Box 2. Definition of incapacity under the Mental Capacity Act 2008

A person lacks mental capacity if impaired in one of the following areas:

- communicate his or her decision by any means
- remember specific information required for decision-making
- understand the information relevant to the decision-making
- use or weigh relevant information as part of the decision-making process.

Box 2 summarises the definition of incapacity. The donee is expected to make decisions based on the best interests, wishes, beliefs and values of the donor. The Act requires an independent certificate issuer, such as a lawyer, psychiatrist or accredited general practitioner, to explain the terms of the LPA and ensure that the donor understands the implications before the LPA is signed voluntarily. There is a 6-week period before the LPA can be registered and this provides opportunities for other parties to raise objections and concerns if there is a violation of the Act. The LPA does not cover areas such as decision to resuscitate, consent to treatment, advanced medical directives, execution of wills or consent to marriage or divorce.

The Act allows a court to appoint a deputy to make decisions on behalf of an individual. As a result, parents of children with intellectual disability can apply to the court and appoint themselves as deputies for their children and another person as a successor deputy when the parents themselves lose capacity or pass away.

The Act follows the British Mental Capacity Act and requires the establishment of the Office of Public Guardian. This office appoints a board of visitors to protect donors by monitoring donees and court-appointed deputies. Visitors are registered health professionals who can provide independent advice to donors, donees and deputies.

Conclusions

The mental health legislation in Singapore and the UK share a common root. There are still some aspects of the Mental Health Act which require ongoing consultation and refinement, such as supervised treatment in community settings, clear legal and clinical criteria for fitness to drive and the establishment of gazette wards in general hospitals. Recent improvements to education in forensic psychiatry in the undergraduate and postgraduate curriculum will certainly beget a better cadre of doctors and psychiatrists for the future.

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Legislation

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SPECIAL PAPER

Access to community-based mental healthcare and psychosocial support within a disaster context

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After a large-scale humanitarian disaster, 30–50% of victims develop moderate or severe psychological distress. Rates of mild and moderate mental disorders increase by 5–10% and severe disorders by 1–2%. Those with such disorders need access to mental healthcare. Primary care clinics are appropriate due to their easy accessibility and the non-stigmatising environment. There is a consensus among experts that the mental health effects of disaster are best addressed by existing services, that is, through capacity building rather than by establishing parallel systems. Mental health interventions in emergencies should begin with a clear vision for the long-term advancement of community services.

Mental health and psychosocial support (MHPSS) services are often inadequate before a disaster (Saxena *et al*, 2007). Worldwide, disaster settings are challenged to provide appropriate access to mental healthcare. Haiti had a severe shortage of mental health institutions and professionals prior to the 2010 earthquake. In Sri Lanka, two general practitioners provided MHPSS in tsunami-affected Kalmunai and Hambantota districts with populations over 400 000, because district general hospitals had no departments to treat mental health patients. In Pakistan, two psychiatrists and one mental health hospital in Mansehra provided services to the North-West Frontier, with a population over 1 million, before it was hit by a major earthquake in 2005. In Jordan, 150 000 Iraqi refugees from the 2003 war sought costly mental

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health services from private psychiatrists or the psychiatric hospital in Amman, since Jordanian general hospitals had no psychiatric wards. There were long waiting-lists and shortages of medication. In Croatia, before the 1991–95 war, mental health services were accessible at the community level, although general and psychiatric hospitals provided most services. Mental healthcare in pre-war Iraq was provided at two state psychiatric hospitals in Baghdad and 22 psychiatric units attached to general hospitals.

After a disaster, gaps between needs and services widen. Some 30–50% of victims develop moderate or severe psychological distress. This group can benefit from social interventions and basic psychological treatment. Rates of mild and moderate mental disorders increase by 5–10% and severe disorders by 1–2% (Van Ommeren *et al*, 2005). Those with such disorders need access to mental healthcare, which is best provided through primary healthcare or community mental healthcare. Primary care clinics are appropriate owing to their easy accessibility and the non-stigmatising environment (Van Ommeren *et al*, 2005).

There is a global consensus among experts that the effects of disaster on mental health are best addressed by existing services, that is, through capacity building rather than by establishing parallel systems (Inter-Agency Standing Committee, 2007). MHPSS interventions in emergencies should begin with a clear vision for the long-term advancement of community mental health services (Perez-Salez *et al*, 2011). A post-disaster focus on mental health, paired with professional expertise, can improve community services and access for affected populations (Saraceno *et al*, 2007).

The aims for mental healthcare and psychosocial care after disasters

After a disaster, MHPSS is designed to improve the emotional, mental and social well-being of beneficiaries. Individuals are empowered and thereby enhance their resilience and emotional stability. Stress disorders are managed in order to prevent severe mental health problems. At the societal level, families and groups are assisted through support networks. Interventions serve to raise awareness, mitigate stress and restore social and cultural constructs. Access at the community level to mental health services is ensured.

The broad and long-term impact of disasters on population mental health necessitates community-oriented services to address psychological problems. The process of community strengthening provides a fertile social context to mitigate the emotional response to adversity (Global Fund, 2014).

Interventions

Evidence-based experience in disaster settings supports certain psychological and social interventions. The training of volunteers and para-professionals can quickly improve access to basic psychosocial services for the population. In Sri Lanka after the tsunami, 500 community-level workers were recruited, trained and appointed to 14 tsunami-affected communities, nine of which had no psychiatrist. In Haiti after the 2010 earthquake, 190 community-level workers trained by Cordaid, an international non-governmental organisation (INGO), brought crucial interventions to five targeted departments. In Syria, the United Nations High Commissioner for Refugees (UNHCR) used community outreach and psychosocial centres to provide MHPSS and improve well-being.

Community-level mental healthcare can be enhanced by supporting primary care with training, assistance and supervision by mental health professionals (World Health Organization, 2008). Training can increase knowledge and improve competency. A 6-month training programme in mental health for general practitioners and mid-level public health staff by INGO International Medical Corps (IMC) in Sri Lanka after the tsunami increased knowledge, improved detection of mental disorders and led to the registration of more mental health patients in all administrative areas. Thirteen out-patient mental health clinics, operated by trained primary care staff, were opened after IMC provided training in one district and four new mental health clinics were opened in another district. In Lebanon, IMC trained 152 primary care doctors, nurses and social workers in the identification, management and referral of patients with mental health problems. Trainees increased their knowledge and met competency standards. In Haiti, INGO Cordaid provided training in mental health to 115 non-specialist healthcare providers.

To enhance and support broad community recovery after a disaster, health agencies should collaborate with other sectors, especially in the restitution of education services, shelter and people's livelihoods. Collaboration will help achieve the goals of demystifying mental health issues, supporting the well-being of populations affected by emergencies and providing a forum for advocacy (Inter-Agency Standing Committee, 2007).

Discussion

Mental health interventions in post-disaster settings can develop service capacity and community access through non-specialist health practitioners and community-level workers. Community-level interventions can improve well-being, resilience and awareness. Stigma can be reduced and mental health services for more severe mental illness can be provided, especially in the short and mid-term.

The disaster response should enhance access to mental health services (Perez-Salez *et al*, 2011) and improve preparedness for future emergencies (Inter-Agency Standing Committee, 2007), but new services are often unsustainable. Although unsustainable, rapid and broad access is usually valued over long-term development. The long-term impact and sustainability of interventions

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depend heavily on linkages with the health and social welfare systems (World Health Organization, 2013). Health system leaders can catalyse the development of community mental health services, so integrating MHPSS programmes with existing systems is preferred to stand-alone programmes (Inter-Agency Standing Committee, 2007; Saraceno *et al*, 2007; Perez-Salez *et al*, 2011; World Health Organization, 2013). An intervention by INGO Center for Attitudinal Healing during and after the war in Croatia (1994–96) developed linkages with international and local stakeholders but was not sustainable due to poor linkages with the government health sector.

Sustainable change in mental health services is facilitated by the political will of the government to formulate policy that integrates mental healthcare with primary healthcare through both funding and professional expertise. Primary care workers and mental healthcare professionals may best be trained by professionally designed and implemented methods, including on-the-job psychiatrist supervision (World Health Organization, 2008). This was achieved in Sri Lanka after the tsunami, but not in Pakistan after the 2005 earthquake. In Pakistan, the major challenge was poor implementation of mental health policy by trained primary care workers. In Haiti, the shortage of psychiatrists was a serious limiting factor for the implementation of a shared-care model of psychiatric consultation with non-specialist providers.

When MHPSS interventions are implemented by foreign organisations after a disaster, co-operation with local governments should be sought, cultivated and monitored for improvement. After the Croatian war, a mental health centre developed for the community failed to become an official unit of the mental health service. The first community mental health centre recognised within the Croatian mental health service came a decade later, with the Mental Health Project for South-Eastern Europe (SEE) under a Social Cohesion Initiative. The SEE Mental Health Project had favourable operational factors, high political visibility and an approach to overall health which improved social cohesion in the region (World Health Organization Regional Office for Europe, 2008).

The political support for long-term change within the mental health system was important for that European project and in other disaster settings, for example in Sri Lanka after the tsunami. Financial sustainability of gains achieved by disaster-related MHPSS interventions is consistently problematic due to insufficient budgets for community mental health services. Training budgets, salaries and organisational costs cannot be covered by the limited health sector funds available in most disaster-affected societies.

The future

Post-disaster MHPSS projects have been conducted worldwide, but usually without plans for sustainability or scaling up. Future endeavours should seek sustainability beyond the initial funding by international donors. Up-scaling of such programmes should be a cooperative effort with governments of affected countries, modelled through health and social welfare sectors. Community projects can plant seeds for service development if properly positioned and fashioned to integrate with local practices.

Context-specific methods should be emphasised and local approaches should be respected. This is achieved through proper assessment and identification of existing MHPSS needs and services. The focus should be on evidence-based outcome indicators such as the well-being and resilience of disaster-affected populations (Perez-Salez *et al*, 2011). Inclusion of MHPSS interventions in the basic package of health services provided during an emergency is recommended to improve sustainability. Sustainable progress may be achieved through cyclical interventions with foreign and local cooperation and a long-term view. Local players can gradually assume full responsibility for improved mental health services, especially if consistent with strategy for a whole region (Jitendra *et al*, 2007).

More evidence is needed on the effectiveness of MHPSS interventions, targeting provider training, psychosocial support and sustainable services post-disaster, and in particular on the clinical effectiveness, feasibility and cost-effectiveness of low-intensity, low-cost interventions that may be extended to practice settings (Overseas Development Institute, 2013).

Importantly, a post-disaster focus on improving access to community-based MHPSS is a priority for global relief agencies, including the World Health Organization (Van Ommeren *et al*, 2005), the United Nations High Commissioner for Refugees (2013), the International Federation of Red Cross and Red Crescent Societies, and Doctors Without Borders.

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SPECIAL PAPER

Psychosocial rehabilitation for severe mental illnesses in general hospital psychiatric settings in South Asia

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In South Asia, general hospital psychiatric units (GHPUs) have developed as an alternative to mental hospitals for the provision of comprehensive mental health services, training and research. GHPUs provide clinical care for all types of patients, including those with severe mental illnesses (SMIs). However, psychosocial rehabilitation is often neglected in GHPUs, partly because of the predominance of the medical model in routine clinical care and a lack of resources. This paper discusses the challenges in the management of SMIs in GHPUs and proposes a model of psychosocial rehabilitation which could be used in such settings.

In South Asia, patients with severe mental illnesses (SMIs) are seen in a variety of mental health service settings, including general hospital psychiatric units (GHPUs), psychiatric hospitals, psychiatric nursing homes, poly-clinics and office-based practices. A GHPU is a psychiatric wing in a medical school or general hospital (Wig, 1987).

The GHPUs are the main resource for general mental healthcare in South Asia. They serve large numbers of patients with SMIs, common mental disorders, substance misuse, psychosexual disorders and childhood psychiatric disorders. Liaison work constitutes only a small proportion of the total. The GHPUs also serve as the main teaching set-ups. However, psychosocial rehabilitation (PSR) is often neglected in GHPUs. This paper focuses on a model of PSR which could be used in such settings.

Development and advantages of GHPUs

In South Asia, GHPUs started under the influence of wider international developments, like the establishment of psychiatric services in general hospitals and the introduction of effective psychotropic medication. The first GHPU was started in India at Kolkata in 1933 and in Sri Lanka at Colombo in 1949. The subsequent increase in the number of GHPUs was not due to the closure of psychiatric hospitals or a decrease in the number of psychiatric beds as was seen in the West (Mendis, 2003) but was the result of poor mental health resources. In high-income countries, psychiatric services in general hospital settings generally include out-patient clinics, liaison services, emergency psychiatry, day care, substance use treatment and some other specialist clinics with or without a short-stay in-patient unit. There may also be teaching and research (Lipsitt, 2003). A large proportion of the mental healthcare is provided by specialist mental health centres or in community settings.

In contrast, GHPUs provide comprehensive mental health services in the form of clinical care, training and research. Patients with all types of psychiatric disorder, including SMIs, are managed there. They are not referred to mental hospitals and are given long-term follow-up care. The services are mostly publicly funded and patients are admitted to open wards for a short duration, either free or at very low cost (US$10–15 a month, which includes food, essential medicines and basic recreation facilities). Family members are usually expected to stay with the patient.

The advantages of running services from GHPUs are manifold: availability of services in the community; involvement of family members in care; a reduction of stigma; and increased rates of help seeking for mental health problems. Due to inter-specialty collaboration, the physical problems associated with mental illnesses and conversely psychiatric problems associated with physical illnesses are better addressed. Also, emergency psychiatric services are integrated with hospital emergency services. GHPUs in medical schools play an important role in undergraduate teaching

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