After 7 weeks of observation, a ward case conference was held, attended by my whole team. Conclusions were drawn and I submitted my report to the court and awaited further instruction. The report stated that Maria had chronic schizophrenia and was currently in a defect state. She had relapsed in the past, with frank delusions of being a witch and hearing God's voice tell her that she had extraordinary powers to make anyone disappear. She was of somewhat low intelligence. She had no children of her own and liked playing with small children from the neighbourhood. She longed for a daughter of her own and sometimes claimed someone else's child and was unwilling to return the child to the parents. No one took her seriously. During psychotic relapse she boasted of her supernatural prowess. It was during such a relapse that the recent incident had occurred.

Thus, Maria was mentally ill and needed psychiatric care. By reason of her mental condition, she was not responsible for the offence. I asked the court to issue an order for Maria's treatment.

The prosecutor tried to demolish my report by quoting cases of witchcraft he had seen. He told the court to reject my report *in toto*, as no one in the local population believed that Maria was mad or mentally ill: she *was* a witch and used witchcraft to kidnap children. He wanted the court to convict her as charged and asked that Maria be given exemplary punishment in order to deter other acts of child abduction. He wondered whether a Western-trained psychiatrist knew anything at all about indigenous illnesses or was aware of *ngulu*.

The court rejected the prosecution's arguments and accepted my report. Maria was remanded to a mental ward. Most members of the public were not entirely satisfied with the verdict and left the court in disappointment. Maria was duly admitted to my ward, was treated with depot injections and was asymptomatic 3 years later.

Comment

Maria fitted the traditional stereotype of a witch. Her local community did not believe that she had a mental disorder, even after the court verdict. They also doubted my knowledge and understanding of indigenous illness. Laher (2014), in her study of illness conceptualisation in African, Hindu and Islamic faiths, recommends that the training of mental health workers include knowledge of local culture, skills and awareness. I have held this view and have incorporated it in my teaching.

The fall-out of this case was interesting. The press debated witchcraft *vis-à-vis* mental illness and argued whether traditional healers and Western-trained mental health workers could work together. I followed their suggestion and sought the advice of known healers to assist me in managing some cases of *ngulu*. From his personal experience in Nigeria, Prince (1964) has suggested that traditional healers have a role in dealing with cases of spirit possession and could be helpful in treatment. Cooperation between Western-trained psychiatrists and traditional healers was rewarding. Some years later I learned with regret that the arrangement with healers had been discontinued.

In the early 1980s, while doing research in primary health clinics in rural Kenya, I found that a significant number of patients with a diagnosable mental illness seen in psychiatric clinics (urban as well as rural) had visited traditional healers. Therefore, Western-trained psychiatrists should familiarise themselves with the local concepts of mental illness and spirit possession. This idea is well supported by Incayawar *et al* (2009); they term this an 'unwitting partnership'. I have been unable to find any reference to a psychiatrist having defended a psychotic witch in a traditional court.

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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)

MDGs a missed opportunity?

Lack of investment in mental health is a key driver of poverty and inequality in low- and middle-income countries. Neuropsychiatric disorders account for 13% of the global burden of disease, with 70% of these accounted for by low- and middle-income countries. The year 2000, a time of optimism, marked the Millennium Declaration, and the start of the Millennium Development Goals (MDGs), a 15-year international agenda for global development, was greeted with hope. That programme focused on health challenges, guiding health budgets of national governments, non-governmental organisations (NGOs) and the wider aid community, and its achievements should not be underestimated. However, it was a missed opportunity as far as mental health is concerned. According to McGovern, in a commentary appearing in the *International Journal of Mental Health Systems*, the MDGs failed adequately to consider mental health and he urges that a specific focus be placed on mental disorders in the post-2015 agenda for development. He argues that investment in mental health pays wider dividends than purely on the level of clinical outcomes, and recommends that the post-2015 agenda specifically includes access to mental healthcare and the use of evidence-based diagnosis and management. Better investment in mental health can address the global burden of mental disorders.

McGovern, P. (2014) Why should mental health have a place in the post-2015 global health agenda? *International Journal of Mental Health Systems*, **8**, 38.

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