disposals. These strategies are interlinked and require significant structural investment, human resource development and multi-agency commitment. It may be helpful to consider the examples of offender management in other countries, where mental health programmes are run jointly by criminal justice and health services, for example the development of psychiatric treatment facilities within a secure prison perimeter.

A way to stimulate a multidisciplinary approach is to have regular dialogue between mental health, community and criminal justice services. This has started to some extent, as case discussions have been extended to include broader, systemic issues. There has been a good response from stakeholders such as the police, the prison service, public prosecutors, the Attorney General's chambers and the magistrate's court. This could develop into more comprehensive and strategic planning. A case management system would be particularly helpful for individuals with complex multiple needs such as management of a chronic illness and/or substance misuse, and provision of housing, occupational rehabilitation and carer support, in order to best manage the risk of reoffending.

Conclusions

There have been recent improvements in the treatment of offenders with mental disorders in Brunei, an area that had not received much attention previously. There are opportunities for further advancement. Structural investment, human resource development, multi-agency commitment and strategic planning are essential.

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GLOBAL ECHOES

Mental health and psychosocial support in Calais: a reflection on research in a challenging environment

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This reflection focuses on research conducted in 'The Jungle' in Calais, an informal camp of approximately 6000 refugees (Help Refugees, 2016). My self-designed qualitative study aimed to assess the availability and nature of mental health and psychosocial support (MHPSS) by interviewing service providers about their role in MHPSS. The research questioned whether MHPSS was evidence-based (Tol *et al*, 2011), what types of MHPSS was available, what service providers envisaged to be the most immediate needs, and barriers and enabling factors in MHPSS.

I interviewed 13 service providers – paid professionals employed by non-governmental organisations (NGOs) or the French clinic situated in the camp, professionals who volunteered in the camp – mostly UK National Health Service (NHS) psychiatrists, nurses and doctors who used their annual leave to volunteer – and longer-term volunteers. The semi-structured interviews followed a topic guide based on my observations and field notes from the camp and a literature review on MHPSS in similar settings. Ethical approval for the research was gained from the Leeds Institute of Health Sciences Research Ethics Sub-Committee (FMHREC-16-1.1) and all participants gave informed consent.

The longer-term volunteers had lived and worked in the camp for over 9 months, but had no previous experience of working in mental health and lacked qualifications in this area. All participants expressed their shock at living conditions in the camp and described a population of stressed and frustrated refugees, whose mental health seemed to worsen the longer they stayed in the camp. Participants described a lack of trained and experienced service providers and an inability to deliver high-quality sustainable MHPSS.

Living conditions

It is difficult to understand how a makeshift camp like 'The Jungle' (which was nominally closed in October 2016) existed in Calais for so long and easy to forget that this pocket of refugees were only a small proportion of those living in Europe. There are doubtless many other unsafe, unsanitary and inhumane camps. One of the first things that participants told me was to not to call it a refugee camp. Instead, they described it as a *favela*, or a slum, and asked me to talk about toddlers playing in faeces when I wrote up my findings. Calling the camp 'The Jungle' felt dehumanising, but in retrospect it epitomises the sense of danger, an unspoken hierarchy and a lack of law and order.

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My first impressions of the camp were of poor, bedraggled tents and overflowing rubbish; although there were makeshift shop fronts and 'streets' marked out, they were pot-holed, muddy and not suitable for cars. The toilets were overflowing and refugees washed at the taps haphazardly set around the camp. The police in riot gear at the entrance seemed more interested in keeping refugees inside than in their security. By noon, the majority of refugees had woken up after a night of 'trying', trying to get to the UK by any means possible. The men (most of the population were men, from over 20 different nations) knew where to find the limited wifi and, if fortunate, hot drinks and meals. The women and children were more difficult to speak to and tended to congregate in the Women and Children's Centre, housed on an old double-decker bus, the Youth Centre, or the Kids Cafe, a space with an old pool table and television, popular with Afghani youngsters. Long-term volunteers were protective of the women and children that they were aware of, but it was difficult to keep track of who was in the camp as there was no formal registration service. As one participant explained, the women and children who were most at risk were the ones that volunteers never saw.

Service provision

It quickly became clear that there was a lack of official channels or agreed system to access healthcare and that the larger NGOs were not able to sustain a continued presence in the camp. If it had been an official camp, NGOs may have made the changes suggested in interviews: ensuring emergency services had access, clean water and safe facilities for drinking and washing and implementation of guidelines on the provision of evidence-based MHPSS produced by the Inter-Agency Standing Committee (2007). However, politically this may have also legitimised the camp's presence.

Among different volunteer groups, I was surprised to see a homeopathic medicine tent next door to a first-aid tent (staffed mainly by volunteer NHS nurses and doctors): the homeopathic practitioners offered tuberculosis remedies to one refugee who had been discharged from the local hospital but was unable to pick up his prescription, whereas the first-aid tents offered education and advice. Service providers from the NHS were unable to prescribe medication for fear of litigation and a lack of quality-assured supplies. Similar issues in continuity of care were described in stories of refugees discharged from the local hospital after suicide attempts or a man repeatedly violent during psychotic episodes who may have benefited from in-patient care, but who was discharged to the camp. Volunteers felt either inexperienced in providing psychiatric care or unable to offer the kind of care that they practised in the UK due to lack of resources.

Participants complained that MHPSS was offered by well-meaning volunteers, some of whom visited the camp for a week to offer activities such as art therapy or dream interpretation. These therapeutic services were not monitored or evaluated and lacked sustainability.

Ethical dilemmas

Lack of follow-up and sustainability were factors in my decision not to interview the refugees themselves. It was unlikely that I would be able to signpost a refugee to MHPSS if interviews were distressing; many refugees whom I spoke to casually wanted to share and document torture, abuse and traumatic journeys once they realised I was researching mental health. It was unsurprising that they were described as stressed and displaying signs of psychosis, anxiety and grief; the refugees were far from their normal support networks (United Nations High Commissioner for Refugees, 2013) and their situation was complicated by political context and living conditions.

Due to a limited budget, it would also have been difficult to find translators to speak all the different languages at the camp. Although refugees often asked to share their stories with me and offered to translate the stories of their friends, it was difficult to ensure confidentiality in this setting and I was wary of increasing stigma towards those with mental health problems. Refugees were suspicious of French and English officials; consultations took place which ended with refugees tearing up their notes in case they were used against them in the future. Finally, there were limited ways of refugees withdrawing their consent. The lack of a registration system, along with frequent new arrivals and departures, meant that refugees were difficult to track down. Those who may have withdrawn their consent at a later date may not have been able to contact me.

Recommendations

There were difficulties in coordinating MHPSS and a lack of trained and qualified healthcare professionals. NGOs played a part in MHPSS and had roaming clinics which offered therapeutic activities and one-on-one counselling. However, the service providers with the closest relationships with refugees were the least well trained in how to spot psychiatric disorders and felt overwhelmed in triaging those who were more in need of care. Long-term volunteers spoke of feeling out of their depth and those NHS professionals who volunteered intermittently felt they could not offer a therapeutic relationship if they could not commit to seeing refugees regularly. NGOs and professionals at times wanted to distance themselves from volunteers when they recognised poorly evidence-based practice or overtly political groups. Training in psychological first aid (PFA) for volunteers and refugee community leaders was recommended, as was a single official and experienced body to take ownership of healthcare in the camp.

The future

By 2016, half of the camp had been bulldozed. All participants said that this had raised tensions and

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led to clashes between different cultural groups. Safe places, make-shift mosques, churches and children's centres had been destroyed or relocated and yet the number of camp inhabitants had continued to increase, including numbers of unaccompanied children. News reports in early 2017 suggested that following closure of 'The Jungle' in October 2016, the numbers of refugees arriving in the area continues to increase and more informal camps have since appeared. A prediction of one of the participants seems accurate, that the camp's closure would leave refugees more vulnerable, as they would lose their community–volunteer links and neighbourhood watch system of 'The Jungle' and the media would lose interest.

My learning

It is tempting to focus on refugees' countries of origin and imagine what political and social difficulties they may have faced there. Meeting the refugees in Calais I understood how key refugees' journeys are in shaping their lives and experience of trauma. Now, when considering a patient's story, I need to ask not only why they left home, but also how.

Although it is possible to be critical of some aspects of MHPSS in Calais, there was a caring and supportive community of volunteers. When refugees find some stability or a new home in Europe, they may lose this support and feel isolated. Service providers need to help to empower communities and build trusting relationships with refugees, such as those between volunteers and refugees in 'The Jungle'.

Moving forward

Volunteers in the UK may be willing and ready to help refugees arriving from Europe; it would be useful for them to be trained to support refugees effectively, for example in PFA.

Refugees are unused to stable long-term therapeutic relationships; this is something that the NHS and NGOs in the UK can offer.

Refugees remain vulnerable even after reaching the UK, especially women and children. Tracing their families and loved ones needs to be a priority. Putting them in touch with other refugees may be empowering and protective for their mental health.

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PANDORA'S BOX

Pandora searches the world literature for evidence, news and other sources on matters of interest (doesn't shy away from controversy) to bring to the reader. She welcomes comments and suggestions (via ip@rcpsych.ac.uk)

The puzzle of adolescent brain development solved

The hitherto accepted view that both brain volume and cortical thickness decline from childhood to young adulthood is re-examined in a recent study. The researchers evaluated over 1000 young people (8–23 years old) who had taken part in the Philadelphia Neurodevelopmental Cohort, a community-based study of brain development, using neuroimaging and cognitive data. They examined age-related effects and gender differences in four measures of grey matter from 1625 brain regions: grey matter density (GMD), grey matter volume (GMV), grey matter mass (GMM) and cortical thickness (CT).

They found that while GMV and CT generally decrease with age and GMM shows a slight decline overall, in contrast GMD increases. Females have lower GMV but higher GMD than males throughout the brain. These results suggest that GMD is 'a prime phenotype for assessment of brain development and likely cognition'. Very importantly, the finding that GMD increases with age explains why cognitive performance improves from childhood to young adulthood despite the decline in brain volume and cortical thickness.

Gennatas, E. D., Avants, B. B., Wolf, D. H., *et al* (2017) MRI-derived gray matter measures, density, volume, mass, and cortical thickness, show distinct age and sex effects, as well as age-dependent intermodal correlations around adolescence. *Journal of Neuroscience*. https://doi.org/10.1523/JNEUROSCI.3550-16.2017.

Can we stop ourselves ageing?

As we age in years the ability of our body cells to divide and grow deteriorates, causing our body to degrade and letting diseases of senility creep in. Getting old is a biological reality and an irreversible process, or at least so we believed until now.

Not so, say a Korean research team from DGIST (Daegu Gyeongbuk Institute of Science and Technology), who are working on reversing the ageing process. In the process of screening for compounds that can alleviate senescence, they identified the ataxia telengiectasia mutated (ATM) inhibitor KU-60019 as a possible agent. The researchers found that ATM interacted with the subunits of vacuolar adenosine triphosphatase (v-ATPase), which is involved in the regulation of lysosomal activity. As cell ageing progresses, the ATM protein phosphorylates v-ATPase, weakening the binding force between the v-ATPase subunits and causing the function of the lysosomes to deteriorate. They also demonstrated that by inhibiting ATM with KU-60019 they reduced the phosphorylation of v-ATPase, hence inducing recovery of cell mitochondrial function, functional recovery of the lysosome and autophagy system and metabolic reprogramming and promoting wound healing in animal ageing models.

Could ATM inhibitors be effective in preventing brain ageing or promote repair of brain damage?

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