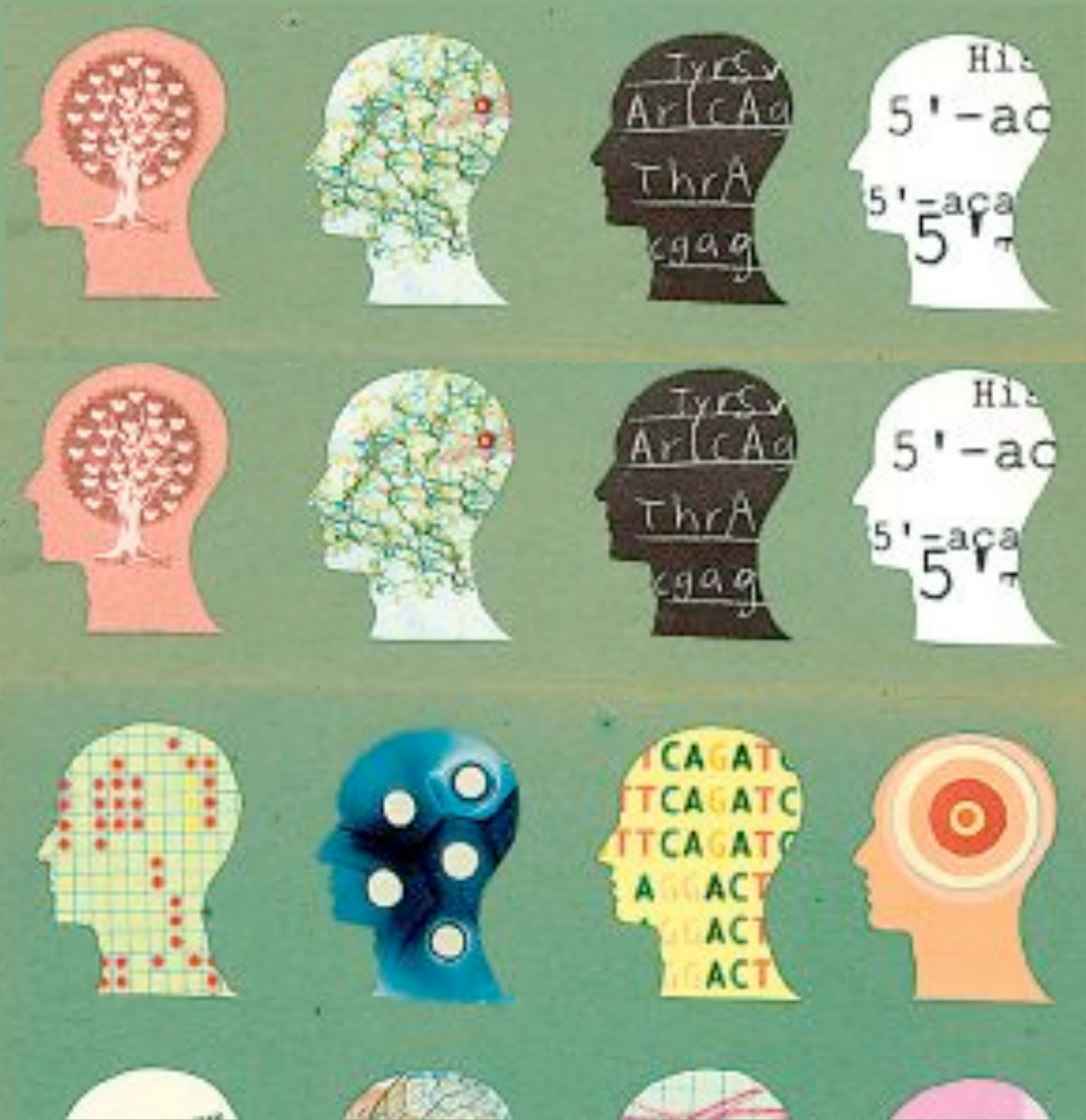
Volunteering & International Psychiatry.RCPSYCH

Newsletter of the Volunteering & International Psychiatry Special Interest Group #6



VIPSIG 10/13

Volunteering & International Psychiatry

Welcome to the sixth 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 Susannah Whitwell
Dr Daniel Wolde-Giorgis
Dr Manshant Rani Kaur
Dr Kiran Purandare
Dr Lucy Potter
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 susie.whitwell@gmail.com

The next VIPSIG meeting will be held on Friday 10 January 2014, Venue to be confirmed.

For more details check the VIPSIG webpage at www.rcpsych.ac.uk

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

DONATIONS

All cheque payments should be made out to the 'R*oyal 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 susie.whitwell@gmail.com

VIPSIG contents

Volunteering and International Psychiatry in Pictures:
Mental Health Nursing in Somalia

Abdiqani Askar is a nurse who completed his nursing BSc in Amoud University in Somaliland. He has a special interest in mental health and since graduating, he has worked in Somaliland and Puntland, in clinical settings where there are no other trained mental health specialists. He has close ties to the King's THET Somaliland Partnership, King's College London through which he is supported by mental health nurses in the UK.

In June 2013, Abdiqani visited Mogadishu in South Central Somalia. Habeeb is the only psychiatric hospital in Mogadishu with 250 inpatients.

Abdiqani Askar Nursing BSc, Amoud University, Somaliland.

In addition to visiting the mental hospital, Abdiqani spoke on Radio Shabale about mobilizing the community to support mental health.

For more information about Abdiqani's experience of mental health in Somaliland:

Doyle, M.J.& Askar, A. (2013) Fostering Clinical Links Between the UK and Somaliland. British Journal of Mental Health Nursing, 2 (2), 102-4

www.kcl.ac.uk/globalhealth

Habeeb, the only psychiatric hospital in Mogadishu

Mogadishu, South Central Somalia

Radio Shabale

The Psychiatric Trainee Abroad:

The subjective experience of a cohort of higher trainees in Accra, Ghana

Jeremy Rampling
jmr@doctors.org.uk

In 2007, South West London and St George's Mental Health trust developed a partnership with Challenges Worldwide and the Ghana Mental Health Unit to develop a twelve week placement for their higher trainees in Accra, Ghana. Since its inception it has expanded its eligibility to trainees throughout the London Deanery and its mandate has evolved from service provision to an exclusively educational placement. This author reflected on the challenges that arose during his placement in November 2011- February 2012 and on his return gathered feedback from those who had gone before him, discovering that the subjective experiences held consistent features. Many were unexpected prior to the placement, and this article should prove relevant reading to any trainee considering a brief international placement.

This author interviewed two veterans of the scheme and reviewed the on-line blogs of five other veterans. He collated themes of these reflections and added them to his own subjective experience to create this piece, identifying some of the aspects of being an expert volunteer that are infrequently considered prior to commencing the placement.

It is hoped that this piece will mirror the experience of other trainees on international placements, but it must be highlighted that the reports were taken only from those from the above scheme, to a psychiatric service in Accra, Ghana.

Before departure

The pre-departure challenges are almost overwhelming in themselves and advice from someone who has recently been through the experience is invaluable, preferably in the form of a structured checklist. Visas, insurance, professional indemnity and registration with the local medical board will all take longer than expected. Innoculations and malaria prophylaxis are an inevitability, and may be provided by your local occupational health department. Disentangling the cause of the creeping anxiety and restless nights in the weeks prior to departure can be a challenge; is it a side effect of malaria prophylaxis or fear of the unknown?

Early thoughts

You arrive with some trepidation but overloaded with enthusiasm. The greeting is invariably welcoming and reassuring. But at some point on that first day you are left alone, and sometime in the first week you begin work. The differences between this work environment and that of home are striking. Staff may appear to be taking huge amounts of responsibility compared with British standards, and without any substantial backup. They may have been working many years outside of their training and have picked up certain established habits along the way which are hard to challenge. All your training, you realise, is situationally specific and you may have to adapt to combat the feeling of being a "novice in a new environment". What can I do to improve practice in a mere three month period?

Forming relationships

Local staff can appear sceptical at first and you may be given the impression that change is not welcome. Some trainees felt intimidated in the first week, being explicitly told that there was a certain local way of doing things which would be resistant to change. The trainee may feel they are being evaluated by their new colleagues; too dictatorial and you can be accused of being colonialist, yet too passive and you may let unacceptable practice pass. It is a deeply introspective challenge to find the right balance. Independent international guidance from the WHO mhGAP[1] can provide objective clinical support for one's teaching message.

The nature of relationships can lead to self-doubt. Trainees felt a respect and politeness from their colleagues in the way they were spoken to, but this was not always mirrored in action. Suggestions may be ignored and meetings unattended. Trainees have wondered whether they are disliked, misunderstood, deliberately undermined, or whether this is inherent in the ethos of the country.

Getting down to work and finding a role

There is a strong temptation to get stuck into clinical work. Some trainees have felt a need to hold clinics early in their attachment to gain the trust and respect of the local staff, and also to inform subsequent teaching. Staff will want you to help out clinically and it is a comfortable and familiar role for the trainee. But if the placement is meant to provide something more sustainable than taking up the workload then volunteering to run early clinics can become an expectation and detract from the educational opportunities.

Clinical decisions may need to be made before the trainee feels adequately grounded in the new environment. One of the most frequently encountered early challenges was the deprivation of a patient's liberty without the framework of a Mental Health Act as guidance, although this was due to change in mid-2012 with the passing of a Mental Health Bill in Ghana. Even with self-assuredness and the support of a patient's family, working outside of a legal framework can be unsettling.

After a short time on the clinical work, self-doubt is common. The trainee may pick up on the necessity of keeping the

consultation concise, focussed on MSE, social and collateral histories but this may lead them to ask if they are being thorough enough. It may also be hard to target what is an acceptable clinical standard to teach. The clinical responsibilities may extend far beyond what is familiar- trainees being asked to manage epilepsy, dermatology and tropical diseases in addition to the psychiatric specialities such as learning disability and child psychiatry.

One trainee had his visit to the rural north of Ghana announced on local radio. He was described as a visiting expert, and hundreds of patients turned up to see him. This could be both exciting and intimidating, and can lead to question one's role. The expertise you bring are in western standards, but the conditions you apply them in are emphatically non-Western. When in a clinical situation, the expected safety-net of asking 'how would I manage this situation at home?' is often invalid, facilities, expectations and social structures differ and you are forced to improvise with the resources in front of you.

The culture shock

This is perhaps the most individual of all the topics, each trainee was surprised by different elements of Ghanaian life. Some themes were clinical, such as the infrastructure within the hospital or the divide between medical and traditional healers. Traditional healers have the advantage of being able to promise cures, whereas the medical framework offers mere treatment. Drug supply is inconsistent, patients are prescribed based on availability and cost, not illness profile. An entire ward is converted to a specific antipsychotic for a month because the batch is soon to reach expiry date. There may be no rota, no system for inpatient reviews, inpatients may be well but are not discharged as there are no relatives to take them home. Even where English is the lingua franca, strong accents can result in difficulties in communication. Consultations in local languages can pass you by, and lead to an over-reliance on body-language in the mental state examination. A few relevant words of the language can help to get the gist and prevent from being utterly lost in a room.

The slower pace of work takes some by surprise. Staff may attend hours late, yet clinics are inevitably overattended and rushed. Clinic confidentiality does not seem to be an issue, the clinic seems an open-door and patients see this as normal. Staff answer phones during meetings, consultations, lectures…

One recognises cultural features that pervade through and beyond the workplace. This is a very hierarchical society in which social standing influences all elements of daily living. Patients and relatives appear more appreciative and the view of the clinician appears to be held with utmost respect. Even acutely psychotic patients may sit quietly in a clinical consultation until they are spoken to. It is also patriarchal, and women may find it harder to be accepted as an expert by staff of either gender. Male staff dispute the existence of baby blues, indicative of their detachment from their wives around the time of childbirth.

There is a differing cultural attitude to death; it is more visible, more accepted. Funerals are celebrations, advertised in public as a "call to glory". Religion is overt and publicised on billboards. Belief in the spiritual world affords an immediacy to talk of possession and witchcraft. It is a very different community from that which trainees have come, and this might lead to periods of cultural or social solitude during the placement.

The psychiatry

As the placement develops, one becomes accustomed to the differences between the illnesses, presentations and management here against at home, and come to realise how much similarity there is. Yet trainees were inconsistent as to what they felt they saw, reflecting a personal interpretation of presentation. Substance misuse is unequivocally ubiquitous, with alcohol and cannabis abuse paramount. The use of other drugs is more dependent on location, with cocaine more prevalent in the large cities and ports, which function as a hub in the route from S America to Europe. Heroin use is rare, restricted to those who have travelled to the West. Somatisation and conversion are seen, as are personality disorders, but you have to actively look for them as they are often misinterpreted as psychosis. Attitudes to medicine differ, patients and staff alike think that injections are more potent than oral and it can be a challenge to confront this belief.

One must not lose sight of the financial cost of your decisions. Patients pay for their own investigations and medicines, and this may only become apparent if the trainee themselves requires some medical treatment. Lack of affordability is a sure-fire way to guarantee non-compliance.

Teaching

Clinical demands on staff often prevent attendance at teaching provided by the trainee, yet there will be clamour for lectures and MCQs. With the heavy investment of time allocated in preparing teaching sessions, this can be highly frustrating. One-to-one teaching seems to work best by observing and guiding during clinic and resisting the temptation to lead by example. Objectifying performance with scores is well received, as are workplaced based assessments which the local staff can slot into their fledgling portfolios. Certificates are well appreciated too.

Success

Success may not be evident until the latter stages of the placement, but all blogs concluded with tips for success. A common theme was the need to limit the objectives to a few key messages, and the importance of repetition in getting an important message across. Even with a timetable days may lose structure, and a good trainee will persevere and publicise their educational intentions.

One trainee reflected that the most effective means of delivering work is to aim for small changes and support individuals on a one-to-one basis. In order for this to be successful there needs a consistent handover and trainees should build on the work of those who have gone before, repeating important messages, observing the development of good practice, and offering new and more advanced concepts when indicated. The key to making the project sustainable is to identify local staff to champion the message, so you should aim to identify those who are motivated to carry on the work. Some trainees felt there was an initial reluctance to change practice but this developed over time, as the purpose and feasibility of the change became apparent. Yet without a local champion, even this is unlikely to be maintained.

A supervisor with experience in international psychiatry is invaluable, to provide real-life advice where ideologies become compromised. Likewise a local supervisor will provide inside knowledge and a link between the trainee and the local staff. Where there is doubt over the merits of one's input, asking for direct feedback can be reassuring and even motivating, but local staff in a hierarchical society are often too polite to be reliable. Feedback from somebody of equal standing may be more accurate.

Regrets

Not many trainees mentioned regrets. It seems unlikely that they had none, more perhaps that they felt a need to justify their placement. This author would suggest that spending some time in the early weeks on the basics of the language would have afforded more insight into the intricacies of the clinic. Some early travelling would also have helped to gain a wider contextual understanding of the client coming from afar, and the national psychiatric mission.

It is also interesting that few of the blogs analysed mentioned frustrations, fears and failures and rather intellectualised their focus onto the clinical work. One wonders how hard it can be for a trainee to admit to doubts or failures, when so much has been invested in their placement.

Reflection

Without the distractions of one's home life, there is plenty of time for rumination. All trainees were in agreement that this was a placement like no other and a clinical and personal learning experience. Once described it as 'perspective changing' whilst another commented on the confrontation with one's own established practice, challenging and re-evaluating his concept of psychiatry. One learns of the universality of psychiatric presentations and their cultural nuances, and that clinical concepts that are taken for granted in British training may have to be deconstructed to aid the staff you are there to benefit. Consider attempting to explain why a patient with pseudohallucinations may not warrant antipsychotic treatment in a culture unfamiliar with the diagnosis of personality disorder and a group of staff with a rudimentary understanding of psychosis.

Self doubt is a natural part of this process and if not present to some degree, it may indicate that the trainee is not putting themself into appropriately exposed situations. It is natural to question the validity of the placement and the effectiveness of one's own individual role within it. Yet most trainees who had felt that staff were sceptical towards them during their placement felt accepted by the end, and all trainees had positive comments to make about their role on reflection.

This author found greatest satisfaction to be had from seeing his lessons being put into practice. This is an advantage of the intensive, one-to-one apprentice model where it is possible to see progress first hand. Such changes tend to come from repeating the message and encouraging the student to reflect on their practice, and highlighting achievements as well as room for improvement.

The twelve weeks timescale is a paradox, being not quite long enough to fully embed yourself into a culture; it can feel like an age, yet concurrently pass in the blink of an eye. Complex emotions are expected and will pass, and the overriding memories tend to the positive. It is a great learning experience, encouraging self-awareness, reflective thought, challenging cultural preconceptions around the speciality and developing leadership. The sustainability of this project, and others like it, relies on a throughput of trainees, and for that more volunteers are required.

Reference

1. *MhGAP Action Programme* http://www.who.int/mental_health/mhgap/en/ *accessed June 26 2013*

BOX1: Common Timeline in 12 Week Placement

Before departure: *Last Minute Rush*

Weeks 1-2: *The Deep End*. Headlong enthusiasm, tempered by recognition of irreconcilable differences. Turn to mhGAP for support.

Weeks 3-5: *Levelling Out*. Recognise interpersonal intricacies, take reassurance from the good days and remain conflicted by the bad. Less shocked by surprises. Perceived lack of progress.

Weeks 6-7: *Midway Lull*. Despondency. No longer a novelty but still an outsider. Self-doubt returns.

Weeks 8-11: *Urgency*. A month left and so much to complete. Know your surroundings, and in the zone.

Week 12: *Goodbye*. Loose ends tied up and honest goodbyes. Leave with positivity and a sense of having been valued.

Breaking big rocks into smaller rocks:

the hard core approach to mental health recovery

Maggie Baker

Breaking rocks with a sledge hammer for days on end may not be an expected approach to dealing with mental health difficulties. It works though, for me.

Depressed and with other complications as a teenager, I had a major breakdown aged 39. For some years I wasn't able to do paid work, then built up to part-time, and started a full-time job again – in an entirely new area of work – when I was 51. I'm still doing that now, aged 57 going on 58, so I must be doing something right, at least some of the time.

Voluntary work featured early on in my recovery journey. I was determined that I would find a role with meaning and purpose for myself in this world, even though all I really wanted to do was crawl into a hole, close my eyes, and never have to open them again.

For many years I continued to lurch into and beyond further crises, pushing through prickly hedges and barbed wire fences with the aim of re-establishing myself with some sense of dignity and independence in the world, including the world of work.

In the spring of 2008 I realised that I needed something to motivate me outside the workplace if I was going to be able to sustain myself in the longer term. I'd already had to go to extremes, just to pull through, and continued to search out some sort of context that would help me to put past experiences behind me, enabling me to move on and through to firmer ground.

I'd been a conservation volunteer in the past and turned to this as a possibility again. In line with my ongoing strategy of putting myself into difficult situations and finding ways of dealing with them, I decided to do things a little differently. I had never been to the States before so I performed a Google search: conservation +voluntary work +USA. The results included a link to the site of the Appalachian Trail Conservancy organisation (ATC).

After an exchange of emails I recognised this organisation operated in a way that could meet my needs and I set off to spend two weeks working on the trail in Pennsylvania. Lying on a bed in a clean but austere room in a travellers' hostel in Manchester the night before my flight, I thought to myself: "What am I doing here?" Those two weeks turned out to be fine, though. I made friends and started to find out about an amazing, dynamic 'institution' – the trail itself – and the many thousands of people who walk and work upon it every year. In awe, one day I watched a crew colleague break rocks into small pieces that were then used as hard core for steps, water bars and other trail features. She worked seemingly tirelessly, for hours on end. At that time I didn't think I would be able to concentrate or maintain the physical effort for long enough to be able to do what she was doing. I now know that I can, and do.

With decades of uncertainty behind me, I resolved to create and maintain a thread of continuity into the future by committing to being an ATC crew member year on year. I also decided that I needed the mountains, as a further motivational influence and challenge to help me regain and maintain physical fitness levels. In October 2009, therefore, I joined the ATC's 'Rocky Top Crew' in Tennessee for the first time.

I was able to supplement my annual leave allowance with five days' special leave for volunteering that my employing organisation provides. This year will be my fifth 'Rocky Top' experience and I hope it won't be my last.

With help from much-loved but still very heavily-laden mules, we pack all our gear and supplies up to a height of around 6,000 feet and work on a particular stretch of trail in the Great Smoky Mountains National Park. Our crew camp site has to be specially permitted and managed on a low-impact 'leave no trace' basis. Apart from a diesel-driven chainsaw, we use hand tools: pick-mattocks, sledge-hammers, rock bars, shovels. Safety is always emphasised, with daily reminders to ensure that we wear the appropriate headgear, protective shin guards and goggles. Fun is also a feature and good humour passes between us as we share tools, knowledge, ideas and muscle power.

Being a part of that trail crew community for those few weeks works wonders for my health, wellbeing – and waistline! Each year I learn more about trail-building techniques but I find the experience inspirational in so many other ways too.

Last year the approach taken by the leader when one of the crew members lost their way at the end of a glorious sunny day that had turned into a cold, wet and hostile night was second to none: he set out, went the extra 7 miles and found him.

Another crew member, aged 85, finding it hard going in the first 8-day work session, bought a pair of hiking poles, embarked on some 'training' walks in the 3-day break period, and then went up again for more. He still walks and works at a faster pace than I ever will, although nobody is ever expected to do any more than they can.

Clear direction is a key feature of leadership demonstrated by managers and directors of these trail crew projects. This helps to ensure that the crews properly fulfil their purpose as part of an overall environmental management programme. Quality prevails as we dig and bash, prise and roll, carry, shape and place our way as part of a team.

Looking back, it's amazing to see what we've done and to know that it will stand the test of pounding feet for many years to come. Like my recovery journey, I hope: a bit of a trail but sustainable now, and then some.

Breaking rocks, making trails; it's a way to go.

Maggie Baker is a civil servant. The views expressed in this article are her own and not those of anyone else or any organisation identified in or associated with this article.

About ATC: http://www.appalachiantrail.org/ ■

The Appalachian Trail Conservancy organisation

My Six Years in the Middle East

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Introduction:

On the morning of the 2nd of April 2013, the first telephone call I received at 8.30 in the morning was from a lady asking for an appointment for her 32 months old son, whom she described as having possible "autistic behaviour".

Shortly after that I received my second telephone call from the National Center of Mental Health Hospital to arrange a two hours seminar on child psychiatry.

I compared the situation two decades ago, when I was doing my psychiatric training in Jordan, at that time there was very little or no child psychiatry included in the training program and there were no clinics to assess children who were possibly suffering from autism and other complex child disorders.

It was a long journey to reach this level of awareness and to change the way in which people in a developing country start to look at mental health issues.

I moved back to Jordan and started my work in Jordan six years ago, at that time I was the only fully qualified child and adolescent psychiatrist in the country. I received a small number of patients in a poorly furnished poorly decorated small clinic. When I look to the large number of telephone calls I have been receiving now, and the referral from clinicians, families and schools about all types of child mental health problems.

It was a nice coincidence for the beginning of the article to happen in the day the WHO has chosen to be the "international autism day".

Mental Health Problems:Better Recognition and limited interventions

A number of factors have contributed to the increase in recognition of child mental disorders and likelihood of seeking help in Jordan; among those are:

- People are more health-educated and more aware than twenty years ago, this is the result of the influential media, internet and other means of knowledge that have made parents more aware of their children's difficulties.
- Various campaigns have led to better awareness. An example is the WHO work with the Ministry of Health to spread mental health expertise, by implementing programs like mental health GAP (mh GAP) intervention. There have also been efforts by other organizations like Save the Children, UNICEF, International Medical Corps (IMC), and many other NGOs and agencies who are interested in supporting displaced people, an issue which had effected a number of middle-eastern countries. Local NGOs(for example: Jordanian Medical Help Organisation) have also built some capacity to allow them to participate in this concerted effort.
- Increase in the literacy level in the majority of the developing countries.
- Popularity of charity work especially in the health sector.

Both WHO and IMC have funded Professional Development programs , Supervision and consultation for clinicians, school counselors and educational psychologists. Participants have attended mental health workshops/ seminars, and received training and supervision in general and child and adolescent mental health through outreach and field work.

In addition to the above, we have focused on building capacity and developing expertise in psychological and social therapeutic interventions. There has been significant success; however we have faced difficulty in retention due to lack of funds. The main bulk of funding goes to feed refugees and cover the costs of emergency care. Many of the young promising and enthusiastic clinicians have left the country seeking well paid jobs in the Arabian Gulf region; many others that stayed had to cope with this drain of talent.

One other hurdle was the resistance to change and insistence on following the Medical Model by psychiatrists. Subsequently this led to relying on using medication as the main, if not the only, intervention.

One more negative result was the marginalization of Team Work and Multidisciplinary approach, in favor of individual psychiatric practice.

Response to disasters in the Middle East :

The intense conflicts in the Middles East in the past decade have led to ever worsening crises, which stimulated response and led to mobilization of local, national and international NGOs who helped to improve the forgotten or neglected areas of health, for example mental health for children.

I have also been working with some of those organizations like Foundation Together, IMC and WHO. The focus was directed towards countries that were devastated by lengthy and damaging wars ; Iran-Iraq war1980-1988; invasion of Kuwait(1990) and war in 1991, followed by thirteen years of UN sanctions with massive damage to the infrastructure and deterioration of health services in Iraq. All that was followed by the 2003 war and occupation which led to further devastation and ongoing unrest, with a huge increase in mental disorders.

Several NGOs worked with Iraqi refugees in Jordan. Some of these like IMC, UNICEF and Save the Children have a special interest in mental health (including child mental health). Their work has helped to rescue some aspects of the mental health system in Iraq.

In addition to the above they put additional efforts to support and develop mental health systems in both Iraq and Jordan.

At the present time the emergency effort of most NGOs is directed towards the influx of Syrian refugees who are fleeing Syria by thousands.

Efforts of WHO in Jordan:

The WHO mission to Jordan has taken a pragmatic approach in helping the health system to develop and expand, to build capacity to be able to respond to urgent needs for local patients and refugees from neighboring countries. There have also been significant efforts in developing mental health legislations, mental health planning and policy making. This has resulted in the formation of a National Committee of Mental Health which has developed priorities and put targets for a mental health system in Jordan. Progress also is being made to integrate mental health services within primary health care.

Jordan is currently implementing the WHO mental health Gap Action Programme (mhGAP), which includes intervention guidelines for primary care-based diagnosis and treatment.

The Mental Health Policy and Plan were formally launched in January 2011. They are based on the vision of equitable, cost-effective and accessible mental health care for all people. According to the vision, services are bio-psychosocial in nature and feature multidisciplinary interventions, with emphasis on human rights, user participation, and cultural relevance.

CONCLUSIONS AND LESSONS LEARNED:

1. Countries can use international attention on a regional crisis to improve mental health services for both citizens and refugees.
2. Educating the public on mental health is vital and essential for the improvement of services.
3. It takes only a few local genuinely passionate individuals to make reform possible.
4. Participation of all stakeholders in the reform and improvement process is essential for success.
5. We should be flexible and courageous and prepared to take hard decisions.
6. Outreach activities are essential in volunteering work.
7. Building capacity should be accompanied by encouraging retention.
8. Various NGOs working in the region should coordinate their efforts to improve life for refugees and displaced.
9. In mental health Aid priority should be given to vulnerable groups eg. children and families and others identified in this group.

ACKNOWLEDGMENTS:

I AM VERY GRATEFUL FOR ALL COLLEAGUES AND FRIENDS IN MOH, WHO AND IMC JORDAN FOR THEIR HELP IN PREPARING THIS ARTICLE. SPECIAL THANKS TO:

Anita Marini, Zain Ayoub and Asma Nashawati from WHO office Jordan, Maryjo Baca,Ola Al-Sherif, Ahmed Bawaneh and Yazan Al-smadi from IMC office Jordan ■

The Second Annual Mental Health Conference: Freetown, Sierra Leone, March 19th 2013

Dr Ruth Fowler-Dixon MBChB. MRCPsych, Retired Locum Consultant in Psychiatry

Delegates gathered at the British Council building for this, the second Mental Health Conference to be held in Sierra Leone. About 200 people came, including those from the US, Europe, and other African countries. Traditional healers, nursing students, and the group of primary care workers who had recently completed their mhGAP training were there, amongst other health care workers. This conference had acted as a magnet for those interested and committed to improving mental health provision in Sierra Leone and other West African countries. There was a definite buzz of anticipation as old contacts and friendships were renewed.

The conference was initiated and organised by the Mental Health Coalition of Sierra Leone. Financial contributions were made by the Mental Health Leadership and Advocacy Programme (mhLAP), Enabling Access to Mental Health in Sierra Leone and other member organisations within the coalition. International representatives paid the modest sum of £20 or equivalent to make up the funding.

Regular readers of this newsletter will be aware of the demographics of Sierra Leone, well described by Dr Suzi Irwin (issue 01/13), and by Dr Michael Yousif and Dr Julian Summerfield (issue 02/12). The country is currently 11th from bottom in the United Nations Human Development Index. It is suffering from the loss of infrastructure that occurred during the 1991-2002 civil war.

The meeting was chaired by Dr Gladys Palmer, a psychologist based in Freetown. It opened with a speech by the First Lady of Sierra Leone, who had, in a previous role been one of only three community psychiatric nurses in the country. By coincidence, it was also her birthday, and the audience sang the appropriate song.

Opening statements were given by Ministers of different government departments, followed by Walter Carew (Coalition Chairman), and Joshua Duncan (on behalf of Prof. Oye Gureje, Executive Director mhLAP, Ibadan, Nigeria).

The keynote address 'Mental health in Society' was given by Dr Janice Cooper, a Liberian repatriate. This was a description of recent advances in mental health services in Liberia. These sound impressive. The Carter Centre (founded thirty years ago by President Carter and ex First Lady Rosalynn Carter) has worked in collaboration with the Ministry of Health and Social Welfare (MOHSW). The approach is to integrate mental health into primary care, and to have one national referral hospital. Since then Mental Health legislation has been drafted with five main aims. These are a) providing and protecting rights, b) formulating the Mental Health Essential medical list, c) establishing outcomes research d) including mental health services at all levels of health services, and e) stigma reduction. Seventy nine credentialed mental health practitioners have now been trained and are placed in primary health care centres throughout Liberia.

Lunch was a tasty plate of chicken and rice, followed by a music and streetdance showcase 'Fight Drugs with Music' by youth ambassadors from GOAL Ireland (an NGO with a base in Sierra Leone).

The afternoon opened with a talk by Mr Donald Conteh, on 'Challenging Stigma and Discrimination'. He covered the topics of stereotypes, prejudice, discrimination and stigma, and described strategies to deal with and combat these. Dr Alfred Makanjuolo then spoke on 'Substance Abuse- a Menace in Society'. He described the social and mental health consequences of drug abuse, and related this to the situation in West Africa and Sierra Leone.

Dr Theresa Betancourt (of the Harvard School of Public health USA) gave an informative and inspiring talk on 'Child Development and Mental Health'. Over a billion children live in countries currently affected by armed conflict. There was a need for a developmentally informed approach, because up to now much research has either been cross sectional or short lived. During the civil war in Sierra Leone it is estimated that 15,000-22,000 children were associated with armed groups. There were deliberate attempts to sever family ties. After the ceasefire, the Sierra Leone Longitudinal Study followed the mental health and psychological development of over 4,250 formerly abducted children. Interim care centres were set up and risk and protective factors identified. The Sierra Leone Youth Readiness Facilitators manual has been produced as a result of information gained from the long follow up period.

The last speaker was Dr Julian Eaton (CBM Togo). He spoke on 'Integrating Mental Health into Primary Health Care'. Dr Eaton gave an overview on the challenges facing mental health services in Africa, especially Sierra Leone. Currently in many African countries only 15-20% of people with mental health problems receive the care that they need. Usually it is hospital based, with a high cost, and only facilities for treating low numbers. However in Sierra Leone there are several positive examples of solid progress being made in policy development. It is a mhGAP priority country. There is a well organised coalition, which was established in 2011. Several NGOs are working here.

Dr Gladys Palmer convened a lively panel discussion. One expatriate doctor declared that the day had inspired him to return. The day ended with closing remarks by Dr Andrew Muana, the Medical Director of Kissy Psychiatric Hospital, Freetown, and a vote of thanks by Ms Heather Weaver, the Overall Project Coordinator for Enabling Access to Mental Health in Sierra Leone.

All those I spoke to afterwards found aspects of the day stimulating and educational. I felt fortunate and privileged to have been there.

The next conference is scheduled for March 2014. Information on the exact date will be posted on the coalition's blog https://enablingaccesstomentalhealthsl.com ■

Volunteering & International Psychiatry.

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