

to provide adequate explanations. Firstly, we did not argue against punishment for false certificates of mental illness; instead, we discussed how a stronger mental health system can complement the new mental health act without jeopardising the existing workforce.² If a certificate of mental illness is claimed to be false, experts would have to make further assessments of the patient, the quality of diagnoses according to existing guidelines, and the competence of the medical practitioner before confirming these claims. Because of the pre-existing scarcity of mental health specialists in Bangladesh, assessment by experts would be tough to obtain. Strengthening the mental health system through capacity building and protecting the mental health rights of the citizens would alleviate this difficulty.

Secondly, negative attitudes of physicians towards new legislative or administrative initiatives have had well-documented effects on health access in older and developed economies.³ The way in which malpractice claims are assessed can have numerous financial and legal implications, and can have profound effects on medical professionals and the environment in which they thrive and serve.⁴ Additionally, Bangladesh has no malpractice insurers or lawyers dedicated to medical malpractice claims, so mental health-care professionals have no access to financial protection or specialised legal support.

Lastly, we did not mention the tougher punishments medical practitioners would face for misconduct and negligence. We acknowledge that describing all aspects of the new act was beyond the scope of our Correspondence. Bangladesh already has several laws which address misconduct and negligence;⁴ further research and broader perspectives would be required to understand the enforcement of existing legal statutes

and how the new Mental Health Act will fit into this complex legal environment.

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Psychiatry research and gender diversity: authors, editors, and peer reviewers

Despite substantial progress, gender inequality continues to exist in most scientific fields,¹ including medicine.^{2,3} A recent gender analysis of authors who publish in *The Lancet*

journals⁴ found that only one third of authors are women, which is striking considering that women make up more than half of the graduates in medical sciences.⁵ Nevertheless, the gender analysis showed one notable exception: female representation in *The Lancet Psychiatry* was 45%, rising to 51% among first authors.

Expanding our focus, we selected 40 journals from the Web of Science “PSYCHIATRY” category to examine their authorship, editors, and peer reviewers. We grouped journals by quartile (Q1–Q4) according to their impact factor, and then selected the top ten journals from each quartile (appendix).⁶ All articles and reviews published in the 40 journals during the years 2015–17 were extracted. From a total of 103 995 authors, gender could be identified in 87 642 (84.3%). Gender was identified on the basis of author names, biographical information, or photos found through web searches. In total, women represented 35 348 (43.3%) of 81 673 article authors, and 2347 (39.3%) of 5969 review authors (table). The figure shows the percentage of women in each quartile and the corresponding percentages of women who were first or last author (absolute values in the appendix). Three observations were particularly noteworthy: women were

See Online for appendix



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	Total	Gender identified	Women (%)	Men (%)
Authors				
All papers	103 995	87 642	37 695 (43.0%)	49 947 (57.0%)
Articles	97 236	81 673	35 348 (43.3%)	46 325 (56.7%)
Reviews	6 759	5 969	2 347 (39.3%)	3 622 (60.7%)
Editors				
Editors-in-chief	48	48	5 (10.4%)	43 (89.6%)
Editors	332	331	102 (30.8%)	229 (69.2%)
Members of editorial boards	1 585	1 567	379 (24.2%)	1 188 (75.8%)
Peer reviewers	9 495	8 858	3 045 (34.4%)	5 813 (65.6%)

Journals were selected from the “PSYCHIATRY” category of the Web of Science database. Lists of peer reviewers were obtained from 17 journals.

Table: Gender diversity of authors, editors, and peer reviewers of 40 journals in 2015–17

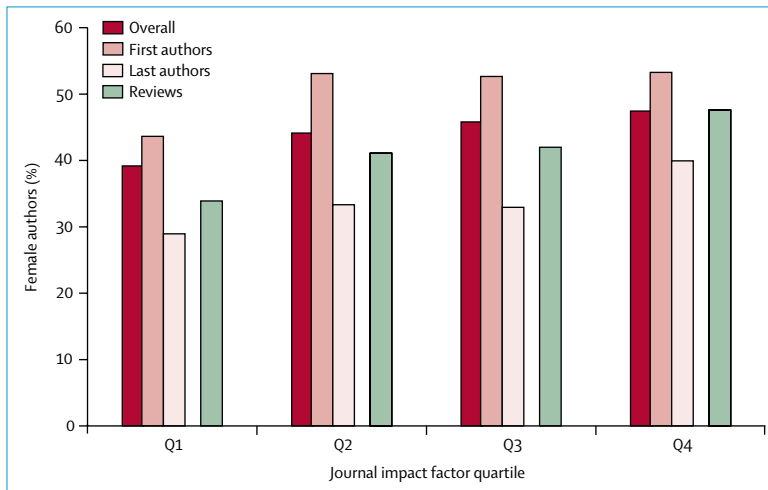


Figure: Representation of women as authors of articles and reviews published in 2015–17
Journals were selected from the “PSYCHIATRY” category of the Web of Science database and grouped by quartiles according to their impact factor. Last authors were counted if papers had at least three co-authors. No restrictions were made with first authors.

less present in higher impact journals; women were overrepresented as first authors, surpassing men in the last three quartiles; and women were underrepresented as last or senior authors. The first author is usually the one who has made the most substantial contribution in terms of time and performance—in many cases, they are junior researchers publishing their first postdoctoral papers. Regarding the journal editors, only 10% of editors-in-chief were women. Women represented 30.8% of staff editors and 24.2% of editorial boards. We obtained lists of peer reviewers from 17 journals and one third of those were women.

In summary, psychiatry shows a smaller gender asymmetry than other medical fields, but it has not yet achieved gender parity among scientists, particularly in publications with more visibility and higher impact. Regarding authorships, we observed a pattern also found in other contemporary gender studies:^{1,4} an overrepresentation of women as first authors and a pronounced underrepresentation as senior authors. This fact, along with a lower proportion of women among editors and peer reviewers, suggests that age might play a certain modulating role in

the gender composition of psychiatry researchers.

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New guidelines on mental health in Peru

In October, 2018, the Ministry of Health of Peru approved the sectoral policy guidelines on mental health,¹ which update those published 14 years ago. The five guidelines highlight

the transitional framework of public mental health, from tertiary care (psychiatric hospitals) to secondary and primary care. They also call for the inclusion of mental health management in non-specialised centres and for the implementation of new community mental health centres across the country.² The Ministry of Health took into account social determinants of health, human rights, and intercultural, intersectional, and territorial approaches for the development of these guidelines.

Neuropsychiatric diseases are a major contributor to the burden of disease in Peru,³ and mental health has been neglected for many years.⁴ The first guideline aims to strengthen the responsiveness of the national health system to the demands of the population, by reorganising the management of mental health at all levels of the national health system, and by reorganising the management of investments, social communication, national health information systems, and research in community mental health. The second guideline covers the community model for mental health care, promoting mental health as a component of health at all levels and recognising the biological, psychological, social, and spiritual factors affecting the mental health of individuals. Additionally, this guideline establishes the management of mental health care in defined territories, providing a framework for each territory to identify population groups, improve communication between health-care providers, and solve any problems that need to be addressed. The third guideline focuses on the most vulnerable population groups and communities: children, teenagers, women, older people, disabled people, ethnic minorities, victims of political violence, LGBT individuals, survivors of natural disasters, and immigrants. The fourth guideline addresses the workforce, and responds mainly to the uneven