Cultural psychiatry, diversity and political correctness in a shrinking world

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It is perhaps unusual for an academic journal like the *Lancet* to spearhead a 'movement' to advocate the scaling up of mental health services in low-income countries. Yet at the movement's launch in London in November 2007, attended by representatives from World Health Organization (WHO), the World Bank, donor agencies, as well as the World Psychiatric Association (WPA) and the Royal College of Psychiatrists, it was clear that a seminal series of papers, published in September of last year, was of the utmost importance for world psychiatry and for our planet. The five papers in the series 'Global Mental Health' had the following titles: 'No health without mental health'; 'Resources for mental health: scarcity, equity, and in-efficiency'; 'Treatment and prevention of mental disorders in low-income and middle-income countries'; 'Mental health systems in countries: where are we now?'; and 'Barriers to improvement of mental health services in low-income and middle-income countries' (*Lancet*, September 2007, vol. 370, nos 9590–9593).

These papers, published by a syndicate of experts, succinctly summarise and usefully tabulate evidence that the provision of mental health services and the distribution of mental health personnel in the world are inequitable. They also calculate the cost of the measures that could be undertaken to scale up the services and to promote public mental health more effectively. They review evidence that poverty, discrimination, natural disasters, ethnic violence and stigma are particularly lethal for low-income countries, and that the world community, especially at local government level, should now act to avoid a tragedy that could affect the future of us all.

I was provoked by this series of papers to reconsider the adverse effects of climate change on mental health; also to reflect on the centrality of *Lancet* papers published earlier that year on poverty, maternal mental illness and child development (Graham-McGregor *et al*, 2007), and on the effect of untreated mental disorder on politicians' policies and teachers' effectiveness. The increased risk of student suicide, and the demoralisation and depression of staff that characterised the university campus during the worst years of the Amin regime in Uganda, as well as the lack of therapists, could readily be recalled (Cox, 1975).

The *Lancet* has called not only for a politically correct advocacy group to scale up mental health services in low-income countries (in which, on average, 1 in 16 mothers die in childbirth, and 30% of which have no mental health legis-lation), but also for a less politically correct movement, the direction of which cannot be precisely foreseen, nor its limits scrutinised in any WPA manual of procedures.

The prestigious academics from India and the UK who led this initiative called for more vision, more focused altruism and more public mental health advocacy. They invoked values as well as science and are aware that the resource-rich coun-tries are part of the problem, as well as being able to provide solutions. The cost of the brain drain, for example, will surely be itemised in the report awaited from the WPA Task Force that will be debated at the WPA General Assembly in Prague in September 2008. Thus the juggernauts, such as the Royal College and the WPA, are now considering how to respond to the *Lancet* movement and where to nail their colours to this particular mast.

There are, nevertheless, several additional factors to consider if this movement is to succeed and to be fully acceptable to those clinicians working at the sharp edge in low-income countries. Cultural sensitivity is vital for the implementation of the vision and promotion of these ideas; hints of paternal-ism, or a perceived lack of a historical political perspective, are disadvantageous, and the movement needs to retain leaders who are immersed day by day in the rigours of clinical work in the developing world, and so be aware of the sheer hard work necessary to sustain the morale of community mental health professionals, whether these are psychiatric clinical officers in Uganda or family support workers in Chile. The scaling up of services that is called for will benefit from online continuing professional development (CPD), as well as roving CPD advocates equipped with motor bikes or a Land Rover. The College's Volunteer Scheme, its proposed support for the African diaspora, as well as the International Divisions, could make other contributions to this scaling-up programme.

However, institutional lethargy and personal feelings of helplessness when one is confronted by an overwhelm-ing task can intervene and have to be taken into account. Where, for example, is the long-promised College guidance on cultural competence? Is it lost, perhaps, in the politically correct endorsement of 'diversity' and 'values', to the neglect of culture and medical anthropology? Have we really lost clinical and academic interest in intercultural similarities and differences of rituals, symbols and kinship, as well as the understanding of religious beliefs and language pertinent to the management of mental disorder?

Are we really taking for granted the skills necessary to provide mental health services in multicultural Britain, with an increase of recently arrived migrants from eastern Europe, as well as refugees and asylum seekers? If so, this would be regrettable and untimely, because globalisation has in-creased the need to water cultural roots – including the culture 'within'. Cultural competence includes the develop-ment of empathy and 'connected knowledge', as well as the recognition that others may view the world through a different cultural lens (Fitzgerald, 2000). Such general cultural competence is different from culture-specific and

even intercultural competence, and yet can be acquired by critical incident analysis and using role-play. Teachers are, however, required to be fully sensitive themselves to the personal issues such training may evoke, otherwise prejudice and cultural insensitivity can be increased.

The World Federation for Mental Health in 2007 high-lighted cultural psychiatry for World Mental Health Day, and the expressed wish of service users that their beliefs, illness assumptions, rituals and family networks are considered and understood. In order for it to succeed, the *Lancet* movement must likewise consider these cultural issues and the roots of culture in language and religion. The need to scale up child development programmes illustrates well the breadth of this general scaling-up agenda. The early years of life are the cradle of cultural acquisition in low- as well as high-income countries, and are adversely affected by poverty and un-treated mental disorder. What happens to the foetus and to pre-school infants is of the utmost importance to the child's ability to become a good citizen. It is politically incorrect, therefore, to omit the newborn from maternal child health (MCH) services – MNCH is indeed a more useful acronym (World Health Organization, 2005).

Religious beliefs (including secular humanism), as well as language and dialect, also express the cultural values of societies. Any 'religiosity gap' or 'language gap' between patient and professional is therefore a disadvantage.

These cultural and training issues need to be carefully considered by any movement that sets out to change the world in which we live. But political correctness is not always an asset.

References

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Mental health services in sub-Saharan Africa

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Within the continent of Africa, mental health services are relatively undeveloped. In the sub-Saharan countries of Malawi, Kenya and Nigeria, similar problems are faced by dedicated psychiatrists who are struggling to create and sustain an educational, management and political structure for psychiatry.

Malawi exemplifies some of the most pressing issues. As Dr Kauye recounts, this is a country with an excessively low gross domestic product (GDP) per capita, even by African standards. Moreover, the overly centralised administrative structure for medical services militates against the provision of adequate community care. There are very few trained psychiatrists, and in most out-patient and in-patient settings nurses take on major responsibilities for the everyday care of patients. However, the shortage of nursing staff means that many psychiatric nurses end up doing general nursing duties. A further issue, pertinent to the need to retain appropriately trained staff, concerns medical staff who are so poorly paid that retention of their services is often linked to private sponsorship. This provides a temporary supplement to their meagre salaries. The supply chain for medication is especially vulnerable to disruption, and procurement at a national level is less secure than it should be, especially for psychiatric treatments. Ways of tackling this continuing concern are discussed by Dr Kauye.

Kenya and Nigeria are wealthier countries than Malawi, but they experience similar problems. Professor Ndetei describes how difficult it has been to retain psychiatrists in Kenya over the past decade, despite the country having made a tremendous effort to train them. Unfortunately, they migrate in ever greater numbers. As in Malawi, trained psychiatric nurses are often redeployed in order to provide general nursing duties, and at a community level there are few appropriately trained staff to deliver services to individuals with mental health disorders. We have discussed in previous issues the potential benefits of using native healers to supplement conventional psychiatric services; this is an issue discussed by Professor Ndetei with approval. As in Malawi, a lack of epidemiological research has meant that relatively little is known about the nature and scale of disorders at the level of community mental health, and there is an associated danger that research expertise is unduly centralised and remote.

Finally, Dr Olugbile and colleagues discuss the issue of mental health education in Nigeria. They provide a relatively structured account of the current state of knowledge about mental health issues in two surveys, the first concerning primary healthcare workers and the second specifically targeted at general practitioners. The authors discuss, first, a survey they conducted with a national sample of primary healthcare centres. Remarkably, none of the centres surveyed had any psychotropic drugs available in their pharmacies, nor were there any medically trained practitioners working in them. The survey was therefore focused mainly upon nurses