MedCrave
Step into the World of Research

Journal of Psychology and Clinical Psychiatry

Case Report

Open Access

CrossMark

Mental health and youth of kashmir

Volume 7 Issue 3 - 2017

Sayed Aqeel,[1] Mohammad Muzaffar Khan,[2] Shekhar Saxena,[3] Saleem ur Rehman[4]

[1]Consultant Psychiatrist Lincolnshire partnership NHS Foundation Trust, UK

[2]Consultant Psychologist and Director Police Deaddiction services Kashmir, India

[3]Director WHO Mental health and Substance Abuse

[4]Director Health Services Kashmir, India

Correspondence: Sayed Aqeel, Consultant Psychiatrist Lincolnshire partnership NHS Foundation Trust, UK, Email aqeelhussain1972@gmail.com

Received: February 10, 2017 | **Published:** February 17, 2017

Case report

This report is being written in the context of current political turmoil in Kashmir and the impact it had on the mental health of the Youth of Kashmir. To begin with let us define what Mental health means.

According to WHO Mental health is a state of well being in which an individual realizes his or her own abilities, can cope with the normal stresses of life , can work productively and is able to make contribution to his or her community. In this positive sense mental health is the foundation for individual well being and the effective functioning of a community.

It becomes a disability if it has long term effect on normal day to day activity which is something an individual does regularly in a normal day.

A person whose state of mental health as defined above is disturbed needs help to restore the equilibrium which can be achieved by help from family , friends or professional help.

Before explaining the role of professionals it is important to evaluate the services available in the field of mental health.

According to WHO only 1% of the global workforce works in mental health and the median public expenditure on mental health per person is 2$ in low and middle income countries compared to 50$ in High income countries.

Similarly there are only 5 mental health beds per 100,000 population in low and middle income countries compared to 50 mental health beds per 100,000 population.

Only 2/3 WHO Member states have a stand alone policy or plan for mental health and only ½ WHO Member states have a stand alone MENTAL HEALTH LAW. However these policies are often not fully in line with international human rights covenants and implementation is weak.

In view of the scarcity of resources in our settings it is important that much work needs to be done in the field of promotion and prevention.

WHO has recommended various programme in the field of promotion and prevention and which we need to adopt and work on in our settings which includes mental health awareness/anti stigma campaign, maternal mental health promotion, school based mental health promotion, parental/family mental health promotion, violence prevention (women, child abuse), workplace mental health promotion and suicide prevention.

In order to improve service delivery in the field of mental health WHO in 2013 launched the comprehensive Mental Health Action plan 2013-2020 with four main objectives of Strengthening leadership and governance for mental health. Providing comprehensive mental health and social care services in community settings. Implementing strategies to promote and prevent mental health. Strengthening information systems, evidence and research.

We need to work on all four objectives in our state as well if we want to improve service delivery in the mental health field for our population suffering from political turmoil for the past two decades which had significant impact on the mental health of our population especially our youth who have lived and grown in the environment of turmoil.

The action plan relies on six cross cutting principles and approaches

1. Universal health coverages…. Regardless of age, sex, socioeconomic status, race ,ethnicity or sexual orientation and following the principle of equity persons with mental disorders should be able to access without the risk of improverishing themselves, essential health and social services that enable them to achieve recovery and the highest attainable standard of health.

2. Human Rights… Mental health strategies, actions and interventions for treatment , prevention and promotion must be compliant with the Convention of the Rights of Persons with Disabilities and other international and regional human rights instruments.

3. Evidence based practice. Mental Health strategies and interventions for treatment, prevention and promotion need to be based on scientific evidence and best practice taking cultural considerations into account.

4. Life course approach. Policies plans and services for mental health need to take account of health and social needs at all stages of the life course, including infancy, childhood, adolescence, adulthood and older age.

5. Multisectoral approach. A comprehensive and coordinated response for mental health requires partnership with multiple public sectors such as health, education, employment, judicial, housing, social and other relevant sectors as well as the private sector as appropriate to the country situation

6. Empowerment of persons with mental disorders and psychosocial disabilities. Persons with mental disorders and psychosocial disabilities should e empowered and involved in mental health advocacy, policy, planning, legislation, service provision, monitoring, research and evaluation.

Following the launch of action plan all International Collaborative partners were invited to the mhGAP forum in Geneva to share their expertise and submit recommendations in order to successfully implement the Global Mental Health Action Plan and I had the opportunity to attend the forum at the invitation of WHO Director Mental Health Dr Shekhar Saxena.

Following the recommendation it was agreed that more stress should be laid on improving mental health rather than focussing specifically on mental disorders.

Spirituality should be considered as an important dimension in the concept of recovery

Emphasis was laid on transcultural issues e.g recognition of depression and potential value of other cultural models.

With regards to the above principles and recommendations the major limitations in service provision in our state included.

Treatment Gap in universal access to mental health services

Gaps are even larger with regard to preventive, promotive mental health program as well as rehabilitation services.

We are too slow in realizing the basic human rights of people with mental illness.

At the government level their was poor inter ministerial coordination. Rehabilitation is the responsibility of Ministry of Social Justice and Empowerment where as Mental health is the responsibility of MOHFW.

Many persons with mental illness, especially those with chronic mental illness require a combination of medical treatment and rehabilitation to facilitate recovery. This will be Applicable to Those Who Have Suffered Permanent Injuries during Current Political Turmoil.

The lack of seamless provision of health and rehabilitation services can be partly attributed to this separation of responsibilities towards health and rehabilitation and the lack of intersectoral coordination in the delivery of these services.

Poor inter departmental coordination at the state level.

Department of psychiatry in GMC comes under the Directorate of Medical Education and the Primary Health Centres are under the Directorate of Health Services.

The lack of effective coordination between these two directorates impacts negatively on developing and implementing mental health services in the community.

The below data highlights the need for effective and improved delivery of services in the field of mental health.

Data with regards to number of patients treated in the Government Psychiatry Disease Hospital revealed that in 1985 only few thousand people visited Government Psychiatry Disease Hospital where as in 2012 the number had increased to more than one lakh highlighting the need to reduce the workload and establish effective mental health services in the community.

Similarly data from the survey done on participants of mhGAP which included professionals from various fields including doctors, nurses, psychologists, teachers, social workers, police personals, lawyers and other professionals reported that in the past one month majority of the cases of mental health they had contact with were new patients and majority were having symptoms suggestive of depression and anxiety.

Similarly during the three month monitoring and evaluation phase of mhGAP in District Ganderbal more than 80 percent patients with mental illness were having symptoms suggestive of depression followed by PTSD.

The patients were identified by both BUMS and Allopathic doctors and were successfully treated, provided counselling or referred to psychiatrist or secondary care services highlighting the effectiveness of community training under mhGAP.

Similarly the results of the survey conducted by MSF in 2015 the results of which were presented by me both at mhGAP Forum in Geneva in the WHO assembly as well at International Humantarian Congress in Berlin co-hosted by MSF Germany and Red Cross Germany at the request of MSF Kashmir division showed that from 5600 households selected from more than 400 villages in 10 districts 1.8 million adults (45% of the adult population) are experiencing symptoms of mental distress with 41% exhibiting symptoms of probable depression 26% probable anxiety and 19% probable PTSD.

The study also revealed that those with lower education outcome were more likely to have mental distress and individuals with secondary and tertiary education were shown to have significant decreased risk of showing signs of mental distress.

The results indicated that on average an adult in the Kashmir valley has witnessed or experienced 7.7 traumatic events during his/her lifetime. Exposure to multiple traumatic events was positively associated with all three mental disorders. There was a dose response relationship between traumatic events experienced or witnessed and the development of symptoms of depression anxiety and PTSD. There was an upward trend in the proportion of all three disorders in districts reporting greater number of traumatic events in the population.

The most reported problems of daily life faced by adults living in the valley were financial issues, poor health and unemployment.

The main coping strategies adopted by Kashmiri adults were praying, talking to family member of friend and keeping busy.

In view of the significant treatment gap between service need and service delivery majority of the population sought help both from faith healers and professionals.

As recommended by WHO about the importance of spirituality as an important dimension of recovery as well as the recommendation by Professor Sue Bailey ex president of the Royal College of Psychiatrists London to engage faith healers in service delivery during my meeting with her to get approval for the mhGAP project there is clear evidence that faith healers can and play a significant part in providing support and informal counselling in significant number of patients with mental health problems but at the same time there is need for them to recognise that more severe cases need active psychiatric intervention in addition to the support provided by the faith healers.

There is need for professionals and faith healers to work in collaboration rather competing with each other in providing services to the vast majority of people suffering from mental illness in the valley.

Majority of the population did not understand the western concept of structured counselling and relied mostly on biomedical model for treatment of mental illness. The evidence for the bio medical model was corroborated by the fact that 11% of Kashmiri adults were taking benzodiazepines. The report highlighted people's desire for decentralisation as well as need for improved employment opportunities and business and skill development as necessary for improved mental health.

Following the survey a meeting was coordinated by MSF which was chaired by Principal Medical College Srinagar and was attended by experts and representatives of Psychiatry Disease hospital, Department of Psychology University of Kashmir, department of sociology university of Kashmir, police deaddiction services and state coordinator of the mhGAP team.

The expert panel stressed the need and importance of decentralisation, training of people at grass root level in the community and the necessity of establishing a crisis team in all districts of Kashmir. The panel also stressed the importance of research especially in areas related to suicide and child and adolescent mental health and the need to work on improving prevention and promotion strategies with regards to mental health.

The need for crisis team in all districts of Kashmir was also highlighted during my meeting with Director Health services Kashmir Dr Saleem ur Rehman. As part of MOU signed between the Royal college of Psychiatrists London and Health and Medical Education Department of Jammu and Kashmir to improve mental health services in Kashmir a project proposal was submitted by me to Royal College of Psychiatrists London and WHO which was accepted both by the Royal College of Psychiatrists London and WHO Geneva .The project proposal was discussed by me in the mhGAP forum at WHO assembly in Geneva.

The project proposal highlighted the need to train the psychiatrists as trainers for establishing crisis team in the community which will be followed by invitation to psychiatric trainers to UK where they will have an opportunity to get an insight into working of the crisis team in UK as well interact with team members which will help in establishing effective crisis team in various districts of the valley.

The aim of the team will be early identification of patients in crisis, provide treatment and support , refer to tertiary care where needed ,follow up suicide attempt cases for support and treatment and contribute data towards the research.

The team will be led by psychiatrist where available in each district of Kashmir. It is worth mentioning that I am responsible for leading the crisis and community team in Lincolnshire Partnership NHS foundation Trust in UK.

The project proposal is awaiting go ahead both from the Govt Psychiatric disease hospital and Directorate of Health Services Kashmir and will contribute significantly to providing support to those at risk of suicide or those who had attempted suicide. mhGAP Trainers from Royal College of Psychiatrists London in House Boat in 2014 and looking forward to invitation from Kashmir for establishing CRISIS TEAM as part of Memorandum of Understanding.

Feed back by trainers

Thanks to the vision and excellent organizing skills of Dr. Aqeel and Dr Muzaffar this was a truly extraordinary and intense learning experience for both the participants as well as the trainers. The mhGAP training is well designed, easy to teach and learn from and very applicable. As one participant commented for her the course has been an "eye-opener" and I think the same can be said for some of the European trainers. Becoming aware how much can be done with little means and how much need and enthusiasm exists here to improve the lives of those with mental illness was at times a humbling experience. Thank You!"

Enormous efforts had gone into [this mhGAP initiative in Kashmir], this I know for sure, as I am trying to setup 2 mhGap trainings in India, without much success so far"-Dr Mina Bobdey, a mhGAP Trainer in Kashmir1

The WHO launched its first suicide report in the WHO assembly in 2015 and all the international collaboraters were invited to attend the WHO assembly and I also had an opportunity to be invited discuss and review the findings of the WHO suicide report.

With regards to Suicide in May 2013, the sixty sixth World Health Assembly dopted the first ever Mental Health Action Plan of the WHO. Suicide prevention was an integral part of the plan with the goal of reducing the suicide in countries by 10% by 2020.

There is no single explaination of why people die by suicide. However many suicides happen impulsively and in such circumstances, easy access to a means of suicide –such as pesticides or firearms-can make the difference as to whether a person lives or dies.

Social, psychological, cultural and other factors can interact to lead a person to suicidal behaviour, but the stigma attached to mental disorders and suicide means that many people are unable to seek help. Despite the evidence that many deaths are preventable suicide is too often a low priority for government and policy holders.

We should all aim at prioritizing suicide prevention on the global public health and public policy agendas and to raise awareness of suicide as a public health issue.

With regards to WHO data on suicide an estimated 800,000 suicide deaths occurred worldwide in 2012 representing an annual global age standardized suicide rate of 11.4 per 100,000 population (15 for males and 8 for females). However since suicide is a sensitive issue and even illegal in some countries.it is very likely that it is under reported. In countries with good vital registration data, suicide may often be misclassified as an accident or another cause of death. Registering a suicide is a complicated procedure involving several different authorities often including law enforcement and in countries without reliable registration of deaths, suicides simply die uncounted.

In richer countries three times as many men die of suicide than women do, but in low and middle income countries the male female ratio is much lower at 1.5 men to women. Globally suicides account for 50%of all violent deaths in men and 71% in women. With regards

to age suicide rates are highest in persons aged 70 years or over for both men and women in almost all regions of the world. In some countries suicide rate is highest among the young and globally suicide is the second leading cause of death in 15-29year old. The ingestion of pesticide, hanging and firearms are among the most common methods of suicide globally, but many other methods are used with the choice of method often varying according to population group.

For every suicide there are many more people who attempt suicide every year. Significantly a prior suicide attempt is the most important risk factor for suicide in general population. For both suicide and suicide attempts improved availability and quality of data from vital registration, hospital based systems and surveys are required for effective suicide prevention.

Restricting access to the means of suicide is a key element of suicide prevention methods.

With regards to data from india

More than one lakh lives are lost every year due to suicide, the suicide rate has increased from 7.9 to 10.3 per 100000. There is a wide variation across the country with southern states of kerala, Karnataka, Tamil Nadu have a suicide rate of >15 while the northern states of Punjab, bihar and j and k the suicide rate is around 3 per 100000.This variable has been stable for the past 20years. No reliable study has been done to estimate the impact of political turmoil on the suicide rates in Kashmir which is all the more important for formulating effective preventive and treatment strategies.

The majority of suicides (37.8%) in India were by those below the age of 30years. The fact that 71% of suicides in Inida are by persons below the age of 44years imposes a huge social, emotional and economical burden on the society. The near equal suicide rates in young men and women denote that more Indian women die of suicide than their western counterpart. Poisoning 36.6%, hanging 32.1% and self immolation (7.9%) were the common methods used to commit suicide. Two large epidemiological verbal autopsy studies in rural Tamil nadu reveal that the annual suicide rate is six to nine times the official rate. If these figures are extrapolated it suggests that there are at least half a million suicide in India every year. It is estimated that one in 60 person in our country are affected by suicide. It includes both those who have attempted suicide and those who have been affected by the suicide of a close family or friend. Thus suicide is a major public and mental health problem which demands urgent action.

Although suicide is deeply personal and individual act, suicidal behaviour is determined by a number of individual and social factors .Ever since Esquirol wrote “all those who committed suicide are insane” and Durkheim proposed that suicide was an outcome of social/societal situations the debate of individual vulnerability versus social stressors in the causation of suicide has divided our thoughts on suicide. Suicide is best understood as a multidimensional, multifactorial malaise. Suicide is perceived as a social problem in our country and hence mental disorder is given equal conceptual status with family conflicts, social maladjustmenst etc. According to the official data the reason for suicide is not known in about 43% of suicides while illness and family problems contribute to about 44% of suicides.

Mental disorder occupy a premier positon in the matrix of causation of suicide. Majority of studies note that around 90% of those who die by suicide have a mental disorder. The number of published reports specifically studying the psychiatric diagnosis of people who die by suicide has been relatively small. The majority (82.2%) of such reports come from Europe and North America with a mere 1.3% from developing countries.

In a presentation at the Humantarian congress in Berlin which I attended data by WHO was shown which showed that no reliable data is available from J and K compared to rest of India which makes it more important to conduct reliable studies on suicide in our state.

In one study conducted by department of sociology university of Kashmir showed that only 48% percent showed signs of depression before committing suicide compared to 52% who did not.

Similarly only 9% had signs of mental illness compared to 91% who did not shows that other factors besides mental illness contributed to the cause of suicide.

Similarly 21% had drug related problems compared to 69% who did not showing that there was not significant correlation between drug misuse and suicide in Kashmir.

In order to formulate strategies to deal with the suicide in our valley an one day interactive session was held on world suicide prevention day in 2015 which was organised by Dr Mohammad Muzaffar Khan with support from Help foundation.

The session was attended by NGOs like Unicef, Action Aid, CRDP, Borderless world foundation, HPVT, Drud deaddiction centre, SOS children childline 1098 besides advocates, myself as consultant psychiatrist, Media personal and Religious scholars.

The forum made the following recommendation.

To put efforts in drafting an authentic research base in order to carry out studies and intervention in the same area.

To promote advocacy for suicide prevention with Govt bodies particular police department at par with the standards set by International community.

Building up strong network with Mental Health institutions to deal with the issue of suicide and its cause and effect relationship at individual and institution level.

Implement the modalities and strategies at the basic school level.

Incorporation of the various life skills at elementary level to supplement the prevention strategies regarding suicide.

Ensure the follow up of suicidal attempted cases after being reported and dealt with the relevant medical intervention.

Considering and revisiting the legal aspects of suicide and its implications.

Sensitizing the communities and civil society to deal with the issue of suicide at the grass root level.

Another important strategy needed to reduce impulsive suicides and use of pesticides was presented by Dr Vijay Lakshmi in the WHO assembly on the launch of first suicide report.

Dr Lakshmi had recommended to Govt of Tamilnadu to introduce special supplementary exams for 10th and 12th classes so that students who have failed in only three subjects were able to resit the exam after 3months thus saving them the year and their career.

Another innovation introduced was the establishment of pesticide banks in panchayat where people stored their pesticides and not at home thus reducing easy access to pesticides especially in case of impulsive overdoses and suicides.

Following my discussion at forum with Dr Vijay Lakshmi, Dr Lakshmi reported that both these measures have significantly led to reduction of suicides in young boys and girls.

Another important maladaptive coping strategy that people use is to use illicit drugs. Recent data from Police Deaddiction Centre provided by Director Police deaddiction centre and state coordinator for mhGAP revealed that in the past four months from June 2016, 171 patients with substance abuse were rehabilitated at the drug deaddiction centre in Srinagar according to data released by DIG police. Of the 336 patients seen this year 38 were admitted and 93 were on waiting list due to lack of infrastructure and doctors. The centre had 15 bed capacity and the unit was working on improving the capacity to 30 to cater for the increasing demand for treatment and rehabilitation.

Last year 1383 patients were seen at the Srinagar centre of whom 713 were confirmed as victims of substance abuse, 400 of multiple substance abuse, 108 cannabis, 58 of opium, 37 of volatile solvents, 27 alcohol and 17 of benzodiazepines. The average stay of patients at deaddiction centre was 21days. The total number of patients seen in the opd since 2008 was 13972 of which 1266 were admitted.

The above data emphasises the need to develop effective services to help the young population who are resorting to illicit substance misuse as a maladaptive coping strategy to deal with the problems which could be enhanced or complicated by the political turmoil.

As we are aware that mental illness+stigma+ lesser treatment facility+financial crisis+socio-political disturbances makes it a complex phenomena.

People in conflict zones live in constant fear, adults are strained and mostly unavailable for normal contact and child rearing.

Damage to and destruction of home and community, destruction of normal life and no structured days for children has a significant impact of psychosocial development of the young population. Boys less than 18 get involved in the process which are in conflict with law.

When minors enter the legal process it may be in conflict with convention on the rights of children.

In war and conflict the mentally vulnerable children are therefore even more at risk due to heightened confusion and fear.

What can be done at Least?

We need to ensure schools are open and safe.

Emergency psycho social support exists.

Effective monitoring mechanism to stop all forms of child abuse and ensure rights of children.

Adequate mental health facility

Availability of services at grass root level and staff trained to detect mental health issues at the earliest.

Most importantly

Parents, teachers, police and social workers should be aware that more extreme difficult, pre delinquent /delinquent behaviours require not punishment but psychosocial and even psychiatric help.

If possible we must find alternatives to locking up manageable youngesters as it is a very serious violation of there human dignity.

To summarize the interventions as recommended for restoration of mental health and rehabilitation we need to focus on.

Health promotion

Health promotion interventions are provided to increase awareness of the mental health needs of the children and increase community resilience. These includes.

A. Peer support Groups.

B. Community sensitization.

C. Psychoeducation.

Prevention

Prevention activities which target subgroups of children with psychosocial distress and include

Detection using brief context sensitive screener in schools

Structured group intervention to address the symptoms of distress and strengthen protective factors

Treatment

Children with severe mental health problems should receive treatment as necessary which may include. Individual counselling.

Parental support.

Referral to a psychiatrist.

They should be helped to use their natural coping mechanism to regain a sense of control which can include.

a. Get enough rest.

b. Eat as regularly as possible and drink water.

c. Talk and spend time with family and friends.

d. Discuss problems with someone they trust.

e. Relax, walk, pray and play.

f. Exercise.

g. Avoid alcohol or drugs, caffein, nicotine

h. Attend to personal hygiene.

One the major stumbling blocks for people to seek help is stigma associated with mental health studies have revealed that 42% of people with a mental illness face stigma and discrimination at least once a month. 58% of sufferers say the stigma and discrimination is as damaging to deal with than the illness itself and 63% of adults know someone with a mental health problems besides stigma some other factors that stop people from seeking help include could not afford cost believe could handle problems without treatment Did not know where to go for services

Did not had time

Treatment would not help

Did not feel the need for treatment

Might cause neighbours/community to have negative opinion

Did not want others to find out

Might have negative effect on job.

Fear of being committed/having to take medicine

Concerned about confidentiality.

Besides helping themselves it is important to help others which can give satisfaction and sense and purpose in life.

WHO has recommended Psychological First Aid Training and we conducted the first such training in Kashmir last month attended by more than 40 participants from various local, national and International organisations.

The report was presented by myself to the WHO assembly in Geneva as this years theme was Psychological First Aid. The report has been validated by WHO and is available on WHO website for people to use all over the globe.

It is strongly recommended that most young people should get trained in PFA and I am going to summarise briefly the principles of the PFA.

What is PFA

Humane supportive and practical assistance to fellow human beings who recently suffered exposure to serious stressors and involves:

1. Non intrusive practical care and support.
2. Assessing needs and concerns
3. Helping people to address basic needs
4. Listening but not pressuring people to talk
5. Comforting people and helping them feel calm
6. Helping people connect to information,services and social support
7. Protecting people from further harm

What PFA is Not

i. It is not something only professionals can do

ii. It is not professional counselling

iii. It is not psychological debriefing that is no detailed discussion of the distressing event

iv. It is not asking people to analyse what happened or put time events in order

v. Although PFA involves being available to listen to peoples stories it is not pressuring people to tell you their feelings or reactions to an event.

Who may benefit from PFA

1. Very distressed people who are being exposed to violence.
2. Can be provided to adults and children.
3. Not everyone who experiences a crisis event will need or want PFA.
4. We should not force help on those who don't want it, but make ourselves available and easily accessible to those who may want support.

Who Needs More Advanced Support than PFA Alone

a. People with serious life threatening injuries

b. People so upset that they can't care for themselves or their children

c. People who may hurt themselves

d. People who may hurt or endanger the lives of others.

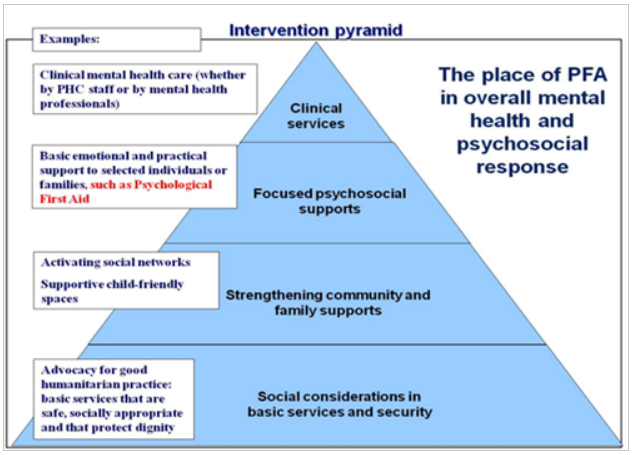
Why PFA

People do better over the long term if they Feel safe, connected to others, calm and hopeful. Have access to social, physical and emotional support. Regain a sense of control by being able to help themselves.

People may have very different reactions to an event. The particulars of the event, such as the degree of violence or the element of surprise may also shape victim's reactions. Traumatic events shake the foundations of a person's life. Certain traumatic experiences, such as extremely early experiences of abuse, may interfere with or even prevent a person from developing a solid sense of self.

Emotional makeup, personal history, social relationships, previous coping strategies, age at the time of the trauma, and the availability of support before, during, and following the traumatic experience-all these factors help to shape the meaning of the event for the victim.

The particular ways in which people are affected by stressful events can differ widely. This reflects the normal differences among people.



PFA action principles

Prepare	Learn about the crisis event.
	Learn about available services and supports.
	Learn about safety and security concerns.
Look	Observe for safety.
	Observe for people with obvious urgent basic needs.
	Observe for people with severe distress reactions.
Listen	Make contact with people who may need support?
	Ask about people's needs and concerns.
	Listen to people and help them feel calm.
Link	Help people address basic needs and access services
	Help people cope with problems
	Give information
	Connect people with loved ones and social support

We all should aim at building our resilience

There are many definitions and understandings of resilience. IFRC's definition of resilience is "the ability of individuals,

communities, organizations or countries exposed to disasters and crises and underlying vulnerabilities to anticipate, reduce the impact of, cope with, and recover from the effects of shocks and stresses without compromising their long-term prospects" (IFRC, 2015).

And finally we should aim for positive health as defined below with each individual having his own ways to achieve it with varying support.

Although definitions vary, positive mental health is generally seen as including:

a. Emotion (affect/feeling),

b. Cognition (perception, thinking, reasoning)

c. Social functioning (relations with others and society)

d. Coherence (sense of meaning and purpose in life).

I would dedicate the world disability day on 3rd December in Kashmir to those injured in current political turmoil and ensure we all work together as a family to help them rehabilitate them into the community as best as possible.

I hope this report will be helpful in improving and developing services and support for the youth of Kashmir.

Dedicated to the People of Kashmir.

Dr Sayed Aqeel Hussain MRCPsych (UK)

Consultant Psychiatrist Lincolnshire partnership NHS Foundation Trust UK

Incharge Crisis resolution team

Master Trainer for mhGAP and PFA on behalf of WHO.

International Coordinator for mhGAP. Email: sayedaqeel@gmail.com

Copy To

1. Hon'ble Chief Minster Ms Mehbooba Mufti
2. Hon'ble Deputy Chief Minister Dr Nirmal Kumar Singh
3. Hon'ble Minister for Health and Medical Education Mr Bali Bhagat
4. Hon,ble Minister for Revenue Relief and Rehabilitation Syed Basharat Ahmad Bukhari
5. Hon'ble Minister for Information Technology, Technical Education & Youth Services
6. & Sports Mr Imran Raza Ansari
7. Hon'ble Minister for Education Mr Naeem Akhtar
8. Hon'ble Minister for Social welfare ARI & Training Science and Technology Mr Sajad Gani Lone
9. Hon'ble Minister for finance Culture Labour & Employment Mr Haseeb A Drabu

World Health Organization

Message from the World Health Organization: soliciting your interest in a new mental health campaign

I am contacting you to solicit your interest in engaging with us at the World Health Organization (WHO) on an exciting new campaign to improve understanding of and support for a condition that affects a staggering 350 million people around the world – depression.

Depression is the leading cause of disability worldwide. In addition, as many of you will have heard during the recent World Bank-WHO co-hosted event "Out of the shadows: making mental health a global development priority", when considered with anxiety, depression costs the global economy US$1 trillion a year. At worst, depression can lead to suicide.

This is why the focus of World Health Day 2017 will be depression, together with its causes and consequences.

World Health Day is celebrated on 7 April every year to mark the anniversary of the founding of WHO in 1948. A different theme is selected every year. World Health Day will complement efforts for World Mental Health Day, held on 10 October every year.

The purpose of this is to determine your interest in engaging with us as we move forward with planning.

We look forward to hearing from you.

Sincerely, Shekhar Saxena

Director

Department of Mental Health and Substance Abuse

World Health Organization

Link of WHO site on mhGAP Kashmir.

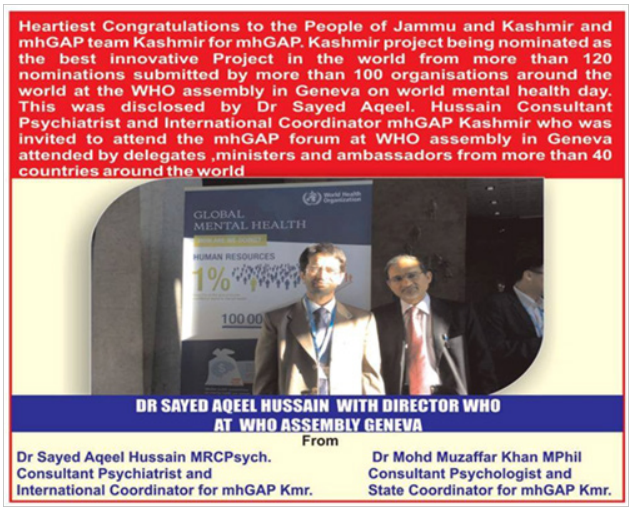
http://mhinnovation.net/innovations/mhgap-implementation-kashmir#.VTs5LtKqqko

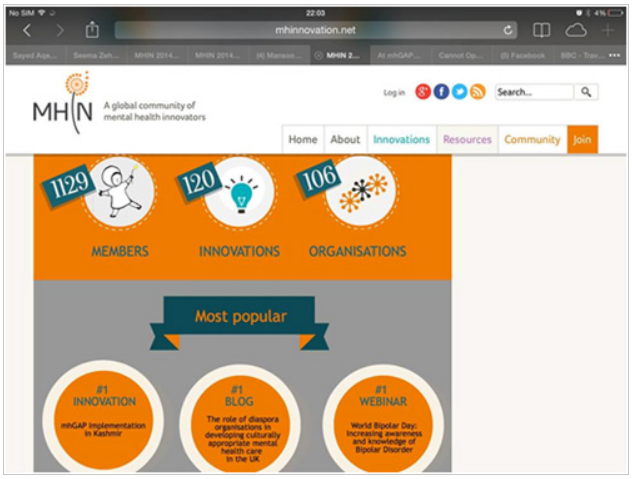
mhgap intervention guide [Clicks:50949times]. [mhgap evidence resource centre [Clicks:25981times]... mhgap kashmir [Clicks:110434times]. Some statistics about mhGAP on line

Representing the Institute of Psychiatry at the WHO Assembly

mhGAP Kashmir Being Nominated as the Most Popular Innovation By WHO

mhGAP Kashmir Being Nominated as Role Model mhGAP Project In Who Assembly On Oct 10 2016 For Implementation of mhGAP Projects Across 90 Countries Around The World.





The Photo Is The Kashmiri Lattice Window With Women Praying Behind It Representing The People of Kashmir Praying For The Success Of The Project.

Painting By Masood Hussain Renowned Artist of Kashmir.

With Dr Shekhar Saxena Director Who Mental Health, Dr Khalid Saeed Incharge Who Mediterranean Including Iraq, Syria, Yemen, And All Middle East Countries, Dr Tarun Dua Incharge Research And Action On Mental And Brain Disorders In Who Headquarters On October 10 2016 On World Mental Health Day

Famous Disability Chair outside United Nations Unit in Geneva

With Theme That Even Though Even If There Is Disability a Person Is Still A Human Being And Entitled To All Rights Respect And Dignity

Message from Secretary General United Nations on World Disability Day

International Day of Persons with Disabilities 3 December

"We mark this year's International Day of Persons with Disabilities in the wake of the adoption of the ambitious 2030 Agenda for

Sustainable Development. This global blueprint for action summons us to "leave no one behind"." *Secretary-General Ban Ki-moon.*

Acknowledgments

None.

Conflicts of interest

Author declares there are no conflicts of interest.

Funding

None.