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GUEST EDITORIAL

Prisoner mental health in the USA

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The mental health of prisoners in the USA is affected by American history: Dorothea Dix's 1830s campaign; the Civil War and slavery; presidential interventions; the Great Depression; and the introduction of Medicaid and the Affordable Care Act. In 1934, the ratio of prisoners to mental hospital patients was 0.4; now, it is 3:1, with states varying from 10:1 to 1:1. Those states with the highest ratios also have the highest rates of imprisonment and the lowest expenditures on mental health. Litigation is likely to improve mental health services in prisons and to keep people who are mentally ill out of prisons.

Several strands of American history have contributed to the current mental health status of prisoners in the USA:

- from Dorothea Dix's 1830s campaign to improve the plight of people with severe mental illness by building state hospitals, to deinstitutionalisation without adequate community services
- from slavery and the Civil War, to the invalidation of the Voting Rights Act and racism, with disparity and racial differences persisting
- from a penal culture that promoted rehabilitation (before the 1970s), to one that emphasised mandatory sentencing and punishment, then to a recent realisation that this is inappropriate
- from President Franklin Roosevelt's New Deal with 'the test … is whether we provide enough for those who have too little', to President Ronald Reagan's 'We're the party that wants to see an America in which people can still get rich' and the rise in the appeal of 'small government'
- from Medicare and Medicaid, introduced in the 1960s, to provide healthcare for people who are elderly, poor or mentally ill, to the Affordable Care Act (ACA) of 2010, which increases Medicaid as well as insurance
- from De Tocqueville's 19th-century observation that 'sooner or later in the United States every controversy ends up in court', to litigation to improve mental health services in prisons
- from the civil rights of those who are mentally ill being largely ignored until the 1960s, when 'civil rights' legislation and case law dangerously limited involuntary hospitalisation, to court-ordered out-patient treatment and mental health courts.

Increasing and unequal prison incarceration

The USA has the highest rate of incarceration in the world: one of every 100 adults, a 600% increase in 40 years (Baillargeon *et al*, 2009; Rich *et al*, 2011; see also the website of the Bureau of Justice Statistics, http://www.bjs.gov, for statistics here and below). This rate is, though, at last decreasing, as mandatory sentencing laws (introduced during the 'crack' epidemic and a time of rising crime rates) are being repealed (Rich *et al*, 2011). Black men are disproportionately likely to be in prison: 9% of all African Americans are behind bars or on probation or parole, compared with only 3.7% of Hispanics and 2.2% of Caucasians (Baillargeon *et al*, 2009). In Michigan, half the prisoners are Black while the population is 14% Black. African Americans average 23% of the population in the ten states with the highest rates of incarceration. These include seven of the nine states that were covered by the Voting Rights Act until it was invalidated by the Supreme Court, which will make voting harder for the poor, minorities and people who are mentally ill.

Prisons are where those tried and sentenced to more than a year are housed. Jails are for those arrested, awaiting court appearance or sentenced to less than a year. The states are responsible for prisons and the mental health of prisoners, although some states (such as Louisiana) have private for-profit prisons and some (such as South Carolina) neglect and abuse such prisoners, despite court orders (Cohen, 2014). Jails are administered by cities and counties.

The overall proportion of the population with mental disorders in correctional facilities and hospitals together is about the same as 50 years ago. Then, however, 75% of that population were in mental hospitals and 25% incarcerated; now, it is 5% in mental hospitals and 95% incarcerated (Gilligan & Lee, 2013). In 1934, the ratio of prisoners to mental hospital patients was 0.4 (Penrose, 1943); now, it is 3:1, with states varying from 10:1 to 1:1 (Torrey *et al*, 2010). Those states with the highest ratios – mainly the same states as in 1934, as reported by Penrose (1943) – also have the highest rates of imprisonment (and of murder, gun deaths, poverty and teenage pregnancy – and they vote Republican) and lowest expenditures on mental health (Torrey *et al*, 2010). The average expenditure on mental health of the ten states with the highest rates of incarceration is $75 per person and of the ten with the lowest is $143 (according to the Kaiser Family Foundation, http://kff.org). But in the current recession, $1.6 billion has been cut

from state mental health budgets, federal Medicaid (which covers 46% of state mental health costs) has been reduced (National Alliance on Mental Illness, 2011) and counties, which pay about 16% of Medicaid costs from property taxes, are also cutting back: Rockland County, where the author lives, has decimated its once model services and has just closed its in-patient unit, which will probably increase the numbers of people with a mental illness in jails.

Prisoners who are mentally ill

Once incarcerated, half of inmates are found to have a psychiatric disorder and 15–20% a serious mental illness (Torrey *et al*, 2010). In the 1930s, only 1.5% of 9958 prisoners in New York City had a psychosis (Bromberg & Thompson, 1937). Now, New York City's jail, Riker's Island, with 12 000 inmates, has 40% with a psychiatric diagnosis, and a third of those have major mental illnesses (Gilligan & Lee, 2013). A recent good diagnostic study found 14% of males and 31% of females in jails had a serious mental illness (Steadman *et al*, 2009), although a meta-analysis of good prison studies found no increase in psychosis (rate about 3.5%) from 1966 to 2010 but an increase in depression (about 11%) (Fazel & Seewald, 2012). Black men have higher rates of serious mental illness and much higher rates of court-ordered out-patient treatment (Swanson *et al*, 2009). Prisoners with a mental illness are more likely than other prisoners to have: violated prison rules (58% *v.* 43%), been assaulted (24% *v.* 14%), been injured in a prison fight (20% *v.* 10%), been in solitary confinement (American Civil Liberties Union, 2009) and had multiple incarcerations. And they cost more: $180 per day against $80 per day (Torrey *et al*, 2010).

In 2011, 34% of state prisoners, 24% of federal prisoners and 17% of jail inmates received mental health treatment. In 2000, of the 1558 state public and private adult correctional facilities, 1394 provided mental health services: 70% screened inmates, 65% conducted psychiatric assessments, 51% provided 24-hour mental healthcare, 71% provided therapy or counselling, 73% provided psychotropic medications and 66% helped released inmates obtain community mental health services.

States vary in the provision of treatment: therapy is provided for 2.7% to 37% of prisoners; medication for 1.1% to 39%. Those states that provide the least are among the ten states with the highest rates of incarceration. In a Michigan study, 17% of prisoners were receiving treatment (100% therapy, 95% medication), but 65% of those with a serious diagnosis (13% of all prisoners) were not being treated (Swanson *et al*, 2009).

In New York prisons, services consist of 'out-patient' clinics, day programmes, hospital units within the prison and a forensic hospital. In Riker's Island jail, a private company provides the services for New York City and two city hospitals have prison wards. All inmates have a medical examination within 24 hours of admission and a mental health assessment within 72 hours. In Texas, all inmates have an hour-long medical and psychiatric examination, and 20% are referred for further psychiatric evaluation (Baillargeon *et al*, 2009).

The law and access to treatment

Federal laws mandating treatment of prisoners with mental illness apply only to federal prisons. The Eighth Amendment of the US Constitution forbids 'cruel and unusual punishment', which the courts have interpreted as including 'deliberate indifference to serious medical needs' (American Civil Liberties Union, 2009). This has been used to force states (where state law is inadequate) to provide appropriate services: in Massachusetts resulting in a dramatic reduction in rioting, murders, suicides, rape and injuries in prison; in California resulting in a judge having oversight of the treatment of incarcerated people with serious mental illness.

Litigation usually results in 'consent decrees', where the states agree to a set of conditions and the courts monitor them. They are in effect in most states. For example, in Mississippi, where 1000 men were held in solitary confinement in a super-maximum-security unit, a consent decree excluded from that unit all those who had a severe mental illness and introduced mental health workers, which resulted in a 70% decrease in serious incidents (American Civil Liberties Union, 2009). In New York in response to a law suit (and some tragic deaths) the state agreed to end all solitary confinement for those who were young or pregnant, or who had an intellectual disability or mental illness. Yet in the USA there were still 80 000 prisoners (disproportionately mentally ill) in solitary confinement in July 2013.

Another major source of concern and litigation is suicide, which occurs much more in prisons and jails and is the leading cause of death: 41 per year per 100 000 inmates in the decade to 2011 (12 per 100 000 in the general population).

Diversion from incarceration

States with high and low rates of imprisonment, recognising that the rights and dignity of people with a mental disorder are compromised, share initiatives aimed at reducing their incarceration. Forty-seven states have police crisis intervention teams that work to avoid the arrest of people who are mentally ill (Aron *et al*, 2009). Additionally, mental health courts (200 of them, in 43 states) and drug courts (2600) divert the arrested person to psychiatric treatment (Aron *et al*, 2009). A review of these 'criminal justice liaison and diversion' services found they were beneficial (Scott *et al*, 2013). 'Assisted out-patient treatment' (court-ordered treatment, usually at hospital or on prison discharge) significantly reduces rates of arrest and incarceration (Torrey *et al*, 2010) and can halve total costs in the first year (Swanson *et al*, 2013).

Adverse outcomes

Released prisoners are 129 times more likely to die from drug overdose and 12 times more likely to

die from any cause in the first 2 weeks (Rich *et al*, 2011). In New York, a charitable organisation helps 1000 offenders with mental illness released from Riker's Island every year. The Affordable Care Act, through a Medicaid mandate, will help released prisoners throughout the country get services (Rich *et al*, 2011), although many states, mainly the poorest and those with high imprisonment rates, are resisting participation under the Act, aided by attack advertisements paid for by very wealthy outsiders.

Conclusion

The historical strands, interacting with the tension between federal laws and regulations, states' rights and the Constitution, and enormously variable and highly polarised views, have resulted in great variation in incarceration rates and prisoner mental health across the USA. Overall, there are signs of improvement, with decreasing numbers in prison, but there are still far too many people with mental illness in jail and prison. Litigation and concern for the most vulnerable have helped ensure better treatment in jails and prisons but the high suicide rate shows that it remains inadequate. In this time of economic difficulty, funds for community services are being cut back, which will only increase the incarceration of people who are mentally ill. Psychiatrists and other mental health professionals must give high priority to campaigning to persuade the public and the politicians that it is right and moral to provide appropriate treatment and services for everyone who is mentally ill, irrespective of where they find themselves. Any resulting reduction in imprisonment, hospitalisation and costs is a bonus.

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THEMATIC PAPERS

Managing the mental health of prisoners: dilemmas and solutions

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As psychiatrists, we are well aware that all around the world people with serious mental health problems are in prison, where their condition is often unrecognised and untreated. In the UK there have been moves in recent years to provide more mental health support to the prison population. Louis Appleby and colleagues review the success of this initiative, introduced just over a decade ago; he was until recently the national clinical director for offender health. Their analysis points up some significant dilemmas, not least of which is the difficulty prison staff have in differentiating serious mental illness from pervasive but more minor mental disturbance. There clearly needs to be better identification of those most at risk, particularly of suicidal behaviour.

In Brazil, which incarcerates an exceptionally high proportion of its population, there are serious problems due to overcrowding and little support for prisoners with mental disorders, as discussed by Sergio Baxter Andreoli and fellow authors. Their recent research has shown that the prevalence of mental disorder is very high among prisoners, up to ten times greater than that in the general population. Most prison psychiatric hospitals lack mental health teams to run them. The authors question the logic by which individuals with a serious mental illness, whose offence was linked to their disorder, may end up in conventional prisons in Brazil, where they receive no adequate treatment. On their release, their chances of rehabilitation are seriously compromised as a consequence of the failure of the law to take appropriate account of their condition.

Finally, we have a fascinating study from Somaliland, where a novel in-reach service has been developed. The authors, Jibril Handuleh and Ronan McIvor, invite us to consider the project as providing a model for the development of in-reach services in other low-income countries. Their study was built on long-standing foundations, in terms of a collaborative venture between King's College London, the Tropical Health and Education Trust, and Somaliland partners. Training was provided to prison guards and police officers in Borama Prison, working jointly with a local university. Benefits included a direct ban on khat use by prisoners, as well as an indirect influence on the awareness of mental illness among local judicial and governmental authorities. Given the country has no resident psychiatrists and no mental health legislation, this is a remarkable result.

MANAGING THE MENTAL HEALTH OF PRISONERS

THEMATIC PAPER

The management of mental health problems among prisoners in England and Wales

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This paper reviews the major organisational changes made to the delivery of mental healthcare in prisons in England and Wales since the turn of the century. These changes have included the introduction of 'in-reach' services for prisoners with serious mental illness, replicating the work of community mental health teams. In addition, healthcare budgets and commissioning responsibilities have been transferred to the National Health Service. Measures to reduce the rate of suicide in prisons are also considered.

The overrepresentation of people with mental illness is a feature of prison systems and a challenge to governments, prison administrators and healthcare providers across the globe. Data from large-scale epidemiological studies of psychiatric morbidity are reported fully elsewhere (e.g. Singleton *et al*, 1998; Fazel & Danesh, 2002) and, while somewhat dated, such surveys show that all types of mental illness, personality disorder and substance misuse, commonly coexisting, are significantly more common in prison populations than in the wider community.

Since the turn of the century there have been major organisational changes to the delivery of healthcare in prisons in England and Wales. In 1999, the National Health Service (NHS) entered into a clinical improvement partnership with Her Majesty's Prison Service (HMPS), designed to achieve equivalence in the range and quality of prison-based services to those provided to the wider community (HMPS & NHS Executive, 1999). As part of this, changes to mental healthcare delivery, notably the introduction of 'in-reach' services for prisoners with serious mental illness (SMI), replicating the work of community mental health teams (CMHTs), were introduced (Department of Health, 2001) and healthcare budgets and commissioning responsibilities were transferred to the NHS.

Current issues in prison mental healthcare in England and Wales

In 2002, Martin Narey, then Director General of HMPS, described in-reach team staff as 'the

cavalry coming over the hill … from the NHS'; however, this optimistic tone was tempered immediately by his candid acknowledgement that the problem faced was 'near overwhelming' (Narey, 2002).

After nearly 10 years of operation, a national evaluation of mental health in-reach services was conducted. The study, undertaken in six prisons in England and that included 3492 male and female adult prisoners, concluded that only 25% of those with an SMI, defined as major depressive disorder, bipolar disorder and/or any form of psychosis, were assessed by in-reach services within a month of reception into custody. Furthermore, only 13% were actually accepted onto in-reach team case-loads for ongoing treatment (Senior *et al*, 2013). A much earlier study with similar methodology reported that only 23% of prisoners with SMI were identified by routine health screening upon reception into custody and that, if not identified at this stage, mental disorder was likely to remain unidentified throughout a person's time in custody (Birmingham *et al*, 1996). Thus, with more than a decade and a half between the two studies, during which a nationwide policy initiative specifically designed to improve care for this vulnerable group was championed, rates of identification and treatment of prisoners with SMI appear unchanged. How did this happen, and what are the lessons to be learnt?

In-reach services were introduced to treat those with SMI, but were immediately hampered in that task by the relentless referral of those experiencing a wide range of mental distress, including common mental health problems, personality disorders and people simply experiencing distressing, but arguably normal, reactions to their incarceration. In prison, the concept of mental illness is very expansive and many aberrant or disruptive behaviours which compromise the running of an inflexible regime may be labelled 'illness'. Steel *et al* (2007) used the term 'mission creep' to describe the on-the-ground expectation that in-reach services should deal with the full range of mental health issues presented by prisoners, despite any policy-endorsed delineation of responsibility. It therefore rapidly became evident that, by sticking to a core remit of dealing with people with SMI, the introduction of in-reach as a single-tier mental health service did not address the majority of clinical problems that prison staff wanted most help with: personality disorder and multiple comorbidities.

Since the evaluation of prison in-reach services was completed, there have been several promising developments designed to address the deficits identified. The importance of providing robust primary mental health services to the high proportion with common mental health problems is now widely understood. As a result, services have proliferated, particularly Improved Access to Psychological Therapies (IAPT), offered in the community to facilitate rapid treatment for anxiety and depression. In 2013, the NHS published an updated positive practice guide for those developing IAPT services for offenders and a nationwide forum for prison-based practitioners has been established (NHS, 2013).

Work is also underway to tackle the separation of prison-based mental health services from mainstream community provision, identifying how best to support the transition between prison and community. Innovative models of 'through the gate' services are being trialled, designed to promote long-term engagement with community mental health services, increase community tenure and decrease lifestyle chaos and, potentially, reoffending. One such development involves an adaptation of 'critical time intervention' (CTI; Susser *et al*, 1997), an intervention initially developed to reduce homelessness in people discharged from psychiatric facilities in the USA. In a pilot study, adapted CTI in the UK was found to significantly increase engagement with mental health services after release, compared with treatment as usual, a finding now being tested in a full randomised controlled trial.

Suicide in prison

Offenders have long been recognised to be a high-risk group for suicide within governmental suicide prevention strategies. Until recently, there had been a consistent downward trend in the rate of completed suicides in prisons in England and Wales, from a peak of 141 per 100 000 prisoners in 1999 to 68 per 100 000 in 2010 (Shaw *et al*, 2013). However, this downward trend appears to have stalled and the rate may even be starting to rise again. Even this much reduced rate remains significantly greater than the general population rate of 12 deaths per 100 000 (Office for National Statistics, 2013). Perhaps this is not too surprising; risk factors for suicide in the general community, for example being male, young, unemployed and with complex personality disorder or substance misuse problems, are common in prison populations.

During the decade when prison suicide rates fell, suicide and self-harm management procedures were overhauled in prisons in England and Wales. Those considered to be at especial risk are cared for using the Assessment, Care in Custody and Teamwork (ACCT) procedures. Any member of prison staff can initiate ACCT processes for any prisoners under their care whom they consider to be of particular concern. Under ACCT, a prisoner should be offered an individual assessment of needs and risks, followed by the formulation of a care plan, known as a CAREMAP, which guides intervention from the multidisciplinary team and provides a mechanism for ongoing reviews of progress. CAREMAPs are drawn up and agreed by a core group of multidisciplinary staff involved with the at-risk individual, and guidance states that there should be an identified key worker and that the prisoners should be actively involved in all stages of their care. ACCT recognises that identifying those at risk of suicide is a prison-wide responsibility in which all staff are expected to play an active role. In many prisons, peer schemes comprising prisoners known as listeners, trained

by the Samaritans, also offer support. Changes to the physical environment have also taken place, notably the creation of 'safer cells' with no ligature points and the creation of first-night centres to offer closer supervision in the early, particularly risky, days of custody.

These physical and procedural changes are only part of the story, however. The training that prison officers, the largest single occupational group with the most hands-on contact with prisoners, receive in the management of suicide and self-harm risk is limited and generally confined to their initial induction period, with no requirement for mandatory updates throughout their career. This lack of training likely contributes to the faulty identification of those at risk of suicide; a recently published review found that 79% of 280 prisoners investigated by the Prison and Probation Ombudsman (PPO) between 2008 and 2012 were not being cared for under ACCT procedures at the time of their apparently self-inflicted death (PPO, 2014). Of course, this also means that one in five people who died by suicide actually had been identified as being at risk, yet the care put in place had, ultimately, been insufficient to keep them safe.

Both the PPO and independent researchers have identified issues with the operation of the CAREMAPs, with over one in four of the CAREMAPs relating to the deaths investigated by the PPO (2014) found to be inadequate, including insufficient support being offered to help prisoners achieve specified goals. In line with our own research, the PPO also recommended that individual staff be allocated responsibility for specific CAREMAP actions, to increase the chances of their completion.

Risk of suicide is not restricted to those in prison; those recently released are also at elevated risk, particularly in the first month. Pratt *et al* (2006) concluded that the overall age-standardised mortality ratio for recently released prisoners was 8.3 for men and 35.8 for women compared with the general population. This finding strengthens the need for mental health services to engage in proactive, 'through the gate' support.

Conclusion

Offenders with mental disorders have been described as 'the unloved, unlovely and unlovable' of our society (Prins, 1993). They are complex individuals who routinely present with comorbid physical, mental, substance misuse and personality disorders. When in the community their use of non-routine care, such as accident and emergency and ambulance services, is high and engagement with any type of health service is typically sporadic and crisis-driven. While policy dictates that services for prisoners should to be 'equivalent' to those provided to the wider community, equivalence cannot simply be taken to mean 'the same'; responding to the significantly increased levels of all types of mental health morbidity and suicide rate inevitably requires changes to service modalities and risk formulation.

To meet their needs effectively, services both in and out of prison need to be responsive, inclusive, flexible and, importantly, holistic, addressing both discrete health issues and wider social care needs. Risk is best managed by working in partnership with other agencies, including a range of health services, wider criminal justice organisations and third-sector providers. Services have to fully understand and respond in a timely manner to the issues being presented. Notably, multiple and complex morbidities have to be accepted as the norm; commissioners, service managers and practitioners need to honestly embrace the indisputable fact that maintaining engagement with chaotic individuals requires commitment and diligence, as well as adequate resourcing; and special care is required at risky points of transition between prison and the community.

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THEMATIC PAPER

MANAGING THE MENTAL HEALTH OF PRISONERS

Prison is not the right place for people with mental disorders: the Brazilian case

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The large number of individuals with severe mental disorders in prisons worldwide has alarming implications, which leads to the question of the appropriateness of the prison system for people with this type of morbidity. This article discusses these implications, the problems in therapeutic approaches and the legal aspects in the Brazilian context.

Brazil is the fifth most populous country in the world (United States Census Bureau, 2013) and has the fourth largest prison population (Gombata, 2014). The USA, China and Russia occupy the top three positions in number of prisoners, but while their prisons operate within the limits of available places, the same is not observed in Brazil, whose prison system capacity is 281 520 places for some half a million people, meaning that prisons accommodate approximately twice their capacity.

Prison overcrowding in Brazil is exacerbated by the high prevalence of mental disorders among the inmates. A recent study conducted by our group found that lifetime and 12-month prevalence rates of mental disorders among prisoners in the state of São Paulo were 63% (56% among men and 69% among women) and 30% (22% among men and 39% among women), respectively. We found high lifetime prevalence rates of phobic anxiety disorders (42%), drug misuse/addiction (28%) and serious mental disorder (SMD – psychotic disorder, major depression and bipolar affective disorder) (11%) (Andreoli *et al*, 2014).

Lifetime prevalence rates of mental disorders are also high in countries such as Italy (85% among men) (Zoccali *et al*, 2008) and Canada (69.6% among women) (Lafortune, 2010).

The large number of individuals with severe mental disorders in prisons worldwide has alarming implications, which leads to the question of the appropriateness of the prison system for people with this type of morbidity. This article discusses these implications, the problems in therapeutic approaches, and the legal aspects in the Brazilian context.

One systematic review of 22 studies found that the prevalence of mental disorders among prisoners was reported to range from 55% to 80% (Brink, 2005). Besides the higher prevalence rates, the severity of mental disorders also tends to be higher in the prison population. In the USA, the number of individuals with SMD is estimated to be ten times higher in prisons than in psychiatric hospitals (Torrey *et al*, 2014). In Brazil, the prevalence of severe mental disorders is 5–10 times higher in the prison population than in the general population (Andreoli *et al*, 2014) and is similar to that found in other low- and middle-income countries (Fazel & Seewald, 2012).

Brazil: implications of imprisonment for the mental health of individuals with severe mental disorders

Human rights violations have been widely described, especially regarding the health services available to the prison population. These violations occur due to the insufficient availability of human and material resources, which, combined with institutional characteristics, aggravate or even cause health problems (Andreoli *et al*, 2014).

Many prisoners with SMD serve time in correctional facilities that lack the health programmes and human resources required for the diagnosis and treatment of mental illness. Even prison psychiatric hospitals (PPHs) lack the human resources required to care for prisoners with SMD. According to the latest data from the National Register of Health Institutions, there are only five interdisciplinary healthcare teams in nineteen Brazilian PPHs.

The conditions in prison facilities (e.g. poor hygiene, lack of air circulation, and drug use) increase the risk of infectious diseases. Prison overpopulation exacerbates these conditions and hinders the access of health professionals to prisoners, the diagnosis and treatment of mental disorders, and mental health promotion.

The lack of treatment and the consequent chronicity of psychiatric disorders aggravate the problems between individuals with SMD and other prisoners and staff and, as a result, prisoners with SMD become potential victims of various forms of physical and psychological violence (Birmingham, 2003). Additionally, any existing family relationships and work activities after release from prison deteriorate, aggravating the difficulties of adapting to freedom. For prisoners with SMD, the stigma of being a criminal, coupled with the mental health condition, compromise occupational rehabilitation, integration into the community and the quality of family relationships. Thus, the lack of psychiatric treatment during and after

incarceration increases the chances of recidivism in people with SMD.

Prisoners with SMD are more vulnerable to these adversities because the changes to their functional mental state make them more prone to risk behaviours such as involvement in fights, indiscipline, drug misuse and self-harm.

Moreover, a large proportion of the prisoners who do suffer from mental illness do not seek psychiatric treatment because they are unaware of their condition. For instance, in a study conducted by our group in the prison population of the state of São Paulo, 50% of respondents with SMD denied having a mental health problem. In addition to being unaware of their condition, prisoners with SMD do not seek treatment because of the stigma and for fear of being referred to PPHs (Zoccali *et al*, 2008). Thus, when health demands are insufficiently met, a vicious cycle of illness is created.

Another aggravating factor for prisoners with SMD is coping with stress from incarceration, which, as in any total institution, results in the curtailment of freedom, dissolution of autonomy, social isolation and, consequently, annihilation of individuality. This context is contrary to the ideals of health promotion and social rehabilitation, which are goals of the prison system.

The structural characteristics and dynamics of a prison facility tend to preclude the implementation and continuity of psychiatric interventions. Outdated interventions based on long-term hospitalisation and exclusively pharmacological treatments are still the norm in PPHs, as opposed to occupational and psychological interventions that may promote greater well-being and quality of life (Silva, 2010).

According to international law, social rights should not be affected by the application of a judicial penalty and should be guaranteed by the state during custody or the execution of the sentence. Thus, prisoners should have guaranteed access to education, social and legal assistance, leisure and health. However, prisoners with SMD are not protected by the law, subjecting them to a double penalty: one imposed by the justice system, which considers prisoners with SMD to be 'common' prisoners, who are forced to serve their time in common correctional facilities; and another imposed when they are victimised by having their rights to physical and mental integrity and healthcare violated (Torrey *et al*, 2014).

The process of forensic psychiatric examination is often slow or nonexistent, either due to a lack of personnel or because of bureaucratic obstacles. Additionally, there are some complicating factors to consider, such as the lack of diagnostic instruments, limited records and observations during forensic examination, and the tendency for symptoms of aggression, anxiety and delirium to be more readily detected than others, such as sadness, isolation and insomnia (Lafortune, 2010).

Arboleda-Flórez (2003) argues that the closure of psychiatric hospitals in some Western countries due to the psychiatric reform process and the inefficiency of the public health system have increased the demand for forensic psychiatric services and, consequently, the number of persons with a mental illness in prisons. Even though these assumptions have not been tested, the public health system must be better prepared to promote mental health and to detect and prevent cases in which people with SMD are at risk of committing unlawful acts.

The problem of criminal law for individuals with mental disorders and its application

The criminal legislation of many countries excuses individuals with mental illness of accountability and culpability by reason of diminished capacity. Thus, in place of a criminal sentence, the individual is sentenced to a PPH or health institution. This alternative sentence serves both to prevent individuals with mental illness who have committed a criminal offence and whose dangerousness has been demonstrated committing another crime and to ensure that they receive proper treatment.

The contradictions arise from the concept of mental illness and its implications for justice. The law, as a cultural and historical construct, has adopted a stereotyped concept of mental illness that is associated with the notion of danger. Thus, the application of an alternative sentence assumes the dangerousness of the actor, and thus the need to keep him or her in a closed system for his or her own protection and that of society at large, as long as there is a risk of recidivism (Peres & Filho, 2002). Because there is no cure for most SMDs, in the understanding of the law an individual's dangerousness remains high; this, coupled with the lack of treatment and social isolation, as well as the chronicity of the disease, means that a sentence at a PPH invariably represents a life sentence. Thus, there is a discrepancy between the law and psychiatry. For the latter, the focus is not the cure, but promoting autonomy and social rehabilitation.

Final remarks

The data presented here show the unsuitability of prisons for treating and rehabilitating prisoners with SMD. Besides, the prison system can aggravate prisoners' health conditions and it tends to be a more severe sentence for them than it is for prisoners without these disorders. Thus, to prevent such individuals being admitted to general correctional facilities, it is crucial to improve screening procedures and psychiatric examinations, to increase the number of health professionals working in the prison system, to facilitate prisoner transfers, and to reform penal law.

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THEMATIC PAPER

MANAGING THE MENTAL HEALTH OF PRISONERS

A novel prison mental health in-reach service in Somaliland: a model for low-income countries?

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We express particular thanks to colleagues in Borama, including Mr Omer Said, the former head of Borama Prison, and Mr Said Ali, the current head, for their support. We offer special thanks to Professor Fadma Abu-Bakr, Dean of Amoud Nursing School, and Dr Walhad, Dean of the College of Health Science at Amoud University, for their encouragement in working within the prison. We owe a debt of thanks to Mr Abdikani Askar, our nurse colleague who provided such excellent input to the prisoners.

Prison in-reach mental health services are reasonably well developed in advanced economies, but virtually nonexistent in low- and middle-income countries. We describe the development of a small prison in-reach project in Somaliland, a self-declared independent state which has experienced conflict and poverty in equal measure. After careful planning and cooperation with local agencies, the service provides sessional input to a regional prison, including assessment and treatment of a wide range of psychiatric conditions. The project has had some unexpected benefits, which are described. The success of the project reflects the effectiveness of collaboration between local stakeholders and international agencies, and could be used as a model for the development of in-reach services in other low-income countries.

There are over 10 million people in prisons worldwide. Prisoners are more likely than the general population to experience psychiatric morbidity, with about one in seven having a treatable mental illness (Fazel & Baillargeon, 2011). Substance misuse, personality factors and risk of suicide (World Health Organization, 2007) are particular problems, and prisoners often present with complex and multiple needs (Singleton *et al*, 1998). Over the past few decades, the concept of equivalence – that prisoners are entitled to the same standard of healthcare as that provided outside prison – has been the main driving force in improving prison mental healthcare (Exworthy *et al*, 2012). Services have attempted to put systems in place to identify at-risk prisoners, both at the time of reception and during their incarceration. For example, in the UK, prisoners are screened for mental health problems on detention and referred to prison in-reach services (staffed by mental health nursing and medical personnel) if required. Detainees can be transferred to the prison health-care wing or moved to an external hospital under the provisions of mental health legislation. Despite this progress, equivalence is still rarely achieved and demand for in-reach services far outstrips supply (Ginn, 2012).

Notwithstanding these difficulties, prison mental health services in high-income countries are much better than those in emerging economies. In many jurisdictions, services appear to be virtually nonexistent. For example, prison-based mental health services in India are unheard of (Sarkar & Dutt, 2006). We are not aware of any in-reach services on the African continent, despite the high prevalence of mental disorders (Audi *et al*, 2008; Naidoo & Mkize, 2012).

It was with this background that we considered the development of a basic in-reach mental health service within a prison in Somaliland, following a

visit to Borama Prison in October 2010. We hope that the model may be appropriate for other low-income countries.

Somaliland and the King's THET Somaliland Partnership

Somaliland is an autonomous region that declared independence from Somalia in 1991, following a traumatic civil war. Despite relative stability and political progress, it remains one of the poorest countries of the world, and its healthcare system continues to struggle. Mental health is very much neglected, and has no state funding. There are no resident psychiatrists and no mental health legislation to safeguard the rights of patients. There are, though, a number of psychiatric hospitals, both public and private, in the main population centres, and some out-patient clinics.

Mental illness is exacerbated by the almost universal use of khat, a euphoriant drug associated with behavioural disturbance and the development of psychosis (Odenwald *et al*, 2009).

As in many countries, mental illness is stigmatised, with families reluctant to access the limited services available. As a result, patients can represent a huge burden to relatives, who are usually the main carers. Acutely disturbed behaviour, due to the lack of appropriate treatment, is often managed at home by chaining the patient. Some families rely on the prison system for containment and respite, even when their ill relative has not committed any crime (Handuleh, 2012). There is a strong local belief in spirit (*jinn*) possession as a cause of mental illness, and therefore traditional and religious healers play a significant role in management.

Over the past 12 years, mental health services in Somaliland have improved greatly, thanks in part to a collaboration between King's College London, a British charity called the Tropical Health and Education Trust (THET) and local partners in Somaliland (Leather *et al*, 2006; Sheriff & Whitwell, 2012). This King's THET Somaliland Partnership (KTSP) has offered capacity building in the country's healthcare system since 2000, in all fields of medicine. Psychiatrists, nurses, pharmacists and other disciplines from the KTSP mental health group support undergraduate and postgraduate teaching, curriculum development, service improvements and external examination, by working closely with university deans and other clinical leaders (Gavaghan & Hughes, 2013). The group supports professional development through distance learning via Medicine Africa (http://www.medicineafrica.com). The authors are both members of KTSP.

Development of the prison in-reach service

There are seven prisons in Somaliland, controlled and managed by the Ministry of Justice, in collaboration with the Ministry of the Interior and the Police Department. Courts do consider mental health issues in those attending trial, but there is no mental health legislation which influences disposal. Therefore, those defendants with mental health problems found guilty of an imprisonable offence are sent to prison rather than hospital, where they remain untreated.

Borama Prison has approximately 300–400 inmates at any time, the vast majority being men. Most of the prisoners have been convicted, while others are on remand. As noted above, a large number of the inmates with mental illness have been neither convicted nor charged with an offence, but are incarcerated to provide containment or respite for their families, at the latter's request. The prison is busy and overcrowded.

Phase 1 – consultation

We discussed the need for in-reach support and developed a model that might be provided within current resources, based on provision in UK prisons. We agreed a phased plan of implementation, following discussions with the Dean of Amoud Medical School and local partners. With permission from the Ministry of Justice and the Police Department, we met with the prison director to discuss our ideas and seek support for the project. He was very receptive and recognised the impact of mental health problems in the overall management of the prison. He estimated that 40% of inmates displayed unusual behaviour that might be related to mental illness and/or khat use. He acknowledged that some prisoners who were behaviourally challenging because of mental illness might be kept in their cells continuously or chained, because prison officers did not know how to manage them.

We liaised with the legal department of Amoud University, to ensure that lawyers working within the court system were aware of the project and to encourage their support when representing clients with mental health problems.

Finally, we discussed our proposals with local families and carers.

Phase 2 – training

Following the agreement of the prison authorities, J.I.M.H. began training sessions for prison guards and some police officers, over the course of 3 months. This focused on basic information on mental illness and management, including signs and symptoms, suicide risk and self-harm, managing challenging behaviour, de-escalation techniques, the role of medication and the impact of khat on behaviour and psychosis. The curriculum was based on that used by the KTSP mental health group for teaching medical and nursing students, but modified for the present population. Fifteen staff members, including female guards, completed the training.

Pre- and post-training questionnaires indicated that there was significant improvement in prison officers' knowledge and ability to identify those with mental illness, especially depression and personality difficulties, and the impact of khat and illicit substances. Officers were open to considering

alternative approaches to managing prisoners with mental health problems.

Following the training session, the prison governor decided to stop khat use throughout the prison. This intervention alone resulted in improvements in adverse behaviour as the project progressed.

It was agreed that the in-reach team would consist of one doctor (J.I.M.H.) and a nurse, who had shown an interest and aptitude in the assessment and treatment of mental illness. The nurse was given additional training in triage, initial treatment options, management of challenging behaviour and referral pathways to hospital if necessary. He was able to administer medication. During the project, support and supervision were provided by KTSP clinicians based in the UK.

Phase 3 – intervention

The in-reach service began in May 2011, initially as one weekly session lasting 3 hours. Prisoners requiring assessment were selected by prison officers and taken from their cells to a visitor room to be assessed. Officers usually selected between four and six prisoners per week for clinical assessment. Initially, assessments were carried out by J.I.M.H., with the nurse observing. As the project proceeded, the nurse took over and successfully treated most of the patients, supervised by J.I.M.H. Treatment included a range of oral and depot antipsychotic medication, in addition to antidepressants. Medication was supplied by charities in accordance with World Health Organization recommendations. Advice was given to staff regarding management. Some of the prisoners who were released continued treatment at the local out-patient clinic. Treatment was free.

The development of the project had an unexpected impact on the judicial and governmental authorities locally. As knowledge of the service grew, lawyers and judges began to request the assessment of defendants who appeared obviously unwell, primarily regarding their fitness to plead. They began to reflect on the presence of mental illness when considering disposal and sentencing. During the project, several detainees who were clearly psychotic were transferred to the newly opened in-patient unit at Borama hospital, guarded by prison officers during their stay.

Other positive consequences emerged as the project continued. J.I.M.H. was able to identify and treat comorbid medical conditions in the prisoners assessed. We noted this was another unmet need in the service. In addition, the team agreed to see prison guards and their family members with mental health problems. Consequently, these workers appeared better able to perform their duties and sickness absence decreased.

Findings

During the 1-year period from May 2011 to April 2012, there were approximately 340 male and 4 female inmates in the prison. In total, 161 people were assessed under the project: 146 prisoners and 15 prison guards (Table 1). Their ages ranged from 16 to 65 years. It is noteworthy that 57 inmates had not been charged or convicted, but imprisoned at the request of relatives for containment and respite. Interestingly, most of this group had a history of violence, so it was likely that families had a low threshold for requesting support from prison authorities. All of the prisoners assessed had a history of khat use, but this was considered of diagnostic significance in only 45, who presented with khat-induced psychosis.

Conclusion

This novel prison in-reach mental health service in a low-income country built on local resources and expertise and was supported by international partnerships. Although based on the principle of equivalence, it differed from Western models in a number of ways. For example, it was not embedded within the prison itself, but was provided through regular sessional out-patient support for assessment and treatment. We are not aware of similar projects elsewhere in northern Africa, or indeed beyond.

Table 1
Population assessed

	Inmates	Prison guards	Total assessed
Male	142 (88.1%)	11 (6.9%)	153 (95.1%)
Female	4 (2.4%)	4 (2.4%)	8 (4.9%)
Total	146 (90.7%)	15 (9.3%)	161 (100%)
Offences (inmates only): *n* = 146 (90.7% of total assessed)			
Robbery	17 (10.5%)		
Murder	20 (12.4%)		
Arson	42 (26%)		
Rape	10 (6.2%)		
No charge	57 (35.4%)		
Diagnosis (inmates and prison officers combined): *n* = 161 (100%)			
Primary substance misuse (khat)			45 (27.9%)
Psychosomatic presentation			31 (19.3%)
Delusional disorder			25 (15.5%)
Depression			24 (14.9%)
Bipolar mania			14 (8.7%)
Schizophrenia			13 (8.1%)
Dementia			9 (5.6%)

The project identified a large need, with around 50% of prisoners experiencing psychiatric distress over the study period. The project was implemented without additional cost, but with increasing use of nursing input over time. Prison officers, with training, were able to identify psychiatric morbidity, a finding previously recognised in other countries (Birmingham, 1999).

We were surprised by the large number of people admitted to prison at the request of relatives. We hope this number will fall, following the opening of the first in-patient unit in Borama during the study period. Treatment of prisoners, in addition to the prohibition of khat at the prison, led to a noticeable reduction in violence and allowed prisoners to spend additional time out of their cells. The use of chaining and physical coercion reduced. Once engaged, prisoners were offered out-patient follow-up on release.

The project also had some unintended positive consequences. Medical conditions among prisoners were identified and treated and prison staff were supported in their own mental health needs, leading to improvements in management and economic benefits. There appeared to be improvements in attitudes to mental disorder among staff and families, although this was not measured. The project seemed to lead to improvements in the legal assessment and disposal of prisoners with mental health problems and led to the release of six inmates who were arrested while acutely mentally ill.

We hope this model can be used as a template to introduce similar services in other low-income countries. Cooperation with prison and government agencies is essential.

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MENTAL HEALTH LAW PROFILES

Mental health law profiles

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While in a general sense both Canada and Malta belong to the Anglo-Saxon tradition of case law, with respect to Canada this is only partially so, because the country's federal structure necessitates 13 different mental health laws and Quebec, one of the federal provinces, follows the French tradition of basing law in statute. This diversity notwithstanding and despite the fact that there are differences between the federal provinces' laws, the authors have performed impressively in summarising these various laws and demonstrating the fundamental unity that underlies them, namely giving primacy to universally agreed human rights. Canadian law, as summarised here, appears to reflect a historically conservative but politically/philosophically liberal approach to human rights, the emphasis of which is on protection of the citizen from undue intrusion from the state.

The new Mental Health Act in Malta, while maintaining this focus, also aims to move a step further forwards by addressing issues of social inclusion and well-being as well. This is one of the remits of the newly created post of Commissioner in that country. Such a widening of perspective seems wise in view of the repeated reports in previous papers in this series, that often law protective of human rights is enacted but services – both to provide safe and secure care and to support social inclusion – are lacking.

MENTAL HEALTH LAW PROFILE

Canada's mental health legislation

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In Canada the ten provinces and three territories are responsible for their own health laws and services. The 13 mental health acts have core similarities, but there are clinically significant differences. In most Canadian jurisdictions legislation is based on common law; in Quebec, it is based on a civil code. Canadian jurisdictions favour voluntary admission and sometimes make this explicit in their mental health acts. For involuntary admission or compulsory in-patient or community treatment to be valid, three elements must be applied correctly: the process, the criteria and the rights procedures. These are reviewed in this paper.

There are 13 mental health acts in Canada because the ten provinces and three territories are responsible for their own health laws and services. Canadian mental health acts have core similarities, but there are clinically significant differences among them (Gray & O'Reilly, 2001). All Canadian laws must conform to the overarching Canadian Charter of Rights and Freedoms, which is part of the country's constitution. In most Canadian jurisdictions, apart from the province of Quebec, legislation is based on common law; in Quebec, it is based on a civil code, as is the case in France.

Canadian jurisdictions favour voluntary admission and sometimes make this explicit in their mental health acts. For involuntary admission or compulsory in-patient or community treatment to be valid, three elements must be applied correctly: the committal process, the committal criteria and the rights procedures.

Committal process

In all Canadian jurisdictions, a physician completes the initial civil commitment certificate, which provides authority for a brief hospitalisation for assessment. All jurisdictions require that a second physician agrees that committal criteria are met if a patient is to be detained in hospital longer. Thus, in most Canadian jurisdictions committal decisions are made entirely by physicians. The exceptions are the provinces of Quebec and New Brunswick. These provinces also require that two physicians agree on the need for committal, but in Quebec the physicians must then petition a court, and in New Brunswick a tribunal, to obtain final authorisation.

When it is not possible for a physician to undertake an examination, a judge, or in some cases a justice of the peace, can order the person to be examined. In addition, a police officer may take the person to a hospital for an out-patient examination if the officer has grounds to believe that the person has a mental illness and will cause harm to him- or herself or to others. Some provinces allow a police officer to take a person for a psychiatric assessment if the officer believes the person to be at risk of mental or physical deterioration.

Committal criteria

Definition of mental disorder

In all Canadian jurisdictions, to be involuntarily admitted a person must have a defined mental disorder. While a formal diagnosis is not required, most jurisdictions have specific definitions of what constitutes a mental disorder. For example, the province of Alberta defines mental disorder as:

> A substantial disorder of thought, perception, mood, orientation or memory, which seriously impairs the person's judgment, behaviour, capacity to recognize reality or ability to meet the demands of everyday life.

A few jurisdictions, including Ontario, retain the broad 'any disease or disability of the mind' found in the Mental Health Act in England and Wales.

Harm and deterioration

People can be admitted in Canada only if their mental disorder causes them to be likely to harm themselves or others or to suffer significant deterioration. In some provinces, the legislation specifies that the person must need psychiatric treatment. In provinces that do not have this exclusion, it is possible to detain people with untreatable disorders, such as antisocial personality disorder, although this is not common in practice.

Following trends in the USA in the 1960s and 1970s, a number of Canadian jurisdictions changed their committal criteria from a need for treatment to a risk of physical dangerousness. Subsequently, most jurisdictions added a broader 'serious harm' criterion.

Many provinces have amended their legislation to allow committal based on a likelihood of substantial mental or physical deterioration as an alternative to the dangerousness/harm criteria. Ontario has placed restrictions on the use of this provision, so that it can be applied only if: (1) the patient is incapable of making a psychiatric treatment decision; (2) the patient's substitute decision-maker agrees with the decision to treat the patient in hospital; and (3) the patient's mental disorder has previously responded to treatment.

Saskatchewan, Nova Scotia, and Newfoundland and Labrador add a capability criterion to the effect that if the person is capable of making an admission or treatment decision, he or she cannot be admitted as an involuntary patient. This is consistent with the model advocated by Dawson & Szmukler (2006).

Rights procedures

Mental health acts require that when patients are detained, they are informed of their rights, including the reasons for detention, the right to consult a lawyer and the right to appeal to a quasi-judicial tribunal for release. In some jurisdictions a person named by the patient or next of kin are also informed of these rights. In most jurisdictions, this information is provided by the clinicians and in some by special rights advisors.

Treatment authorisation for committed patients

The right to refuse treatment

Ontario and several other provinces give primacy to capacity. In these provinces, a person who is found capable of making a treatment decision cannot be forcibly treated even when committed to hospital. In practice, people who are capable rarely exercise this right (Solomon *et al*, 2009). However, procedures designed to enable an involuntary patient to challenge a finding of treatment incapacity regularly result in delays in initiating treatment (Kelly *et al*, 2002).

Other Canadian jurisdictions take the position that when the state takes away a person's freedom because of risk associated with a mental disorder, the state has the responsibility to provide the person with the treatment necessary to regain his or her freedom. For example, in British Columbia the medical director of a psychiatric facility provides consent for psychiatric treatment in cases when a committed patient refuses.

The three provinces which require a finding of treatment incapacity as a criterion for in-patient commitment do so as a pre-emptive approach to the quandary of detaining but not treating a patient. This is possible because these provinces use a high threshold for capacity: the person must be 'fully capable'.

Advance directives

An extension of the tension between respect for autonomy and the right to treatment is the manner in which Canadian jurisdictions deal with advance directives. In Ontario, an advance directive to refuse a treatment must be followed if it is applicable to the circumstances. Thus, individuals who state that they do not want psychiatric treatment, even if committed to a hospital, could remain in hospital for the rest of their lives unless they experience a spontaneous recovery. In some provinces, such as Saskatchewan, physicians must consider, but are not bound by, advance directives that prohibit standard treatment of psychiatric disorders for involuntarily hospitalised patients. In other provinces, such as Manitoba, the person's competent wishes must be followed by the substitute decision-maker except if doing so would endanger the physical or mental health of the patient or others. In those circumstances, the decision must be made in the patient's best interests.

Consent to treatment for incapable patients

Canada has two models for authorising treatment for individuals who lack the capacity to consent to treatment. In the 'state' model an independent appointee of the state (hospital administrator, physician, quasi-judicial tribunal or court) makes this decision, whereas in the 'private' model a substitute decision-maker, who may or may not be a relative, makes decisions for an incapable patient (Gray *et al*, 2008, p. 200).

Compulsory treatment in the community

Community treatment orders (CTOs) and similar mechanisms for compulsory community treatment, such as conditional leave, are now available in 8 of the 13 Canadian jurisdictions. Canadian CTOs are similar to those used in Scotland and in England and Wales. Depending on the jurisdiction, one or more physicians must complete the required forms. The process can be initiated while a patient is hospitalised or in the community. In practice, most CTOs are initiated while a patient is awaiting discharge from an involuntary admission.

In contrast to Australia, in Canada a person must have had a stipulated amount of in-patient psychiatric care before being placed on a CTO (Gray *et al*, 2010). For example, Newfoundland and Labrador requires that the person has been involuntarily hospitalised on three or more occasions or for a minimum of 60 days in the previous 2 years. Thus, from a policy perspective, CTOs attempt to solve the revolving-door phenomenon rather than being an attempt to adhere to the principle of using the least restrictive alternative. Alberta is the exception, as it has incorporated flexibility in its CTO provision. The basic CTO requires that the person has had two or more involuntary admissions or has had one admission of 30 or more days in hospital in the previous 3 years. Alternatively in Alberta, people can be placed on a CTO without previous hospital admissions if they have exhibited a recurrent pattern of behaviour that indicates that they are likely to cause harm or to deteriorate if not on a CTO (Gray *et al*, 2012).

Formal treatment planning, including family involvement, is a required part of the CTO in some jurisdictions. Furthermore, all jurisdictions require that the services necessary to support the CTO are actually available to the patient.

The introduction of CTOs has been controversial in some Canadian jurisdictions, especially in Ontario. In 2013, an application that CTOs contravened the Canadian Charter of Rights and Freedoms was dismissed by the Ontario Superior Court (*Thompson v. Attorney General 2013*).

Other rights and safeguards

In Canada, a person committed to a psychiatric hospital or on a CTO has the same rights and privileges as any other person except if these are specifically restricted by law. Thus, a committed person has the right to vote and to communicate with others. As noted above, patients must be

informed of their rights when they are involuntarily detained or when determined to be incapable of consenting to their own treatment. Most Canadian jurisdictions have mandatory reviews of commitment and CTOs after a prescribed period of time. Decisions reached by these review boards may be appealed to the courts.

Conclusion

The 13 mental health acts have shared core features, but also show some important variation in the major elements. There are similarities to the provisions in many other democratic jurisdictions. The ability to challenge any provision as not being in accord with the Canadian Charter of Rights and Freedoms, ultimately in the Supreme Court of Canada, is an important safeguard against unreasonable laws.

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MENTAL HEALTH LAW PROFILE

A new Mental Health Act for Malta

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Until recently, the care of persons with mental disorder in Malta was regulated by mental health legislation enacted in 1976. This was closely modelled on the 1959 British Mental Health Act. Now, the Mental Health Act 2012 is being implemented in two steps, in 2013 and 2014. The paper reviews its provisions.

The Maltese islands constitute a small independent country, a member state of the European Union since 2004, with a population of around 420 000 (National Statistics Office, 2011). Until recently, the care of persons with mental disorder was regulated by mental health legislation enacted in 1976. This was closely modelled on the 1959 British Mental Health Act (Saliba, 1994), focused on setting out formal procedures to be followed within mental healthcare provision.

The Mental Health Act 2012 was in development for over a decade; it is being implemented in two steps, in 2013 and 2014.

The Act has 11 parts, each comprising several articles. Its main aims are presented within the short title, 'an act to regulate the provision of mental health services, care and rehabilitation whilst promoting and upholding the rights of people suffering from mental disorders'. Such explicit expression of the principles guiding the legislation is a significant departure from the prescriptive nature of the previous law.

This paper outlines the more salient changes that have been introduced, following the structure of the Act itself.

Part I: Preliminary

Part I focuses on operational definitions of terms used within the Act. The new terminology used in this law reflects the division between clinical and managerial responsibility within mental healthcare facilities, recognises the contribution of all professions working in mental healthcare, removes stigmatising terminology and provides a more clinical definition of 'mental disorder'. Mental disorder has been defined as a significant mental or behavioural dysfunction exhibited by signs or symptoms including disturbance of thought, mood, volition, perception, cognition, orientation or memory, and deemed pathological in accordance with internationally accepted standards. Treatment has been defined as being medical, nursing, psychological and social, implicitly following the biopsychosocial model (Engel, 1980), and is a core component of care as defined by this law.

Part II: Rights of users and carers

The rights of persons with mental disorders and their carers are clearly stated. Treatment is to be delivered in the least restrictive manner and setting, with an emphasis on having treatment delivered primarily within the community. The law also sets out the principles of active participation of the patient in the planning of care, adequate information about the disorder, treatment options and services available, free informed consent, confidentiality, access to clinical information, free and unrestricted communication with the outside world and the right to receive visitors in private within all reasonable times.

A new concept of 'responsible carer' is introduced, wherein the person being provided with mental healthcare has the right to appoint a trusted person of choice to take an active representative role within the multidisciplinary care team and in other instances as required. This is a significant change from the earlier legislation, which had automatically designated the nearest relative as the person with a representative role. One of the projected advantages of having a carer chosen by the patient is to address the possible conflict of interests and to ensure greater autonomy for the patient. In cases of suspected abuse, the Commissioner (see below) may act to substitute the nominated carer.

Part III: Commissioner

A new role of Commissioner for the promotion of the rights of persons with mental disorders is introduced. This Commissioner is ascribed myriad functions, including the promotion and safeguarding of the rights of persons suffering from a mental disorder as well as of their carers, reviewing operational policies to facilitate social inclusion and well-being, and ensuring that patients are not held in institutional care any longer than necessary. The Commissioner ultimately approves orders for hospital involuntary treatment beyond the 10-day period of involuntary admission for observation or involuntary treatment in the community, through a process of external peer review.

The role of the Commissioner also extends to monitoring persons certified as lacking mental capacity and who are under curatorship or tutorship, authorising special treatments and clinical research, and ensuring guidelines and protocols to minimise restrictive care are in place. The Commissioner is the identified authority to receive and investigate complaints of breach of patient rights.

The Commissioner's functions are thus extensive and also subsume those of the previous Mental Health Review Tribunal, which therefore becomes redundant. Decisions or orders made by the Commissioner are all subject to appeal within the Court of Voluntary Jurisdiction.

Part IV: Admission to a licensed facility and community treatment

A person may be admitted to a facility specifically licensed to provide mental healthcare on either a voluntary or an involuntary basis.

Involuntary admission and treatment within a facility are based on three conditions, namely (1) the person has to have a severe mental disorder, due to which (2) there is a serious risk of physical harm to self or others, and (3) failure to admit the person would likely result in serious deterioration of the condition or prevent adequate treatment which cannot be safely provided in the community. Should one of these conditions cease to remain present, the person may no longer be kept under involuntary care.

Applications for involuntary admission for observation are still to be made by the responsible carer (previously the nearest relative) or the mental welfare officer, with recommendations by two medical practitioners, one of whom must be a specialist in psychiatry. The period of involuntary admission for observation cannot exceed 10 days, whereas under the previous act this was 28 days. An exception remains in the case of an emergency, where a single medical recommendation by a medical practitioner together with the application from a responsible carer is sufficient for involuntary admission for observation. This retains holding power within a licensed mental health facility for 24 hours, as compared with the 72 hours under the previous act. The treatment order period has been reduced from the previous 12-month period to 10 weeks.

The possibility of having compulsory treatment in the community is another development introduced by this Act. Persons on a community treatment order may now be prescribed treatment in the community, within the context of a care plan focused on facilitating integration within a community setting.

Part V: Mental capacity

The Mental Health Act states that persons with mental disorders are presumed to retain mental capacity and competence to make decisions unless otherwise certified by a specialist in psychiatry. Capacity is broadly defined as the ability and competence to make and be responsible for different types of decisions, and may be determined by one psychiatric specialist.

The approaches to lack of capacity are contingent on the expected duration of this condition, with a period of less than 14 days requiring only documentation in the clinical case notes. If the lack of capacity is expected to last longer than 26 weeks, an application in the civil courts for incapacitation or interdiction can result in the appointment of a curator. Passage of parallel legislation will also enable the possibility of applying for a guardianship order as an alternative to incapacitation or interdiction in the near future.

Part VI: Minors

The law specifically mentions the need to preserve the relationship between persons under the age of 18 years who might be admitted into a facility providing mental healthcare and their parents or responsible carers, even if this is somewhat limited to providing flexible visiting hours. The prescribed periods of involuntary admission for observation and treatment are shortened in the case of minors to a maximum of 12 weeks. Continuing detention orders may be approved for a maximum 3 months, renewable.

Part VII: Special treatments, restrictive care and clinical trials or other medical or scientific research

Electroconvulsive therapy may be administered only after a second specialist opinion and with the informed consent of the patient. In the case of lack

of capacity to provide consent, a responsible carer shall provide such consent.

Part VIII: Patients involved in criminal proceedings

The courts may issue orders for observation in a mental health facility in order to assess the mental capacity of persons charged with a criminal offence for periods of 3 months, renewable. Power to order the discharge of a person detained in a mental healthcare facility upon the plea of insanity can be exercised by the court after a recommendation to the court by three specialists, one of whom is the responsible specialist. Leave of absence may still be granted by the minister responsible for justice in the context of a multidisciplinary treatment plan.

Part IX: Mental health licensed facility

All facilities which provide a mental health service will continue to be duly licensed as currently provided. However, facilities which provide services to persons detained on an involuntary basis, minors, and forensic patients (persons concerned in criminal proceedings and prisoners) need a specific licence to operate. Every licensed facility must have written patient care management protocols and operational guidelines for implementation of the requirements imposed by the new legislation.

Part X: Promotion of social inclusion

The law emphasises the need for social inclusion, and gives the Commissioner an advocacy role with legislative bodies to make recommendations on social policy. This part also gives the Commissioner an executive role in taking appropriate action against discrimination or exploitation of persons by reason of their mental health status.

Conclusion: challenges and opportunities

The new Act explicitly states a set of values and principles: the promotion of patient autonomy; care delivered to persons integrated in their community; the use of the least restrictive methods of care; and a managerial approach, with defined time frames, care plans and goals. It is expected to provide logistic challenges in its implementation, but if these are met, it can be expected that mental healthcare in Malta will reflect the progress made in clinical and academic psychiatry.

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RESEARCH PAPER

A survey of the mental healthcare systems in five Francophone countries in West Africa: Bénin, Burkina Faso, Côte d'Ivoire, Niger and Togo

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A French translation of this paper is available on request from the corresponding author
Une traduction française de ce document est disponible sur demande auprès de l'auteur correspondant

Sub-Saharan Africa has a wide mental health treatment gap, with low levels of access to mental health services. This paper presents the findings of systematic situation analyses carried out in five Francophone countries in West Africa, which are among the poorest in the world. The findings showed low levels of budgetary allocation to mental health, poor health infrastructure (especially at primary level) and unequal distribution of human and financial resources. In this challenging context, there are signs of reform of services, based on international best-practice guidelines and practical considerations such as decentralisation of services, task-sharing and strengthening stakeholder skills to advocate for change.

Finding a way to respond to the huge burden of mental illness is a major public health challenge, particularly in low-income countries, where 76–85% of people with severe mental disorders receive no treatment (World Mental Health Survey Consortium, 2004).

In this paper, we assess aspects of mental healthcare in five Francophone countries of West Africa (Bénin, Burkina Faso, Côte d'Ivoire, Niger and Togo) and how they are reforming services to make them more accessible.

Method

The comparison uses situation analysis studies conducted in Côte d'Ivoire (2013), Togo (2012), Burkina Faso (2011) and Niger (2011) to guide

This review was based largely on country situation analyses sponsored by CBM International, and carried out by the following leaders in mental health in their respective Francophone countries in West Africa. We gratefully acknowledge their commitment and work:
Burkina Faso – M. Pale Koffi;
Côte d'Ivoire – Dr Brou N'Guessan, Prof. Joseph Delafosse;
Niger – Dr Djibo Douma Maiga;
Togo – Professor Valentin Dassa, Dr Kokou Messanh Soedje

J.E. works for CBM, which sponsored the situation analyses used as the raw data in this paper

D.D.M. works for the Government of Niger as the National Mental Health Programme Coordinator

Table 1
Framework demographic data

	Bénin	Burkina Faso	Côte d'Ivoire	Niger	Togo
Population (millions)	10.05	17.00	19.84	15.20	6.10
Area (km^2)	114 763	274 200	322 462	1 267 000	56 785
Population density (persons per km^2)	60	51.8	65.3	12.5	95
Expenditure on health (% of gross domestic product)	4.6	15.46[a]	4.34	6	4.36
Life expectancy at birth	56.5	55.9	56.0	55.1	57.5
Human Development Index, 2012 (and rank out of 186 countries)[b]	0.459 (166)	0.332 (183)	0.444 (168)	0.313 (186)	0.542 (159)
Literacy rate (%)	42.4	21.8	56.2	28.7	57.1

[a] The budgeting of other ministries and institutions related to health were included from 2008.
[b] Non-income Human Development Index (HDI): United Nations Development Programme (UNDP) statistics from http://hdr.undp.org/en/countries/

collaborative mental health work between government ministries and CBM, an international development organisation. The information was used to plan evidence-based interventions, appropriate for the country, based on the World Health Organization's mhGAP programme (WHO, 2008). In Bénin, data were taken from the World Health Organization's AIMS report (WHO, 2011a).

A common framework was used for each analysis, based on recognised structured assessment tools (Cohen *et al*, 2011), principles for effective integration with general healthcare (WHO, 2001) and information useful for programme development.

Context

West Africa is among the poorest regions in the world, reflected in very low Human Development Index rankings (Table 1), particularly for Niger. Côte d'Ivoire has historically had a stronger economy, but this was set back by the civil war of 2002–11. Life expectancy and literacy rates are also low regionally (Table 1), reflecting weak health, education and social services.

In each country, government spending on mental health is low: less than 1% of health budgets (WHO, 2011b). Non-governmental organisations provide financial and technical support, either through government systems or in private and religious/humanitarian services. Civil society organisations also act as forums for advocacy around disability, human rights and related issues.

The five countries were all French colonies until independence in the early 1960s, and this legacy has resulted in similar administration of health systems.

None of the five countries possesses detailed information about mental, neurological or substance use (MNS) disorders in decentralised services. There are few primary-level or community mental health services. Health information systems at the primary level do not distinguish MNS disorders as distinct categories. Such data are either completely absent or limited to broad categories such as 'mental illness'. This is one of the obstacles to the development of community mental healthcare, because planning has always been based exclusively on hospital data (Patel & Kleinman, 2003). Community studies are rare, and not usually undertaken by government, so are not considered in planning (Gureje & Alem, 2000).

Mental health needs and beliefs

There are limited published data on prevalence in the region. All the countries provided statistics based on presentation to services in major centres, but there were no good epidemiological data from community-level surveys. The main presentations in hospital statistics were psychotic disorders, depression, anxiety disorders, bipolar disorder and epilepsy, with no significant differences between countries. In all these countries, there were raised risk factors for mental illness such as poverty, malnutrition and inequity of access to health services; in addition, war has been a recent experience in West Africa.

The five countries surveyed are ethnically diverse and have populations who are of Christian, Muslim and traditional religious persuasions. In general, Christianity is more common in the south and coastal parts of the region, with Islam more common to the north. In practice, traditional polytheistic beliefs are widely followed by members of communities who describe themselves as Muslim or Christian. This is very relevant to health-seeking behaviour, with mental illness commonly considered to have a spiritual cause, and people typically turn to traditional or religious healers first.

Traditional treatments are of course peculiar to different areas and ethnic groups, but often take the form of herbal remedies or ceremonies against possession. Christian and Muslim leaders offer prayer or perform ceremonies to respond to the perceived spiritual cause of emotional distress or socially unacceptable behaviour. Some are identified as experts in this area. Unfortunately, in all the countries, human rights abuse has been reported in traditional or religious settings, and such establishments have often become places of long-term containment.

When faced with long-lasting or relapsing conditions, families often try several types of care, sometimes including travelling to a specialist hospital. All these options are expensive, sometimes catastrophically so for families.

Table 2
Policies, plans and legislation in mental health

	Bénin	Burkina Faso	Côte d'Ivoire	Niger	Togo
Mental health policy	Policy in place	Specific mental health strategic plans or general health strategy includes mental health items			
Services programme coordination of mental health activities: national directorate (all have coordinator)	Yes	Created in 1993	Created in 2007	Created in 1993	Created in 1994
Strategic plan for mental health (last valid plan)	2009–18	2011–20	2013–15	2010–14	2012–15
Legislation[a]	Code of Persons and the Family (articles 457, 458) and Penal Code	Integrated in other laws	Civil Code (articles 489–512)	Drafted but not yet adopted	Civil Code (articles 489–515) and Penal Code (article 411)
Civil society	Each country has local, regional or national mental health organisations, but none are managed by people with mental health problems themselves, or carers				

[a] Draft legislation exists in Niger and is being elaborated in Bénin.

Table 3
Provision of mental health services

	Bénin	Burkina Faso	Côte d'Ivoire	Niger	Togo
Number of mental healthcare specialists[a] per 100 000 population	0.16	0.70	0.59	0.29	0.10
Mental health training schools for medical doctors	1	1	1	0	0
Mental health training schools for general nurses	0	1	1	1	1
Tertiary services	University Neuro Psychiatric Centre of Jacquot and a psychiatry department at Borgou Hospital	Psychiatry departments at Yalgado Ouédrago Hospital (Ouaga) and Bobo Dioulasso	Psychiatric hospitals of Bengerville (1962) and Bouake (1970)	Psychiatry departments at National Hospitals of Niamey (1956) and Zinder	Psychiatric centre of Zébé (1904) and psychiatry and psychology clinical service of Tokoin, Lomé
Proportion of regions with psychiatric units in general hospitals, or secondary hospitals providing mental healthcare[b]	4/6	9/9	11/17	8/8	0/6
Proportion of districts with primary-level services providing mental healthcare	0/34	27 /42	3/48	3/42	0/35
Psychiatric beds per 100 000	0.44	0.85	1.3	0.95	1.80

[a] Mental healthcare specialists are both psychiatrists and nurses skilled in mental healthcare. It is important to note that the discussion has focused on the status of psychologists in mental healthcare, but many are not clinically trained.
[b] Secondary-level health services at named regional hospital centres in the five countries.

Policies and legislation in mental health

The study highlights a lack of mental health policies in these countries. Bénin developed, validated and adopted a mental health policy in 2009, but it is not well endorsed. In the other four countries, the annual health strategic plan routinely has a mental health component (Table 2) but this is rarely implemented.

Laws relating to mental illness are enshrined in the colonial order of 1938 establishing a psychiatric service in French West Africa (Collignon, 1978), and some legislation defines how mental illness should be treated in the criminal code. Despite the fact that all five countries have signed the UN Convention on the Rights of Persons with Disabilities, and all but Côte d'Ivoire have gone on to ratify it, current legislative practice fails to protect these rights.

Governance, services and the provision of mental healthcare

Governance

Administratively, each country has a national coordinator in the Ministry of Health, who is generally the senior psychiatrist in the country. In all cases, mental health is a small department under 'non-communicable diseases', with little political impact, as this field has not been a priority. One result is the allocation of few resources to mental health, so although policy exists, and strategic plans are developed, these are hardly ever budgeted for, beyond maintenance of existing core (hospital) services and staff salaries. Increased interest from the international community, including agencies such as the World Health Organization, which launched a Global Mental Health Action Plan in 2013, is starting to change this.

Services are unevenly distributed geographically, with the great majority based in the capital cities. Studies in the region suggest that only around 15% of people with severe mental illness access care (Gureje & Lasebikan, 2006). This rate is likely to be the same or worse in the Francophone countries, which generally have fewer resources.

At the tertiary level, all five countries have psychiatric hospitals and/or a department of psychiatry in teaching hospitals. Despite hospital-based care being the strongest sector in all these countries, the availability of hospital beds is low (Table 3), with just a few in general hospitals.

At the secondary level of care, services are limited. In the early 2000s there was a successful process of decentralisation in Burkina Faso, which

resulted in many regions having a mental health unit in general hospitals, staffed by a specialist mental health nurse. In other countries, less than 10% of regional or district hospitals have a person dedicated to mental health.

Besides government services, non-profit, faith-based organisations provide care in each country. There are two mental health centres in Bénin, four in Côte d'Ivoire and three in Togo. In addition, the psychiatrists in each country run private clinics in the capital cities.

The provision of psychotropic drugs in these five countries is characterised by unreliability of supply and poor quality (McBain *et al*, 2012) at both primary and secondary levels of the health pyramid. Psychotropic drug supplies are much more reliable at the tertiary level and in the largest private pharmacies, but these medications are expensive, making long-term use of them impossible for most of the population.

Psychological and social interventions are available only at tertiary hospitals in some countries (Burkina Faso, Niger, Côte d'Ivoire). While in Togo there is a relatively large number of psychology graduates, they are not appropriately trained or employed for clinical work. Each country has a Ministry of Social Welfare, but there is little communication between sectors, with no dedicated social workers for people with mental health problems.

Human resource development

Côte d'Ivoire and Burkina Faso have been training mental health specialist nurses and doctors for at least two decades. They therefore have more mental health staff than the other three countries. In Bénin, despite training specialists in mental health since 1985, levels remain low due to the length of training, and because there is little interest in this specialty, due to stigma. Niger and Togo have offered training in mental health nursing since 2007 and 2012, respectively.

Discussion

Mental healthcare in these five countries is going through a period of reform. The absence of a policy framework has hindered this process, with the other main barrier being lack of personnel. Placing a greater emphasis on non-specialists providing care (task-sharing), with specialists mainly supervising, would alleviate this problem.

Poor supply of essential psychotropic medicines and poor health information management were also consistent findings. Decentralisation and provision of services at the primary-care level is probably the main priority. The five countries currently have pilot projects informed by mhGAP, either complete (Bénin), in progress (Niger) or due to commence (Burkina Faso, Côte d'Ivoire and Togo). Generally, these involve taking a systems approach to coordination and integration of mental health into routine health services (information systems, medication), building personnel capacity, ensuring ongoing support and supervision, and strengthening civil society networks in mental health. The impact of these pilots is difficult to predict. It is hoped that in a context of ongoing advocacy with government, scale-up can follow. They have certainly raised the profile of mental health in the countries; for example, some extra resources have already been released in Niger to expand the programme. International partners have primed and helped implement these pilots. In the current economic environment, such private–public partnership is essential in leveraging at least some of the resources necessary for scale-up.

In several of the countries, organisations already exist that involve users and their families in community-based rehabilitation (parts of Burkina Faso, Niger, Togo and Bénin), or provide other non-governmental, mainly faith-based, services.

Conclusion

This comparison found similar environments of great need and limited resources across the region. The political and health systems had many parallels, which allows approaches to service reform to be shared. There is now a growing understanding of the importance of integration into general health systems, geographical decentralisation, and working through other sectors. This more integrated approach, coupled with the use of non-specialists in care provision, means that the wide mental health gap may be bridged in a practical way in these low-resource settings.

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SPECIAL PAPER

Is there a resumption of political psychiatry in the former Soviet Union?

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There is no declared interest of the author other than his stance on human rights. In 2013 the European Parliament published his report on the issue of the resumption of the political abuse of psychiatry in the former Soviet republics: *Psychiatry as a Toll of Coercion in Post-Soviet Countries* (16 July 2013). Directorate General for External Policies, European Parliament, EXPO/B/DROI/2013/02

After the outbreak of the Ukrainian crisis in the spring of 2014, the former Soviet Union again became front-page news. The sequence of events led to an atmosphere reminiscent of the Cold War. In Russia itself it led to a hunt for 'national traitors' and 'foreign agents' and observers both inside the country and abroad fear a return to Soviet-style repression. For the outside world this may come as a surprise, but human rights activists have been ringing the alarm bells for a few years. Ever since Vladimir Putin took power, the human rights situation has deteriorated. One of the warning signs was the return of the use of psychiatry for political purposes, to 'prevent' social or political activism or to ostracise an activist.

What is political abuse of psychiatry?

Political abuse of psychiatry refers to the misuse of psychiatric diagnosis, treatment and detention for the purposes of obstructing the fundamental human rights of certain individuals and groups in a given society. The practice is common in, but not exclusive to, countries governed by totalitarian regimes. In these regimes, abuses of the human rights of those politically opposed to the state are often hidden under the guise of psychiatric treatment. In democratic societies 'whistle-blowers' on covert illegal practices by major corporations have been subjected to the political misuse of psychiatry.

The Soviet Union was a country where political abuse of psychiatry took place, but over the past decades quite extensive documentation has been published on similar abuses in other countries as well.[1] The fact that the use of psychiatry for political purposes is reported from so many diverse countries reveals an ongoing tension between politics and psychiatry, and also that using psychiatry to stifle opponents or to solve conflicts appeals not only to dictatorial regimes but also to well established democratic societies. Nevertheless, it is clear that the political use of psychiatry has been a favourite of collectivist (socialist or communist) regimes. An explanation might be that ideologies that envision ideal societies – where all are equal and all will be happy – often conclude that those who oppose this must be of an unsound mind.[2]

Soviet psychiatric abuse

The use of psychiatry to incarcerate dissidents in psychiatric hospitals in the Soviet Union started to have a systematic character in the late 1950s and early 1960s. However, there are cases of political abuse of psychiatry known from much earlier. Nonetheless, in the course of the 1960s the political abuse of psychiatry in the Soviet Union became one of the main methods of repression. By the end of that decade many well-known dissidents were diagnosed as being mentally ill. According to our data, approximately one-third of all political prisoners were diagnosed as being 'mentally ill'. A crucial role in this was played by KGB Chairman Yuri Andropov, who in 1967 took the helm of that organisation and made the struggle against 'ideological diversion' the centrepiece of his KGB work. According to a former general in the Ukrainian KGB, it was Andropov who, together with a selected group of associates, developed the political abuse of psychiatry as a systematic means of repression (see, among others, Bloch & Reddaway, 1977; van Voren, 2010).

The political abuse of psychiatry in the Soviet Union developed within a totalitarian

[1] There were extensive reports on the systematic political abuse of psychiatry in Romania, and also reports on individual cases in Czechoslovakia, Hungary and Bulgaria but without evidence of systematic abuse. Research on East Germany came to the latter conclusion, although politics and psychiatry appeared to have been closely intermingled. Later, information appeared on the political abuse of psychiatry in Cuba, and there are frequent reports on systematic abuse of psychiatry for political purposes in the People's Republic of China. In the 1990s, a case of political abuse of psychiatry took place in The Netherlands, in the course of which the Ministry of Defence tried to silence a social worker by falsifying several of his psychiatric diagnoses and pretending his behaviour was the result of mental health problems. See IAPUP (1989), Süss (1998), Brown & Lago (1991), Munro (2001, 2006), Nijeboer (2006).

[2] It is also important to note that political abuse of psychiatry stands out from general abusive practices in psychiatry. The latter include general human rights violations in mental institutions, such as adverse living conditions, abuse by staff, unlawful incarceration, inhumane treatment, as well as 'economic abuse' of psychiatry. There is also a vast 'grey area' involving people who are hospitalised simply because they are considered bothersome, as well as people who do suffer from mental health problems but who should never have been compulsorily treated or hospitalised. This was the case in the Soviet Union and is presently the case in China, where many victims are so-called 'petitioners', who travel to Beijing from the provinces in order to issue complaints against local officials. Instead of being heard they are hospitalised and frightened with psychiatric 'treatment'.

environment, which greatly facilitated its growth. The diagnosis of 'sluggish schizophrenia', developed by the Moscow School of Psychiatry and in particular by academician Andrei Snezhnevsky, provided a handy framework to explain this behaviour. According to the theories of Snezhnevsky, schizophrenia was much more prevalent than previously thought, because the illness could be present with relatively mild symptoms and progress only later. According to Snezhnevsky, patients with sluggish schizophrenia were able to function almost normally in the social sense. Their symptoms could resemble those of a neurosis or could take on a paranoid quality. Patients with paranoid symptoms retained some insight into their condition, but overvalued their own importance and might exhibit grandiose ideas of reforming society. Thus, symptoms of sluggish schizophrenia could be 'reform delusions', 'struggle for the truth' and 'perseverance' (see Bloch, 1989).

The post-Soviet period

When in 1991 the Soviet Union imploded, all 15 Soviet republics gained or regained their independence. Some did this with considerable success, others with a long list of hiccups, fallbacks and periods of civil war, bouts of despotism or conflicts with neighbours. The collapse of the Soviet Union saw the development of a non-governmental sector in mental health. Until the late 1980s, Soviet psychiatry was dominated by one psychiatric association, the All-Union Society of Psychiatrists and Neuropathologists (AUSPN), which was directly controlled by the Ministry of Health of the Soviet Union (the stationery of the AUSPN even had the heading 'AUSPN' and then as a sub-heading 'Ministry of Health of the USSR'). In the course of the 1990s a dozen psychiatric associations were set up, as were professional bodies for, among others, psychiatric nurses; relatives' organisations were also established and, by the end of the century, the first groups of consumers of mental health services. A vibrant web of groups, committees and associations emerged that strived to humanise services.

The practice of using psychiatry against political opponents virtually ceased to exist, although a few cases surfaced, notably in 1996 in Turkmenistan and in Uzbekistan. What came in its place, however, was a very disturbing collection of other forms of abuse, including 'economic abuse' (e.g. having relatives declared mentally ill in order to take control of their property) and criminals avoiding incarceration by bribing psychiatrists to deliver false diagnoses. Furthermore, human rights abuses in the mental health system in the former Soviet republics remained rampant, due to lack of resources, outdated methods of treatment, lack of understanding of individual human rights and a growing lack of tolerance in society where *survivalism* became the main philosophy.

In Russia, the reform movement in mental health had only a limited impact. Many of the mental health institutions remained inhuman environments, while the level of psychiatric care was far from acceptable and knowledge about modern therapeutic approaches, the role of relatives and carers and the self-help capabilities of mental health service users remained scarce and limited. One of the main reasons for this situation was the fact that the leadership of Soviet psychiatry in Russia maintained its power base. Most leaders of Russian psychiatry also revoked the earlier confession that psychiatry in the Soviet Union had been abused systematically for political purposes and instead referred to 'individual cases of hyperdiagnosis' or 'academic differences of opinion' (Dmitrieva, 2001, pp. 116–130).

The number of individual cases of political abuse of psychiatry has increased significantly over the past few years, in particular in Russia, Belarus and Kazakhstan. So far it appears not to be yet a *systematic* repression of dissidents through the mental health system. In most cases, citizens fall victim to regional authorities in localised disputes, or to private antagonists who have the means to bribe their way through the courts.

The resumption of political abuse in individual cases is closely linked to the deteriorating human rights situation and the fact that lower-level authorities feel much more freedom to clamp down on undesired elements than previously. An air of untouchability is returning, and the rule of law has increasingly become subject to political machinations. In particular, in Russia much of the structure is still in place that allowed the political abuse of psychiatry to happen. The first cases of renewed political abuse of psychiatry started to emerge at the beginning of the 21st century, after Vladimir Putin resumed the Presidency and the downward spiral towards increased repression commenced (see e.g. Murphy, 2006).

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NEWS AND NOTES

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

Mental Health and Deafness World Congress

The European Society for Mental Health and Deafness, in collaboration with Queen's University Belfast and the Royal College of Psychiatrists, has announced that the 6th World Congress on Mental Health and Deafness will be held in Belfast, Northern Ireland, 16–19 September 2014. The theme is 'Pathways to rights'. A rights-based approach ensures that mental and physical health and access to care are available to all people on a fair basis.

Keynote speakers include: Emeritus Professor Sir David Goldberg, winner of the RCPsych Lifetime Achievement Award; and Dr Liisa Kauppinen, former President of the World Federation of the Deaf and winner of the United Nations Human Rights Award 2013.

One in 1000 of the world's population is severely or profoundly deaf from birth or early life, a total of about 7 million people. Many belong to their country's deaf cultural community, with their national sign language as their first or preferred language. However, as the great majority are born into hearing families, they may have experienced language delay as children. As adults, deaf people can be subject to discrimination and social exclusion. Deaf people have at least the same range and prevalence of mental health problems as the general population, but have reduced access to services. For further information and to register see the website http://www.wcmhd2014.org

Emeritus Professor Sir David Goldberg, winner of the RCPsych Lifetime Achievement Award, will be a keynote speaker at the 6th World Congress on Mental Health and Deafness

International bursary schemes

The College Faculty of the Psychiatry of Old Age has established an annual bursary to enable a psychiatrist from a low- or middle-income country to attend the Faculty Annual Residential Meeting (usually held in March) in order to give an oral or poster presentation, or deliver a workshop. The bursary is intended to cover the cost of travel, accommodation and registration fees up to a maximum of £1500. Informal mentors will be identified for bursary-holders to enhance their introduction to Faculty members and their enjoyment of the meeting. For information on how to apply, please contact Kitti Kottasz (kkottasz@rcpsych.ac.uk).

The College Faculty of the Psychiatry of Intellectual Disability is now running an annual bursary scheme to enable a psychiatrist from a low- or middle-income country to attend the Faculty Annual Residential Meeting (usually held in October). The recipient will give an oral or poster presentation, or deliver a workshop. The bursary will cover the cost of travel, accommodation, registration and attendance at the Conference dinner, up to a maximum of £1500. An informal mentor will also be appointed to the successful candidate. For further information or to apply, please contact Kitti Kottasz (kkottasz@rcpsych.ac.uk).

Careif Global Suicide and Suicide Prevention Essay Competition 2014

Careif, an international mental health charity with a special focus on protecting and promoting the health and well-being of young people living in culturally diverse societies around the world, holds an annual essay prize competition to encourage 'state of the art' essays on key mental health themes. Students are invited to submit, in open competition, an essay on suicide and suicide prevention and to explore its socio-religious context, cultural meaning and association with stigma. Entries must be no more than 4000 words, should be referenced using the Harvard style, and submitted by email to essay14@careif.org by 21 December 2014.

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Thomas Szasz

Sir: In their papers in the May issue, Moncrieff (2014) and Turner (2014) naturally focus on Szasz's polemical views on mental illness from the early 1960s onwards. I would like to draw readers' attention to a less well known paper he co-authored (Szasz & Hollender, 1956), which I have found much more constructive and enduring.

The paper outlines three models of doctor–patient relationship: activity–passivity; guidance–cooperation; mutual participation. It makes the point that different disorders require different approaches (in particular, that long-term conditions require more collaborative ground rules) and even the same disorder may require different approaches at different times. It suggests that different doctors (and patients) are temperamentally suited to different models, and may experience problems if unable to change model as the clinical situation requires. It emphasises

the importance of complementarity between the patient's model and the doctor's. In contrast to Szasz's later critique of mental illness, the paper accepts the importance of disorder of function as well as physical lesions.

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Moncrieff, J. (2014) 'Freedom is more important than health': Thomas Szasz and the problem of paternalism. *International Psychiatry*, **11**, 46–48.

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Szasz in the context of low-income countries

Sir: It was refreshing to read in the May issue the paper by Moncrieff (2014) and the follow-on comment by Turner (2014). Taking heed from experiences in low-income countries and involving the community to accrue the best benefits when designing interventions are cited in Moncrieff's article. The parallel drawn between health and freedom is a paradox if one is to take the context of mental illness in many low-income countries. Most patients with mental illness in Africa are disadvantaged by the absence of mental health legislation frameworks that somehow favour 'health' over 'freedom', as only 44.4% of countries in Africa have drafted mental health legislation (Word Health Organization, 2011). Some are literally chained and subjected to witchcraft, such is the stigma of mental illness. Freedom in all its forms as advocated by Szasz, and buoyed in Moncrieff's article, is not 'missed' in low-income countries in the context of mental illness, but rather is conveniently lacking, due to stigma.

As should professionals in any branch of medicine, psychiatrists, be it in low-income countries or globally, should be advancing modern and evidence-based understanding of mental illness and advocate for patients in times of sickness and vulnerability to deliver the best available care. At times, the treatment offered might involve the patient's temporary loss of liberty, but this should always be done with due and appropriate consideration to maintaining human rights and dignity. In the long run, advocating advanced and improved mental healthcare will enhance equal opportunities of liberty and freedom.

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Forthcoming international events

13–17 August 2014
Third International Congress of Psychology and Education
Panamá, Panamá
Website: http://www.medical-events.com/

22–26 August 2014
National Conference on Addiction Disorders
St. Louis, USA
Website: http://www.addictionpro.com/ncad-conference/national-conference-addiction-disorders

25–29 August 2014
7th World Congress for Psychotherapy
Durban, South Africa
Website: http://wcp2014.com

27–30 August 2014
15th European Symposium on Suicide and Suicidal Behaviour
Tallinn, Estonia
Website: http://esssb15.org/

1–5 September 2014
13th International Conference 'Economy and Business'
Elenite Holiday Village, Bulgaria
www.sciencebg.net/en/conferences/economy-and-business/

4–8 September 2014
5th International Conference 'Education, Research and Development'
Elenite Holiday Village, Bulgaria
http://www.sciencebg.net/en/conferences/education-research-and-development/

7–11 September 2014
8th International Conference 'Language, Individual and Society'
Elenite Holiday Village, Bulgaria
http://www.sciencebg.net/en/conferences/language-individual-and-society/

10–12 September 2014
3rd World Congress of Clinical Safety (3WCCS) Main theme: Clinical Risk Management
Madrid, Spain
Website: http://www.medineo.org

10–12 September 2014
3rd European Conference on Mental Health
Tallinn, Estonia
Website: http://www.evipro.fi/joomla/index.php/3rd-european-conference-on-mental-health

10–14 September 2014
3rd International Conference 'Media and Mass Communication'
Elenite Holiday Village, Bulgaria
http://www.sciencebg.net/en/conferences/media-and-mass-communication/

11–12 September 2014
Memory: Forgetting and Creating
Gdańsk, Poland
Website: http://memoryforgetting.ug.edu.pl/

14–18 September 2014
XVI World Congress of Psychiatry
Madrid, Spain
Website: http://www.wpamadrid2014.com/

16–19 September 2014
6th World Congress on Mental Health and Deafness
Belfast, UK
Website: http://www.wcmhd2014.org/

17–19 September 2014
18th International Forum of Psychoanalysis, 'Psychoanalysis, Trauma and Severe Mental Disorders'
Kaunas, Lithuania
Website: http://www.ifps-forum2014.com/

24–26 September 2014
2nd Global Conference: Suicide, Self-harm and Assisted Dying
Oxford, UK
Website: http://www.inter-disciplinary.net/probing-the-boundaries/persons/suicide-self-harm-and-assisted-dying/suicide-self-harm-and-assisted-dying/

25–28 September 2014
1st Global Conference of Biological Psychiatry
New Delhi, India
Website: http://wfsbpindia.com/

9–11 October 2014
International Congress of the World Federation for Mental Health: Living with Schizophrenia
Aegli Zappeiou, Athens, Greece
Website: http://www.wfmh2014.gr/

10–11 October 2014
Fall Global Psychology Symposium
Los Angeles, USA
Website: http://www.conferencealerts.com/psychiatry.htm

16–18 October 2014
3rd International Congress on Borderline Personality Disorder and Allied Disorders
Rome, Italy
Website: http://www.borderline-congress.org/

22–24 October 2014
4th International Conference on Violence in the Health Sector
Miami, USA
Website: http://www.oudconsultancy.nl/MiamiSite/violence/invitation-third.html

30 October–2 November 2014
WPA Thematic Conference on Intersectional Collaboration
5th European Congress of INA & 2nd Interdisciplinary Congress on Psychiatry and Related Sciences
Athens, Greece
Website: http://www.psych-relatedsciences.org/

7–9 November 2014
Asia Pacific Regional Conference – Alzheimer's Disease International
New Delhi, India
Website: http://www.aprc2014-india.com/

4–7 December 2014
10th International Congress on Mental Dysfunction and Non-Motor Features of Parkinson's Disease and Related Disorders
Nice, France
Website: http://www2.kenes.com/mdpd2014

12–14 December 2014
WPA Regional Congress: Yin and Yang of Mental Health in Asia – Balancing Polarities
Hong Kong, China
Website: http://www.wpa2014hongkong.org/index.html

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