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Foreword by: Prof. Kam Bhui, Chair TSIG

TSIG now has a much stronger membership than many other transcultural psychiatry groups. As such, it is well placed to make a major global impact in the coming decade. We continue to contribute to the work of The World Psychiatric Association and World Association of Cultural Psychiatry – meetings are scheduled in Prague in Sept 2008, Firenze in April 2009 and Orvieto in Sept 2009. I recently attended the GLADET conference - the inaugural meeting of the Latin American Transcultural Psychiatry Group. A specialist group has also been established in Russia. These developments make for exciting times.

Nationally, the Delivering Race Equality Programme continues to challenge clinicians and policy makers alike. TSIG continues to support policy and practise to improve the care of socially excluded and marginalised groups where culture is influential in the expression and management of mental distress. We also need to continue work in teaching, training and curriculum development to ensure that cultural competency remains an essential component in the assessment of the clinical competencies of all psychiatrists. Resistance to change has always been a part of our work but I believe that this represents an acknowledgement that our work is being noticed and is having an overall impact.

As I leave office as TSIG Chair, I wanted to congratulate Dr Parimala Moodley for so ably chairing The Special Committee on Ethnic Issues with support from consecutive College Presidents and the CEO. As the working life of SCEI now comes to an end, the legacy of Race Equality is firmly enshrined within College policy. TSIG will need to be ready to assume responsibility for continuing this pioneering work with input from College Officers. The assistance of our Membership is vital to undertake this. Whilst Office bearers change, the business of TSIG must nonetheless continue and I know that our incoming chair, Rizkar Amin, will value the active support of the membership just as I have done.

ETHICAL THINKING: INTERNATIONAL MENTAL HEALTH ACTIVITIES AND COMMUNITIES

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Preamble

Recently a group that was planning to establish an organisation to provide psychosocial services to disaster-affected communities contacted me. They were interested in developing guidelines for how to effectively and sensitively conduct research and services in a cultural context where the organisational team was not intimately familiar with this. They were looking for a document which would lay out practical, clinical and ethical principles in the guidelines, the desired goals of adaptation, translation work and an evidence informed protocol for them to follow to conduct their organisational work in a way which met these goals whilst assuring mitigation of intrusive, offensive or culturally inappropriate activities.

I found that their plans did not refer to local communities. Assuming that the plan was to work with (as opposed to helping) people, then communities need to play a major role in adaptation and translation of research and services. They wanted help in trying to see how to effectively and sensitively to conduct research in a cultural setting. I wondered what made an organisational team ineffective or lacking sensitivity in an unfamiliar culture. This emphasised the need for an organisational team to establish relationships with communities on the basis of trust and honour in developing common ground to work with when dealing with unfamiliar cultures. My suggestion was that their organisation should think about how they could collaborate with local communities to help tap into available cultural knowledge thus strengthening existing community strategies and local capacity.

My knowledge of conflict disaster affected countries, made me think that this organisation might need to consider an internal cultural shift to accept communities as equal agents of positive change or at least in a dialogue to effect change.

This experience led me to consider psychosocial interventions in conflict and disaster affected countries and ethics. I believe that ethics concern how international and national organisations could measure and monitor their “fair and honest dealings” (Kellehear 1993, p14) with the communities in which they work. Also needing to be considered are psychosocial services and research dealing with sensitive issues such as torture, violence and bereavement as this requires reflection, reassessment, awareness to the changing situation and ethical approaches.

Several ethical frameworks have been produced by professional bodies such as British Association for Counselling and Psychotherapy (BACP, 2004) as well as guidelines from Inter-Agency Standing Committee Guidelines on Mental Health

and Psychosocial Support in Emergency Settings¹ (IASC, 2007). There are no monitoring mechanisms for mental health practitioners working in countries affected by conflict and disaster. This has led to a situation where anybody with little or no knowledge about mental health can go into communities to conduct 'psychosocial' activities or programmes.

This paper questions the needs of such standalone activities, the ethics of conducting such programmes in communities and monitoring unethical practices in communities by international mental health experts.

Pageant of Interventions

The existing humanitarian discourse has changed towards the assumption that conflict and disaster affected communities need psychosocial and mental health assistance. According to Pupavac (2001, p.358) "trauma is displacing hunger in Western coverage of wars and disasters". The mental health experts from the West argue that disaster-affected communities, including children, often have negative outcomes - including ill health, loss of motivation, and depression. (Coddington, 1972; Vogel & Vernberg, 1993; and Joseph, Williams & Yule, 1995)

But the real question is "were such communities seeking mental health and psychosocial assistance framed in this way?" The impression gained from field level discussions is that they were not. They did not want counselling; pointing instead to shattered homes and livelihoods. Their children were observed to be sad and some experienced nightmares but were well functioning and keen to have their schools rebuilt. (Personal observations in post-tsunami Sri Lanka, 2004-2005) Surveys from the war affected north eastern Sri Lanka indicate that even people who turned up at mental health centres were primarily concerned with issues like jobs. (Millar, 2005, p.309) Community priorities centred on how to regain their lives and livelihood. A human rights assessment conducted by Action Aid International (January 2006) found that major problems in land, housing, livelihood, discrimination of women and inequity in reconstruction programmes in tsunami-affected countries had persisted. The report notes that "a major effort is required to prevent further abuse of human rights and to correct the wrongs that characterised the first year of the tsunami response [by all parties]" (Tsunami Response: A Human Rights Assessment, Action Aid, January 2006, p.10).

Despite community concerns and longstanding arguments by Summerfield, Hume and Toser (1991,1992, and 2000) about the limitation of Western medical models of mental health, International agencies continue their pageant of psychosocial activity around the world.

"He came in to our village after the tsunami with an assistant. We were told [by the local NGO] that he is a mental health expert from the UK. They said that they are going to treat us with our mental health problems. Then this man sat down in front of my wife and started pointing a finger at her eyes. Yes, we are sad and upset about all what happen. I thought that they are going to help us to re-build our lives, but I got really mad when I saw this strange man pointing a finger at my wife. When I questioned this in an angry

¹ Ceased to exist by the end of 2007

tone, the translator said that my anger is the mental health problem and I need special support. What nonsense? I asked them to leave my place immediately.”

A fisherman from tsunami affected Eastern Sri Lanka (Direct Discussion with the Author), October 2005ⁱ

The above example about a tsunami affected area shows how people were offered psychotherapeutic tools without much explanation. Further discussion between the author and the fisherman revealed that the western mental health expert and his assistant were trying to use EMDR (Eye Movement Desensitization and Reprocessing) Therapy for his wife. Scholars such as Ashcroft, review the personal and moral qualities of the practitioner, stressing the role of the personal dimension and the quality of the relationship in therapy. Further, Ashcroft (2001;10) states “Counselling and psychotherapy are thoroughly ethical activities, in the deepest sense of the term ‘ethical’. They are concerned with the process of discovering the good life”. However, the statement by the Sri Lankan fisherman does not tally with this ethical sense explained by Ashcroft.

“One morning a team of ‘psychosocial specialists’ came to our camp. We were told that they are from the US and here to help us to provide psychosocial activities. All of us gathered in the community hall and through translation they told us the importance of sharing our sadness and grief about our losses from the tsunami. Then the man and the woman who came from the US started hugging us. I felt very uncomfortable and irritated. During the tea break I went home and told my mother and she told me to keep away from them”

A teenage girl from tsunami affected Eastern Sri Lanka (Direct discussions with the author), October 2005ⁱⁱ

It was revealed that the ‘psychosocial experts’ had come from the US and had little concept about boundaries in Sri Lankan culture. Although it may be comforting to hug a person who is sad or grieving in the US even when one is not personally acquainted with them, the Sri Lankan culture in general does not allow for the hugging of strangers. The APA Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations (1990)² specifically mention the need for service providers to consider diversity of values, interactional styles, and cultural expectations in a systematic fashion within a psychosocial cultural framework. Knowledge and skills for multicultural assessment and intervention need to include abilities to:

1. Recognize cultural diversity;
2. Understand the role that culture and ethnicity/race play in the socio-psychological and economic development of ethnic and culturally diverse populations;
3. Understand that socio-economic and political factors significantly impact on the psychosocial, political and economic development of ethnic and culturally diverse groups;
4. Help clients to understand/maintain/resolve their own socio-cultural identification and understand the interaction of culture, gender, and sexual orientation on behaviour and needs.

² Public Interest Directorate, American Psychological Association, <http://www.apa.org/pi/guide.html>, approved by the Council of Representatives in August of 1990 during the 98th Annual Convention in Boston, Massachusetts

There are many similar guidelines and ethical frameworks in the US and Europe. However, it seems to me that none of these are being practiced or monitored in the field. An additional complication is that local practitioners who receive training from Western experts, start to think as counsellors or psychotherapists rather than concentrating on the urgent psychosocial needs of themselves and their communities.

"I received two weeks training from the psychologists from the head quarters of my organisation [a European based NGO] about a year ago. This training mainly focused on how raped or torture victims can express their feelings and how counsellors like me can help them to get in touch with their feelings. This is a rewarding job and all most all the women I come in to this counselling room freely talk about their feelings and cry. But the real problem is men. They don't cry and do not like to talk about their feelings and emotions."

A Sudanese Counsellor from Garsilla, Western Darfur
(Direct Discussion with the Author), May 2005ⁱⁱⁱ

The counsellor from Sudan is not alone in this confusion.

"I became the senior counsellor of my organisation [an Australian based NGO] after receiving three and half weeks training in South Africa on counselling refugees in 2002. The trainers are from the US and Australia. I had some previous training on counselling when I trained as a social worker in the US in 1987. My counselling work is mainly for female refugees who have been abused, raped and tortured. But the problem is that most of them do not want to share their stories with me. They want me to help them financially or get access to other services. Rarely do they discuss about feelings or emotions. I get tired about their financial or service requests and they get angry with me as I push them to express their feelings and emotions. This is a very difficult job"

An Urban Counsellor from Lilongwe, Malawi
(Direct Discussion with the Author), October, 2006^{iv}

Most field practitioners seem to receive two to three weeks counselling training before being sent to countries like Sri Lanka, Pakistan or Jordan. This is very different from UK practise where members of the British Association for Counselling and Psychotherapy³ (BACP, 2008) are required to successfully complete a one year full time or two year part time counselling/psychotherapy course. This course includes supervised placements. US members of the American Psychological Association⁴ (APA, 2008) need to have a doctoral degree in psychology or a related field from a regionally accredited graduate or professional school or a school that achieved such accreditation within 5 years of the doctoral degree (or a school of similar standing outside of the United States). These membership organisations demand continuing professional development, ethical supervision and monitoring as well as opportunities to meet peers from the field.

"After receiving a two and half weeks training, my organisation promoted me as the senior counsellor of the organisation [a US based NGO] in 2001. Since then I have participated in three more one week trainings. I am suppose to train new counsellors, supervise them and provide them support when they have difficulties. But I do not have

³ http://www.bacp.co.uk/join_bacp/membership_categories/ind_membership.php

⁴ <http://www.apa.org/membership/join/html>

any of that. Since Iraqi refugees start coming in again my workload has gone up and it pushed me to work more than 18 hours per day. I learn new skills and concepts through reading books I buy through the internet and when I meet people like you from outside. Regarding my personal life, I have minimum time for my wife and no time to spend."

A Senior Counsellor in Amman, Jordan
(Direct Discussion with the Author), November 2007^v

This shows that the lack of ethical supervision, training and monitoring in the field. Action Sheet 4.3 of the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings (Organise orientation and training of aid workers on mental health and psychosocial support, 2007, p.81) states that "essential teaching may be organised through brief orientation and training seminars followed by ongoing support and supervision. Seminars must accentuate practical instruction and focus on the essential skills, knowledge, ethics and guidelines needed for emergency response." Although this document has been agreed by most international players on mental health and psychosocial support, the reality in the field is very different.

These discussions with practitioners in the field reveal that this training has made them believe that expressing feelings and emotions is the best remedy. Summerfield (1995, p.06) White and Marsella (1982) noted that the use of 'talk therapy' aimed at change through gaining insight into one's psychological life is firmly rooted in the Western concept of a person as a distinct and independent individual capable of self-transformation in relative isolation from the social context. But the cultures of Africa, Asia or the Middle East do not embody an individualistic perspective of life. People in these regions always identified themselves in relation to other people in society. This community centred view of life seems to be in contrast with the Western view of individual self.

Existing Efforts and Failures

During 2007, an effort was made by the Inter Agency Task Force to field test the guidelines on Mental Health and Psychosocial Support in Emergency Settings in Sri Lanka.

"The workshop was filled with presentations and should have done in a more participatory manner. I don't think that one could become really qualified to implement even parts of these guidelines after a two days workshop. Also, they expect us to give feedback about the effectiveness about these guidelines within two or three months. Well, this is too much pressure and rushing. There were no discussions per say about how Sri Lanka could adopt these guidelines in to local realities. Then the workshops they conducted in local languages had so many errors with bad translations. I think that this will not produce anything effective as there is no support mechanism in Sri Lanka to assist field level problems and I am not aware about any monitoring process"

A Sri Lankan UN staff member that work on mental health
(Direct Discussion with the Author), March 2007^{vi}

The IASC Task Force on Mental Health and Psychosocial Support in Emergency Settings ceased to exist at the end of 2007 and hoped that the agencies would continue to work together to strengthen these guidelines (Van

Ommeren, 2007, public e-mail)⁵. However, field reality has not matched this hope.

"We don't like the way this Working Group has been functioning. Two months ago it was one international agency that was chairing this and today we realised that there is a UN agency that is co-chairing this without consulting us as members. Then they are giving us orders on how to conduct our own projects and activities. We are going to leave this Working Group and continue to do our own activities as we used to do"

An International Agency representative about the Psychosocial Working Group in Jordan
(Direct discussion with the Author), November 2007^{vii}

At a local level there are many issues among humanitarian agencies working together. "Individual and international nongovernmental agencies bring their own missions and organisational strategies to their aid efforts and their managers and leaders quite naturally find it difficult to see the world through other lenses than those perspective supplies" (Scott, 2003; Quoted by Stephenson and Kehler, 2004, p.04) Further, "Donor behaviour currently represents a patchwork of policies and activities by individual governments which, taken together, do not provide a coherent or effective system for financing the international humanitarian enterprise." (Smillie and Minear, 2003, p.01) These differences and policy issues in the humanitarian sector create a situation where agencies do not necessarily work together. My own experience is that soon after the tsunami, many agencies in Sri Lanka did not want to co-ordinate their activities with those of the UN or other agencies. The problem is that anyone who claims to be an 'expert' in mental health and psychosocial issues could conduct whatever research they wish at a community level. However, the communities could suffer far more through these activities than the catastrophe they experienced.

These un-coordinated and unethical interventions in the field often included 'counselling sessions' or 'therapeutic activities' for survivors of the disaster by unknown international experts and poorly trained non-governmental organisation (NGO) staff and volunteers, despite the limited supportive evidence of efficacy of immediate post-disaster critical incident stress debriefing (Gray, Maguen & Litz, 2004).

"The foreigner who came to our camp asked all of us to list down our problems after the tsunami. We listed things like schools, education, housing and difficulties in this camp. After listening to us he said that we have mental problems as we do not want to discuss our feelings. He wanted to us to talk about our mental problems. We could not understand any of that and we left the foreigner and his workshop"

Teenage girl from Tsunami Affected Western Province in Sri Lanka
(Direct Discussion with the Author), March 2005^{viii}

Summerfield (1999) believes that it is common for International agencies and experts to expect disaster affected people to have emotional problems rather than practical problems.

⁵ Van Ommeren, Mark, Launch of IASC Guidelines: Thank you to all reviewers, IASC Task Force on Mental Health and Psychosocial Support in Emergency Settings, Group E-mail on 08

"The foreign woman who came with a translator asked me what my problems are. So I said that I want to go to school and there is no proper schooling in this village. Also, I said that my sisters and brothers do not have enough food as my parents do not have work to make enough money for food. But she kept asking me whether I have been raped or abused. When I said no, she told me that if I ever get raped or abused they are there to help me. I am really confused about this as why can't they help us now?"

Teenage girl from Umkher, Western Darfur in Sudan
(Direct Discussion with the Author), May 2005^x

Conclusion: Morals, Ethics and Question

Morals are the base of ethics. Kleinman (2006) states that this does not mean that morals are always good or positive. But different communities, countries and institutions have different moral values and ethical frameworks that others could consider as negative or bad. As discussed, when it comes to international mental health activities, these become the universalised expectations of international agencies and experts. This creates problematic, unacceptable and unethical situations in the field. Beyond that, local practitioners get confused and communities become weary of international mental health activities when their need to survive is paramount.

Different ethical frameworks are based on available morals and may not necessarily be universal. In many ways, this can be similar to justice. One person's justice can be other person's punishment. Equally, approaches that may be suitable to Western settings are not necessarily suitable in non-western community settings. Kleinman (2006, p.02) argues that, "...what looks so wrong from outside may not look that way from the inside". Most mental health experts visiting disaster and conflict affected countries without knowledge of local traditions and culture judge communities from the outside. Clearly this is unacceptable.

In conclusion this article raises the following question for research and policy discourse:

1. What is the real need for standalone international mental health activities in disaster and conflict affected communities?
2. How to develop flexible and sensitive ethical frameworks for such work?
3. What is an effective approach to monitor international 'experts' going to the field and how does one prevent unethical activities?

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i The Community Mental Health and Wellbeing Programme of Disaster and Development Centre was working in Sri Lanka in collaboration with the Green Movement of Sri Lanka on damage assessments, emergency food, shelter and medical assistance and long term housing, livelihood and social re-building between December 26, 2004 to March 2006.

ii The Community Mental Health and Wellbeing Programme of Disaster and Development Centre was working in Sri Lanka in collaboration with the Green Movement of Sri Lanka on damage assessments, emergency food, shelter and medical assistance and long term housing, livelihood and social re-building between December 26, 2004 to March 2006.

iii Partnership activities between the Community Mental Health and Wellbeing Programme of Disaster and Development Centre with UN Refugee Agency in Western Darfur, April to July 2005

iv Partnership activities between the Community Mental Health and Wellbeing Programme of Disaster and Development Centre with UN Refugee Agency in Malawi, August to November 2006

v Partnership activities between the Community Mental Health and Wellbeing Programme of Disaster and Development Centre with UN Refugee Agency, October to November, 2007

vi Discussion with a former colleague who is now working for the UN, March 2007

vii Discussion with a participant of the Psychosocial Forum in Jordan, November 2007

viii The Community Mental Health and Wellbeing Programme of Disaster and Development Centre was working in Sri Lanka in collaboration with the Green Movement of Sri Lanka on damage assessments, emergency food, shelter and medical assistance and long term housing, livelihood and social re-building between December 26, 2004 to March 2006.

ix Partnership activities between the Community Mental Health and Wellbeing Programme of Disaster and Development Centre with UN Refugee Agency in Western Darfur, April to July 2005

RACE EQUALITY ACTION PLAN: IMPLICATIONS FOR GENERAL ADULT AND COMMUNITY PSYCHIATRY

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Introduction

The Royal College of Psychiatrists was named in the Race Relations (Amendment) Act 2000 as a public authority with a general duty in respect of Race Relations. The College took this role seriously by establishing a Race Equality Statement of Intent (RESI). This led to the Race Equality Scheme (RES) with implementation through the College's Race Equality Action Plan

(REAP). This was developed with assistance from the University of Central Lancashire and monitored by the College's Special Committee on Ethnic Issues (SCEI) Moodley et al (2005). The implications of REAP on General Adult and Community Psychiatry is reviewed in this paper.

Background

Since 1971 the UK population has increased by 8%. In 2001 the Black and Minority Ethnic (BME) population stood at 4.6 million (7.9% of the total UK population). At 2%, Indians constituted the largest group, followed by Pakistanis, then those of Mixed ethnic backgrounds, then Black Caribbeans, Black Africans and Bangladeshis. The remaining BME groups together accounted for a further 1.4% of the UK population. London has the highest proportion of BME people. Black Caribbeans constitute more than ten per cent of the population of the London boroughs of Lewisham, Lambeth, Brent and Hackney. Leicester has the highest proportion of Indians (25.7%) Census (2001).

The first major national study of prevalence of mental health problems in BME people found significant variations in severe mental health problems. Black Caribbean people showed a two fold excess, Pakistani people had a 60% higher rate whilst Bangladeshi people had a 25% lower rate. There were no apparent gender differences Empiric (2000). The 2007 'Count Me In' census confirmed these differences. Overall, the findings were similar to those of the 2005 and 2006 census users, i.e. admission rates were higher for BME groups except for Indian, Pakistani, and Chinese people. Especially high rates of admission were noted amongst Black Caribbean, Black African, Other Black, White/Black Caribbean Mixed and White/Black African Mixed groups. These groups also had consistently lower than average rates of referral via GPs and to community mental health teams. These groups also demonstrated the highest rates of referral through the criminal justice system in each census. Overall, higher than average rates of detention persisted among Black Caribbean, Black African and Other Black groups. Detention under Section 37/41 (imposed by courts) was also consistently higher in the Black Caribbean and Other Black groups, Count me in (2007).

Key Issues

Language and Communication Barriers

This can create difficulties for BME people when accessing as well as continuing mental health care. This reduces opportunities for appropriate and relevant two-way interaction. The 'Good Medical Practice' document confirms that: "to communicate effectively, you must make sure, wherever practical, that arrangements are made to meet patients' language and communication needs", GMC (2006). Patients with limited English proficiency who do not have access to interpreter services end up with more medical tests, with higher costs and longer periods of hospitalisation, Cochraine (2007). A recent US study worryingly demonstrated a greater level of adverse effects in hospital patients

with limited English proficiency. This study emphasised the important role of providing competent language services, Divi et al (2007). The December 2006 BBC report 'Cost in Translation' prompted the Government to review the availability of language services. Any reduction in the availability of language resources undoubtedly adversely affects equality in accessing health care, especially mental healthcare.

Racial Discrimination

This is defined by the UN as "any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life", Convention (1966). The link between Race and Mental Health is a complex one. This has generated considerable debate including whether racial discrimination exists in the mental health services and whether the system is institutionally racist. Irrefutable statistics demonstrate that:

- there is an overrepresentation of Black and Caribbean men in the mental health system.
- there is an increased prevalence of depression in South Asian and African – Caribbean people.
- there is a higher rate of suicide in South Asian women.

The Fourth UK National Survey of Ethnic Minorities provided evidence of a cross-sectional association between interpersonal racism and mental illness, Kennedy et al (1997). A recent US study found that community-level racist attitudes could be related to mental illness for BME groups, Karlsen et al (2002). The existence of institutional racism was formally acknowledged in the Macpherson (1999) report. The report into Tony Bennett's death concluded that local Mental Health Services had been institutionally racist, Bennett (2003). This led to the Government publication of an action plan for delivering race equality (now known as DRE).

Kwame McKenzie went further by arguing that if racism was causing mental illness in BME groups, then a public health approach might be best equipped to counter this. An acknowledgement and better understanding of institutional racism in psychiatry needs to take place. This should lead to improved and focused services in areas such as housing, benefits and education. This public health approach will lead to concerted secondary and tertiary prevention, McKenzie (2002). A systematic review by Bhui et al found that Black people are over represented as mental health inpatients and that their pathway of care to specialist services was more complex, with crisis routes of entry into care being much higher, Bhui (2003).

Researchers continue to investigate social and biological associations as well as the conceptual framework of modern psychiatry, Fernando (1988), to try to make some sense of these issues.

Mental Health Act Admissions

This totalled 43% in 2007, 40% in 2006 and 39% in 2005. This represents a year on year increase. The 2007 "Count Me In" census also reported higher than average rates of detention (38%) among the Black Caribbean, Black African, Other Black and White/Black Caribbean Mixed groups when compared to non BME groups (19%). Even though the Code of Practice for the Mental Health Act 2007 is not yet available, Lee Jasper, Chair of the African Caribbean Mental Health Commission, said that "it will inevitably lead to an increase in the number of Black men who find themselves sectioned under the Mental Health Act as this new law allows many more health professionals to authorise forced detention. This adds up to licensed discrimination under mental health service provision. Despite calls by many organisations such as Black Mental Health UK, The Black Police Association, ACEA etc the Mental Health Act (2007) has not addressed their concerns. Hardly surprising then that the coalition of 75 organisations forming the Mental Health Alliance described this legislation as a 'missed opportunity'.

Staff training and development

Though ongoing training of psychiatrists and trainees in racism and cultural diversity together with its impact on mental health and mental health services is encouraged, there is little information available on these issues in mainstream psychiatric textbooks. The training manual in cultural capability for use both in the MRCPsych education programme and for continuing professional development (being produced by Prof. Richard Williams and Dr Parimala Moodley) should go some way in redressing this imbalance. PMETB specifically reviews equality issues in training and education. This should help to firmly establish the importance of these issues in the training of all psychiatrists.

Conclusion

As general adult and community psychiatry is the largest Faculty in the College, the impact of REAP on our practises is significant. It behoves us to deliver appropriate and adequately resourced services valued by users and carers alike. To do this, service must meet the needs of all the communities we serve. One way of doing this is promoting cultural capability of the workforce. Ongoing research will help to fine tune this approach. There has never been a better time than now to do so to best meet the needs of our patients and their carers. As general adult and community psychiatrists we owe this to our profession and to our patients.

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HOW SCIENTIFICALLY VALID IS THE KNOWLEDGE BASE OF GLOBAL MENTAL HEALTH?

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Global mental health now has its own academic units, literature, study, and training courses and the World Health Organization is a major articulator of this work. Last September, a series on global mental health in the *Lancet* asserted that mental disorders now represent a substantial "though largely hidden" proportion of the world's overall disease burden, that every year up to 30% of the global population would develop some form of disorder, and that there was strong evidence for scaling up mental health services worldwide.^{1 2} In this article I examine the evidence for these claims and challenge the assumption that Western frameworks can generate a universally valid knowledge base.

Classification and diagnosis

Psychiatric research and practice rest on empiricist convention rather than on timeless discovery. The principal classification systems, the *International Classification of Diseases (ICD)* and the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, are shaped by contemporary notions about what constitutes a real disorder, what counts as scientific evidence, and how research should be conducted. They are Western cultural documents par excellence.³ The diagnostic categories within these classifications are essentially conceptual devices emerging from committee decisions. The authors of both of these

classifications are careful to point out that "there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries dividing it from other mental disorders or from no disorder."⁴ Despite this, in everyday practice these categories have been effectively accepted as if they were unequivocal diseases like, say, tuberculosis.

Claims for the universality of a particular psychiatric category would be compelling if a straightforward biological cause had been established. But this is the case for only a few categories in the Western psychiatric canon. Official psychiatric categories evolve, disappear, or appear, reflecting Western social and cultural trends as much as medical thinking. For example, DSM-III, published in 1980, expunged homosexuality as a classified mental illness and installed post-traumatic stress disorder for the first time. It would be extraordinary if these classification systems made sense across the great diversity of societies and situations worldwide.

Validity in mental health research

The psychiatric literature contains large numbers of studies of non-Western subjects, and publications on refugees and populations affected by disaster rose exponentially during the 1990s.⁵ However, in a review of 183 published studies on the mental health of refugees, four fifths of the studies relied exclusively on measures of psychopathology developed with Western populations.⁶ Although a few researchers have sought to garner culture specific information, they too have retained Western psychiatric categories as their basic template.^{7 8}

The relevance of much of this published literature is therefore questionable because it fails the fundamental test of scientific validity. Validity is a concept meant to assess "the nature of reality" for the people being studied. Methods for research into the mind cannot rely on the merely technical and quantifiable, since "the nature of reality" is bound up with local forms of knowledge and philosophy. To ignore the test that follows – whose reality, whose knowledge, whose philosophy – is to risk pseudodiagnoses and interventions that are an unwanted distraction in the hard pressed lives of non-Western subjects.

It is telling that published studies of non-Western populations often refer to participants' "limited knowledge of mental disorders," their lack of "mental health literacy," or the need to "teach" health workers and the people they serve about mental health. Here Western psychological discourse is setting out to instruct, regulate, and modernise, presenting as definitive the contemporary Western way of being a person. It is unclear why this should be good for mental health in Africa or Asia. This is medical imperialism, similar to the marginalisation of indigenous knowledge systems in the colonial era, and is generally to the disadvantage of local populations.^{9 10}

Cultural variability of mental disorder

Many ethnomedical systems have categories that range across the physical, supernatural, and moral realms and do not conceive of illness as situated in body or mind alone.¹¹ Distress is commonly understood and expressed in terms of disruptions to the social and moral order. As Kleinman and Good put it, "Cultural worlds may differ so dramatically that translation of emotional terms means more than finding semantic equivalents. Describing how it feels to be aggrieved or melancholic in another society leads directly into an analysis of a radically different way of being a person."¹²

Since the 1970s many ethnographic studies have shown that the presentation, attribution, classification, prevalence, and prognosis of mental disorders varies greatly between cultures. Journals such as *Social Science and Medicine*, *Transcultural Psychiatry*, *Anthropology and Medicine*, and *Culture, Medicine and Psychiatry* are replete with this work. However, it is under-represented in the mainstream psychiatric literature, which tends to overemphasise cross-cultural similarities and minimise the differences.¹³

Depression as an example

WHO has stated that "depression" is a worldwide epidemic that within a decade will be second only to cardiovascular disease in terms of global disease burden. But it is a basic error of validity to assume that because Western mental phenomena can be identified in non-Western settings, they mean the same as they do in the Western world. Some central and southern African societies recognise a local condition - often translated as "thinking too much" – which has some physiological overlap with Western depression, but the understandings, attributions, and remedies applied to it are very different.

As discussed above, the DSM or ICD definition of depression is merely a descriptive syndrome, highly heterogeneous and socially shaped, albeit subsuming a small subset of severely dysfunctional people who do fit the model of depression as a disease. This term simply cannot be used (as WHO uses it) to denote a universally valid mental disorder that is amenable to a standard mental health toolkit.¹⁴

A meta-analysis of 56 published studies of refugees' mental health totalling 67 294 participants found the strongest moderating factor to be social conditions after displacement.¹⁵ Resolution of the conflict that had displaced them also had positive effects. This suggests that the mental phenomena being identified as satisfying criteria for a mental disorder (typically depression or post-traumatic stress disorder) were mostly incidental and a normal reaction to their circumstances.¹⁵ My research and clinical experience in war affected rural Zimbabwe, with rural peasants and wounded former soldiers in Nicaragua, and with HIV positive African women and other asylum seekers in the United Kingdom indicated that a diagnosis such as depression, although commonly made, had little power to explain their problems.^{16 17}

Lastly, WHO is backing the global application of technologies like checklists to estimate population prevalences of depression and the therapeutic value of antidepressants or counselling when the strength of their evidence base even in Western societies remains controversial.¹⁸

Mental health in a broken social world

Social scientists agree that wellbeing and personal resilience are linked to social connectedness and the sense of a coherent world. Throughout the non-Western world, structural poverty and injustice, violent conflict, debt repayments, shifting weather patterns, environmental degradation, and inadequate budgets for health, education, and social welfare provide a barely viable social context for millions of people. Around 85% of Kenya's population growth in the 1990s was absorbed into the slums of Nairobi and Mombasa, reflecting a rapid withering of traditionally self-sufficient ways of life.¹⁹ Average life expectancy is falling in many countries, and one third of the world's children are undernourished. Can psychiatric approaches honed in relatively well-resourced and stable societies distinguish mental disorder from normal responses to a social world that is no longer coherent or functional? The danger of the medicalisation of everyday life is that it deflects attention from what millions of people worldwide might cite as the basis of their distress - for example, poverty and lack of rights.

Valid assessment

Until these fundamental queries about the knowledge base are answered, claims about the current state of global mental health seem risible. There needs to be agreement that Western psychiatry is but one among many ethnopsychiatries. New research ideally needs to engage with participants in a way that carries no preformed notions about what is "mental" or "health" in their world: local concepts must be the starting point for the creation of valid instruments for screening or diagnosis.

The so-called common mental disorders, such as post-traumatic stress disorder and depression, have strongly featured in the research literature to date, but there are reasons to query how much the impetus for this has come from those on the ground, as opposed to interested parties from outside. WHO's prevalence figures lack credibility and would seriously mislead health planners and providers.

Research into more severe mental disorders is on firmer ground. These disorders are much more likely to have a neuropsychiatric component and to stretch local social and healthcare resources. Based on a survey of 2739 households, Patel and colleagues estimated standardised prevalence ratios of psychosis (2.79), learning difficulties (1.48), and seizures (2.00) (seizures are commonly seen as a mental disorder in much of Africa) in rural and urban Mozambique.²⁰ Psychosis would not of course be a homogeneous category, since it would subsume various organic cerebral states that merited attention in their own right – not least AIDS encephalopathy or dementia.

An emphasis on qualitative work would promote more grass roots ownership of the terms of reference of mental health and enable a robust and relevant knowledge base to emerge. The apparent failure of the £1.1 trillion spent on development aid in Africa over the past 50 years to change anything is partly because donors lacked knowledge of the situations on the ground in poor countries and because of over-reliance on expensive consultants from donor countries.²¹ Local voices were weakly represented. This poses an ethical challenge for global mental health: non-Western people can give properly informed consent only if the terms in which they are being represented, which here means candidature for psychiatric caseness, are not alien or irrelevant to their interpretations of the world.

Contributors and sources: DS has studied, lectured, and published widely on health and human rights in Africa, Central America, and the Middle East, particularly in war affected populations and on asylum seekers in the UK. He is also a teaching associate at Refugee Studies Centre, University of Oxford.

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The Contribution of Section 12(2) Courses to the Understanding of Black and Ethnic Minority Issues

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As a trainee Psychiatrist, one learns the importance of ensuring that cultural issues are foremost when assessing patients though this can sometimes be taken for granted. There is evidence to suggest that ethnic bias exists in the application of the Mental Health Act, 1983. Black people on inpatient units are four times more likely to have been compulsorily admitted than White people (Bhui et al 2003). Compulsory admissions to secure units are 2.9 – 5.6 times higher for Black patients than for White patients (Dein et al 2007).

I attended Section 12(2) induction training in September 2007. The course material made reference to the current Code of Practice, which states that information should be gathered about the patient's social and family circumstances, what is known about the patient by their nearest relative, relatives, friends and professionals (Code 2.6). This highlights the need to gather collateral information including the clarification of beliefs and practices prevalent in their community.

There was a brief section on the European Commission for Human Rights. Article 5.2 states, 'Everyone who is arrested shall be informed promptly, in a language which he understands, of the reasons for his arrest and the charge against him.' Article 5.5 states, 'Everyone who has been the victim of arrest or detention in contravention of the provisions of this article shall have an enforceable right to compensation.' Article 14 states, 'The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.'

The course included interactive workshops with videos of patients being assessed under the Mental Health Act and a presentation by a past service user. These presented the impact of detention on patients and raised awareness about the impact that the application of the Act can have. Until I attended the Transcultural SIG meeting in October 2007, it did not occur to me that neither the service user nor the patients in the video came from BME communities. There was little mention of BME issues in the course. This could be due to my own lack of attention rather than a possible lacuna in the course. This lack of emphasis on BME issues is worrying.

The issue now is how Section 12(2) Approval and Refresher courses can enhance awareness of and promote sensitivity to BME issues amongst psychiatrists. One suggestion could be to introduce specific presentations or workshops on BME issues, with time being allocated for this. This would provide an excellent opportunity to emphasize cultural and ethnic issues and

how these impact on assessment and outcome. Course material needs to be updated to include aspects of the ECHR, especially with regard to the sections on discrimination and ensuring that communication takes place in a language that patients understand. Courses need to emphasise the use of interpreters and consideration of the patient's culture in the context of beliefs and cultural practices. Case studies on BME issues and presentations by BME service users should also be useful.

Section 12(2) Approval is associated with a significant amount of responsibility and power. Section 12(2) courses need to emphasise this responsibility to psychiatrists. Keeping in perspective the multicultural nature of British society, the importance of being culturally aware and sensitive to BME issues needs emphasis. This is particularly relevant as the Mental Health Act, 2007 and the new Code of Practice become operational. Section 12(2) courses will need to be redesigned and course material amended to reflect the changes introduced by the new Mental Health Act and the new Code of Practice. This presents an ideal opportunity for courses to incorporate awareness about Black and Minority Ethnic issues, especially in relation to the application of the Mental Health Act 2007.

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NEW SPECIALIST ASSOCIATE GRADE

Formal approval from the Privy Council for the establishment of this new grade has been received. The process of application requires candidates to be supported by the Chair of the college Division in which they are currently working. A process that is speedy and not overlybureaucratic is being discussed at this time. Application forms will be available from the College. The application will require a completed CV form, citation form signed by 2 members of the College and evidence of entry on the Specialist Register on the GMC. Applications for Specialist Associateship received in 2008 will have the initial registration fee waived. Specialist Associateship does not imply the award of a qualification by the College and there are no post nominals attached to this application.

NEW TSIG OFFICERS – from July 2008 AGM

Chair: Dr Rizkar Amin (rizkar.amin@nhs.net)
Secretary: Dr Imran Ali
Financial Officer: Dr Shahid Latif (shahid.latif@leicspart.nhs.uk)

FORTHCOMING EVENTS

1 – 4 July 2008

Annual Meeting of Royal College of Psychiatrists
Imperial College, London

29 – 29 September 2008

11th Congress for Bridging Eastern and Western Psychiatry
Antalya, Turkey
Website: <http://www.turkeybipolar.com/>

17 – 19 October 2008

3rd International Conference on Schizophrenia
Chennai, India
Contact: Dr R Thara
Email: SCARF@vsnl.com
Website: <http://www.icons-scarf.org>

28 – 31 October 2008

International Conference on Priorities in Health Care
Gateshead, UK
Email: Eileen.coope@ncl.ac.uk

6 – 8 November 2008

2nd International Conference on Intellectual Disability/Mental Retardation
Bangkok, Thailand
Contact: Dr Shekhar Saxena
Email: bangkokconference2007@sss.gouv.qc.ca
Website: <http://www.bangkok-id-conference.org>

2 – 5 June 2009

Annual Meeting of Royal College of Psychiatrists
“A fair deal for all: Mental Health in a Multi cultural society”
Arena and Convention Centre, Liverpool

This is a publication of the Transcultural Special Interest Group. The views expressed here are not necessarily those of TSIG or the Royal College of Psychiatrists.

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