

psychosis and likelihood to use cannabis.⁶ Di Forti and colleagues' study asks participants about their cannabis use prior to their first episode psychosis diagnosis, but it is possible that subclinical symptoms might have existed prior to cannabis initiation, meaning that associations in the opposite direction cannot be ruled out.

It is perfectly possible that the association between cannabis and psychosis is bidirectional, as suggested by other work using genetic variables as proxies for the exposures of interest in a Mendelian randomisation design.^{7,8} Di Forti and colleagues' study adds a new and novel study design to the evidence available, which consistently indicates that for some individuals there is an increased risk of psychosis resulting from daily use of high potency cannabis. Given the changing legal status of cannabis across the world, and the associated potential for an increase in use, the next priority is to identify which individuals are at risk from daily potent cannabis use, and to develop educational strategies and interventions to mitigate this.

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Engaging families to advance global mental health intervention research

Across cultures, family members often play important and even critical roles in the lives of adults who suffer from depression and other chronic mental health conditions. These roles could be even more pronounced in low-income and middle-income countries (LMIC), where cultural values and norms might more strongly encourage family involvement and family is often the *de facto* provider of mental health care when mental health services are scarce. International guidelines and recommendations have attempted to draw attention to the evidence base supporting the need for family involvement.^{1,2} Despite compelling reasons for adapting evidence-based treatments for adults to include families in LMIC, the topic has received surprisingly little attention in the literature about global mental health services and implementation, with the exception of a few studies that have involved family in the treatment of

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patients with psychotic disorders,³ substance abuse,⁴ and dementia.^{5,6} A review⁷ of community and home-based interventions for people with neuropsychiatric disorders in LMIC showed that fewer than 10% of the interventions involved family members.

This gap is an important missed opportunity. A substantial body of literature, comprised predominantly of observational work in both the social sciences and the medical field, describes the roles of family members involved in the lives of persons living mental illness, which include providing practical support for illness management and treatment adherence in the home, influencing care-seeking pathways, and accompaniment and support during clinic visits and inpatient psychiatric hospitalisations. Family caregiving also has important moral and emotional dimensions with potential to both affirm and ameliorate suffering.⁸

Panel: Recommendations for involving families in interventions for adults with neuropsychiatric disorders

- Involve families in the design and adaptation process for interventions for neuropsychiatric disorders, including ongoing supervision and refinement of the intervention during implementation.
- When designing and offering interventions, consider that family members might often be present during clinical visits and available for participation.
- Identify a range of opportunities for family involvement, such as providing collateral information, participation in psychoeducation, personalising behavioural interventions to family context and circumstances, actively supporting behavioural interventions, promoting adherence, and relapse prevention planning.
- Balance benefits of family's active involvement in the intervention process with potential economic, time, and emotional burdens of caregiving and patient preferences.

Inattention to the role of family in the global mental health intervention field has several potentially important consequences. First, individually focused psychosocial interventions introduced within cultural settings in which a high value is placed on family involvement might separate the patient from naturally occurring social supports and increase social isolation or risk of stigmatisation. Second, psychosocial interventions focused solely in the individual might miss crucial opportunities to strengthen treatment through engagement and involvement of family. Third, a narrow focus on individual outcomes prevents broader examination of the effects of psychosocial interventions (both positive and negative) on the family.

Engagement of family also highlights important challenges and caveats. From an ethical perspective, family-centred models must take into consideration the family resources and competing demands, and should protect families from undue burden. Issues to consider when families are involved are loss of economic engagement in other livelihood activities, interference with domestic duties, and secondary stigmatisation.⁹ Particularly in LMIC, where resources are scarce, task sharing can easily become task dumping and place unrealistic demands on family members—especially women—who might risk harm. Furthermore, intervention models need to account for situations in which family relationships might be so strained or dysfunctional that involvement in mental health care could be counter-productive. In a previous work,¹⁰

for example, we have highlighted the potential for families to both impede and facilitate depression care. In some situations, separation from the family might be necessary for mental health recovery, although it is especially complicated in situations where interpersonal violence is the primary driver of psychological distress. Finally, involving families has the potential to diminish the autonomy of individuals with neuropsychiatric disorders, particularly when the individual's preferences are not adequately assessed and addressed by treatment providers when the family is also present.

With the growing emphasis on integration of mental health in primary care, there is an acute need for work to adapt evidence-based treatments for depression, anxiety, and other non-psychotic disorders to include family members. For example, family can play various roles in depression treatment, such as providing collateral information to inform the initial assessment, promoting adherence to non-pharmacological treatment (eg, behavioural activation) or medications, monitoring symptoms and side effects, helping in relapse and prevention planning, or simply being a supportive presence during therapeutic sessions.^{10,11} Since people with neuropsychiatric disorders might have comorbid health problems and rely on family members for help in managing these conditions, engaging these family members as partners in the treatment of coexisting mental health conditions is often a natural extension of their caregiving role.

The issues we have raised have great relevance also for high-income countries. A 2016 report by the National Academies of Sciences, Engineering, and Medicine¹² highlighted how the US health-care system, for example, does not adequately support and involve family caregivers in clinical care. Evidence-based treatments developed in high-income countries reflect the broader limitation (ie, the existence of a bias toward more individualistic models of care) highlighted by this Comment, and present a challenge for LMIC as they seek to culturally adapt and scale-up these evidence-based treatment interventions. High-income countries might have much to learn from LMIC about innovative and family-based models. The entire field of global mental health, we argue, will be enriched and advanced by more explicit consideration of the role that family members can play in evidence-based psychosocial interventions (panel).

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Race, mental health, and the research gap



The over-representation of black, Asian, and other ethnic minorities in the UK mental health system raises concerns about professionals' attitudes to race. Littlewood and Lipsedge¹ argued that this over-representation can be explained by the cultural distance between white western European psychiatrists and black men, which has led to the medical profession being out of touch with the reality of this community's experiences. They stated that it had contributed to black and minority ethnic minority groups being twice as likely to be misdiagnosed and subjected to an inappropriate service-led approach to their mental health needs in Britain.

Arguably, an unintended consequence of the 1994 Richie Report² into Christopher Clunis's misdiagnosis and insufficient resources, which led to the manslaughter of Jonathan Zito, was the alignment of race with dangerousness. Subsequent attempts to analyse racism in mental health have not addressed the systemic problems underlying the tragedy. They have not examined how race manifests itself through political and economic forms of inequality, which impact on culturally inappropriate services for black and ethnic minority communities. Brown³ argues that

the social constructs of race and mental health disorder reflect the needs to examine conflicting norms and the effect of exposure to race-related generic stress. He suggests that what has emerged is racial stratification, based on racism faced by black communities. This argument is developed by Fernando,⁴ who posits that race and racism have become an institutional part of the history of western psychiatry. However, neither analyse the microdynamics between practitioner and service user to understand racism in mental health work.

These theories of race and mental health tend to focus on abstract arguments without measuring the inequalities that black and minority ethnic communities face. Although Keating⁵ reported that in the UK, African and Caribbean men are 67% more likely than white men to be in secure detention, there is no analysis of how racism affects psychiatric assessments. According to the 2011 Count Me In census of inpatients and patients on supervised community treatment in mental health and learning disability services in England and Wales,⁶ admission of members of the black community to these services has increased by 40% in four annual surveys in 2005–08. They are three times more likely to be sectioned to a psychiatric hospital than other ethnic