EDITORIAL

Mental health and life on a small island

David Skuse

University of London Institute of Child Health, London, UK; email: d.skuse@ucl.ac.uk

doi:10.1192/bji.2018.3

Desert Island Discs has been a popular radio programme in the UK since 1942. Guests are asked to choose the discs they would most want to save, in order to make life on a desert island bearable after shipwreck. The potential impact of loneliness on the unfortunate celebrity's mental health is rarely discussed. Yet the inhabitants of small islands do suffer mental health problems, and our theme this month is a discussion of the ways in which services to assist them are being delivered. Yutaro Setoya and Dévora Kestel discuss how the World Health Organization is offering support to several small island states in the Pacific and the Caribbean through the Mental Health Gap Action Programme. Training has been delivered to a few Caribbean islands over the internet as a pilot project, and the strategy has caught on with such enthusiasm that it is going to be rolled out to many more small island states soon.

Far from the sunny Caribbean are the Falkland Islands (or Malvinas). These islands are geographically remote and have a small population of mainly British descent. There are frequent visitors from ships sailing to the Cape or Antarctica, as well as many fishing vessels, with fishermen bringing their own problems to the attention of the medical services available there. Remarkably, because the Falkland Islands are British Territories, the provision of legislation for the management of mental health problems is subject (at least for now) to the European Convention of Human Rights. Updating the former Mental Health Ordinance for the islands, which was not compliant, brought about new opportunities and demands for training local staff. Karen Rimicans and Dr Tim McInerny provide a fascinating insight into the challenges faced by such a remote community.

Finally, we consider the provision of psychiatric services to the Shetland Isles, which lie well north of Scotland and not too far from Norway. Martin Scholtz and Almarie Harmse give us a glimpse into the history of these islands, which are warmed by the Gulf Stream and whose population is rapidly recovering from its lowest point over the past 50 years. The economy of the islands has been improving owing to initiatives in the oil and the seafood industries, and with this growth has come a demand for more medical and mental health services. Dependency on mainland facilities for major mental health support poses a range of logistical problems, and so novel crisis and home treatment protocols have been introduced, which seem highly effective in reducing admissions. The small island experience has been a positive one for the authors of this contribution to our theme this month.

THEMATIC PAPER

WHO Mental Health Gap Action Programme implementation in the Small Island Development States: experience from the Pacific and English-speaking Caribbean countries

Yutaro Setoya[1] and Dévora Kestel[2]

[1]Technical Officer Mental Health, Division of Pacific Technical Support, Western Pacific Region, WHO, Nuku'alofa, Tonga; email setoyay@who.int

[2]Unit Chief, Mental Health and Substance Use, Pan American Health Organization (PAHO/WHO), Washington, DC, USA

Owing to the relatively small population sizes and remoteness of the Small Island Development States (SIDS), their mental health systems face many common difficulties. These include having few mental health specialists per country, limited access to mental health services and low awareness.

To overcome these limitations, the World Health Organization (WHO) Mental Health Gap Action Programme (mhGAP), which aims to decrease the treatment gap by training non-specialists, was implemented in more than 20 Pacific and English-speaking Caribbean countries. Many lessons were learnt

Conflicts of interest. None.

doi:10.1192/bji.2017.16

from the experience. Mental health specialist support is crucial, and online training and supervision could be a solution. mhGAP training proved to be effective to improve knowledge and attitude, but close monitoring and supervision are needed to change clinical practice. Awareness raising and mental health service capacity building need to occur simultaneously. To realise sustainable development goals, countries need to invest more in mental health, especially in human resources; mhGAP will be one effective solution.

Background

Although many of the Small Island Development States (SIDS) are renowned as holiday destinations, they are not unscathed by the same mental health issues which affect other countries. Owing to the relatively small population sizes of SIDS – ranging from countries as small as Niue (population about 1200) to Jamaica with nearly 3 million people – and their remoteness, their mental health systems face many common difficulties, including the following.

- Few mental health specialists owing to population size, high turnover and brain drain. Some of the countries have a population below 10 000, which makes it difficult to afford psychiatrists or mental health specialists.
- Limited access to mental health services in countries with small, scattered islands. In some countries, mental health services are only available on the main island, which may take days or even weeks to reach from remote islands with infrequent transfers by boat.
- Low mental health awareness, which leads to stigma and discrimination. Confidentiality is difficult to maintain, owing to the small population and closeness of community members; everybody knows everybody else.
- Non-communicable diseases are a serious concern, leading to an increase in mental health issues.
- High alcohol use owing to limited leisure activities, or to attract tourism. Gender-based violence is common and usually associated with alcohol misuse.
- Vulnerability to climate change, especially related to the increase in natural disasters. Most recently, Fiji has been struck by Cyclone Winston, and Hurricane Matthew has hit several Caribbean countries and provoked serious damage in Haiti. Mental health and psychosocial support are needed for those affected.

However, there are also the following strengths.

- Strong cultural bonding because of the relatively small population. Strong community solidarity and a strong sense of supporting each other.
- Strong informal support, which compliments the weak formal social support in areas such as social security, housing services and disability pensions.
- Availability of functioning basic health services via general hospitals, primary healthcare clinics and, in some countries, dispensaries. Most of the countries have a tax-based health system, similar to the British system. The government pays medical fees, including the cost of medicines, and provides services as part of a public system.

Because of these limitations and strengths, the World Health Organization (WHO) Mental Health Gap Action Programme (mhGAP) (WHO, 2008), which aims to decrease the treatment gap by training non-specialists, is the obvious strategy for SIDS. mhGAP is a programme developed by WHO, which aims to increase mental health service coverage and to reduce the gap between needs and supply. The programme was launched in 2008, and its clinical protocol to assess and manage priority mental disorders and conditions, the mhGAP Intervention Guide (mhGAP-IG), was developed in 2010 (WHO, 2010). A second version was revised and released in 2016 (WHO, 2016). mhGAP-IG targets non-specialist health workers, mainly doctors and nurses who do not specialise in mental health. Since then, more than 90 countries across the world have implemented mhGAP, including more than 20 SIDS.

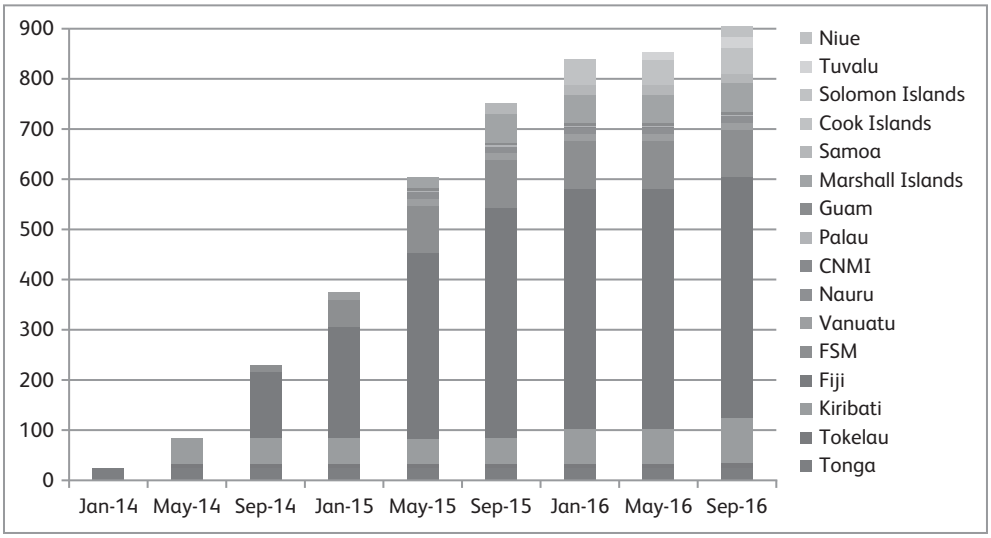
Here, we will describe examples of mhGAP implementation in the Pacific and the Caribbean regions, then discuss lessons learned and the way forward.

mhGAP implementation

Example from the Pacific

Implementation of mhGAP in the Pacific island countries started with an in-country planning workshop to which key mental health stakeholders were invited. During the workshop, stakeholders discussed various topics related to mhGAP implementation, such as who to train, who the trainer will be, who the supervisor will be, establishing support and a supervision system, ensuring drug availability at the target facilities, and monitoring and evaluation of the whole process. Adaptations of mhGAP implementation to the local context, such as which conditions and medications to train in as a priority, and what the consultation and referral pathways will be, were also discussed. Cultural adaptation was usually addressed through the training. Depending on the priority of the country and number of training days, the sessions usually focused on the modules for depression, psychosis, alcohol, suicide, and other significant emotional or medically unexplained complaints.

For larger countries, a 'training of the trainers' (ToT) model was applied, in which mental health specialists were to become mhGAP trainers. The



CNMI: Commonwealth of Northern Marian Islands, FSM: Federated States of Micronesia

Fig. 1
Number of mhGAP trainees in the Pacific island countries.

mhGAP training programme developed by WHO is designed to be interactive, using discussions, case studies, roleplays and videos. The first mhGAP training in each country was completed by a combination of international and local facilitators, and then rolled out by local facilitators, depending on the country's capacity and needs.

Three mhGAP ToTs were conducted in the Pacific: two in Fiji with participants from Kiribati, Tonga and Vanuatu, and one in Guam with participants from the Marshall Islands, Federated States of Micronesia, Palau and Northern Mariana. So far, 14 countries have initiated mhGAP and trained more than 900 doctors and nurses (Fig. 1). Pre- and post-training tests showed remarkable improvement in knowledge, and the trainees showed confidence in assessing and managing people with mental disorders after completing the training.

Learning from the Caribbean experience (below), an online version of the training is planned for 2017, mainly targeting busy medical doctors.

Example from the Caribbean

The limited presence of specialised professionals in several Caribbean countries, particularly in the smaller ones, makes even more clear the need to strengthen primary health care capacities to provide care for people with mental health conditions. The small number of health professionals made it challenging to carry out training in each island, and to request all the general practitioners and nurses to attend a few days of training. In 2013 the Pan American Health Organization (PAHO) proposed a web-based modality for training professionals in English-speaking Caribbean countries. The training was implemented through PAHO Virtual Campus, a tool for technical cooperation developed to promote and facilitate networked learning in the region of the Americas. A team of key partners, led by PAHO, revised and adapted mhGAP to be delivered online, with the support of three tutors and a technical coordinator. Six countries were selected, and Ministries of Health from those countries and territories were invited to identify participants for the training. Over the course of 5 months, 28 general practitioners and nurses from six Caribbean countries and territories were able to complete the training at their own rhythm and pace.

Despite initial doubts or concerns regarding the use of the virtual modality to train clinical concepts, evidence revealed a positive acquisition of the knowledge through participant feedback and a post-training survey. Participants achieved the learning objectives by interacting with each other and with tutors over a long period of time. The length and modality of the course allowed participants to continue their clinical practice and to share their real-life patients' challenging situations with their peers and tutors.

Based on the positive feedback, a second round was proposed in 2015, this time with an open call. From the 158 postulants, we selected 42 participants from 13 Caribbean countries. A third round for Spanish-speaking participants took place in 2016; another one for the Caribbean in 2017.

Lessons learned and the way forward

From implementation of mhGAP in more than 20 SIDS, many lessons have been learned regarding the way forward. We will discuss a few of the most important ones.

Mental health specialist support is crucial. Each mhGAP trainee will be trained to assess and manage common mental disorders, but will need a mental health specialist who can support, supervise, continue to train and be a reference for the more difficult cases. Online training and supervision could be one solution to this problem.

mhGAP training has been proved to be effective to improve the trainees' knowledge and attitudes towards people with mental disorders, but close monitoring and supervision is needed to change their clinical practice.

It is crucial to raise awareness on mental health and also on the availability of mental health services to increase help-seeking behaviour. Awareness raising and mental health service capacity building need to go hand in hand.

Weak health information systems make monitoring and evaluation difficult. There is a need to integrate and strengthen health information systems, and to report on a core set of mental health indicators.

Mental health has been included in Sustainable Development Goals (United Nations 2016); for example, target 3.4 states: 'By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being'. Target 3.c recommends an increase in the health workforce in SIDS: 'Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States'. To realise these targets by 2030, countries need to invest more in mental health, especially in human resources. Mental health services do not require expensive equipment, but they do need more trained human resources. mhGAP is one effective solution, but there is also need to increase human resources at all levels – specialists, non-specialists and community/village health workers.

References

United Nations (2016) *Sustainable Development Goals*. UN. Available at https://sustainabledevelopment.un.org/sdgs (accessed 1 November 2016).

World Health Organization (2008) *mhGAP: Mental Health Gap Action Programme: Scaling up Care for Mental, Neurological, and Substance Use Disorders*. WHO. Available at http://www.who.int/mental_health/evidence/mhGAP/en/ (accessed 1 November 2016).

World Health Organization (2010) *mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings*. WHO. Available at http://www.who.int/mental_health/publications/mhGAP_intervention_guide/en/ (accessed 1 November 2016).

World Health Organization (2016) *mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings – Version 2.0*. WHO. Available at http://www.who.int/mental_health/mhgap/mhGAP_intervention_guide_02/en/ (accessed 1 November 2016).

THEMATIC PAPER

52 degrees south: mental health services in the Falkland Islands

Karen Rimicans[1] and Tim McInerny[2]

[1]RMN, Specialist Practitioner in Community Mental Health Nursing, Nurse Teacher, and Senior Community Psychiatric Nurse, Falkland Islands

[2]Visiting Psychiatrist, Falkland Islands; South London and Maudsley National Health Service Foundation Trust, Bethlem Royal Hospital, Beckenham, UK; email tim.mcinerny@slam.nhs.uk

Conflicts of interest. None.

doi:10.1192/bji.2017.15

This article discusses the factors that have shaped the development of the new mental health legislation within the Falkland Islands. The process of implementing new legislation within this remote island community is discussed, including the aspirations underlying the new legislation, the management of psychiatric emergencies and the needs of the clinical team.

The management of mental health needs in the British Overseas Territories is influenced by many factors, including economic capacity to invest in services, organisational structure and resources, perceptions of mental health need and the accessibility of mental health resources within neighbouring countries or the UK.

The Falkland Islands are self-governed and self-funded with the exception of defence. Public administration, including health and education, operate in parallel to English systems with local adaptations in place.

The Falkland Islands are situated approximately 8000 miles from the UK and 400 miles from South America. The islands are geographically remote with limited access by sea and air. There are 700 islands, of which 50 are sparsely populated, spread across an area of 12 000 square miles. The Falkland Islands have 2931 residents, composed of islanders mainly of British descent who immigrated in the 1800s, and expatriates from the UK, St Helena, Chile, Peru, the Philippines and other countries. Of the residents, 62% have lived in the islands for more than 10 years. The majority of people live in Stanley, the capital of the islands, while the remainder live in Camp, the local term for the countryside outside Stanley (Falkland Islands Government, 2015).

Transient visitors to the islands include seafarers and fishermen who work on the international commercial fishing ships within Falkland Islands waters. The fishing industry has a unique working environment and holds the unenviable rank of highest occupational mortality rate, with fishermen being considered 52.4 times more likely to have a fatal accident at work relative to other