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Number 4
November 2014
ISSN 1749-3676

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International psychiatry

Volume 11
Number 4
November 2014
ISSN 1749-3676

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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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GUEST EDITORIAL

The mental health needs of immigrant workers in Gulf countries

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The oil-rich member states of the Gulf Cooperation Council (GCC) attract large numbers of migrant workers. The reported rates of psychiatric morbidity among these migrant workers are higher than among nationals, while the mental health services in the GCC countries remain inadequate in terms of both staff and service delivery. The multi-ethnic origin of migrants poses considerable challenges in this respect. The development of mental illness in migrants, especially when many of them remain untreated or inadequately treated, results in their premature repatriation, and the mentally ill migrant ends up facing the same economic hardships which led to migration in the first place. The availability of trained interpreters and transcultural psychiatrists, psychologists and social workers should make psychiatric diagnoses more accurate. Suitable rehabilitation services are also needed.

Migration and the international mobility of labour have made the Arabian Gulf a unique part of the world. The oil-rich member states of the Gulf Cooperation Council (GCC) – Saudi Arabia, Kuwait, Bahrain, United Arab Emirates (UAE), Oman and Qatar – attract the largest number of international migrants after the European Union and North America. This has given the GCC countries a unique demographic make-up, where local indigenous populations often constitute a minority of inhabitants. However, despite its overwhelming importance for economies and societies, the mental health of these migrants is underdocumented, underresearched and underreported.

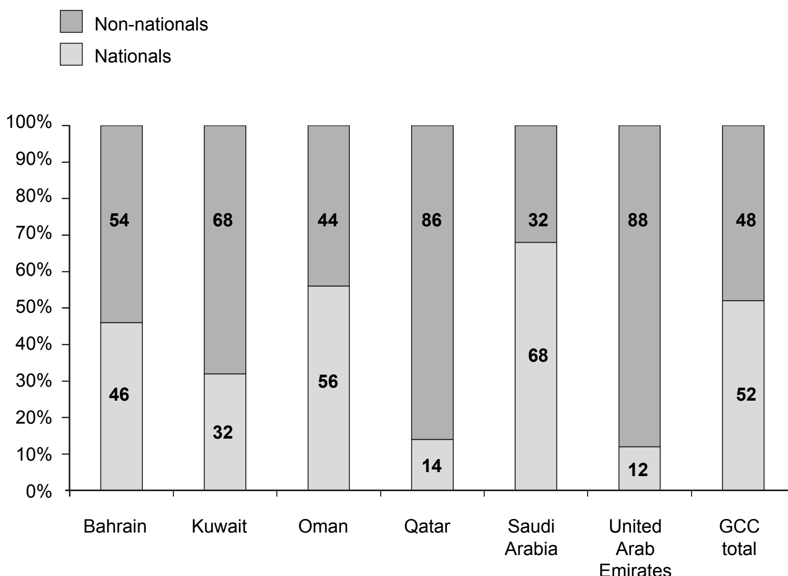

Fig. 1
Percentage of nationals and non-nationals in member states of the Gulf Cooperation Council (GCC). Figures for around 2010. Source: Most recent national data from the database of the Gulf Labour Markets and Migration (GLMM) programme (2013), European University Institute (EUI) and Gulf Research Center (GRC). Updated 8 November 2013

Demographic characteristics of the GCC countries

Overall, migrants make up almost half (48%) of the population of the GCC countries (Fig. 1). However, this population parity is mainly accounted for by Saudi Arabia, the most populous of the GCC states, and, to a lesser extent, Oman, where nationals marginally outnumber the migrants. In the remaining four GCC countries, the proportion of migrants ranges from 54% (Bahrain) to 88% (UAE). Most migrants come from the Indian subcontinent and the Middle East. 'Service workers', including housemaids and non-skilled workers, constitute the largest subgroup, accounting for about a third of the workforce.

Mental health services in GCC countries

Mental health services in the GCC countries are provided free of charge for the local population while nominal charges are levied on expatriates. Although efforts to develop modern multidisciplinary mental health services are underway, the services remain inadequate in terms of both staff and service delivery (Table 1). The number of psychiatrists per 100 000 ranges from 0.3 (UAE) to 8.2 (Bahrain) and the number of beds per 100 000 ranges from 1.7 (UAE) to 33 (Kuwait). The shortage of allied mental health professionals, including psychologists and social workers, is even greater. The number of social workers per 100 000 ranges from 0.07 (Oman) to 2.9 (Saudi Arabia). The provision of mental health services is largely hospital based, with out-patient clinic facilities in some selected general hospitals. There have been recent moves towards decentralisation of services with stepwise expansion to the level of primary health clinics. The unique population demographics of the GCC countries pose considerable challenges for the already insufficient resources for provision of mental health services in the host countries.

Mental health of migrants in GCC countries

Migrants' mental health in the GCC countries remains underinvestigated and few studies have addressed this important subject. A Scopus literature search, for instance, using the search terms

Table 1
Psychiatric services (beds and professionals per 100 000 population) in Gulf countries

	Hospital beds	Psychiatrists	Psychologists	Social workers
Kuwait	32.78	2.62	2.29	0.66
Saudi Arabia	11.43	2.91	1.66	2.9
Oman	2.2	2.31	0.17	0.07
Qatar	3.98	1.66	1.26	0.46
Bahrain	28	8.18	0.5	0.87
United Arab Emirates	1.7	0.3	0.51	0.25

Data from World Health Organization (2011).

'GCC countries AND mental health OR mental disorder' and 'refugees AND mental health OR mental disorder' for the period 2010–13 revealed 8 and 291 citations, respectively. Zahid *et al* (2002, 2003, 2004), in a 2-year prospective study of hospitalised housemaids, reported that psychiatric morbidity was twice as common among them than in the local population. The researchers identified pre-immigration risk factors and precipitating factors, and described the nature of psychiatric disorders in this subgroup of immigrants. The pre-immigration risk factors included a history of psychiatric disorder, physical illness or hospitalisation. Almost half (48%) of the housemaids required interpreter assistance for assessment. Stress-related disorders were the commonest (49%) type of disorder; more than half of the housemaids had a breakdown within the first 3 months of their arrival; and the lack of contact with the family back home and harassment at work were identified as the commonest precipitating factors. Most (81%) of the housemaids were prematurely deported following their discharge from hospital (Zahid *et al*, 2002, 2003, 2004). Many housemaids, especially those with young children back home, and engaged in looking after employers' young children, may experience guilt for having 'abandoned' their own (similar) children. Such a conflict may add to the distress of the already homesick housemaid. In another study, from the UAE, rates of depression and suicidal ideation were found to be higher in immigrant workers than in the native population (Al-Maskari *et al*, 2011). In view of the sample selection bias inherent in these studies and the dearth of methodologically sound studies, it is difficult to draw firm conclusions.

Given the psychosocial stresses surrounding the act of migration, coupled with the adjustment difficulties in the new environment, a considerable number of migrants develop mental illness. It is possible that many migrants with mild to moderate mental illness, especially in the absence of significant occupational impairment, simply pass unnoticed. The development of mental illness in migrants, especially when many of them remain untreated or inadequately treated, results in their premature repatriation. In addition to causing considerable inconvenience to the employer, mentally ill migrants end up facing the same economic hardships which led to their migration in the first place. The resultant migration failure perpetuates their difficulties as they have now to pay back the considerable sum of money, usually borrowed, paid to the immigration agent prior to the migration.

Mental health needs of migrants

The atypical presentation of some psychiatric disorders in migrants coupled with the reported mismatch between the various diagnostic criteria and phenomenology of the disorder, as described by migrants who are mentally ill, within the specific cultural context, present unique challenges for mental health service providers. Depressive illness in migrants, for example, has been reported to present with comorbid somatoform, anxiety and dissociative features (Saraga *et al*, 2013). The diagnostic process is further complicated by the cultural differences between the migrant and the therapist. All cultures develop processes that facilitate adjustment and conflict resolution, as well as pressures that foster conflict, deviation and maladjustment, defining thereby the spectrum of 'normal behaviours' as well as thresholds for tolerance of psychosocial stresses resulting in 'abnormal behaviour'. Similarly, the culture-specific stresses and the beliefs and rituals used to cope with psychological tension underline the importance of diversifying the mental health staff resources in the GCC countries to include professionals familiar with, and sensitive to, the culture-specific spectrum of behavioural disturbances in subgroups of migrants with mental disorder. In a survey of European migrants, most thought that healthcare providers underestimated their language problems and that language difficulties made them more aggressive and paranoid towards the care provider (Watters, 2002). The availability of trained interpreters, transcultural psychiatrists, psychologists and social workers should make psychiatric diagnoses more accurate. Suitable rehabilitation services will help migrants receive mental healthcare and thereby gain either re-employment or settlement of deportation terms as stipulated in their contract of employment.

A rising demand for highly skilled people will increasingly expose the GCC states to what has become a global competition for talent. Nonetheless, low-skilled or unskilled manual workers will also be needed due to non-availability of local nationals to carry out such jobs. It is time now to regulate the flow of migrants, with stringent controls on recruitment procedures. Pre-immigration orientation programmes aimed at familiarising migrants with their prospective job responsibilities, and basic linguistic instruction, can help allay some of the anxieties related to working conditions in the new environment. Similarly, facilitation of regular contact with families back home, especially during the first few weeks after arrival, may help minimise psychiatric breakdown and migration 'failure'. Lastly, given the limitations of the GCC countries in coping with the multicultural mental healthcare needs of migrants, collaboration with

organisations such as the Red Cross and Red Crescent may help overcome some of these difficulties.

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GUEST EDITORIAL

What's so special about military veterans?

Neil Greenberg

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The mental health of military veterans has been, and continues to be, a topic of heated political and journalistic debate. There is a well-documented impact of conflict upon the mental health of service personnel, and most nations have aimed to provide effective care for individuals who have fought for their country. However, as the three thematic papers in this issue demonstrate, the realities of service-related mental health are rather more complex than they initially appear.

The mental health of military veterans has been, and continues to be, a topic of heated political and journalistic debate. Because of the well-documented impact of conflict upon the mental health of service personnel (Hunt *et al*, 2014), most nations have, for wholly understandable reasons, aimed to provide effective care for individuals who have fought for their country. Thus the argument for nations providing services for the mental health of war veterans, whether arising out of gratitude or of moral duty, seems to be simple common sense.

However, as the three thematic papers in this issue demonstrate, the realities of service-related mental health are rather more complex than they initially appear. First, it seems that although one might expect the main burden of operational stress injuries to occur during or soon after deployment, while individuals are still serving, it appears that mental health problems may in fact be more common once personnel have left service, months or years later.

Secondly, most of the authors note that the link between deployment and poor mental health is less clear than might be expected. There is now considerable evidence that soldiers who have served on peacekeeping (rather than combat) operations also experience traumatic stress-related disorders (Greenberg *et al*, 2008) and indeed that a significant proportion (about half) of post-traumatic stress disorder (PTSD) in the military is not related to deployment (Jones *et al*, 2013).

Thirdly, while not discussed in detail in the thematic papers in this issue, there is considerable evidence that pre-enlistment factors such as childhood adversity and sociodemographic factors significantly affect the risk of developing mental health problems during or after service. For instance, a UK study of post-deployment violence showed that pre-enlistment violent offending was the most influential risk factor (adjusted hazard ratio 3.85), whereas deployment itself was not an independent risk factor (MacManus *et al*, 2013).

Fourthly, while the debate about veterans' mental health often appears to centre on how to increase the scope, efficiency or availability of mental health services for veterans, there is considerable evidence that most veterans who suffer with mental health problems do not in fact seek any help at all for them. This lack of help-seeking seems to result both from a lack of recognition of the existence of mental health problems and from fears or concerns about the consequences of seeking help, which may be practical (e.g. regarding the impact of receiving treatment for a mental health problem on career prospects) or perceptual (e.g. regarding self-perception as a resilient person or the perceptions of others). Research has shown that these concerns are not in any way unique to the military and a reluctance to seek help seems just as common within the general population as among those who have served in the military.

Lastly, there seems to be a general consensus among researchers that the process of transition

out of the military may contribute in some way to the development of mental health problems. The reasons for this are less obvious but clearly transition out of the military is not directly a deployment issue; indeed, transition is about leaving the liability to be sent to a hostile area behind and settling into the somewhat safer civilian world.

The above five points are important because they all suggest veterans' mental health problems are not particularly related to either deployment or the traumatic experiences that service personnel may experience while deployed. Instead, they suggest a much more diverse, and complex, explanation for the *apparent* excess of mental health problems that veterans experience. The word 'apparent' is appropriate here because while there is some, although inconclusive, evidence that the prevalence of mental health disorders is raised in veterans compared with those still serving and the general (never-served) population, few (if any) studies have compared veterans with people who have worked in similarly hierarchical professions. If high-quality evidence were available about veterans from other hierarchical organisations that rely heavily on teams 'pulling together' in often uncertain and challenging environments (e.g. fire or police workers), it might emerge that these veterans too would have similar risks of post-service mental health difficulties. It might also be useful to examine how social factors (e.g. relationships with family and friends) influence post-employment mental health outcomes, given that we know that the quality and availability of social networks are of the utmost importance to mental health. For instance, a UK study showed that military veterans who continue to rely on service-related social networks (e.g. mixing with individuals who are still serving) fare much less well than those who form sustaining civilian networks (Hatch *et al*, 2013). It may be that veterans are not especially experienced in forming supportive bonds unless they are in the face of intense adversity, which, thankfully, while commonplace in the military, is not so in the wider community. If this were found to be true, then further work would be needed to know whether this social deficit was a result of pre-service factors or of military service itself.

So, on one hand it appears that, contrary to the popular public perception of the 'damaged war hero', veterans' mental health problems are not, in the main, particularly related to combat experiences. Instead, other factors, such as pre-enlistment vulnerabilities, difficulties in forming or using post-service social networks and a lack of appropriate help-seeking behaviours (not in any way solely a veterans' issue, however), seem important determinants of post-service mental health. On the other hand, there is an abundance of data showing that personnel exposed to traumatic events (e.g. combat troops, those taken hostage, the physically injured) do suffer more mental health problems than other military personnel. Indeed, some of the US data on this topic suggest that almost one-third of US combat troops suffer from PTSD (Thomas *et al*, 2010). Additionally, particularly relevant to the US context, the issue of deployment-related mild traumatic brain injury (mTBI) appears inextricably linked to mental health disorders, with studies showing that a substantial proportion of personnel who report symptoms of mTBI also suffer with deployment-related mental health difficulties.

While on the face of it these two broad findings seem at odds with each other, in reality they only seem so because of the rather misplaced public view of what service life is about. The innumerable films and books about military life have propagated a misplaced belief that all military personnel frequently face overwhelming enemy forces and encounter tragedy or horror or some other 'story-worthy' challenge. Rarely do 'military stories' depict well-planned, successful missions, the mundaneness of life in main operating bases, the consistent challenges of being away from family for months on end or, indeed, the sense of humour, satisfaction, learning and personal 'growth' which deployment can generate. For instance, there is a growing, although not yet mature, literature on post-traumatic growth which suggests that even the most challenging of experiences can have positive outcomes (Dekel *et al*, 2011). To what extent deployment itself might lead to growth is still unclear, however.

Military service is not 'inevitably' bad for an individual's mental health. While some service personnel will undoubtedly suffer operational stress injuries, in the longer term others, even those who have experienced the most traumatic of deployment incidents, may experience improved, rather than degraded, resilience. When considering the mental health of veterans as a whole, given the diversity of the experience of military service, it is not at all surprising that some groups of military personnel are at higher risk of developing mental health disorders and other groups at considerably lower risk. Given the often challenging pre-service backgrounds of people who join the military, perhaps politicians and journalists should applaud the military for the overall highly reasonable state of mental health of their active-service forces. How much the apparent deterioration in mental state of individuals as they transition to veteran status is a return to their more vulnerable pre-enlistment state or a function of their military experiences is not yet clear. What is clear, however, is that it is certainly not all about deployment.

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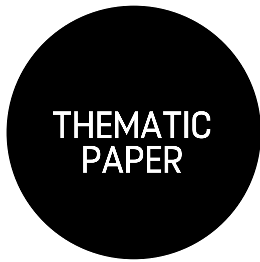

THE MENTAL HEALTH OF MILITARY VETERANS

Veteran and military mental health: the Australian experience

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Acknowledgements and declaration of conflict of interest: The research centre affiliated with the authors receives funding from the Department of Veterans' Affairs and the Department of Defence

Australia has deployed over 25 000 personnel to recent conflicts in the Middle East and has been involved in peacekeeping missions. Australian veterans report elevated rates of mental health problems such as post-traumatic stress disorder, anxiety disorders, affective disorders and substance use disorders. Veteran healthcare is delivered through publicly funded services, as well as through private services, at primary, secondary and tertiary levels. Some of the challenges involve coordination of services for veterans transitioning from Defence to Veterans' Affairs, service delivery across a large continent and stigma inhibiting service-seeking. Initiatives have been introduced in screening and delivery of evidence-based treatments. While challenges remain, Australia has come a long way towards an integrated and comprehensive approach to veteran mental healthcare.

Australia has a long tradition of celebrating its military history, dating back to the Gallipoli campaign in the First World War, which took place shortly after federation. Despite the lack of military success in Gallipoli, the courage and mateship displayed by the Australian soldiers have become stuff of national legend (Stanley, 2002). Although a century has passed, this legend pervades modern Australian culture and is still, for many, synonymous with what it means 'to be an Australian'. As a result of this core identification with military conflicts, the Australian community advocates strongly for the support and care of their veterans, colloquially known as 'diggers'.

Since federation, Australian military personnel have served in both World Wars as well as in other major international conflicts, such as Korea, Vietnam and the Gulf. Australia has deployed over 25 000 personnel to recent conflicts in the Middle East, where it maintains a presence. In addition to combat roles, Australia has become a major player in international peacekeeping missions, including spearheading the United Nations mission in East Timor, as well as humanitarian deployments both in Australia and overseas. This diversity of deployments means that 'contemporary veterans' (defined as having served since 1999) are likely to have participated in a combination of combat, peacekeeping and other deployments. They are also the largest cohort of Australian veterans, at an estimated 61 900 in 2013 and rising (Department of Veterans' Affairs, 2013a). In comparison, in 2013 surviving veterans of the Vietnam War and the Second World War numbered 46 000 and 58 200, respectively.

Mental health in Australian military and veteran populations

Several studies have investigated the mental health of Australian veterans, with most reporting substantial morbidity. Comprehensive studies of Australian Korean War veterans (Ikin *et al*, 2009), Vietnam veterans (O'Toole *et al*, 2009) and veterans from the first Gulf War (Ikin *et al*, 2004) have found significantly elevated rates of mental health problems such as post-traumatic stress disorder (PTSD), anxiety disorders, affective disorders and substance use disorders relative to non-deployed personnel and comparable civilian populations. This increased risk of mental health disorders is not restricted to combat deployments. A recently completed study of 1067 Australian Defence Force personnel deployed on one or more peacekeeping missions between 1991 and 2002, for example, revealed surprisingly high rates of mental disorder (Hawthorne *et al*, 2014). Prevalence rates for disorders such as PTSD, alcohol misuse, depression and anxiety were not only higher than among civilian comparators but also higher than those found following other Australian deployments.

While rates of mental disorder are higher in Australian veterans than among civilians, this is not the case for currently serving military personnel, among whom the overall rate is similar to that among civilians, although rates differ across disorders (McFarlane *et al*, 2011). Serving personnel were found to have higher 12-month prevalence rates of depression and PTSD and lower rates of alcohol use disorders than a community sample.

Surprisingly, there was no clear difference between deployed and non-deployed personnel, although rates were higher in those with greater exposure to potentially traumatic events. Given that overall rates of mental disorder in currently serving personnel are comparable to those in civilians, but veteran rates are significantly higher, it is reasonable to speculate that the transition from military to civilian life is a high-risk period for the development of mental health conditions. Little is known about the mental health status of members who have recently transitioned out of the Defence Force but a large research project (the Mental Health and Wellbeing Transition Study) is currently underway to explore this question.

Mental healthcare for veterans in Australia: strengths and challenges

While strong community support exists, several challenges confront the delivery of mental health services to Australian veterans. The care of veterans is managed by two federal government departments, the Department of Defence and the Department of Veterans' Affairs (DVA), which function independently and have largely exclusive service systems. This can lead to increased burden and confusion for those applying for assistance, bureaucratic delays and needy individuals slipping through gaps that exist between the service systems. Both departments recognise these limitations and are committed to working together more closely. A memorandum of understanding signed in 2013 proposes a 'support continuum' of care that formally recognises the specific roles each department plays in providing care to veterans and their families (Department of Veterans' Affairs, 2013b). Such collaborations extend to research projects, a good example being the Mental Health and Wellbeing Transition Study mentioned above. Both departments recognise that the transition from military to civilian life is critical and requires a cohesive service and continuity of care.

Veteran healthcare is delivered through a range of publicly funded state and federal health services, as well as through private services at primary, secondary and tertiary levels. Some of the greatest challenges in service delivery are geographical. Australia is a large continent with a small population, featuring sparsely located capital cities around the perimeter of the country and often vast distances separating rural towns. For those living in rural and remote locations, the lack of local healthcare resources, as well as the time and cost of travel to the nearest facilities, are barriers to effective care. Technological developments are able to overcome some of these challenges and many recent mental health initiatives introduced by the Department of Defence and DVA attempt to address these barriers through the use of telemedicine, online resources and mobile app technology.

Another substantial barrier to mental healthcare is stigma, a problem common in varying degrees to all defence forces. The most frequently reported barrier to Australian military personnel seeking help for emotional or mental health problems was concern that it may reduce deployability; in one survey over a quarter of respondents were concerned about being seen as weak (McFarlane *et al*, 2011). The current Mental Health and Wellbeing Action Plan initiated by the Department of Defence is aimed at tackling stigma by increasing mental health literacy and awareness. Specific programmes such as 'Keep Your Mates Safe' are aimed at building peer support networks by training individuals to recognise signs of psychological distress and provide support to their colleagues. DVA has mounted similar campaigns to tackle stigma and other barriers to mental healthcare (see http://www.defence.gov.au/health and http://www.at-ease.dva.gov.au for examples of such mental health programmes).

Tackling problems: screening, identification and early intervention

Both the Department of Defence and DVA recognise the benefits of early identification of mental health problems. The former conducts screening at critical points in the military life cycle, including post-deployment, after serious incidents and during transition to civilian life. While the ability of population screening to identify potential cases accurately remains a matter of debate, the screening programme has the added benefit of raising awareness and providing a context for simple low-level interventions and support. In 2014, DVA announced a new comprehensive health assessment accessible through general practitioners with the aim of identifying and diagnosing mental health problems early.

In addition to screening and identification, a comprehensive approach to mental health requires attention to prevention and intervention. BattleSMART (Self-Management and Resilience Training) for military personnel is targeted at the earliest stage of intervention, focusing on building psychological resilience and coping strategies among serving personnel with a view to preventing the development of mental health problems. Although further research on such interventions is urgently required, preliminary evaluations are encouraging (Cohn *et al*, 2010). Similarly, international expert consensus promotes psychological first aid (PFA) as the recommended intervention in the immediate aftermath of a potentially traumatic event and this is now routinely employed.

For those with diagnosable psychiatric conditions such as PTSD, depression, anxiety and substance use disorders, free treatment is available to veterans and serving personnel through private and public sector providers, as well as through DVA's own Veterans and Veterans' Families Counselling Service (VVCS). Mental health treatments funded by the Department of Defence or DVA are expected to be evidence based. Although some clinical accountability mechanisms are in place, ensuring that all treatment provided to veterans and serving personnel is high quality and evidence based remains a challenge. A higher level of

accountability is applied to PTSD treatments, particularly group programmes (Forbes *et al*, 2008). In line with the 2008 US Veterans Affairs mandate, it is expected that Australian veterans with PTSD have access to prolonged exposure or cognitive processing therapy (CPT). Recent local research demonstrated the efficacy of CPT for Australian veterans (Forbes *et al*, 2012) and this approach is being systematically rolled out through the VVCS.

Conclusions

Psychiatric casualties will always be a part of war and it is incumbent on those tasked with the care of veterans to provide the best possible prevention, early intervention, treatment and long-term management. While many challenges remain, Australia has come a long way in the past few decades towards an integrated and comprehensive approach to veteran mental healthcare.

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THE MENTAL HEALTH OF MILITARY VETERANS

Out of the shadows: mental health of Canadian armed forces veterans

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In the past 15 years in Canada, as in other nations, the mental health of veterans has emerged as a key concern for both government and the public. As mental health service enhancement unfolded, the need for wider population studies became apparent. This paper describes the renewal of services and key findings from national surveys of serving personnel and veterans.

In the past 15 years in Canada, as in other countries, the mental health of veterans has emerged as a key concern for both government and the public. Policies and programmes tailored for Second World War veterans dominated in Canada until the wake of the difficult deployments in the Persian Gulf, the Balkans, Somalia, Rwanda and elsewhere in the 1990s. A 1999 survey of contemporary (post-Korean War) serving Canadian armed forces (CAF) personnel and veterans (ex-service CAF personnel) participating in Veterans Affairs Canada (VAC) programmes brought to light the extent of mental health problems. The CAF, Department of National Defence (DND) and VAC recognised the need to strengthen mental health services for serving personnel and veterans.

This emerging awareness of mental health issues in military populations and increased recognition of post-traumatic stress disorder (PTSD) coincided with national efforts to bring the mental health of all Canadians out of the shadows. Studies conducted in the 1990s included only serving personnel and veterans who were receiving services from VAC, who today represent less than 12% of the estimated 599 200 contemporary CAF veterans. As mental health service enhancement unfolded, the need for wider population

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Declaration of interest: Drs Thompson, Zamorski, Fikretoglu, VanTil, Carrese and Pedlar, Ms MacLean and Mr Macintosh are employees of the government of Canada

studies became apparent. This paper describes the renewal of services and key findings from national surveys of CAF serving personnel and veterans.

Service renewal

The CAF largely comprise two groups: full-time Regular Force serving personnel and primary Reserve Force personnel, who serve part-time, sometimes with periods of full-time service. Health services for serving Regular Force personnel are mostly provided through the CAF health system, while Reserve Force personnel generally receive care from civilian providers in their home communities through publicly funded provincial healthcare plans. The CAF provide occupational health services for both Regular and Reserve Force personnel. The CAF mental health service renewal included establishing seven regional centres for the treatment of occupational mental health problems, doubling the number of mental health clinicians, and post-deployment screening. Destigmatisation efforts included educational programming, introduction of the term 'operational stress injury' (OSI) to describe persistent service-related psychological difficulties and development of an OSI peer support programme in partnership with VAC.

Eligible serving personnel can participate in VAC programmes prior to release. After release from service, veterans receive healthcare from publicly funded provincial healthcare systems. VAC pays for access to civilian healthcare and rehabilitation services primarily for service-related health problems, and provides case management for complex needs. In 2002, VAC contracted a national network of OSI clinics to provide specialised mental healthcare. The 2006 Canadian Forces and Veterans Reestablishment and Compensation Act established a cash award to compensate for service-related disability and provided an array of healthcare, rehabilitation and financial supports tailored to meet the needs of contemporary CAF veterans transitioning to civilian life, shifting the focus from chronic health maintenance to promotion of ability, well-being and independence.

Population surveys of mental health in serving CAF personnel

The first comprehensive population study of the mental health of serving CAF personnel was the 2002 Canadian Forces Mental Health Supplement (CFMHS) to the Canadian Community Health Survey (CCHS), which included serving Regular and Reserve Force personnel. The prevalence of any past-year mental disorder was 15% (Sareen *et al,* 2007) and past-year PTSD prevalence was 2%. Prevalences of most disorders were similar to those in the general Canadian population but there was a twofold higher prevalence of major depression in serving Regular Force personnel. The mental health of serving Reserve Force personnel was similar to that of civilians.

Analyses of the CFMHS 2002 data showed that deployment to peacekeeping operations was not associated with increased prevalence of mental disorders and perceived need for care, except when there was exposure to combat and witnessing of atrocities (Sareen *et al,* 2007). While PTSD was associated with exposure to combat, the majority of 'mental health outcomes' (mental disorders, perceived need and service use) were not attributable to combat or peacekeeping deployment, highlighting the roles of other determinants of mental health (Sareen *et al,* 2008, 2013).

Less than half of those with a past-year disorder had sought care, and the leading barrier appeared to be failure to recognise an unmet need for care. Median delay in help-seeking ranged from 3 to 26 years for various disorders (Fikretoglu *et al,* 2010). Delayed-onset PTSD was seen in 9% of those with lifetime PTSD, mostly related to childhood trauma (Fikretoglu & Liu, 2012).

The 2002 CFMHS was undertaken before the deployment of more than 40 000 personnel in support of the mission in Afghanistan and prior to the renewal of mental health services in DND/CAF. For this reason, the CAF undertook a second CFMHS in 2013. Many CAF personnel who served in Afghanistan are still in service and most are in good mental health. However, 13.5% were diagnosed with a mental disorder related to the mission within 4 years of their return (Boulos & Zamorski, 2013), 8.0% had PTSD and 5.5% had other mental health disorders. For personnel deployed to high-threat locations, the cumulative incidence of diagnosed deployment-related mental disorders approached 30% at 8 years. Analyses underway of data from the 2013 CFMHS will shed further light on the effects of both the Afghanistan missions and DND/CAF service renewal.

Population surveys of Canadian veterans after transition to civilian life

Since 2002, there have been three surveys of veterans living in the general population. The 2002–03 CCHS of self-identified veterans (MacLean *et al,* 2013) provided the first national picture of the size and health of the entire veteran population. The 2010 Survey on Transition to Civilian Life (Thompson *et al,* 2012) and the 2013 Life After Service Study (Thompson *et al,* 2014a) more comprehensively explored the health of CAF veterans who left the armed forces after 1998.

In all three surveys, most contemporary veterans were employed and doing well and the majority had very good or excellent self-rated mental health. In the 2002–03 CCHS, the prevalence of self-reported diagnosed chronic mental health conditions in CAF veterans did not differ from that in the general population. However, in the most recent surveys mental health conditions were present in 9% of class A/B Primary Reserve Force veterans (not deployed), 17% of class C (deployed) Primary Reserve Force veterans and 24% of Regular Force veterans (deployed and non-deployed) (Thompson *et al*, 2014a) and were associated with difficult adjustment to civilian life (MacLean *et al,* 2014). Mood and anxiety disorders

were considerably more prevalent in Regular Force and deployed Reserve Force veterans than in the age-matched general Canadian population. The prevalence of PTSD in serving personnel in the 2002 CFMHS was lower, at 2% (Sareen *et al*, 2007) than among Regular Force veterans (13%) and deployed Reserve Force veterans (7%) surveyed in 2013 (Thompson *et al*, 2014a).

Differences in prevalences between surveys are due in part to differences in survey instruments and the types of health conditions included in the questionnaires. The surveys of serving personnel assessed symptoms in personal interviews, while the veteran surveys used self-report of diagnosed conditions in telephone interviews.

Comorbidity of physical and mental health conditions is a marker of case complexity and is associated with poorer outcomes, such as disability, poorer quality of life and suicide. The great majority of Reserve and Regular Force veterans with mental health conditions also had chronic physical health conditions (73–95%) and more than half (67%) of Regular Force veterans with mental health conditions had a musculoskeletal condition and chronic pain. The surveys did not assess whether conditions were service related. Poor physical health contributed significantly to poorer health-related quality of life in those with mental health conditions and was associated with suicidal ideation after adjustment for mental health (Thompson *et al,* 2014b). More than half of respondents with suicidal ideation were veterans with at least one mental condition and three or more physical conditions.

Disability was two to three times more prevalent in Regular Force and deployed Reserve Force veterans compared with the general Canadian population. The odds of disability were elevated in those with mental health conditions and highest in those with both mental and physical health conditions (Thompson *et al,* 2014c).

Barriers to care continue to challenge service provision for serving personnel and veterans. Many do not perceive need and do not seek help for mental health problems. For example, about a third (35%) of Regular Force veterans did not seek help for suicidal ideation or suicide attempts. Factors affecting access to mental healthcare include not perceiving need for assistance, scepticism about treatment effectiveness, difficulty in accessing effective care, fear of stigma (discrimination and prejudice) and geographical barriers for the one in five Canadian veterans living in rural and remote communities.

Conclusions and priorities for further research

While the majority of veterans are doing well, the studies found that an important minority have mental health problems affecting functioning and successful transition to civilian life. Moreover, there was evidence of a higher prevalence of mental health problems in recent veterans compared with serving personnel, earlier contemporary veterans and the Canadian general population. These findings underline the need for strong mental health services for today's veterans.

Priorities for further research include:

- better understanding of the determinants and natural history of mental health conditions across the life course of Canadian military personnel
- clarification of relationships between mental health, physical health, (dis)ability and employment
- ways to address barriers to effective care
- development and dissemination of evidence-based treatment and rehabilitation practices for veterans with mental health problems
- assessment of the effectiveness of policies, programmes and services designed to enhance the mental health and well-being of Canadian veterans.

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THE MENTAL HEALTH OF MILITARY VETERANS

The mental health of military veterans in the UK

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Risk factors for poor mental health among UK veterans include demonstrating symptoms while in service, being unmarried, holding lower rank, experiencing childhood adversity and having a combat role; however, deployment to a combat zone does not appear to be associated with mental health outcomes. While presentation of late-onset, post-service difficulties may explain some of the difference between veterans and those in service, delayed-onset post-traumatic stress disorder (PTSD) appears to be partly explained by prior subthreshold PTSD, as well as other mental health difficulties. In the longer term, veterans do not appear to suffer worse mental health than equivalent civilians. This overall lack of difference, despite increased mental health difficulties in those who have recently left, suggests that veterans are not at risk of worse mental health and/or that poor mental health is a cause, rather than a consequence, of leaving service.

Around 20000, or 10%, of the regular strength of the UK armed forces leave every year. The vast majority will qualify as veterans in the UK, as a single day's service is the only criterion for that status. Estimates utilising the 2007 Adult Psychiatric Morbidity Survey in England (APMS) suggest that there are 3–5 million veterans in England alone (Woodhead *et al*, 2009).

Prevalence

It is difficult to determine the prevalence of mental health conditions among UK veterans, in part because veterans are difficult to identify and trace, as they are widely dispersed on leaving service and have no obligation to declare their veteran status. Studies of the UK armed forces which include comparisons between serving personnel and veterans provide some evidence that those who have left the services are more likely to report symptoms of common mental disorders and post-traumatic stress disorder (PTSD) than those who stay in service (Hatch *et al*, 2013; Jones *et al*, 2013); however, these samples were constructed primarily with regard to deployable and recently serving cohorts, rather that being veteran specific, and are not representative of the wider veteran population. Furthermore, as personnel are downgraded due to ill-health, it is to be expected that reports of poor health will be more common among those who have been discharged.

Despite difficulties in studying these populations, one study specific to UK veterans of the Gulf and Bosnia eras found 38% suffering from common mental disorders and 13% were identified as having a 'post-traumatic stress reaction' using a measure based on the Mississippi Scale for PTSD (compared with 28% and 5% respectively for those still in service) (Iversen *et al*, 2005a). A separate study of veterans using the APMS ($n = 257$, a heterogeneous veteran sample that included personnel who had left any time between 1960 and 2007, and hence many had been out of service for longer than in the previous study) found 7.6% of male veterans suffering alcohol misuse, 8.5% neurotic disorder and 2.9% PTSD (Woodhead *et al*, 2011). Risk factors for poor mental health among UK veterans include demonstrating symptoms while in service, as well as being unmarried, holding lower rank, experiencing childhood adversity and having a combat role. Of note, however, is that deployment to a combat zone does not appear to be associated with mental health outcomes (Iversen *et al*, 2005b; Jones *et al*, 2013). Veterans are also at risk of reduced levels of social integration compared with those still in service, in that they report less social participation outside of their work. As in other settings, reporting poor social networks is linked to poor mental health (Hatch *et al*, 2013).

Mental health problems may not surface until after leaving service; veterans of recent conflicts in Iraq and Afghanistan who seek help from Combat Stress, the major charitable provider of mental healthcare for veterans, average 2 years between leaving and initially presenting for care (van Hoorn *et al*, 2013). While presentation of late-onset, post-service difficulties may explain some of the difference between veterans and those in service, delayed-onset PTSD appears to be partly explained by prior subthreshold PTSD, as well as other mental health difficulties; furthermore, the study found that delayed-onset PTSD was not associated with leaving service (Goodwin *et al*, 2012).

There is also some evidence that, in the longer term, veterans do not appear to suffer worse mental health than equivalent civilians. A study using the 2007 APMS data on veterans made comparisons between veterans and age- and gender-matched civilian controls and found no

significant differences between them as regards alcohol misuse, neurotic disorders or PTSD (Woodhead *et al*, 2011). However, it is important to note that the sample of veterans in this study was relatively small and did not include many recent service leavers.

Nonetheless, the overall lack of difference between veterans and the general population, despite increased mental health difficulties in those who have recently left compared with their equivalents still in service, suggests that veterans are not at risk of worse mental health and/or that poor mental health is a cause, rather than a consequence, of leaving service.

The role of alcohol

Alcohol appears to play an important, although complex, role in military mental health. Alcohol has traditionally been used to assist unit cohesion (Jones & Fear, 2011) and unit cohesion may protect against mental health problems (Du Preez *et al*, 2012). However, enhanced comradeship comes at the price of higher alcohol misuse (Du Preez *et al*, 2012) and the long history of alcohol use in the UK armed forces (Jones & Fear, 2011) makes effective intervention difficult. While those in service may be capable of functioning at high levels while consuming large amounts of alcohol, the functional consequences for veterans are unknown.

Service provision

Once members of the UK military leave the armed forces, their mental and physical healthcare is provided by the National Health Service (NHS). There are concerns that veterans may 'fall between the cracks', presenting mental health challenges that are outside the expertise of primary care but below the threshold of secondary services, which focus on severe and chronic cases (Macmanus & Wessely, 2013). Charitable providers have expanded to compensate in some regards, but the resulting myriad of providers risks confusion for those who need help. Moreover, knowledge of the veteran charitable sector is lower among younger people in the general population (Gribble *et al*, 2014) and so many at-risk early service leavers, who are largely young adults, are likely to be unaware of the charitable support available to them. Furthermore, fund-raising activities risk portraying veterans as victims. The latter risk has particular consequences, as the manner in which veterans perceive the outside world affects their mental health; PTSD and suicidal behaviour are associated with negative world perceptions, including rejection of civilian life (Brewin *et al*, 2011).

With the Armed Forces Covenant enshrined in law, it is possible that the health of UK veterans will transition away from being embedded within the civilian services provided by the NHS, and towards a model more resembling that of the US Department of Veterans Affairs; however, so far, specific veteran health provision is limited to prosthetics and mental health (Macmanus & Wessely, 2013).

Conclusion

While there is currently no definitive evidence showing that veterans are at an increased overall risk of mental health difficulties compared with civilians, poor mental health may be a factor causing personnel to leave the armed forces. With UK troops about to complete their withdrawal from the highly politicised Afghanistan conflict in the next year, it is likely that their mental health status will remain in the media spotlight as UK society grapples with the effects of significant financial cuts across all aspects of government, including defence and health.

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MENTAL HEALTH LAW PROFILES

Mental health law profiles

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In this instalment of mental health law profiles we travel to two countries which neighbour each other on the west side of Latin America. They have important natural resources and complex histories of indigenous civilisations decimated by colonial conquests, later wars of liberation from the imperial centre and legacies of social inequality and violent internal conflict during the Cold War era. They also differ from each other in important respects, such as levels of ethnic diversity and economic development, Peru being more ethnically diverse and Chile more economically developed. In both countries, the authors inform us, there is cause for concern about the welfare and human rights of people who are mentally ill.

There is an increasing realisation in recent decades of the need for improvement in both Chile and Peru. Both the 1978 American Convention on Human Rights and the Peruvian Constitution (the latter unusually perhaps) make specific reference to mental illness and its management, and provide some welcome foundations to build on. It is good to read that local policies advocate the establishment of community facilities for the care of patients with a mental illness and recognise the importance of least restrictive treatment. However, definitions of mental illness, rights of appeal and engagement of informal carers are unclear or lacking in important respects and offer examples of the magnitude of the task ahead.

The establishment of the National Commission for the Protection of People with Mental Illness (CNPPAEM) in Chile, with responsibility for letting the Court of Appeal know of any violation of the rights of those affected by a mental or intellectual disability, suggests a level of commitment in that society to go beyond policy and towards implementation; this is something that has often been reported as lacking in previous articles on some other countries in this series. The proposed Law 29889 in Peru, as reported here, also offers hope for progress. Those working locally to address shortcomings deserve the active support of the international psychiatric community.

MENTAL HEALTH LAW PROFILE

Mental health legislation in Chile

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Chile does not have a mental health law or act, and no single legal body protecting those deemed to be afflicted by a mental disorder, setting standards of care and protecting and promoting their rights. Instead, pieces of mental health legislation are scattered about in different legal and administrative documents, including the country's Constitution, Health Code, Criminal Code and Civil Code. Remarkably, mental health legislation was the object of virtually no change or amendment from the middle of the 19th century until the year 2001. New pieces of legislation have been issued since but, despite improvements in the protection of people suffering from a mental illness, a mental health law in Chile is still needed.

Chile lacks a specific mental health law that would provide a legal framework for the care of people with mental ill-health. Instead, the country's mental health legislation is scattered across different legal and administrative documents, ranging from the country's Constitution, to the Health Code, the Criminal Code, the Civil Code and other documents. The first legislation regulating the care of those who are mentally ill, issued in 1856, was the 'Mad House Law', which was mostly inspired by a French law of 1838. In 1927 the General Code for the Organisation and Care Provision of Mental Health Services, Hospitalisation and Confinement of the Insane enacted articles 178 and 261 of the National Health Code, regulating both private and public mental healthcare institutions (Vásquez, 1935; Naveillan, 1991). There were no other changes until the year 2001.

Decree 570

In January 2001 the government issued the Code for the Hospitalisation of the Mentally Ill and for

the Appropriate Institutions (Decree 570), which abolished the General Code of 1927. Importantly, since Decree 570 was an administrative presidential act and not a law approved by the national parliament, it operated more like a code of practice.

Definitions

A psychiatric patient is defined as 'a person suffering from a mental disorder who is under the care and supervision of medical services'. Mental disorder is in turn defined as a 'morbid condition affecting an individual in varying degrees, their mental function, organism, personality and its social interaction, either temporarily or permanently'.

Admission

Decree 570 aims to establish a fair and clear decision-making process that takes into account patients' rights. In section II, it specifies that hospitalisation can be recommended only by a medical doctor, ideally the treating physician, who should be an accredited psychiatrist. Section III indicates that the hospitalisation of people with mental disorders should be done in such a way as to minimise the impact upon their personal rights and freedom, and should be undertaken only if they cannot be assessed or treated as out-patients, or if their mental state poses an imminent risk of physical, psychological or psychosocial harm to themselves or others.

In article 10, Decree 570 indicates that admission to hospital can be voluntary or compulsory. There are three types of compulsory hospitalisation: emergency, administrative and judicial.

An emergency admission (article 13) can take place for a period of assessment of up to 72 hours. If further time is necessary but the patient does not consent to it, the treating clinician must inform the respective local health authority, which, within 72 hours, must decide if it authorises what would then be an administrative admission (see below). If it rejects the extension, the patient is discharged from hospital; relatives do not have a formal role in this process.

An administrative admission (article 14) is one in which a health authority authorises the compulsory hospitalisation of an individual who appears to be suffering from a mental disorder but who does not agree to be admitted and who is considered to be a risk to self or others, or who disrupts the public order. This is done at the request of the police, relatives, the treating physician or a member of the public. Administrative admissions must be reviewed every 30 days by another psychiatrist, who must inform the health authority that originally authorised the hospitalisation.

Lastly, a judicial admission is a compulsory admission which has been ordered by the courts in the context of criminal or civil proceedings.

Discharge

Article 41 of Decree 570 indicates that discharge from any compulsory admission will be determined by the health authority that authorised it at the request of the treating physician. Independent legal review by a tribunal is not considered, unless the case is one of judicial admission; again, relatives do not have a role in this process.

Treatment

Decree 570 also regulates hospital treatment. Reversible treatment can be carried out without consent (article 22) only for children (where consent is provided by parents or a guardian) and for elderly people who lack capacity to consent; relatives' consent and the agreement of the director of the hospital is required in these cases. Reversible treatment can also be carried out for unconscious patients, provided that the treatment is required to preserve their life or prevent further deterioration of health, as well as for patients whose compulsory admission has been ordered by a court (judicial admission).

Article 25 indicates that for non-consensual irreversible treatments (e.g. psychosurgery, sterilisation and long-term hormone therapy) all the relevant information must be sent to the National Commission for the Protection of People with Mental Illness (CNPPAEM) at the Department of Health. Between the years 2000 and 2013 a total of 31 cases were referred to the Commission for the consideration of psychosurgery, of which 8 were approved (for obsessive–compulsive disorder). Regarding sterilisations, 63 applications were made between 2003 and 2013, of which 26 were approved.

Decree 570 does not deal with compulsory community treatment or the treatment of people with drug addictions or intellectual disabilities.

Law 20.584

Since July 2012, Law 20.584 has regulated the rights and duties of any person in relation to actions linked to their healthcare. In its paragraph 8, it deals with the rights of people affected by what it calls a 'mental or intellectual disability'. Of note, Law 20.584 does not define with precision the concept of mental disorder; indeed, it seems to conflate mental disorder and intellectual disability.

The relationship between Law 20.584 and Decree 570 is complex, as the latter remains valid and there are areas where Law 20.584 does not provide guidance.

In its article 29 Law 20.584 confirms the role of the CNPPAEM and assigns to it responsibility for letting the Court of Appeal know of any violation of the rights of those affected by a mental or intellectual disability (Box 1). The Commission is to be composed of two members of a mental health professional association, one lawyer, two representatives of a mental health academic association, two representatives of a service users' association, two representatives of a relatives' association and one representative of the health authority.

Regarding access to records and confidentiality, in article 23 Law 20.584 establishes that in

Box 1 Responsibilities of the National Commission for the Protection of People with Mental Illness (CNPPAEM)

- Protect and promote the human rights of people affected by mental or intellectual disability.
- Suggest to the health authority ways of joint working with human rights agencies.
- Monitor invasive and/or irreversible treatments.
- Monitor potential infringement of patients' human rights.
- Monitor deaths during hospital stays.

Box 2 Criteria for compulsory admission

Compulsory admission is indicated if:

- the mental state of the individual poses an imminent risk of harm to him- or herself or others
- the admission has a therapeutic goal
- a less restrictive option is not available
- the patient's views have been considered whenever possible; otherwise, the opinion of the legal representative must be sought.

cases where the medical information is considered harmful for the patient, access to the clinical records can be restricted or denied to the patient but it can be provided to their legal representative.

Article 24 indicates that if a person with a mental disability is unable to give consent to invasive and/or irreversible treatments, an opinion from the local ethics committee should be sought.

Article 25 indicates the conditions required for a compulsory admission (Box 2). In particular, the regional health authority and the CNPPAEM must be informed of all such admissions.

Law 20.584 does not provide specific procedures for the process of discharge from hospital; it mentions only the potential involvement of the Court of Appeal at the request of the CNPPAEM, the patient or legal representative. Law 20.584 provides some guidance regarding indications for physical and pharmacological restraint and confinement; it also mentions the involvement of patients in research.

Areas requiring clarification

The notion of patient capacity is in need of legal clarification. In fact, a procedure for the assessment of capacity to consent to treatment is yet to be defined, so the opinion of the treating physician is not based on an explicit legal test. Similarly, the definition of legal representative remains rather vague, with the risk that, in practice, that role may be allocated to anyone accompanying the patient, even when this is not necessarily in the patient's best interest.

Conclusion

From the year 2000 onwards an awareness of the need for more appropriate mental health legislation started to develop. Decree 570, although far from perfect, was a step in the direction of setting standards of care in hospitals and clinics. Also, since Chile's return to democratic rule in 1990, community mental healthcare has gradually expanded, non-pharmacological interventions have been implemented, and access to medication has improved (World Health Organization, 2007).

Despite these developments, our view is that the care of patients with severe mental illness continues to be marked by stigma, discrimination and, last but not least, abuse due to the lack of a coherent legal framework. In fact, the coexistence of laws and codes whose relationship to each other is unclear may not make the situation better. We believe that modern, rights-centred and evidence-based mental health legislation in Chile is urgently required.

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Mental health law in Peru: work in progress

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Mental health law in Peru is developing. The Peruvian Constitution enshrines important human rights principles in relation to people with mental health problems but the enactment of such principles into national legislation is very patchy. This means that people with mental health problems, especially those admitted to hospital, may not receive optimum care and may be at risk of having their human rights breached. In this article we consider how far the current national legislation meets these constitutional rights and what the legislation that is in development may ultimately achieve.

Mental health law in Peru is developing in the context of changing mental health services. Since 1920, the Peruvian Constitution has enshrined important human rights principles in relation to people with mental health problems, but the enactment of such principles into national legislation is currently patchy. This means that people with mental health problems, especially those admitted to hospital, may not receive optimum care and may be at risk of having their human rights breached. In that regard, Peru is a signatory to the 1978 American Convention on Human Rights.

Here we consider how far the current national legislation meets these constitutional rights and what the legislation that is in development may ultimately achieve.

Overview of legislative developments

Peru does not have a dedicated mental health law at present. Legislation relevant to mental health falls under the General Health Law (Law 26842 of 1979). Article 11 of this law states that every individual has the right to the prevention of mental illness, recovery, rehabilitation and promotion of his or her mental health. The article includes drug and alcohol addictions and domestic violence as mental health problems, in addition to psychiatric disorders. The article makes no provision in relation to involuntary admission to hospital.

In July 2011 a new law (number 29675 of that year) was proposed to amend article 11 of the General Health Law, with the main aim of regulating involuntary admissions. However, it was not adopted as it did not comply with the American Convention on Human Rights.

In 2012 the National Committee of Mental Health attempted to draft a new law (number 29889) again to amend article 11. The law aimed to regulate involuntary admissions, reduce institutionalisation and ensure compliance with human rights. Additional aims included improved prevention and the promotion of mental health. Measures to require local authorities to fund and implement community services were also included. Two types of community home were proposed:

- *casas de medio camino* – rehabilitation care homes promoting the social integration of psychiatric patients
- *hogares protegidos* – for psychiatric patients without families, requiring continuing care but not assessment or treatment in hospital.

Drafts of Law 29889 have been sent back for revision several times by the legislature (most recently in January 2013), because of ongoing human rights concerns.

On 24 December 2012, Congress passed Law 29973, the General Law on People with Disabilities, which reiterates the promotion of mental health and recognises diversity and equality.

Definition of mental disorder

Neither the General Health Law nor the General Law on People with Disabilities has a clear definition of mental disorder; as noted above, article 11 of the General Health Law considers alcoholism, drug addiction and domestic violence to be mental health problems that warrant mental healthcare (voluntary and involuntary), prevention, promotion and rehabilitation. Nonetheless, the DSM-IV criteria for mental disorders (American Psychiatric Association, 1994) are widely applied in Peru.

Grounds for detention

The General Health Law has no provisions for the regulation of involuntary admissions. However, the Constitution of the Republic of Peru does enshrine certain rights for people with mental health problems. Under article 2 every individual (whether or not he or she has a disability) has the right to liberty, deprivation of which is permitted only if an individual has broken a law. Similarly, the 1978 American Convention on Human Rights establishes that no one should be deprived of their liberty, except under conditions legitimately determined by pertinent laws.

In relation to the admission of psychiatric patients, the Constitution protects the rights of patients, requires the delivery of high standards of mental healthcare and distinguishes between voluntary and involuntary admission.

According to article 15 of the Constitution, when a person requires treatment in a psychiatric institution, measures should be put in place to help avoid an involuntary admission. Voluntarily admitted patients must authorise their treatment, and they have the right to leave the psychiatric institution at any time, unless there are sufficient grounds to justify an involuntary detention.

Article 16 determines that a patient can be detained involuntarily only when a physician establishes that this person suffers from a mental disorder and considers that:

- due to the mental disorder, there is an immediate or imminent risk to the patient or others
- the mental disorder is severe and the patient's capacity is affected
- there is the prospect of a significant deterioration in the patient's clinical condition
- the appropriate treatment would not otherwise be given.

Treatment should nonetheless be provided according to the principles of least restriction.

Article 16 also states that involuntary admissions should be time limited and determined by national legislation, and that an independent body should scrutinise the admission.

Article 17 states that patients have the right to ask an independent body to question decisions involving their treatment, and that their admission to the psychiatric institution will be periodically reviewed by this independent body.

Despite the Constitution of the Republic requiring the protection of the rights of psychiatric patients and requiring national legislation to govern this, there are as yet no laws enacted that specifically regulate voluntary and involuntary admission. In addition, an independent body has not been established to review involuntary admissions.

The role of the family and informed consent to treatment

General Health Law 26842 states that people can give informed consent only if they have capacity, have been given information prior to procedures and have not been coerced.

For those who lack capacity, decisions about their care should be made by their family, or in their absence by the appropriately allocated curator (advocate) provided by the Ministry of Justice. The family or curators can discharge patients from psychiatric institutions provided the medical team agrees, but there is no clear legal framework for this, and medical decisions overrule the role of the family or curator when the required treatment is deemed necessary and urgent, to prevent an immediate and imminent risk to the patient or others.

Any treatment can be given to those patients who are admitted involuntarily, without the need to obtain informed consent or other safeguards. This includes mechanical restraint, medication and electroconvulsive therapy (ECT).

Relatives can declare a patient with a mental disorder to be incapacitous (under the 2002 Civil Procedure Law, number 1/2000) and have the power to make decisions for them in relation to their psychiatric care, finance and social care. These powers are not clearly defined, and there is therefore the potential for decisions that may not be in the person's best interests. The proposed mental health law (Law 29889) aims to clarify this.

People with mental health disorders who lack capacity but need continuing care and who are an ongoing a risk to others are entitled to have a guardian appointed, who will be responsible for their well-being (under the 1984 Civil Code, Legislative Decree 295). If the guardian believes a patient needs admission to hospital, an assessment by two independent psychiatrists (or one physician in an emergency) and judicial authorisation are required.

Treatment provisions under the proposed mental health law

Law 29889 will clarify and regulate involuntary admissions, emphasising that these have to be for clinical reasons and never for social problems or abandonment by relatives. It states that treatments should be the least restrictive possible, that the necessary psychotropic medications should be available and that hospital conditions should improve.

Patients must be treated in general hospitals, near their homes, and will be referred to a psychiatric hospital only if a particular treatment is unavailable in the general hospital. General hospitals will have to provide a certain number of beds for psychiatric patients and provide treatment in emergencies.

If a patient lacks capacity to provide informed consent for admission, a medical review body comprising at least two psychiatrists will be able to admit him or her for a maximum of 4 days to an acute assessment unit. A different medical tribunal will then determine whether the patient needs a longer stay.

Conclusions

The Constitution of the Republic of Peru provides a good basis for the development of mental health law in Peru. However, there are currently major gaps in provision, leading to significant human rights breaches. The most important are the lack of a proper procedure to authorise admission, the lack of an appeal process and problems in relation to maximising the potential for people with mental health problems to make decisions for themselves. The Peruvian government is trying to address these issues.

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RESEARCH PAPER

Therapeutic alliance: satisfaction and attrition of patients from a mental health clinic in Ayacucho, Peru

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This study examines the role of the patient–provider relationship (alliance) and patient satisfaction in early patient withdrawal from mental health therapy in rural Peru. A prospective comparison of 60 patients demonstrated that early withdrawal was associated with the clinician's, but not the patient's, evaluation of the patient–provider alliance. This suggests that the satisfaction and alliance questionnaires typically used in high-income countries may not be effective in evaluating patient attitudes in this population, but may be useful for clinician evaluations of the alliance. Clinicians can use the Working Alliance Inventory to indicate the need for early intervention to prevent patient drop-out in middle- and low-income countries.

Early patient withdrawal from mental health therapy is a common problem in middle- and low-income countries (Lhullier *et al*, 2000). Patients who have access to mental healthcare often discontinue treatment before improvement of symptoms and quality of life. Patients who leave therapeutic programmes early have poorer outcomes; therefore, it is essential to find methods to reduce early patient withdrawal (Rossi *et al*, 2008).

Although there are no data for low-income countries, research in high-income countries suggests that 57.6–67.2% of patients will require a minimum of 12.7 sessions of evidence-based interventions in order to recover (Hansen *et al*, 2002). Many patients do not fulfil this minimum, as indicated in a recent review, which found that 20–70% of patients terminate their therapy after the first session, 50% by the third session and up to 65% by the tenth session, giving an overall estimated attrition rate of 47% (Barrett *et al*, 2008).

Premature patient withdrawal results from a variety of factors, ranging from the qualities of the treatment programme to patient and clinician characteristics. Patient characteristics that affect premature termination include gender, age, income level, minority status, substance misuse, occupational stability, psychiatric diagnosis, expectations regarding therapy and academic achievement. Characteristics of the treating clinician that influence premature termination include patient–provider gender match, expectation of patient improvement, empathy for the patient and skill level. Other factors that affect patient withdrawal include the type of therapy (e.g. pharmacological versus behavioural), strength of the patient–provider relationship, length of delay to first appointment and accessibility of clinics. The majority of these factors are cross-cultural and have been found to be important in multiple studies worldwide (Edlund *et al*, 2002; Barrett *et al*, 2008; Morlino *et al*, 2009; Reneses *et al*, 2009).

The strength of the patient–provider relationship we here term *therapeutic alliance*, a concept characterised by how comfortable the patient and treating clinician are with one another and the therapy plan (Martin *et al*, 2000; Santibáñez Fernández *et al*, 2009). This factor has not been well studied outside of high-income countries. The present study explores this aspect as a factor in early patient withdrawal from a rural Peruvian mental health clinic.

Method

Setting and sampling strategy

The study was conducted at a free mental health out-patient clinic in the rural Andes city of Ayacucho, Peru, which serves a low-income population. The study participants consisted of 60 Spanish-speaking patients, aged 18–66 years, completing their first out-patient consultation with a psychologist or psychiatrist. After giving their informed consent, participants completed the Spanish-language client versions of the Working Alliance Inventory (WAI) and the Satisfaction with Services (SWS) questionnaire following their first out-patient therapy session. To prevent biases in questionnaire responses or behavioural changes in attendance, clinicians did not discuss the study with participants.

The participants' treating clinicians (six psychologists and four psychiatrists) completed the Clinician Questionnaire and the Spanish-language therapist version of the WAI.

Three months following questionnaire completion, the participants' attendance at treatment sessions was evaluated through the clinic's database. Participants who did not attend their second treatment session within 3 months of their first therapy session were categorised as *early withdrawers*.

Additional data gathered from patient clinical records included age, gender, religion, income, substance misuse history, occupation, diagnosis and education.

Working Alliance Inventory (WAI)

The WAI is a 36-item questionnaire regarding patient and clinician attitudes to their bond and agreement on goals and treatment tasks (Horvath & Greenberg, 1989). Both the patient and the clinician score each item on a seven-point Likert scale. The Spanish version of the questionnaire (Inventario de Alianza de Trabajo) has been validated by Santibañez (2003).

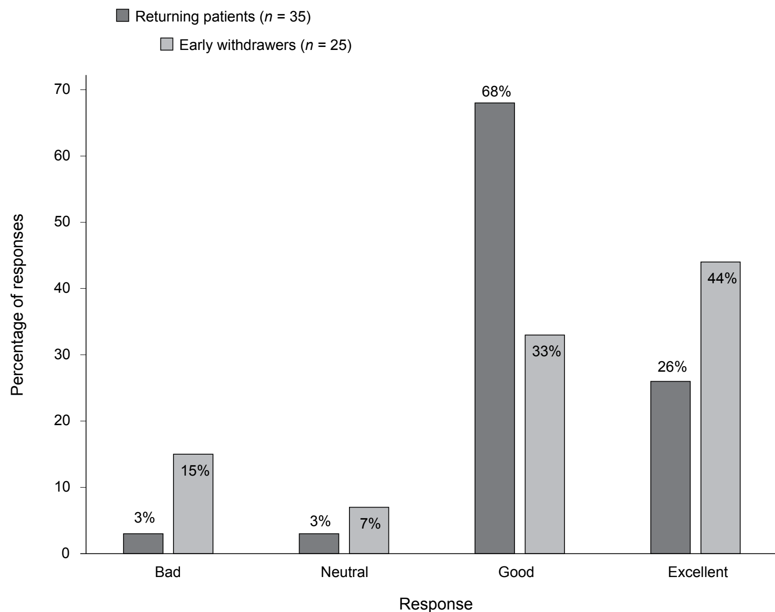

Fig. 1
Patient responses on the Satisfaction with Services (SWS) questionnaire, question 18: 'How would you rate the quality of services you have received?'

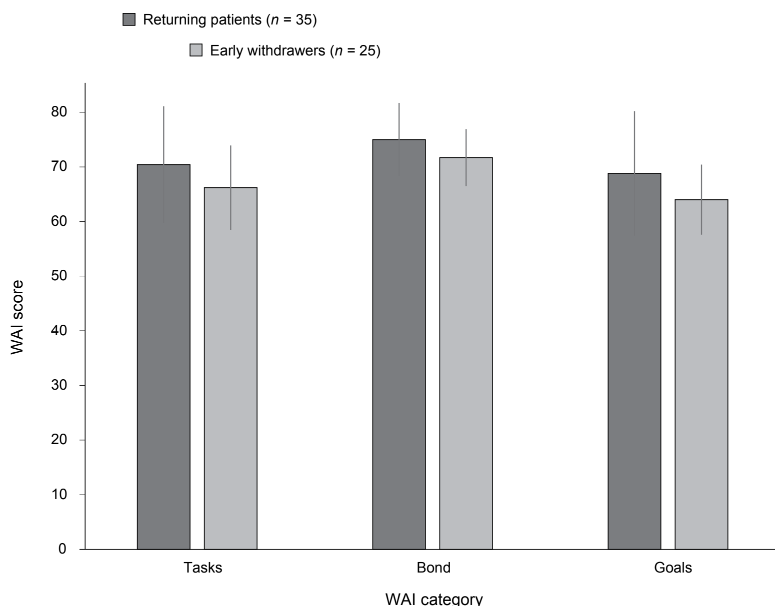

Fig. 2
Clinician scores on the Working Alliance Inventory (WAI) questionnaire, scored in categories of tasks, bond and goals (error bars indicated 1 s.d.)

Satisfaction with Services questionnaire (SWS)

The SWS is a 25-item patient questionnaire developed at Yale University in Spanish (Satisfacción con los Servicios) to evaluate patient satisfaction with clinic services and accessibility. The items are presented as yes/no responses and as five-point Likert scales (Paris *et al*, 2005).

Clinician questionnaire

Clinicians completed a six-question survey that recorded the therapist's gender, age, profession (e.g. psychiatrist), years active in providing therapy, treatment style/theory (e.g. cognitive therapy) and primary language. It was created for the present study to gather basic data.

Statistical analysis

Participant and clinician characteristics and WAI and SWS responses were compared between early withdrawers and participants who attended at least one additional session in the 3 observation months. Statistics were analysed with Spearman's ρ, χ^2 and Wilcoxon tests. Statistical significance was set at $P = 0.05$.

Results

The overall attrition rate for the 60 participants was 42%. No statistically significant differences between groups were found for patient characteristics (age, gender, occupation, income, education, diagnosis and substance misuse) or clinician characteristics (profession, age, gender, years practising, treatment style and gender match with the patient). Participants' level of education was categorised as completion of primary only for 8%, secondary 46% and university 46%. Clinicians had an average of 5.8 years of actively providing therapy, and treatment styles included cognitive, systemic, behavioural, interpersonal, cognitive–behavioural and gestalt therapy.

Only one of the 25 SWS questions had a statistically significant difference in response between groups: 'How would you rate the quality of services you have received?' ($\chi^2 = 9$, $P < 0.05$). Of the returning participants, 68% rated the quality as 'good' and 26% 'excellent'; of the early withdrawers, 33% rated it as 'good' and 44% 'excellent' (Fig. 1).

Participant WAI scores in all three categories (bond, goals and tasks) were not statistically different between groups. However, clinician WAI scores were statistically different between groups in all three categories (Fig. 2): tasks, $F_{1,56} = 4.5$, $P < 0.05$; bond, $F_{1,56} = 5.7$, $P < 0.05$; and goals, $F_{1,56} = 5.7$, $P < 0.05$. There was a correlation between the participant and clinician WAI scores in the category 'tasks' for returning participants only ($\rho = 0.31$, $P < 0.05$), but not for 'bond' or 'goals'.

Discussion

This study provides an initial understanding of factors influencing patient attrition from mental health treatment in middle- and low-income countries. Our examination of early patient

withdrawal indicates an attrition rate of 42% after one session of therapy for this population. This figure is consistent with previous studies in high-income countries indicating an overall attrition rate of approximately 47% (Barrett *et al*, 2008).

The SWS responses were mostly not related to patient attrition. This suggests that satisfaction is not related to premature termination; however, we suspect that the Likert-based questions were unsuited to this population. The only significantly different response between the two groups on the SWS (Fig. 1) was in fact counter to what might have been expected: the early withdrawers rated their satisfaction 'excellent' more often than 'good', whereas the returning group rated it 'good' more often than 'excellent'.

The participants' ratings of patient–provider alliance on the WAI were also a poor indicator of premature termination; there were no differences between groups in the three categories of tasks, bond and goals. However, clinicians prospectively gave early withdrawers lower scores for alliance on tasks, bonds and goals on the WAI after only one treatment session. In addition, the scores of the returning participants were correlated with those of the clinicians in the category 'tasks', suggesting that agreement on treatment tasks may affect patient retention.

These results suggest that satisfaction and alliance questionnaires developed in high-income countries may not be effective in evaluating patient attitudes in this population, but are effective for clinician evaluation of alliance. One factor affecting their effectiveness for patients may be the Likert format of the questionnaires; in the present study this is exemplified by participants responding very positively to most questions and consequently producing an overall ceiling effect for both the SWS and the WAI data.

Another important consideration is cultural values: participants may feel inhibited from reflecting negatively on the charitable services provided by the clinic. Education level should also be considered; however, this likely had minimal impact on questionnaire comprehension, as a large majority of participants had completed at least secondary education. Nonetheless, multiple participants did comment on their unfamiliarity with the Likert-scale format. Given the present results, we feel that further examination is necessary to determine the validity of this questionnaire style for this population.

Additionally, the overall sample size should be kept in mind when interpreting the data, as well as other explanations for early termination, such as the participants' belief that an adequate level of benefit was reached in their first session.

This study does, however, suggest that clinician scores on the WAI can be used in middle- and low-income countries, at least in rural populations, for estimates of patients' likelihood of early treatment termination. Barrett *et al* (2008) provide a thorough summary of effective methods of preventing patient attrition in high-income countries, particularly in relation to patient–provider alliance. The attrition rate in our study and the demonstrated predictive value of the clinician WAI for premature termination are similar to findings in high-income countries. Therefore, we believe that many of the intervention strategies used in high-income countries, as noted by Barrett *et al* (2008), may also be effective for patients in low- and middle-income countries.

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RESEARCH PAPER

Gambling addiction in China: a survey of Chinese psychiatrists

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We studied Chinese psychiatrists' understanding of gambling addiction, as well as their experiences of and confidence in assessing and treating these patients. To this end, we carried out a postal questionnaire survey of 110 psychiatrists working in China. A majority had seen people with gambling addiction in their practice but only 1 of the 110 psychiatrists had ever received any training in the management of the condition. A large majority of psychiatrists indicated that gambling addiction was an important public health problem and 71.8% said they would like to be more involved in its management. Much more needs to be done to improve the identification and treatment of gambling addiction in China.

Gambling as a recreational pursuit is common in most cultures. For most of those who engage in gambling it is merely a leisure activity and never becomes problematic. However, for a minority – 1% of the general population in most Western countries (Shaffer *et al*, 1999) – it develops into gambling addiction or pathological gambling. According to ICD-10 (World Health Organization, 1992), the essential diagnostic feature of pathological gambling is 'persistently repeated gambling, which continues and often increases despite adverse consequences such as impoverishment, impaired family relationships and disruption of personal life'.

Gambling in China possibly dates back to the Xia dynasty (2000 to 1500 BC) (Wu Ping-an, 2006). The prevalence of gambling addiction in China is much higher than in any Western country, at 2.5–4% of the adult population. This is despite most forms of gambling being banned in mainland China, with the exception of state-run lotteries. These lotteries were first introduced in 1987 and continue to generate substantial revenue, which the government uses to fund public welfare activities. However, illegal gambling is very popular in mainland China and it is estimated that the size of the illegal gambling industry is at least 10 times that of legal gambling (lotteries). Given all this, it is surprising that there is very little treatment provision for gambling addiction in China. Indeed, gambling addiction does not have a place within mainstream Chinese psychiatry or even Chinese addiction psychiatry.

In this context, we carried out a survey of 110 psychiatrists in China. We sought to explore their 'exposure' to patients with gambling addiction, their ability to manage them, their understanding of gambling addiction, their perceived role, their confidence in getting involved and their views on commissioning services for gamblers. To our knowledge, this is the first survey of its kind in China.

Method

A brief questionnaire was devised by the authors. It consisted of some demographic questions (age, gender, number of years working as a psychiatrist, etc.), some questions with yes/no answers, some statements with the option of choosing responses from 'strongly agree' to 'strongly disagree', and two open-ended questions. A copy of the questionnaire is available from the corresponding author upon request.

Eighty of these questionnaires were sent to psychiatrists at two psychiatric hospitals in Beijing, and 25 were sent to psychiatrists in a psychiatric hospital in the Guangdong province; another 15 were sent to psychiatrists who were encountered by one of the authors at an academic conference. Completed questionnaires were returned by 110 of these 120 psychiatrists.

Results

The age distribution of the sample was as follows: 31–40 years (35; 31.8%); 41–50 years (60; 54.5%); 51–60 (13; 11.8%); and aged 60 and above (2; 1.8%). Sixty per cent (66) of the sample were men and 40% (44) were women. Table 1 summarises their understanding of the problem of gambling addiction.

Psychiatrists' 'exposure' to patients with gambling addiction

Of the 110 psychiatrists, 61 (55.4%) said they had seen patients with gambling addiction in their practice. The number of such patients seen varied: 41 psychiatrists had seen between 1 and 5; 15 had seen between 6 and 10; and 5 had seen more than 10 gamblers. Equally important was that 50 (45.4%) psychiatrists also said they had seen patients who did not meet the threshold for diagnosis but nevertheless had a gambling problem. Forty (36.4%) of the surveyed psychiatrists said they had seen patients affected by the gambling of a third party.

Psychiatrists were also asked if they had had any training in the management of gambling addiction: only one had.

Table 1
Psychiatrists' understanding of gambling addiction

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
Gambling is an important public health problem	57 (51.8 %)	41 (37.3 %)	9 (8.2 %)	3 (2.7 %)	0
Gambling is an addictive disorder	39 (35.4 %)	52 (47.3 %)	10 (9.1 %)	7 (6.4 %)	1 (0.9 %)
People with gambling addiction have significant psychiatric comorbidity	22 (20.0 %)	53 (48.2 %)	27 (24.5 %)	7 (6.4 %)	0
Undetected comorbid gambling problems can adversely affect mental health	21 (19.1 %)	78 (70.9 %)	9 (8.2 %)	1 (0.9 %)	0
Gambling addiction can negatively impact on family members	62 (56.4 %)	46 (41.8 %)	1 (0.9 %)	0	1 (0.9 %)

Psychiatrists' roles in the management of gambling addiction

In response to the question 'Would you like more involvement in the management of gambling?', 79 psychiatrists (71.8%) said they would like to get involved.

When asked about the feasibility of 'psychiatrists getting involved in the management of gambling addicts', 22.0% strongly agreed, 60.9% agreed, 10.9% neither agreed nor disagreed, 5.4% disagreed and 0.9% strongly disagreed.

Responses to the question 'What would encourage you to get more involved in the management of gamblers?' were: 'more knowledge' (77.8%), 'more training' (7.3%) and 'more resources' (7.3%); some opted for more than one response.

Discussion

Before discussing some of our key findings and their implications, we acknowledge some limitations of our survey, specifically a relatively small sample size ($n = 110$), with its possible response bias. Nevertheless, we believe this survey provides useful information that could inform future plans for engagement of psychiatrists and the implementation of relevant training programmes for psychiatrists. Our findings could also serve as a useful baseline measure of psychiatrists' awareness of and attitudes towards gambling addiction. Yet another shortcoming, potentially limiting the generalisability of our findings, is that this survey was mostly limited to two geographical regions of China (61 of the respondents were working in Beijing and 23 were in Guanzhou). However, in our view, there is nothing to suggest that these Chinese psychiatrists are not representative of the profession across the country.

It was interesting to note that the majority of the psychiatrists (55.4%) had seen patients with gambling addiction in their day-to-day practice, 45.4% had seen patients with gambling problems who did not meet the diagnostic criteria and 36.4% had seen patients affected by the gambling of a third party. This confirms the view that people with gambling problems do present to psychiatrists in China. However, we cannot comment on these patients' reasons for presentation, as this information was not captured in this survey. Despite this 'exposure' of psychiatrists to patients with gambling problems, it was shocking to find that only 1 of the 110 psychiatrists had ever received any training in the management of gambling addiction. This reveals a huge gap between need and provision that requires urgent attention.

Notwithstanding this lack of training, it was encouraging to note that most of those who were surveyed acknowledged gambling addiction as an addictive disorder (82.7 %), as an important public health disorder (89.1%) and as a disorder with important negative consequences. An acknowledgement that gambling addiction is a problem warranting attention is a necessary minimum requirement to incentivise psychiatrists to participate in future teaching programmes. Equally encouraging was the proportion of psychiatrists who said they would like to receive further training in the management of gambling disorders in primary care (71.8%). Furthermore, 83.0% of respondents also felt that it would be feasible for them to be involved in the management of gambling addiction. This presents a great opportunity to introduce programmes aimed at increasing the knowledge of professionals in this neglected area of addiction psychiatry.

Conclusion

We end with a call for more to be done in mainland China to help people with gambling addiction; Chinese psychiatry and its practitioners have an important role to play in driving this agenda forward. Increasing the knowledge of gambling addiction among Chinese psychiatrists through training and teaching may be a good starting point, and here international collaborations will be beneficial.

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SPECIAL PAPER

Mental healthcare in Brunei Darussalam: recent developments in mental health services and mental health law

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Mental health services and legislation in Brunei Darussalam have undergone a period of development and reform. This paper describes the challenges met, recent innovations and priority areas for the next 10 years.

Brunei Darussalam (population 406 000) is a small country in South East Asia. It scores highly on economic, health and social indicators (United Nations, 2013) and is classified as a high-income economy (World Bank, 2014). Mental health services in Brunei started as a single ward in the old general hospital in the capital, Bandar Seri Begawan. In 1984, this was replaced by a bigger hospital, named Raja Isteri Pengiran Anak Saleha (RIPAS Hospital). Medical services are based in this and three other district hospitals, with large out-patient clinics. There is a growing network of primary health centres. Healthcare for citizens and permanent residents is virtually free of charge. Unlike in many other countries, there has never been a large asylum for those with a mental disorder. At the same time, there are no organisations or advocacy groups for mental illness. There is limited understanding of the range and complexity of mental disorders. Traditional and cultural beliefs predominate over a scientific understanding of mental disorders. Stigma and prejudice present a challenge.

Cultural beliefs and attitudes to mental disorder

Mental disorders are poorly understood. Stigma and prejudice against those with mental disorder are pervasive and discourage people from seeking treatment. Mental illness is often believed to be caused by spirit possession and black magic. All mental health problems are thrown into a single category, *gila*, loosely translated as 'crazy'. These people are identified by their observed abnormal behaviour rather than any proper understanding of the causes or features of mental disorders. Unsurprisingly, such conditions are associated with shame and rejection by society.

Relatives often turn to religious and spiritual healers first, and approach hospitals only when the afflicted person becomes violent. Thus many people suffer from a mental disorder for years before they are brought to the attention of health services. Perhaps for these reasons, there are no non-governmental organisations for mental illness, although groups for autistic disorders and children with intellectual disabilities have recently been formed. However, the mental health service receives some assistance from charitable organisations which provide support in terms of volunteers and resources for specific projects. The Department of Psychiatry at RIPAS Hospital runs a family education programme in a community rehabilitation centre in Bandar Seri Begawan, which aims to provide a place where the relatives and carers of people with mental disorders can learn, meet and find support.

Service configuration

Mental health services are all government run and are largely based in the Department of Psychiatry at RIPAS Hospital and in Suri Seri Begawan (SSB) Hospital in Kuala Belait town. A mental health country report on Brunei Darussalam has been published in this journal (Sabri & Khan, 2008).

There has been a period of development since then. There are 32 designated psychiatric beds in the country (20 in RIPAS Hospital and 12 in SSB Hospital), but the ward in RIPAS Hospital is regularly filled over capacity. There are no subspecialty in-patient wards and so all patients requiring in-patient treatment are admitted to the same general wards.

It was clear that new mental health legislation was needed to replace the outdated 1929 Lunacy Act and work on this was started in 2011. Under the Lunacy Act, patients could be involuntarily admitted to hospital. This required a family member or police officer to approach a magistrates' court with an application. This did not require a medical practitioner's recommendation by law, which often caused considerable difficulty in clinical practice. While awaiting improved legislation, a system was introduced in RIPAS Hospital where patients' families are encouraged to take the patient to see a doctor and obtain a written medical opinion before making an application. With this, there has been some improvement in the management of involuntary admissions.

Community mental health teams have expanded. These teams serve each of the four geographical districts, and comprise two to four psychiatric nurses and sessional doctors. The focus of visits is on medication, monitoring of mental state and engaging the patients and their families in treatment. It is common for multiple generations to live together in the same household. There

is a community child and adolescent mental health team, with three nurses supervised by a child and adolescent specialist in psychiatry. There are day-hospital facilities in each district, staffed by nurses, who are often shared with community team services. A community rehabilitation centre is fairly well established in Bandar Seri Begawan.

Referrals are received from primary care doctors or other medical practitioners. The general public can self-present to obtain an appointment, but are encouraged to see a primary care doctor first. There are busy general psychiatric clinics in each of the four district hospitals. In addition, psychiatric clinics have been established in some primary health centres in order to improve the accessibility of psychiatric care and to ease congestion in the hospital clinics.

Referrals for psychiatric reports are received from the police, courts and criminal justice systems. Mental health legislation dealing with offenders with a mental disorder is less well developed than in other modern jurisdictions. The 1951 Criminal Procedure Code addresses 'persons of unsound mind' but contains no definition of such persons. Offenders with a mental disorder requiring assessment and treatment in hospital are brought to general wards under police escort. Patients assessed as being too high a risk to place in the wards are treated in prison, though the prisons do not have medical wards. However, forensic psychiatric clinics have been established in the two national prisons and residential drug rehabilitation centre.

Professional healthcare staff

Human resources and service sustainability are significant challenges. The numbers of professionals working in the health services are presented in Table 1. There are six consultants or specialist psychiatrists working full time, two of whom were newly recruited at the end of 2013. There are eight full-time 'medical officers' or 'senior medical officers' in psychiatry. These are medical graduates with some psychiatric training. The majority of medical staff are foreign nationals who are employed on a 3-year contract.

There is a medical school which offers a pre-clinical undergraduate course. Students are sent overseas to partner institutions in order to complete their clinical training. In recent years, a 2-year foundation training scheme has been set up for returning medical graduates, similar to the UK system. There is an established vocational training scheme for primary care doctors. Both schemes offer 3- to 4-month rotations through psychiatry. There is no established postgraduate training scheme for psychiatry as a specialty. Promising local doctors are sent overseas to train, funded by the government. The Department of Psychiatry at RIPAS Hospital is exploring the opportunities for fellowship or exchange programmes with psychiatric training schemes abroad and is planning to start a higher training programme in partnership with an overseas institution.

There are 50 trained nurses working in mental health. Staff nurses are recruited into psychiatry with a basic general nursing qualification. They may apply to do a diploma in mental health nursing after working in the Department of Psychiatry at RIPAS Hospital or SSB Hospital. Some have the opportunity to be sent overseas or to the local university for further studies. Nurses are supplemented by mental health workers, nursing assistants and attendants.

There are three occupational therapists working in mental health. Psychologists are consulted from the general pool of psychologists in RIPAS Hospital or in the community clinics. There are 'medical social workers' or social officers working in the hospitals. Community welfare services exist but require much development. There are no formal training schemes for clinical psychologists, occupational therapists or social workers. There have been advances in multidisciplinary and multisectorial collaboration; however, this requires urgent development in order to provide fully holistic patient care.

Innovation and commitment

Despite these challenges, Brunei can be a rewarding place to work. In the past year, seclusion, nursing observations, rapid tranquillisation, control and restraint, admission and discharge, and incident-reporting protocols have been implemented on the psychiatric ward at RIPAS Hospital. These are now also being introduced in the psychiatric

Table 1

Numbers of health professionals working in mental health, audited in 2013

Health professionals working in mental health services	Total number	Number per 100 000 population	Median rate per 100 000 across the Western Pacific Region area	Median rate per 100 000 across the world	Median rate per 100 000 across high-income countries
Consultant psychiatrists/specialists	6	1.5	0.90	1.27	8.59
Other medical doctors	8	2.0	0.81	0.33	1.49
Nurses (staff-nurse grade and above)	50	12.5	7.70	4.95	29.15
Occupational therapists	3	0.75	0.00	0.06	1.51
Clinical psychologists	4	1.0	0.00	0.33	3.79
Social workers	0.5	0.125	0.00	0.24	2.16

Median rates are taken from the *Mental Health Atlas* (World Health Organization, 2011).

ward in SSB Hospital. Formal training in control and restraint has been provided to all staff. There are plans to expand in-patient facilities over the next 2 years. Offenders with mental disorders in custodial institutions now have access to in-reach psychiatric treatment.

National delegates were in attendance at the 65th World Health Assembly, which endorsed the Comprehensive Mental Health Action Plan 2013–2020 (World Health Organization, 2013).

The relatively small scale of services in Brunei facilitates change and there is plenty of scope for innovation, with an eye on meeting targets set out by the World Health Organization, in particular the increase of service coverage and community-based holistic care, health promotion across multiple sectors and the introduction of modern mental health legislation.

The expansion of community mental health and rehabilitation services is a priority, in order to shift towards the integration of mental healthcare into non-specialised settings. Mental health clinics have been introduced in primary health centres and more are being planned, with a vision to integrate mental health clinics and rehabilitation/day care into all primary health centres. A new assisted-living unit in the community has been opened in order to provide long-term in-patients with a supported home. Primary care doctors have access to training for the management of common mental disorders and psychiatry is part of the syllabus in the vocational training scheme for primary care doctors. Multidisciplinary mental health teams are being developed with involvement from occupational therapists, psychologists and social workers. The National Health Systems Masterplan includes a strategy for mental healthcare at primary and secondary levels, as well as the establishment of a National Mental Health Institute as a centre for tertiary care, training and research.

To date, there has been little population-based research in mental health. The introduction of an electronic patient information management system in the hospitals and primary care centres in 2013 is an opportunity to start the collection of population-based data. Research and population data are required to inform a National Mental Health Plan to meet the needs of the population over the next decade.

Public education is important, to address stigma against mental disorders and to improve the acceptability of mental health services. The Ministry of Health has a rolling annual programme of mental health promotion forums which are used as a discussion platform for community groups such as village heads, school teachers and students, community welfare workers, community groups and interested individuals. Engaging with partner agencies, community leaders and policy makers can be a useful way to gain support.

In 2014 Brunei chaired and hosted the second meeting of the Association of South East Asian Nations (ASEAN) Mental Health Task Force, a group which works to improve mental healthcare in the region.

Perhaps the biggest body of work to date has been the preparation of new mental health legislation, the 2014 Mental Health Order. This essential legislation replaces the 1929 Lunacy Act and is designed to address the care, treatment, welfare and protection of people with a mental disorder. It has been the result of 3 years of stakeholder consultation and careful redrafting. A national stakeholder's road-show and training programme are underway to prepare for the implementation date of 1 November 2014. This order is unique in that although it is civil legislation, it is also compliant with the principles of Syariah law to ensure consistency across the country's two legal systems.

Conclusion

There is growing recognition of the importance of mental healthcare in Brunei. The establishment of sustainable, modern mental health services is a challenging task that requires innovation and commitment from ground to government level. Consistent leadership, innovation and human resource development are essential.

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Forthcoming international events

13–15 November 2014
World Association of Social Psychiatry (WASP) Jubilee Congress
London, UK
http://www.waspjubilee2014.com/

4–7 December 2014
10th International Congress on Non-Motor Dysfunctions in Parkinson's Disease and Related Disorders
Nice, France
Website: http://www.kenes.com/mdpd2014

10–12 December 2014
IFMAD 2014 – The 14th International Forum on Mood and Anxiety Disorders
Vienna, Austria
Website: http://www.ifmad.org/2014/

12–14 December 2014
WPA Regional Congress, Hong Kong
Hong Kong, China
Website: http://www.wpa2014hongkong.org/index.html

18–19 December 2014
International Conference of Public Mental Health and Neurosciences
Bangalore, India
Website: http://sarvasumana.in/Events/

19–20 December 2014
MacroTrend Conference on Health and Medicine
Paris, France
Website: http://macrojournals.com/paris/health_and_medicine

3–4 January 2015
International Conference On Advances In Economics, Social Science and Human Behaviour Study
Bangkok, Thailand
Website: http://esshbs.theired.org

6–9 January 2015
Annual International Conference on Cognitive - Social, and Behavioural Sciences (icCSBs 2015)
Nicosia, Cyprus
Website: http://www.futureacademy.org.uk/

4–6 March 2015
Faculty of Forensic Psychiatry Annual Conference
Budapest, Hungary
Website: http://www.rcpsych.ac.uk/traininpsychiatry/conferencestraining/facultysectionconferences/forensicconference2015.aspx

5–6 March 2015
Journey to Recovery: The International Conference of Attachment and Trauma Informed Practice
Melbourne, Victoria, Australia
Website: http://www.lighthouseconference.com.au

6–7 March 2015
22nd International Symposium about Current Issues and Controversies in Psychiatry
Barcelona, Spain
Website: http://www.controversiasbarcelona.org/

22–25 March 2015
6th World Congress on Women's Mental Health
Tokyo, Japan
Website: http://www.congre.co.jp/iawmh2015/

7–11 April 2015
17th International Neuroscience Winter Conference
Soelden, Austria
Website: http://www.winterneuroscience.org/2015/

16–18 April 2015
11th International Conference on Psychiatry 'Translational Psychiatry; From Science to Practice'
Jeddah, Saudi Arabia
Website: http://jed.sghgroup.com.sa/

16–19 May 2015
22nd Annual International 'Stress and Behavior' Neuroscience and Biopsychiatry Conference
St Petersburg, Russia
Website: http://www.stressandbehavior.com

19–22 May 2015
Recent Advances in Neuropsychiatric, Psychological and Social Sciences
Athens, Greece
Website: http://www.appac.gr/

3–6 June 2015
17th Annual Conference of the International Society for Bipolar Disorders
Toronto, Canada
Website: http://www.isbd2015.com/

22–24 June 2015
5th International Regional 'Stress and Behavior' Neuroscience and Biopsychiatry Conference (North America)
Miami, USA
Website: http://www.scribd.com/doc/229265453

29 June–2 July 2015
Royal College of Psychiatrists' International Congress 2015
Theme: Psychiatry at the Forefront of Science
ICC, Birmingham, UK
Website: http://www.rcpsych.ac.uk/traininpsychiatry/conferencestraining/internationalcongress2015.aspx

18–22 September 2016
22nd International Association for Child & Adolescent Psychiatry and Allied Professions World Congress
Calgary, Alberta, Canada
Website: http://www.iacapap2016.org

23–25 July 2015
Mind, Value and Mental Health: Philosophy and Psychiatry Summer School and Conference
Oxford, UK
Website: http://www.conted.ox.ac.uk/ppssc1

25–26 July 2015
6th International Neuroscience and Biological Psychiatry Regional ISBS Conference: Stress and Behavior
Kobe, Japan
Website: http://www.scribd.com/doc/192758215

30 August–2 September 2015
9th World Psychotherapy Conference Asia 2015
Kuching, Malaysia
Website: http://counselingmalaysia.com/