK healthcare delivery system and healthcare models. We expect those on placement to participate in educational and academic activities and to act as a bridge. We want to enable the host country to develop links with Europe and to facilitate further exchanges. Although we envisage that it is psychiatric trainees who will be best placed to take up placements, there is a need at non-training levels for continuing professional development in this area. It is our hope, as our organisation grows, to facilitate exchanges of other professionals allied to medicine too.

We have arranged for trainees to visit the UK, starting with a placement programme in London, where SUD World Project is based, with opportunities to attend various clinical settings, both community and in-patient, in different specialist services. These programmes can be tailored to the trainee's needs, from 2-week 'taster'-type



placements up to 6 months. If the exchange trainee wants to be involved with research, links have been established with the Institute of Psychiatry and the Royal College of Psychiatrists. These projects can form the basis of continuing links between the UK and Latin America.

### Towards developing community working

We are formulating a project for the development of community workers in Ecuador. We aim to train staff to monitor and follow up patients in the community. The longer-term objective is to support, train and supervise past service users so that they can become leaders of the rehabilitation process. They will lead the next group of service users in their passage of integration into the community. We would hope to use this process as a way to promote equality and tackle stigma, involving carers, family and workers as far as possible. Our goal is improved quality and autonomy of life for individuals with mental illness. There are five elements to the proposed community rehabilitation service:

- Using the new 'attention' model of rehabilitation, patients will receive a psychosocial diagnosis of their rehabilitation potential after 3 months of contact with the service.
- The service users will be provided with detailed multidisciplinary rehabilitation plans.
- Goals will be determined and set for short-, medium- and long-term rehabilitation. This will enable the selection of the appropriate candidates for integration into pre-employment, employment and supported accommodation.
- Our main intervention will be at the level of training professionals to determine when

service users are ready to be reintegrated into the community, using evidence-based assessments that will predict the outcome of the rehabilitation process. We will create a training programme for workers, who will include nurses, assistants and social workers, to help them to monitor the progress of service users in the community and to build the new 'attention' model of rehabilitation, one that is not currently available in Ecuador.

- We will include psychoeducation and family interventions in the multidisciplinary rehabilitation system.

### Conclusion

Our goal is that the links we create will actively enhance high-quality education and training in mental health in both South America and Europe.

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# Innovations in mental health training – the Kintampo Project, Ghana

Mark Roberts,<sup>1</sup> Emmanuel Teye Adjase<sup>2</sup> and Jim Crabb<sup>3</sup>

<sup>1</sup>Consultant Psychiatrist, Kintampo Project Lead (UK), Southern Health NHS Foundation Trust, UK

<sup>2</sup>Kintampo Project Lead (Ghana), Director of the Kintampo Rural Health Training School

<sup>3</sup>Consultant Psychiatrist and Honorary Senior Clinical Lecturer, Institute of Health & Wellbeing, University of Glasgow, UK, email enquiries@thekintampotruster.org

**The landscape of some low- and middle-income countries is sadly all too often littered with the remains of well intentioned health development projects that have failed. The Kintampo Project in Ghana is an education intervention that is set to achieve the most elusive of outcomes in development work, namely genuine sustainability. This article focuses on the challenges faced by the project and the factors that have allowed it to reach its targets.**

### Background

Until recently only 2% of people with a mental illness in Ghana, West Africa, received treatment or assessment by health services, as there were only around 18 psychiatrists and 1177 other trained mental health workers for the whole country of 24 million people (Roberts *et al.*, 2013). A high-income country (e.g. the UK) would expect nearer 24000 such workers for 24 million people. Ghana now has a growing health budget but has nevertheless experienced a doctor and nurse 'brain drain'.

Concerns about human rights abuses and the emergence of increasingly Western disease profiles have focused the country on improving mental health services. In 2007 the Ghana government resolved to strengthen community services by developing two new types of middle-level mental health worker, the clinical psychiatric officer (CPO) (initially called the medical assistant psychiatry, MAP) and the community mental health officer (CMHO). The CPO performs a similar role to district-level psychiatrists and the CMHO works with community psychiatric nurses (CPNs) and acts as a bridge with primary care. They cost less to train than doctors and nurses. The new roles also provide specialist career opportunities to improve workforce retention. Those trained in the new roles should be less likely than doctors and nurses to leave for work abroad, as their knowledge and skills are specifically designed for best practice in their own country.

### Project set-up

This led to the Kintampo Project, a partnership since 2007 between Southern Health NHS Foundation Trust (formerly Hampshire Partnership NHS Foundation Trust), UK, and the College of Health and Wellbeing, Kintampo (CoHK) (formerly the Kintampo Rural Health Training School). The partnership was formed to develop mental health education programmes for CPOs and CMHOs.

The project has focused on three key interconnected areas:

- service needs (providing for the mental health needs of ill people)
- workforce requirements (the types and projected numbers of staff required to meet the needs)
- the educational needs of staff.

Although a mental health initiative, the Kintampo Project has largely been an education intervention with mental health as the beneficiary.

### Project achievements

Between 2011 and 2013 the Kintampo Project realised the following achievements:

#### Box 1 Factors that have facilitated the success of the Kintampo Project

- Political mandate for change in the host country
- Strong local champions for the project
- A single, accountable project lead in each country
- Being an education intervention with mental health as the beneficiary
- A strong focus on educational theory, driven by a culturally acceptable curriculum
- Educating of educators rather than undertaking direct teaching
- A strong focus on communications
- Successfully accessing funding
- A focus on project management and 'hard graft'

- it has increased the number of trained CMHOs by 96%
- it has enabled an extra 86530 individuals to access mental health treatment in Ghana.

By 2017 the Kintampo Project will have produced the intended number of CMHOs for Ghana, which will be enough to bring the country to the level expected for its economic status. End-point objectives for the project include ensuring that supervision, continuing professional development and clinical governance structures are in place for the new workforce. Preparations are underway for the UK project team to withdraw in 2017, by which time the mental health system in Ghana will be fully recruiting, training and retaining the new workforce without outside assistance.

### Factors that have led to success

The Kintampo Project has been very successful. Sometimes low- and middle-income countries are subject to the unilateral efforts of well intentioned health development projects but failure can occur owing to lack of alignment with government plans. Fortunately, this has not been the fate of the Kintampo Project. Factors that have led to success where other ventures have failed have included the following (see also Box 1):

- alignment with government plans from the outset
- exceptionally strong local sponsorship from the Ghana project lead, the Rector of the College of Health and Wellbeing, Kintampo, and his educational institution, which has a long-established track record of delivering community health programmes (this made the Kintampo Project credible in Ghana from the outset)
- the UK project lead previously lived and worked in Ghana as a front-line clinician for over 2 years, which meant authenticity and realism was instilled in project's UK partners from the outset
- an expert in education from the University of Winchester Faculty of Education helped to ensure a very robust curriculum development for the CPO and CMHO programmes throughout, which created the bedrock for the long-term sustainability of the programme
- an unrelenting focus on the educating of educators rather than direct teaching
- a UK volunteer expert in communications being involved from the outset, helping to drive awareness-raising and producing consistent, clear and accessible messages about the Kintampo Project
- the drafting and implementation of a new Ghana Mental Health Act (846 of 2012), which is now providing the structures and mechanisms for community mental health services (this has demonstrated the political will in Ghana for

mental health to be as important as other areas of health).

The hard-pressed economy in Ghana has meant that the mental health service development tasked for the Kintampo Project was risky and needed innovation. The task was to design a training programme for health professionals that did not exist at the time. For this reason, the recruiting of the enthusiastic and respected Professor of Medical Education as a volunteer was critical to the success of the project.

### Curriculum development

Curriculum development is an iterative process achieved by repeated cycles of consultation, agreement, refinement and redesign. The choice of education model was important and the project used a model described by Stenhouse (1975) in which the process of education is seen along a continuum of product, process and enquiry. This continuum has didactic lecture-type teaching at the product end and formative discovery-based approaches at the enquiry end. As practice in Ghana tends to be mainly 'product' oriented, the College of Health and Wellbeing, Kintampo, started the CPO and CMHO curricula in the process area, with a leaning towards enquiry. The College is keen to move further towards the enquiry method through gradual change. The enquiry approach has advantages in an environment where mental health educators are scarce and where the requirements of future practice are uncertain.

### Lessons from the project

Development project volunteers can become overwhelmed when faced with heavy administration and management tasks, so finding individuals with an aptitude and appetite for these work areas has been core to the Kintampo Project's achievement of its objectives on time and within budget.

The Kintampo Project can be conceptualised as a 'programme' consisting of an extensive portfolio of projects. For any complex set of projects to succeed, clear leadership and direction with good project and programme management are critical. By their very nature, development projects attract volunteers who, not unreasonably, come and go, depending on their other commitments. This can mean that the projects and even the programme lose focus over time, leading ultimately to failure.

The Kintampo Project has had single strong and highly energetic leads in the UK and Ghana, who have set the direction of travel, and coordinated and overseen the entire process, and who have been accountable to their employers and the full team of volunteers for 'getting the job done'. At an early stage, the Kintampo Project leads produced a helpful one-page vision and project plan; it was then regularly updated and adapted (Roberts & Adjase, 2013). This channelled the enthusiasm of volunteers into a coherent whole. The role of programme leader is demanding and in practice has been equivalent to an extra full-time job for the UK lead, albeit one that is unpaid. The commitment must be there for the duration of the development project (in this case spanning several years). Without this role it is likely that the Kintampo Project would not have managed to achieve its considerable success.

The Kintampo Project established an exit point from day 1. Theoretically, every development project should be working towards putting itself out of business, aiming for the local population to manage their own affairs independently, without the assistance of outsiders. This is best achieved by clearly stating at the outset the objectives and when they are to be completed, and by committing to a time for withdrawal.

### Conclusions

The Kintampo Project has achieved the rarest of things in development work, namely a sustainable outcome. The project is now in the seventh year of its 10-year programme and is on course to end according to plan. Ghana took a bold decision to improve its mental health services despite having extremely limited capacity to do so. The Kintampo Project has been an important addition to the international knowledge base on ways to introduce a new and successful workforce.

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#### Bursaries for psychiatrists from developing countries

The Faculty of the Psychiatry of Intellectual Disability and the Faculty of the Psychiatry of Old Age both offer annual bursaries for a psychiatrist from a low- or middle-income country (LMIC) to attend their Annual Residential Meetings (ARMs). The recipients of these respective bursaries will give an oral or poster presentation, or deliver a workshop at the meetings. The deadline to apply for the Intellectual Disability ARM bursary is 31 May 2014, and the deadline for applications for the Old Age ARM bursary is 31 October 2014. Please contact Kitti Kottasz ([kkottasz@rcpsych.ac.uk](mailto:kkottasz@rcpsych.ac.uk)) for more information.

# Mental health reform in Fiji and opportunities for training assistance

M. Parameshvara Deva

Professor of Psychiatry, Faculty of Medicine and Health Sciences, University Tunku Abdul Rahman, Sg Long Campus, Ceras, Malaysia, email parameshvara@utar.edu.my

**Fiji inherited a British colonial healthcare system. In 2010 the long dormant mental health law was replaced by the Mental Health Decree (MHD), which set up divisional mental health units for the purpose of managing mental health problems outside of the old asylum. The Ministry of Health recruited an overseas consultant to help improve training. Under the MHD, stress management wards, stress management clinics and stress management day centres have been set up, to decentralise and deinstitutionalise psychiatric care. These are on the whole doing reasonably well and have good client acceptance.**

The Western Pacific region is home to 16 countries, from Papua New Guinea in the west to the Cook Islands in the east. Among these island countries, Fiji is the second largest in terms of population, after Papua New Guinea. Fiji is a Melanesian tropical island nation of 18 274 km<sup>2</sup> and over 332 islands situated in the Western Pacific, about 2000 km north-east of New Zealand. Only 110 or so of the islands have permanent residents. Fiji has been inhabited for at least 5000 years. Today, the population numbers around 865 000, with about 55% of its people Melanesian and 38% of Indian origin. Indian migrants were brought in by the British administrators in the 19th century to help develop the sugar industry, which became the mainstay of the economy. There are sizeable numbers of Polynesians from Samoa and Tonga in Fiji and smaller numbers of Chinese and Europeans. Fiji has two large islands where most of the population lives. Viti Levu is the larger of the two and has over three-quarters of the population and most of the industry in Fiji. The capital, Suva, is on the island of Viti Levu. Fiji gained independence in 1970, after 100 years of British rule, and, despite several periods of unrest and military rule, remains a peaceful, beautiful and friendly country which attracts increasingly large numbers of tourists.

Fiji inherited an administrative and healthcare system that was initially set in place by the British and the country continues to maintain that inheritance. The region's first medical school, the Fiji School of Medicine, was founded in 1885 and the first mental asylum, named St Giles, was established in Suva a year earlier.

## Health and mental health services in Fiji

The health services are extensive and cover the numerous islands; the primary care service in

particular is of good quality. There are 24 hospitals in Fiji: three divisional hospitals, at Suva, Lautoka and Labasa, which have specialist services; 16 sub-divisional hospitals; three area hospitals; and two special hospitals, including the St Giles hospital in Suva, with 136 beds and housing about 90 patients at any one time. Supporting these 24 hospitals are hundreds of health centres and an even larger number of nursing stations, together with numerous village health workers.

There are over 450 doctors, 67 dentists and 1572 nurses in Fiji within all sectors. The Fiji School of Medicine, the Fiji School of Nursing and the School of Public Health are now amalgamated under the Fiji National University (FNU) in Suva. A second medical school exists in association with a private university in Lautoka (the University of Fiji), from which the first set of students graduated in 2013.

Mental health services in Fiji date back to 1884, with the setting up of the St Giles Lunatic Asylum in Suva for the care of four European, four Indian and two Fijian patients. This was probably the first mental hospital in the region and remained much the same, with small numbers of patients, until 1935, when the name was changed to St Giles Mental Asylum. Patient numbers had increased to 227 by 1959. In 1968 psychiatry was added to the formal curriculum of the Fiji School of Medicine. The first psychiatrist in Fiji was Dr D. F. McGregor, who was appointed in 1965. In 1970 the first qualified nurse was appointed to the St Giles hospital. The first Fijian was appointed as a psychiatrist around 1985. The St Giles hospital is situated on a hill overlooking the picturesque city of Suva and the harbour and bay. It consists of mostly old but renovated wooden buildings, with parts added over many years. It possesses a variety of measures for security, reflecting changing trends. The hospital has a boundary with the Suva prison and borders the large Suva cemetery.

Mental health was not initially included in the work of the hospitals, health centres and nursing stations throughout Fiji. Instead, people with a mental illness were routinely transferred at great expense and difficulty to St Giles when they needed evaluation or treatment. It was only in 1995 that the two psychiatrists from St Giles managed to open peripheral psychiatric clinics in some outlying towns, but these functioned only at infrequent intervals.

## The 2010 Mental Health Decree

In 2010, Fiji's mental health law, which had been long dormant, was replaced by the Mental Health

Decree (MHD), after much discussion. Under the MHD there was provision for the formal setting up of divisional mental health units for the purpose of managing mental health problems outside of the old asylum.

The MHD had a deadline of 1 July 2010 for the implementation of its provisions, but neither the doctors and nurses in mental health work nor those in general hospitals were ready for the paradigm shift that aimed to extend mental healthcare beyond St Giles. Most felt that there was no need for there to be psychiatry beds in general hospitals. They had been taught that patients with a mental illness needed the security of a mental institution where the wards were secure and staff had been trained to deal with violence. Identifying where the new psychiatric wards should go was another major problem, as hospital administrators said they could offer no space for them, citing as the reasons security worries and a lack of space. But the need to implement a government decree finally produced change.

The first ward was opened on 20 May 2011 in Labasa. It was a five-bed ward run by three trained psychiatric nurses, who had been working in non-psychiatric wards till then, and a medical officer with 1 year's experience at St Giles. It proved to be far less threatening than many had feared. It was called a stress management ward (SMW) in a move to avoid the stigma attached to mental illness.

A second SMW opened in June 2011 at Suva Divisional Hospital. The administration had finally decided to allocate eight beds in a renovated surgical ward for psychiatric use. But the opening of this ward proved more difficult than anticipated, due to administrative problems.

A third SMW, with ten beds, opened in June 2011 in Lautoka Divisional Hospital and was run by a medical officer with a few months' training in St Giles and two trained psychiatric nurses.

The move out of St Giles actually started about 2 months before the first SMW opened when, with the help of the FNU, a stress management clinic (SMC) was started in a primary care centre in Samabula, a suburb of Suva city. This was established largely to provide a facility without the atmosphere of a specialist mental health clinic for those with emotional distress. It also served to teach students and post-basic nursing students about psychiatric problems in primary care. It was run by psychiatrists at the Fiji School of Medicine.

In 2012, after many attempts to start a day psychosocial rehabilitation centre in Suva had failed for lack of space and support, a decision was made to start such a centre at the SMW in Labasa (the most successful of the three SMWs). A grant of £1000 from the Royal College of Psychiatrists Western Pacific International Division helped to equip this centre. A space next to the hospital was allocated to the SMW for its stress management day programme for psychosocial rehabilitation. The new centre opened in November 2012 and was run with the assistance of a volunteer occupational therapist from Australia.

## Training

A visiting professor of psychiatry from Malaysia was contracted by the FNU to help the Fiji School of Medicine and the associated Faculty of Medicine improve training in psychiatry for medical students and nurses, and to help the FNU establish a postgraduate course to produce psychiatrists for Fiji. An international seminar was held in February 2011 to work out the details of the postgraduate training. Plans were laid for visiting volunteer psychiatrists from overseas to work with the three local psychiatrists. Overseas consultants attending the seminar worked with the two academic staff of the Fiji School of Medicine, as well as with the only psychiatrist at St Giles, and with the College of General Practitioners, in order to produce an outline of the postgraduate teaching programme.

Many discussions were held and it was decided that there should be new training courses to help nurses learn how a general hospital psychiatric ward should function. The establishment of such wards had been stipulated by the MHD. Unfortunately, when the first 2-day training workshop was organised in the divisional hospital in Suva, none of the nurses at that hospital turned up.

In 2012, the Postgraduate Diploma in Mental Health (PGDMH) programme, initially attended by three doctors and three senior nurses, commenced at the FNU. The teaching of these health staff continued to be based primarily at St Giles, despite an earlier intention to move the teaching to an SMW. Plans for overseas psychiatrists to support the local psychiatrists in teaching were not implemented. The training of medical students, nursing students, post-basic nurses in psychiatry (as well as the teaching of the three doctors who had obtained the first batch of PGDMHs) has continued to be based at St Giles, with nominal clinical supervision by the two university teachers.

In 2012 the Fiji Ministry of Health's only psychiatrist resigned. The Ministry had had plans to improve the training of local doctors and nurses in psychiatry (who were all employees of the Ministry), to solve the problems of providing adequate mental healthcare throughout Fiji. Accordingly, the Ministry recruited the overseas consultant who had come in 2011 to the FNU to help improve training, in particular the clinical supervision of clinical trainees and staff. Improvements in supervision at St Giles, at the three SMWs and at over ten outlying clinics were carried out in the following 6 months. The consultant helped recruit a further six trainees for the second PGDMH course in 2013, including the first-ever trainee psychiatrists from the Pacific Island countries of Palau, Kiribati and Vanuatu.

## Conclusions

The move from care based in an old mental institution to mental healthcare outside the institutional model of care was not an easy transition. It was spearheaded by the Fiji Minister of Health himself, despite considerable resistance from professionals

in the healthcare system. The SMWs and SMCs – as well as some stress management day centres that have also been established under the MHD – are on the whole doing reasonably well and have good client acceptance.

The reasons for the resistance to change lie in the fact that the teaching of psychiatry to doctors and nurses had been based for many years at St Giles. The old asylum was the model for mental healthcare, not only for Fiji but also for hundreds of Pacific Islands students. While the rest of medicine was moving forwards in Fiji, the practice of psychiatry had stagnated (arguably by design). The medical students of the Pacific had been trained in the St Giles institutional model of psychiatric care, a venerable mental hospital with locked doors. They had become the consultants and decision-makers in many Pacific Island countries. Their training in a custodial mental hospital had made an indelible mark on their understanding of what constituted optimal facilities for psychiatric care.

After so much effort, and despite many difficulties, the three SMWs set up under the MHD are now functioning reasonably well. Fiji also has three more diploma-level psychiatrists in the three SMWs and one new medical superintendent at St Giles. The country still lacks occupational therapists, clinical psychologists and social workers. The clinical skills of doctors and nurses and medical students should be improved, and training should be based at the SMWs rather than the mental hospital. Ongoing efforts aim to improve the running of the mental hospital through better ward management, including the separation of patients with

acute illnesses from those with forensic problems and intellectual disabilities.

After much debate on the curriculum of the PGDMH, it was felt that the programme needed a review. In an attempt to improve the training of future psychiatrists for Fiji and the region, help from the Royal College of Psychiatrists was sought through the Western Pacific International Division. A request was sent to College members in the region. In early 2013 the overseas consultant, in collaboration with the Western Pacific International Division of the College, drew up a list of over 70 volunteer senior psychiatrists. Most of them were based in Australia and New Zealand. They were keen to help the PGDMH and the nurse training programmes of the FNU. Their names have been submitted to the Ministry of Health and await approval by the FNU.

Meanwhile, the first-ever psychiatrists from the islands of Vanuatu, Palau and Kiribati, who had been trained in the 1-year PGDMH, graduated in 2013 and are now working in their respective countries.

Fiji has come a very long way in changing its pattern of psychiatric care, which had stagnated, in contrast to the care of the people presenting with physical conditions, which had progressed reasonably well. The next logical step is for Fiji, on which other Pacific Island nations depend for medical education, to improve its training in psychiatry so that all undergraduate students of medicine and nursing and PGDMH students can be taught modern methods of psychiatric care. This would be of major benefit to the entire region.



## Mental health law profiles

George Ikkos

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

The East African state of Uganda has recently become the focus of international opprobrium because of proposed legislation advocating the death penalty, later reduced to life imprisonment, for homosexual relationships. In such a difficult environment some progress is nonetheless being made and the historical development of efforts to improve human rights for people who have a mental illness is clearly set out in the paper by Ssebunnya and colleagues. The importance of the World Health Organization's mental health rights advocacy and guidance stands out in relation to

this (see <http://www.mindbank.info>), which clearly remains unfinished business.

The legislative environment is no less difficult in Sudan, where civil war has raged for decades, recently dividing the country officially in two. Saeed and colleagues seem to suggest that healthcare, including mental healthcare, has, as a result, gone backwards from a relatively advanced level. Sudanese psychiatrists now based in the UK and Ireland appear to be extending an active hand to work together with local people to overcome this catastrophic legacy for people who are mentally ill.



# Mental health law reforms in Uganda: lessons learnt

Joshua Ssebunnya,<sup>1</sup> Sheila Ndyabangi<sup>2</sup> and Fred Kigozi<sup>3</sup>

<sup>1</sup>Project Coordinator for PRIME (DFID-funded research consortium), Butabika National Referral and Teaching Mental Hospital, Uganda, email joy95h@yahoo.co.uk

<sup>2</sup>Principal Medical Officer (in charge of mental health), Ministry of Health, Uganda Government, Uganda

<sup>3</sup>Principal Investigator for PRIME (DFID-funded research consortium), Butabika National Referral and Teaching Mental Hospital, Uganda

**Ugandan mental health legislation, which dates from 1964, principally aims to remove persons with mental disorders from the community but also to protect their safety, by keeping them in confinement, although this has been without consideration for clinical care. In response to criticism from various stakeholders and advocates and the need to reflect modern clinical care, Uganda undertook to review and amend the mental health legislation, as part of the Mental Health and Poverty Project (MHaPP). We report on work in progress advancing new legislation.**

The authors wish to acknowledge the MHaPP Research Programme Consortium. The Mental Health and Poverty Project (MHaPP) is a Research Programme Consortium (RPC) funded by the UK Department for International Development (DFID) (RPC HD6 2005–10) for the benefit of low- and middle-income countries. RPC members included Alan J. Flisher (Director) and Crick Lund (Coordinator) (University of Cape Town, Republic of South Africa); Therese Agossou, Natalie Drew, Edwige Faydi and Michelle Funk (World Health Organization); Arvin Bhana (Human Sciences Research Council, Republic of South Africa); Victor Doku (Kintampo Health Research Centre, Ghana); Andrew Green and Mayeh Omar (University of Leeds, UK); Fred Kigozi (Butabika Hospital, Uganda); Martin Knapp (University of London, UK); John Mayeya (Ministry of Health, Zambia); Eva N. Mulutsi (Department of Health, Republic of South Africa); Sheila Zaramba Ndyabangi (Ministry of Health, Uganda); Angela Ofori-Atta (University of Ghana); Akwasi Osei (Ghana Health Service); and Inge Petersen (University of KwaZulu-Natal, Republic of South Africa).

Globally, about 25% of countries, with nearly 31% of the world's population, have no national mental health legislation, although some countries with a federal system of governance may have state mental health laws. Half of the countries which do have mental health legislation had their laws enacted before 1990, with some 15% having legislation that was enacted before 1960, well before the advent of modern treatments (World Health Organization, 2001).

In the Ugandan context, the overall objective of the mental health legislation of 1964 (the Mental Treatment Act) was to remove persons with mental disorders from the community but also to ensure their safety, by keeping them in confinement, although this was without consideration for clinical care. However, in response to criticism from various stakeholders and advocates and the need to reflect modern clinical care, Uganda undertook to review and amend its mental health legislation, as part of the Mental Health and Poverty Project (MHaPP) (Flisher *et al*, 2007), which included a review of the country's mental health system.

In this paper we briefly summarise aspects of the 1964 Mental Treatment Act and report on work in progress advancing the new legislation.

## The old mental health law

The Mental Treatment Act came into force soon after independence in 1964, as a revised version of the colonial Mental Treatment Ordinance of 1935. It focuses largely on issues to do with the 'detention' of people with mental illness, thereby failing adequately to promote and protect their rights either within the healthcare context or in the community. The implicit perspective of the Act is that mental illness is a disgrace rather than a sickness. It does not provide for the rights of persons with mental illness in the community, and concentrates

on those in mental hospitals. Many of the provisions of the Act are aimed at protecting the public from persons with mental illness (Mulumba, 2007). The law is basically concerned with treatment, as its title suggests, despite the fact that mental health services comprise more than just treatment. Furthermore, the law does not specify the principles for development and standards of services.

## Need for a new law

Following the major health reforms in many other countries during the early 1990s, with the decentralisation of health services, with primary healthcare as the basis of health interventions and a national minimum healthcare package, the mental health programme in Uganda was mandated to integrate mental healthcare into healthcare services, at all levels, including the community level. At about the same time, mental health user support groups and associations became active and started advocating for human rights considerations in the law. Coincidentally, as Uganda was reviewing its law, the World Health Organization (WHO) embarked on developing guidelines for mental health legislation. As Uganda was one of the countries which participated in this process, the MHaPP Uganda team was able to appreciate the gaps in the old law and the principles guiding development of the new law.

## Process of revising the law

It should be noted that the WHO recommends reviewing mental health laws every 5–10 years (World Health Organization, 2003) and that, before embarking on drafting legislation, a number of preliminary steps should be undertaken:

- Identify the country's principal mental health needs and problems, as well as existing and likely barriers to the implementation of new mental health policies, plans and programmes.
- Examine existing mental health law and identify general laws that address mental health issues, looking at specific aspects that are lacking or in need of reform, and examining barriers with respect to their implementation.
- Study those international human rights conventions and standards that include provisions related to mental health, and identify governments' obligations for fulfilling the requirements of those instruments.
- Study components of mental health legislation in other countries, especially those with similar

socioeconomic and political structures and backgrounds.

- Build a consensus and negotiate for change.
- Educate the public on issues of mental health and human rights.

The process of revising the Ugandan law began with the development of a memo on principles, gaps to be addressed and justification for the review. This was followed by evaluation of the existing law using a WHO checklist.

The exercise revealed the strengths and weaknesses of the existing legislation, and helped in the identification of provisions for inclusion in the new law. A drafting committee was then constituted for the task. Mental health laws from other countries such as Kenya and South Africa were reviewed, in addition to information on mental health in the country to guide the drafting exercise. Furthermore, wide stakeholder consultation was undertaken before the final draft was submitted for restructuring by the Ministry of Justice into legal language.

### The new legislation

The revised mental health bill provides for a number of changes in the administrative pattern of mental health services in the country, in conformity with the UN Convention on the Rights of Persons with Disability (CRPD), to which Uganda is a signatory. It makes mental health services part of all health facilities. Outdated terms, such as 'lunatic', 'idiot' and 'person of unsound mind', which have long carried derogatory connotations, were substituted with new terms such as 'person with mental illness' or 'patient', and 'detention' was replaced by 'admission'. Furthermore, the bill provides definitions of important terms such as 'mental disorder'. This is expected to significantly reduce stigma and discrimination.

In the new bill, the criteria for voluntary and involuntary admissions and treatment are explicitly spelt out. Decisions for examination, admission and treatment are to be undertaken at a mental health unit and performed by a psychiatrist or senior psychiatric clinical officer (a clinical officer with 2 years of specialised training in psychiatry).

The new bill has a specific focus on the rights of persons with mental illness. For example, one of the clauses states: 'In upholding the rights and performing the duties under this part, regard shall be given to the best interests of the patient'. The new bill is silent on protecting the public from persons with mental illness.

### Challenges and enabling factors

The process involved a number of challenges. First, it was quite bureaucratic and slow; it took close to 10 years to reach the stage of drafting the bill. Because mental health has been a low priority, some stakeholders never responded when called upon. Convincing the Ministry of Finance that the mental health bill was worth the extra cost it would

impose on the Ministry of Health's budget was also a struggle. Resource constraints meant that assessment of the existing mental health law was not to be informed by formal research. Furthermore, there were frequent changes of ministers of health, which took the process back many steps each time. Also, the Ministry of Health lacked an in-house legal officer, hence the drafting committee had to depend on volunteers and the first parliamentary counsel from the Ministry of Justice, who was not up to date with the current approaches in mental healthcare.

In contrast, the enabling factors included:

- persistence by mental health specialists in advocacy for the law
- the growth of the mental health user movement and non-governmental organisations (NGOs) operating in the field of mental health
- the existence of a legislation task force in the Ministry of Health, where mental health was represented
- the strong commitment to the drafting of the bill by the Junior Minister of Health in Charge of General Duties
- advocacy and lobbying of the political leadership at the Ministry of Health, by the parliamentary Committee for Disability
- the inclusion of the review of the bill in the Ministry of Health's strategic plan
- increasing demand for the law to cover mental health services that had been successfully integrated into primary healthcare
- the earlier findings of the situation analysis of the mental health system and the policy briefs to the Ministry of Health by the Mental Health and Poverty Project.

### Conclusion

The proposed mental health bill is much needed and timely, as the 1964 Mental Treatment Act is outdated in terms of language and concepts, and is not in line with either contemporary mental healthcare or current practice in the Ugandan health system. The new act should reflect the major changes in treatment, philosophy and practice.

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# The draft Mental Health Act in Sudan

Mahmoud Saeed,<sup>1</sup> Saoud Sultan<sup>2</sup> and Abdelazim Ali<sup>3</sup>

<sup>1</sup>Consultant Psychiatrist,  
Birmingham and Solihull Mental  
Health NHS Foundation Trust, UK

<sup>2</sup>Consultant Psychiatrist and  
College Tutor, North East London  
NHS Foundation Trust, UK

<sup>3</sup>Aneurin Bevan Health Board, UK,  
email abdelazimali@hotmail.com

**At a workshop in 2012 in Khartoum, attended by Sudanese psychiatrists based in both the UK and Sudan, as well as psychologists, social workers and lawyers from Sudan and elsewhere, a draft Mental Health Act for Sudan was approved; it is due to be submitted to the Sudanese Parliament. We give a summary of the draft Act and outline some of the areas that need further discussion.**

Sudan was a pioneer in developing mental health services. The first Black African to be awarded the UK Diploma in Psychological Medicine was from Sudan – Eltigani Elmahi, in 1949. He returned to Khartoum and in 1951 established the first psychiatric out-patient clinic in sub-Saharan Africa. In the following 60 years the country was ravaged by the longest civil war in Africa, which culminated in the secession of the southern part of the country to form the independent South Sudan in 2011 (not considered in this article). This led to significant deterioration in public services in general. Mental health services are now concentrated in the big cities of Sudan and vast areas of the country have few services or none at all.

Sudanese psychiatrists continued with their efforts to improve the mental health services. In the absence of any formal powers for health professionals, psychiatric patients are currently brought to hospital by their relatives, who generally have to remain in the hospital to ensure that patients adhere to their treatment plan and do not leave the hospital against medical advice.

In 1997 a Mental Health Act had been drafted, but this was not followed up by the health authorities. In 2012, the Sudanese government asked the Sudanese Psychiatrists Association to prepare a new draft Act. A draft was prepared and discussed at a special workshop organised by the Sudanese Psychiatrists Association, in collaboration with its sister organisation, the Sudanese Psychiatrists Association (UK and Ireland). Sudanese psychiatrists from around the world gathered in Khartoum in December 2012 and agreed on the final draft. This will eventually be submitted to the Sudanese Parliament for approval.

The new draft Mental Health Act consists of seven chapters.

## Chapter 1. Preliminary provisions and definitions

This chapter is about definitions and the application of the Act. The Act uses the World Health Organization's definition of mental health as 'a state of well-being in which every individual

realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community' (see e.g. [http://www.who.int/features/factfiles/mental\\_health/en/](http://www.who.int/features/factfiles/mental_health/en/)). The Act defines the patient as 'a person suffering from a mental disorder'. The mental disorder is defined as 'any complete or partial disturbance in thinking, behaviour, mood, cognition, memory or mental ability', and this 'should not include any behaviour [that is merely] contrary to customs and traditions' or 'abuse of or dependence on alcohol or illicit substances, unless it is associated with mental disorder'.

## Chapter 2. Principles and objectives

This chapter outlines the main principles and aims of the law, including the rights of people who suffer from a mental disorder to receive the best available psychiatric care.

## Chapter 3. Licence and mental health councils

This chapter is mainly about the proposed National Mental Health Council and its branches in the different states of Sudan. The role of the Council will be to regulate the profession and issue licences to practise.

## Chapter 4. Human rights

This important part of the draft outlines the human rights of people with mental disorders, such as the right to medical care. It covers consent to treatment if capacity is impaired. It states the importance of patients' privacy and their right to make complaints about the care they receive. It also states the right of patients to have legal advocates to represent them.

## Chapter 5. Hospital admissions

This chapter defines the two types of admission to psychiatric hospital, voluntary and compulsory.

### Voluntary admission

If adults aged 18 or more have been assessed and it is decided that they need hospital admission, they should be asked whether they agree to it or not. They have the right to leave or discharge themselves at any time, unless there are grounds for compulsory detention.

### Compulsory admission

If a patient refuses voluntary admission and there is evidence of a severe mental disorder, compulsory admission may be appropriate in any of the following further circumstances: the mental disorder

requires hospital treatment; admission is in the interest of the patient's health or safety; or admission will serve the protection of others. The draft Act states that a recommendation for compulsory detention can come from: one of the patient's relatives; the police; social workers; or an ambassador where a foreign national is to be admitted.

The on-call psychiatric doctor (no specific qualifications are mentioned to define a psychiatric doctor) can detain people against their wishes, for up to 1 week, if they refuse voluntary admission, provided there are signs of a mental disorder that warrants treatment in hospital, or there is risk to the patient or to others.

Thereafter, the responsible medical officer (a consultant) can either discharge the patient or extend the period of detention by 1 month. If the patient needs to stay longer in hospital, the consultant can extend the period of detention for a further 3 months but has to submit a report to the hospital administration or the health authority to outline the reasons behind that decision.

If, after the 3 months, the patient needs to be detained for longer still, then a decision will be taken by the multidisciplinary team rather than the consultant alone. Compulsory admission can then extend for a maximum of 6 months, which can be renewed again for another 6 months, and so forth.

The right to appeal

Patients who are compulsorily admitted to hospital will have the right to appeal against their detention. A second opinion from a different psychiatric team will have to be sought regarding the appropriateness of the detention.

This part was missing from the original draft and was later added as suggested by the Sudanese Psychiatrists Association (UK and Ireland), reflecting their experience of using the Mental Health Act in the UK.

## Chapter 6. Psychiatric treatment

This chapter stresses the importance of delivering the accepted therapeutic interventions through an integrated and comprehensive care plan for each patient, in consultation with both the patient and family. The mental health team may grant the patient a period of leave outside the hospital grounds if appropriate.

In relation to treatment, the draft legislation stipulates that psychiatric institutions should follow widely accepted treatment options and guidelines. It specifically mentions that 'each patient should have a care plan tailored to his/her needs' and that 'treatment should be given only with the consent of the patient, except for detained patients'.

## Chapter 7. Responsibilities of mental health professionals

Health professionals cannot be held legally responsible for detaining a patient or providing compulsory treatment. However, they can be held

accountable for their actions if there is evidence of a gross misconduct or negligence.

## Discussion

Some points in the draft need further clarification.

First, there is no specific mention of the use of either electroconvulsive therapy (ECT) or seclusion. Nor is there mention of treatment in the community.

No clear mechanisms have been set out for the resolution of any conflicts that may arise between the treating team and the patient's family. This is particularly important in Sudan, where mental illness is considered a stigma, or 'evil doing' that needs to be dealt with by religious healers. Families may therefore object to compulsory detention and the draft does not mention what the treating team can do in such circumstances.

In Chapter 5 it is mentioned that the treating team has the power to detain a patient for up to 6 months (see above); however, it is not clear what types of professionals need to be members of this team (its skill mix of doctors, nurses, social workers, psychologists and so on). Also, there is no clear mechanism for the resolution of any disagreement among members of the team if they fail to reach one opinion about the detention of a patient.

The procedures for appeal are not clear. Although the draft Act states that patients can be assessed by a 'different team' if they appeal against detention, it is not clear, for example, whether that team should be from the same hospital or from a different one.

Most importantly, the implementation of the legislation will add to the demands on limited resources. Most psychiatrists practise in Khartoum and the big cities only. There are whole provinces where there is only one psychiatrist, or none at all, and it is not clear how compulsory detention can be applied in such circumstances. This needs further discussion.

To ensure proper application of the Act, mental health workers should be offered appropriate training on its provisions. It is not clear who would be responsible for the training.

Finally, clear safeguards and appeal mechanisms should be in place to ensure patients' relatives or the authorities do not abuse the new Mental Health Act.

## Conclusion

Despite shortfalls and gaps in the draft Act, it is our opinion that this is a major step towards the reform of mental health practice in Sudan and should be praised and supported. It is our understanding that legal experts will review the draft before it is submitted to Parliament.

We will continue to work hard with our colleagues in Sudan to improve and to implement the draft Mental Health Act, which will be the first such legislation in Sudan. Without it, Sudanese patients with mental illnesses will continue to be vulnerable and mistreated.

# Medical and nursing students' attitudes to people with mental illness in Nigeria: a tale of two teaching hospitals

Theddeus Iheanacho,<sup>1</sup> Elina Stefanovics,<sup>2</sup> Victor Makanjuola,<sup>3</sup> Carla Marienfeld<sup>4</sup> and Robert Rosenheck<sup>5</sup>

<sup>1</sup>Assistant Professor of Psychiatry, Yale University School of Medicine, New Haven, Connecticut, USA, email [theddeus.iheanacho@yale.edu](mailto:theddeus.iheanacho@yale.edu)

<sup>2</sup>Associate Research Scientist in Psychiatry, Yale University, New Haven, Connecticut, USA

<sup>3</sup>Consultant Psychiatrist, University College Hospital, Ibadan, Nigeria

<sup>4</sup>Assistant Professor of Psychiatry, Yale University School of Medicine, New Haven, Connecticut, USA

<sup>5</sup>Professor of Psychiatry and Public Health, Yale University School of Medicine, New Haven, Connecticut, USA

We thank the staff of Imo State University Teaching Hospital, Orlu, Nigeria, University College Hospital, Ibadan, Nigeria and Dr Chijioke Nzewuihe for facilitating this experience.

**This study compared beliefs about and attitudes to mental illness among medical and nursing students at two teaching hospitals in Nigeria with very different levels of psychiatric instructional capacity. Factor analysis of responses to a 43-item self-report questionnaire identified three domains: social acceptance of people with mental illness; belief in non-superstitious causation of mental illness; and stress, trauma and poverty as external causes of mental illness, with entitlement to employment rights. Students at the hospital with a larger, functioning psychiatry department had significantly higher scores on all three factors. Culturally enshrined beliefs and attitudes about mental illness are not uncommon among medical trainees. The availability of psychiatric education and services may have a positive effect on beliefs and attitudes.**

Stigma and negative attitudes to people with mental illness are common in low- and middle-income countries (LMICs), among the general population, medical professionals and trainees (Wolff *et al*, 1996; Ogunsemi *et al*, 2008). Studies have demonstrated the presence of such attitudes in Nigeria (Gureje *et al*, 2005); they are informed and reinforced by traditional, cultural and religious beliefs about the causes of mental illness (Gureje *et al*, 2006) and have been shown to inhibit help-seeking behaviour (Segal *et al*, 2005). Furthermore, beliefs about and attitudes to mental illness among healthcare professionals can influence treatment outcomes (Schulze, 2007). Medical and nursing students are at a critical phase of attitude formation: while their beliefs and attitudes will reflect those of the larger society (Ogunsemi *et al*, 2008) they may be influenced by educational experiences and training in psychiatry (Fischel *et al*, 2008).

In Nigeria, as in other LMICs, psychiatric resources are limited and unevenly distributed (Saxena *et al*, 2006). No studies, to our knowledge, have examined the influence of the availability of psychiatric educational resources on the attitudes to and beliefs about mental illness of healthcare trainees. This study examined students' attitudes to and beliefs about mental illness in two Nigerian university medical schools with very different levels of psychiatric teaching presence. The medical

school at Ibadan, in south-western Nigeria, has been a leader in psychiatric research and education in West Africa since the 1950s. It has a fully functioning psychiatry department with over ten faculty members, a psychiatry resident training programme and a full range of in-patient and out-patient clinical services. The medical school at Owerri, in south-eastern Nigeria, had no full-time psychiatric faculty and had very basic clinical activity at the time of the survey. No psychiatric academic activities had been made available for medical and nursing students. In both universities, the blueprint is for nursing schools to conduct their psychiatric training through and in collaboration with the academic departments of psychiatry, with academic resources shared between the colleges of medicine and the nursing schools.

The differences in psychiatric resources between the two centres may relate to the funding priorities of the responsible agencies. While the University of Ibadan is a nationally funded institution, Imo State University is state funded. Furthermore, Ibadan is one of the major urban centres, and tends to attract more of the available medical specialists than do less urban centres like Owerri (Klecha *et al*, 2004). We sought to identify the influence of the presence of an active department of psychiatry on the attitudes to and beliefs about mental illness among medical and nursing students at these two universities, through survey responses.

## Methods

A team of professionals from the Department of Psychiatry of Yale School of Medicine was invited to visit both universities during November 2011 to provide a brief educational introduction to the basic principles and diagnoses in psychiatry for medical and nursing students at Owerri and to present lectures on mental health services research to the faculty at Ibadan.

A self-report assessment instrument was distributed after the introduction of the teachers but prior to any training at Owerri, and after the visit to Ibadan (which did not involve contact with students). No data were requested that would identify respondents, to preserve confidentiality and promote candid responses.

Convenience samples of medical students and nursing students from the two universities in their final years of training voluntarily participated. At

the University of Ibadan the sample comprised 51 medical students and 31 nursing students; that school represents a teaching centre with robust psychiatric educational resources. At Imo State University the sample comprised 48 medical students and 50 nursing students; that school represents an area with extremely limited psychiatric educational resources.

The questionnaire was constructed from three widely used instruments: the Fear and Behavioral Intentions toward the mentally ill scale (FABI) (Wolff *et al.*, 1996), the Community Attitudes to Mental Illness (CAMI) scale (Taylor & Dear, 1981) and a questionnaire from the Programme to Reduce Stigma and Discrimination (World Psychiatric Association, 2000). The final version was adapted for local use by adding 'witchcraft' and 'curses' as options in relation to the causation of mental illness. It consisted of 43 dichotomous questions with sub-parts. The questionnaire documented: self-reported sociodemographic characteristics and professional experience; conceptions of the cause of mental illness; possible treatment options; social distance; and social acceptance and social stigma.

Chi-square tests and analysis of variance were performed to examine potentially confounding sociodemographic differences between students from Ibadan and Owerri. Their responses were subjected to exploratory factor analysis with varimax rotation to identify uncorrelated independent factors. The optimum number of factors was determined by inspection of a scree plot and eigenvalues. Analysis of covariance was used to determine whether differences between scores from each school were statistically significant, adjusting for two potential confounds: marital status and years of education. All analyses were performed using SAS 9.1 statistical software (SAS institute Inc, Cary, North Carolina, USA). Statistical significance was evaluated at the 0.05 level.

## Results

The students at Ibadan were significantly less likely to be married ( $P < 0.02$ ) and had more years of education (16 years *v.* 14 years,  $P < 0.04$ ) (Table 1).

Three factors were identified: social acceptance of people with mental illness; non-belief in witchcraft or curses as causes of mental illness; and stress, trauma and poverty as causes of mental illness and entitlement to employment rights. Chronbach's alpha showed high levels of internal consistency for

factors 1 and 2 ( $\alpha = 0.9$  and  $0.8$ , respectively) and a moderate level for factor 3 ( $\alpha = 0.6$ ).

## Factors

Factor 1. Social acceptance of people with mental illness

These 16 items had factor loadings from 0.431 to 0.788. In order of decreasing loadings they were: Not afraid of people with mental illness; Would not be afraid to have a conversation with a mentally ill person; Would not be upset or disturbed about working on the same job with a mentally ill person; Would live with a next-door neighbour who is a former psychiatric patient; Willing to have a friend who is a former psychiatric patient; Willing to work with a former psychiatric patient; Willing to share a room with a former psychiatric patient; Not ashamed if someone from the family had been a former psychiatric patient; Would marry a person who was previously mentally ill; Would not avoid a conversation with a neighbour who was previously a psychiatric patient; Would visit a neighbour who was a former psychiatric patient; Could maintain a friendship with someone who is mentally ill; People with a mental illness could work at regular jobs; Would invite someone into my house who has suffered from mental illness; Would not mind people with mental problems living in residential neighbourhoods; Would not object to having a mentally ill person in my neighbourhood.

Factor 2. Non-belief in witchcraft or curses as causes of mental illness

These four items had factor loadings from 0.604 to 0.757. In order of decreasing loadings they were: Mental illness is not caused by witchcraft; Mental illness is not caused by someone putting a curse on you; Mental illness is not caused by possession by an evil spirit; Mental illness is not God's punishment.

Factor 3. Stress, trauma and poverty as causes of mental illness and entitlement to employment rights

These five items had factor loadings from 0.414 to 0.575. In order of decreasing loadings they were: Mental illness is caused by physical abuse; People with mental illness are far less of a danger than most people suppose; People with a mental health problem should have the same rights to a job as anyone else; Mental illness is caused by poverty; Mental illness is caused by stress.

## Comparison of scores from Ibadan and Owerri

Comparison of scores from Ibadan and Owerri showed significant differences on all three factors, with higher scores (representing more progressive attitudes) at Ibadan (all  $P < 0.0001$ ) and a large effect size (0.82) for the difference on factor 3. A significant difference was also observed on factor 1, with a moderately large effect size of 0.68. A smaller but substantial effect size of magnitude 0.55 was identified for factor 2, representing non-superstitious causation of mental illness, although only 40% of Owerri responses and 63% of Ibadan of responses endorsed such non-belief.

**Table 1**

Comparison of sociodemographic characteristics of student samples at Ibadan and Owerri, Nigeria

	Ibadan (n = 82)	Owerri (n = 98)	t	P
No. of women	62	74	2.25	0.13
No. married	3	13	5.07	0.02
Mean (s.d.) age	23.5 (0.66)	24.5 (0.61)	1.31	0.19
Mean (s.d.) years in education	16.1 (0.74)	14.1 (0.65)	-2.07	0.04

**Table 2**

Items representing largest differences in response between Ibadan and Owerri: % (no.) of students

	Ibadan	Owerri	P	Factor
People with a mental health problem should have the same rights to a job as anyone else	70 (58)	19 (17)	<0.0001	3
People with a mental illness could work at regular jobs	57 (46)	14 (14)	<0.0001	1
Mental illness is not God's punishment	45 (40)	16 (13)	<0.0001	2
Willing to work with a former psychiatric patient	51 (42)	24 (23)	0.0002	1
Mental illness is not caused by possession by an evil spirit	79 (72)	53 (43)	0.0003	2
Would not be upset or disturbed about working on the same job with a mentally ill person	63 (60)	38 (31)	0.001	1
Would not mind people with mental problems living in residential neighbourhoods	53 (50)	29 (24)	0.0001	3
Not afraid of people with mental illness	59 (56)	36 (30)	0.003	1
Mental illness is caused by stress	91 (75)	69 (65)	0.0003	3
Willing to share a room with a former psychiatric patient	40 (33)	19 (18)	0.002	1

The individual items with the largest differences between the sites included five of the 16 items (31%) in factor 1 (social acceptance), two of the four items in factor 2 (50%) (witchcraft not being a cause of mental illness) and three of the five from factor 3 (60%) (stress, trauma, poverty as causes of mental illness) (Table 2).

## Discussion

This small study showed that the students at Ibadan had significantly higher scores on all three factors, reflecting higher social acceptance of people with mental illness, less belief in witchcraft as a cause of mental illness and a greater probability of believing that stress, trauma and poverty can contribute to the onset of mental illness. While we cannot conclude without further studies that the differences observed in the two groups of students can be accounted for by the difference in the availability of psychiatric resources, it is reasonable to expect a significant positive impact from the regular clinical exposure of Ibadan students to people with mental illness and ongoing educational activities associated with the presence of fully functional psychiatric department (Corrigan, 2011).

The smallest difference between the two groups was observed in the level of non-belief in superstitious causes of mental illness. Thus, some degree of belief in witchcraft or curses as causes of mental illness is not uncommon among the students, albeit less so in the context of a relative abundance of psychiatric educational resources. This likely reflects the ongoing influence of cultural and magico-religious beliefs associating witchcraft with mental illness in much of sub-Saharan Africa and some other LMICs (Lauber & Rossler, 2007) and highlights the need to incorporate culturally relevant teaching interventions in the general psychiatric curriculum. A psychiatric clerkship curriculum for medical and nursing students based on current Western psychiatry teachings may not be adequate to address these beliefs about and attitudes to

mental illness, attitudes that could impair the psychiatric care provided by these future medical professionals. To understand these attitudes and explore areas of intervention, if any, the authors are conducting further studies to compare the attitudes of first-year students to those of graduating students and professionals from different specialties in the same institutions.

The limitations of this study include the relatively small size of the samples and the fact that their representativeness was not determined. Also, the observed differences in attitudes may reflect broader regional, cultural and religious differences that have affected both student attitudes and medical school structures. These factors may be independent of medical school faculty composition and academic offerings and need to be examined. Furthermore, this was a quantitative analysis. A complementary qualitative approach would aid interpretation of these results. Nevertheless, the data suggest that the availability of sophisticated psychiatric educational resources and services may have a positive effect on the progressiveness of beliefs about and attitudes towards people with mental illness.

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# 'Freedom is more important than health': Thomas Szasz and the problem of paternalism

Joanna Moncrieff

Senior Lecturer, Department of Mental Health Sciences, University College London, UK, email j.moncrieff@ucl.ac.uk

**When Thomas Szasz summed up his philosophical principles at the Royal College of Psychiatrists' annual meeting in Edinburgh in 2010, he declared that 'freedom is more important than health'. Psychiatry is the arena in which the conflict between freedom and health comes most sharply into focus, according to Szasz. This paper proposes some parallels with medicine in low-income countries for pointers towards a resolution of this conflict.**

When Thomas Szasz summed up his philosophical principles at the Royal College of Psychiatrists' annual meeting in Edinburgh in 2010, he declared that 'freedom is more important than health'. This view was nurtured by his experience of fleeing the Nazis in the 1930s, and his eventual arrival in the USA, the land of the free. For the whole of his career Szasz maintained that fostering the ability of individuals to make their own choices was the most important principle of a modern society, 'a society in which man has a chance, however small, to develop his own powers and to become an individual' (Szasz, 1988, p. 128). He opposed prohibitions on the use of any class of drug, restrictions designed to prevent suicide and anything that he perceived as state interference in the private lives and actions of individuals.

The importance Szasz placed on freedom was associated with a concern for human dignity, and a belief that dignity comes from the ability to live an independent, self-determined life, free of control and potential humiliation at the hands of others. Since freedom (and responsibility) is the 'crucial moral characteristic of the human condition' (Szasz, 1988, p. xv), any circumstance that renders people dependent on others to make decisions for them automatically makes individuals less than fully human, and consequently reduces the dignity of human life.

Sickness and infirmity involve dependency and hence a loss of dignity, but medical treatment also renders the 'invalid' dependent on the doctor or healer, and in this sense treatment is also inherently undignified. In this position Szasz is close to Ivan Illich, and the thesis set out in the latter's classic book, *Medical Nemesis*, that the dependency-inducing effects of modern medicine have depleted the natural resources of human beings to endure and combat suffering. Rather than enhancing life, medicine has, in this view, diminished humanity as a whole (Illich, 1976).

When people are very sick, they may become incapable of making informed and thoughtful decisions about what they want to be done. In this situation, relatives, friends, carers and doctors have to make judgements on the patient's behalf. The idea that people can make judgements that are solely in another person's best interests is what we call 'paternalism'. Szasz, among others, was perennially suspicious of paternalism, seeing it as an evil to be avoided if possible and quoting Kant, who said 'nobody may compel me to be happy in his own way. Paternalism is the greatest despotism imaginable' (cited in Szasz, 1990, p. 39).

As well as infringing the autonomy of the individual, paternalism is dangerous, according to Szasz, because it disguises the fact that other motivations are always at stake. No decision about how to treat another human being is ever truly neutral or objective. In medical situations, there are always interests other than the patient's that intrude, whether this be the interests of the family, the doctor or the community or organisation the doctor represents. The idea of paternalism only obfuscates these other influences (Szasz, 1988).

It has been argued, however, that freedom is a preoccupation of those who are already healthy, wealthy and secure. Where daily existence remains a struggle, the self-determination of each individual may seem relatively unimportant. The French philosopher Georges Canguilhem cited the surgeon René Leriche when he described health as the 'silence of the organs' and drew attention to the fact that the impact of disease and infirmity is often not appreciated when good health is taken for granted (Canguilhem, 2012). In some low- and middle-income countries, as in the ghettos of Western cities, where freedom means the freedom to scratch a living from the margins of affluent society, its loss may not be greatly mourned. Moreover, the health problems that continue to beset much of Africa for example – malnutrition and infectious disease – are significantly reduced by simple procedures such as improved sanitation, nutrition, immunisation and the administration of antibiotics that involve little loss of dignity. The health benefits that accrue help to increase individuals' capacity to lead autonomous and independent lives.

Even in high-income countries, freedom is sometimes subordinated to the general health of the populace. In the USA, for example, vaccination of children is mandated because the immunity of society in general is prioritised over the choice

of individual families. Similarly, many countries, including the UK, have public health laws that contain measures to enforce treatment of tuberculosis, including the forcible confinement of an infected individual if this is thought necessary.

Although Szasz may have acknowledged that a self-aware paternalism was necessary in the care of people who are seriously physically sick, he was critical of the extension of the paternalistic principle to other areas of life, including psychiatry. In fact, Szasz argued that the reason for constructing certain forms of behaviour as illness is precisely in order to justify managing them in a paternalistic fashion. Famously, for Szasz 'mental illness' is not the same sort of entity as a bodily illness or disease, and can be rightly understood as an illness only in a metaphorical sense. The metaphor has been mistaken for reality because of the social functions it serves, one of which is to provide a convenient mechanism for the management of socially disruptive and unpredictable behaviour.

The purpose of the concept of mental illness in this account is thus 'to disguise and render more palatable the bitter pill of moral conflict in human relations' (Szasz, 1970, p. 24). Defining such situations as the illness of a particular individual enables the freedom of that individual to be curtailed and interventions to adjust unwanted behaviour to be represented as 'treatment'. In other words, an individual can be subjected to the will of others, including being removed from society, confined in an institution and forced to take mind-altering substances, but these actions can be construed as being in the individual's 'best interests'. So psychiatry is the arena in which the conflict between freedom and health comes most sharply into focus, but it is also an artificial conflict, according to Szasz. The language of health and illness is only a gloss that is applied to the daily struggles that occur between people who want to behave in a certain way, and those who want them to behave otherwise.

Mental health problems do not need to be conceived of as illnesses in order to justify paternalistic intervention, however. Although ultimately rejected by the British government, the notion of basing mental health legislation on the concept of 'capacity' has been proposed by various commentators, including the government-appointed Richardson committee in 1999 (Department of Health, 1999). Under these proposals, intervention that was judged to be in an individual's 'best interests' could be justified when that individual was deemed to have lost the capacity to make rational decisions, whether the loss of capacity was occasioned by a bona fide brain disease or an episode of mental disturbance that would be diagnosed as a mental disorder of some kind.

Reservations about paternalism apply regardless of how mental disorder is conceptualised, and judgements about the nature of 'incapacity' and what really constitutes the individual's 'best interests' are always going to be subjective. Removing the link with illness might make the nature and

purpose of coercive interventions in psychiatry more apparent, however.

Szasz felt that individuals should not be forced to receive an intervention they do not want, even if their life without such an intervention appears to be squalid, limited, unrewarding and uncomfortable. In contrast to physical medicine, where paternalism might sometimes be a necessary evil, in psychiatry it is unacceptable, because it denies human beings the dignity of making their own choices, however unwise or self-destructive those choices might sometimes seem to be. Reflecting on Canguilhem's insights, however, suggests that, although from the point of view of sanity it may be possible to value the dignity of human freedom above the ability to function in the actual world, someone has to have a basic level of rational capacity in order to make that judgement. When this is impaired, then a paternalistic approach that aims to restore that capacity could be seen as supporting human dignity and autonomy, rather than depleting them.

Psychiatrists who work with people who are severely mentally ill face these dilemmas daily. Do they leave patients who are deeply psychotic to themselves, allowing them to sink into a state of extreme apathy and internal preoccupation, or do they force them to take antipsychotic medication that might restore some degree of contact with the external world? Similarly, do they attempt to engage such individuals in some social interaction that, initially at least, they might resist, in order to try and establish what appears to be a more rewarding and socially engaged life? If all patients woke up from their psychosis and thanked their psychiatrists for restoring them to sanity, the quandary would not exist. But most do not. Many people who are forced to receive psychiatric treatment, such as antipsychotic drugs, against their wishes either feel they have not benefited, or that the benefits do not outweigh the negative impact of the treatment. Although symptoms may be reduced, some people feel that an important aspect of their personality has been lost too, and that their mental life has become more limited. One patient summed up the dilemma like this: 'In losing my periods of madness, I have had to pay with my soul' (Wescott, 1979, p. 989).

Using forced treatment to increase autonomy in mental health services is thus fraught with difficulties. It is impossible to predict reliably who is likely to appreciate the effects of treatment and who might feel diminished by them. Again, a parallel with medicine in low- and middle-income countries might provide pointers to a solution.

Although the benefits of simple health measures such as improved sanitation appear obvious, they may still be resented and resisted if they are imposed from outside. Only when healthcare is designed and implemented by the community itself will it be able to foster the development of capable and autonomous individuals. In a similar way, society as a whole needs to take responsibility for the things we do to people who are

designated as having mental disorders. There needs to be a transparent debate about when it is justifiable to subject someone to forcible confinement and mind-altering interventions. Crucially, the verdicts of people who have experienced such measures need to be heard. As Szasz identified, however, this is unlikely to happen as long as these conditions are defined as medical illness and intervention as 'medical treatment'. A system is possible, however, which reduces the gap that sometimes exists between freedom and sanity.

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# The legacy – or not – of Dr Thomas Szasz (1920–2012)

Trevor Turner

Consultant Psychiatrist, Keats House, 24–26 St Thomas Street, London SE1 9RS, UK, email [turne@hotmail.co.uk](mailto:turne@hotmail.co.uk)

**Dr Trevor Turner was asked to provide a commentary on the preceding paper in this issue, “Freedom is more important than health”: Thomas Szasz and the problem of paternalism’, by Joanna Moncrieff.**

During the 1960s and 1970s the arguments put forward by Thomas Szasz, a Hungarian émigré who established himself in the psychoanalytic world of the USA, becoming Professor of Psychiatry at the State University of New York in Syracuse, were widely discussed and even admired. His arguments, made most forcefully in his 1961 book *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*, essentially stated that psychiatry was an emperor with no clothes. He considered that physical health could be dealt with in ‘anatomical and physiological terms’, while mental health was inextricably tied to the ‘social’ (including ethical) context in which an individual lives. He regarded the term ‘mental illness’ as a metaphor, and used the analogy of a defective television set to explain his meaning. It was as if, in his view, a television viewer were ‘to send for a TV repair man because he dislikes the programme he sees on the screen’.

As outlined in the previous article in this issue, by Joanna Moncrieff (2014), Szasz held freedom to be more important than anything, seeing psychiatrists as paternalistic and imposing a myth on capacious individuals whom they deem to have a ‘mental illness’, but who are actually suffering from degrees of social deviation rather than a formal disorder. He wrote numerous articles and books, and was popular at meetings. In the early 1990s, at a meeting of the European Association of the History of Psychiatry, he was quite charming, impervious to argument, and a little hard to understand because of his unique accent.

Szasz’s views over the 30 or 40 years of his working life never changed, the patient being someone who paid you money to receive discussion and advice. He worshipped at the throne of the contractual life, denying schizophrenia’s illness status, there being no organic factors. Detention under the Mental Health Act he saw as a threat to individual liberty, not a therapeutic event. Patients seeking help from psychiatrists he found perplexing. The logic of his view, therefore, would see Parkinsonism (when first described in the 19th century) as a non-disease, it being just a description of behaviours rather than linked to physical pathology. Martin Roth (1976) gave an excellent critique of his theories.

What did emerge from the antipsychiatry movement was the realisation that psychiatry needed to get its diagnostic house in order. The development of stricter criteria for defining schizophrenia, led by the World Health Organization, established a most reliable diagnosis. Perversely, this move away from the more psychoanalytic versions (of schizophrenia and hysteria, for example) to the first-rank and functional criteria of the modern period reduced psychiatry’s standing in the artistic and intellectual worlds. The psychotherapeutic doctor hero (Szasz, even?) in many 1960s and 1970s films has now become the white-coated figure in a secure unit, injecting people and giving them shock therapy, and even the ultimate psychiatric monster, Dr Hannibal Lecter (an ultra-Szaszian version of how he portrayed psychiatrists).

In her commentary on Thomas Szasz’ work, Dr Moncrieff has suggested that ‘Only when healthcare is designed and implemented by the community itself will it be able to foster the development of capable and autonomous individuals’. This view is quite Szaszian, in denying the specialist skills of psychiatry. But while, for example, a



diabetic patient after 10 years of illness may know much about both his symptoms and his treatment needs, the extraordinary debate in the USA about health insurance for everyone (not just the rich) and the shooting of vaccination workers in Pakistan seem to indicate that 'sensible' beliefs about healthcare are not necessarily the norm. We do have intense debates about mental health in the UK (e.g. the 10-year discussion around a new Mental Health Act, an admirable social construction), and the battle against stigma is long and wearying.

Whatever psychiatry is, it is clearly a part of medicine in terms of taking a history, examining patients and reaching a diagnosis to provide

treatment, and can be seen as one of the most thoughtful parts of medicine. Everyone has a right to treatment, the best available, and detained patients rarely take umbrage once they become well. Dr Szasz has had his time, and paying him privately is not (in my view) the way to construct modern doctor–patient relationships.

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## NEWS AND NOTES

Contributions to the 'News and notes' column should be sent to [ip@rcpsych.ac.uk](mailto:ip@rcpsych.ac.uk)

### Turning the World Upside Down

'Turning the World Upside Down' is a project that aims to provide a forum for health workers in low- and middle-income countries around the world, in which to share experiences, case studies of good practice and innovation. One of the project's themed competitions – the 'Mental Health Challenge' – sought examples of approaches to mental health in low- and middle-income countries which could be used in high-income countries. This competition culminated in a showcase which was held in November 2013 and chaired by Lord Nigel Crisp. Four case studies were presented, including a telepsychiatry service run from a bus in Kerala which connects to mobile technology, and the winning project: the 'Dream-A-World Cultural Therapy' (DAW CT) programme in Jamaica. Led by Professor Hickling, DAW CT is a multimodal intervention for high-risk primary school children, which fosters impoverished children's creativity to boost their academic performance, self-esteem and behaviour. All 34 case studies submitted to the Mental Health Challenge competition can be viewed on the 'Turning the World Upside Down: Mental Health' website (<http://www.ttwud.org/mentalhealth>).

### Diaspora conference – Academy of Medical Royal Colleges

In November 2013, the Royal College of Physicians hosted a diaspora conference for the Academy of Medical Royal Colleges with the theme of 'models of collaboration between medical diaspora and professional medical organisations'. The meeting reinforced the value of the work of these organisations and collaboration between them at a professional and personal level, with benefits both in the UK and overseas. For instance, advocacy work is enabling UK-based volunteers to be released more easily from their work commitments with the National Health Service, and the Medical Initiative Training Programme is underway to allow doctors from overseas to get training

experience in the UK. The event also highlighted the need for psychiatrists to engage with Health Education England and equivalent bodies in the UK countries.

Over 30 medical diaspora organisations were in attendance and several of these demonstrated their work in their home countries; there were some remarkable presentations on exciting projects and a masterful poster session. Mental health was well represented, with projects from diverse locations such as Uganda, Latin America and Iraq. For instance, the Zambia UK Health Workforce Alliance (ZUKHWA) is a network of UK-based groups who have united with Zambia-based organisations to support the Zambian government; this model is also being developed in Uganda. There was a lot to learn from the collective experiences on offer at the diaspora conference and there are plans to develop the ideas formulated there and to synergise the work that was exhibited on the day.

### UK-Med

The UK has formalised its system for sending humanitarian volunteers to disasters around the world. In the past, there has been a lack of co-ordination during humanitarian crises but now UK-Med has developed a UK International Emergency Trauma Register.

The register brings together healthcare practitioners with a range of skills and talents from all areas, including mental health professionals, paramedics, nurses and surgeons. All members on the register will be trained and once they have gained some experience they can be deployed for 2–3 weeks when a major international catastrophe occurs, at just 24–48 hours' notice. More information is available on the UK-Med website (<http://www.uk-med.org>).

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

## Need for decriminalisation of suicide in low- and middle-income countries

**Sir:** The guest editorial in the February issue by Pathare *et al* (2014) about the need to reform mental health legislation in Commonwealth nations highlighted the fact that many countries have laws that are out of date. The criminalisation of suicide is an important example that warrants urgent attention and reform.

In 13th-century England, 'self-murder' was considered a mortal sin. Those who died by suicide were denied a Christian burial and their property was confiscated from their families. Even as recently as 1956, people surviving a suicide attempt were subject to criminal proceedings, with penalties ranging from probation and fines to prison sentences, rather than a psychiatric assessment and treatment. After some urging from both the medical profession and even the churches by that time, in 1961 the British Parliament finally enacted the Suicide Act, whereby attempted suicide ceased to be an offence (Holt, 2011). In contrast, many continental European countries had done so much earlier, beginning with the French Revolution of 1789 (Law Commission of India, 2008).

Unfortunately, as a legacy of British colonialism, the criminalisation of suicide continues in a majority of Commonwealth countries, including India, Bangladesh, Pakistan, Singapore, Malaysia, Ghana and Uganda (Law Commission of India, 2008; Adinkrah, 2012; *The Hindu*, 2013), despite the World Health Organization consistently objecting that labelling suicidal behaviours as a punishable offence has a negative effect on public health (Law Commission of India, 2008). The criminalisation of suicide is known to deter those who are considering suicide from seeking emotional, physical and mental health support. It also skews data collection regarding suicide statistics, as suicide attempts tend to be registered instead as accidental poisonings, for example. The consequent lack of reliable data means that the extent of the problem is unknown, which in turn makes effective intervention strategies more difficult to formulate (Law Commission of India, 2008).

The Law Commission of India (2008) reiterated the conclusion of a 1971 report in highlighting the need to decriminalise suicide. It further stated that suicide attempts 'may be regarded more as a manifestation of a diseased condition of mind

deserving treatment and care rather than an offence to be visited with punishment'. It cited the example of Sri Lanka (perhaps an exception among Commonwealth countries), where suicide was decriminalised in early 2000 and where the suicide rate is tending to decrease.

Since 1970, many social activists and mental health professionals in India have been clamouring for the decriminalisation of suicide (Law Commission of India, 2008). Thankfully, in August 2013 a bill to amend the India's mental health law was proposed. The bill seeks to decriminalise acts of suicide by explicitly clarifying that the act of suicide and the mental health of the person are inseparably linked, and have to be seen together rather than in isolation. It is important to note that the bill also seeks to provide for mental healthcare for persons with mental illnesses and to protect, promote and fulfil the rights of such persons during the delivery of mental healthcare and services. We sincerely hope that the bill becomes an Act of Parliament as soon as possible.

More widely, it is imperative that everyone recommends and supports the decriminalisation of suicide as an element of progressive mental health treatment and suicide prevention strategies throughout the Commonwealth as well as in other low- and middle-income countries.

### A. Mukherjee<sup>1</sup> and R. Bhandarkar<sup>2</sup>

<sup>1</sup>ST4 LAS in Psychiatry, Old Oak Mental Health Recovery Team, West London Mental Health Trust, UK, email Amit.Mukherjee@nhs.net; <sup>2</sup>Consultant Psychiatrist, National Brain Injury Centre, St Andrews Healthcare, Northampton, UK

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# Forthcoming international events

5–7 June 2014

**Neurobiology and Complex Treatment of Psychiatric Disorders and Addiction (World Psychiatric Association Thematic Conference)**

Warsaw, Poland

Website: <http://www.wpatcwarsaw2014.com>

6 June 2014

**Cognitive Remediation in Psychiatry: New Directions for the 21st Century**

New York, NY, USA

Website: <http://www.cognitive-remediation.org/>

12–14 June 2014

**3rd International Symposium on Controversies in Psychiatry**

Mexico City, Mexico

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

24–27 June 2014

**Royal College of Psychiatrists International Congress 2014, 'Psychiatry: The Heartland of Medicine'**

The Barbican Centre, London, UK

Website: <http://www.rcpsych.ac.uk/traininpsychiatry/eventsandcourses/internationalcongress2014.aspx>

25–29 June 2014

**Cognition and Action: The Jagiellonian-Rutgers Conference in Cognitive Science 2014 (CogSciJR14)**

Kraków, Poland

Website: <http://cognitivescience.eu/>

4–6 August 2014

**3rd International Conference and Exhibition on Addiction Research and Therapy**

Chicago, USA

Website: <http://addictiontherapy2014.conferenceseries.net/index.php>

13–17 August 2014

**Third International Congress of Psychology and Education**

Panamá, Panamá

Website: <http://www.medical-events.com/congress/third-international-congress-of-psychology-and-education-4851>

25–29 August 2014

**7th World Congress for Psychotherapy**

Durban, South Africa

Website: <http://wcp2014.com/>

10–12 September 2014

**3rd World Congress of Clinical Safety (3WCCS) Main theme: Clinical Risk Management**

Madrid, Spain

Website: <http://iarmm.org/3WCCS/>

14–18 September 2014

**XVI World Congress of Psychiatry: Focusing on access, quality and humane care**

Madrid, Spain

Website: <http://www.wpamadrid2014.com/>

16 September 2014

**6th World Congress on Mental Health and Deafness**

Belfast, UK

Website: <http://www.wcmhd2014.org/>

24–26 September 2014

**2nd Global Conference: Suicide, Self-harm and Assisted Dying**

Oxford, UK

Website: <http://www.inter-disciplinary.net/probing-the-boundaries/persons/suicide-self-harm-and-assisted-dying/suicide-self-harm-and-assisted-dying/>

10–11 October 2014

**Fall Global Psychology Symposium**

Los Angeles, USA

Website: <http://www.conferencealerts.com/psychiatry.htm>

22–24 October 2014

**4th International Conference on Violence in the Health Sector**

Miami, USA

Website: <http://www.oudconsultancy.nl/MiamiSite2014/violence/invitation-four.html>

30 October–2 November 2014

**WPA Thematic Conference on Intersectional Collaboration, 5th European Congress of INA & 2nd Interdisciplinary Congress on Psychiatry and Related Sciences**

Athens, Greece

Website: <http://www.psych-relatedsciences.org/>

4–7 December 2014

**10th International Congress on Mental Dysfunction and Non-Motor Features of Parkinson's Disease and Related Disorders**

Nice, France

Website: <http://www.kenes-group.com/events>

12–14 December 2014

**WPA Regional Congress, Hong Kong**

Hong Kong, China

Website: <http://www.wpa2014hongkong.org/>

## Contents of the *African Journal of Psychiatry* (affiliated journal)

Volume 17 Number 1 January 2014

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#### **Recurrent panic attack and ubiquinone treatment: a case report**

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### Original articles

#### **Ethnic differences in eating attitudes, body image and self-esteem among adolescent females living in urban South Africa**

Tabitha M. Gitau, Lisa K. Micklesfield, John M. Pettifor, Shane A. Norris

#### **Handedness in schizophrenia and schizoaffective disorder in an Afrikaner founder population**

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#### **Clinical and demographic profile of patients using a liaison-psychiatry service in a general hospital setting in Abeokuta, Nigeria**

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#### **Duration of untreated psychosis and associated factors in first episode psychosis in Mzuzu in Northern Malawi**

Harris K. Chilale, Richard Banda, Japhet Muyawa, Atipatsa C. Kamanga

