EDITORIAL

Training innovations in low- and middle-income countries

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Is it feasible for a centre of excellence in another country to provide video-link training on managing psychiatric disorders to Low- and Middle-Income Countries (LMICs) that lack the local infrastructure for such services? Our main theme in this issue discusses innovatory attempts to do so, with mixed results.

Salutary warnings are provided by Julian Leff in his fascinating contribution, drawn from lessons he learned when working as a transcultural psychiatrist in the WHO's International Pilot Study of Schizophrenia some years ago. Those lessons are likely to continue to be relevant today. He emphasises the observation that in many lower-income countries there is an attitude of caring acceptance of mental health problems, especially among extended families living in rural areas, which means that families expect to be involved in mental health interventions. A further lesson he learned is that if active treatment has been sought it may be (at least initially) provided by traditional healers who are trusted by the indigenous population and who are often well aware of the limitations of their expertise. Yassir Abbasi and colleagues attempted to provide a mental health awareness programme to Mogadishu, with the assistance of the Community Interest Company Praxis at their Evaluation and Research Institute in Liverpool. The course was delivered by audio/video link using volunteer tutors from a variety of backgrounds and professions. Somali participants comprised nurses, doctors and a few other professions allied to medicine. The aim was to raise awareness of mental health problems and their treatment in Somalia, a country that, as the authors describe, has a culturally derived lack of understanding of mental illness, yet a massive need for services. The success of this programme proved hard to evaluate objectively. Finally, we present a review from another UK-based group, Samantha Waterman and colleagues, who attempted to facilitate Group CBT by Skyping with healthcare workers in Sierra Leone. Their clients comprised 12 staff who had previously been employed to deal with Ebola cases. The purpose of this novel programme was to teach this small number of key individuals to deliver a Group CBT treatment programme to over 250 peers who may have been experiencing post-traumatic anxiety and depression as a consequence of their Ebola-related experiences. Barriers to the successful implementation of this programme are discussed; some of them were remarkably fundamental, such as the importance of providing a snack to group CBT participants who may have travelled long distances to attend. This was valued more than the reimbursement of their travel expenses.

SPECIAL PAPER

The lessons I learned as a psychiatrist from my transcultural work in low- and middle-income countries

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Transcultural observations offer an opportunity to study attitude to mental illness in different societies and family structures. The disparity between industrialised and lower-income societies reflects greater tolerance due to the ability of extended families to compensate for the patient's limitations.

My early work in London with families of people with schizophrenia was enriched by participation in the World Health Organization International Pilot Study of Schizophrenia (WHO IPSS), conducted in nine low- and middle-income countries. This gave me the opportunity to study the way in which families cope with mental illness in different societies and family structures.

Even in low-income societies, differences emerged between rural and urban domains. The