

Volunteering & International Psychiatry . RCPSYCH



Newsletter of the Volunteering & International Psychiatry Special Interest Group #9

02/16



Suicide prevention:
The Global Picture

Japanese
Society of
Psychiatry and
Neurology
Fellowship

Myanmar: The
Golden Land

mhGAP training
weekend

**Global Mental
Health:** Summer
School

Volunteering & International Psychiatry

Welcome to the 9th issue of the **Volunteering and International Psychiatry Special Interest Group** Newsletter

We welcome article submissions, and details for potential authors can be found below. Don't forget to leave feedback on what you thought of this issue of the VIPSIG newsletter at www.surveymonkey.com/s/VIPSIGnewsletterfeedback We hope you enjoy the newsletter!

Dr Daniel Wolde-Giorgis
Dr Manshant Rani Kaur
Dr Lucy Potter
Dr Faheem Naqvi
VIPSIG Newsletter Editorial Team

If you have comments about any of the articles in this issue or would like to get more involved in VIPSIG please email us at arnilaxmi@yahoo.co.uk

Details of the next VIPSIG meetings can be found online. Please see the VIPSIG webpage at www.rcpsych.ac.uk

We are currently looking for a *new editor* to join. Please send expressions of interest to arnilaxmi@yahoo.co.uk

If you wish to make a donation to maintain the group and support volunteering, please see details below:

DONATIONS

All cheque payments should be made out to the 'Royal College of Psychiatrists'. Please include details of the payment such as what the payment is for and name of the SIG.

DETAILS FOR POTENTIAL AUTHORS

We welcome contributions to the Volunteering and International psychiatry SIG on topics of interest to our membership including letters. We are particularly interested in articles from medical students and trainees 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 1000 words excluding any references or appendices; they need to be submitted in MS word format, we encourage the use of photographs and figures submitted as separate .jpg files. Letters should not exceed 200 words. Please include your full name 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.

Articles to be submitted electronically to arnilaxmi@yahoo.co.uk

Volunteering & International Psychiatry



DR PETER HUGHES

Chairman, VIPSIG

I wish all a happy and fruitful new year for 2016.

We can celebrate our achievements in 2015.

We have been well represented at many of the College meetings in relation to International Psychiatry as well as many other global conferences and networks. We were at the College annual Congress in Birmingham and plan to be represented in 2016.

We are seen as having a role in recruitment, retention,

professional and personal development.

The mhGAP orientation event is turning into an annual event and was successful again in 2015.

Unfortunately our psychological first aid event was cancelled and needs to be rescheduled.

During 2015 we saw the new mhGAP humanitarian edition released and an opportunity for VIPSIG to promote.

We have worked hard at the website to make it as dynamic as possible .

We have increased members on our facebook page and we continue to use Twitter .

Challenges this year have been the changes of costs of organizing conferences making events harder to set up.

Each meeting we have new faces and new enthusiasm. We have representatives from training doctors, non-training, all ages and specialties and from many diaspora groups.

We also have representation from medical students.

At the most recent meeting we discussed plans for many potential global projects. We have a group heading out to Myanmar soon to deliver mhGAP training.

What is clear is that the dynamism of the group is entirely dependent on its individual members and we hope that they will continue to inspire new interest, new projects and build on the phenomenon that is global mental health.

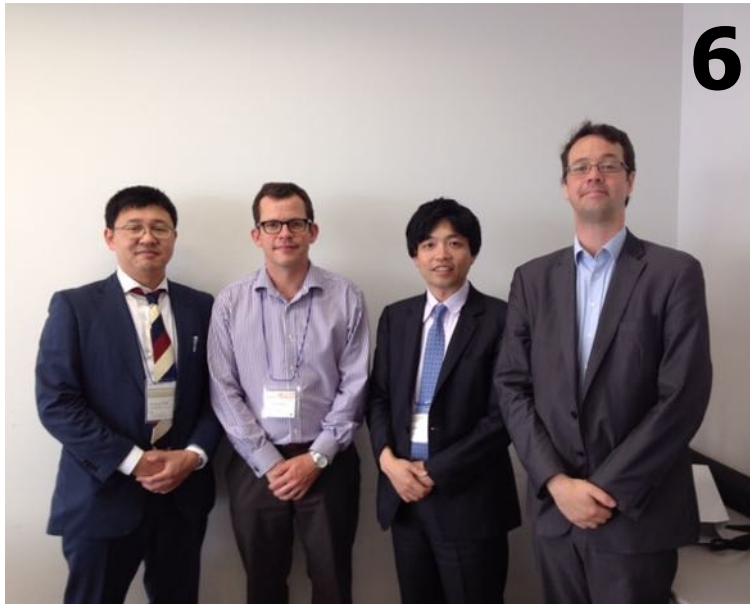
Currently there is a human disaster in Syria and neighboring countries. The Syrian Refugee Task force is established to help. We hope the VIPSIG can promote this work as well.

Please continue to send in articles for the newsletter, ideas for development of the group, attend meetings or establish local groups, join the college volunteering scheme and plan for a vibrant successful 2016.

Follow us on twitter:

@psychvolunteer

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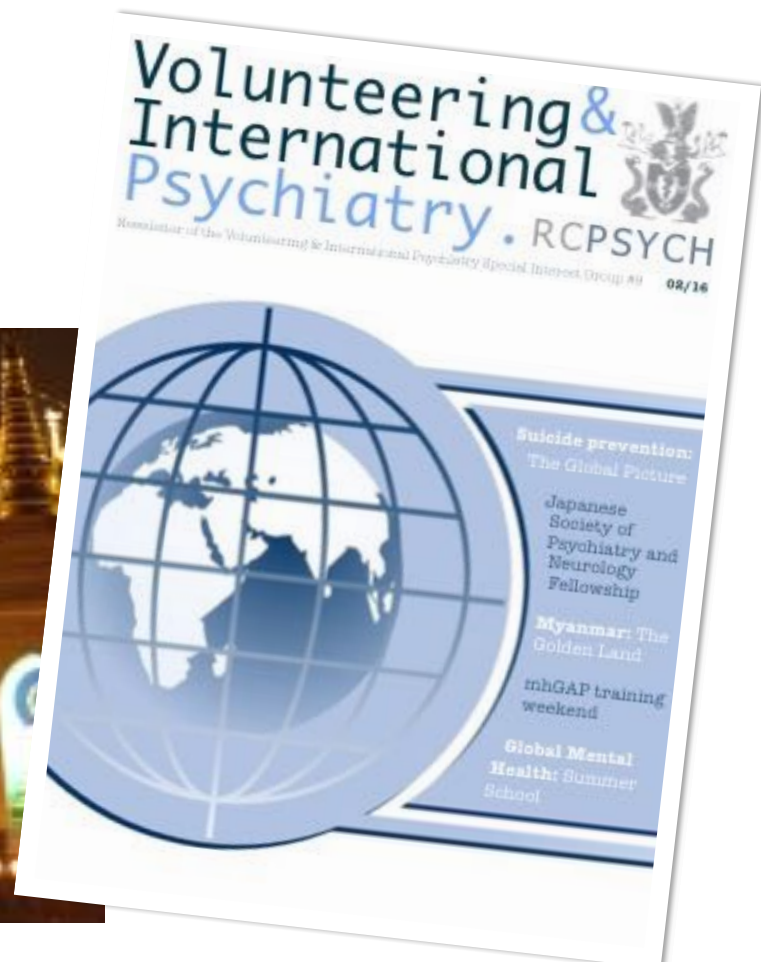
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Suicide Prevention: The Global Picture

The theme of World Suicide Prevention Day 2015 was 'Reaching Out and Saving Lives' (<https://www.iasp.info/wspd/>), with the objective to highlight how simply offering support could make a difference to suicide prevention efforts across the world. The campaign stated that provision of support should not be limited to healthcare professionals; friends, relatives and communities were encouraged to think about ways they could help. This focus on connectedness emphasizes that suicide is everyone's concern, and that prevention can take many forms.

The World Health Organization (WHO) identifies two main components to global suicide prevention: reliable, country-specific data on suicide and suicide attempts, and appropriate strategies to prevent suicide within these contexts (WHO, 2014). While there are good examples of suicide rate surveillance in high-income countries, such monitoring is more sporadic, and sometimes absent, in low- and middle-income countries. However, even in countries where established systems exist to record suicide deaths, there are rarely definitive criteria for assigning a suicide verdict. In the UK, for example, regional differences in suicide rates may partly reflect some coroners' tendencies to use alternative verdicts (Gunnell et al., 2013).

The WHO estimated the global suicide rate in 2012, the most recent year for which worldwide data are available, to be around 11.4 per 100,000 population (WHO, 2014). Overall rates were higher for males (15.0 per 100,000) than females (8.0), though the ratio was less pronounced in low- and middle-income countries. The suicide rate was highest in high-income countries, and lowest in low- and middle-income countries (12.7 vs. 11.2 per 100,000), though there was very wide variation between individual countries. Though they have the lowest rates, as low- and middle-income countries make up a larger proportion of the population globally, they account for 75.5% of all suicides globally. South East Asian low- and middle- income countries had the highest suicide rate at 17.7 per 100,000.

Sarah Steeg and Pauline Turnbull

Lower suicide rates in some countries may reflect under-reporting, perhaps due to cultural attitudes, religious beliefs or the lack of resources available for recording suicides (Milner and De Leo, 2010). For example, in Uganda, suicide is a crime and those surviving a suicide attempt face prosecution and stigma from the community (Hjelmeland et al., 2008). Whilst exploratory investigations have been carried out in some sub-Saharan African countries, in general there is a lack of knowledge about the prevalence of suicide and the context in which it occurs in these countries.

There is consistent evidence that the suicide rate increases in countries affected by economic crises and job losses. Rates of suicide in many European and American countries increased following the economic crisis in 2008 and subsequent attempts to manage the crisis, with the most marked increases seen in men and countries with the greatest job losses (Chang et al., 2013).

Monitoring suicide attempts (including any intentional act of self-harm) is identified as an important element of suicide prevention strategies. In part, this is because a prior suicide attempt is a major risk factor for suicide (WHO, 2014) and also increases the risk of premature death (Bergen et al., 2012). Furthermore, rates of suicide attempts are relatively high compared to rates of suicide, resulting in high levels of service utilisation as well as indicating a significant burden to individuals and those close to them. Accurate data on suicide attempts can provide a benchmark from which to estimate effects of policy changes and interventions, in terms of reductions in suicides and suicide attempts (Kapur et al., 2015).

In order to work towards a comprehensive suicide prevention response, the WHO recommends that the first step is to develop a national suicide prevention strategy (WHO, 2014). Key elements include identifying those most at risk, providing

crisis support, reducing stigma, restricting access to methods of suicide, and promoting responsible coverage of suicide through media guidelines. Some seemingly simple actions have resulted in considerable reductions in suicide rates; a public awareness campaign about depression and suicide in Nagoya, Japan was found to be associated with a decrease in the suicide rate over the following months (Matsubayashi et al., 2014). In England and Wales, restrictions on the sale of paracetamol (commonly used in overdose in the UK) were followed by significant reductions in the number of suicides resulting from paracetamol ingestion (Hawton et al., 2013). Conversely, irresponsible media coverage of particular methods may be related to increases in the rates. In Hong Kong, carbon monoxide poisoning from charcoal burning became one of the predominant methods of suicide within a very short period of time, possibly as a result of media portrayal of these suicide deaths (Liu et al., 2007). While preventing suicide by reducing access to methods can be difficult, removing charcoal packs from all supermarkets in a region of Hong Kong was followed by a significant fall in the suicide rate by charcoal burning in that area (Yip et al., 2010).

Unsurprisingly, countries with more limited financial resources are less likely to have suicide prevention strategies in place (WHO, 2014). It may be that a significant source of support in some of these countries comes from communities rather than health services. The development of a suicide prevention strategy may help to promote and sustain existing informal sources of support. Unfortunately, with low-income countries more likely to face challenges such as scarce healthcare resources and poverty, widespread and coordinated suicide prevention activities may be unfeasible until these inequities are addressed.

Strengthening existing protective factors in communities is an important element of any suicide prevention strategy, and should be tackled alongside reducing risk. This may take the form of providing gatekeeper training to community leaders, and education to break down taboos and help fight stigma. Fostering social connectedness within a community and between family and friends may help to promote resilience and encourage help-seeking. A society with these strengths, alongside a health service which responds and intervenes appropriately, may help to reduce the number of lives being lost to suicide. ■

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Japanese Society of Psychiatry and Neurology Fellowship

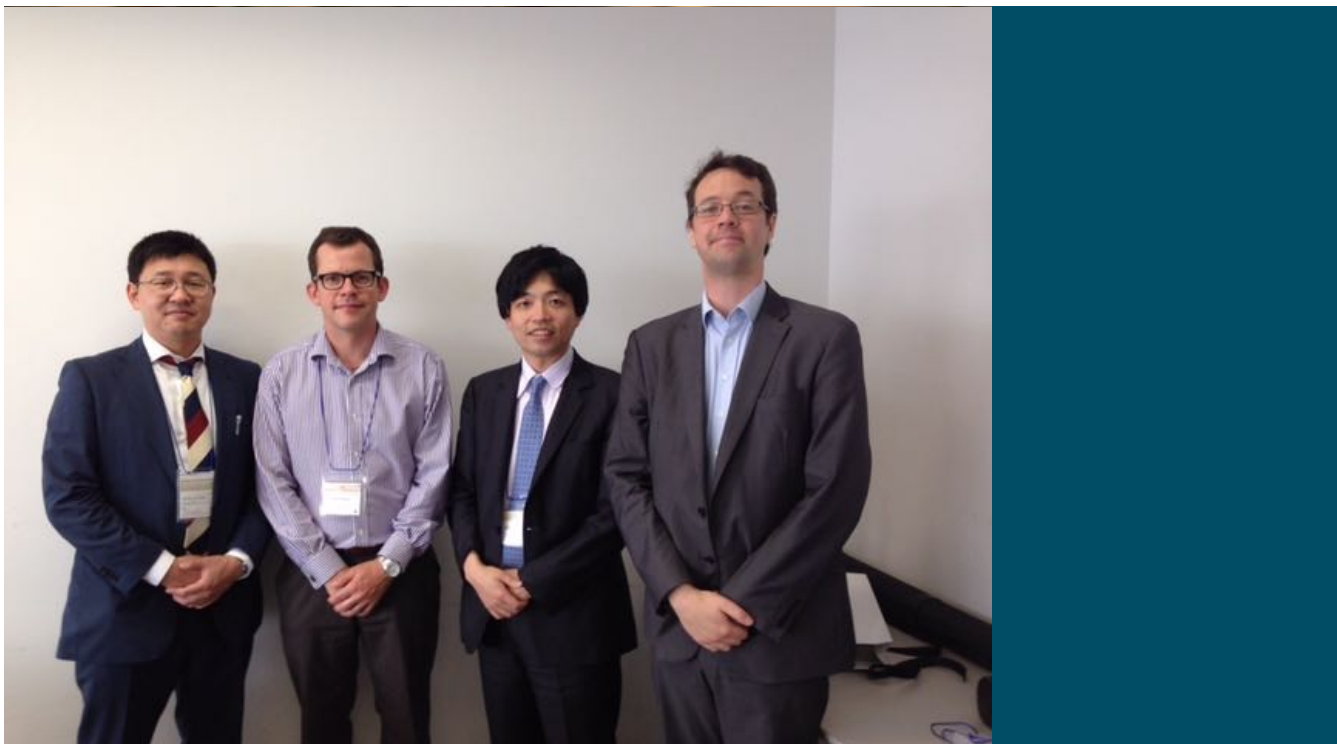
Dr Howard Ryland and Dr Karl Scheeres

Japan is a land of mystery and excitement to the Western mind; one that seems tantalising similar because of its advanced economic development, but simultaneously very culturally distinct. But what is psychiatry like in Japan? How do attitudes to mental illness differ and how are services delivered? The generous fellowship from the Japanese Society of Psychiatry and Neurology allows twelve lucky young psychiatrists from around the globe the chance to find out.

We travelled to Osaka to join other fellows from countries as diverse as Nigeria, Thailand, Georgia

and Slovenia. This year there was the added bonus that the annual JSPN conference was combined with the regional incarnation of the World Psychiatric Association conference. The culture shock began before we even left the UK, with the receipt of a preliminary programme in Japanese characters and decorated with manga-style flowers.

The conference opened with an impressive recorded message of support from the Prime Minister. Take note please Mr Cameron! We were welcomed by members of the Japanese Young Psychiatrists' Organisation (JYPO) the equivalent



of the Royal College of Psychiatrists' Trainee Committee (PTC), who continued to look after us very attentively throughout our stay. A highlight was a special dinner, where we were the guests of honour and were treated to our choice of delicious hotpot, seated on the floor in the traditional style.

Each of the fellows was given the opportunity to present in symposia jointly chaired by a world-renowned psychiatrist and a Japanese young psychiatrist. The sessions focussed on the two topics of emergency and forensic psychiatry, with fellows outlining the situation in their respective countries. This

afforded a fascinating insight in to the current state of psychiatry across a wide sweep of the world, delivered from the perspective of young psychiatrists.

The rest of the conference was divided in to English and Japanese sessions, although technology was never far away, with simultaneous translation provided through earpieces for the linguistically challenged. Highlights included an insightful assessment of the state of psychiatry by the brilliant Professor Norman Sartorius, a presentation on the psychological effects of earthquakes in Japan and a highly thoughtful session reflecting on the

atrocities committed by psychiatrists during the Nazi regime.

The gala dinner offered more pleasant surprises. As we arrived a bow-tied and white-jacketed crooner serenaded us with classic Japanese love songs. To our amazement, we were told that this was a respected professor of psychiatry! The entertainment continued with an elaborate ritual display of dancing and music. After eating our fill of a range of fantastic local delicacies all the fellows were called up on stage to receive a framed award. The fellow from Nigeria, who spoke on behalf of all of us, described his anticipated pride when he would be able to hang the framed certificate on his wall and the increase in his 'swagger' as a result. It was an unforgettable evening.

After the conference formally finished members of JYPO guided us on a tour of a local psychiatric inpatient clinic. The wards were absolutely immaculate with ample occupational therapy facilities, including a 'training flat' complete with tatami mat and futon. We were surprised to learn that the



average length of stay in Japan is almost a year. In stark contrast with the UK, they experience the problem of having too many psychiatric beds. Some of the psychiatrists that we met were eager to learn more about community services in the UK, as these are relatively under-developed in Japan.

It was a real privilege to be able to share our experiences with colleagues from all over the world. We learned almost as much about psychiatry in the other fellows' home countries, as about the situation in Japan, both through the formal symposia and casual conversation. We have been able to maintain a network of links with the other fellows and our friends from JYPO beyond the end of the conference that will be invaluable in the years to come. We

hope to be able to strengthen the ties of friendship and collaboration with our Japanese colleagues in the future.

The JSPN Fellowship runs on an annual basis. To apply you need to be nominated by the Royal College of Psychiatrists, with applicants selected by the International Advisory Committee. Contact the manager of the IAC for more details. If nominated you can then submit an application to be considered by the Fellowship panel in Japan. Applicants will usually be expected to submit an abstract in one of two themes, which change each year. More details are available at https://www.jspn.or.jp/modules/english/index.php?content_id=1. ■

BRAIN TEASER

1. You know me, you use me every day. You can't see me, but I am always there. I go in one form, I come out changed. My only purpose is to live. What am I?
2. I'm a five-letter word, yet it sounds strange to say, six still remains when you take two letters away!
3. If you do it once, it's good. If you do it twice on the same day, though, it's a serious crime. What is it?

Answers: 1. Air, 2. Sixty, 3. Vote



Myanmar/Burma: The Golden Land

Dr Sophie Thomson

Indeed a magical place with the energy of a beautiful Buddhist culture growing fast into a modern Asian country. After nine months of careful preparation, seven trainers from the College were privileged to spend a week in Yangon and then another week training in Mandalay in January 2015. We found the doctors keen to have training in mental health and psychological issues, as most had had either none at all during medical school or had spent a week or two in a large institution. They were initially a little unsure about our teaching methods, having been used to lectures only, but quickly engaged in interactive learning.

Our groups were 60-70 GPs from each local area. Somewhat to our surprise most understood English well enough for us to work with our language. Well, we were helped by having 2 Burmese speakers in our trainers group, who helped

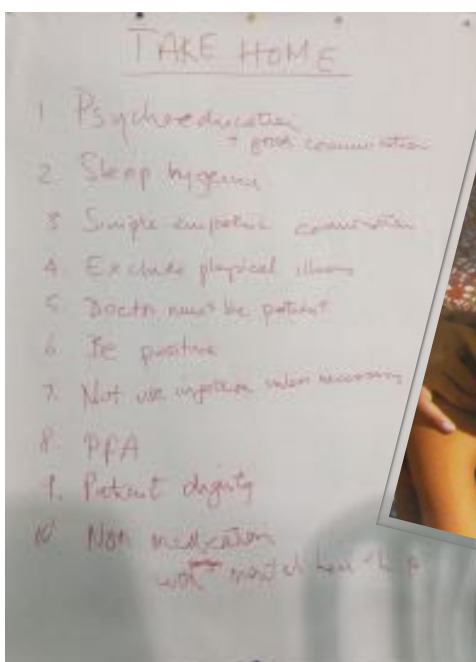
to make sure the participants understood. Additionally, it was also really helpful having 2 psychiatry trainees in Mandalay, who were able to explain local services and how it all works in their area. Many Thanks to them and their consultants, who released them from their long 6-7 day per week schedules.

The preparation paid off, with welcome speeches from Yangon and Mandalay Medical Associations and lots of participation in our very carefully crafted full programme of presentations, video teachings, small group work and loads of role play. Mh GAP manuals were given to each doctor (printed locally at very low cost) and the GPs followed the manual though diagnosis and management of depression, stress, childrens problems, drug and alcohol and dementia. They learnt simple practical tools such as sleep hygiene,

the hand technique for psychosocial support, motivational interviewing, star charts, medication management dementia screening and simple problem solving techniques.

We learnt that Burmese people are extremely hospitable, polite, know how to start work at 8.30am, take great pictures in huge volumes, and can do fabulous role plays.

The formal evaluations pre and post training will be followed up 3 months afterwards. Initial feedback looks most encouraging...and we may be invited back to do a training the trainers module as well as more GP training. ■



mhGAP Training Weekend

Dr Faheem Naqvi

**19th - 20th September 2015,
Springfield University Hospital**

The extremely successful annual mhGAP Orientation training weekend was attended by over 70 delegates consisting of mental health professionals as well as those from primary care medicine. The venue of the event was Springfield University Hospital in Tooting, South London.

The magnitude of the global burden of mental health disorders is increasingly becoming recognised in both the developed and developing world,

not to mention during and after conflict and humanitarian crisis.

The delegates were interested in getting involved with mental health volunteering projects both within the UK and abroad, some of whom had previous experience whereas many had not. The MHGAP Orientation Weekend was delivered by Dr Peter Hughes and Dr Sophie Thomson, both stalwarts of VIPSIG and international mental health volunteering. The delegates had the opportunity to ask questions and draw upon the vast experiences of Dr Hughes and Dr Thomson in places such as the ever topical Syria and Iraq as well as volunteering in places like Nepal and Burma.

The training involved the delegates familiarising themselves with the invaluable and unique WHO mhGAP intervention guide and practicing using the mhGAP manual in certain scenarios and role plays. The mhGAP manual covers concisely the common mental health disorders including substance misuse disorders and sets out algorithms for the assessment, diagnosis and management of these disorders that can be practically used on the field.

The mhGAP intervention guide is available online to view through the WHO website, further mhGAP orientation training sessions to be announced in 2016. ■

The Syrian Refugee Crisis has captured the hearts and minds of the public, moreso since the tragic scene of three year old Syrian Aylan Kurdi being found washed ashore lifeless face down in the sand on a Turkish beach. Aylan, together with his family were making a drastic attempt to flee the ever unfolding brutal war in Syria.

The Syrian Crisis started in 2011 as a protest against Bashar al-Assad in context of the Arab Spring, however very quickly spiralled from a civil war into a regional war and now unfolding is an extremely complex war that is being fought on the world stage with least regard given to civilians.

In the four years since the start of The Syrian Crisis, Amnesty International report that a staggering 11 million people have been displaced and over two hundred thousand people have lost their lives.

Syrians have been fleeing Syria out of desperation and have long been in basic refugee camps situated in Turkey, Jordan and Lebanon offering little prospect. As Aylan 'washed ashore' started to dominate social media and public outcry there was a sway of cautious sympathy from some European political leaders allowing access to a proportion of Refugees into Europe.

Many health professionals have been volunteering in aid of Refugees coming into Europe in many places including Calais and Greece. They have experienced first hand the magnitude of the humanitarian crisis in terms of both the physical and psychological trauma.

The VIPSIG Editorial board would like to invite volunteers to submit their volunteering work in relation to the Refugee Crisis both in the UK and abroad for the next VIPSIG Newsletter.

Global Mental Health Summer School

Dr Howard Ryland

An increasing interest in mental health in low and middle-income countries has seen the establishment of the Centre for Global Mental Health (CGMH) in London as a collaboration between the London School of Hygiene and Tropical Medicine (LSHTM) and King's Health Partners (KHP). This makes sense, as the LSHTM is a world-leading powerhouse of global health research and KHP includes the internationally renowned Institute of Psychiatry, Psychology and Neuroscience. The centre has been developing a portfolio of exciting new training opportunities including the summer school in global mental health, which I participated in between 14th and 17th September 2015.

Unfortunately a 'summer' school in September in London was always going to be hostage to the mercurial British climate. The many international delegates, from as far afield as Brasil, Nigeria and Japan, appeared bemused by the unrelenting rain, wondering exactly when the summer component of the school would begin. This exciting mix of attendees from around the world made the course an infinitely rich and truly global experience.

The course opened with Professor Martin Prince, one of CGMH's co-directors, talking about the rise of global mental health as a new discipline. He outlined the importance of work in this area and the complexities of scaling up mental health care in resource poor settings. Over the four days we were presented with several case studies of projects that were attempting to do just this.

What became clear was that the line between 'research' and 'action' was blurred. It is not a simple linear approach of implementing a system change, evaluating it and then using those results to inform further change. Instead the process was much more fluid, with teams needing to take advantage of opportunities whenever they presented themselves, which didn't necessarily neatly fit the model.

This message was emphasised by Professor Vikram Patel, who highlighted the Medical Research Council's Framework for Complex Interventions, which was altered for its second incarnation to reflect this lack of linearity in the real world.

The lectures covered a wide range of topics relevant to those considering research in resource-limited settings. For example, the complexities of translating a psychological instrument for use in a different cultural context were exposed, emphasising the difficulties not only of language, but also of entirely different perspectives on mental illness.

The need to understand the diverse nature of mental health systems was considered. These exist in their own particular policy contexts, where mental health is frequently low on the list of priorities. We were advised about ways of getting our message across and influencing people in a positive way, to alter mental health policy.

Professor Graham Thornicroft highlighted the high burden and persistent nature of stigma and discrimination across national borders. Efforts to tackle this problem have to be tailored to the particular cultural content and there were some inspiring examples of campaigns, using film, posters and personal stories.

Special consideration was given to the tragic interaction between war and violence with mental health. There were also a range of case studies from a range of projects based in settings ranging from Nepal to Ethiopia, which helped to bring the theoretical concepts to life and served to underline the need for pragmatism and adaptability in conducting this type of work.

One of the recurring themes was the importance of recognising cultural influence in mental health research and practice. The experienced faculty warned against an overly simplistic conceptualisation of 'culture', with a common pitfall being the belief that all individuals in a particular country, region or society share exactly the same cultural identity.

A highlight of the summer school was the social event, which was an opportunity to get to know the other delegates, who were truly international in their composition. It is testament to the high profile of the course that it is able to attract people from all corners of the world, some of whom had flown many hours just to attend. It is not every day that you get to have an animated conversation about community mental health services with psychiatrists from several other continents simultaneously!

For me the summer school was an intense, but highly engaging, introduction to the issues involved in the research and practice in the field of global mental health. I feel that I now have a better grasp of the nature of this rapidly expanding field and am inspired to get more involved as a result.

The Summer School runs on an annual basis and more information about this and other courses run by the Centre for Global Mental Health is available on their website:

<http://www.centreforglobalmentalhealth.org/teaching> ■

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Disclaimer: The opinions expressed in this newsletter are those of individual authors

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