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THEMATIC PAPER

Psychiatry in Shetland

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The Shetland Isles are a place of breathtaking landscapes and pristine wildlife. As harsh as the weather can be, so warm and welcoming are the people and their proud half-Scottish, half-Scandinavian culture. Practising psychiatry in this northernmost outpost of the UK involves significant challenges. The authors were the only two psychiatrists based on this remote island group, which is home to 23 000 people.

Where is Shetland?

Shetland is Britain's northernmost community – a group of over 100 islands, 15 of which are inhabited. The main town, Lerwick, is 217 miles north of Aberdeen. Norway is just over 200 miles to the east and the Faroe Islands lie a similar distance to the north-west, with Iceland only another 300 miles beyond Faroe. The Shetland Island group stretches a hundred miles from north to south and lies at a latitude of 60 degrees north. This is as far north as St Petersburg and Anchorage, but warm ocean currents give Shetland significantly milder temperatures. The average wind speed over the year is around force 4, and wind speeds of hurricane force 12 are not unknown in winter. Shetland is served by commercial flights from five Scottish airports and by an overnight ferry from Aberdeen (Shetland.org, 2018).

Historical overview of the Shetland Isles

Shetland was inhabited by Neolithic farmers by 3000 BC. Viking invasions started around 800 AD, with Shetland part of the Pictish culture prior to the arrival of the Vikings. Norse (Viking) rule ended as the result of a marriage treaty in 1468 between James III of Scotland and Margaret, a Danish princess. The Danish struggled to raise the funds for Margaret's dowry, so that Shetland was mortgaged to Scotland (Shetland.org, 2018).

After the Norse warlords, came four centuries when Shetland sold its salted fish to the outside world through the Hanseatic League of merchants, based in Bergen, Bremen, Lubeck and Hamburg. After the 1707 Treaty of Union, the new British government ousted the Hansa and, during the 18th century, local merchant-lairds ruled the land by means of a feudal system and built lavish mansions (known as Haa houses) in every part of Shetland.

The First World War destroyed the markets for the booming herring fisheries, which at the turn of the century had lifted many islanders out of poverty, and emigration increased during most of the 20th century. During the Second World War, Shetland was the base for a secret and dangerous operation that saw small fishing boats, known as the Shetland Bus, supporting the Norwegian resistance against Nazi occupation.

By 1971, the population had dropped to just 17 325 compared with 31 670 in 1861. However, a home-grown revival based on fishing, agriculture, knitwear and tourism made Shetland's economy grow so strongly that, when oil and gas were discovered offshore in the early 1970s, the Council was able to strike a remarkable deal that gave Shetland a share of oil revenues.

Culture

For historical reasons, Shetland has maintained a close relationship with Norway. The dialect spoken by Shetlanders contains many Old Norse words. The houses that people build in Shetland are often in a Scandinavian style and indeed are sometimes supplied from Norway. Norwegian flags are also commonly seen, and place-names are almost exclusively Norse. In Lerwick, many street names celebrate Norse figures such as King Harald. The spectacular annual Up-Helly-Aa fire festival is Shetlanders' celebration of their rich Viking heritage. Shetland has a vibrant art scene and is popular with artists, writers, poets, photographers, musicians, architects, textile designers and a wide range of craftspeople from all over the world. Several music festivals take place during the year, including the world-renowned Shetland Folk Festival (Shetland.org, 2018).

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Economy

When oil arrived in the late 1970s, it was thought unlikely that production from Shetland would last beyond the millennium. However, ingenious ways have been found to extend the life of oil fields, and large-scale investment continues (Shetland.org, 2018). Shetland currently has one of the highest employment rates in the UK (Shetland.org, 2018). Since 2003, house prices in Shetland have more than doubled: the greatest regional increase in Scotland (Ft.com, 2018). A new, state-of-the-art secondary school for 900 learners was completed in 2017. The seafood industry, which includes the catching, farming and processing of fish and shellfish, is Shetland's biggest and worth £300 m a year to the local economy (Shetland.org, 2018). Shetland's hardy local breed of sheep produces high-quality meat and exceptionally fine, soft wool which forms the basis of the famous Shetland and Fair Isle knitwear industry (Shetland.org, 2018). Local firms in Shetland are involved in cutting-edge technology such as wave and wind energy (Shetland.org, 2018).

Public service and healthcare

For its size, Shetland has a large public sector, and Shetland Islands Council and National Health Service (NHS) Shetland are the biggest employers. The provision of services across 15 inhabited islands presents unusual challenges and opportunities. Public sector staff work throughout the islands, for example, as teachers, doctors, community workers, nurses or ferry staff. A social worker, nurse, doctor, town planner or customs officer may find that they need to travel by ferry or light aircraft in the course of their work (Shetland.org, 2018).

In 2014, under the new Public Bodies (Joint Working) (Scotland) Act 2014, Shetland Islands Council and the Board of NHS Shetland joined forces to form the Integrated Joint Board, which was intended to ensure seamless health and social care provision (Shetland.gov.uk, 2018).

Shetland NHS Board provides healthcare for a population of around 23 000. Hospital and community services are provided from the Gilbert Bain Hospital and ten health centres. Visiting consultants from NHS Grampian provide outpatient clinics, as well as in-patient and day-case surgery, to supplement the service provided by the locally based consultants in medicine, surgery, anaesthetics and psychiatry (Shb.scot.nhs.uk, 2018) There are no psychiatric in-patient beds in Shetland. Patients requiring admission are transferred to Aberdeen, and cared for on the medical ward in Shetland while awaiting transfer.

The mental health service

The mental health service is made up of the community mental health team (CMHT), the substance misuse and recovery service (SMRS), the talking therapy service (TTS) and the dementia assessment team. The CMHT and SMRS work closely together, especially with those patients with dual diagnoses. The two teams are staffed by community psychiatric nurses. In addition, the SMRS benefits from a general practitioner with a special interest in addictions and recovery workers. There is a small child and adolescent mental health service, which falls under the Children's Service directorate.

A full-time consultant psychiatrist and middle-grade (specialty doctor) psychiatrist provide clinical leadership for the CMHT and SMRS and share out-of-hours telephone on-call duties. They visit Royal Cornhill Hospital in Aberdeen monthly for academic activities, mentoring, and clinical and management interface, and to review any in-patients from Shetland.

The CMHT works closely with a small team of mental health officers, who are social workers with special training and experience in working with people who have mental illness or learning disability. They are knowledgeable about the Mental Health Act (Scotland) and participate with the psychiatrists in Mental Health Act assessments. A full-time consultant clinical psychologist provides clinical leadership for the TTS, as well as input into the CMHT. The service works in partnership with several non-NHS or 'third sector' organisations, and with a forum for patients and carers.

Challenges

Higher costs, difficulty with recruitment and retention of staff, extended professional roles, boundary issues, limited patient choice and professional isolation are some of the challenges that may affect the quality of mental health service provision in rural areas (Nicholson, 2008). This is true for Shetland.

Patient transfers are often delayed because of strong winds, rough seas or fog, testing the skill and resilience of health professionals. The high financial cost and the disruption to patients and

Table 1

Reduction in in-patient admissions to Royal Cornhill Hospital in Aberdeen during the 2015–2017 financial years (data from the Scottish Morbidity Records, SMR04 (http://www.ndc.scot.nhs.uk/National-Datasets/data.asp?SubID=7))

Year	Admissions	Bed days
2014–2015	46	1290
2015–2016	15	1132
2016–2017	19	594

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their families of transfers and admissions to Aberdeen was one of the major challenges for mental health services in Shetland for many years. In the summer of 2015, we implemented evidence-based approaches for those who suffered from personality disorders. This group of patients had in the past made up a large proportion of hospital admissions to Aberdeen. A very helpful voluntary peer review by experts in personality disorders from the Royal College of Psychiatrists resulted in further improvements in clinical practice. In addition, crisis and home treatment principles were implemented, preventing hospital admissions in many cases. As a result acute, psychiatric admissions to Royal Cornhill Hospital in Aberdeen reduced significantly over the following 2 years (Table 1).

Conclusion

Practising psychiatry in Shetland is a unique and potentially rewarding experience, both personally and professionally. It provides the opportunity to develop as a generalist in challenging conditions and to lead on service development. Photos of Shetland by the author can be found in the supplementary material.

Supplementary material

Supplementary material is available online at https://doi.org/10.1192/bji.2018.2.

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PSYCHIATRY UNDER RESTRICTIVE CONDITIONS

Correctional psychiatry in Nigeria: dynamics of mental healthcare in the most restrictive alternative

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Nigeria has poorly structured services for correctional mental health driven by a mix of socioeconomic and legal factors. The archaic asylum systems established in the early part of the 20th century under the Lunacy ordinance of 1916 are no longer fit for purpose. The present strategy is to provide mental healthcare for mentally abnormal offenders within some prisons in the country. The current models for this are poorly staffed and underfunded. Adoption of task-shifting approaches based on evidence-based strategies within the context of professional innovation, government commitment and international collaboration should help to develop and sustain the needed correctional psychiatry services.

The history of correctional psychiatry in Nigeria can be traced to the earliest part of the 20th century when two important lines of 'asylums' were established under the Lunacy Ordinance of 1916 by the British colonial administration. The first line involved what could be regarded as 'non-prison' asylums in the southern protectorate, with two asylums being established in Calabar and Yaba by 1907 and a third one following in 1944 in Lantoro (Laws of Nigeria, 1948). These asylums were for the custody of people with mental illness who were not necessarily offenders. In addition to these three, selected native authorities mainly in the northern protectorate of Nigeria (as it was then known) were also empowered by the ordinance to establish asylums. The second line related to prison-based asylums that essentially comprised prison cells designated for the custody of offenders with mental illness (Laws of Nigeria, 1948).

Over time, the non-prison asylums were either neglected or they were mainstreamed into modern day psychiatric hospitals without specific facilities to secure and treat offenders with mental disorders (Ogunlesi *et al*, 2012). Although the non-prison asylum arrangements are still recognized by law, they are no longer properly funded and their oversight mechanisms ('visiting committees') have become obsolete. Thus, offenders with mental illness are now treated in prisons even when found 'not guilty by reason of insanity' (NGBROI) per section 230 of the Criminal Procedure Act (Laws of the Federation of Nigeria, 2004a). Although this act directs the NGBROI convict to be remanded in an asylum

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