Volunteering & International Psychiatry

RCPSYCH

Newsletter of the Volunteering & International Psychiatry Special Interest Group #14 **06/20**

Mental Health & COVID19: Special Edition

VIPSIG 06/20

Volunteering & International Psychiatry

Welcome to the 14th issue of the Volunteering and International Psychiatry Special Interest Group Newsletter

Special Edition: COVID19 & Mental Health

VIPSIG Editorial Team,

We hope you enjoy this special edition newsletter'.

Please contact us on the emails provided for feedback.

Dr Faheem Naqvi

Dr Hina Rehman

Dr Lucia Almazan Sanchez

VIPSIG Newsletter Editorial Team

If you have comments about any of the articles in this issue or would like to get more involved with VIPSIG please email us at:

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We are currently looking for a *new editors* to join us. Please send expressions of interest to:

drfnaqvi@gmail.com

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DETAILS FOR POTENTIAL AUTHORS

We welcome contributions to the Volunteering and International psychiatry SIG on topics of interest to our membership. We are particularly interested in articles from medical students, trainees, middle grades and consultants regarding volunteering internationally and within the UK, from charities and NGOs who provide volunteering opportunities and advice to clinicians who want to undertake this kind of work. Articles should be a maximum of 500 words excluding any references or appendices; they need to be submitted in word format, we encourage the use of photographs and figures submitted as separate .jpg files. Please include your full name, your photograph and titles, place of work and email contact details. Opinions expressed in the Newsletter are those of the authors and not of the College, unless otherwise stated. The editors reserve the right to edit contributions. Please email your submissions to the emails provided above.

VIPSIG 06/19

Volunteering & International Psychiatry

Message from The VIPSIG Chair:

Welcome to the VIPSIG Newsletter 2020

Hopefully you and your families are well and managing well enough during this difficult time. It will come as no surprise that this edition will include articles on the COVID pandemic, as well some of the essay prize winner contributions, which were excellent this year. Also, an enjoyable blog from the successful Myanmar project, and more!

Also, the big news for 2020 is the arrival of the first ever College International Strategy. This is very exciting as it outlines the development of international work for the next 3 years and includes support for the increased numbers of volunteering projects and an RCPsych Certificate for international colleagues and more!

I know many people are hoping to find opportunities for Volunteering locally and internationally, so we need your help. If you have contacts or organisations whom we could contact to discuss a project, please let us know via Catherine.langley@rcpsych.ac.uk.

Finally, Thanks for your continued interest and support.

Dr Sophie Thomson
VIPSIG Chair

VIPSIG Essay prize 2019/2020

The Annual VIPSIG Essay Prize was established to promote interest and encourage excellence in volunteering (UK or abroad) and international psychiatry. Submissions may include descriptions of a clinical experiences, elective report, reflective essays, editorial or research and can be proposed by medical students, foundation trainees, psychiatry trainees, SAS and specialty doctors.

This year, we announced the winning entries, listed below, on May 25th on the wishes of Dr Zafrina Majid, whose essay received a commendation and is included in this newsletter. This is in memory of her sibling Dr Syad Arshad Abbas, who passed away on this date in 2011. These year's winners along with entries from past years and details on how to participate next year can be found online on the VIPSIG Essay Prize website.

Winners

Shaheen Sardar. *Familial Relationships: A Protective or Detrimental Factor against Psychiatric Conditions in Female Refugees?(PDF)* (Medical Student)

Sarah Parry. *Mental Health Services in Cambodia: research and reflection (PDF)*.

Runners-up

Gunjan Sharma. *East vs West: Psychiatry in the Himalayas (PDF)*. (CT1)

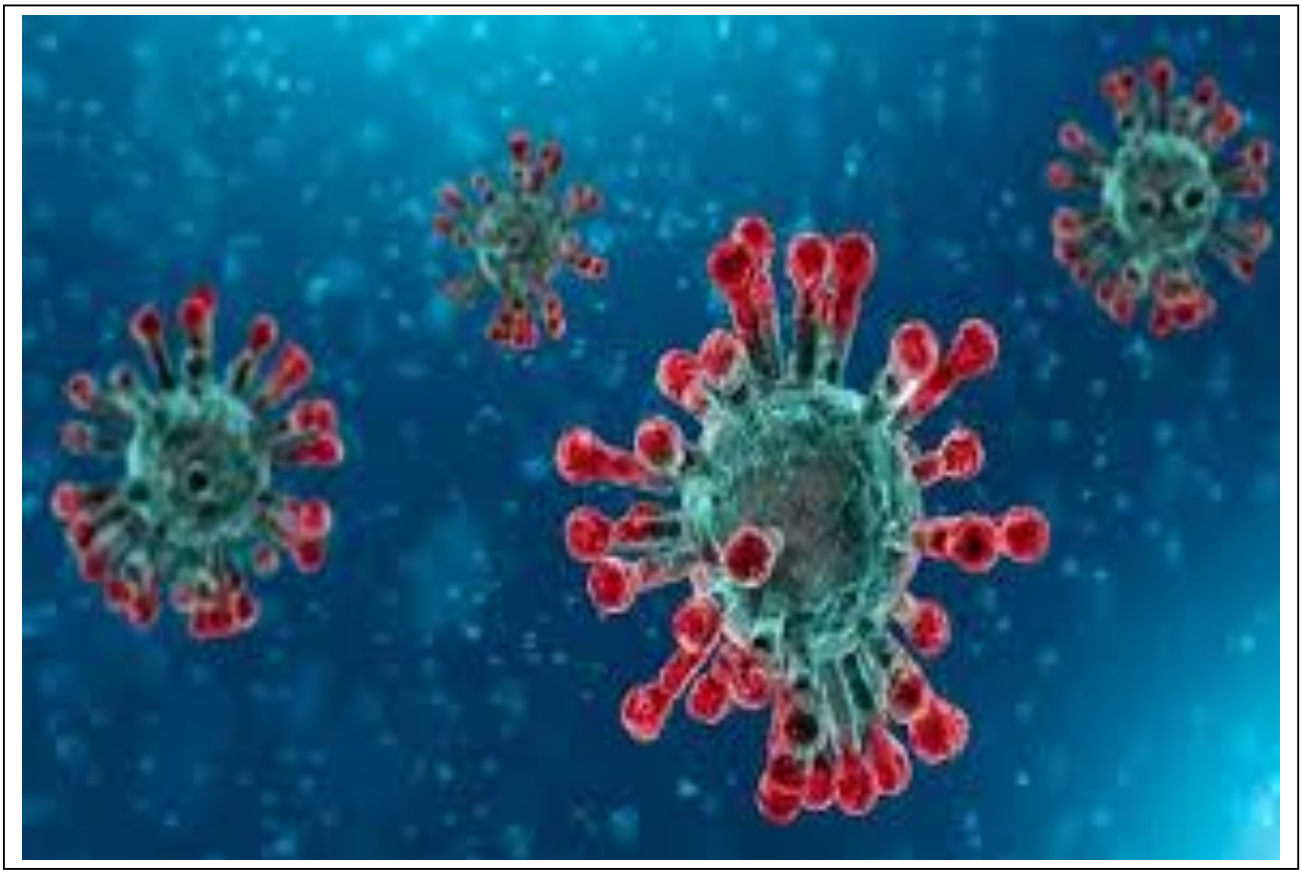
Natalie Cook. *SKIP: Emotional Wellbeing Interventions (PDF)*. (ST4)

Commendations

Fiona Martin. *Volunteering in a mental health service in Uganda: challenges and rewards*. (ST4)

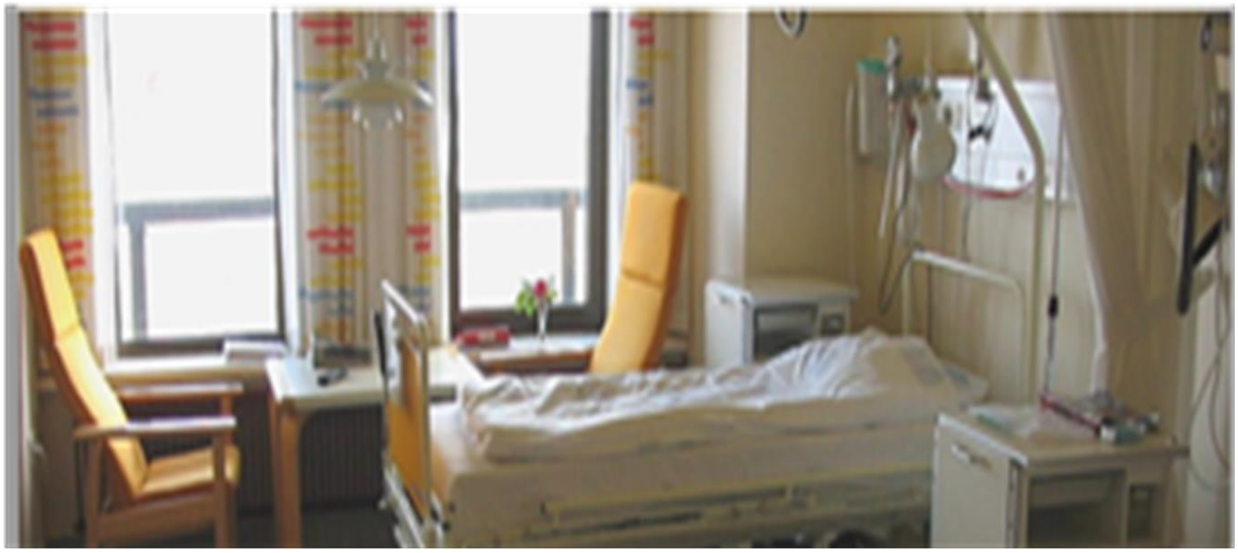
Zafrina Majid. *What Appears to be the End, May Really Be a New Beginning (PDF)*. (ST4)

VIPSIG contents



MENTAL HEALTH IN THE TIME OF

C O V I D-19



FOREWORD

by Gergana Manolova, GloballyMinded.org

As the world is being changed irrevocably by the COVID-19 pandemic, mental health work may yet turn out to be our most important tool in the times to come. What we know, what we practice is desperately needed for all those whose lives are traumatised and upset by the disruption, whose mental health conditions may have been exacerbated, or who feel helpless and let down by everything around them. Add that to the usual workload of patients, who sometimes have prolonged and complex treatment and maintenance needs, along with the heavy toll that the pandemic is taking on medical wards, and the job of the mental health professional becomes a fraught one. I asked mental health professionals around the world to tell us how they are coping in these times and what their observations are on the mental health needs during this pandemic. Here are their answers. I would like to thank the team of the VIPSIG newsletter for the opportunity to do so, and thank Dr Peter Hughes for his valuable contribution in connecting me to colleagues who wished to share their experience. Most importantly, I thank each and every one of them for taking the time and telling us what they felt and thought.

Anonymous, Consultant psychiatrist on a female psychiatric ward, London, UK

How are you feeling working in the pandemic conditions?
It is quite anxiety-provoking, especially with the uncertainty about infectiousness and treatment. There is a constant worry about keeping the family safe. Mental health workforce has remained the same, if not fewer with illness and shielding staff, while there has been constant demand on service and it is becoming more and more.

What is the effect of the pandemic on your mental health work and the patients you see?
I work in an inpatient unit, we are already seeing an increase in admissions secondary to the isolation from lockdown. We are also seeing impact on professionals who have treated COVID patients in general hospital or intensive treatment units.

What are the mental health needs that you see brought on by the pandemic?
Stress and anxiety because of isolation during lockdown, demands on women having to cope with family and work and children at home. For women who live on their own, loneliness is hard.

What has been your biggest challenge in this situation? What has helped the most?
I feel government planning didn't have mental health at forefront, hence early days were extremely anxiety-provoking as clear pathway were not there how to procure PPE, when to wear which PPE, how much protection to take at work, what to do with mentally unwell patients who are not able to or refusing to isolate. Additionally, some mental health staff were not able to comprehend the seriousness of the virus, it was difficult to get them on board. And the most important challenge was keeping myself and my family well, managing childcare, managing increased work load and increased work on the home front with less help, no childcare. There were lots of personal challenges. I have been trying to sleep early and switch off before bed watching something on my mobile to distract and unwind. I tried Headspace, but couldn't concentrate as too much was going on. Sharing was helpful, but finding people to share with was a struggle! Reading from reliable sources kept me up to date, also reading some Facebook groups kept me grounded, I could see the perspective of some other women or people who are going through a challenging time.

Tarisai Bere, Clinical Psychologist, Harare, Zimbabwe

How are you feeling working in The pandemic conditions?
It has been really scary because unlike everything we've known before, this pandemic is affecting everyone, including me. It's been quite emotionally watching and trying to help not just my patients, but people really close to me like my sister, niece and mentor. They are in the UK, so for them social isolation has meant staying connected with family abroad. Speaking to them and seeing them trying to be strong on video online has been really difficult. You feel helpless.

What is the effect of the pandemic on your mental health work and the patients you see?
I've seen a lot of new patients who are struggling with generalized anxiety disorder and depression. More men are seeking help than before. Adolescents are bored stiff with the lockdown and quite a number of them have resorted to alcohol and drug use. The elderly poeple are also very scared, the uncertainty is too much for them.

What are the mental health needs that you see brought on by the pandemic?
Fear is causing a lot of anxiety, substance use and depression. A lot of people have been stripped of hope and fell quite helpless. Besides that, a lot of people in my country have lost livelihoods, which means that they can't take care of themselves and families, which continues to bring about fear, worry and thinking too much.

What has been your biggest challenge in this situation? What has helped the most?
The biggest challenge for me has been trying to stay strong. I'm not exempt, I am asthmatic and therefore am constantly reminded of how I'm in the vulnerable group. I have had to keep reminding myself of the facts to have the strength to carry on. Having family and very close people getting infected was also difficult. As a psychologist you also want to in still hope but it gets really complicated when you are not even sure when and how the pandemic will continue to affect your country. What has helped me the most is to stay up to date with information and research. I've also given lectures and presentation on the pandemic and preparing the material has forced me to learn more about the virus, which has helped me to be less afraid.

Dr Ehab Khattab, Consultant Psychiatrist in Learning Disabilities, North East London Foundation Trust UK

How are you feeling working in the pandemic conditions?

I feel an acute sense of responsibility for the welfare of my patients. I feel proud in the professionalism, responsiveness and genuine concern over the mental and physical health of shown by all the disciplines within the team I lead. I am truly impressed by the manner in which both the clinical and the operational leaderships in my trust came together to support health care workers and community providers alike.

What is the effect of the pandemic on your mental health work and the patients you see?

The rapid switch to virtual clinical work through use of communication technologies was an eye opener. On the other hand, the extensive lists compiled for vulnerable individuals which fed into person centred care plans ironically made us all feel more on top of the needs of our clients even more so than before. Surprisingly, more clients than not seem to be coping well with the dramatic changes in their lives. There was also evident gratitude from clients, families, and community providers towards the team's efforts to support them.

What are the mental health needs that you see brought on by the pandemic?

There is evidence that certain client groups have shown an increase in challenging behaviours, perhaps partly induced by the relative social isolation they continue to experience. Other groups appear to feel less stressed by a reduction in the social demands previously put on them. However, it is too early to assess the situation in its totality. We remain vigilant and anticipate a need to step up services as the wider picture becomes clear.

What has been your biggest challenge in this situation? What has helped the most?

The biggest challenge was to implement management plans which rely on access to community provisions such as day centres and face-to-face contact. This latter variable continues to prove to be central the field of mental health. Another challenge was to keep abrest of relevant policies and advice amidst an incredible amount of information via emails and social media.

Dr Menna Dakroury, general adult psychiatrist, Egypt

How are you feeling working in the pandemic conditions?
At first, I was very anxious about leaving home and I didn't go for any face-to-face sessions with my clients, I transferred all my work into tele-sessions. Then after two months I started again to go to my clinic twice a week and see not more than 3 to 4 clients a day, observing social distancing, wearing masks and washing my hands... Going back to face-to-face work makes me feel anxious every time I go back home, which makes me wash my hands more than once after reaching home, trying to avoid touching my kids for a while, till I feel safe after washing my hands several times.

What is the effect of the pandemic on your mental health work and the patients you see?
The pandemic affected my mental health badly, I became more anxious, my sleep is disturbed. I'm always worried about my kids' future and wondering for how long they would be able to survive in these conditions. This affected me very badly at work and many times I found myself losing track of what my client was telling me because I had a negative thought about the world because of COVID-19.

What are the mental health needs that you see brought on by the pandemic?
We need to offer mental health services support to the health workers, they are under severe stress. We need to provide huge platforms for tele-psychiatry to make it available for each one and safer at the same time.

What has been your biggest challenge in this situation? What has helped the most?
My biggest challenge was keeping calm and optimistic because my kids are so young and copying my thoughts and feelings. What helped me that I am living in a family building so I have good social support from my brother and my mum as we all practiced social distancing together, we isolated ourselves from others, so I have people in my life supporting me other than my husband and my kids.

"I feel government planning didn't have mental health at front."

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"Surprisingly, more clients than not seem to be coping well with the dramatic changes in their lives."

Anonymous, retired Hungarian psychiatrist

How are you feeling working in the pandemic conditions?

I have worked for years in disaster situations. Since I was sensitized to similar conditions in the Ebola epidemic, I'm in the privileged position to keep a distance and watch also the opportunities, positive changes brought about
by the crisis.

What is the effect of the pandemic on your mental health work and the patients you see?

Together with a community mental health team of Semmelweis University I'm attending online conferences where a number of service users participate. Though the crisis caused difficulties in the routine of social and health care,
those who are recovering are coping well and when we talk about the crisis-related troubles, stigma attached to those with chronic mental disorders is less.

What are the mental health needs that you see brought on by the pandemic?

The needs are for simple, practical support - more attention to the psychosocial needs.

What has been your biggest challenge in this situation? What has helped the most?

The need for psychosocial first aid - in a proper referral and supervision context is obvious. Apparently, we are more attentive and humbler towards each other. My major challenge is how to learn more from the crisis and how to sustain better care - responsibility in the communities.

Anonymous, GP in London, UK

How are you feeling working in the pandemic conditions?

As it was starting, I felt something harden inside of me and went into emergency mode, where I have been ever since. The things that became important were basic - food, rest, shelter and trying to get adequate PPE. We did not have adequate PPE so I chased around for six weeks to find some of my own. Working in this pandemic feels like working in other emergency settings I have been in in low-income countries, except this one is more disorganised. I think this may be because the UK is not used to dealing with such emergencies and the health governance and structures are not primed to make a quick response.

What is the effect of the pandemic on your mental health work and the patients you see?

I have noticed a higher level of anxiety and irritability in myself, as well as in colleagues. Some of our anxious patients suddenly feel less anxious as their experience is now mirrored in society, so they feel seen. For others, their anxiety and OCD is worse, especially if it centers around becoming ill or cleaning issues. However, for the most part I feel we are managing more anxiety in our patient population who are frightened of any respiratory symptoms or are frightened of catching COVID-19. About half of a COVID-19 consult is managing anxiety. It hasn't helped that many of our questions centre of how people's breathing is, and as people become more aware of their breath they appear to get more anxious. Another large factor is people's illusions of control are being challenged. Most people appear to believe they have control of their breath, their thoughts, their jobs, their health. Of course, they do not, but many buy into these illusions and gain a sense of agency and meaning through this. This situation has thrown all that up in the air, and as people notice they do not have control over such things, this is challenging their sense of safety, security and control. I have noticed patients are asking questions that we really cannot answer and existential questions about their lives, such as wanting us to tell them if COVID-19 will kill them. They are looking for certainty, which we cannot provide.

What are the mental health needs that you see brought on by the pandemic?

A lot of homeless people have been offered housing temporarily and we are picking up a lot of them. I am noticing that, as they are having their basic security needs taken care of, their mental and physical health problems are now becoming apparent and they may not have seen a doctor for many years. So we are doing what we can to help them, but we also worry about what will happen to them if the accommodation is removed, which it will likely be as they have only been housed to try and reduce the COVID-19 risk on the street. I am noticing slightly more inter-family stress and violence. I have not noticed an increase in presentations of people already known to services with severe and enduring mental illness, such as those with bipolar disorder or schizophrenia. I have noticed a slight increase in calls from those with more dependent personalities, and I think many people are finding it hard not to have face-to-face, 3-dimensional contact with their GPs. As most things are being done via phone or video calls, this does not necessarily meet the need for human contact that some people require to feel that they have been fully cared for.

What has been your biggest challenge in this situation? What has helped the most?

I think the largest problem comes under the heading of poor management. Changes to the way we operate have not been communicated well and happened in a haphazard fashion. We were not consulted at all, and whilst a central command and control structure tends to work well in emergencies, this requires the people at the top to know what they are doing. I have discovered that those at the top do not know what they are doing, as they have not had to deal with such an emergency before. There are also many organisations with a stake in this which do not necessarily agree on how to cascade a plan. Secondly, evidence suggests that involving ground-level staff in working out how to best deliver the service within the limits provided is the best way to ensure a service runs smoothly, then staff buy into changes and feel empowered.

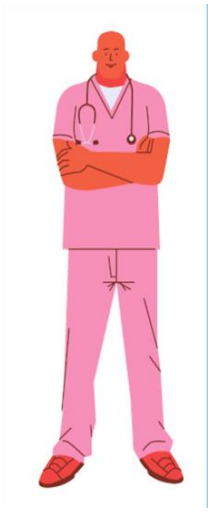
None of this has happened. This has led to poor staff morale and a feeling of not being valued. The Thursday night clapping feels like a slap in the face under these circumstances. Staff in my service have not been risk assessed based on their health and safety to work, and so this is an elephant in the room. Some staff are very stressed about catching COVID-19, others are very relaxed. Social distancing has not been maintained at work, and yet outside we are expected to see no-one, which gives no balance in one's life, and this has been a source of stress for me. The things that have helped are trying to connect with colleagues, not doing overtime, minimizing COVID-19 reading to only the essentials, and spending time in nature.

Lynn Wroe, senior mental health practitioner/non-medical prescribing nurse, Midlands, UK

How are you feeling working in the pandemic conditions?

I work in assertive outreach service in mental health in one of the few services remaining, but sadly soon to be disbanded. I feel stressed on occasions, unable to fulfil my role safely and frustrated with managers not appreciating challenges of working in the community and developing a division between inpatient and community staff.

"Stigma attached to those with chronic mental disorders is less."



What is the effect of the pandemic on your mental health work and the patients you see?

Working with community mental health patients is challenging due to limited direct contact to assess risks, interventions and monitoring. We found huge expectations from carers and carer strain; they need additional support, some with unrealistic expectations, and struggle to accept change to support due to COVID-19 restrictions. For me it is a whole new way of working. The team is fragmented, there is emotional and mental stress at times. We keep team communicating and supporting staff emotional needs too. Staffing is reduced due to shielding and redeployment.

What are the mental health needs that you see brought on by the pandemic?

I work with existing clients with schizophrenia, bipolar disorder with additional drug and alcohol problems. Some patients have been totally oblivious to the pandemic and their behaviour hasn't changed. With some others, it has fed into their paranoia and confirmed their delusional beliefs. There is reduction in drug use due to improvement in mental health. Interestingly, also reduction in admissions or crisis. The biggest change is not providing intensive team direct support to patients and highlighting patients can be resilient in managing their needs. Personally, there was a shift in how my team is working -introduction of working from home, virtual meetings, returning to having to wear a uniform and being more visible in the community rather than trying to blend in.

What has been your biggest challenge in this situation? What has helped the most?

The challenge is overcoming communication challenges when going with patients. When local protocols state telephone support, it is a challenge is the patients do not have them. There is also over planning by senior managers who have lost sight of what clinicians are doing on the frontline, resulting in introducing unworkable protocols. What has helped is having a fantastic line manager who was realistic, supporting and a great sounding-off board. Also, my depleted team's humour, compassion and dedication to the job of caring for patients.

Dr M Tasdik Hasan, global mental health researcher, Bangladesh

How are you feeling working in the pandemic conditions?

I am trying to cope in this changed scenario. Working from home is not a new thing for me but the overwhelming stressors relevant to the pandemic are making everything exceptionally challenging. I often feel stressed and helpless but at the same time when I complete a relevant activity (i.e. contributing in a paper related to COVID-19 & mental health, presenting in a webinar, advocacy activities etc.) I feel content. I assume any relevant contribution is making me happy whilst all regular work assignments are sort of exhausting and tiring considering uncertainty around that project now.

What is the effect of the pandemic on your mental health work and the patients you see?

I am deeply affected with uncertainty around the progression of the pandemic and the inconsistent responses from the policy makers of my country. I am having trouble concentrating on anything, altered sleep cycles and anger management is also an issue to me. I am aware and take support when needed. I don't visit patients directly, being a researcher, though in this pandemic I am attending a couple of patients and organizing series of basic stress management workshops mainly for frontline health care workers. They are extremely stressed; clinical depression is evident and many of them are having continuous panic attacks. COVID-19 patients (either recovered or under treatment or isolated) and their families are suffering to a great extent. Many of them have expressed their concerns about financial insecurities in relation to mental health in this hard time.

What are the mental health needs that you see brought on by the pandemic?

I felt an intense need of remote and periodic stress management strategies with effective delivery of social media-based advocacy materials to teach people on basic signs and symptoms of anxiety, panic attack, suicide, depression etc. and proper (clear and directive) guidance of referral (when to report and where).

Psychosocial skills are much needed, to be delivered using mass media, though these need to be culturally adapted and linguistically accepted before dissemination.

What has been your biggest challenge in this situation? What has helped the most?

To me the biggest challenge was maintaining a sane state of mind and deciding as per the need of this demanding situation. I considered safety of my family members as the most important priority for me and considering the limited resources available it was (and still is) a big challenge to me to manage the most appropriate health care facility in my locality. I followed only authentic information source relevant to my country and avoided all misleading or unauthentic information. I focused on contribution from my territory of expertise, collaborated distantly and globally for effective contribution. It helped me to get inspiration and kept me going. I think that helped me the most in this pandemic.

"Psychosocial skills are much needed, to be delivered using mass media, though these need to be culturally adapted and linguistically accepted before dissemination."

Dr Peter Hughes, Consultant Psychiatrist, UK

How are you feeling working in the pandemic conditions?

I am working in direct patient contact on a COVID-19 ward. However, I feel more anxious using public transport or walking past people on the street. I have an underlying health condition so I am particularly anxious about my own personal risks. I can't afford to get COVID as it could be fatal. I have seen a few patients with COVID-19 and it is very chilling indeed to hear that COVID-19 cough and wait for the confirmatory swab. Currently the number of cases has decreased but we are nervous about what will happen in the future. In a sense this is the worst part – the uncertainty. I wear a face mask at work constantly which is very uncomfortable. I wonder if it is effective or worth wearing at present when cases seem to be reducing. I am getting used to this, but every time I hear someone coughing or see someone with a temperature my alarm system fires up. I have sat next to people who went on to have COVID-19 symptoms so feel lucky to have escaped so far. Overall it is something that is hanging over us all. I have worked in epidemic situations before but then I could get a plane and leave - now I can't, as the emergency has landed on my doorstep.

What is the effect of the pandemic on your mental health work and the patients you see?

There is a clear increase of anxiety but also frustration at how things are being set up in the NHS and the conflicting information from government. I have seen the effect of COVID-19 on patients. I have seen the direct reckless disregard of social distancing. There was one poignant assessment of a patient ignoring social distancing. I knew my colleague in the assessment had recently lost one of their family to COVID-19. The patient's behaviour became close and personal and actually dangerous to us. Yet we needed to remain objective and keep our own feelings under wraps. I have also seen cases where COVID-19 has been a precipitant as a trigger to mental ill health as well as compounding factors of lockdown accentuating the emotional state.

An epidemic/pandemic or natural disaster tend to bring out the best and the worst of people. We see patients managing very well and others that are being admitted with COVID-19 being a trigger. What is surprising is how easily the patients have taken to us staff wearing masks all the time and using video facilities. I am impressed how readily patients agree to have COVID-19 testing. They have also adapted to the rules around visitors and no leave policy surprisingly well. Of course, the cigarette issue remains the biggest stress for people. I spend much time trying to defend the prohibition of leave to smoke. As well as our patients, I have been reached out to by staff who are feeling very stressed at home in lockdown or shielding. Anxiety levels are high and time for introspection has led to somatic complaints, poor sleep, etc. I have spoken to others in lockdown with relapse of anxiety, obsessive disorder and depression. We are beginning to see psychosis content around COVID-19. There was a long period of quietness on our ward with the unheard-of empty beds. That has gone now and we are overflowing again. Our patients are worried about being in a close environment with other patients and staff who could have COVID-19. Social distancing cannot readily take place. Acutely unwell people are in hospital already as they are not well enough to be managed in the community. Expecting social distancing is ambitious.

"Currently the number of cases has decreased but we are nervous about what will happen in the future. In a sense this is the worst part – the uncertainty."

What are the mental health needs that you see brought on by the pandemic?

We see the anxieties of staff and those in quarantine, somatisation. Of the patients we see that their needs are a bit different in an inpatient setting. We cannot give leave. There are no visitors. Care coordinators do not visit. Home visits are not possible. Even for people to get a change of clothes is a challenge. Everything has become more difficult. There are the usual needs but people are more isolated now and have less social support. Schools have been closed, which creates childcare issues. There is the grief of those who have lost family and been unable to see them in hospital or limited funerals. Patients have been triggered by COVID-19 with relapse of their mental health issues. Substance abuse has decreased a little due to access but some of our patients have remarkable resourcefulness in accessing their drugs when unwell.

What has been your biggest challenge in this situation? What has helped the most?

Working on a COVID-19 ward, the challenge has been the huge volume of patients being admitted acutely unwell and trying to manage them. We have had to change our whole way of working to be totally centred around COVID-19. We have had to quickly focus on rapid assessment and work less on longer term plans. Linking with community services has diminished. A personal challenge has been to keep myself safe. What I have seen is the best coming out in my colleagues on my ward who protect me from risk. I have extra PPE and a proper mask. I can see that the NHS has struggled with these changes. As can happen, some of the staff members of the team have been left out. I made sure that the domestic [cleaning] staff were brought into the discussions. The domestic staff have their own personal health problems and this hadn't really been on the radar before. I really want to make sure that we protect all staff on the ward, including the domestic staff who may be very much a risk group. What has helped the most is my wonderful ward manager keeping me sane and putting up with me and doing an excellent job to make us fit for working with COVID-19. Having worked in epidemics before did not help particularly. If I could have had one of my infectious diseases' colleagues from the Ebola work in West Africa, it would have helped enormously, as infection control is somewhere between science and art. I will never be able to meet their standards and would love their expert overview of our system.

We are now hoping that COVID-19 will be in decline, with London having been a large angry circle of epicentre.

"There are no visitors. Care coordinators do not visit. Home visits are not possible. Even for people to get a change of clothes is a challenge. Everything has become more difficult."

Dealing with the mental health impact of COVID-19: an overview of initiatives from India

Dr Nandini Chakraborty, Associate Dean for Equivalence, Royal College of Psychiatrists; Honorary Associate Professor, University of Leicester; Consultant Psychiatrist, University of Leicester

The COVID-19 pandemic has left an unprecedented impact on the world not only in terms of physical morbidity and mortality but also mental health. India with its population of over a billion has been dealing with COVID-19 as rest of the world. This article gives an overview of the initiatives taken by mental health professionals in India's diverse regions to tackle the challenges posed by the pandemic.

Telemind Covid 19 Helpline: An initiative by Indian Psychiatric Society, West Bengal State Branch (IPS WB)

By Dr Rajashree Ray, MD, FRCPsych (UK), CCT (General Adult and Addiction Psychiatry, UK), PGDMLE (NLSIU, Bangalore), PGMHSC (De Montfort Univ, UK) , Consultant Psychiatrist and Psychotherapist Institute of Neurosciences, Kolkata

On 25th March 2020, a nationwide complete lockdown for 3 weeks was declared in India, following the breakout of the Pandemic in the world. The very next day around 54 psychiatrists of West Bengal joined hands to launch the TeleMind project from IPS WB, a free 12-hour daily telephone helpline for any citizen of India to access for psychological support and advice during this lockdown period. We recognized that this is an unprecedented period and though the lockdown was to guard ourselves from a microbe, there will be a potential cumulative effect of this global pandemic, lockdown and social isolation on the mental health of the population.

The main project leads were Dr Rajashree Ray (Executive Council Member, IPS WB and Co-Chairperson of Yoga and Meditation Task Force, Indian Psychiatric Society, Dr Ranjan Bhattacharyya , Secretary, Indian Psychiatric and Hon Sec, IPS WB and Dr Gautam Saha, Vice President cum President Elect, Indian Psychiatric Society and Vice –President, SAARC Federation).

This helpline had 12 one-hour slots, with 4 to 5 psychiatrists being available in each slot, every day from 8 am to 8 pm. The consultations were on phone calls as network connections did not support video calls in remote areas. Because of this limiting factor we were not able to prescribe medicines in the consultation (as per Medical Council of India, MCI, guidelines) and referred them to the nearest psychiatric services if it was felt after assessment that medication was required. Supportive therapy, assurance, advice on relaxation techniques, ways to cope with lockdown and isolation, general lifestyle, sleep and dietary advice were given.

The enthusiasm and helpfulness of the psychiatrists was excellent and every member participated in the rota with great dedication. The guidelines issued by MCI for TeleMedicine were consulted. Dr Suresh Badamath of NIMHANS was the chief advisor of this project. During the first few weeks we received calls as many as 40 a day and callers sought help for a variety of reasons. The most common were queries related to continuation of existing psychotropic medication, advice on where to seek help if suspected symptoms of COVID 19 appeared, apprehension and fears related to being infected with the virus, relationship and interpersonal and issues arising from the environmental changes of lockdown and isolation. Anxious parents called on behalf of their children who were midway in appearing for their Board Exams. Calls were received on behalf of elderly citizens who were worried that they might be infected. We tried to instill faith, hope and positivity amongst our callers and emphasized on building inner strength, resilience and disciplined lifestyle to live through these times.

We participated in a number of Television and Radio shows to talk about mental health issues during the Lockdown and the TeleMind Project. We did promotional videos for TeleMind. Since writing of this report, this is the Sixth Week of the project and the team is determined to continue this noble work for the entire Lockdown period.

A short report of psychological work in migrant colonies of Delhi

By Dr Manisha Jha, Clinical Psychologist, Institute of Human Behaviour and Allied Sciences, New Delhi.

An unprecedented situation in the fight against coronavirus pandemic was the mass movement of millions of migrant laborer in an attempt to reach their home villages. Consequent to the Ministry of Home Affairs direction for nationwide lockdown, an enormous task of managing those who did not reach their hometowns was taken up by Delhi Government.

Measures were announced immediately to provide shelter, food, personal hygiene essentials and medical care for the migrant population to ensure people stay indoors. Also need was felt to address their anxiety and distress along with other mental health issues for which counselling services was provided to the occupants of shelter home and relief camps in all 11 districts of Delhi by clinical psychologists and trained counsellors of District Mental Health Programme of a tertiary care Government mental health institution situated in Delhi. They also initiated tele counselling and counselling through Skype for crisis support for persons impacted by COVID-19. Counselling with the migrant population was directed towards empathic listening, fostering need for social distancing and maintaining hygiene, encouraging shared responsibility and relevant information.

Inadvertently, during these sessions, very few people reported primary mental health problems consequent to current pandemic, to the extent of needing psychological help. Some of the issues for which they sought help were for managing withdrawal symptoms of substance abuse (due to unavailability of illicit substances) or family conflict. Utilization of tele-counselling services was limited. It was encouraging to observe significant resilience and perseverance against odds among migrants as well as general population.

Unusual times: a report from Kerala

By Dr Manoj Kumar, Clinical Director MHAT (Mental Health Action Trust), Kerala, India.

Introduction

An oft quoted phrase during the ongoing COVID 19 pandemic is that unusual (or desperate) times call for unusual (or desperate) measures. However, in our community mental health program we have been able to steer clear of desperate measures and still continue to provide quality services. Over the last few years, we had gradually steered towards increasing the use of technology in our services not in anticipation of a lockdown but due to economic reasons. As our services grew, in a cash strapped situation, we had to constantly innovate. Several of these innovations were to place ourselves squarely in the voluntary sector, use of a devolved, decentralized model, use task sharing to reduce the dependency on high paid professionals and to use various aspects of technology in our day to day practice.

But first, the backdrop for our work. MHAT (the Mental Health Action Trust) is a registered Charitable Trust based in Northern Kerala, India which has been at the forefront of a community psychiatry movement in Kerala for more than a decade. MHAT takes care of, at any point in time, more than 2000 extremely poor severely ill people with enduring mental illnesses in an entirely community-based model. The care is long term and is provided free of cost, in partnership with about 50 community based organisations (CBO). The ownership of the local services is with the CBO. MHAT provides the professional input (both medical and psychosocial), sets standards and decides on the systems to be in place for efficient delivery of good quality care. In the community, more than 1000 volunteers spread across 50 centres provides the day to day care and communication.

The COVID 19 situation

The first reported COVID 19 positive person in India was a student who had returned to his home state of Kerala in late January 2020. Kerala is a densely populated state, nestled in the south western corner of India, with a population of about 36 million people. Subsequently, 2 more students tested positive. The well-oiled State health machinery had already swung into anticipatory action 4 days earlier, having coped well with 2 massive floods and a Nipah virus epidemic, all in the previous 2 years. Kerala is home to a large population of expatriate Indians, spread all over the world. So, it was no surprise that over the next 2 months, there was a steady trickle of positive cases, mostly people returning from abroad and their contacts.

Innovation

Before the pandemic, the MHAT teams travelled out to the 50 clinics across the State, 6 days a week. Anticipating a total lockdown, we drew up contingency plans so that when it actually happened, we were well prepared to deal with a potential disruption in services. Almost overnight, we shifted to a running a virtual service with all travel and face to face contact with services ceasing.

Several key aspects of the MHAT model helped ensure a smooth transition to a model of remote delivery of clinical services.

1. A decentralized, devolved pattern of working with empowered local communities.

2. Involvement of more than 1000 volunteers who run the community service

3. Task sharing model

4. Effective use of telepsychiatry

Nearly 6 weeks into a new way of working, the experience has been surprisingly positive. Clinicians in MHAT run virtual clinics with telephone contacts replacing direct face to face contact. Sometimes theses are conference calls involving the community level mental health workers of MHAT as well as the volunteers outside of MHAT. Prescriptions for medications are generated by the database. Whenever there has been difficulty with procurement of medications, MHAT has stepped in and procured medicines centrally from distributors. Transfer of medicines across districts is facilitated by the fire services who have set up a system for such a need as most courier services are not operating. Medications are supplied at home the vast majority of patients thus obviating the need for them to come out of their houses. All three groups of people involved, clinicians (professionals), and community mental health workers (non-professionals) employed by MHAT and volunteers of local partners offer support remotely and the MHAT workers provide limited psycho social interventions also. People requiring consultations and psychotherapy are encouraged to seek these through our website where exists a facility to book virtual appointments.

Training and feedback

Within MHAT, on an almost daily basis, training sessions are provided for staff. From the beginning we have recognised the importance of training in our task sharing model and the lockdown has given us an opportunity to intensify it. For the wider public also sessions are provided all through video conferencing. The latter includes talks, interactive sessions, quiz sessions and sharing of recovery stories. In all this, experts from outside of MHAT and from even as far the United Kingdom are involved.

We have also been holding video conferences with our community partners who have been divided into 8 zones. Feedback is sought through this and also a daily review of activities within MHAT. 2 conclusions emerge from these:

1. Relapse rates have been surprisingly low with the overwhelming majority of patients remaining stable.

2. An opinion is also emerging that, counterintuitively, actually our large cohort of patients is doing even better than before. This is due to the high levels of motivation during this time of crisis particularly amongst the volunteers who, fearing a relapse, have been even more supportive and attentive than before.

Discussion

Traditionally, medical services have depended on direct face to face contact between service providers and clients. This is of course of paramount importance as clinical medicine and psychosocial services are extensions of a basic human contract of trust, concern and love between a person in need and people who are sanctioned by the society to meet that need. However, this may need re-examining after the world recovers. Can at least some of these contacts be virtual? In other spheres of human activity, we haves moved on. Many of the traditional ways of working and commerce such as banking have moved to the internet. In general, medicine, for the above-mentioned reasons has shied away from delivering consultations and care over the internet except as a necessity when resources are scarce.

Conclusions

What we have learnt is that in a volunteer led model with high levels of motivation, it is possible to keep a large cohort of people with severe mental illness stable and well looked after. Of course, this was made possible by the systematic use of already existing technology. The transition to a virtual service has not only been smooth but it is even possible that it has increased overall quality. This may not be generalizable as it can be said that we benefitted form a way of working which we had established over a decade in the voluntary sector. During these unusual times, an unusual model seems to have found its fit.

Teaching counselling and therapy skills to psychiatrists in Mandalay, Myanmar – January 2020

27/1/20: Midday in sunny Mandalay and we're figuring out how to get to the city psychiatric hospital. It's miles out of town, surrounded by dusty lanes and canals irrigating fields of maze, sunflowers and rice. In an hours' time we – that's Sophie Thomson chair of VIPSIG, Damon Mason clinical psychologist and myself - start 3 days of training in counselling and psychotherapy skills, working with about 40 local trainee and consultant psychiatrists. Turns out the hospital is too far out of town to register on Grab (the SE Asian Uber – makes getting around simple if you don't know the Myanmar script: မြန်မာအက္ခရာ ကိုမသိရင်ရိုး ရှင်းအောင်လုပ်တယ်). Just now a helpful hotel receptionist is explaining our preferred destination to a tuk-tuk driver… looks like we may be on our way. He's got the map we've been given:

What could possibly go wrong?

A group of UK-based psychiatrists have been coming to Myanmar regularly since 2015, invited by the Myanmar Medical Assoc to train GPs using the WHO primary mental health care guide MHGAP. It's voluntary work, supported by VIPSIG and with manuals and training materials provided by the UK-based charity Mind to Mind Myanmar (set up and run by Dr Nwe Thein, a Burmese psychiatrist working in the NHS who is well networked into the Burmese medical world). Over the last 5 years the team has developed an effective style for training Myanmar GPs.

However, this invitation to deliver subspecialty training to psychiatrists is new – in fact a first for VIPSIG anywhere in the world. Mandalay Psychiatric Hospital is the second largest in the country with 200 inpatients. The government mental health service comprises hospitals and a few post-discharge clinics. There are no community services. For the few city-dwellers who can pay there are private outpatient clinics, staffed by hard-working psychiatrists working evenings and weekends to supplement a meagre government salary. Myanmar trainees do 3 years of exclusively ward-based work and follow a biomedicine-heavy curriculum. They learn some psychology theory but get no psychotherapeutic experience. We were struck that in a service that provides many opiate and alcohol detox treatments, trainees had heard of the Cycle of Change but had no idea about its therapeutic application. So, the invitation from Prof Sangar at the Mandalay Dept of Psychiatry was welcome. We've been asked to include group working techniques because the trainees all work on inpatient wards with little or no therapeutic structure where patients get bored. They want to start running ward groups.

We're not sure quite what is expected of us and at what level to pitch it. This is my first year with the team. I'm apprehensive about language and culture and wonder if my years of medical education experience in the UK can really transfer usefully. We'll see – if we ever get there.

28/1/20: Back at our hotel now after day 2/3. So far obstacles have been surmounted, we've worked out the transport, borrowed a laptop from a trainee that syncs with the projector, and with plenty of reminding from my teammates I've learnt to talk slowly enough for my English to be to be understood. The more fluent English speakers translate now and again for their colleagues. As far as we can tell it's going well. The post-evaluation questionnaire may tell us more. We've done an opening Q & A on expectations and aims, explored some principles and core skills of talking therapies, covered group therapy basics and practical tips, discussed Rogerian values, and taught the "hand" technique for mobilising psychosocial support. People were reserved as we started yesterday, but puzzled looks have mostly changed to expressions of interest and engagement.

They've done role playing in pairs - after a slow start they've really got into this – and we've split them into 3 smaller groups to discuss how they might implement group work on the wards. Tomorrow we will try to facilitate Balint-style reflective practice groups.

We were heartened (and surprised!) that 3 ward groups had taken place at 8.30 this morning. We wondered if they'd been firmly instructed by the seniors to get on with it. We heard from each, they were preoccupied with group administration question which patients should be invited, can psychotic patients attend, should patients come if about to be discharged? All 3 groups had taken place on a detox ward where patients usually stay less than 2 weeks, so we suggested Yes – patients might benefit even if they attend only once. All the Drs who'd led groups told us it had gone well, and they hadn't felt nervous, certainly not my experience of starting to lead therapeutic groups all those years ago. Now the 3 of us are wondering how easy it is in Myanmar is to acknowledge struggling and feeling out of one's depth.

29/1/20: 3 days completed, Phew! Today we recapped on what's been covered, introduced family work and CBT, and role-played teaching patients psychosocial skills.

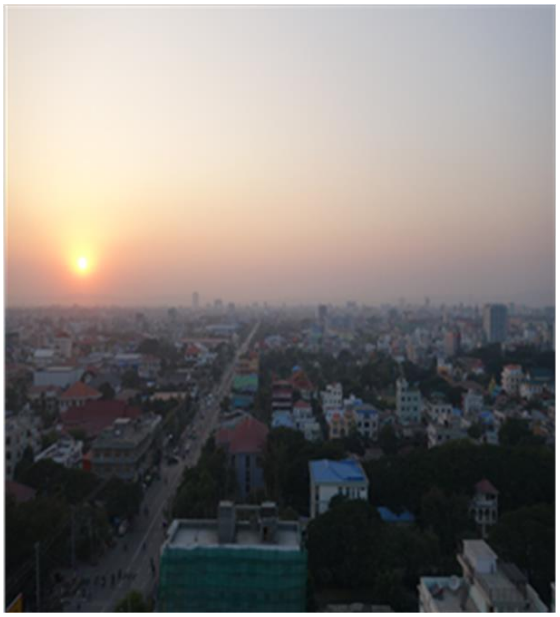
In small groups we tried to reflect on experiences of working as psychiatrists – not easy to get this off the ground: trainees seemed to expect to be asking seniors, and seniors seemed to expect to provide answers. However, we did get some insights into the emotional difficulties of the work such as feeling hopeless working with alcoholic patients. We improvised a response to this, the 3 of us role playing motivational working at different points on the Cycle of Change. And we talked about it being OK not to know the answer, uncertainty in the work not something to conceal or be ashamed of.

We finished with post-training questionnaires. Most of Myanmar psychiatrists gave positive feedback; 40/41 rated the training overall as Good or Excellent. We're very pleased, though mindful that in Burmese society politeness is highly valued were they being nice to us? Then finally to photos and presenting certificates – as I learnt, a very important part of training events in Myanmar.

Where next with this work? Well, with Professor Sangar's blessing several enthusiastic Psychiatry trainees will be joining us day after tomorrow on the 4-day mhGAP training programme for 80 GPs. Some of them may want to do the same again next year. In time they could become the trainers themselves, with no need for visitors taking carbon emitting long haul flights. Thus, we try to build sustainability into this mental health training project in Myanmar.

We have been invited back next year to revisit and build upon this year's counselling and therapy introduction, and to see if the Mandalay psychiatrists have managed to put their newly learnt skills into practice. We are wondering about offering ongoing Skype supervision to those who keep on running ward groups – please contact VIPSIG if you might want to contribute in this way.

Now, time for a drink at the hotel roof top bar and watch the sun go down over Mandalay and the distant Irrawaddy River.



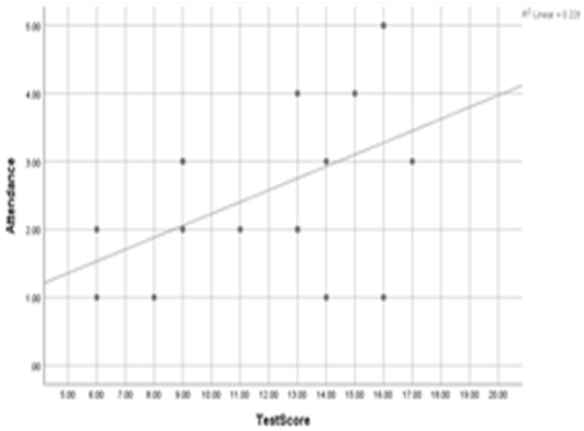
Developing and Delivering a Pilot Psychiatry Teaching Programme to Refugee and Asylum-Seeking Doctors

Dr Jan Klimach

Dr Amy McCullogh

REACHE North West is an education centre funded by Health Education England, which delivers comprehensive training for doctors who are refugees and asylum seekers. REACHE North West also offers pastoral support and provides facilities for study to help doctors gain the necessary skills and qualifications to re-enter their profession and become safe and effective practitioners in the NHS.

We developed a pilot psychiatry teaching programme comprising of six sessions to sit within the REACHE North West Curriculum. The sessions covered key psychiatric presentations such as dementia, anxiety, bipolar disorder and schizophrenia. We also delivered psychiatry skills sessions covering mental state examination, risk assessment and use of section 5(2) of the Mental Health Act. Most of the doctors were preparing for the Professional and Linguistic Assessments Board (PLAB) tests so we chose the topics that commonly come up the PLAB tests to assist them with their preparation. We also covered the structure of metal health services in the UK and basic knowledge of the Mental Health Act because most of the doctors were not familiar with this.



Thirty-three doctors took part in the pilot teaching programme and we asked them to complete a short knowledge test before and after the course, plus an evaluation at the end of the course. The number of sessions attended was positively correlated with the post-test score. The average pre-course test score was 8.3/20 and the average post-course test score was 12.1/20. In the post-course evaluation, the doctors gave an average score of 4.65/5 for delivery, 4.76/5 for organisation, and 4.88/5 for relevance to the PLAB tests. The feedback was predominantly positive and described the course as useful, interesting, relevant and helpful.

“The sessions were very informative and very useful related to my preparation to PLAB1 and 2 exams.”

One of the challenges of delivering the programme is the fluid nature of the group. Doctors join and leave the teaching programme throughout the year so whilst some doctors attended most of the sessions, we also had new doctors at every session. Another challenge was the wide variety of knowledge and experience of psychiatry within the group, some of the doctors had been practicing for many years in their home countries whilst others had just finished university. There was also a wide range of English language ability within the group. We learnt as the course progressed to reduce the amount of content in each session and allow plenty of time for questions and discussion.

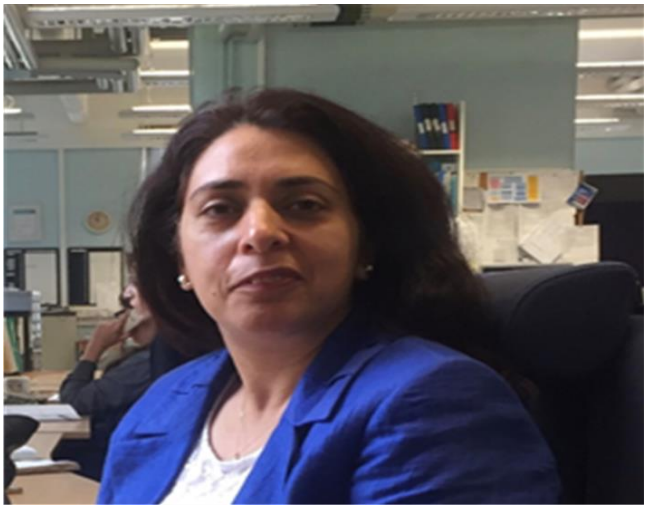
Overall it was a pleasure to deliver the sessions, the doctors were enthusiastic about learning and engaged well. The mix of backgrounds and experiences within the group stimulated interesting discussions about the role of psychiatry and the ethical implications of mental health care.

“Thank you for all information which you gave us. Well-arranged course and well done.”

We asked the doctors to identify additional topics they would like to cover in future sessions. We have taken on board their feedback and plan to deliver an extended course in the new year. We will incorporate more knowledge sessions including neurodevelopmental conditions, personality disorder and addiction plus practical sessions to allow the doctors to practice communication skills, history taking and risk assessments. We will need a bigger team of psychiatrists to deliver all the sessions so if you would be interested in contributing please contact us on jklimach@doctors.net.uk or amymcculloch@nhs.net

"What Appears to be the End, May Really Be a New Beginning"

Dr. Zafrina Majid, Higher Specialist Trainee, Surrey & Borders Partnership NHS Foundation Trust
Email:zafrinamajeed@yahoo.com



It was the fateful night of the 25th May 2011, when my only sibling, Dr.Syed Arshad Abbas, stepped forward to support his team to transfer a critically ill patient to the Apollo Hospital, Delhi, in an Air Ambulance. The air ambulance on route to Delhi with seven people on board crashed.

The Dr.Syed Arshad Abbas Memorial Trust was established in June 2012, in his memory. It is a non-profitable Trust. Initially, we started by setting up a free medical health camp twice a year at the family clinic in a small hamlet named Nowlari, in Kashmir. Work to date includes running the health camps twice a year

In collaboration with the Red Cross, a blood donation camp was set up in Sep 2012.The Red Cross team were surprised with the overwhelming response from the donors, as they fell short of equipment.

My father donated an ambulance to the Trust which is available 24 hours a day. I have a vivid memory of transferring a teenage boy to tertiary care, who presented with Acute Appendicitis. He was operated on within 2 hours because of the availability of an ambulance.

We provide financial assistance for children from low income families to go through primary and secondary school. We also provide financial help to patients with Breast Cancer & Renal Failure for their chemotherapy and dialysis costs. In 2018, I raised funds for a patient for a renal transplant. I received a text from him after the transplant, "Thank God for my third day of life after a successful surgery". We also support an orphan who is completing Diploma in Cardiology.

We have supported victims of the Kashmir floods in Sep 2014. During my supervision, my supervisor and I discussed how the floods affected people of Kashmir, how I, along with my then 9-year-old daughter, organised a cake sale in her school. My supervisor, my husband who works as a Consultant in the same Trust, and I set up a GoFundMe to raise money for a Rehabilitation Centre in Kashmir, which was badly affected by floods. My daughter and I went to Kashmir in Oct 2014 following the floods. We helped one school, also donated wheelchairs, medicines & surgical equipment to 2 hospitals. 12 families were chosen in our neighbouring area who had been badly affected and were provided with basic commodities for the next 6 months.

As my husband and I work in the UK. We offer specialist psychiatric services whilst participating in a health camp each year. We have noticed that there has been increase in Depression, Anxiety Disorder & PTSD, because of the turmoil caused by the conflict in the Kashmir. Drug & Alcohol problems are a real concern amongst parents whose children are affected by it. There is an issue of polypharmacy.

Since 2015 we have set up Mental Health Awareness talks in Universities & received positive feedback.

My sibling; Dr. Syed Arshad Abbas

Syria Trip 2018

Dr Hasanen Al-Taiar, Consultant Forensic Psychiatrist, Oxford, UK
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Syria is a country in Western Asia, bordering Lebanon and the Mediterranean Sea to the west, Turkey to the north, Iraq to the east, Jordan to the south, and Israel to the southwest. Syria's capital and largest city is Damascus. A country of fertile plains, high mountains, and deserts, Syria is home to diverse ethnic and religious groups, including Syrian Arabs, Greeks, Armenians, Assyrians, Kurds, Circassians, Mandeans and Turks.

The Syrian war is an ongoing multi-sided armed conflict in Syria fought between the Ba'athist Syrian Arab Republic led by President Bashar al-Assad, along with its allies, and various forces opposing both the government and each other in varying combinations.

The unrest in Syria, part of a wider wave of the 2011 Arab Spring protests, grew out of discontent with the Assad government and escalated to an armed conflict. The government seized control of most of the country apart from Idlib governorate in the north west.

This military conflict has left thousands of people dead and others displaced internally and externally.

Historically, the third psychiatric hospital in the world was built in Damascus in 1270, at a time when the west dealt with mental illness with condemning and punishment. Currently, mental healthcare is not very developed in Syria. Before the crisis there were around 100 psychiatrists in Syria for 22 million people. Only five of those were child psychiatrists, and there were very few psychologists and community mental health specialists.

The World Health Organization (WHO) estimates that 50% of doctors have fled the country because of the war, so when you extrapolate that, there is around 50 psychiatrists still practicing in Syria.

A team of volunteers from Lady Zainab Helping Hands flew to Syria via Beirut Airport at the end of September 2018 with the aim of providing logistic, and emotional supports to orphans and widows affected by the conflict.

I was able to deliver an interactive workshop on 29th September 2018 addressing the common mental health problems in Syria e.g. depression, posttraumatic stress and other disorders. The workshop involved discussions around Cognitive Behavioural Therapy (CBT) where participants were taught the concept that human thoughts, feelings, physical sensations and actions are interconnected, and that negative thoughts and feelings can trap patients in a vicious cycle. CBT aims to help patients deal with overwhelming problems in a more positive way by breaking them down into smaller parts.

The workshop was very well received, and many attendees returned to meet me enquiring about further input into raising their awareness of psychiatric problems and how to deal with them using the available resources.

For me, it was a very emotionally loaded trip which enabled me to be in closer contact with active sufferers, to reflect on our current psychiatric experiences and how to support and improve the lives of those needy people.

Iraq Trip 2018

Dr Hasanen Al-Taiar, Consultant Forensic Psychiatrist, Oxford, UK
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Dear all

I am pleased to let you know that the recent trip to Iraq was very productive and useful. Colleagues at the United Iraqi Medical Association in UK and Ireland (UIMA) including myself were invited by Dr Hilal Al-Saffar (chair of the medical education council in Iraq) to speak about various clinical and educational topics at the medical city conference 12-13 December 2018.

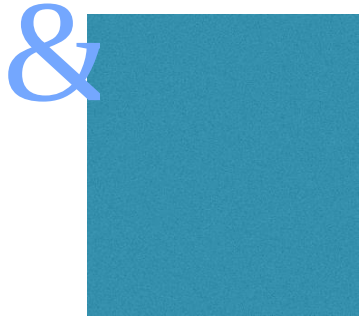
On 16th December 2018, I visited my medical school, Al-Nahrain College of Medicine and it was very sensational to see my colleagues and teachers I developed with many years ago. I had the opportunity to deliver workshops on mentoring and forensic psychiatry to the academic staff at the medical school. Mentoring is defined as a process for the informal transmission of knowledge, social capital, and the psychosocial support perceived by the recipient as relevant to work, career, or professional development. It entails informal communication, usually face-to-face and during a sustained period of time, between a person who is perceived to have greater relevant knowledge, wisdom, or experience (the mentor) and a person who is perceived to have less (the protégé). In addition, I was invited by the Dean to participate at the upcoming medical school conference in September 2019.

Dr Nesif Al-Hemiary (chair of the Iraqi Board of Psychiatry) invited me to speak to his trainees in the medical city teaching hospital in Baghdad. On 17th December 2018, I was able to deliver a psychiatry workshop to the Iraqi and Arab Board trainees at the Medical City in Baghdad. The workshop was interactive and bilaterally useful. The new generation of Iraqi psychiatrists are keen to learn and develop themselves professionally, ethically and clinically. We discussed risk assessment and suicide awareness and prevention. Suicide is one of the top leading causes of death around the world. The WHO is working towards reducing the overall suicide rate and the recent Suicide Prevention Strategy has a particular focus on high risk groups. People in contact with mental health services are a high-risk group and the aim of this project is to make recommendations for training and practice to reduce the rate of suicide within this population across the region. Feedback from the workshop was very positive and colleagues have found the information very useful.

I am hoping that our colleagues in Iraq continue endeavouring to work at high levels of professionalism and I urge the Iraqi government and health authorities to strongly invest in this sector with the aim of providing sustainable and safe mental health provision.


IMET 2009 PAL

Volunteering International Psychiatry.



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