

In our experience, international clinical and research exchange can make a significant contribution to mutual learning and the consolidation of expertise. It represents a bi-directional transfer of the knowledge and experience between the North and the South.

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Diaspora and peer support working: benefits of and challenges for the Butabika–East London Link

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The International Health Partnership ('the Link') between the East London NHS Foundation Trust and Butabika Hospital in Uganda was set up in 2005. It has facilitated staff exchanges and set up many workstreams (e.g. in child and adolescent psychiatry, nursing and psychology) and projects (e.g. a peer support worker project and a violence reduction programme). The Link has been collaborative and mutually beneficial. The authors describe benefits and challenges at individual and organisational levels. Notably, the Link has achieved a commitment to service user involvement and an increasingly central involvement of the Ugandan diaspora working in mental health in the UK.

International health partnerships (or Links) are formalised voluntary partnerships between UK health institutions and counterpart health institutions in low-income countries, intended for mutual benefit, through sharing of learning, experience and capacity building. Over 25 years, the Tropical Health and Education Trust (THET) has supported and

built a partnership approach that aims to harness knowledge and technical expertise to strengthen health systems through the training of healthcare workers in low-income settings (THET, 2009). It is involved in the allocation of Department for International Development (DfID) funds to Links. Links are advocated as a vehicle for international development (Crisp, 2007) with potential benefits to individual health workers (Longstaff, 2012) as well as UK institutions (All Parliamentary Party Group on Global Health, 2013, 2014; Forrington et al, 2014).

The Butabika–East London Link (Baillie et al, 2009) was set up in 2005 between interested staff at an English mental health trust (East London NHS Foundation Trust, ELFT) and Butabika Hospital, the national referral and teaching psychiatric hospital in Uganda. Since then, 40 Ugandan staff have come to London for training and over 70 UK staff have visited Uganda, collaborating on a series of work-streams and projects (see Box 1). Exchange staff have included psychiatrists, nurses, occupational therapists, social workers, psychologists, pharmacists, service users and administrative staff.

Box 1. Selected achievements of the Butabika–East London Link

- *Peer support worker (PSW) training and development.* Twenty-eight PSWs have been trained to work alongside the community recovery team to deliver community-based peer support to service users discharged from Butabika Hospital (Baillie *et al.*, 2013).
- *Development of the Ugandan Diaspora Health Foundation.* The Foundation supports the strengthening of Ugandan mental health services and promotes advocacy for mental health in the diaspora community (<http://www.ugandadiasporahealthfoundation.org>; see also Mulimira & Stoddard, 2014).
- *Service user involvement.* Three East London staff and three service users went to Uganda to advocate for service user involvement, which led to the development of an organisation led by service users (Heartsounds Uganda; <http://heartsounds.ning.com>), development of peer working, the Kampala Hearing Voices Group (Sentamu *et al.*, 2012) and the Kampala Mental Health Film Club.
- *Child and adolescent activity* (Messant, 2009). This has included training in family therapy, children's accelerated trauma treatment and the development of a diploma in child and adolescent psychiatry, which is due to be taken over by Mbarara University as a diploma course.
- *The Management of Aggression and Potential Aggression (MAPA) project.* This involved 'train the trainers' training delivered to 12 Butabika staff. It was on de-escalation techniques and the safe management of aggression, and was rolled out to front-line nursing staff at Butabika. It led to a reduction in violence on the wards.
- *Training in psychological interventions for psychologists.* This has included cognitive-behavioural therapy (CBT) and trauma-focused CBT (d'Ardenne *et al.*, 2009).
- *Training psychiatric clinical officers (PCOs).* Training has been delivered in motivational interviewing, solution-focused therapy and trauma-focused CBT (see <http://www.butabikaeastlondon.com>; Hall *et al.*, 2014).

The Link aims to be collaborative and mutually beneficial. In this article, we share some of the authors' reflections on the benefits and challenges to the UK of being involved in Link work.

Benefits to the individual

Engaging in the projects has resulted in beneficial outcomes for Ugandan staff, who have noted practical gains, such as opening email accounts and becoming more connected. Their knowledge and skills have been enhanced by observing healthcare in a different country and context, experiencing different types of supervision, learning new therapeutic approaches and interventions, and engaging with service user involvement.

Involvement in Link work promotes the development of increased confidence, better communication skills, problem-solving and presentation skills, and leadership and project management skills, competencies all listed in the Knowledge and Skills Framework (KSF) and the National Health Service (NHS) Leadership Framework (Longstaff, 2012). It provides an opportunity for NHS staff to reflect on core skills and personal practice, which forms a key part of the appraisal process for doctors in the UK (Royal College of Psychiatrists, 2010).

UK staff describe increased job satisfaction and motivation. They feel that they are able to make a

difference and contribute at a local and national level.

Given limited resources, there is an opportunity and a need to be creative and innovative and to value the co-production of solutions with service users and Ugandan staff. The training of 28 service users to work as peer support workers (PSWs) alongside a small community rehabilitation team in Kampala (see Box 1) gave D.B. experience of a different relationship between professionals and service users. PSWs became friends and colleagues, as they worked together towards a common goal. The experience fostered hope and optimism about the potential of the PSWs. For the PSWs, it provided an empowering relationship that seemed more therapeutic than the usual doctor–patient relationship. All UK-based staff gained the confidence to be bolder in the implementation of peer working in the UK and are now leading initiatives in developing this in London teams.

For M.A., growing up in Uganda produced a pessimistic view about service users' capacity for recovery. Seeing the transformation of service users who were trained and worked as PSWs, and observing the change of a Ugandan psychiatrist's attitude to peer working, were powerful influences on changing her attitudes to recovery. Having the Ugandan lead PSW speak to staff and service users in East London was catalytic in allowing peer working to be accepted on a psychiatric intensive care unit and prompted a service user from the ward to train as a PSW.

Uganda diaspora staff describe learning about their culture and African mental health as well as developing an enhanced confidence in their dual identity and culture, describing themselves as becoming more Ugandan British than before.

Cultural awareness

We all believe that we have developed a deeper cultural awareness. Underlying this is a sense of a better understanding of global mental health, with the challenges of translating Western concepts of illness and treatment approaches to a different cultural context.

Being involved in diaspora work has helped M.M. to synthesise the experience of having two cultural backgrounds (being born in Uganda and being raised in the UK since adolescence). He has shared this insight with Ugandan service users in East London, and with first- and second-generation migrants to the UK. His understanding has enhanced his work as a nurse in East London, an ethnically diverse area with a significant migrant population.

Working with Ugandan families and colleagues in the PSW training and the Hearing Voices Group (see Box 1) has given experience of how collectivist cultures conceptualise and approach mental health problems. UK mental health training emphasises a biomedical understanding of mental illness, often sceptical of different explanatory models, and this is challenged through the experience of working in Uganda.

Working with service users in Uganda exposed to acute poverty, not tempered by a welfare safety net, provides a stark reminder of how challenging it is to deal with adversity in the face of significant economic hardship. This gave greater understanding of the realities faced by service users in the UK, who carry the burden of current austerity measures. It also demonstrated the importance of even modest earnings and having a role and status in enhancing recovery from mental health challenges. Despite the adversity faced by service users in Uganda, many have demonstrated huge resilience in their path to recovery. In the UK, we are not always sufficiently hopeful and positive about what our patients can achieve.

In Uganda, there is an impressively different approach to positive risk-taking, with less institutional risk aversion. This experience of a different approach to risk-taking can be both empowering and liberating.

Benefits to the organisation

Benefits to Ugandan services include: the development of specialist services; improved nurse–patient relationships; increased confidence in responding to aggression and violence; reduced patient-reported violence on wards; improved service user involvement in the planning and delivery of services; improved psychological competency for the psychiatric clinical officers; and the development of child and adolescent training around the country.

Involvement in NHS Links provides organisations with an opportunity to demonstrate corporate responsibility as well as a commitment to diversity and equality, something recognised in ELFT policy. The Link has produced a greater understanding of systems and the complexity of working in partnership, as well as an orientating principle of focusing on the service user. The development of a person-centred focus is an important counterbalance to the concerns about a lack of compassion in some UK services. The experience of working in the Link increases staff morale, which, in turn, may improve staff recruitment and retention.

Benefits to the NHS

Current challenges to NHS services include operating effectively in times of austerity, how to maintain quality and how to make better use of existing resources. Collaborating with other countries can provide opportunities for the NHS to learn how to be effective with fewer resources and to learn from examples of task shifting. The PSW project trained 28 service users, greatly increasing the capacity of the community team of four community psychiatric nurses: an important lesson for overworked and understaffed services in the UK.

Challenges to the individual

Working in a context where both financial and human resources are limited can be emotionally, professionally and ethically challenging. Cultural misunderstandings can weaken established trust

and collaboration. There can be a mismatch of perceived good practice; for example, informal working relationships can facilitate rapport and engagement in Uganda while more formalised modes of working are more common in the UK. Link work can be demanding for NHS staff and its value may not be officially recognised and supported.

Challenges to the organisation

At times, it can be difficult to engage partners in initiating, maintaining and sustaining project activity, raising concerns about whether activity is truly collaborative. Project work is often donor driven. In this partnership, the main donor is the ELFT, with Butabika often needing to fit into the funder's objectives. In Uganda, where the need is enormous, all projects have been acknowledged to add value to psychiatric practice and to expose staff to innovation, but the risk is that the collaboration remains unequal.

The financial and human resource challenges at Butabika will mean that there will always be areas of practice that excite concern in East London partners, and we need to be aware that the threat of withholding or withdrawing support is an ineffective means of influence. There can be a lack of compassion and understanding of the extreme challenges facing Ugandan colleagues: with only single clinicians covering a whole ward or clinic, UK standards could never be achieved. UK staff pointing this out to Ugandan staff serves only to demoralise them further and to undermine their professionalism.

Conclusion

The Butabika–East London Link is notable for its commitment to service user involvement and the increasingly central involvement of the Ugandan diaspora. The experience of training and working with PSWs in Uganda has provided important lessons for the UK and harnessing diaspora energy has inspired the workforce. Involvement in Link activity provides benefits for those involved, particularly with regard to developing knowledge, skills, leadership and cultural awareness, as well as opportunities for institutional learning. There are also considerable challenges that need to be negotiated, but these can provide opportunities for learning and adapting within the NHS environment. Future collaborations will include the enhancement of peer training in Uganda and the development of staff resilience.

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Mental health law profiles

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Germany and Russia are giants of European civilisation (Figes, 2002; Watson, 2010). In the world of arts and letters the names of Beethoven and Goethe, Tchaikovsky and Dostoyevsky have universal appeal. Many others could be included. In the history of psychiatry, Kraepelin and Pavlov stand at the very foundations of modern psychopathology. Yet when one looks in these countries' histories, one also finds grave offences against those who are mentally ill and against psychiatry. Though this is far from particular to these countries, some of the offences that occurred there have unique significance for our professionalism (Ikkos, 2010).

After the First World War, in the midst of a universal economic crisis and in the context of humiliation and destitution resulting from the harsh insistence by victorious allies on the payment of reparations by defeated Germany, the psychiatrist and pathologist Alfred Hoche was instrumental in developing the ideology of 'life unworthy of life', which led to the designation of people with a mental illness or intellectual disability as 'useless eaters'. Starting in hospitals with the killing by paediatricians of children with severe disabilities in Leipzig in the early 1930s and supported by the gross practice of collaborating psychiatrists signing certificates condemning people with mental

illness, intellectual disability and epilepsy to the gas chambers, this ultimately led to the systematic extermination of 100 000 psychiatric patients in specially designated 'hospitals' in the early 1940s. The Nazi Holocaust started with people with an intellectual disability or mental illness (Friedlander, 1995) and the German psychiatric profession has apologised since.

In Russia, during the Soviet era, the offence was the use of psychiatry against political dissidents, rather than against people with a mental illness (Musto, 2009). Through the unfounded invention of 'sluggish schizophrenia' by the Soviet psychiatrist Andrei Snezhnevsky, political dissidents were detained as mentally ill and subjected to systematic torture through 'psychiatric treatment' such as electroconvulsive therapy and insulin infusions. Victims included psychiatrists, such as the brave dissident Anatoly Koryagin, who questioned the legitimacy of such practices and other injustices.

This history reminds us why the scientific grounding and ethical integrity of psychiatric diagnostic systems and of practising psychiatrists, conventions on human rights, mental health law and just health and social policies are of such importance for both our patients and the profession. On the evidence of the two papers presented here,