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Taking the path less trodden: UK psychiatrists working in low- and middle-income countries

SUMMARY
UK-based psychiatrists have the opportunity to work in low- and middle-income countries. The political climate is supportive, as evidenced by the recent Crisp report on 'Global Health Partnerships: The UK Contribution to Health in Developing Countries', and the Royal College of Psychiatrists volunteer scheme. However, many psychiatrists are unaware of ways in which they might contribute. In this article, we give examples of the diverse ways in which UK-based psychiatrists are already engaged in collaborative work overseas. We discuss some of the mutual benefits that such partnerships can bring and highlight the under-recognised benefits to the UK, both to the individual and to the National Health Service.

UK-based psychiatrists have the opportunity to work in low- and middle-income countries. The political climate is supportive, as evidenced by the recent Crisp (2007) report *Global Health Partnerships: The UK Contribution to Health in Developing Countries* and the Royal College of Psychiatrists' volunteer scheme. However, many psychiatrists do not know how they might contribute. In this article, we give examples of the diverse ways in which UK-based psychiatrists are already engaged in collaborative work overseas. We also discuss some of the mutual benefits that such partnerships can bring, highlighting the under-recognised benefits to the UK, both to individuals and to the National Health Service (NHS).

Approximately 12% of the global burden of disease, in terms of premature mortality and years lived with a disability, is caused by mental and neurological disorders. However, stigma and a lack of resources hinder their prevention, detection and treatment. There is an estimated shortage of 4.3 million health workers in low- and middle-income countries. In Sub-Saharan Africa there is less than 1 psychiatrist per 1 million of people compared with 1 psychiatrist per 15–25 000 people in the UK (World Health Organization, 2001, 2006, 2007).

Training and retention of health workers are major issues facing low- and middle-income countries, with both internal migration and external brain-drain threatening the sustainability of services (Patel, 2000; Ahmad, 2005; Kumar, 2007). The NHS has benefited greatly from skills brought in from those countries and there is room for reciprocity. By supporting UK psychiatrists to contribute their skills and time, we can help offset this deficit and bring benefits to both parties.

Current climate

The current situation is positive for health workers interested in working in low- and middle-income countries. The UK government has signed up to the United Nations' Millennium Development Goals (www.un.org/millenniumgoals/) and pledged further health commit-

Box 1. Examples of UK involvement with mental health services overseas

1. Partnerships between countries/medical institutions:
- Scotland – Malawi Partnership
- NHS links through THET (www.thet.org.uk)
  - East London & City Mental Health/Butabika Hospital, Uganda
  - Sheffield Care Trust/Adjumani Hospital, Uganda
  - King's College Hospital/Somaliland
- Royal College of Psychiatrists' Volunteer Programme for Senior Psychiatrists and Specialist Registrars

2. Working for non-governmental organisations
- *Medicins Sans Frontieres*, *Medicins du Monde*, Christian Blind Mission, International Medical Corps, Global Initiative on Psychiatry and Basic Needs

3. Academic/research
- King's College London (Institute of Psychiatry) – Addis Ababa University exchange
- Wellcome Trust Research Training Fellowships (through tropical medicine centres)
- Self-financed post-graduate courses overseas

4. Individually organised

THET, Tropical Health Education Trust.

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Box 2. Julian Eaton, Mental Health Advisor, West Africa, CBM International

'Our decision to break from our NHS careers at that time was a difficult one, but finding the "right time" is almost impossible. Although it is patronising to go before being adequately trained, no amount of further training in the UK can prepare you for the utterly different demands of healthcare work in Africa.

I was lucky to meet a supporter of a project in Nigeria that worked with the homeless mentally ill (or "vagrant psychotics" as they are known there) as well as running a community psychiatric programme. Having met the small UK support group and been impressed with what we heard from them, we set of for 2 years in the south-east of Nigeria.

I am now employed by CBM International. I have a 4-year contract, by the end of which I should have trained a West African colleague to continue my work.'

ments with other G8 countries following recommendations by the Commission for Africa. There are many positive examples of UK organisations and individuals working in mental health services in low- and middle-income countries and forging partnerships with the UK (Boxes 1–6). Whereas concerns over national training in health services dominate the news (Eaton, 2007), the new opportunities for international training and collaboration should not be forgotten.

Particularly relevant for those interested in work in low- and middle-income countries is the global health partnerships report by Lord Crisp (2007), the former NHS chief executive, which sets out recommendations on how the UK, and specifically the NHS, can contribute to health in such countries. It argues that the current crisis in human resources worldwide is preventing progress to the Millennium Development Goals on health (e.g. combating HIV/AIDS, malaria and other diseases, improving maternal and child health, and ensuring access to essential medicines). The report highlights the key areas where UK experience and expertise could be used:

- strengthening public health, health systems and institutions

Box 3. Charlotte Hanlon, Specialist Registrar (London), Wellcome Trust Fellowship in Tropical Clinical Epidemiology

'It was a privilege to be able to live and work in Ethiopia for 2 years. Setting up a research project was challenging and couldn't have happened without the great cooperation and support of my Ethiopian colleagues. We built up a team of collaborators, providing training in research methods, supervising student projects and encouraging involvement in research publications. I gained valuable teaching experience on the psychiatrist training programme. I was also able to observe the development of a mental health policy for Ethiopia. I have no doubt that I have greatly benefited personally from my experiences, but also that I bring back skills and perspectives that benefit my work in the NHS. My link with Ethiopia goes on and I hope will continue to bring benefits to both sides.'

- providing education and training for health workers and retaining the ones already trained
- making knowledge, research, evidence and best practice accessible to health workers, policy makers and the public alike.

The report recognises the UK's responsibility to support low- and middle-income countries to take the lead in the delivery of their own health plans, to support UK health workers to work in such countries and to create global health partnerships that will be mutually beneficial. The implementation of the recommendations requires the support not only of the Department of Health and the Department for International Development, but also NHS trusts, medical Royal Colleges, Postgraduate Medical Education and Training Board (PMETB) and medical schools. It also depends on the initiative and motivation of individual health workers.

The Crisp report was closely followed by a report from the British Medical Association (2007). Although lending further support for health workers volunteering overseas, the report was criticised for the lack of practical advice, as well as neglecting to mention the vast and unmet need for mental health services in low- and middle-income countries (Mabey, 2007; Patel, 2007).

Different ways of working overseas

There are many options for psychiatrists and other mental health professionals to work with colleagues in low- and middle-income countries, ranging from the lone volunteer to partnerships between hospitals, academic institutions and countries (Box 1).

Rather than providing *ad hoc* clinical services, it is arguably more useful to strengthen health systems in partnership with colleagues in low- and middle-income countries by providing training in organisational management, assisting in policy development, increasing the capacity of training institutions and carrying out practice-based research (Patel *et al*, 2006).

Working overseas under the umbrella of an existing institutional/country partnership has some advantages. Much of the groundwork has already been done, so any contribution will be part of a bigger picture and potentially have greater longer-term benefits. The Crisp report recommends going through existing links and working with intermediary organisations, such as the Tropical Health Education Trust (THET) and Voluntary Services Overseas. Contacting the volunteers programme at the Royal College of Psychiatrists in the initial stages may also be worthwhile as they hold a database of requests from low- and middle-income countries and seek to match volunteers with placements.

Emergency and development health programmes

With increasing recognition of the importance of mental health both in emergency and development health programmes, many international non-governmental organisations now recruit psychiatrists. The Crisp report

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recommends that the NHS should support doctors in finding a placement and that the Department for International Development could hold a database of health professionals with skills for humanitarian emergencies.

In emergency response planning, lessons can be learnt from previous controversial psychosocial programmes in Rwanda, Kosovo and after the tsunami in Indonesia in 2004. Interventions need to be appropriate and guided by local needs – some suggestions can be found in the World Health Organization's report (van Ommeren *et al*, 2005). A positive example is the International Medical Corps (IMC), which provides an emergency response to crises by supporting local primary care services and introducing mental healthcare by training primary healthcare workers, thus ensuring enduring benefits after the IMC volunteers have left.

Longer-term placements are often preferable as volunteers take a while to settle in and therefore may paradoxically create more work for their hosts in the short-term. Building up strong personal contacts is likely to lead to a more successful and enduring partnership. Preliminary discussions with relevant contacts in the host country will help identify needs. For countries with little overseas involvement, a preparatory visit is often invaluable.

Mutual benefits

Evaluating the benefits of working overseas to the volunteer, the host country and the NHS is increasingly important to justify time away from clinical duties in the UK. Not all benefits are immediately tangible. We outline those from our own and our colleagues' experiences.

Service provision

Meeting acute shortfalls in teaching or service provision can be important, for example in response to a humanitarian crisis or to help a training programme get off the ground. Training health workers in mental health can also build long-term capacity (Boxes 2–4). A less obvious but important result is linking our colleagues from low- and middle-income countries into the wider psychiatric community.

Research

Academic partnerships have the potential for greater equality in comparison with the more common donor–recipient relationship. Despite this, care needs to be taken to avoid a donor-driven research agenda and to ensure that local researchers benefit maximally. Collaboration between the researchers from low- and middle-income countries and high-income countries may help to reduce the under-representation of published research from the former (Horton, 2000; Patel & Kim, 2007). A high standard of English is often necessary for publication in international journals and, similarly, grant proposals, protocols and finished research can benefit from input by an English native speaker. Providing opportunities for research degrees and training also helps to build up research capacity. Those who have worked overseas often continue research collaboration on return to the UK (Boxes 3 and 5) and this can provide a platform for multicentre, high-quality, pragmatic research relevant to clinical practice globally.

Box 4. Nick Bass, Consultant Psychiatrist, East London – Butabika Link

'We are concentrating on "training the trainers" rather than direct staff training. It is crucial to be able to leave our colleagues with a sustainable programme that they can continue and adapt according to their needs. We are keen to avoid creating any dependency on our trust as the "donor" . . . The emphasis is on a partnership with a view to long-term mutual learning and support.

Uganda has an established track record of having significantly improved their infectious disease outcomes (especially for HIV) against the odds. They have identified mental illness as being the second health priority of the population and clearly have the will and motivation to tackle this. We anticipate that we have much to learn to the benefit of our own patients and services from our Ugandan colleagues.'

Box 5. Robert Stewart, General Adult Specialist Registrar, Manchester

I spent 1 year working in Malawi carrying out a mixture of research, teaching and clinical work . . . All the hard preparatory work was more than worth it; my year in Malawi was fascinating, challenging and fun. In addition to great memories, I returned with experience in managing a small research team, improved teaching skills, and a deeper understanding of cultural influences upon mental disorder. I am now back working in a busy inner city NHS hospital where my interactions with clients who are immigrants or asylum seekers are informed and enhanced by my overseas experiences. I have been able to maintain involvement with Malawi through the Scotland Malawi Psychiatry Project and know that all involved in this link feel that it provides a stimulating and motivating addition to their working lives.

Box 6. Jim Crabb, Psychiatry Specialist Registrar, Basic Needs

'The experience of being a psychiatrist in Ghana has been everything I expected it to be and more. . . . My work as a volunteer psychiatrist for the NGO Basic Needs has been one of the most rewarding experiences in my career . . . As a psychiatrist who was progressing into the world of psychotherapy it was a surprise when the work in Africa demanded I relearn my basic medical skills without the safety net of batteries of investigations and specialist medical colleagues to consult (there are none, you are on your own)! This made me return to the days of simple first aid and problem solving more in common with being a bush doctor than a psychiatrist. I feel this process of learning has improved my competency and confidence as a doctor. You have to learn to be resourceful with what is available as staff, medicines, electricity and even running water all too frequently disappear.'

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Benefits to the NHS

The benefits to the NHS of supporting staff to work in resource-poor, culturally diverse settings are increasingly recognised (Johnstone & McConnan, 1995; McKenzie *et al*, 2004). Improved clinical skills (especially for comorbid physical health problems) and cultural competence are readily transferred back to the UK setting (Boxes 5 and 6). An appreciation of issues in service development and the wider functioning of health systems also enrich specialist training and may help to cultivate innovation and leadership skills for the future (Boxes 2 and 4). Furthermore, merely living in an alien culture can help develop flexibility, willingness to learn (e.g. learn the language and about the culture), interpersonal skills and resourcefulness to cope with the unexpected.

Practicalities

> 'An NHS framework for international development should explicitly recognise the value of overseas experience and training for UK health workers and encourage educators, employers and regulators to make it easier to gain this experience and training' (Recommendation 7, Crisp, 2007).

Even though it seems an unnecessarily burdensome task to organise work overseas, it is easier than one might expect and there are many unexpected and long-lasting rewards. Issues to consider include the following.

Training, revalidation and accreditation

Many of those who work overseas aim to continue training or employment within the NHS afterwards. It is therefore useful to discuss overseas plans with the relevant parties, including senior colleagues, deaneries and the Royal College of Psychiatrists who may allow up to 1 year of specialist training to be accredited for time out from a programme. An experienced UK mentor may aid professional development while abroad, encourage reflection and support maintenance of professional links with the UK.

Before Modernising Medical Careers (MMC), there were often reciprocal training agreements with accreditation, usually between medical colleges of high-income countries. Training overseas was possible at certain points in the training system, for example after passing the College membership examination. Currently, the intrinsic structure of MMC may mean that gaining overseas experience is more difficult at these traditionally transitional points of professional development. On the other hand, it may be possible to reconsider how international medical training and overseas work might be included in the higher medical training posts in the foundation years and within specialist training (Crisp, 2007). It is hoped that opportunities to work overseas will become encouraged, accredited and utilised within a developing MMC.

Most doctors who work abroad want to retain the ability to practise in the UK. This involves a professional license to practise and a suitable insurance. Revalidation, as well as training, is in a state of flux. Depending on the work pattern undertaken overseas and also on one's seniority, one might either choose to continue revalidation when abroad or to relinquish it and regain the license to practise on one's return. In recent years, the General Medical Council has been active in designing efficient and flexible ways of doing this. Doctors may also wish to relinquish payments to UK medical indemnity organisations but care must be taken to put in place suitable alternatives for those who are on a placement abroad.

Breaks in NHS pensions

An initial uninterrupted period of NHS employment for at least 1 year is necessary if a doctor wants to continue to pay into the same NHS pension fund after they have worked overseas. If there is a longer history of previous NHS employment, the position of the individual is strengthened if they can prove that the experience overseas was beneficial for their training.

Before you go

Before you go, you may wish to take the following courses: public health, international mental health, research methodology or epidemiology. However, perhaps even more invaluable is a refresher of basic medical skills, as the psychiatrist may often be called upon as the only available doctor.

Conclusions

Many psychiatrists, including trainees, are keen to work overseas. Despite the current flux in training, the political climate is encouraging. The variety of ways to become involved in working overseas allows choice in terms of the timing and content of the work undertaken. Learning from the experiences of those who have undertaken work overseas enables us to optimally utilise these opportunities. However, sensitivity to the needs of the recipient country, consideration of sustainability and a focus on the priority areas of strengthening health systems and training institutions is crucial. There is much to be learned for clinicians, researchers and service developers from our colleagues working in settings where resources are poor. Mutual benefits, both obvious and more subtle, can be numerous and far-reaching.

Declaration of interest

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