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## **MENTAL HEALTH**



A HEALTHY MIND IS THE GREATEST TREASURE TO FIND

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This issue of the Pharmatimes presents a wide range of narratives on aspects of Mental Health in COVID-19 times. A gap analysis of the Fiji Mental and Suicide Prevention Policy document :2015-19 which needs General Practitioner attention and advocacy as part of our ethical principles forms part of this edition. More discussion and partnerships need to be developed with the public and private sectors to improve the quality of life of the afflicted. More individuals are being impacted with the current pandemic. A grassroots contribution from Dr. Shanita Sen addressing practical ground rules is also presented. 2020 has been unique with public health issues: unprecedented mortality and morbidity in the northern hemisphere and the psychological and mental stress being taken to great heights. We are fortunate to be isolated geographically in the Pacific and our quarantine has proved beneficial. The reports from the Fiji Women's Rights Movement and the Crisis Center indicate a huge increase in domestic violence in our settings. COVID -19 is driving this addition pandemic to greatest heights. As GP's we need to be proactive in our professional interactions with patients in early clinical interventions.

Additionally, this issue highlights some medical progress with the establishment of the three Stress Management wards in Fiji's hospitals in 2010. Professor Deva was the strategist behind this move in the 2009-2014 era of the second wave of reform in the Fijian health sector. Possibly ongoing future post graduate training for more GP's will assist in the devolution of mental-stress management to subdivisional level. Mental Health and wellbeing can be appropriately managed in our GP settings if we aspire for that. Again, another opportunity for advocacy by our private healthcare sector with the Government's Private, Public Partnership proposals.

The economic impact has been catastrophic, globally. Some of our Fiji private practitioners are having great difficulty with loan repayments with a declared 25-30% downturn in monthly revenue during the first quarter of 2020 and thereafter. The ensuing economic depression to follow, has resulted in great mental health risks. How the economic phoenix will arise is conjectural currently as second and third waves of this multivariant virus unmask. Health issues do take precedence over the economic and fiscal downturns. Very much on our minds, one needs to consider public safety and health concerns of increasing poverty in our communities. In these hard-economic times, the current overbearing public health crisis, we all need the healthcare profession to rise above past normal to the new normal. Take care of all your components of health and wellbeing: i.e. Physical, emotional, spiritual, intellectual, social, occupational and environmental. Your MEHAW study is very illuminating in so many ways. Results are being analyzed.

We all look forward to some merry making to conclude the most devastating year of our existence: the double-digit year of 20-20. Season's greetings once again.  
Merry Xmas.

NEIL SHARMA

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## SHIFTING THE PARADIGM OF MENTAL HEALTH IN FIJI

### A Real Story Unfolded

Prof Deva, Dept of Psychiatry, Universiti Teknologi Mara, Malaysia

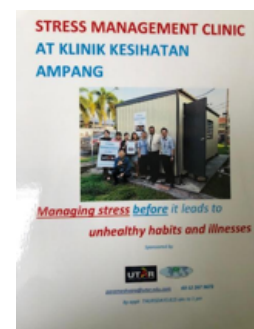
In May 2011, as a visiting Professor it was possible in far away Fiji to open a Stress Management Ward in a general hospital in Labasa to care for people under emotional stress, after over 120 years of treatment in the country's only facility for the mentally ill, a custodial mental hospital in Suva on the main island. It was not an easy transition. Much opposition to opening a psychiatric ward in a general hospital ensued the idea mooted by the Minister of Health, including of all people medical and psychiatric professionals. Clearly changes in mental health concepts that had developed in many countries. Luckily the then military government in Fiji put in place a Mental Health Decree that requires the setting up of 3 mental wards in the 3 Divisional hospitals in Suva, Labasa and Lautoka by 30 June 2011 – by decree. And so, the first of these came to fruition on 24 May 2011- picture below.



With a cutting of a ribbon the over 120 years of custodial care in St Giles' hospital for those with mental illness and distress on Reservoir Road in Suva between the city's largest rubbish dump and the country's largest prison, and an old leprosy asylum, ceased to be the only place for treatment for mental illness. Set in idyllic settings on a ridge overlooking the beautiful Suva harbour, from the former Harbourmaster's house, St Giles also generated indelible stigma and became the centre of teaching of all mental health courses for health care students, not only in Fiji but across 16 lower income countries of the vast Pacific.

If one asked why stigma of mental illnesses and mentally ill continues in the Pacific one cannot ignore the role the custodial nature of St Giles and exemplified as indeed by its place in the capital city. It is typical of the state of psychiatry in many a low-income country in the Asia Pacific country. Mental illnesses need a major shift of the paradigm they have laboured under for centuries and the millions of suffering humanity have endured. A name change is a small beginning that costs nothing except the will to venture out of the box of the comfort zone. A change of the place of treatments needs a small investment in cost such as the example below.

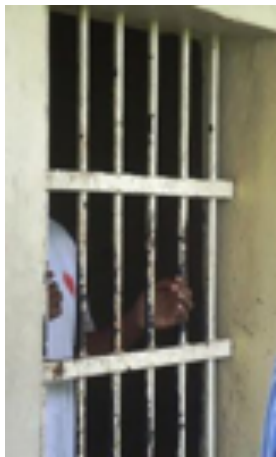
The teaching of Stress related to daily lives to medical students began on seeing this primary care clinic in Ampang Malaysia that sees over 1200 patients every day in cramped conditions. The WHO has done studies the world over that show not less than 25% of them have significant stress related anxiety and depressive symptoms – which are seldom detected and even less often managed satisfactorily in PHC settings. But even if a psychiatrist volunteered to help out there is simply no space to see the patients or treat them.





**The KK Ampang Primary clinic on a Monday morning**

Thus one sees how most students are taught a heavy dose of severe and often psychotic syndromes in the name of psychiatry teaching in readily available psychiatric wards or even custodial mental hospitals.



**SHIFTING THE PARADIGM- CHANGING MINDS**



**CHANGING NAMES, SHEDDING STIGMA**



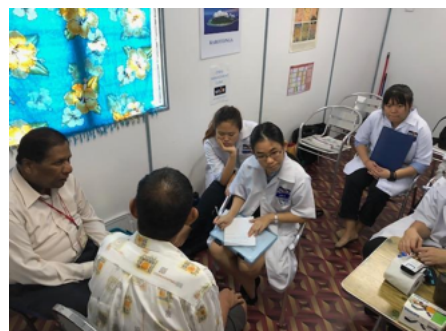
**CHANGING PLACES, CHANGING MINDS**



**REFRESHING ATTITUDES, CARING NOT FEARING**



**TEACHING, LEARNING IN NORMAL SETTINGS**



**CLINICAL HISTORY TAKING & INTERVIEWING**



**TEACHING & PRACTICING RELAXATION TECHNIQUES**

## An Independent Policy Gap Analysis and Recommendation on the Fijian Mental Health and Suicide Prevention Policy: 2015-2019

A possible roadmap to achieve the Sustainable Development Goals: 2015-30

The World Health Organization (WHO) defines health as:

A state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity. Health is a dynamic condition resulting from a body's constant adjustment and adaptation in response to stresses and changes in the environment for maintaining an inner equilibrium called homeostasis. **(1)**

The recently released WHO document World Health Statistics (2017) Monitoring Health for the Sustainable Development Goals (SDG) (2015-2030) outlines the six lines of action to promote health in the 2015-2030 Agenda for Sustainable Development endorsed by the 194 member States of the United Nations **(2)**.

Status of the health-related SDGs referencing non-communicable diseases and specifically mental health is clearly defined. Each of the 194 National States have endorsed the need to address the SDG Goals and Targets in their jurisdictions, including the Republic of Fiji.

The World Health Statistics also estimate that global, regional and national mental health prevalence and incidence utilizing WHO mortality database statistics and projection methodologies. **(3)**

SDG Target 3.4 aims to reduce by one third, premature mortality from non-communicable diseases through prevention, treatment inclusive of promoting mental health and well-being, by 2030. **(3, 4)**

Unfortunately, the Fijian National Mental Health and Suicide Prevention Policy (2015 -2019) and the relevant Strategic Plan (2016-2020) remain unendorsed by the sequential health ministers since 2015. **(5)**

The Fijian **Mental and Suicide Prevention Health Policy**, a seminal document addresses the ten pillars of mental health strategic development. The policy document is commendable as it integrates the top-down and bottom-up community involvement and engagement strategies. However, the policy document remains in a draft format at the doorstep of its major review in 2019.

These pillars include *Leadership and Governance, Workforce/ Human Resources, Financing, Essential Supplies, Health Information, Research, Services Delivery, Stakeholder Collaboration, Monitoring & Evaluation and Community Empowerment* (5, 6).

*In the absence of any real time, ongoing Monitoring & Evaluation of the pillars, policy and its strategic plans are rendered ineffective and dysfunctional.*

*Historically the amalgamation of the National Mental Health and National Suicide Prevention Policies into a unified National Mental Health and Suicide Prevention Policy (NMHSPP)-2015 was a milestone alignment following the triple pronged programmatic approach to the introduction of a new "Mental Health Decree (2010)", decentralization of mental health service delivery and the commencement of post graduate training for medical personnel with newer approaches to nurse training.*

**The NMHSPP (2015) has ten policy pillar statements** with a nationally determined, alignment to the six WHO blocks- outlined as the "Objectives" of the policy.

- 1. Leadership and Governance.**
- 2. Health Information Systems.**
- 3. Health Workforce.**
- 4. Health Service Delivery.**
- 5. Access to Essential Medicine.**
- 6. Health Systems Finance.**



Reviewing the ten pillars for policy gaps, providing discussions/options to streamline programs could possibly result in “effective” outcomes even at the mid-review period scheduled in 2019.

## **NMHSP (2015) has ten broad policy statements:**

### **1. *Mental Health services will be organized in such a way as to provide all Fijians with timely access to high quality, coordinated care appropriate to their condition and circumstances.***

Pillar one remains a broad visionary overview, subject to the six objectives being addressed successfully. This may not be the achievable as inadequate expertise, manpower shortfalls, delayed and poor planning, ineffective program implementation and health financing continue as constraining challenges. Modernization of health laws, decentralization of service delivery and advanced training of personnel has come slow, with many challenges from within the health delivery systems. Health financing has remained static with submissions for appropriate financing getting no attention at annual budget allocation meetings in “health” and “all of government” budget subcommittees.

### **2. *National policies, strategies, programs, laws and regulations relating to mental health and suicide prevention will continue to be developed, monitored and implemented in line with evidence, best-practice, the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments.***

Pillar two demonstrates a clear strategic intention, acknowledging in principle, the established international guidelines of service delivery, yet basic services remain absent at the community interphase. With inadequate leadership and governance, inadequately trained manpower, the policy and its strategy remain desperately wanting in all practical levels.

At the Doctor/ nurse and community/personal interphase

services are not available as demonstrated in the recent Sigatoka study (7). The senior level medical staff are leaving for other disciplines as financial remuneration is now graded as level three, compared to other clinical disciplines who are rated level one by comparison by a recent review of salaries by government.

No community education and advocacy programs exist in real time. (7) If Non-Government Organizations (NGO), civil society groups exist, they do on paper as the funding support is functionally nonexistent. With all these health workforce restraints the policy, strategy and programs are not effective operationally.

### **3. *Knowledge and skills of general and specialized health care workers will be built to deliver evidence-based, culturally-appropriate and human rights-oriented mental health and social care services.***

Pillar three addresses workforce / human resource issues which need urgent attention.

With logistic support from WHO a postgraduate Diploma in Mental Health was professionally crafted in 2010. The first three Fijian intakes additional to three participants from the other pacific isle territories graduated. The program ran for a second term but challenges see a limited intake of local and regional candidates in the subsequent years. Qualifications beyond the post graduate diploma program is non-existent. Attempts to establish a Master’s Vocational Program in Mental Health has run aground due to lack of local expertise, personality issues with expatriate expertise brought in to design a pacific based vocational program and finally the healthcare system not pushing the frontiers adequately.

WHO endorsed and financially supported an international program on “Mental Health, Human Rights and the Law” run in Pune, India has not had a Fiji candidate, after a pioneering candidate completed the course successfully in 2013, as part of departmental upskilling and retention strategy.

The James Cook University from Queensland, Australia was requested to restructure nursing training to address grass-roots services delivery. The selection criteria and subsequent deployment of nurses is matter of great concern. Such personnel once trained revert their original or other nursing disciplines leaving the mental health services still disabled largely, despite manpower statistics demonstrating the program as a success. The individual nursing stations, health centers and sub-divisional hospitals are largely manpower constrained in the mental health discipline.

The absence of co-ordination by the health leadership/ nursing division is matter for great concern if one is to lift the service with well trained and experienced teams, acquiring adequate supervision and regular retraining.

#### **4. A dedicated mental health budget will be provided for the successful implementation of this policy, strategic plan and mental health legislation.**

Under Pillar 4, health financing shortfalls continue to remain to underpin the multiple, complex relations in all facets of providing quality, comprehensive healthcare. Piecemeal allocations for infrastructural renovations, medication modernization/ modification, technology purchases and staff training is not in the interests of meaningful progression of this pillar. Very little funding grants, if any remain available to civil society organizations for community advocacy and awareness building.

#### **5. Essential psychotropic medications, medical products and technology will be continuously and consistently available at all facilities providing mental health services.**

Pillar 5 is a very important patient care item. Medication outages is not in the interests of any patient's management. Clear directives by health administration on pharmaceuticals supply chain management and its need of regular monitoring and evaluation remains mandatory.

There is need to review medication use, regular alignment to the WHO essentials list of pharmaceutical items for the developing world, containing costs and standardizing clinical use. Regular need for technology procurement and service arrangements is needed with respect to Electro Convulsive Therapy (ECT) and other technological needs and possibly upgraded periodically.

#### **6. Mental Health will be integrated into the routine health information system. This will identify, collate, routinely report and use core mental health data, desegregated by sex and age (including on completed and attempted suicides) to improve mental health service delivery, promotion and preventive strategies.**

With WHO Sub regional Office based in Suva, Fiji with a mental health expert in the region, the Fijian health leadership, policy and program developers are failing to use the robust global health recording systems to their advantage, The question of the lack of Health Information Systems and Monitoring and Evaluation are interlinked important self-limiting deterrents to policy implementation. This is an all of Government issue to fast track digitalization of data.

National Data desegregated, is necessary to establish the essentials of the full range of health services and training needs for this escalating medical matter now on the SDG target list. No information on patient load, clinical management inclusive of behavioral management, regular medication availability is available to health planners

Likewise, the coronal and forensic police records must interphase with the health information network. Especially in the area of attempted and completed suicides for meaningful data for the stated purposes of policy development, strategic planning, community / desegregated patient awareness, counselling and prevention strategies.

**7. *There will be improved research capacity and academic collaboration on national priorities for research in mental health and suicide prevention, particularly for operational research with direct relevance to service development and implementation and the exercise of human rights by persons with mental disorders.***

This is another area in great need of evaluation. The ground remains ripe for case studies, cohort and field analysis by team players at all levels. Organizational statistics remains an area which is failing to be recorded for subsequent monitoring and evaluation of operational research. Medical Interns are required to undertake two pieces of research as part of their training and similarly service registrars, post graduate students of medicine and mental health should be mandated to produce research article worthy of publication annually. Consultants also need to lead by example with their reports in some operational research format to complete the cycle of improved service delivery. Nursing graduates should be encouraged to do likewise on their experiences with patient care.

The established academic units at both Universities are also capable of research, publication and assisting national policy directives. The subject of service delivery being evidence based is noted, however the whole cycle of service delivery cannot improve without research input.

**8. *Locus of care will be systematically shifted away from long-stay psychiatric hospitals towards non-specialized health settings with increased coverage of evidence-based interventions, using a network of linked community-based mental health services, collaborating with non-government organizations.***

The decentralization from the asylum concept in 2009 was to be effected with a planned inpatient management strategy i.e. return to domiciliary care within a fixed schedule from the Stress management wards in the three divisional hospitals. Only the difficult complex cases were for admission to St.

Giles Hospital.

The development of stress management wards at sub-divisional hospitals was envisioned as the next phase, in a fixed timeline. The caveat being major professional manpower development in trained and supervised health workers, as a precursor.

Greater NGO and Civil Society groups with community health workers and district nurses was to complete the advocacy, awareness and early diagnostic chain. The establishment of new Mental Health hospital /Unit for Research, Service delivery and regional training at an alternate Tamavua site. This development, in an advanced stage, was on the drawing board but has subsequently fallen off the Governments development program due to lack of support from within the ministry leadership.

This was to replace the dilapidated, stigmatized St Giles Hospital establishment. Getting the new structure on track will raise hope for its health workers, patients and communities at large. International Partnerships were ready to assist with a turn-key operation.

**9. *Stakeholders from all relevant sectors, including persons with mental disorders, carers and family members will be engaged in the development and implementation of policies, laws and services relating to mental health and suicide prevention.***

Pillar Nine reiterates the importance of multiple stakeholders remains paramount in the review of the complexities of mental health care delivery. The umbrella “Alliance for Mental Health” was a breath of fresh air and much should been achieved since inauguration, in 2013.

All stakeholders interacting, from survivors, champions, carers and family members of patients, civil society groups, NGO’s, help line attendants, counsellors, nursing, medical and other personnel from the relevant ministries with International partnerships would have a say in inputs and outputs of health



delivery and care.

Funding grants would be readily sought and programs would run effectively, based on best available evidence and real time monitoring/ evaluation. Unfortunately, the six objectives of the Mental Health and Suicide Prevention pillars do not have a position statement on the role of Civil society organizations, NGO and interested groups. There is little by way of a distinct voice, funding grant, strategic directives in the **NMHSP (2016-2020)**. Such groups must be supported financially and monitored periodically. The continuation of the NCOPS remains mandated in the Mental Health Decree and the need to review funding grants is long overdue.

**10. *People with mental disorders and psychosocial disabilities will be given a formal role and authority to influence the process of designing, planning and implementing policy, law and services.***

Pillar 10 stands on its own and formalizes the human rights angle most eloquently. It remains a stand-alone item, uncontested. It is an international agreement item, a basic human right for human expression and remains unquestionable. As a beacon of a pillar on its own, one realizes the importance of Mental Health. The Mental health challenges must be addressed fully if no-one is to be left behind. An all-inclusive policy and strategy is mandated by all concerned stakeholders.

#### **Recommendations:**

This Independent Policy Gap Analysis of the Fijian Mental Health and Suicide Prevention Policy (2015-2019.) aims to provide a possible roadmap to achieve the Sustainable Development Goals: 2015-30. Based on the ten pillars and six Objectives the following recommendations are provided.

**1. Leadership and Governance** needs to be reviewed by the most senior political and executive level. Endorsing the policy, its strategy and operationalizing the programs with a catchup

midterm review to address gaps in health service delivery by end of 2019.

**2. The Health Information System** must be upgraded to include desegregated data mental health data almost immediately, integrating the public health web with other clinical, forensic and coronal databases. This data base will provide disease/risk taking patterns, trend in time, research capabilities optimizing health outcomes.

**3. Health Workforce** optimization with relevant training et re-training / retention, career succession planning and salary restructuring in comparison to other specialties must be given due consideration. A master's program should not be delayed. Nurses must be retained in this specialty and a career line to specialist nurse status must be drawn up.

**4. Health Services** inclusive of supply chain of medication, technological needs must be addressed regularly with appropriate funding allocation. (The process of taking health care to the periphery and the people is important.) Community ownership, in alignment with traditional and cultural variables is needed. The interphase with the community / individuals and their healthcare providers must be addressed with a decentralized approach. Stress management must be spread to sub-divisional level effectively in the NMHSPP 2016-2020 phase.

**5. Health Financing** for mental health services needs a major cost / benefits analysis, as Mental ill-health is projected to develop into a leading Non Communicable Diseases by 2030. Inclusive of developing a Center of Excellence, a new infrastructure for training, research and clinical practice devoid of the St Giles stigmata recommended.

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## SOCIAL DISTANCING, QUARANTINE and ISOLATION, in COVID-19 TIMES

### Introduction.

The response to pandemic COVID-19 has seen the mobilization of various social isolation strategies to provide containment from an invisible, new warrior.

Whilst global healthcare systems struggle to contain spread, these restrictive public health measures are themselves creating additional stress and distress to individuals and society generally. Undoubtedly isolation benefits containment effort and reduces spread of the virus but we face a catch-22 situation. Medical complications to social distancing, self-isolation, enforced quarantine measures, and locked-downs add important variables to psychological and health stressors, to an increasing number of individuals and communities, globally and are largely unaddressed (1,2).

This paper outlines important health issues related to pandemic isolation strategies currently in play. These health issues are reported as wide ranging, substantial and long lasting (3). The health impact is not only confined to the physical but mental, emotional and spiritual well being of those impacted by these measures of social distancing, self or mandatory quarantines. We discuss salient health, social and gender connotations as it impacts on society in the short- and long-term vulnerable groups inclusive of children, women, aged and the disabled.

### The socially Interactive Humanity.

Most humans by nature are socially interactive and this remains vital to their health and wellbeing. Enforced social isolation under pandemic circumstances has its down side and the ensuring signs and symptoms of loneliness are under-appreciated public health risks(4).

With SARS 2-Corona Virus 2019, the COVID19 pandemic has created a state of uncertainty, confusion and great pain at all levels of the global communities. There are many variables unaccounted for and the science is in catchup phase.

## **The Health impacts of Social distancing, quarantines and isolation measures:**

Without question, poorly structured planning and without adequate free flow of information in isolation and quarantines the circumstances can be problematic for both the enforcers and the quarantined. Such was the case when a kissing couple on the Suva foreshore were charged for failure to distance socially. Without clear guidelines on procedures and processes, individuals are prone to negative feelings, emotional unrest, lost routines and financial concerns and in the above-mentioned case legal action. Resulting anxiety manifests as confusion, anger, low mood, irritability, insomnia and if prolonged leads to depression with potentials of self-harm as documented in the Ebola pandemics in the recent past (2). In the longer term, such individuals exhibit avoidance behaviours in large crowds and paranoia to hand washing and difficult socialization skills. Some positive measures in the isolation phase can assist in reducing these potentially lethal longer-term behavior changes.

## **Establishing a new pattern to daily existence.**

- Essentials of daily routines must be encouraged, avoiding emotional despair, boredom and personal frustration.
- Time spent on daily exercise routines such as walks and body conditioning is mandatory. A sense of physical health impacts on the sequela of emotional, spiritual and mental wellbeing. The “happy hormones” from the brain creates positivity in the self. Meditation and Breathing exercise carry great weight in the lives of individuals whether of religious or non-denomination origins are good examples of such.
- Revisiting old hobbies (music, arts, gardening) can be reviewed as the learning curve to these remain relatively flat. Acquiring new skills in this computerized, digital world can be challenges learnt for procuring entertainment, knowledge and study. Online exposure does require some skills up-building but it's never late to learn with discounted rates on offer. Some

online study keeps the mind active and pushes dementia further away.

- How about some learning some cooking skills or taking up backyard gardening? That does not need computers and internet or WIFI access.

## **Social Issues – Vulnerable Children**

The vulnerability of children in this period is poorly researched. Structured daily routines are paramount especially on young minds lying idle without the formal school environment of being taught, learning and interacting with their peers and friends in the classroom and sporting areas.

The commendable efforts of Fiji parents and the Ministry of Education (MOE) is acknowledged to maintain sanity in the home environment. Structured “Home Schooling” is important on a daily basis akin to the school patterns with intermittent breaks. Some monitoring of teaching and learning skills by both children and their new found home-school teachers is almost mandatory to acknowledge lessons learnt are in fact meaningfully achieved. The prompt assistance by the MOE in on-lining programs and subsequently getting the schools to draw up their teaching and learning schedules, surely is worthy of rosy achievement.

Intermittently allowing children, play time and organized family oriented physical activities strengthens some of those currently loosening bonds Experiences from the 20th Century of rearing our millennials than by the baby boomers became problematic with the focus on materialism. This will now pan out on the millennial parents if they do not take heed. The pandemic is well positioned to make amends. Those strong familial bonds are the strengths in society which matter: pandemic or no pandemic. Cherish and grow them with love and empathy. The social and gender issues interphase in the area of how society cherishes the girl child and womankind.

## **Women and the Pandemic.**

There has been an accelerated application for divorce proceedings in China after the COVID19 outbreak – lockdowns.



Women have been the target of domestic violence in most States but we in the Pacific resolve our stress and tension in physical ways. Domestic Violence is on increase in COVID 19 times. Fijian data is very disturbing. No longer just an increase in reporting but the degree and increase of violence is stunning and shameful (4). Husbands / partners no longer financially stable resort to domestic violence when confronted for their inappropriate coping strategies such as drinking grog and not sustaining the financial pressures of daily living. Perpetrators can use the existing restrictive measures to express gender inequality through increased violence against women and girls. Emerging global data reveal that with the emergence of the COVID-19 pandemic, the violence against women and girls (VAWG) and particularly domestic violence has intensified (5). The female has the difficult task of managing the children, the household and manage the restricted food budget and even work outside the domestic confines. Voicing her concerns, she ends up as a punching bag for her distraught male companion or husband. Post pandemic the societal issues could worsen with high divorce rates, single parenthood and fragmentation of family units.

## COVID19 – impact on the Aged

Social measures to contain COVID-19 additionally impacts by worsening the loneliness of the aged, globally. Compounded with immunes challenged medical conditions of non-communicable disease (Hypertension, Heart diseases, diabetes, respiratory illnesses and cancer.) Their morbidity and mortality remain high in many state jurisdictions, take UK as an example for that matter. Compounded with low socio-economic ranking, minority races and ethnicities, one cannot help noticing the social inequities the 20th Century with its fiscal dominated agenda leading millions prone and susceptible to the new microscopic warrior. Even in the most developed countries look at USA, Colored and Hispanics are greatly affected compared to white Americans.

What will transpire in the develop world is in a conjectural

stage.

## The Disabled/Challenged face greater Health Threats.

Poor communication ability of the disabled/ challenged or with miscommunication the abled-body fails to comprehend the needs and wants of their disabled brethren would result in compounding stress to this significant component in society. That voice of the disabled has not been heard so far. Is it muffled, lost in bureaucracy?

The special and specific health needs during this pandemic of disabled/challenged needs to be identified, tabled and the onus would be to interweave their specific needs into the mainstream, akin to normal times. Much work needs to start in this area soon globally and in the sovereign states of the affected world. There has been very little research in this area so far and one needs to address the needs of all parties in the community and ideally not leave the disabled behind.

## Reality Check.

As we possibly exist from the first wave of the COVID 19 there are some important pointers on our moral compass, guiding us into the future.

1. There have been many pandemics in the last 250 years and all have invariably been followed by devastating second and third waves with greater human calamity. The improved documentation since the Spanish influenza (102 years ago), we are experiencing the 8th pandemic and that each has had a second wave, with high mortality and mortality on all counts, worse than the first. We don't need Nostradamus to spell that out.
2. The question of masks and gloves remain and the fashion changes. For what its worth stays within the established guidelines. Oop, recent research suggests aerosol droplets travel up to 3metres and that should be the distancing separation? Oh!

3. In different jurisdictions different population groups are affected: We note the disproportionately high rates in the aged in UK retirement homes. The socially disadvantaged, people of color and minorities in USA. The millennials having stroke events post COVID19 in USA and now more recently “Kawasaki Syndrome” in American children. The jigsaw puzzle remains to unfold its true picture.

4. The talk of the pandemic going “endemic” is also being raised. With the seasons changing we may seem to be doomed with no vaccine in sight. That will be another matter as the virus family can mutate and how humanity learns to mitigate is another unanswered question. Will vaccines be available in the developing world and at what cost are difficult questions to answer just yet.

## In the current Country specific Exit Strategy.

The public health issues remain paramount today although economic restructuring needs planning invariably. “Go slow” is the mantra. Phased and structured re-opening based on “need not wants” is essential. Serious thoughts to keep focused in addressing public health needs cannot be given second place to resurrecting the economy. Porous borders do not help long term. Freight flights continue to bring in human cargo who have outlived their visitor status abroad and help sustain revenue to our national airlines. A moot point indeed. Pre-planned measures inclusive of distancing, quarantining and isolation strategy must be thought out planned and executed efficiently for the next wave: COVID 20. Reducing the quarantine phase “stress” in isolation which can be emotionally substantial and long term must be given greater thought. Where are our counsellors and psychiatrists? The Fijian general practitioners are good listeners but not engaged in our healthcare rapid review of the evidence, unfortunately. On a brighter note, give some thoughts to how humanity will choose to travel in future. This is still conjectural theory.

I had hoped for a Sea Cruise someday but have some second thoughts now. Hopefully the Environmental manmade disaster “Climate change, global pollution may demonstrate reversals as humanity pauses, takes on new directions from its previous materialistic course. Thank you: SARS 2-Corona Virus for leading the path, as much as it pains. A new world order will evolve. Will the world see another hegemon?

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## **General Practitioners and their Approach to Mental health impact of Covid 19**

The role of family physician or General Practitioners is immensely important in a population affected by coronavirus disease (COVID-19) and at risk of mental health problems. Limited availability of mental health service in the country further highlights their roles in combating mental health impact of this pandemic (1).

Increased vulnerability of affected community could be the result of the high level of stress and multiple challenges in controlling infection outbreak. During a pandemic, accessing mental health services may be difficult due to multiple reasons like travel restriction imposed by authorities, the limited number of the psychiatrist and their availability. A century ago, GPs had to deal with the psychological impact of a pandemic, as mental health specialists were not available and psychiatry as a medical speciality was not established. It is yet to establish a suitable approach for primary care psychiatry in an outbreak like COVID-19 [2]. Understanding of epidemiology of psychiatry disorder can help to plan better strategies to manage mental health issues during a crisis like COVID-19 [3]. Considering the role of cultural factors and their proximity to the community, GPs can play a significant role in addressing psychological problems due to COVID-19 [4].

### **Normal Stress**

We respond to stress in different ways using the various coping mechanism. People affected by pandemic can develop a variety of psychological disturbances in the form of anxiety, panic attacks, and depressive symptoms. Most of the time these symptoms are intermittent and less severe and does not meet the criteria for a syndromic diagnosis, hence it is important for GPs to avoid over-diagnosing psychiatric disorder among these individuals. A certain level of stress required for optimum functioning is known as 'Eustress'. Therefore, it is important to differentiate 'Eustress' from distress (which im-

pairs functioning). Every individual exhibiting the symptoms of stress does not require pharmacological treatment as it could be a part of an adaptation process, not a psychiatric disorder [5]. Unless there is significant interference in any aspect of biopsychosocial functioning, stress responses can be managed with reassurance and monitoring by the GP, such individuals can be managed at primary care level without the need of psychotropic medications or referral to a psychiatrist.

### **Psychological Symptoms, not Disorder**

A recent review of mental health and COVID-19 has inferred from limited studies conducted in only a few countries affected by COVID-19 that 16–28% people showed the symptoms of depression and anxiety [6]. However, it is not known what proportion of the patients have a disorder, not just symptoms and requires professional help. Therefore, it very common for GPs during the current pandemic to see patient with psychological symptoms which do not meet the criterion for a psychiatric disorder in terms of either intensity or frequency or duration or degree of impairment. For example, panic disorder is classified in 'Neurotic, stress-related and somatoform disorders' according to International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) [7]. Panic attacks may occur during a stressful period like COVID-19 outbreak however it is not a psychiatric disorder [8] [9]. The patient can be managed with reassurance and relaxation exercises unless such anxiety attacks are frequent and disabling. In some cases, low dose benzodiazepines can be prescribed 'as on required' basis for a short duration with clear instruction in the prescription for maximum no of tablets to be dispensed from the pharmacy[10]. This approach will decrease the risk of accidental overdose and suicide.

### **New Psychiatric Disorder**

Primary physician should consider the possibility of psychiatric disorder if psychological symptoms are either frequent



or persistent and causing significant distress or impairment in functioning. Psychiatric disorders are known for their chronicity, but there are exceptions like acute stress reaction (ASR), adjustment disorder and acute transient psychotic disorder. These disorders are short-lasting and self-remitting in nature. GPs need to be aware of the dramatic and diverse variety of symptoms of ASR as it can lead to the false impression of other major psychiatric disorder. [11]

Acute stress disorder develops in response to stress either physical or psychological in nature and exceptional in severity. Restrictive measures (like lockdown and quarantine) and its consequences (like huge economic loss or sudden death of family member) can cause an ASR. It is characterised by a variety of symptoms like feeling dazed, withdrawal from surrounding, agitation and autonomic changes (like palpitation, sweating, flushing). Although very distressing to both patient and family member, an episode of ASR resolves quickly, mostly within 48–72hrs therefore, ASR can be easily managed at the primary care level with supportive care and short term of use of benzodiazepines [12,13].

The patients suffering from medical disorders are vulnerable to psychiatric disorders. Diabetes and thyroid dysfunctions are well-known risk factors for depression [14]. It may be difficult for a GP to diagnose depression in such patients given the overlapping symptoms like tiredness, change in appetite and difficulty in concentration. Hospital Anxiety and Depression Scale (HADS) and Patient Health Questionnaire (PHQ-9) have been found particularly useful for general practitioners to detect depression [15]. Altered eating habits and physical activity during a pandemic can cause worsening of previously controlled medical disorders. Therefore, it is worth to distinguish worsening of medical illness from depression by relevant investigations like thyroid profile and blood sugar level. Although both Selective serotonin reuptake inhibitors (SSRIs)

and tricyclic antidepressants (TCAs) are effective for the treatment of depression with co-morbid medical illness, SSRIs are preferred because of side effects profile [16]. GP should be aware that antidepressants may take at least 2–4 weeks to act, therefore they should inform and educate patient accordingly. If required, benzodiazepines can be tried for a short duration to cover the initial period to allay their anxiety [17].

Substance use disorder may pose a great challenge during a pandemic due to increased chance of withdrawal symptoms because of reduced availability of substance in quarantine and lockdown period. Alcohol withdrawal syndrome can be managed by use of benzodiazepines preferably lorazepam because of its relative safety in hepatic impairment. [18,20]. It is needless to say that thiamine supplementation should be on priority to prevent Wernicke–Korsakoff syndrome. Patients with opioid withdrawal symptoms can be treated with either buprenorphine or methadone if available [19]. As accessibility to de-addiction service is difficult, symptomatic treatment of opioid withdrawal symptoms should be the primary target [21].

### Psychopharmacology at Primary Care Level

GPs should be cautious of possible drug interactions of psychotropic with other medication commonly used at primary care level like analgesics, antibiotics and antihistamines.

Antidepressant of choice should be SSRI, preferably those having simpler dosing regimen like fluoxetine. TCA should be avoided in patient with benign prostatic hyperplasia, ischaemic heart disease, glaucoma and constipation. It is worth informing the patient about worsening of anxiety and irritability may occur in the first week of treatment. Antipsychotic medications can be used as an antimanic agent but the use of mood stabilisers should be deferred as it requires frequent blood investigations and monitoring.

Benzodiazepines can be used for management of irritability and agitation. They should be started at a low dose and given for a short period. Among anti-obsessional drugs, fluoxetine is easy to use and has less potential for withdrawal symptoms in case the patient is facing difficulty in accessing pharmacy during a pandemic or placed in remote areas.

GPs may encounter problems using psychotropics in a certain group of people (children, elderly, pregnant woman and lactating mother). A very few psychotropics are approved to use in the paediatric age group. The general practitioner should avoid prescribing psychotropics for children and should seek advice from a psychiatrist through telemedicine to decide on urgent intervention required. Elderly people are sensitive to the side effects of psychotropics and take a longer time to respond [23]. Hence their use should be guided by the principle of 'start low, go slow'. GP should avoid starting psychotropic particularly mood stabiliser in a pregnant woman as they involve the risk of teratogenicity and developmental abnormality in their children. [25] There are few drugs approved for the treatment of postpartum psychiatric disorders because of the risk of exposure to baby via breast milk [24]. GP should refer these cases to the secondary or tertiary centre as they require careful consideration of risk and benefits of psychotropic medication for both baby and mother by the multidisciplinary team. In emergency cases, Olanzapine can be tried to treat severe cases of postpartum depression and psychosis [26].

### Conclusion.

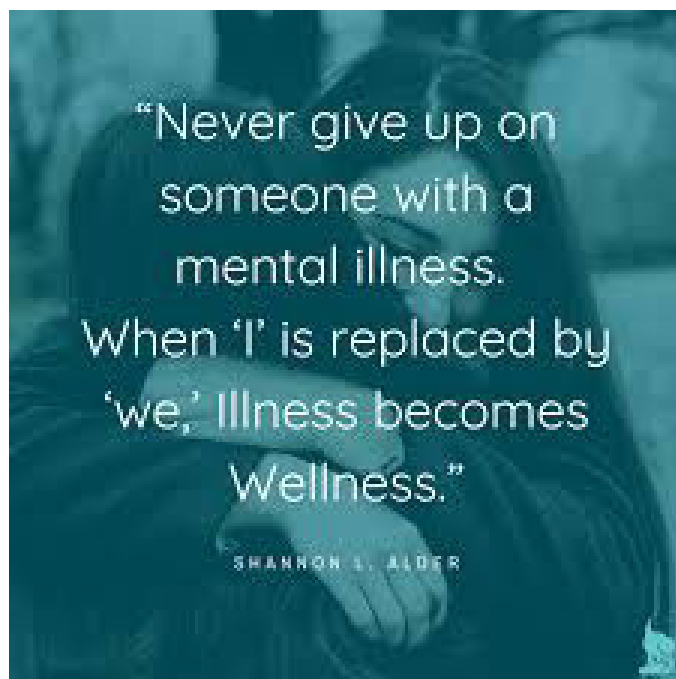
Because of various measures taken to control a pandemic like quarantine and lockdown, a large number of people are at risk of psychological disorder. Considering the limited mental health services available in the country and their restricted access to the community during COVID-19 pandemic, General Practitioners are required to deal with psychological problems along with medical illness. It is not just desirable but a

must for GPs to be both aware and skilled to address common mental health issues arising in infection outbreak situation like COVID-19. Most mental health issues arising in this crisis can be handled by GPs in the community both independently and in some cases, through assistance with mental health specialists. Recent evidence suggests that telemedicine can play an important role and has been proven both effective and acceptable for both primary health care professional and community affected by the current pandemic[27]. It is essential to accommodate the knowledge of basic psychopharmacology and use of essential psychotropic at undergraduate level so that family physician can confidently use psychotropic at primary care level. Therefore, GPs can reduce both mental health burden of the community and reliance on psychiatrist and therefore abridging the existing treatment gap. Both quantitative and qualitative studies exploring epidemiology of psychological disorder in a pandemic situation may help in planning an appropriate strategy to handle mental health issues in case a similar situation arises in future.



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# JOKES

Funny one-liners, exactly as typed by medical secretaries:

- Patient has left her white blood cells at another hospital.
- Patient has chest pain if she lies on her left side for over a year.
- On the second day the knee was better and on the third day it disappeared.
- The patient has been depressed since she began seeing me in 1993.
- Discharge status: Alive, but without my permission.
- Patient had waffles for breakfast and anorexia for lunch.
- While in ER, Eva was examined, x-rated and sent home.
- Skin: somewhat pale, but present.

- Patient has two teenage children, but no other abnormalities.
- The patient was in his usual state of good health until his airplane ran out of fuel and crashed.
- Mrs. Evans slipped on the ice and apparently her legs went in separate directions in early December.
- Patient was seen in consultation by Dr. Jones, who felt we should sit on the abdomen and I agree.
- The patient refused autopsy.
- The patient has no previous history of suicides.
- She is numb from her toes down.
- She stated that she had been constipated for most of her life until she got a divorce.

A non habit forming calming formula to bring the balance in life



For : stress, anxiety, mild depression, insomnia, mood swings and emotional instability



KEY INGREDIENT	PURPOSE
Avena Sativa	Has a soothing effect on the nervous system, helps increase in attention span, improved mental performance
Brahmi	Helps reduce stress and anxiety by elevating your mood and reducing levels of cortisol, a hormone that is closely linked to stress levels
Chamomilla	Helps in sleeping and relaxes the body
Ignatia	Has the ability to reduce nervousness and help in reducing insomnia
Passiflora	Helps in reducing stress and anxiety. Helps in correcting sleep disorders
Valeriana	Helps in reducing sleep disorders and psychological stress

Piracetam has a long history of many beneficial effects on cognition & mental health and Piracetam is still searching for newer indications in which it can be used.

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## Piracetam is effective in regaining cognitive functions

The efficacy of Piracetam in the treatment of the consequences of moderate and severe closed traumatic brain injury was assessed in 42 patients (age: 12-18 years) who suffered from traumatic disorders.

20 patients received Piracetam in dosage of 40-50 mg/kg (or 1600-2400 mg daily) for one month.

22 patients of the second group were examined as controls.

Positive therapeutic effects of Piracetam on cognitive (memory, attention) functions and motor (coordination) functions as well as the speed of cognitive and motor performances were found.

**Neurolep<sup>®</sup>** helps in regaining cognitive function after **Traumatic Brain Injury**





## DERMATOLOGY QUIZ



37 yr old Indian Lady presented with a few days history of pruritic rashes as shown  
What is your diagnosis and treatment and differential diagnosis ?

Email the answer to [rraju@connect.com.fj](mailto:rraju@connect.com.fj)  
All correct responses go into a draw for a FJD 200 prize money

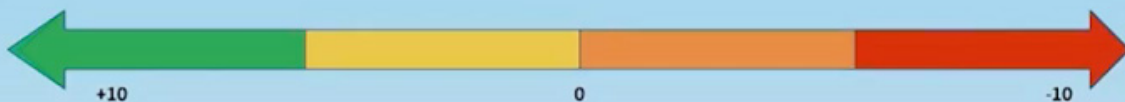
## LAUGHTER



I'M NOT RIGHT IN THE HEAD.COM

Mental Wellness

Mental Illness



Meaningful Life

Grateful

Contented

Other-centered



Engaged Life

Busy

Distracted

Involved



Pleasurable Life

Pleasure seeking

Preoccupied

Unsatisfied



Struggling  
Self-focused  
Negative

