WORLD PSYCHIATRIC ASSOCIATION

Education & Psychiatry

Issue 2, Dec. 2024

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Editors' Column

Dear Colleagues,

The WPA Education and Scientific Publications Committee extends its greetings as we present the second issue of the WPA e-journal Psychiatry and Education. Encouraged by the positive reception of the inaugural issue, we continue our efforts to provide a comprehensive global overview of psychiatry education. This journal is designed to facilitate the exchange of innovative ideas and foster collaboration, enhancing learning outcomes on a global scale.

The WPA Education and Scientific Publications Committee oversees the development of WPA's educational programs, including preparation and implementation of continuing medical education accreditation, as well as the formulation of publications policies and materials for publication.

Before discussing the details of this issue, I would like to highlight two significant activities planned for 2025.

The WPA Global Study on Psychiatric Training

This initiative emphasizes the growing need for accessible psychiatric care amidst global crises and is set to launch in 2025. It will focus on how psychiatry is taught to medical students by conducting a comprehensive global study to evaluate its integration into undergraduate medical curricula. The study aims to identify gaps, enhance training practices, and develop strategies to attract more medical students to the field of psychiatry. Ultimately, it seeks to address global mental health demands more effectively. To achieve these goals, the WPA will collaborate with national psychiatric societies through an online questionnaire, encouraging their active participation in data collection and analysis. For further insights, please refer to the February 2025 issue of "*World Psychiatry*", which will feature an article titled The WPA Global Study on Psychiatric Training.

The WPA Educational Portal

The WPA Educational Portal is undergoing a significant phase of technical and content revision to enhance its utility for the global psychiatry community. The updated portal will feature improved functionalities and new, high-quality educational content designed to support learning and professional collaboration.

We are also working to expand and diversify the resources available on the platform. We invite contributions from the community—whether it's innovative ideas, educational materials, or suggestions for topics to be featured. Your input can help shape the portal into an even more valuable resource for psychiatry professionals and learners worldwide. The updated WPA Educational Portal is scheduled for launch in 2025, and we are eager to see the impact it will have on advancing education and fostering engagement within the field. If you would like to contribute or have any inquiries, please do not hesitate to contact us.

This issue features a range of insightful contributions. Dainius Pūras, former UN Special Rapporteur on the right to health (2014–2020), advocates for mental health reform that embraces human rights-based, non-coercive approaches

In addition, we present country reports offering valuable insights into psychiatry education and training across Egypt, Australia, El Salvador, Indonesia, and Guatemala. Meeting reports provide updates on significant initiatives such as the Lancet Commission on Ukraine, a psychotherapy workshop for early career psychiatrists in South Asia,

and an international mental health conference in Kyrgyzstan. The book presentation introduces a practical guide for clinicians interested in volunteering in global mental health.

I would like to thank all contributors, reviewers, editorial board members, and Ms. Nathalie Lewkowicz, the WPA Secretariat staff member, for her technical support in the publication of this issue.

We hope this issue inspires thoughtful discussions and innovative ideas in psychiatry education.

Happy reading!

Prof. Norbert Skokauskas MD PhD

WPA Secretary for Education and Scientific Publications

Editor, “Education and Psychiatry”

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Can we all agree on main issues related to human rights-based approaches in mental healthcare?

Dainius Pūras
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UN Special rapporteur on the right to physical and mental health (2014-2020)

This editorial outlines my insights on contemporary issues within the global discourse on mental health and human rights. These insights are based on my experience as the UN Special rapporteur on the right to health (2014-2020) and on other activities I have been involved before and after my rapporteurship.

Experts agree on the pressing need to increase investments in mental health and mental health care globally [1], a relatively new priority [2]. However, there are different views among experts about the direction of those investments. I have supported and continue to strongly support the view that the overemphasis on biomedical approaches to mental health fail to account for the social, economic, political, and corporate determinants of health, and that priority should be given to the development and scaling-up of human rights based on non-coercive services that empower service users and thus break the vicious cycle of discrimination, exclusion, coercion and over-medicalization [3]. This view is rooted in international instruments such as the UN Convention on the Rights of Persons with Disabilities (CRPD) and the International Covenant on Economic, Social and Cultural Rights (ICESCR).

An increasing number of documents and initiatives strengthen this position. Several resolutions on mental health and human rights emanating from the UN Human Rights Council, the World Health Organization ‘s Guidance on Community Mental Health Services, Quality Rights Initiative, and Guidance on Mental Health, Human Rights and Legislation send clear messages in this direction. They urge UN Member states and all stakeholders to move away from hospital-based care - which accounts for 40% of high-income countries’ expenditures in mental health, and 80% in low- and middle-income countries - and discriminatory laws and practices toward the empowerment of service users and non-coercive rights-based practices in community settings.
However, despite advances, a holistic approach to mental health and wellbeing is far from prevailing in mental health systems globally, and financing is still largely geared to traditional biomedical interventions [4]. While there may be improvement and willingness to change the status quo at the policy formulation level, implementation remains a distant reality largely because of systemic obstacles. The main obstacles that hinder sustainable development and the expansion of practices that embrace human rights based approaches in mental health are a) the overuse of the biomedical model and biomedical interventions; b) power asymmetries that disempower service users; c) biased use of knowledge and evidence [5]. These are discussed below.

Overuse of the biomedical model

The reductionist approach to mental health that focuses mostly on “chemical imbalances” and the biological bases of mental ill health fail to acknowledge the social, political, economic, and commercial determinants of health. Further, the expansion of psychiatric diagnostic categories leads to diminishing acceptance of the diversity of the human experience. Despite the limited effectiveness of pharmacological interventions alone along with their known risks, they continue to be used as a first line treatment in both high- and middle-income countries.

This model is still dominant in policy, medical education, research, and clinical services and has proved insufficient to meet the health needs of individuals globally.

Power asymmetries

Decision-making power is concentrated in the hands of expert and commercial groups (e.g., mental health providers, researchers within academic psychiatry, pharmaceutical industry) which leads to profound disempowerment of service users. The right to participate in health decision making is undermined and rights violations may occur as a result. An extreme example is that of involuntary commitment and other coercive practices and the remaining high prevalence of such practices both in the global North and South.

The right to participate in decisions that affect our lives is a basic human right. This basic principle is crucial for the realization of the right to physical and mental health. While in the area of physical health there has been substantial change in law and practice towards partnership between users and providers of services, this shift has not happened so far in the field of mental health care. Psychiatric practices continue to perpetuate paternalistic attitudes, and the biomedical paradigm has not kept the promise to empower people with psychosocial disabilities through advances of biological psychiatry.

Biased use of knowledge and evidence

Scientific research funding has been concentrated on uncovering the biological basis of mental ill health over the past several decades. However, the billions of dollars spent have not translated into meaningful improvements in clinical care and management of mental ill health. This narrow view has led to the underfunding of other potentially more effective approaches that are non-coercive, community-based, person-centered, and recovery-oriented. This is due to three main reasons. First is the pharmaceutical industry's influence on the field through funding and agenda setting that aligns with its interest. Second is the power of academic psychiatry in setting the research agenda without the meaningful participation of individuals with lived experience of mental ill health, along with other important stakeholders. Finally, there is the heavy reliance on the dominance of biomedical model that continues to shape medical education and policymaking.

These obstacles reinforce each other and create a vicious cycle of discrimination, disempowerment, coercion and excessive medicalization. This, in turn, challenges the full implementation of the CRPD both in the global North and South.

The Path Forward

The path forward involves concerted efforts at multiple levels. I focus on the need to fully realize the right to participation as a key pillar to address the issues brought up here. To do so, we must move beyond rhetorical commitments to participation and foster leadership, giving people with psychosocial disabilities the tools and formal space to advocate for themselves and set the agenda for the mental health field. We also need to create inclusive governance models that ensure their voices are heard and their needs addressed in policy and service development. Addressing discrimination is key—through legal action, public education and advocacy, we must challenge misconceptions and promote inclusion. States must be held accountable by a robust civic space. We need monitoring and accountability mechanisms that center international human rights standards to measure the process and outcomes of policy decisions, which also guarantee meaningful participation. Finally, national psychiatric bodies must lead the way to liberate the field of psychiatry and mental healthcare from outdated laws, practices and attitudes to stop the discrimination of people with psychosocial disabilities and to empower them.

To address the remaining systemic obstacles that hinder effective implementation of the right to mental health, there is a need for each country and main stakeholders to take these measures:

1. Independent monitoring of resources allocated for the establishment and sustainable provision of innovative non-coercive rights-based mental health services.
2. Independent monitoring of measures taken to substantially reduce, with a view to full elimination, all coercive (non-consensual) practices within mental health services.
3. Active measures taken in collaboration between national authorities, persons with lived experience, professional groups and academia to address existing bias in evidence and to reach sustainable changes in the field of medical education and mental health research.

A few examples illustrate important steps taken in the direction of the full implementation of the CRPD and the realization of the right to health for individuals with psychosocial disabilities include

a) The World Psychiatric Association's support of alternatives to coercion in mental health care.
b) Brazil's national mental health conferences involving stakeholders at all levels, shaping health priorities from the local to the national stage.
c) The abolition of guardianship laws in Peru.

There are many more good practices that demonstrate that effective support to people with psychosocial disabilities is possible after all coercive measures are eliminated and replaced by services that fully embrace human rights-based approach. However, for real change to happen, these innovative services, now endorsed by the WHO, need to be funded as a rule, not as an exception, and be replicated in sustainable way. For this to happen, each country needs support from all important stakeholders, including national leadership of the psychiatric professional bodies.

Returning to the question that inspired this editorial: can we reach a consensus on the core issues surrounding human rights-based mental health approaches? Perhaps absolute agreement is not the goal. The status quo reflects the disproportionate influence and power of certain groups, sidelining critical voices from key discussions and decision-making processes. Those most vulnerable are also the most likely to be excluded. To genuinely advance global mental health, we must acknowledge our shortcomings and uphold the democratic principle of inclusive participation.

References available on the request

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Updates on Psychiatry Training in Egypt, Middle East and North Africa

1 - Okasha Institute of Psychiatry, Neuropsychiatry Department, Ain Shams University (WPA Collaborating Centre for Training and Research in Psychiatry)

2 - Department of Psychiatry, College of Medicine and Health Sciences, UAE University

Prof. Tarek Okasha[1] **Dr. Dina Aly El Gabry [1,2]**

Arab nations, encompassing the member countries of the Arab League in Africa and Asia, host a population ranging from 420 to 450 million. This demographic includes roughly 34 million immigrants, a substantial number of refugees, and internally displaced persons (United Nations High Commissioner for Refugees, 2023; World Bank, 2022). Approximately 38% of the population is under the age of 14, while about 12 million individuals, representing 15% of the labor force, are unemployed. Despite significant progress, adult illiteracy remains high, with an estimated 65 million adults, predominantly women, lacking essential literacy skills (A. Okasha et al., 2012).

Over the past two decades, the prevalence of mental health disorders in the MENA region has remained stable, yet the overall disease burden has increased. Mental health disorders in some Arab countries account for twice the global average of 5% of the total disease burden (Dattani et al., 2023). This is exacerbated by a youthful demographic and a high prevalence of non-communicable diseases, which add to the mental health burden. Contributing factors include significant mental health challenges due to war, geopolitical instability, and natural disasters in the Middle East and North Africa (MENA) region. These issues are compounded by stigma, low awareness, limited resources, inadequate publishing opportunities, insufficient research training, and a scarcity of reliable assessment tools (Ben-Zeev et al., 2024). There is also a notable gap in human resources, including qualified psychiatrists, social workers, mental health nurses, and occupational therapists (T. A. Okasha et al., 2022).

Mental Health Services in Egypt and MENA Region: Gaps and Challenges

In Egypt, there have been notable advancements in mental health services over the past two decades. The implementation of the Mental Health Act (Act No. 71 of 2009) and increased investments in mental health services signify a positive shift. Efforts include awareness campaigns for mental disorders and national programs to combat the stigma associated with mental illness (Elnemais Fawzy, 2017). To combat stigma, the term Brain Synchronization Therapy (BST) was introduced to replace Electroconvulsive Therapy (ECT), aiming to change the wrong perceptions and attitudes to the therapy of both families, patients and community (A. Okasha & Okasha, 2014).

Significant progress has been made in education and training, with improvements in both undergraduate and postgraduate psychiatric education and training, as well as an increase in trainee salaries. The Ministry of Health is establishing recognized training programs in all districts, introducing an appraisal system for trainees, and planning to implement a Continuing Professional Development (CPD) system for all psychiatrists, including trainees (Jenkins et al., 2010).

Despite these advancements, gaps persist that hinder the full realization of the Egyptian government's legal obligations regarding mental healthcare. Structural issues are evident, with the General Secretariat of Mental

Health (GSMHT) under the Ministry of Health (MOH) managing 18 hospitals and centers across 14 governorates. Mental health departments in general hospitals are under the MOH's supervision, while the General Administrative section of the MOH oversees private mental hospitals, NGOs, and outpatient clinics nationwide. Psychiatric departments in public university medical schools also contribute to addressing mental health challenges. However, the inadequate allocation of mental health resources results in disparities in service coverage and access. There is a notable shortage of mental health workers, with only 889 out of 1100 registered psychiatrists working within GSMHAT facilities. This shortage, along with deficiencies in the ratios of mental health workers per 100,000 population compared to WHO standards, highlights the challenges faced in providing adequate mental healthcare. These issues extend beyond Egypt to the wider MENA region, where shortages of doctors and nurses are coupled with high disease burdens and disparities in mental health services. Some countries have higher numbers of psychiatrists but still face shortages, while others severely lack mental health professionals (Crisp & Chen, 2014; A. Okasha et al., 2012). Additionally, disparities in specialized mental health care, particularly for children and adolescents, underscore the need for enhanced services, legislative reforms, increased financial allocation, and adherence to international standards. Economic constraints significantly hinder these goals, affecting documentation, resource evaluation, and participation in global standards (El Gabry et al., 2021).

Undergraduate Psychiatry Programs

Egypt, the most populous Arab country with over 100 million people (Central Agency for Public Mobilization and Statistics, 2008), boasts a robust history of medical education dating back to ancient times (Abdel Aziz et al., 2016). The country hosts 31 reputable governmental and private medical schools listed in the World Directory of Medical Schools, including esteemed institutions such as Cairo University (established in 1827) and Ain Shams University (founded in 1928) (World Federation for Medical Education & Foundation for Advancement of International Medical Education and Research, n.d.).

In 2018–2019, Egypt implemented a new seven-year medical degree program, comprising five years of integrated medical education followed by a two-year internship. During the fourth or fifth year of their studies, medical students undertake a psychiatry rotation lasting between 3 to 7 weeks, varying by institution. Teaching methodologies encompass a range of approaches, including lectures, case scenarios, role-playing, self-directed learning, and clinical training. Assessment methods include Objective Structured Clinical Exams (OSCEs), Multiple Choice Questions (MCQs), modified short essay questions, projects, and assignments. Additionally, medical psychology is typically taught in the second academic year over one credit hour (equivalent to 15 teaching hours). Although significant progress has been made in undergraduate psychiatric education across Arab countries in recent years, there remains a lack of standardization both within individual countries and among different nations (T. A. Okasha et al., 2022).

Postgraduate Psychiatry Education

In postgraduate psychiatry education, Egypt introduced training in the 1950s with a Diploma in Psychiatry and expanded to offer Master's and Doctorate (MD) degrees starting in 1965. Egypt uniquely offers a High Diploma in Psychiatry in addition to Master's and Doctorate degrees. Residency programs in Egypt include two types: one for High Diploma and Master's degrees (3 years), followed by another 3 years for the Doctorate degree, and another for the Egyptian Board of Psychiatry (4 years). Training curricula covers general psychiatry, liaison psychiatry, child and addiction psychiatry, geriatrics, psychopharmacology, psychotherapy, forensic psychiatry, neurology, psychopathology, psychology, and basic sciences. Each rotation's duration varies across programs and universities. For example, Ain Shams University offers a Master's degree in Neuropsychiatry with an 18-month neurology training, while Cairo University provides a Master's degree in Psychiatry with a 2-month neurology rotation. Training methods include supervision, shadowing in outpatient clinics, emergency room attendance, self-learning, participation in journal clubs, weekly conferences for case discussions, and research training.

Evaluation methods encompass workplace assessments, case presentations in clinical rounds, observed clinical interviews, OSCEs, MCQ exams, modified short essay questions, practical management problems (PMPs), and oral exams (T. Okasha & Shaker, 2020).

Saudi Arabia established postgraduate psychiatry training in 1997, offering three 4-year residency programs at academic medical centers in Dammam, Riyadh, and Jeddah. The first two years focus on general psychiatry, consultation-liaison psychiatry, addiction and substance abuse, neurology, basic principles of drug therapy, psychotherapy, and neuroscience topics. The subsequent two years emphasize sub-specialty training in areas such as child psychiatry. These programs collectively graduate 30 residents annually, all seeking board certification, which is required to practice psychiatry in Saudi Arabia (Koenig et al., 2013).

Across Iraq, Jordan, Qatar, Sudan, and the UAE, residency training in psychiatry also spans 4 years. Curricula include general psychiatry, liaison psychiatry, child and addiction psychiatry, geriatrics, psychopharmacology, psychotherapy, forensic psychiatry, neurology, and rehabilitation. Training methods commonly include supervision, shadowing in outpatient clinics, emergency room duties, and self-directed learning. Assessment methods vary slightly among countries but commonly include workplace assessments, case presentations, clinical round discussions, observed clinical interviews, OSCEs, MCQ exams, and oral exams. Graduates are certified by their national boards of psychiatry (T. Okasha & Shaker, 2020).

Some Arab countries align their residency training programs with international standards, such as accreditation from the American Board of Psychiatry (UAE and Lebanon) or the Royal College of Psychiatrists curriculum in the UK (Egypt). In Lebanon and Oman, residency training spans 5 years and covers general psychiatry, liaison psychiatry, child and addiction psychiatry, geriatrics, psychopharmacology, psychotherapy, forensic psychiatry, and neurology. Similar training methods are utilized, including supervision, outpatient clinic observations, emergency room rotations, and self-learning. Assessment methods include workplace assessments, case presentations, clinical round discussions, and MCQ exams, with observed clinical interviews in Lebanon and OSCEs and practical management problems in Jordan. Algeria requires a local competitive examination followed by a 3-year full-time education and training program for psychiatric specialization, culminating in national examinations without a research thesis requirement (Benmebarek, 2017).

The Arab Board of Psychiatry and national boards in individual Arab countries oversee certification processes for residency training programs, emphasizing local accreditation and expertise recognition. Specialized fellowships and Master's programs in psychiatry subfields like child and adolescent psychiatry, addiction, and psychotherapy are available in several countries, contributing to advancing psychiatric education in the Arab world. Although psychiatry research from the Arab region has traditionally made limited global contributions, there has been a notable increase in both volume and quality of publications in recent years, particularly from institutions in Egypt, Saudi Arabia, and Lebanon, advocating for enhanced research outcomes and addressing regional mental health challenges.

In conclusion, Arab nations encounter significant challenges in mental health care, including disparities in resources, training opportunities, and service delivery. Despite advancements in mental health education and training, gaps persist in infrastructure and workforce distribution. Egypt's progress in mental health services exemplifies positive strides, yet barriers remain in meeting legal obligations and ensuring equitable care access. Standardization in mental health service delivery, increased funding, and policy reforms are critical for addressing these disparities effectively and ensuring quality care across the region. Collaborative efforts, heightened investments, and ongoing policy reforms are imperative to bridging gaps in mental health services and achieving equitable access to care for all individuals in need in the Arab world.

References available on the request.

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Psychiatry Training in Australia and Aotearoa New Zealand – A Brief Summary

Dr. Vinay Lakra
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The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is the provider of psychiatry Fellowship training program in Australia and Aotearoa New Zealand. The training program is accredited by Australian Medical Council (AMC) and the Medical Council of New Zealand (MCNZ). After the completion of training and assessment requirements, a Fellowship qualification (FRANZCP) is awarded to the candidates. The qualification provides recognition as a specialist psychiatrist and allows people to practise independently as a psychiatrist in Australia and/or Aotearoa New Zealand subject to medical registration in either country.

Entry Requirements

To apply to the training program, a candidate must be a qualified medical practitioner with at least 24 months of clinical experience. They must have current registration as a medical practitioner in Australia or Aotearoa New Zealand. If they have any special conditions, limitations, notations, undertakings or provisional requirements they must disclose these to the RANZCP in the application. Doctors in Aotearoa New Zealand must hold general medical registration without endorsement.

The Training Program

The training program is competency based and requires a minimum of five years (60 months full-time equivalent (FTE)) and comprises of several key components including rotations in hospitals and community mental health clinics, workplace-based assessments, clinical and written exams, psychotherapy requirements and a scholarly project. The program also requires completion of a formal education course which is offered by several providers including universities. During training, trainees work in paid employment in a hospital or other settings under the supervision of a psychiatrist.

The program is undertaken in three stages:

Stage 1 (12 months FTE) – This is the first year of psychiatry training. The focus is on gaining the knowledge and skills to practice in an adult clinical setting.

Stage 2 (24 months FTE) – This stage comprises the second and third years of psychiatry training. The focus is on applying knowledge and skills within a variety of settings and with diverse patient populations. Stage 2 involves mandatory rotations in child and adolescent psychiatry and consultation-liaison psychiatry of 6 months FTE each, besides additional rotations in a range of areas including addiction psychiatry, adult psychiatry, forensic psychiatry, psychiatry of old age or research experience.

Stage 3 (24 months FTE) – This stage comprises the fourth and fifth years of training. It focuses on increasing levels of responsibility as trainees prepare to become consultant psychiatrists. Trainees may commence a Certificate of Advanced Training during Stage 3. While all graduate as general psychiatrists, the Certificates of Training offer additional certification in Addiction psychiatry, Adult psychiatry, Child and adolescent psychiatry, Consultation-Liaison psychiatry, Forensic psychiatry, Psychiatry of old age and Psychotherapies.

Assessments

Several assessments are conducted during the training. These include workplace-based assessments, conducted during clinical rotations, which contribute to Entrustable Professional Activities to document achieved competence in psychiatric practice and regular In-Training Assessments which report progress against learning

outcomes. Trainees also complete several summative assessments including a Multiple-Choice Questions examination, a Critical Essay Question examination, a Modified Essay Questions examination and a Clinical Competency Assessment. They also complete a scholarly project and a psychotherapy written case, both of which are to be completed by the end of training and are assessed at the standard expected at the end of Stage 3.

There are also several modules available for trainees to complete during the training in a range of areas including indigenous mental health and leadership and management.

International Specialists

For international specialist psychiatrists there are three pathways to attaining Fellowship of the RANZCP. Following an offer of employment from an employing service in Australia or Aotearoa New Zealand the RANZCP undertakes an assessment of their current specialist qualifications. The outcome of the specialist assessment is either 'substantially comparable, partially comparable and not comparable' to an Australian trained specialist. Those who are 'substantially comparable' complete a supervised 12-month work placement and relevant workplace-based assessments. Those 'partially comparable' complete the partial comparability pathway which includes at least two years of supervised training, examinations and other workplace-based assessments. If candidates are considered 'not comparable' after an assessment, they have to follow the full 5-year training pathway after completing the requirements for general registration via AMC.

A new Expedited Specialist pathway is being developed in Australia for implementation by the end of the 2024 details of which are not available yet.

If one is an international psychiatrist wishing to work in Aotearoa New Zealand, they can also apply for vocational registration as an alternative to the Fellowship pathways. The MCNZ regulates specialist registration and seeks the advice of the RANZCP to assess their training and experience as a specialist psychiatrist. This selection process is separate to specialist assessment and is not a pathway to Fellowship.

Other Training and Placement Opportunities

There are mechanisms for other training opportunities available for those who do not wish to achieve recognition as a specialist psychiatrist in Australia or Aotearoa New Zealand. These opportunities allow specialist international medical graduate completing psychiatry training in their home country and international psychiatrists who hold a specialist qualification to gain additional experience in Australia before returning to their home country. These opportunities may be paid employment positions through various employers or supernumerary positions with funding via a scholarship by the persons home country and aim to facilitate experience in a clinical area to allow them to develop expertise to practice in their home country. These positions also require appropriate medical registration.

Several services also offer short-term observerships to enable a brief experience of the mental health system. These are not through the RANZCP and are mostly unpaid opportunities.

International Corresponding Member

RANZCP also offers an International Corresponding Membership for specialist psychiatrists living outside of Australia and Aotearoa New Zealand. The membership offers a range of benefits and services through RANZCP including discounted rates for RANZCP congress and other RANZCP conferences, online access to RANZCP journals and several other professional development resources. This membership does not allow to practice in Australia and Aotearoa New Zealand.

*# The information in this document is from the RANZCP website. For further details about training, international specialist assessment and any other information please visit **www.ranzcp.org***

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Psychiatry training in El Salvador: The role of the Salvadorean Social Security Institute and the Salvadorean Association of Psychiatry

The Republic of El Salvador, situated in Central America, is the smallest country in the Americas, covering an area of just 21,040 square kilometers—smaller than any other nation in the region except for a few Caribbean islands. Despite its modest size, El Salvador is home to a population of approximately 6,029,976 people, making it one of the most densely populated countries in the Americas.

The Psychiatry post-graduate program in El Salvador, through the Salvadoran Social Security Institute, is three-year program what began in 1989 in the Psychiatric Hospital of the Salvadoran Social Security Institute, now called Hospital Policlinico Arce. The first Head of the program was Dr. Francisco Paniagua – honorary member of the Salvadoran Association of Psychiatry. Subsequent chiefs have been members of the Association: Dr. Wilfredo Arevalo, Dr. Manuel Mejía Peña and currently Dr. Sandra Patricia Monge.

Dr. Francisco Antonio Araniva García, *Social Security Institute in El Salvador*

There has always been a close relationship between the Salvadorean Association of Psychiatry -members society of the World Psychiatric Association- and the post-graduate program of the Salvadoran Social Security Institute. The Association was founded in the capital city of San Salvador in 1976. Most of the teachers in the training program belonged to the Association and collaborated with the program. The Salvadorean Association of Psychiatry members have always been committed to supporting the post-graduate program, often pro-bono. In addition, the Association's members are committed to continuing medical education for its members and the broader community of physicians in El Salvador who received excellent training experiences on psychiatry and mental health issues, as demonstrated by the conferences and scientific congresses held over the years, with the majority open to the Salvadoran clinical and scientific community.

The last National Congress of Psychiatry of the Salvadorean Association of Psychiatry was held on 4-5 October 2024 during which trainees in Psychiatry were given the opportunity to exhibit scientific posters highlighting research they carried out. A photograph of this event includes first-head of teaching of the post-graduate program, Dr. Francisco Paniagua, at the far left and the current program head, Dr. Sandra Monge, on the far right. At the center of the photo is Dr. José María Sifontes, current President of the Salvadoran Association of Psychiatry, surrounded the trainees who presented their scientific work.

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Psychiatry Specialty and Subspecialty Residency Training in Indonesia: A Brief Sketch

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Indonesia is an archipelago country comprising around 17.000 islands and 250 million inhabitants. This huge country encompasses 38 provinces from West to East Indonesia, with the most populated provinces being Jakarta, West Java, and Banten. According to the Indonesian Health Survey of 2023, depression was the most common mental disorder (1.4%), and 61% of individuals with depression had ever experienced suicidal ideation at least once. However, the number of general psychiatrists in Indonesia is only around 1,000 and that of subspecialty psychiatrists does not exceed 200 in the entire nation. The existing number of general psychiatry residency training centers in Indonesia is nine (one in North Sumatra Island, six in Java Island, one in Bali Island, and one in South Sulawesi); however, only one subspecialty psychiatry residency training center exists in Indonesia—located at the Faculty of Medicine Universitas Indonesia, Jakarta. Hence, all training centers are currently conducting university-based learning. Therefore, a primary task of the Indonesian Ministry of Health is not only to increase the number of psychiatrists and subspecialty psychiatrists in Indonesia but also the number of specialty and subspecialty residency centers therein.

The National Standard of Curriculum for Psychiatry Residency Training for general psychiatry and subspecialty psychiatry is developed by the Indonesia College of Psychiatry under the Indonesian Psychiatry Association. The National Standard of Curriculum for Psychiatry Residency Training states that general psychiatry residency training is delivered for eight semesters or four years of training and is divided into three levels with general and specific psychiatry competencies that need to be achieved during the study period. General psychiatry competencies include effective communication, understanding ethics and morals in psychiatry practice, research, basic clinical skills in psychiatry, managerial skills, implementation and application of psychiatry theory in clinical practice, and evidence-based learning through advanced technological information. Specific psychiatry competencies depend on the residency training level.

The first level is the apprenticeship period, which lasts for 18 months. During this period, residents acquire basic psychiatry knowledge and skills, such as psychiatric examination including descriptive psychiatric interviews and mental state examinations, psychopathology, diagnostic criteria of mental disorders based on the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM 5) and International Classification of Diseases-10 (ICD-10),

psychopharmacology, supportive psychotherapy, psychoeducation, and basic psychosocial rehabilitation. During this level, residents are placed in charge of inpatient and outpatient psychiatry wards, both in general and mental hospitals; they manage several types of mental disorders, such as delirium and psychotic and mood disorders, but supervisors still directly supervise them. Case-based discussions and theoretical seminars are conducted as scheduled. At the end of this period, residents need to undergo both case-based and written examinations to determine whether they have already attained specific psychiatry competencies for this level and as a pre-requirement to proceed to the second level.

The second level is an intermediate period lasting for 12 months. During this level, the main specific competencies are learning the psychodynamic approach, psychiatric interviews, and psychotherapy. Two types of psychotherapy should be mastered—namely, basic psychodynamic psychotherapy and basic cognitive behavior therapy. At this level, residents mostly work in outpatient psychiatric clinics and handle neurotic cases that require psychotherapy. Although they perform psychotherapy and develop psychotherapy protocols independently, they are still supervised by responsible psychiatrists. Furthermore, they need to present at least one case selected from the several cases managed by them. As at the first level, they should appear for an exit examination at the end of this rotation to demonstrate their proficiency in basic psychotherapy.

The third level is the self-sufficient level, which runs for an additional 18 months. Residents are exposed to several areas of psychiatry subspecialties, such as child and adolescent psychiatry, geriatric psychiatry, addiction psychiatry, forensic psychiatry, consultation-liaison psychiatry, neurology, and community psychiatry. After finishing the entire rotation, residents appear for a national board examination and obtain a certification of competence as a general psychiatrist.

Meanwhile, the psychiatry subspecialty residency training is the subsequent training to become a consultant in a specific area of psychiatry. The requirement for this training is that psychiatrists must have practiced for at least one year. It is delivered over two years (four semesters). The recent National Standard Curriculum for Psychiatry Residency Training in psychiatry subspecialties acknowledges nine psychiatry subspecialties—namely, child and adolescent psychiatry, medical psychotherapy, geriatric psychiatry, addiction psychiatry, forensic psychiatry, consultation-liaison psychiatry, biological and psychopharmacological psychiatry, marital and psychosexual, and community psychiatry. However, currently, formal training only covers seven subspecialties and excludes biological and psychopharmacological psychiatry and marital and psychosexual psychotherapy. All training is university-based but follows the National Standard of Curriculum for Psychiatry Subspecialty Training provided by the Indonesia College of Psychiatry. The curriculum states that after finishing subspecialty training, residents should be competent in managing complex psychiatric cases and become consultants.

The Ministry of Health policy states that tertiary or mental hospitals should have at least three subspecialty psychiatrists (consultants), one of whom should be a child and adolescent psychiatrist. However, one huge challenge to fulfilling this policy is asking general psychiatrists to join the psychiatry subspecialty course because it is a full-time training, and currently, only one center provides the training, rendering it difficult for them to leave their family and work if they are originally not from Jakarta or nearby cities.

Moreover, the number of psychiatry residency training centers throughout Indonesia may not yet be ready to provide this training because the necessary human resources are still limited. Therefore, a new frontier approach is needed to deliver this training such that general psychiatrists can participate therein even if they stay far away from Jakarta, such as developing a sandwich program or delivering some modules via e-learning. Another potentially helpful solution is guiding other psychiatry residency training centers in Indonesia to deliver subspecialty courses by providing them with supportive resources. Although numerous challenges exist, the opportunities are significantly larger.

Graduation day of the psychiatry subspecialty residency training at the Faculty of Medicine University of Indonesia

WORLD PSYCHIATRIC ASSOCIATION

Education & Psychiatry

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Psychiatry Training in Guatemala: History, Opportunities, and Challenges

Dr. José Ricardo López
President of the Guatemalan Psychiatric Association

The training of psychiatrists in Guatemala has a rich, deeply intertwined with the country's social, medical, and educational evolution. The discipline of psychiatry officially took roots in Guatemala during the mid-20th century, spurred by a growing awareness of the need for mental health services. Early developments were marked by the establishment of psychiatric services at the National Hospital for Mental Health, and in 1961, the Faculty of Medicine at the Universidad de San Carlos (USAC) approved the creation of the Department of Psychiatry, with Dr. Carlos Federico Mora at its helm.

Characteristics of Psychiatry Training in Guatemala

Today, psychiatry training in Guatemala is a robust process, designed to produce well-rounded specialists equipped with the skills to diagnose, treat, and manage mental disorders. The program, offered by the USAC School of Medicine, includes three years of residency, followed by one year of supervised professional practice. Aspiring psychiatrists engage in rotations across various disciplines, including neurology, dermatology, forensic psychiatry, internal medicine, and child and adolescent psychiatry, which ensures that they are well-versed in both general medical practices and psychiatric specialization.

Opportunities for the Mental Health Sector in Guatemala

As the need for mental health services in Guatemala becomes more pronounced, there are significant opportunities to further develop psychiatric training programs and mental health services. With an increasing awareness of the importance of mental health, Guatemala can expand its psychiatry programs to not only treat individuals, but also to promote preventive care. The introduction of sub-specialties, such as child psychiatry, signals a growing focus on addressing the mental health needs for specific populations. Moreover, collaborations with international psychiatric societies, and ongoing medical research present an opportunity for further advancement.

Mental Health Statistics in Guatemala

Mental health remains a significant challenge in Guatemala, with estimates that nearly 20% of the population experiences some form of mental illness in their lifetime. Depression and anxiety are among the most common conditions, exacerbated by social issues, such as poverty, violence, and limited access to healthcare. The country has fewer than 1 psychiatrist per 100,000 people, far below the recommended levels by the World Health Organization. This disparity highlights the urgent need for increased mental health services and a greater emphasis on training more mental health professionals.

Challenges Facing Psychiatry Training in Guatemala

Despite the progress made in psychiatric training, Guatemala faces several challenges in meeting the mental health needs of its population. Limited resources, both in terms of funding and infrastructure, are significant. Training programs, while comprehensive, struggle to accommodate the growing demand for mental health professionals. The stigma surrounding mental health continues to be a formidable obstacle, limiting public engagement with mental health services. Furthermore, the reliance on urban-centered care leaves rural areas underserved, creating disparities in access to care.

Conclusion

The evolution of psychiatry training in Guatemala reflects both the strides made and the challenges that remain. As the country continues to develop its mental health infrastructure, there is an urgent need for strategic investments in psychiatric education and mental health services. By expanding training opportunities, promoting preventive mental health care, and addressing the systemic challenges, Guatemala can ensure that its population receives the comprehensive mental health care they deserve.

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Prof. Irina Pinchuk, *President of the Ukrainian Psychiatric Association*

The Lancet Psychiatry Commission on Ukraine

Mental Health Forum “Human Resilience-System Resilience” took place on 27 November 2024 in Kyiv, Ukraine "The Lancet Psychiatry Commission on Mental Health in Ukraine" was presented and discussed as part the WHO efforts to provide expert support for the All-Ukrainian program "How are you?" and the Coordination Center for Mental Health of the Cabinet of Ministers of Ukraine, which provides and implements programs. The Mental Health Forum was a three-day conference for exchanging ideas and experiences for the purpose of developing solutions for building a mental health system in Ukraine, during the war and recovery. Politicians, officials, scientists, and representatives of non-governmental organizations were among the participants of the forum.

During the Opening Session of the Forum, Ukrainian First Lady Elena Zelenskaya offered the following comment: “I thank everyone who, in different sectors, in different conditions, with different experiences, is doing a common job—wrapping Ukrainians in care and giving moral strength. Unfortunately, we cannot heal all wounds. But we can give everyone who is hurting a feeling of support, understanding, and concern”.

The First Lady noted that by implementing the "How Are You?" program, Ukraine is studying the experience of countries where mental health projects have been operating for many years. However, at the same time, Ukraine is following its own unique path, as it faces a challenge that is unlike any other. The Lancet Commission Panel Discussion was attended by the authors of the Commission and representatives from the five thematic groups. The panel discussion was opened by Professor I. Pinchuk, who spoke about the Commission’s organization and structure, the historical aspects of the Ukrainian mental health system, and the prospects for changes in the system. V. Kolokolova, analyst at the Coordination Center for Mental Health of the Cabinet of Ministers of Ukraine, presented key recommendations for community services and the vision for mental health services in Ukraine; S. Chumak, senior researcher at the Institute of Psychiatry, Taras Shevchenko National University of Kyiv, discussed specialist training recommendations; V. Virchenko, Professor, Doctor of Economics, and Director of the Interdisciplinary Analytical Center for Mental Health and Socio-Economic Well-being at Taras Shevchenko National University of Kyiv, addressed restructuring research potential, infrastructure in mental health, and investment recommendations by the Commission; and Elena Protsenko, joining online from Strasbourg, France, where she works at the European Court of Human Rights, commented on legal framework reforms and advocacy in mental health proposed by the Commission

The Lancet Commission discussion ended with a bold message in support of the work and recommendations of the Commission, as well as strong support for Ukraine: “The plan for Ukrainian mental health is ambitious because the mental health needs of Ukraine are vast, but the plan is manageable with the thoughtful transition of services and training to contemporary evidence-based standards of practice, supported by effective research, legal, and financial structures."

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Psychotherapy Workshop for South Asian Early Career Psychiatrists - An Initiative by WPA, Zone 15

Dr Vinay Kumar, *Board Member, WPA, Manoved Mind Hospital Hospital and Research Centre, Patna, India*

Dr Astha, *Tees, Esk and Wear Valleys NHS Foundation Trust, UK*

Dr N G Nihal, *Department of Psychiatry, Gayatri Vidya Parishad Institute of Health Care and Medical Technology, Marikavalasa, Visakhapatnam, Andhra Pradesh, India.*

Dr Kashypi Garg, *Department of Psychiatry, Sarojini Naidu Medical College, Agra, Uttar Pradesh, India*

Dr Vinay Kumar

Introduction

The need to equip psychiatrists for a variety of positions in teaching, research, administration, and public health is increasing as their role extends beyond traditional clinical care. The complicated mental health issues of a rapidly changing society, such as the growing prevalence of mental health illnesses and the requirement for integrated treatment models, must be addressed by the upcoming psychiatrists in the ensuing decades.

Over the years, psychiatry has emerged as a popular field to pursue postgraduate education in South Asian countries. Though the postgraduate training programs offered in these countries are extremely rich clinically and academically, they do not provide deeper insights into the realm of psychotherapy. As conferences and webinars have become central platforms, a psychotherapy workshop for training young psychiatrists has become essential. The psychotherapy workshop was held in Mumbai on September 28 and 29, 2024, under the leadership of Dr. Vinay Kumar (Chair), Dr. Arabinda Brahma (Secretary of the Coordination Committee for WPA Zone-15), and Dr. U.C. Garg (President of the Indian Association of Social Psychiatry). The young psychiatrists' coordinators included representatives from various countries: Dr. Sheehan Williams (Sri Lanka), Dr. Helal Uddin Ahmed (Bangladesh), Dr. Manish Borasi (India), and Dr. Abhash Niraula (Nepal).

The Young Psychiatrists' Coordination Committee of WPA Zone-15 (India, Sri Lanka, Bangladesh, Nepal, Bhutan, and Myanmar) played a major role in organizing the event. Dr. Astha, Dr. N.G. Nihal, and Dr. Kashyapi Garg, the organizing leads for this workshop, provided registration and accommodation to all national and international delegates. Around 260 participants attended from different parts of India, Sri Lanka, and Nepal. The workshop was a grand success, widely appreciated by the delegates and invited faculty members, which included chairs of two member societies.

The resource person for the workshop, Dr. Salman Akhtar, is a well-known psychotherapist and psychoanalyst. An Emeritus Professor of Psychiatry at Jefferson Medical College and training and supervising analyst at the Psychoanalytic Center of Philadelphia, he has authored more than 114 books, including over 23 solo-authored works. His writings have been translated into many languages, and for his immense contributions to psychoanalysis, he has received numerous awards, including the prestigious Sigourney Award. Dr. Salman Akhtar has conducted such workshops in more than 40 countries. His workshops in India have been a regular event over the past decade, organized in different cities across the nation. However, for the first time, it was made an international event.

Layout of the Workshop

Dr. Akhtar's workshop focused on common outpatient problems in psychiatric practice, teaching participants how to approach, interpret, and analyze clinical scenarios effectively. The program was divided into eight sessions held over two days, culminating in a question-and-answer session. Topics discussed included five levels of mental organization, anxiety and its relationship to fear and phobia, normal and pathological grief, childhood sexual abuse and its long-term consequences, childhood trauma and personality disorders, parental loss and its effects, rage, hate and cruelty, and suicide.

The attendees received a workbook designed by the organizing team under the guidance of Dr. Akhtar. It included anecdotes, suggested reading materials, take-home messages, and highlights from the previous year's workshop. Another attraction at the workshop was the bookstall, where recent official publications of the Indian Psychiatry Society were available for the delegates. These included one of the latest books, *Psychotherapy in India: Past, Present, and Future,* edited by Dr. Geeta Desai, Dr. Vinay Kumar, Dr. Pratap Sharan, and Dr. Salman Akhtar.

Conclusion

Psychiatry training has undergone significant changes over the past decade. By addressing challenges and embracing aspirations for the future, teachers and leaders can create a workforce capable and resilient enough to meet the complex needs of our diverse global population. To support early-career psychiatrists in India, reforms in postgraduate training and faculty development programs are essential. Leading institutions, national experts in psychiatry education, and international organizations such as the World Psychiatric Association can collaborate to further this initiative, ensuring long-term benefits for South Asian psychiatrists.

References available upon request

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The International Scientific and Practical Conference "Globalization and Diversity: Seeking Balance in the Field of Mental Health"

The International Scientific and Practical Conference "Globalization and Diversity: Seeking Balance in the Field of Mental Health" dedicated to the 85th anniversary of the Kyrgyz State Medical Academy named after I.K. Akhunbaev and in memory of Professor V.V. Solozhenkin, took place at Issyk-Kul, Kyrgyz Republic, from September 18-21, 2024. This event provided a platform for mental health professionals from the countries in World Psychiatric Association Zone 10, bringing together knowledge, experience, and scientific achievements of specialists from various countries.

Dr. Liliya Panteleeva, *President of the Kyrgyz Psychiatric Association, Kyrgyzstan*

Particularly significant and interesting for the audience and guests of the conference, given the geographical and informational isolation, were presentations on autism spectrum disorders: "New Global Perspectives and Challenges" (Professor Kerim M. Munir), "Improving Services for Children and Adolescents with Mental Health Needs" (Professor Norbert Skokauskas), "Ethical Issues in Psychiatry" (Professor Eka Chkonia), "Results of the Study of Adverse Childhood Experiences in Kazakhstan" (Dr. Nikolay Negay, WPA Zonal representative, Zone 10 - Eastern Europe), and "Modern Capabilities of Personalized Psychopharmacotherapy" (Regina Nasyrova).

The event was opened by the president of the World Psychiatric Association, Dr. Danuta Wasserman, MD, PhD. In her video message, she provided a brief and prospective overview of the main goals and objectives of the World Psychiatric Association, highlighting the main priorities and stages of implementing the WPA action plan for 2023-2026. Danuta Wasserman emphasized that modern psychiatric care should focus its resources on the prevention of mental disorders, presenting examples of successful practices and research. Another important message from the WPA president was the recommendation to focus on a healthy lifestyle as a key priority in promoting mental health, which would contribute to the preservation of mental well-being not only for patients but also for specialists providing psychiatric care.

The educational aspects of the conference provided valuable information on the latest trends and developments in psychiatric practice, which were highlighted in presentations on the treatment of bipolar affective disorder: "Modern Perspectives on Depression in Schizophrenia: Diagnosis, Mechanisms, Therapy" (professor Natalia Petrova), "Rational Approaches to the Treatment of Schizophrenia and Bipolar Affective Disorder with Comorbid Addiction, Neurobiology of Addiction Formation - There is an Entrance, but is There an Exit?" (professor Azat Asadullin), "Premorbid Factors in the Formation of Polyaddiction: Modeling Results Using Machine Learning" (Ph.D. Inara Khairedinova), "Negative Childhood Experiences and Psychiatric Stigma: The Role of Transcultural Assessments for Providing Rehabilitation Care" (associate professor Mikhail Sorokin), "Problematic Issues of Mental and Addictive Disorders in HIV Infection: Clinical Features, Diagnosis, and Therapy" (Dmitry Polyansky), "Using Grounded Theory in the Study of Somatic Representations of Psychological Problems in the Kyrgyz Language" (associate professor Elena Molchanova), "Autism and Diagnostic Challenges" (associate professor Javed Akbar), "New Opportunities for the Use of Antipsychotics" (associate professor Tatiana Galako), and "Enduring Effects of Stress and Anxiety in Irritable Bowel Syndrome" (associate professor Liliia Panteleeva).

Additionally, there were presentations on priority directions for the development of mental health care systems. Nikolay Negay led a session on "Policy Based on Facts: Myth or Reality Through the Lens of Mental Health." He also delivered a report on international standards for drug prevention (UNODC/WHO). Professor Zarifzhon Ashurov, President of the Psychiatric Association of Uzbekistan, highlighted the issue of the personnel crisis in psychiatry and outlined possible solutions. Professor Farit Safuanov, presented a report on "Prospects for the Development of the Organizational and Legal Regulation of Medical Psychologists."

Daily discussions extended beyond the main sessions, continuing during breaks and creating opportunities for knowledge exchange, scientific project planning, and discussions of educational initiatives. The conference also provided an important platform for young specialists, giving them a unique opportunity to expand their knowledge and discuss clinical cases with leading experts.

The conference brought together scientists and professionals in mental health, promoting collaboration to tackle critical challenges in science, education, and healthcare organization, all with the goal of improving population mental health.

Dr. Lilyia Panteleeva *with* ***Dr. Nikolay Negay****, WPA Zonal representative for Eastern Europe (Zone 10)*

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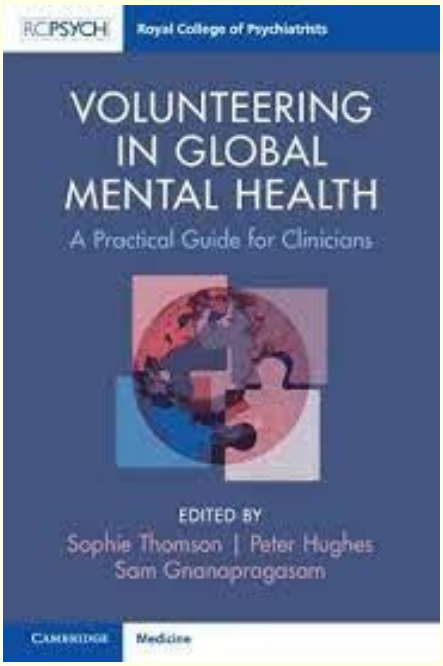
Volunteering in Global Mental Health: A practical Guide for Clinicians

Sophie Thomson (UK), Peter Hughes (UK) and Sam Gnanapragasam (UK)

This book is aimed at clinicians at all levels of training and experience who are interested in global mental health. Although it is written for psychiatrists, it can also be helpful to others interested in primary, community and secondary care. The book builds a framework for volunteers to work in partnerships, train, do clinical work, and learn from others. It inspires and prompts volunteers to bring knowledge learned back home. This book challenges a traditional view of volunteering and poses a modern professionalised model going beyond a narrow medical model to a full psychosocial approach. This book will inspire people to go on the journey of volunteering that can bring great benefits to others as well as changing and enriching themselves. Some volunteers even say they had a life changing experience. This book not only offers background contextural information , including ethical perspectives and policy issues but also very practical guidance based on the experiences of many authors. The book highlights that volunteers are guests that need to be sensitive to culture, reflective, and humble as well as professional. There is a special chapter for trainees and another written for diaspora volunteers. Different narratives about work with partners in Kashmir, The Sudan , Myanmar, Malawi ,Somaliland and other countries demonstrate the variety of opportunities that can make a contribution to the skills of those working with people with mental and psychological difficulties.

There is a simple guide on how to support the setting up of trainings and supervision. The chapters about ongoing supervision and evaluations keep a focus on a commitment to sustainability .There is an invaluable toolkit of 13 psychosocial interventions that will help clinicians wherever they are as well as those who are volunteering. These are the jewel in the crown of this book of useful skills that people can take away with them.

There are tips about avoiding common pitfalls. This book collects the rick experience of what went well as learning from mistakes. There are useful clinical scenarios , packing lists of what to remember and finally a list of possible volunteering opportunities that can be explored and followed up. This book aims to inspire others to have the rewarding and even life changing experiences that the book contributors have had and for many of us have been the most important professional work in our lives.



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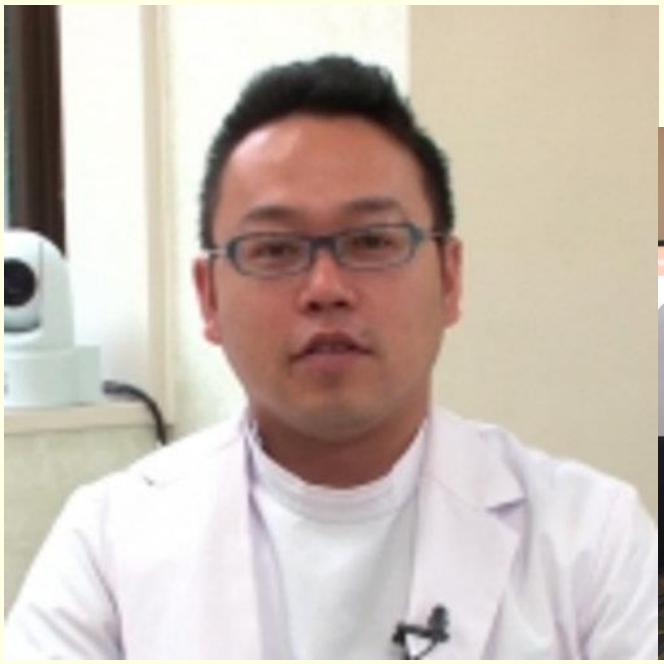
In Memoriam

Dr Takahiko Inagaki *09 June 1975 – 05 November 2024*

Takahiko Inagaki was born in Osaka, Japan on 09 June 1975. He graduated from Siga Medical University, School of Medicine in March 2004. He completed the initial clinical training for medical graduates at Chidoribashi Hospital in Fukuoka-city in April 2006. He returned to Siga Medical University Hospital to train as a psychiatrist and then became an Assistant Professor there. After he worked at Siga Medical University Hospital for a total of 10 years, in April 2016, he moved to Shiga Psychiatric Medical Center at where he spent two and a half years as a Chief Psychiatrist. Then, he started working as Head of the Division Adolescent Psychiatry of Biwako Hospital in Shiga prefecture in October 2018. He contributed to the establishment of a local network of mental health professionals for children and adolescents in the region. He was passionate about early detection and appropriate treatment of childhood depression. He participated in the Effectiveness of Guidelines for Dissemination and Education in Psychiatric Treatment (EGUIDE) project and worked tirelessly to promote appropriate pharmacotherapy. He was a frequent presenter at national and international conferences, including those organized by the WPA where he shared his expertise and insights with global audiences. Takahiko Inagaki absence will be deeply felt by all who had the privilege of knowing him.



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