Chapter 1

Background and Principles of Volunteering in Global Mental Health

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A purposeful, conscientious and well-intentioned mental health volunteer needs to be informed about the background, principles and ethics of global mental health in order to be impactful. This chapter provides background to aid such efforts and introduces global mental health within the wider voluntary context.

Background to Global Mental Health

Mental health is often given low priority or is neglected in health systems worldwide. Although this is true of all settings, including high-income countries, and is dubbed the 'mental health gap', low- and middle-income countries (LMICs) have particular challenges worth noting. The treatment gap between need and access is estimated to be up to 90% in some of the poorest regions in the world[3].

Firstly, owing to the double burden of disease (chronic and communicable diseases), health systems are often stretched. The health burden and financial pressures mean that mental health does not receive adequate funding. Estimates suggest that, on average, spending on mental, neurological and substance use (MNS) disorders is 0.5% in low-income countries and 1.9% in lower- to middle-income countries[5]. Where funded, most of the limited budget for mental health is concentrated in secondary care services with very little community provision for mental health. Often secondary care takes the form of a national hospital, and the service herein may be stretched and standards may be poor, with it catering only for the most ill[6].

Secondly, mental health problems are hugely stigmatised in much of the world. Words for mental illness may be pejorative. People with mental illness are often excluded from active participation in family and community life, and they face discrimination. Research has shown that discrimination often relates to the right to vote (political), the right to inherit property/make a will (economic), employment (personal) and marriage (personal)[7–10]. Mental illness may be a source of shame and may be believed to have a spiritual underpinning.

Human rights are a core area to consider in global mental health[11]. Those with serious mental illness may be kept at home and even detained there, sometimes in secret. They may be locked in, tied up, chained and treated inhumanely. In doing so, their human rights could be infringed. For those with a disability and other vulnerable groups, there is an increased risk of violations of human rights. Globally in mental health work, health workers are confronted with protection (safeguarding) issues on a regular basis, including domestic/intimate partner violence, abuse of disabled people and female genital mutilation, to mention just some. One of the important global human rights and laws we need to be aware of is the Convention of the Rights of Persons with Disability (CRPD) which is described below[12].

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These challenges are related to funding, as well as stigma and discrimination, and result in those suffering with mental health conditions presenting late to services, or not presenting at all[13,14]. This is particularly the case for vulnerable groups such as women, as there can be increased shame to have female members of the family who are mentally unwell.

For many, the first point of call for any mental health problem is the traditional or spiritual healer[15]. The role they play within communities is varied, but often they contribute to both individual and community identity, as well as helping to shape conceptualisation of wellness and illness. What they do can vary, with some using herbs or religious treatments. There are many traditional healers who work with compassion and diligence and indeed have a deep understanding of local idioms of distress. They may actually complement mental health provision. However, there are others who breach human rights by deprivation of liberty by actions such as beatings, starving and neglect.

Even when people do agree to see a mental health professional, there is usually a severe shortage of these specialists[16]. In many countries, mental health is provided by non-specialists such as general trained doctors, nurses or sometimes laypeople[6]. In some countries, such as Uganda, Ghana and Malawi, there are clinical officers. These are non-doctors, but they are prescribers who provide the backbone of health care in many places where there are no psychiatrists. They are equivalent to the physicians' associates found in the UK. Clinical officers are less likely than doctors to leave their home country, and this means that they are an important cadre to support in global mental health work.

The few trained psychiatrists in LMICs will usually be in the large cities and the chance of consulting a psychiatrist for those people who live rurally or in a village is low. The number of psychiatrists may be further depleted by 'brain drain' where mental health specialists move to other countries or to the private or NGO sector[17]. A further barrier to seeing a psychiatrist is poverty[3]. People often cannot afford to go to see a psychiatrist, travel to a big city (because of the cost of the journey and of lost livelihood) or pay for the medicines prescribed. Medication may be relatively cheap when compared to UK standards, but a long course of treatment can simply be unaffordable for many people.

Even where mental health services are present, there is likely to be varied training standards amongst health staff and poor availability or lack of psychotropic medication. In addition, there may be polypharmacy or limited rational prescribing[18]. People with psychosis can be overmedicated and patients with depression undermedicated, for example. There is a common practice of prescribing vitamins and other medications which may not actually be required. These can be costly for people who cannot afford them.

Overall, the situation for people with mental illness is, sadly, poor in much of the world. This treatment gap is worse in LMICs. However, some of the case examples in this book do show some improvement in mental health across recent years and we can always be optimistic for the future. The principles such as the Sustainable Development Goals (SDGs)[19] described below have put a framework in place and have provided momentum to improve further the situation of people with mental illness in the world. Further, it is important to acknowledge that, given the treatment gap in the UK, even high-income settings are not immune from the challenges and thus we should be open and proactive to any lessons and best practices that can be learnt, adapted and implemented.

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International Frameworks in Global Mental Health

This section outlines important international standards, policies, principles and commonly used nomenclature in the field of global mental health. These are essential knowledge for a global volunteer. Although some terms and policies are discussed, this is by no means an exhaustive list. Volunteers are strongly encouraged to do further supplementary reading related to global, regional and local mental health policy and public health principles (see Appendix 1).

Mental Health and Psychosocial Support (MHPSS)

In global mental health and related volunteering, the term *Mental Health and Psychosocial Support* (MHPSS) is currently used rather than mental health. The important underlying principle is to stretch health interventions beyond a narrow medical/pharmacological model and to be able to capture a full range of treatments. It includes the range of support individuals receive to promote their psychosocial well-being and mental state. Support interventions range from individual clinical approaches to those that focus more broadly on financial and social development.

WHO mhGAP Intervention Guide

The WHO mhGAP intervention manual is an excellent guide to some helpful principles of care in managing mental, neurological and substance use (MNS) disorders in a non-specialist setting[20]. It places emphasis on the need for respect, dignity, communication, appropriate assessment and evidenced-based treatment of physical, mental, social and even spiritual domains. This important manual emphasises holistic treatment that incorporates human rights and cultural sensitivity. It can be used by a range of professionals including generalist or primary care doctors, nurses and allied health professionals. The guide provides a series of algorithms to aid clinical decision-making. It is available for free across online formats, as well as on mobile devices through an app.

The Sustainable Development Goals (SDGs) 2013–2030

These are UN internationally agreed goals launched in 2015, with the aim to achieve them by 2030[19, 21]. Goal number three is on health. This goal is to ensure healthy lives and to promote well-being across the whole age spectrum. There are particular targets on suicide and substance use. There are 16 other goals including environmental sustainability, poverty, education, gender equality, peace and justice, all of which interrelate with health. As a volunteer it is worth remembering these different areas. Mental health is a complex area with multifactorial aetiology and management plans. Climate, water supply, conflict and gender inequality all have effects on the genesis of mental health problems. Health, poverty and injustice all go hand in hand.

WHO World Mental Health Action Plan 2013–2020

The WHO World Mental Health Action Plan 2013–2020[22], now extended to 2030, is another useful background guidance for volunteers. It has four main principles:

- Good governance and leadership
- Community-based services
- Prevention and promotion strategies
- Good information technology

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These four principles are useful reference points when volunteers ask the question, 'what can I do?'. A volunteer can find themselves doing things they weren't expecting, such as supporting leadership skills, the promotion of mental health and record keeping, as well as training specifically in mental health.

Inter-Agency Standing Committee (IASC): Principles of Humanitarian Responses

In humanitarian settings there are principles enshrined in the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support (MHPSS) in Emergency Settings[23]. This committee of experts on humanitarian emergencies devised principles for responding in these situations. An important element of this is not to work in isolation but alongside others to ensure that no harm is done, and that there is a co-ordinated benefit. There are many areas of specific guidance that should be followed in humanitarian settings. For example, IASC outlines how to support psychiatric hospitals after emergencies.

Convention of the Rights of Persons with Disability (CRPD)

This important United Nations convention from 2006 to 2008 is hugely influential on the human rights of people with disabilities. The convention includes mental illness as a disability. According to CRPD[12], people with mental illness or psychosocial disability (the preferred term used) should be empowered to be fully participating members of society with access to health, education, justice and family life, etc. It fits with the recovery model of mental illness. Although ratified in many countries, it is patchily implemented in most of the world. It has important implications in how we conduct our psychiatry services.

Mental Health Law and Legislation

Mental health laws, where present, protect the rights of people with mental illness/psychosocial disability. This is particularly relevant for people who are in psychiatric hospitals. It is important to recognise that many countries have no mental health laws or have ones that often date from colonial and/or historic times. Volunteers need to be aware of the laws of the country they visit.

Background to Volunteering

The Oxford Dictionary definition of a volunteer is 'a person who freely offers to take part in an enterprise or undertake a task'[24]. Global volunteering in mental health aims to utilise available skills and resources to improve the well-being and mental health of all people from all countries, religions, genders, ages, cultures, socio-economic backgrounds, sexual orientation, beliefs and disabilities. Volunteering in global mental health is responsive to local need rather than directed by UK volunteers. It is usually mutually beneficial.

As volunteers, it is necessary to appreciate, consider and reflect on the contemporary and historical socio-economic, political and cultural context in which volunteering is undertaken. This is particularly important as volunteers from the UK. On one hand, the UK has a long history of volunteering in other countries around the world and there is value in volunteering by trained specialists from the UK. This individual voluntary spirit has been

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supported by wider governmental priorities – for example, the UK was one of the few countries to commit to 0.7% of GDP for overseas development up to 2021 (note it is now 0.5%). On the other hand, the complex colonial history of the UK and the perceptions of the empire in the recipient countries cannot be ignored. This can still be, understandably, a shadow over work that UK volunteers do globally. Indeed, it is also important to recognise the ongoing systemic causes of inequity that prevailing economic and geo-political factors contribute to in relation to trade, migration and climate challenges.

In his 2007 report Lord Crisp, demonstrated the value of UK volunteering globally and highlighted the value of UK health professionals volunteering in other countries and how this could produce mutual benefit. This report was a spur to some of the current volunteering. The UK parliament produced an All-Party Volunteering Report similarly valuing global health work[25]. The UK commitment to volunteering is exemplified by the Global Health Exchange and UK Med. Health Education England supports Global Health Exchange which provides volunteering opportunities for all professions in the NHS in England to work globally for mutual benefit. UK Med was set up by the UK government to focus humanitarian health expertise in cases of disasters.

There are a number of similar examples of health volunteering across the other regions of Wales, Scotland and Northern Ireland. It is important to be able to justify volunteering globally whilst there are needs at home in the UK, including prevailing inequalities. However, this is not mutually exclusive. Chapter 5 in this book outlines how global volunteering helps the health system of origin (e.g. NHS services) as well as our partner host countries through higher-skilled health, with more satisfied workers returning.

There is a long history of UK psychiatrists volunteering overseas from the NHS, diaspora groups and others. They have helped make significant and sustainable contributions in those countries. The roles of such volunteers have also included organisations such as the United Nations (UN), international non-governmental organisations (INGOs) and other organisations, as well as individually.

This book recognises the limits of volunteering and the geo-political, economic and historical structures that continue to perpetuate inequality around the world. Nonetheless, we highlight the positive impact that volunteers can make to address this gap even a little and aid the movement towards a more just world. In doing so, we accept and advocate for the need to move beyond aid and the voluntary model to a justice and rights-based model in international health governance.

Case Study: The Royal College of Psychiatry Volunteering Project[1]

The Royal College of Psychiatrists (RCPsych) set up a volunteer programme to support work in global mental health. It began with Professor Andrew Sims as president of the College in 2002, in response to the paucity of psychiatrists globally. His aim was to provide a link between UK psychiatric expertise and needs identified by partners globally. As a college with many international medical graduates and international divisions, developing volunteering was important for a global college. The College has been supporting global volunteering since the formation of the volunteer scheme. Subsequent presidents continued this support, particularly Sheila Hollins during her presidential term. She organised a fundraising trek and championed awareness of the value of volunteering.

The programme works through the College holding a list of registered psychiatry volunteers who are then matched with requests from hosts overseas. This means that the College stamp is on these assignments and there is oversight on the quality of the work

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and good governance. Many NGOs and other organisations request at least six months duration for any volunteering. Pragmatically, this scheme has a focus on shorter-term international trips, between several weeks to three-month assignments. This is because this is generally the maximum time psychiatrists can be released from their employment. There have been upwards of 60 assignments since the scheme started. Some of these are described more fully in this book. The Sudan volunteering programme is one example of making the most of short-term assignments by arranging for a series of overlapping volunteer psychiatrists to be integrated into a local postgraduate course for primary care doctors[2]. The teaching was co-facilitated by both the UK psychiatrists and Sudanese psychiatrists and psychologists after an initial trainers' workshop. It is described in Chapter 21. This was a partnership between the RCPsych, WHO, Ministry of Health and a local university. Online supervision followed the face-to-face stage.

Similarly, for Myanmar and Kashmir there have been imaginative ways of making the most of the limited time of individual volunteers, which have helped to make the projects more longer-term. This is described in Chapters 13 and 20, respectively. There is a new Royal College of Psychiatrists' International Strategy (2020)[4] with a plan to scale up volunteering to about 100 volunteer activities per year. This includes opportunities to develop new volunteering projects.

Effect of the Covid-19 Pandemic

The Covid-19 pandemic has shown the potential to work and collaborate virtually without the need for travel. This technological catalyst in virtual working allows volunteers to respect the climate in avoiding unnecessary flight travel. Some very recent examples of successful electronic voluntary work during lockdown have been delivering a whole mental health course (mhGAP) online to health workers in Gaza, giving subspecialty lectures in north-west Syria and supporting the academic programme of psychiatry trainees in Bethlehem. The Royal College of Psychiatrists has also delivered global webinars. Volunteers are continuing to provide online supervision to health workers throughout the world.

At the same time, the pandemic has also shown us the limits of virtual working and the benefits of on-the-ground presence and collaboration. It remains to be fully evaluated how efficacious these online partnerships prove to be, compared to face-to-face working. It is clear that there is a preference for face-to-face work when possible. So much of global volunteering is about building networks and understanding the local environment which can only be done face to face. On a practical level the internet connectivity of much of the world poses a big challenge to online volunteering. However, it is likely that future volunteering, overall, will involve some form of hybrid online and face-to-face volunteering.

Principles of Volunteering in Global Mental Health

The important principles that direct the focus of any intervention in volunteering are described below. It is about people. It is about investing in people, including oneself[26].

Do No Harm

One of the key principles that is embedded in volunteering is the maxim of doing no harm. *Primum non nocere*: first do no harm – this is a very old phrase constantly repeated to every generation of clinicians. This must be the top principle. A volunteer needs to work in

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a professionalised, ethical and evidence-based way. Sometimes the harm that can be done is not immediately apparent. There is a need to always listen to advice to ensure that our interventions are helpful and cause no direct or indirect harm.

Examples of harmful practices:

- Training without follow-up supervision is an example of potentially doing harm as knowledge and skills can get corrupted
- Training people inadequately may lead to faulty practice without adequate supervision
- Telling people what to do or saying they have wrong ideas or behaviour is usually counterproductive
- Abuse of drugs or alcohol in public
- When too much focus is placed on trauma at the expense of supporting people through common and complex mental health problems and building on strength
- Having a special or research interest and using a host population for this may do harm and is probably unethical. For example, diagnosis of post-traumatic stress disorder can be casual at times and overdiagnosed

Justice and Solidarity, Not Charity

Justice for all is a key ideal. Justice is an important part of well-being[11]. It is not always possible to change things ourselves. Volunteers need to be informed and not appear naïve and listen to the stories being told. It is one of the difficulties of volunteering that they can often feel powerless as they hear terrible stories of injustice. They can listen but must never collude with injustice. They need advice on anything else they can do. This emphasises the importance of good supervision and mentoring for any volunteer. There is a movement in global volunteering to speak out against injustices. The remit of the organisation MSF (Medécins Sans Frontières/Doctors without Borders) is just that. They bear testament to injustice. In reality, what can be said can be more nuanced for the risk of causing harm to any project. Volunteers can be removed from a project and country. The project can be shut down. It takes experience, maturity and good advice on how to deal with injustices.

Attention needs to be given to any outdated ideas of 'white saviour' or 'neo-imperialistic altruism'. Modern volunteering is about partnership, solidarity and justice, and not charity.

Human Rights

It cannot be overstated that it is very important to respect human rights as core principles in volunteering[27]. If there are violations of human rights it is necessary to speak about this in an appropriate way. This is where supervision can be important to help frame this. It is important to respect culture without accepting things that can be called cultural but are fundamentally violating human rights, such as domestic violence and female genital mutilation (FGM).

In countries where there are obvious or gross violations of human rights, it can be an ethical challenge to decide whether it is better to stay away or to go and try to help build better services for people with mental illness. There may be increased risks to training programmes, as well as personal safety, if violations are challenged. It is worth taking advice and working with organisations that are accustomed to dealing with this. It is inappropriate

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and unprofessional to give a lecture to people on what is wrong with their country or the way they work.

Evidence-Based Practice

It is important to be able to justify interventions in LMICs. It is clear in the past that there was little research or formal evaluation of health interventions within such contexts[28]. For example, while 85% of the global population live in LMICs, only 6% of mental health published literature in indexed journals used to come from such settings.

This is now changing, and there is a growing wealth of research on global health interventions.

Important literature to read includes the Lancet Commission on Global Mental Health and Sustainable Development in 2007 and then in 2018. This showed that mental health can be treated effectively in LMICs. The cost-effectiveness of treating mental illness is now proven. Non-specialists can be trained to deliver effective mental health care. This research underpins the important principle of integrated mental health in primary care, using trained non-specialist health workers.

As such, there is an obligation on volunteers to utilise and implement evidence-based measures. When deviating from this, stringent monitoring and evaluation is a requirement of any project from the very beginning, and metrics should be co-produced with local service providers and users where possible.

It is to be noted that while programmatic evaluation does not require ethical approval, any research studies or undertakings will need this. This can take some time to get, particularly when both UK and host country ethical approval may be needed. As such, research volunteers would benefit immensely, and indeed would be ethnically obliged to co-develop such research projects with local researchers and clinicians, including where it pertains to project ownership and authorship.

Recognition of Competency, and Limits

In the UK there is a regulated high standard of training for professionals in health and social services. Volunteers can feel confident in their training and how this can be of value to others. However, despite the level of training, it is important to recognise that the training often relates to the UK context and may have significant shortcomings when seeking to be applied elsewhere. Similarly, those without formal training in a UK context will likely have a richer understanding of the local contributors and idioms of distress.

Professional Standing

A volunteer who has come through an organisation such as the Royal College of Psychiatrists bears an important brand and identity that carries a huge impact in many parts of the world. This helps to be confident about the quality of training and skills that can be shared with the world, as well as building up knowledge and experiences from volunteering globally. Legally, it may be necessary to be professionally registered in the country one volunteers in, particularly if one is doing any clinical work. It is essential to follow the law of the country in which one is volunteering.

There are currently no legislative rules for volunteering. However, the volunteering must be professional and, for psychiatrists, match the Royal College of Psychiatrists' values

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of courage, innovation, respect, collaboration, learning and excellence, as well as abiding by General Medical Council standards. Other professions should espouse their organisational standards. The volunteer is likely to need to register with the local regulatory authority. Volunteering programmes will have accountability and professionalism structures built in.

Capacity Building, Sustainable Volunteering, Human Resources

Volunteering should never be done in isolation. It is important for the volunteer to fit in with the national principles and policies of health service and to be well-informed about the country they are invited to visit, this is discussed in Chapter 6 entitled Preparation. Where possible, volunteers should be conducting training and building capacity more than doing clinical work. If there is a need for clinical work, then this should always be seen as a training opportunity for local health workers. Volunteers should not be a substitution for missing clinicians but should work to strengthen the capacity of existing health workers. Examples that have been helpful, apart from the usual general training, include training in rapid tranquillisation principles and breakaway technique.

Global volunteering is almost always an exercise in supporting human resource and system capacity. The term capacity building is often used in developmental and voluntary circles to describe this. Your role as part of capacity building is often in helping to make an investment in the existing health system and the health workers, to allow them to be more capable of managing patients' care. This is through training and building up skills. Another term used is 'task shifting'. This means that health workers, who may not have had the years of mental health training as a specialist psychiatrist, are tasked with service delivery of specific tasks through specific training[29].

Long-Term Commitments

The ideal is to commit to a longer period as a volunteer. Usually there is a six-month minimum period for many organisations. There are many different schemes that have shown long-term commitment over years with a regular supply of volunteers such as the Scottish Malawi project[30] or King's Somaliland/Sierra Leone partnership[31]. One of the highlights described by one volunteer is delivering face-to-face training and following up within two days through an online portal with the very same participants. The Sudan project described in this book in Chapter 19 is an example of a project where short-term volunteering led to a longer more sustainable partnership project[2]. There was a succession of volunteers from around the world who co-ordinated efforts to produce more sustainable useful training followed by online supervision.

Recognition of Vulnerable Groups Such as Women and Children

Women and children are the most vulnerable, generally, in LMICs. An important principle is to gear any programme around their needs. In LMICs, families are very important, and the mother is the linchpin of the community. Women are reported to have higher rates of many mental health conditions. Women are particularly at risk from poverty, poor nutrition and bad housing. They need support to obtain their rights. Children depend on their mothers' good mental health to develop themselves. In some countries women are not able to consent to their own medical procedures. For example,

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in some countries in the African continent, a woman must have consent from her husband to have a caesarean section. In other places, women can be prevented by their families from seeing doctors. Seeing a male doctor or health worker may be unacceptable to them even if it is at the cost of the woman's health. For all these reasons care for women is crucial. Once a woman's mental health is improved, the whole family and the community will benefit.

Culture

As mentioned throughout this book, attention to and appreciation of culture is essential[32]. All volunteers need to make every effort to be fully briefed on the culture of where they go. Volunteers need to respect local values and customs. Even for diaspora volunteers, they may need to remember that their home country has changed. Paradoxically, sometimes diaspora volunteers may be seen as outsiders. There can be a very complex dynamic as we see in Chapter 16.

The UK volunteer will do well to try to understand what the local traditional healers are doing through having respectful and inquisitive conversations with local stakeholders. If there is abuse, this is a serious ethical issue. The volunteer needs to broach this sensitively with their hosts and their UK-based supervisor. The answer to this issue needs to come from the host community.

Supervision and Professional Development

A volunteer needs to be self-reflective and informed. A volunteer needs to engage in continuous professional development, be regularly supervised and evaluated as well as reflecting with peers on their practice, in the way normally expected of UK practitioners.

Day-to-Day Pace, and Flexibility

It takes years to change services and embed new training into regular practice. Volunteers usually need to slow down from the pace of working in their home countries. A volunteer may be starting, or being part of the start, of an ongoing long-term process. Returning home is often when volunteers realise what a frantic pace they work at back home and this can be a learning point for their own well-being.

Flexibility and attention must be applied to individual and host needs. Every volunteering assignment is different, which is why it can be such an exciting opportunity. Any volunteer needs to be flexible and, in a sense, be a doctor, nurse, psychologist and social worker, as well as possessing other management, leadership and logistical skills. Volunteers often have to mobilise skills in education, well-being, livelihood (employment) as well as other areas that map on to the sustainable development goals (SDGs). This recognition and application is not only valuable during the voluntary placement, but it also makes doctors, nurses, psychologists and social workers better at their work upon return to the country of origin as it broadens and accelerates professional skill development.

Psychological Adaptation of the Volunteer Role

Personal adaptation is an important underlying principle in volunteers, and this is often varied depending on the timescale of the assignment. Even for shorter term international work, personal adjustment is an important principle. Whilst this varies from person to

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person, for many there are different stages. For example, with a 12-week assignment, week one to two is often said to be characterised by a sense of panic and questioning of role, and it may be accompanied by feeling overwhelmed. Weeks four to eight is often the period of settling into the local community. Weeks eight to twelve may be intense due to the pressure to complete the stated objectives and ensure the sustainability of programmatic work. The next phase is returning home and adjusting. For some, it is an addictive process and there will be an urge to repeat global volunteering. For others, there is satisfaction and a return to normal 'civilian' life. In almost all stages outlined, most feel a deep sense of purpose and fulfilment.

Learning from Mistakes

Mistakes are natural in everyday life and in clinical medicine. It is important to be mindful of this and to make every effort to learn from mistakes that we make during the course of volunteering. Further, it is useful to reflect on the mistakes commonly made by volunteers and learn from this:

- Having a donor mentality and not one of partnership
- Doing clinical work rather than more sustainable activities such as training
- Not being prepared for the host/voluntary context before departure
- Overestimating, or underestimating, baseline knowledge and skills of local health workers
- Getting over-involved and not keeping professional and personal boundaries
- Doing harm. This remains the most troubling possibility.

Table 1.1 Do's of volunteering

Do's of volunteering
- Do no harm
- Do slow down and then slow down again
- Learn
- Develop partnerships
- Be flexible
- Prepare
- Follow guidelines
- Learn what are affordable, available drugs
- Show humility
- Respect culture
- Follow human rights
- Look after yourself
- Bring enough money to manage
- Follow FCDO guidelines
- Keep well with vaccinations/yellow card
- Wear seat belt

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Table 1.2 Don'ts of volunteering

Don'ts of volunteering
- Volunteer in isolation - Be UK/country of origin centric - 'Try to save the world' – it takes years to make changes - Do not give money away – you have to say 'no' to requests - Support pharmaceutical companies prescribing teaching without emphasis on evidence based practice and decision making - Substitute services that will disappear when you leave

Conclusion

It is important to embark on any volunteering well-prepared with knowledge of the relevant background and principles. This should also be the basis of all future volunteering projects. What is important is the professionalisation of volunteering. A volunteer needs to be following the same standards of professional work as in their home country. A volunteer also needs to be mindful of the ethical issues and be aware of their own lack of knowledge of facts on the ground and how to skilfully negotiate through difficult and sensitive areas. It is important to understand the nature of the treatment gap that exists around the world, and the challenges mental health services face in the context of the competing large burden of disease. There are also challenges related to stigma and human rights, as these often result in delays in accessing care. A range of international frameworks offer guidance, and these include the WHO mhGAP Intervention Guide, SDGs, IASC guidelines and the Global Mental Health Action Plan 2013–2030. Volunteering must first do no harm, and then seek to build upon acts of justice and solidarity in an attempt to build sustainable, evidence-based and culturally appropriate systems.

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