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World Psychiatric Association

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World Psychiatric Association
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Issue 6 | June 2026

WHO WILL LEAD GLOBAL PSYCHIATRY (WPA)?

• INTERVIEWS IN THIS ISSUE •

Prof. Lukoye Atwoli

Prof. Roy Abraham Kallivayalil

Prof. Roger Man Kin NG

Prof. M. S. Renuka-Prasad

Prof. Lade Smith

LEADING IDEAS
Perspectives on education and psychiatry

GLOBAL VOICES
Insights from around the world

INTERVIEWS IN THIS ISSUE
Exclusive conversations with WPA Presidential candidates

EDUCATION INNOVATION
Advances and new approaches

COLLABORATION FOR IMPACT
Building a stronger future together

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Leading, Learning and Collaborating

The advancement of psychiatry relies on scientific inquiry, clinical practice, education, and the sharing of knowledge across professional, cultural, and geographic boundaries. In an increasingly interconnected world, the ability to learn from different experiences and perspectives has become one of the profession's greatest strengths.

This issue reflects the breadth of contemporary psychiatry through contributions spanning leadership, psychiatric education, cultural perspectives, and international collaboration. It brings together established leaders, emerging ideas, and practical experiences from different regions of the world, illustrating both the diversity of psychiatric practice and the common challenges facing our profession.

The issue opens with Bennett Leventhal's thoughtful reflection on leadership and professional responsibility, encouraging readers to consider how psychiatry should respond to increasingly complex social and political challenges. This is followed by interviews with the five candidates for the 2026 World Psychiatric Association Presidency. By presenting each candidate with the same questions, the journal provides readers with a unique opportunity to compare their priorities, values, and visions for the future of both the WPA and global psychiatry.

Attention then turns to educational innovation and international collaboration. Marc Hermans and colleagues describe the evolution of the WPA Volunteering Programme into a sustainable international educational initiative, while Sami Ouanes and colleagues present the *World Psychiatry* Journal Club as an innovative model for translating evidence into clinical practice through global dialogue. These contributions demonstrate how collaborative educational initiatives can strengthen psychiatric training and professional development across different regions and resource settings.

The following articles present national and institutional perspectives on psychiatric education. Tawfik Masaud describes the development of a behavioural and social sciences curriculum for a new medical school in Oman, Leonardo Baldaçara reviews the achievements and continuing challenges of psychiatric training in Brazil, and Ammar Albanna and colleagues present the clinical-academic model developed at Al Amal in the United Arab Emirates. Although these experiences arise from different healthcare systems and educational contexts, they share a common commitment to preparing future psychiatrists through innovation, collaboration, and responsiveness to local needs.

The issue then broadens its focus through two thought-provoking contributions exploring culture, humanities, and conceptual perspectives in psychiatry. Hinemoa Elde introduces

readers to *Ara*, a Māori guidebook of the mind, providing valuable insights into Indigenous understandings of mental wellbeing and reminding us of the importance of cultural knowledge in psychiatric practice. Soochurl Cho invites readers to consider a broader conceptual framework for understanding human beings and mental health, encouraging reflection on some of the fundamental assumptions that underpin psychiatric theory and practice.

The final section highlights the importance of international exchange and professional collaboration. Hojka Gregorič Kumperščak reflects on two decades of psychiatry workshops in Slovenia, demonstrating the enduring value of educational partnerships. Hee Jeong Yoo and colleagues describe ASCAPAP 2026 as a growing international platform for professional exchange and collaboration, while Sulaima Elkhalife and colleagues report on the recent WPA webinar examining the mental health consequences of war, highlighting the profession's response to one of the defining humanitarian challenges of our time.

Taken together, the articles in this issue illustrate the value of learning from different experiences and perspectives. We hope that readers will find these contributions informative, thought-provoking, and relevant to their own clinical, educational, and academic practice.

Happy reading!

Prof. Norbert Skokauskas
Secretary for Education and Scientific Publications
World Psychiatric Association

Editor-in-Chief, Education and Psychiatry

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A Good Example of a Bad Example

Prof. Bennett L. Leventhal (USA) WPA Committee on Education and Scientific Publications

In every community, we seek good examples or role models, especially in our political and social leadership. In recent times, on most days, we arise to learn of new, unexpected, and often disquieting acts by public officials or other community leaders. While these leaders may have different perspectives or political agendas, the days are monotonously the same, with shock and dismay at outrageous actions that jeopardize our health and well-being by ignoring standards of behavior and even abandoning common decency. When questioned, these very leaders claim higher levels of morality, values, or principles, but these claims quickly fade into a quagmire of chaos, conflict, self-serving, threats, and distortions of basic facts. Recently, these events have affected us all by threatening access to healthcare, the environment, free speech, economic stability, and world peace. In short, we are continually faced with and exhausted by leaders who are bad examples of how to behave, misuse information, and fail to apply valuable resources to ensure our shared welfare and well-being. This is likely to be repeated tomorrow in your community, in another city or country, targeting us or others. While we attempt to counter these events by "doing the right thing," it is increasingly clear that these leaders and their actions are not responsive to truth, reason, logic, or acting decently. These are simply good examples of bad examples that provide us with the experience necessary to point us in the direction of corrective action.

As a behavioral scientist, I often wonder why we don't apply our understanding of behavior and behavior management to address the leadership challenges we face today. While we could start by re-reading the papers by Pavlov, Skinner, and others, perhaps the solution is much more straightforward. As it turns out, we, citizens of the 21st Century, are not facing anything novel. Indeed, in the 19th century, American humorist Mark Twain, explained our situation in *A Connecticut Yankee in King Arthur's Court* (1889) with the following artful metaphor:

"The best swordsman in the world doesn't need to fear the second best swordsman in the world; no, the person for him to be afraid of is some ignorant antagonist who has never had a sword in his hand before; he doesn't do the thing he ought to do, and so the expert isn't prepared for him; he does the thing he ought not to do; and often it catches the expert out and ends him on the spot."

We are all trapped in this repetitive duel that, as Twain suggests, "ends [us] on the spot." For the many who are victims of the leadership failures (e.g., immigrants, people needing healthcare

[especially women], indigenous peoples, children needing vaccines, individuals with mental disorders, and so many more), there is only despair and no prospects for tomorrow. These ignorant antagonists who fear for the end of their careers or power do "the thing he ought not to do…" The actions of these leaders make us feel helpless with some addressing this fear by supporting the "ignorant antagonists." Others bury their heads under their pillows and try not to awaken or refuse to see or accept the latest, expected, but nonetheless outrageous behavior. However, then there are a few brave souls who stand up and try to at least oppose the swordsman in another swordfight, that sadly "ends him on the spot."

The situation is disheartening and some have even given up, thinking that our long history of consensus-building and shared purpose is no longer viable. I prefer to once again return to Mr. Twain who, in response to a newspaper article erroneously announcing his demise, countered with, "The report of my death is an exaggeration." As in the case of Twain, the absence of hope is only by our agreeing with "ignorant antagonists" insistence that we accept their exaggerated assertions that science and decency are dead. While we must be wary of Twain's "ignorant antagonists," we can also realize that we will fail if we try to combat their dangerous acts on their terms. We cannot expect them to change their minds and accept that they might be wrong or ignorant. Let's learn from Mark Twain and his 150-year-old wisdom: stop sword fighting, as it is a losing battle. The lesser swordsmen will continue wining if we engage them in swordfights. Let's concede that we cannot beat them in a swordfight!

So, what can we do? Certainly, we cannot engage in a colloquy with them about right and wrong as that is returning to the fight. Instead, we must stand aside and allow the swordsmen to fight the ghosts they create, while we address the meaningful issues of our time, such as providing safety, security, and good health/healthcare for everyone in a healthy environment with economic security for all. These are meaningful goals that are important to everyone. Additionally, we can be confident that these goals are achievable because, in our own recent history, we made progress in achieving them. Vaccines and medications were reducing infectious disease around the world. There was the sense of a shared responsibility to secure clean water, hygiene, adequate nutrition, and to provide medical care for all, with general medical care increasingly including mental healthcare. Sure, mistakes were made and nothing was perfect, but we can proudly point to successes and appreciate that we were moving forward. We can be confident that, if we step away from the sword fights, we can move forward again.

As hard as it might seem, behavior management theory tells us that the best way to extinguish undesirable behavior is to ignore it. So, let's resolve to ignore these "ignorant antagonists" and their exaggerations and misinformation.

We have honed our skills as educators, so let's put these skills to good use and pursue excellence in teaching the truth to our colleagues, students, and the broad public. Let's join together as individuals and professional groups to develop a consensus agenda that allows us to speak in

one voice, provide truly good examples, and map reasonable paths forward, without engaging in exhausting, useless arguments. As "educators" we must be non-defensive, demonstrate kindness to all, and consistently offer a clear agenda that is filled with evidence-based information in a common language that is readily understandable by all. Through this process we can also share our message about our basic, shared values, established scientific facts, evidence-based practices, and a shared vision of a positive future for all citizens of our shared world. Will we be able to teach or convince everyone? Of course not, but if we work together, we can shape the knowledge, ideas, and behavior of most of those who seek responsible leadership in the pursuit of health and happiness for themselves and, most importantly, their children and families. And, for the time-being, with a kind smile, we will ignore "ignorant antagonists," leaving to do battle within their own group.

In short, we can recognize unwinnable fights and when we see a good example of a bad example. The "ignorant antagonist" has learned that if they repeat a lie enough times, many will believe it to be true. However, we tend to forget that if we repeat the truth enough times, even more will believe it to be true. Let's remind ourselves that it is much easier to consistently repeat the truth because, unlike falsehoods, it is unchanging, and related outcomes are better.

As a word of caution, we also know that when the "ignorant antagonists" sense defeat, or we refuse to fight with them, they will attempt to attack us personally. While that is a real risk, we can protect each other. Remember, just like we need "herd immunity," we also need a "herd mentality" of shared truths and messages. By so doing, we can protect each other, and also protect the truth, as well as the health and welfare of friends, family, patients, and communities who depend on us. Let's strive to be a good example and guiding lights for our fellow citizens and leave, for all to see, that we will no longer trifle with each ignorant antagonist who only serves as a good example of a bad example.

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Interview with Prof. Lukoye Atwoli, Presidential Candidate, WPA 2026

What motivated you to stand for the WPA Presidency, and what vision would guide your leadership?

I was motivated by the need to contribute to the global leadership of brain and mental health landscape based on what I have been able to contribute in Kenya, in Africa, and at the WPA Section on Epidemiology and Public Health. My vision had five prongs:

- Strengthening global collaboration: Expanding partnerships across regions, ensuring equitable representation of voices from low- and middle-income countries.
- Advancing scientific excellence: Supporting cutting-edge research dissemination, fostering mentorship for early-career psychiatrists, ensuring WPA remains the leading convener of psychiatric knowledge.
- Promoting advocacy and policy impact: Leveraging WPA's influence to shape global mental health policies, particularly in suicide prevention, substance use, violence reduction, and climate-related mental health challenges.
- Enhancing education and training: Championing innovative curricula, digital learning platforms, and competency-based approaches to prepare psychiatrists for evolving global needs.
- Upholding ethics and professionalism: Building on my extensive research and clinical ethics experience, to ensure WPA continues to set the highest standards of integrity and patient-centered care.

What are the most important challenges currently facing psychiatry globally?

I see the challenges facing psychiatry today include the rising burden of trauma and mental illness, and inequities in access to care. While in many places care provision is increasing, even in places where access is greatest, there are extreme inequalities in access to care. I believe the WPA has a role in providing leadership in advocating for ethical care for people living with mental illness, in revolutionizing education in mental health for providers and the general population, in supporting research that advances knowledge in mental health, and in training the next generation of mental health service providers.
More specifically, I see the main challenges as:

- Workforce shortages and uneven distribution of psychiatrists and mental health workers worldwide
- Stigma and discrimination that continue to limit access to care

- Poor integration of mental health into broader health systems, especially in resource-constrained settings
- Climate change and conflict driving new waves of trauma and psychiatric morbidity
- Digital transformation, both an opportunity and a challenge in ensuring equitable access to innovation

What role should the WPA play in addressing these challenges, and how can it strengthen its global impact?

WPA is the best global forum that can convene all actors in mental health, based on the meetings we convene, our journal, and the public forums that WPA puts together, as well as our position as the voice of mental health workers globally. Specifically, WPA will:

- Strengthen global collaboration by fostering partnerships across regions and disciplines
- Promote evidence dissemination through journals, conferences, and open-access platforms
- Shape global policy by engaging with WHO, UN agencies, and national governments
- Support equity initiatives that ensure diverse representation in leadership and decision-making.

How can the WPA strengthen psychiatric education and training globally, across different regions and resource settings?

The WPA can expand psychiatric education by:

- Developing global curricula adaptable to different regions and resource levels
- Supporting digital learning platforms to reach underserved areas
- Fostering mentorship networks that connect early-career psychiatrists with senior leaders worldwide
- Encouraging reciprocal innovation—learning from both high-income and low-income contexts to enrich training globally

How can the WPA further develop its financial sustainability, organisational structure, and resource mobilisation to better support its global mission?

To sustain and grow its mission, the WPA should:

- Diversify funding streams through partnerships with foundations, governments, and private sector allies
- Enhance membership engagement to increase dues and participation
- Strengthen governance structures for transparency, accountability, and efficiency
- Invest in resource mobilisation strategies that align with global mental health priorities

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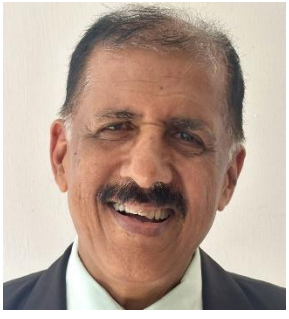
Interview with Prof. Roy Abraham Kallivayalil, Presidential Candidate, WPA 2026

What motivated you to stand for the WPA Presidency, and what vision would guide your leadership?



My motivation comes from three decades of service to WPA and a belief that psychiatry must lead, not follow, in global health. Having served as Secretary General, I have seen WPA's strengths and the gaps where we can do more, especially for colleagues in Low- and Middle-Income Countries.

Vision: "WPA for All - Dignity, Access, Excellence"

1. Dignity: Fight stigma and human rights violations in mental health care across all settings.
2. Access: Make evidence-based psychiatric care available to the 75% of people worldwide who get no treatment today.
3. Excellence: Strengthen psychiatric education, research, and ethical practice so our profession stays relevant and respected.

My leadership will be guided by collaboration, and giving voice to psychiatrists from every region and resource setting.

What are the most important challenges currently facing psychiatry globally?

1. Treatment gap and workforce crisis: Less than 1 psychiatrist per 100,000 in most LMICs. Demand for mental health care is rising post-COVID, but workforce growth is stagnant
2. Stigma and human rights: Coercion, neglect, and discrimination still violate the dignity of persons with mental illness in many countries.
3. Integration with general health: Mental health remains in the periphery in most countries. We must embed psychiatry in primary care, public health and in the strategies against Non-Communicable Diseases (NVDs).
4. Technology & ethics: AI, telepsychiatry, and social media bring opportunities but also risks to confidentiality, data, and the doctor-patient relationship.
5. Burnout among psychiatrists: Moral injury, administrative burden, and violence at work are driving young doctors away from the field.

What role should the WPA play in addressing these challenges, and how can it strengthen its global impact?

WPA must move from a “Congress organization” to a “Change organization”.

The following Roles and Actions need to be pursued.

1. Advocacy: Be the global voice with WHO, UN, and National governments across the world. Use WPA data and position statements to push for mental health funding and laws aligned with human rights.
2. Capacity building: Scale WPA’s educational program and work of Sections to reach district hospitals and primary care clinics, not just academic centres, across the world.
3. Partnerships: Build alliances with patient groups, other medical specialities, NGOs and other global organisations like World Medical Association (WMA) and World Federation for Mental Health (WFMH)
4. Regional empowerment: Strengthen Zonal Representatives and Member Societies. Decisions and resources must flow to regions and countries from WPA Secretariat and vice versa. Global impact comes when a rural doctor in Malaysia and a trainee in Nigeria both feel WPA is working for them.

How can the WPA strengthen psychiatric education and training globally, across different regions and resource settings?

Education is WPA’s most powerful tool. My 18 years as Department Chair +10 years as Dean/ Vice-Dean showed me that one curriculum cannot fit all. Our approach should be “Global Core + Local Context”

1. WPA Core Curriculum: A flexible, competency-based framework that every country can adapt. Include low-resource skills like brief interventions, task-sharing, and mhGAP.
2. Digital Academy: Expand WPA e-Learning with modules in multiple languages- French, Spanish, Italian, Chinese, Russian, Hindi, Tamil, Arabic etc. Make it free for trainees in LMICs.
3. Twinning + Mentorship: Link departments in high-resource and low-resource countries for exchange, supervision, and research. We have done this successfully in India.
4. Faculty development: Train the trainers. Many teachers never learned modern teaching methods or ethics. WPA can lead this.

Goal: Every WPA member society should have access to quality training materials, regardless of budget.

How can the WPA further develop its financial sustainability, organisational structure, and resource mobilization to better?

Financial health leads to organizational independence. We must diversify beyond membership fees and Congress revenue.

Plan:

1. Diversify income: Ethical partnerships with foundations, bilateral agencies, and tech for mental health. Strict conflict-of-interest policy will protect WPA's integrity. Endowment fund for long-term stability.
2. Leverage LMIC strengths: India and other LMICs have huge member base + low-cost expertise. We can host more WPA activities, trainings, and research from here, reducing costs.
3. Structure: Streamline Secretariat + Sections + Zonal Reps for faster decisions. Use digital tools for governance. Transparency in budget and reporting builds member trust.
4. Value to members: When psychiatrists see direct benefit – free education, advocacy, protection – retention and recruitment improve. More members mean, stronger finances.

Having worked as a Psychiatrist in a Low- and Middle-Income Country (LMIC) for 46 years, I know first-hand the difficulties posed by inadequate resources to serve most of the population as is the case in Africa and Asia and most other places except perhaps Europe and North America. This should be a priority focus for the WPA and the next President. Many recent Presidents have come from high resource countries; it is well warranted to have one from a low resource country who understands these needs most experientially.

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Interview with Prof. Roger Man Kin NG, Presidential Candidate, WPA 2026

What motivated you to stand for the WPA Presidency, and what vision would guide your leadership?

Ever since I was a trainee psychiatrist, I have come to understand that mental health is connected with education, housing, employment etc. In a similar way the world is interconnected. I was elected as Secretary for Education for 6 years in 2017 and during this period also acted up as Secretary General after the untimely death of Petr Morozov. For me the key is that we need to learn from each other and help learn not only about treatment of mental illness but also about enhancing personal mental health resilience. We also have to protect social justice, remove structural discrimination, as well as combat stigma. Ensuring equity of access to physical and mental health care and minimising the impact of natural and man-made disasters on mental health. Such work can only be done if I work above and beyond my regular role as a psychiatrist in my clinic. My past experiences as the President of Hong Kong College of Psychiatrists and within the WPA , have convinced me that working at national and international levels are necessary to learn from each other and support each other particularly in global South in order to bring about such meaningful and important changes at a population level.

My vision of leadership is my dream of a future where every individual with mental health needs lives with respect, dignity and equity. Living in such an environment is not only conducive to recovery from mental health issues but also promotes personal health resilience and compassionate communities. Bearing in mind that every individual is vulnerable to distress and mental illnesses how do we support recovery and prevention is extremely crucial.

What are the most important challenges currently facing psychiatry globally?

Basic rights of people with mental health problems are not protected in many parts of the world. This is related to lack of mental health literacy, structural discrimination and stigma towards mental illness. The consequences of such lack of protection result in lack of access to treatment, coercive treatments, lost employment opportunities, deprived voting rights and many other overt and covert injustices that are detrimental to mental health. When basic rights of people with mental health problems are not protected, their carers are not only having the roles of supporting the disabilities of their ill relatives but also experiencing extra burden of facing discrimination and injustices from society. Carers' rights and welfare should therefore be recognised and addressed.

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Basic rights of people with mental health problems and their carers cannot be properly addressed in the absence of a mental health policy in each country. A WPA survey in 2016 showed that only 40% of countries (all signatories to the UN Charter for the Rights of Disabled persons) allow people with mental illnesses their basic rights to vote, marry, inherit property and employment. In addition, according to the WHO Mental Health Atlas, still only 72% of member states have a standalone national mental health policy or plan. This equates to about 140 nations that have established dedicated mental health governance. However, only 48% of all countries have developed their mental health policies to fully comply with international human rights instruments. Over 36% of nations spend less than 1% of their entire health budget on mental health. This is a big challenge for WPA which needs urgent attention.

Lack of mental health plans and poor investment in mental health care directly translate into suboptimal standard of care, poor access to care and poor recruitment into psychiatry. A vicious cycle is set up with low psychiatrist and mental health professionals per population ratio, lack of adequate training for psychiatrists and mental health professionals, low quality mental health care, poor work morale, and further lack of powerful voice in speaking up for mental health in the community. In many countries, Non-Governmental Organisations develop and deliver innovative services but these innovations are not widely known. I would get WPA to create a repository of good practice so people elsewhere are aware and can learn from each other. I strongly and passionately believe that the WPA can be a major force for good across the globe.

In the current century when natural and human-made disasters, warfare and regional political conflicts abound, mental health care needs increase. Without enhancing basic rights of people with mental health needs, they will be deprived of proper care when they are most vulnerable and in need. During times of humanitarian crises, people with mental health issues are at most risk of being displaced, abused, discriminated, and scapegoated, their basic rights should therefore be further highlighted.

What role should the WPA play in addressing these challenges, and how can it strengthen its global impact?

WPA has 147 national member societies representing over 250,000 psychiatrists around the world. It has wide and extensive connections with other world organisations including WHO, WONCA, WFMH etc. WPA must join hands with these world organisations and collaborate with patients and family organisations to affect policy developments and changes through a number of initiatives. I have shown in Hong Kong how this can be achieved through my work in developing recovery-based services in Hong Kong and pioneering peer support workers in each mental health unit in Hong Kong. WPA also has a strong role to play in working with member societies to develop mental health plans if they have none, to update their existing mental health plans so as to comply with international human

rights instruments, and to lobby their respective governments for extra health budgets on mental health. WPA can also collaborate with different member societies, patient and family organisations and other stakeholders to conduct surveys to understand the educational and training needs of their mental health professionals, to canvass their current mental health care expertise and experiences for mutual sharing and education between other society members, and to advocate culturally appropriate and acceptable evidence-based care in different member societies.

How can the WPA strengthen psychiatric education and training globally, across different regions and resource settings?

As the Past Secretary of Education, I have been involved in the development and drafting of eleven WPA position statements/reports and authored/co-authored 28 WPA-related peer-reviewed papers. These scientific publications have provided important insights about the needs and challenges of training and educational systems in different member societies or even among certain professional groups at an international level. These data could not be obtained if these studies were not conducted in collaboration with other world organisations like WONCA or World Federation of Medical Students. In the past WPA has tried to link with universities to create an international degree, we need to revisit this and the core basis is about mutual learning rather than the West telling rest of the world what to do. It is my view that WPA should conduct not only regular surveys with other world organisations on key educational and training areas of needs of mental health professionals to identify gaps before rolling out any major new educational initiatives but also cooperatively create teaching materials.

As the past WPA Secretary of Education (2017-2023), I worked with our past WPA presidents to set up an education portal which already provide a rich source of educational webinars ranging from psychopharmacology, trauma-based treatments, psychotherapy to service-user led recovery-based care in different languages. WPA could build upon this education portal to update the content of the current webinars, expand the number of educational topics, and promote these new courses in WPA social media and websites on a regular basis. Although current webinars do provide WPA CE credits upon successful completion, future development may involve collaboration with reputable universities in developing online courses with quotable qualifications. WPA would then be able to fully utilise the current online management system for the benefit of member societies who do not have easy access to high quality psychiatric education. The types of courses offered could be decided upon the results of the world surveys conducted as suggested above. In addition, monthly regular educational webinars on timely and important topics can also be delivered by inviting world experts through online promotion by WPA. In many countries, burnout is becoming a serious issue and I will set up support networks for people to get together to talk through stresses.

Another initiative that I pioneered as the Secretary of Education was a series of Volunteering Projects which aimed to enhance knowledge and skills of the participants in the recipient member society through the contribution by the expert volunteers from a neighbouring member society with a similar culture if possible. The expert volunteers delivered an online course in collaboration with a local host trainer to a group of selected trainees in the host country on a selected subspecialty topic suggested by the host country. Throughout the online course, there are both didactic lectures, group discussions, interactive role plays, and live demonstrations with an aim to enhance both knowledge and skills. The projects have been pilot tested in Mexico and Pakistan with encouraging results. Both expert volunteers and the trainee participants from the host member societies were highly satisfied. It is also a good way to enhance trust and comradeship between neighbouring member societies through the platform of WPA. It is a highly promising model for further expansion and wider coverage to benefit more member societies. WPA Working Group on Volunteering has prepared a list of comprehensive guidelines on the roles and responsibilities of the host countries, the expert volunteers as well as the participants in these training courses. The Working Group is now also working on the possibility of exploring the possibility of developing mentorship programmes so that mentors and mentees from different member societies may be matched up. Hopefully this will help early career psychiatrists cultivate proper and ethical attitudes and become promising leaders in our psychiatric field. Again, internet technological advances have made all such international collaboration feasible and efficient.

During the mutual learning between the expert volunteers, patients and their carers as well as the local trainers and the participants from the host country in these volunteering projects, it is apparent that evidence-based treatment needs to be culturally appropriate and relevant in order to be effective for clients of different cultures. During my tenure as Secretary of Education, I initiated a pilot work on inviting Prof Peter Falkai to lead a workgroup to prepare a WPA treatment guideline on schizophrenia and related disorders which used Delphi methodology to understand the best treatment practices of experts from around the world. Further development of these treatment guidelines by WPA should be encouraged. Such treatment guidelines on different disorders might provide valuable but complementary perspectives on prevention, treatment and rehabilitation from those written by major member societies based in the Western world.

How can the WPA further develop its financial sustainability, organisational structure, and resource mobilisation to better support its global mission?

As the interim Secretary General of WPA (2022-2023), I am very familiar with the WPA machinery, policies, guidelines and position statements. I chaired the accreditation committee in 2023 and ensured that the general election held in September 2023 was conducted in an open, transparent, and fair manner. As the interim Secretary General, I was aware that the administrative structure and communication channels between WPA office, WPA zonal

representatives, and member societies could be further strengthened. Existing WPA administrative staff should receive updated training in using artificial intelligence and large language modelling (AI & LLM) in maximising their daily administrative work efficiency. Additional part-time administrative staff with AI & LLM knowledge could be recruited with clearly delineated roles and responsibilities to support the work of the WPA officers and for specified projects. All policies, position statements and guidelines should have a well-defined, systematic documentation management system to ensure that WPA official documents are regularly reviewed and updated by the responsible officers. Two-way communication between WPA and the member societies could be strengthened through regular, three-monthly online meetings between WPA officers, WPA administration office, zonal representatives and presidents/representatives from member societies from each continent on a rotational basis.

Through my six-year participation in the WPA executive committee meetings, I had good understanding about the current financial challenges and opportunities of WPA. WPA is a Swiss-based non-governmental international organisation. The main income sources come from member society annual membership dues and profit shares obtained from WPA regional and world congresses. The income from congresses suffered tremendously during the COVID-19 periods when in-person registration was not possible, which may happen again in the form of natural or human-made disasters at any times in the coming future. Besides, this income source base is too narrow and needs to be widened.

As mentioned in the above educational initiatives, WPA could work with reputable universities to deliver online educational courses with quotable qualifications and demand tuition fees according to the income level of the country based on World Bank Classification.

WPA would need to consider recruiting a part-time consultant in marketing and fund-raising in the administration team to assist the WPA Secretary of Finance and Fundraising. The membership of the WPA Committee of Finance might be expanded to include representatives or nominees from member societies who have extensive experience/expertise in fundraising and in working with global philanthropists/corporate donation foundations in their own countries as advisors. Fundraising for WPA requires a diversified global funding model with a revenue stream mix from international grants, global philanthropists, major regional donors, corporate or regional foundations, and special events/campaigns targeted for mental health. Global digital fundraising programmes using online donation appeals, appeals for legacies and monthly regular donations by compassionate society members should not be overlooked. Individual members and societies need to provide funds for specific targeted restricted projects as well as broader initiatives. During the Social Movement in 2019 in Hong Kong, as the President of the Hong Kong College of Psychiatrists, I led the College to launch a two-year “Care for All” Programme” to provide free mental health consultations by volunteer psychiatrists for all people suffering from mental health problems related to the conflicts during the Social Movement. I have successfully secured unrestricted funding provided by large family foundation donations

in Hong Kong to support all these patients throughout the programme. With my connections and past experiences of the EC of the WPA as well as my track records of work in Hong Kong, I am very well placed to build on these to lead WPA to advance further on fundraising endeavours.

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Interview with Prof. M. S. Renuka-Prasad, Presidential Candidate, WPA 2026

What motivated you to stand for the WPA Presidency, and what vision would guide your leadership?

My motivation to stand for WPA President-Elect is rooted in more than three decades of clinical, academic, and leadership experience across India, the United Kingdom, Canada, and the wider international psychiatric community. Although my clinical home is old age psychiatry, the lessons it has taught me are universal: people across the lifespan need timely, compassionate, evidence-based care that protects dignity, supports recovery, and promotes healthy living.

As a Clinical Professor of Psychiatry, Consultant Psychiatrist, former President of the Canadian Psychiatric Association, former WPA Zone 1 Representative, and Chair of the WPA Section of Old Age Psychiatry, I have had the privilege of working with colleagues across cultures, regions, and resource settings. These experiences have strengthened my belief that WPA must be an inclusive global platform for the full breadth of psychiatric practice, education, science, ethics, and advocacy.

My vision is for a WPA that listens, unites, educates, advocates, and acts. It should advance humane, evidence-based, rights-based psychiatry across the lifespan, with particular attention to vulnerable and underserved populations. My leadership would rest on four pillars: compassionate and inclusive care; strong Member Societies and a resilient WPA; excellence in education and knowledge exchange; and transparent, sustainable, impact-driven governance.

What are the most important challenges currently facing psychiatry globally?

Psychiatry faces interconnected challenges across all regions. The burden of mental disorders, addictions, and brain health conditions is rising, while access to care remains deeply unequal. Many countries face shortages of psychiatrists, multidisciplinary teams, and community-based services, especially in low-resource, rural, and remote settings. Mental health services are also often fragmented and underfunded, separated from primary care, public health, social care, and wider health-system planning. This weakens prevention, early intervention, continuity of care, rehabilitation, and recovery.

Stigma, discrimination, outdated legislation, and coercive practices continue to undermine dignity and human rights. These challenges are especially serious for people with severe mental illness, addictions, dementia, disability, poverty, migration, displacement, or limited social support.At the same time, psychiatry must respond to rapidly changing global realities: population ageing, youth mental health needs, substance use, dementia, multimorbidity,

conflict, forced migration, climate-related stress, and widening social inequalities. Digital technologies and artificial intelligence offer opportunities for education and care, but they must be used ethically and equitably so they do not widen existing disparities.

A further challenge is professional sustainability. Many psychiatrists and mental health workers face burnout, moral distress, and workforce pressures. Supporting the well-being and leadership of the psychiatric workforce is essential for the future of global mental health care.

What role should the WPA play in addressing these challenges, and how can it strengthen its global impact?

WPA has a unique role as a global standard-setter, advocate, convener, and capacity-builder for psychiatry. Its greatest strength is its ability to bring Member Societies together around shared values while supporting practical, locally relevant action.

To strengthen its impact, WPA must place Member Societies at the centre of its work. It should listen to their priorities, support their advocacy, and help them address service, workforce, education, and policy needs in their own contexts. WPA should also strengthen collaboration among Sections, Working Groups, and Action Groups so that expertise is translated into useful tools, training, and guidance.

WPA should be a visible global voice for mental health, addictions, brain health, dignity, and human rights. It should work with WHO, United Nations bodies, governments, academic institutions, civil society, and regional organisations to ensure that mental health is embedded in health, development, disability, ageing, humanitarian, and social policy agendas. Its impact will grow if it becomes more accessible, responsive, and practical. This means clearer communication, stronger regional engagement, multilingual resources, support for early-career psychiatrists, and better mechanisms to understand and respond to Member Society needs.

How can the WPA strengthen psychiatric education and training globally, across different regions and resource settings?

Psychiatric education is one of WPA's most important responsibilities. WPA should promote flexible, high-quality, culturally responsive education that can be adapted across regions, languages, and resource settings.

Training should reflect psychiatry across the lifespan and include mental health, addictions, brain health, prevention, rehabilitation, healthy living, ethics, human rights, cultural humility, collaborative care, and leadership. WPA can support modular curricula, competency-based

approaches, case-based teaching, webinars, online courses, mentoring networks, and training-the-trainers programmes.

Digital education offers great promise, but it must be inclusive and affordable. Colleagues in low-resource settings should benefit as much as those in major academic centres. Multilingual resources and regional partnerships will be essential. Education should not be one-directional. Every region has knowledge, experience, and innovation to share. WPA can become a stronger platform for bidirectional learning, where science, clinical wisdom, and lived service realities inform one another.

How can the WPA further develop its financial sustainability, organisational structure, and resource mobilisation to better support its global mission?

For WPA to fulfil its mission, it must be financially sustainable, organisationally strong, and accountable to its Member Societies. A credible global vision requires structures that support continuity, implementation, and impact.

WPA should diversify its resource base through congresses, educational activities, grants, philanthropic partnerships, carefully governed sponsorships, and strategic collaborations. All resource mobilisation must be transparent, ethical, and aligned with WPA's independence and values.

Financial sustainability is closely linked to relevance. Member Societies will remain engaged when WPA provides practical value: policy tools, educational resources, advocacy support, networking, leadership development, and opportunities for collaboration. A stronger Secretariat is also essential. WPA needs continuity, institutional memory, updated communication systems, efficient coordination, and clear follow-through between leadership terms. Transparent reporting on finances, programmes, and outcomes will strengthen trust. Resource mobilisation should serve mission-driven priorities: education, workforce development, multilingual resources, vulnerable populations, and Member Society capacity in under-resourced settings. In this way, financial stewardship becomes not only an administrative responsibility, but a means of advancing dignity, compassion, equity, and access to high-quality psychiatric care across the globe.

The leadership I would bring is collaborative, inclusive, practical, and grounded in service. I would seek to help build a WPA that listens carefully, acts thoughtfully, includes broadly, and delivers meaningfully for its Member Societies and for the people and communities they serve.

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Interview with Prof. Lade Smith, Presidential Candidate, WPA 2026

What motivated you to stand for the WPA Presidency, and what vision would guide your leadership?

My motivation**.** Across the world psychiatry is facing unprecedented challenge - the impact of the covid pandemic, chronic resource deficits, workforce shortages and, of course, increased demand. Mental ill-health has dramatically increased over the past five years, with the WHO estimating that now more than 1 billion people worldwide suffer from a mental health condition. Despite being at least 20% of the disease burden, on average, less than 2% of health spend is on mental health care. Yet mental illnesses are disorders of youth, with 75% of mental health problems arising before the age of 24, 50% before the age of 14, which means that unlike physical health problems, mental illness has a disproportionate impact on a person's education, employment and social function, and ultimately their life chances. However, mental disorders are preventable and treatable, especially if identified and treated early. Without treatment, these children and young people are more likely to become adults with chronic relapsing remitting mental illnesses that interfere with their ability to fulfil their potential and contribute meaningfully to society.

Eighty percent of mental illness can be effectively treated, yet globally, less than 1/3 of people are able to access mental health care, which means that far too many people are unable to access treatment at all, especially in LMICs, and when they do, the treatment is often not good enough to meet their needs, and/or care is provided by people with no training. This means they do not recover well or that the experience they have, in and of itself, creates harm.

Whether in stable, well-resourced countries, or in conflict-ridden low resource regions, people with mental illness are always the most marginalised and neglected, yet have the greatest potential. Now, more than ever, it is our duty to speak out, advocate and bring about change for our patients and the people who look after them. We know that we can alleviate the distress and disability that arises from mental disorder and this is what drives me and this is why I am standing for the WPA Presidency, because I believe the WPA, which speaks for nearly every psychiatrist in the world, is the organisation best placed to ensure that people with mental illness not only receive the care they need, but to ensure that care is excellent and delivered by people who know what they are doing.

For change to happen, psychiatry must convince the policymakers, senior leaders and governments across the world to invest in mental health care. This requires strong and determined leadership that can raise the profile of psychiatry, so that we can get to the decision-making table and are listened to.

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I have demonstrated that I am strong leader, who speaks truth to power. I take an evidence-based approach, I am inclusive and can bring together psychiatrists and mental health stakeholders from across the world to work for the good of all our patients and those caring for them. I have travelled the world and have seen, experienced and worked in different health systems, from Africa, to Asia, to Latin America as well as Europe and the UK where I live. I have spoken to and listened to psychiatrists everywhere through the international collaborations of the WPA, collaborations with fellow psychiatric organisations globally, as well as through the international work of the Royal College of Psychiatrists, which covers most parts of the world. I have represented the world's psychiatrists at the United Nations Global Assembly 80; brought together world psychiatric associations and non-governmental organisations globally to sign up to the Prague Agreement and brought psychiatrists together to run the historic first ever Women in Mental Health Global Webathon in March 2026, and together Lars Lien, I am leading a European taskforce countering antipsychiatry narratives, convening psychiatrists from 9 different countries to promote the positive voice of psychiatry.

In my 33 years of practice, I cannot remember a time when mental health has been discussed so much by so many across the world. We must capitalise on this. I am running for WPA President because strong leadership is needed to fight for resources, to be at the decision-making table and to be listened to, so that psychiatrists can deliver quality, person-centred, equitable and therapeutic care, to everyone who needs it, regardless of where they are on this planet.

My vision is one of collaboration, education, tackling stigma and delivering evidence-based practice such that no matter where you are in the world, if you have a mental illness, you will be able to access a minimum quality standard of mental health care; delivered by someone who has been trained to a minimum quality standard recognised across the world and that there is a minimum quality standard of investment in evidence-based care and treatment proportionate to local population need and national resources and that everywhere, everyone and anyone is able to engage in and develop collaborative research aimed at improving outcomes for people with mental illness.

What are the most important challenges currently facing psychiatry globally?

1. The Treatment Gap
   There is a clinical care gap. The gap between those who need mental healthcare and those who get it has increased over the past few years, particularly as a result of the pandemic. Fewer than 1/3 people who need mental health care can access it. In the UK, £12 billion is spent on mental health annually, yet it costs the UK £300 billion per year. Similar findings are seen across the world in high income as well as low and middle income countries. This has been exacerbated by the chronic underfunding of mental healthcare and must be tackled urgently. We have the evidence to make the case. I will campaign for resources by partnering with key organisations such as the WHO, the UN,

UNICEF, the World Bank and the IMF to show that investing in mental healthcare is cost effective, saves lives and enhances the economy.

2. Funding and Resourcing
   Despite being 20% of the disease burden mental health receives 2% of the funding. There is discrimination against people with mental illness and those who look after people with mental illness and this affects the prioritisation and provision of mental health care. The longstanding historical stigma and discrimination against those with mental illness, particularly those with severe mental illness, means that there is limited understanding of and limited interest in mental health problems. Although the majority of mental health problems can be effectively treated, this knowledge is not widespread amongst senior decision-makers. Yet it is clear that more than any other health conditions, because mental illnesses predominantly arise in youth, they have a disproportionate impact on education, employment and thus productivity and the economic, as well as social development of a country. Any country that wishes to grow must invest in mental health care. This is particularly true for LMICs, which tend to have much younger populations than high income countries. That is why I have been championing the Global Economic Case for investment into mental health – the Prague Agreement.

3. Workforce, workforce, workforce.
   There is a global shortage of psychiatrists, with approximately 0.3 psychiatrists per 100,000 of the population. High income countries compete for psychiatrists to fill their vacancies, offering lucrative remuneration packages, but leaving LMICs drained of their doctors. In places like the UK, which has a population of 70 million, there are 1340 psychiatrists who medically qualified in Nigeria, compared with 280 psychiatrists of Nigerian origin working in Nigeria. A similar situation is replicated in Canada and Australia. We must increase the numbers of people working in psychiatry across the world, but we must, as a matter of urgency take steps to address the shortages in LMICs.

4. Research
   Doing research has enhanced my clinical practice. We know that mental health research lags behind other types of medical resource because we are not properly funded to do it. Yet research-active environments deliver better multi-professional care. Clinical research is essential to improving care and outcomes for patients, not least through informing evidence-based practice. Psychiatry research is the business of everyone in mental health. All psychiatrists can support research, but need to learn how. They can explain and discuss condition-relevant research with patients, and work with research teams to enable patients to access clinical trials, recruit and consent service users into new studies. They can initiate local clinical research activity, develop new research ideas based upon their clinical insights, and facilitate service-user initiated studies and

involvement. In addition, some psychiatrists may wish to pursue clinical academic careers, a role that involves research leadership and dissemination of research findings alongside clinical duties. Every psychiatrist in any country should be able to become "research-active". The WPA is uniquely positioned to support this.

What role should the WPA play in addressing these challenges, and how can it strengthen its global impact?

WPA is uniquely placed to bring psychiatrists from across the world together to achieve consensus in what basic standards of care and treatment for people mental illness should be and also to support national psychiatric associations to lobby for better funding and resources and support research collaboration across the world. While conditions like anxiety, depression and psychosis are found all over the world, there are cultural differences in the expression of these disorders and how conditions are perceived by others within that society.
The WPA can bring together knowledge, expertise and new approaches, and encourage skill-sharing to enhance care and treatment wherever people are in the world.

The WPA represents every single psychiatrist in the world and also represents evidence-based mental healthcare and all the 1 billion people + in the world with mental illness who need us to advocate for them. It is our duty to step up and show leadership to the world about how best to support people with mental illness because this will not only help those who are ill it will also improve the lives of those around them and improve the productivity and social and economic development of the country.

The WPA is the organisation best placed to influence of the WHO and UN, and other worldwide organisations. It is crucial that the WPA is the first port of call for the WHO, the UN and any other global organisation whenever they have anything to say about mental health issues.

The WPA can strengthen its global impact by collaborating more effectively with national psychiatric associations, underpinning and enhancing the role of the regional representatives. Successful NPAs can share their learning on how to influence each government with other partners – this reciprocal learning approach can be developed into a dynamic influencing strategy.

How can the WPA strengthen psychiatric education and training globally, across different regions and resource settings?

WPA should increase its offer through the greater use of technology and by using its convening powers to encourage greater partnerships between regions of that may traditionally not have had much contact, in addition to the regional offer that currently exists.

Technology now allows us to deliver education and training, including supervision, throughout the world. Strengthening of education and training globally could be supported by partnerships,

or "buddying up" of countries, with LMIC leads providing a model that supports reciprocal learning. For example, I have been involved in supporting the development of the Pan African UK Clinical Education Series (PAUCES), an initiative led by colleagues across psychiatric organisations in Africa and the UK. It is a dynamic, recurring webinar series designed to foster reflection, learning, and collaboration among mental health professionals across continents.

It would be good to see an increase in webinars and regional conference but also educational podcasts with academic, clinical and lived experience experts. These could be focused on delivering high quality clinical practice and clinical research; course development and delivery to standardise and enhance training standards in collaboration with experts from across the world. The WPA has the ability to "buddy up" or partner experts from across the world with any region/national psychiatric association that has need.

It is crucial however, that there is reciprocal learning. Clinical practice and research from resource-poor nations can be really helpful in understanding and developing different approaches to care, as well as in supporting HICs to deliver care in resource-poor parts of their countries. An exemplar of this is the Zimbabwe Friendship bench, where "Grannies" deliver psychological interventions to people with anxiety and depression (Chibanda et al 2016). This community intervention has now been replicated in LMICs and HICs across the world.

In addition, the WPA can use its convening powers to bring together more volunteers to support supervision of psychiatrists in places where there are fewer doctors. Finally, the WPA could expand its volunteer programme to support an enhanced worldwide training programme supporting clinical exchange placements to help the development and training of psychiatrists in LMICs and the delivery of mental health care in resource-poor environments.

How can the WPA further develop its financial sustainability, organisational structure, and resource mobilisation to better support its global mission?

Courses, courses and more courses. A sustained programme of courses, from foundational modules to specialist certificates can create a stable financial basis because training is a product that the WPA can offer without geographic constraints. There is ample opportunity to take advantage of courses while practising financial sustainability through many avenues, like accredited and tier-priced courses for different economies, offered to both individuals and institutions, which will also offer a consistent revenue stream that simultaneously strengthens WPA's mission.

Philanthropic partnerships with foundations and high net-worth donors will also fund mental health capacity-building and WPA Is already well-positions to attract this support, framing it as a global public good.

Collaboration with the IMF and the World Bank is also key in developing financial sustainability. These institutions fund large scale health reforms, and WPA's involvement could

secure long-term contracts, high-level consultancy roles, or programme partnerships—coming back to the importance of courses—that bring both revenue and influence.

In order to strengthen WPA's organisations structure, a broader membership model is needed, including large mental health organisations. This would expand both revenue and reach, and would also widen the base of stakeholders who contribute financially and intellectually. To support this, I would conduct a systematic survey of membership, which would give the WPA a mandate for reform. It would also identify unmet needs and ensure that structural changes reflect the priorities of its global community, rather than top-down assumptions.

Educational expansion, institutional partnership, and membership reform are all major levers for growth.

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The WPA Volunteering Programme: From Initiative to Sustainable Development

Marc H.M. Hermans, Sophia Thomson, John Allan and Egor Chumakov

WPA Volunteering Programme

Strengthening capacity building in global Psychiatry requires not only declarations but also the creation of effective mechanisms for knowledge transfer, implemented by a dedicated Working Group. The World Psychiatric Association (WPA) Volunteering Programme has implemented precisely such a mechanism. An analysis of the Group's activities during the 2023-2026 triennium, as well as a reflection on the experiences accumulated since its inception, allow us not only to assess the path travelled but also to outline the contours of the future development of this important initiative.

Former WPA President Prof. Afzal Javed and the Secretary for Education, Prof. Roger NG, established a Working Group on Volunteering to implement the capacity-building task within the 2020-2023 Action Plan. The key idea was to create a platform connecting member societies in need of professional development with volunteer trainers from other countries. During the 2023-2026 triennium, the Group's work continued under the leadership of co-Chairs Sophia Thomson (UK), and Marc H.M. Hermans (Belgium) / John Allan (Australia). The WPA President, Prof. Danuta Wasserman, and WPA Secretary for Education and Publications, Prof. Norbert Skokauskas continued to offer their support.

The Working Group’s activities were driven by the evolution in understanding the very essence of volunteering in education. Initially conceived as a programme of in-person visits, it successfully developed into an online format due to limitations imposed by the COVID-19 pandemic. This transition provided not only technological but also crucial conceptual experiences: it became evident that effective training requires not just the transmission of knowledge, but a deep consideration of the cultural and educational context of the host country. The Working Group aptly formulated this in one of its publications, "*all psychiatry is transcultural.*" The pilot projects launched in the previous triennium in Mexico and Pakistan laid the foundation. In 2023-2026, this experience was successfully scaled. A prime example is the project in Guatemala, where a team led by Dr. Ingrid Vargas-Huicochea (Mexico), with the support of the WPA Zonal Representative, conducted an online workshop on research methodology for psychiatrists and residents.

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The key lessons formulated by the Working Group on Volunteering based on its work can be summarized into several principles:

1. *The Principle of Partnership, Not Donorship*. The host side should act as the leader of the programme, identifying needs and culturally acceptable formats. Volunteers are invited guests who must be humble and flexible.
2. *The Principle of Sustainability.* A project's success depends on its integration into the local system: considering national mental health policies, available resources, and learning styles.
3. *The Principle of Inclusivity.* Involving people with lived experience of mental health conditions and their families in the design and implementation of training, as well as focusing on human rights and alternatives to coercion, aligns with the WPA's global values.
4. *The Principle of Measurability.* Training should be accompanied by intermediate and final evaluations, and its results should have the potential for supervision and further application in clinical practice.

As we approach the end of the current triennium, the Working Group is still full of with enthusiasm. Its experiences have led to a clear vision for its further development.

Firstly, this involves the *institutionalization of connections*. The WG wants to strengthen its interaction with the WPA Section on Education in Psychiatry, the Early Career Psychiatrists (ECPs) Section and WPA Scientific Sections. The WG plans to establish a partnership with the World Health Organization (WHO) allowing projects to reach a new level, combining educational efforts with global mental health agendas.

Secondly, it involves *work on branding and communication*. The ongoing discussion about rebranding both the programme itself and the Working Group’s remit aims to make its activities more transparent and attractive to potential participants, not yet familiar with its work. A new name should reflect the essence: this is not just "volunteering," but a structured programme of educational partnership.

Finally, to *foster an ongoing interaction* between the creation of a "bank" of educational modules with a pool of potential volunteer trainers, while simultaneously intensifying a dialogue with member societies acting as hosts.

Working Group on Volunteering members believe that WPA, disposing of a unique resource of experts from around the world, can become a key tool for reducing educational inequality in psychiatry through its Volunteering Programme.

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The World Psychiatry Journal Club: Bridging Evidence and Practice Through Global Dialogue

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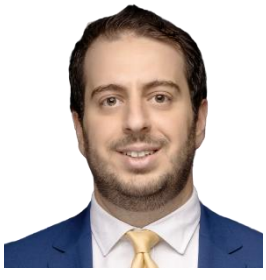
Background



The *journal club* is one of the most enduring traditions in medical education. First formalized by Sir William Osler at McGill University in 1875, its original purpose was to share the cost of journals among residents. Over a century and a half later, the concept has evolved into a cornerstone of evidence-based clinical training (Linzer, 1987). Contemporary journal clubs serve as structured forums for the development of critical appraisal skills, the synthesis of emerging evidence, and the cultivation of a habit of scientific inquiry that extends across an entire career (Bello & Grant, 2023; Deenadayalan et al., 2008; Falcon et al., 2024).

As medicine embraces the evidence-based model, it has become more important than ever for doctors to stay up to date with the literature and to develop the skills to critically read and analyze new papers (Djulbegovic & Guyatt, 2017). Teaching of these skills remains a frequent gap in medical education worldwide, as most curricula prioritize clinical knowledge and technical skills over research literacy and critical appraisal (Albarqouni et al., 2018). In many medical education settings, these competencies are considered relevant only to those engaged in research, despite the reality that current clinical practice must be grounded in rapidly evolving evidence (Sadeghi-Bazargani et al., 2014). Mastering these competencies not only strengthens research literacy but also directly enhances clinical decision-making by enabling clinicians to

interpret emerging evidence, evaluate the relevance and quality of new interventions, and integrate the most up-to-date treatment options into patient care. In this sense, critical appraisal skills should be viewed as complementary to clinical expertise and essential for delivering high-quality, evidence-informed practice (Sackett et al., 1996).

In the context of psychiatry, where the translation of research findings into clinical practice is frequently complex and contested (McGinty et al., 2024), regular engagement with the primary literature carries particular importance. Yet access to structured, high-quality journal club experiences remains unevenly distributed across training environments worldwide. Most psychiatrists practicing outside of major academic centers may have limited opportunities to engage with the latest evidence in a critically rigorous and collegial environment. Multiple challenges have traditionally hindered such sessions, including geographical dispersion, the scarcity of experienced mentors to oversee and guide journal club discussions, and the prioritization of clinical tasks over learning activities.

The World Psychiatry Journal Club: Concept and Structure

In late 2025, the World Psychiatric Association (WPA) Education in Psychiatry Section, in collaboration with the Early Career Psychiatrists (ECP) Section, launched the *World Psychiatry Journal Club* to help bridge this gap in psychiatry education worldwide. The initiative is fully online and open to psychiatrists and psychiatry trainees and allied mental health professionals across the globe. An online format enables geographically dispersed participants to engage without the logistical constraints of in-person sessions, enhancing reach and inclusivity without compromising educational quality (Aweid et al., 2022).

The Journal Club is led by Dr. Sami Ouanes (Digital Engagement Lead, WPA Education in Psychiatry Section), who oversees speaker coordination, session moderation, and the overall scientific program.

Each session is built around a recently published paper of international relevance to psychiatry. The selection process is collaborative: an early career psychiatrist, nominated by the ECP Section, pairs with a senior psychiatrist, and together they identify and agree upon a paper of mutual interest and scientific merit. This co-selection process is intentional, as it encourages intergenerational dialogue from the very first stage of planning. During the preparation phase, the early career psychiatrist is invited to share their draft presentation for the journal club with the senior psychiatrist for feedback. This process allows discussion and refinement not only of the presented results but also of presentation and communication skills.

This approach also provides valuable opportunities for mentorship, professional networking, and academic development.

The session format, spanning one hour, follows a structured interactive model. The early career psychiatrist presents the selected article, engaging the audience with the study's scientific context, methodology, results, and limitations. The senior psychiatrist provides moderation, adding depth of perspective, clinical contextualization, and critical challenge where appropriate. A distinctive feature of this initiative is the systematic invitation of at least one of the article's authors to attend each session, offering participants direct access to the reasoning behind key methodological choices and an opportunity to probe findings in real time. Additional subject-matter experts, which may join from different WPA sections, may also be invited depending on the topic.

Two sessions have already taken place. The inaugural session, held on 10 December 2025, focused on a randomized controlled trial of pramipexole augmentation for the acute phase of treatment-resistant, unipolar depression (Browning et al., 2025). The second session, held on 30 March 2026, examined a systematic review and meta-analysis on digital mental health interventions in inpatient settings (Diel et al., 2024).

Aims and Outlook

The aims of the *World Psychiatry Journal Club* are fourfold: to keep participants abreast of the latest and most impactful publications in psychiatry; to strengthen skills in critical appraisal, evidence synthesis, and scientific reasoning; to foster international dialogue and collaboration across the global psychiatric community; and to build collaborations between WPA sections.

Several features of these first sessions warrant comment ahead of a future formal evaluation of this initiative's impact. The systematic invitation of article authors to each session has emerged as a distinctive pedagogical asset: it enables participants to directly interrogate methodological decisions, probe the reasoning behind analytical choices, and access a quality of expert scientific discussion that is rarely available in standard educational settings. Future evaluation of the initiative could assess participant satisfaction, perceived educational benefit, and the impact on confidence in evidence appraisal and inter-section and international professional collaboration.

The pairing of early career and senior psychiatrists, not merely as presenter and moderator, but as co-architects of each session, reflects a deliberate design philosophy. Structured mentorship within journal club formats supports the development of critical appraisal skills and the professional integration of trainees into evidence-based practice cultures (Deenadayalan et al.,

2008). The *World Psychiatry Journal Club* attempts to operationalize this principle at a global scale.

The program's potential to serve as an equalizing force in psychiatric education is particularly salient. For early career psychiatrists who lack access to institutional journal clubs, or who train in environments where exposure to current international evidence is limited, this initiative offers a structured, collegial, and internationally connected alternative.

The *World Psychiatry Journal Club* represents a novel and internationally scalable model for continuing psychiatric education, with the potential to develop into a lasting global resource that could strengthen evidence-based psychiatric practice. It also represents a successful example of inter-section collaboration between WPA sections, illustrating how cross-section partnerships can foster innovative educational initiatives, promote international academic knowledge exchange, and create new opportunities for mentorship and professional development within the global psychiatric community.

Challenges and Future Directions

Some challenges include time zone differences, which may make it difficult for early career psychiatrists (ECPs) from certain regions to attend live sessions, as well as challenges inherent to the online format, such as connectivity issues, slower communication dynamics, and reduced active participation from attendees behind the screen. Potential alternatives and improvements could include recording sessions to allow later viewing and the creation of a reusable educational repository, organizing in-person sessions during the World Congress of Psychiatry, and incorporating more interactive formats to foster greater audience engagement beyond the presenters themselves.

References available on request

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Building the Human Side of Medicine: Designing a Behavioural and Social Sciences Course for a New Medical School in Oman

Tawfik Masaud, College of Medicine, Dhofar University, Oman

Oman is undergoing rapid social, demographic, and healthcare transformation. As the country continues to strengthen its healthcare system and expand medical education, newly established medical schools have a unique opportunity to shape the next generation of physicians. Beyond scientific competence, future doctors must be equipped to understand the behavioural, social, cultural, and psychological factors that influence health, illness, and healthcare delivery. The establishment of the College of Medicine at Dhofar University provided such an opportunity.

Creating a medical school from the ground up is a rare undertaking. It involves not only constructing facilities and governance structures but also making fundamental decisions about the type of doctors the institution seeks to graduate. While biomedical sciences remain the foundation of medical training, there is growing recognition that effective healthcare depends equally on communication, professionalism, empathy, ethical decision-making, cultural awareness, and an understanding of human behaviour. These competencies are rooted in the behavioural and social sciences.

The College of Medicine at Dhofar University commenced planning in 2022 and welcomed its first cohort of students in 2025. Curriculum development was undertaken through a collaborative partnership with the College of Medicine and Health Sciences at Sultan Qaboos University. During the planning process, behavioural and social sciences emerged as a strategic priority. Rather than viewing these disciplines as supplementary to medical education, the curriculum development team considered them essential to preparing future doctors for contemporary clinical practice in Oman.

This perspective was shaped by several factors. First, healthcare in Oman, as elsewhere, increasingly requires physicians to address the interaction of biological, psychological, and social determinants of health. Family structures, cultural values, religious beliefs, health literacy, and community expectations continue to play important roles in how illness is experienced and how healthcare is accessed. Understanding these influences is fundamental to patient-centred care.

Second, mental health has become an increasingly important national and global healthcare priority. Growing awareness of mental health conditions, together with emerging concerns regarding burnout and wellbeing among healthcare professionals, highlights the need for medical graduates who possess not only clinical knowledge but also emotional intelligence, self-awareness, and resilience.

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Third, medicine is entering an era of unprecedented technological change. Advances in artificial intelligence are already transforming documentation, information retrieval, and aspects of clinical decision-making. As technology assumes a growing number of technical functions, the uniquely human dimensions of medicine become even more important. Empathy, communication, ethical judgement, cultural understanding, relationship-building, and professional identity are qualities that patients continue to value and that technology cannot readily replace. For future doctors in Oman, as elsewhere, these competencies will become increasingly important throughout their careers.

These considerations led to the decision to introduce a dedicated Behavioural and Social Sciences course during the first year of the MD programme. This was a deliberate educational strategy. Professional identity formation begins long before students enter clinical placements. The first year of medical school represents a critical period during which students develop attitudes, values, and professional behaviours that may shape their future practice. This consideration was particularly important for the inaugural cohort, whose experiences would contribute to establishing the culture and traditions of a newly founded medical school.

The decision to offer a standalone course was equally intentional. Contemporary medical curricula often favour extensive horizontal and vertical integration. However, newly established institutions must balance educational aspirations with practical realities. Limited faculty resources, evolving clinical teaching capacity, and the need to establish new educational systems can create challenges for highly integrated curricula. A dedicated course provided a pragmatic and coherent mechanism for introducing foundational behavioural and social science concepts while creating opportunities for future integration throughout the programme.

The syllabus was developed through an iterative process that combined educational theory, clinical experience, international benchmarking, literature review, expert consultation, and accreditation requirements. Backward design principles guided development, with learning outcomes identified before assessment methods and content selection. Particular emphasis was placed on relevance to future clinical practice. Topics were selected not simply because they represented traditional academic disciplines, but because they addressed behavioural, psychological, and social challenges commonly encountered by physicians in everyday medical practice.

An interesting feature of the development process was the careful use of artificial intelligence. AI tools were employed to assist with topic mapping and identification of potential gaps in curriculum coverage. Rather than replacing academic judgement, these tools functioned as supplementary resources that supported curriculum development. All AI-generated suggestions underwent critical review and adaptation to ensure educational relevance, contextual appropriateness, and alignment with programme outcomes. This experience demonstrated that AI can contribute meaningfully to curriculum design when guided by expert oversight.

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The educational approach also reflected the innovative ambitions of the new college. Dhofar University became one of the first medical schools in the region to incorporate team-based learning from the beginning of its programme. Recognising that students entering directly from secondary education may have limited experience with collaborative and self-directed learning, the curriculum adopted a gradual approach. This allowed students to develop confidence while fostering teamwork, communication skills, accountability, and professional behaviour.

Several broader lessons emerged from this experience. First, curriculum development in new medical schools requires innovation tempered by pragmatism. Educational models must be adapted to local realities, institutional capacity, and student needs. Second, behavioural and social sciences can play a central role in fostering professional identity, empathy, and patient-centred care from the earliest stages of training. Third, the growing influence of artificial intelligence increases rather than diminishes the importance of human competencies in medicine. Finally, curriculum development should be viewed as a continuous process of evaluation, reflection, and improvement rather than a one-time exercise.

The experience of developing a Behavioural and Social Sciences course at Dhofar University illustrates how a new medical school in Oman can use curriculum design to shape future professional culture. By placing human behaviour, communication, professionalism, and social understanding at the beginning of medical education, the programme seeks to prepare doctors who are scientifically competent, culturally responsive, and equipped for the realities of twenty-first-century healthcare. Although rooted in the Omani context, the lessons learned may be relevant to other emerging medical schools seeking to balance technological advancement with the enduring human values that remain at the heart of medicine.

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Psychiatric Training in Brazil: Education, Challenges, and Future Perspectives

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Introduction

In 2019, 970 million people worldwide had a mental disorder, or one in eight, while by 2021, the World Health Organization estimated 1.1 billion, or nearly one in seven, with anxiety and depressive disorders accounting for the majority of cases[1-3]. In turn, the weighted mean 12-month prevalence of mental disorders in the Americas is 17.0%, with 14.8% in Latin America and 17.0% in South America, highlighting the epidemiological scale of the problem and regional disparities in access to specialized mental health care[4]. The São Paulo Megacity Mental Health Survey found that 29.6% of adults in a population-based sample had a mental disorder in the past 12 months. This is the only national diagnostic estimate in Brazil. Anxiety disorders were the most prevalent category, followed by mood disorders, impulse-control disorders, and others. These data show a significant burden in large urban areas with social inequality, violence, and rapid population change[5, 6].

With the prevalence and effect of mental disorders, psychiatrists are crucial in their correct detection, diagnosis, treatment, longitudinal care, and prevention. In this context, this article describes the didactic and technical aspects of psychiatric training in Brazil, focusing on the competencies, clinical exposure, and educational standards needed to train psychiatrists to meet the country's complex mental health needs.

Medial Education and Specialization in Psychiatry

Undergraduate medical education in Brazil requires a minimum of 7,200 hours and develops generalist, humanistic, scientific, ethical, and socially accountable clinical competencies[7]. Medical students learn about mental health, psychopathology, and psychiatric care during undergraduate training, especially in clinical and community-based settings; however, doctors learn advanced psychiatric skills after graduation through structured specialist training.

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In Brazil, a physician is legally recognized as a psychiatrist only after the specialty has been registered with the Regional (State) Council of Medicine (Conselho Regional de Medicina, CRM), resulting in the Specialist Qualification Registration (Registro de Qualificação de Especialista, RQE). There are three practical routes to obtaining this registration. The first is completion of a three-year psychiatry medical residency program accredited by the National Medical Residency Commission (Comissão Nacional de Residência Médica, CNRM), after which the physician may register the residency certificate directly with the CRM[8-10]. The second is completion of a three-year specialization program in psychiatry (similar to medical residency) accredited by the Brazilian Medical Association/Brazilian Psychiatric Association (Associação Médica Brasileira/Associação Brasileira de Psiquiatria, AMB/ABP), which qualifies the physician to take the Specialist Title Examination in Psychiatry administered by the ABP. If approved, the physician may then request registration of the specialist title with the CRM[8-10]. The third route applies to physicians who have not completed a CNRM-accredited residency or an AMB/ABP-accredited specialization program but can document six years of professional practice in psychiatry, corresponding to twice the duration of residency training. These physicians may also become eligible to take the Specialist Title Examination; if approved, they may register the specialist title with the CRM[8-10].

Thus, the Specialist Title Examination is not mandatory for physicians who complete a CNRM-accredited psychiatry residency. Rather, it constitutes an alternative certification route for physicians who seek specialist recognition through either an accredited specialization program or documented professional experience. Regardless of the pathway, public presentation as a psychiatrist and formal professional recognition of the specialty require registration with the CRM and issuance of the RQE[10,11].

Psychiatry residency training in Brazil is regulated by CNRM Resolution No. 02/2006, which establishes the duration of medical residency programs and requires 80% to 90% of training to occur as supervised in-service education, complemented by theoretical activities[12]. More recently, CNRM Resolution Nº. 18/2021 approved the competency matrix for psychiatry residency programs, specifying the knowledge, skills, attitudes, clinical exposures, and professional competencies expected during psychiatric training and aligning Brazilian psychiatric education with competency-based medical specialization[13,14].

Competency matrices development during psychiatry training

Competency matrices mark a significant shift in specialized medical education, moving the focus from workload, time-based progression, and mere exposure to clinical services to clearly defined educational objectives, observable clinical performance, and the progressive acquisition

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of knowledge, skills, and professional attitudes. Accordingly, the competency matrix should inform curriculum design, clinical supervision, formative assessment, summative assessment, and the certification of professional proficiency[13,14].

In psychiatry training, residents are expected to acquire competencies in the diagnosis, treatment, follow-up, rehabilitation, and prevention of mental disorders across different levels of clinical complexity. These competencies include psychiatric anamnesis, mental status examination, psychopathological reasoning, use of diagnostic classification systems, clinical formulation, and differential diagnosis. Residents must also develop the ability to use cognitive assessment, psychometric instruments, laboratory investigation, neurophysiological assessment, and neuroimaging when clinically indicated in psychiatric evaluation. Core domains such as neuroscience, genetics, epigenetics, psychopharmacology, human development, sleep medicine, aging, women's mental health, child and adolescent psychiatry, substance-related disorders, and psychiatry related to medical illness must be integrated throughout training[13,14]. Moreover, psychiatric education should be grounded in a person-centered approach that is sensitive to the life cycle and sociocultural context, incorporating biological, psychological, familial, economic, cultural, and spiritual dimensions into the clinical understanding of the patient[13,14].

Beyond technical and diagnostic skills, psychiatric training must include therapeutic, social, ethical, interprofessional, and health-system competencies. The specialist must create and monitor individualized treatment plans, psychopharmacotherapy, psychotherapies, psychosocial interventions, neuromodulation, and rehabilitation strategies in psychiatric emergencies, consultation-liaison settings, outpatient services, hospitals, psychosocial care centers, and other health care venues. The matrix emphasizes the physician-patient-family relationship, clinical communication, multiprofessional teamwork, respect for dignity, autonomy, and individual singularity, ethical and medico-legal principles, forensic psychiatric practice, mental health promotion, illness and complication prevention, and functional recovery[13, 14]. Thus, contemporary psychiatric competence requires a sophisticated integration of psychopathological reasoning, clinical judgment, ethical responsibility, cultural sensitivity, evidence-based practice, and commitment to population mental health.

The acquisition of these competencies is not intended to be merely declarative but should be documented and assessed throughout residency. In Brazil, current national regulation requires resident assessment to be systematic, permanent, and periodic, combining formative and summative procedures[15]. Assessments must address knowledge, technical and clinical skills, professional attitudes, ethical behavior, communication, relationships with patients, families,

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and health teams, decision-making, commitment to learning, and performance within the health system. They should also be linked to the expected level of competence for each stage of training and accompanied by structured feedback that identifies strengths and areas requiring improvement. [13-15]

Operationally, Brazilian residency programs are expected to assess residents at least every four months. Each periodic assessment should include three domains: a cognitive or theoretical assessment; a psychomotor or practical assessment based on performance in clinical settings and supervised activities; and an affective-professional or attitudinal assessment in the workplace[15]. The minimum national standard for progression includes at least 70% sufficiency in the cognitive component and a "satisfactory" concept in practical and attitudinal workplace-based assessments. Progression to the following year also depends on full completion of the annual workload and satisfactory performance across the required evaluations[15].

Programs may additionally use multiple instruments to document competency acquisition in different clinical scenarios. These may include direct observation of clinical encounters, structured workplace-based assessments, logbooks, portfolios, records of procedures and activities, scientific production, and Entrustable Professional Activities, which can support decisions about increasing levels of supervision and autonomy[15]. Annual individual progress testing, when adopted by the specialty society and the local residency committee, can complement the assessment system by monitoring cognitive development over time. Practical tools such as the Clinical Evaluation Exercise, Mini-CEX, and Objective Structured Clinical Examination may also used to evaluate residents' performance in history taking, examination, diagnostic reasoning, treatment planning, communication, counseling, and interpretation of clinical data.

Thus, the competency matrix is operationalized through longitudinal, multimodal assessment rather than through time-based exposure alone[15].

Challenges in Psychiatric Training

According to Medical Demography in Brazil 2025[16], 13,581 doctors were certified in psychiatry, or 6.69 per 100,000 people. According to the same survey, 47.2% of psychiatrists are women and average 52.7 years old. From 6,377 psychiatrists in 2011 to 13,581 in 2025, the number climbed by approximately 113%.[16] Although this rate is higher than that observed in many low-income countries, it remains lower than rates reported in developed countries.

Regional disparities in residency programs and psychiatric experts are serious issues. Large urban places have more training and healthcare resources; however, numerous Brazilian regions

lack specialist professionals. Urban centers have greater supervision, service infrastructure, and job prospects, while peripheral regions, inland locations, and historically disadvantaged territories still lack workers.

Since extending resident posts does not guarantee that graduates will stay in their training territory, psychiatric training must be combined with professional retention plans. Employment, adequate pay, stable career paths, institutional support, continuing professional education, the healthcare network, academic development, and professional integration into the local community affect retention.

Thus, an effective mental health policy and a strategy to build Brazil's specialized mental health workforce must include training competent psychiatrists and ensuring their retention in key regions.

Perspectives

Increasing public health coverage and population-wide access to psychiatric care are key problems. Psychiatric services are more accessible in large capital cities than in the outskirts and smaller inland municipalities. New drugs and evidence-based treatments must be added to the public system’s therapeutic arsenal. Psychotherapy and electroconvulsive therapy (ECT) must also be made more accessible. ECT training is required in psychiatry residency, but not all hospitals offer it, limiting clinical exposure and patient access to an effective treatment. As psychiatric inpatient beds decline, the Brazilian health system needs structural changes to assure continuity of care.

Public and private healthcare systems also use digital resources, particularly telemedicine. However, psychiatric training must be adjusted to ensure that remote care complements face-to-face assessment in some clinical circumstances. Finally, mental illness stigma persists globally, particularly in Latin America and Brazil. Thus, teaching future psychiatrists must address stigma.

Conclusion

Psychiatric training in Brazil is characterized by a rigorous process that combines academic education, supervised clinical practice, and the development of humanistic competencies. Medical residency plays a central role in the training of these specialists, preparing them to manage the complexity of mental disorders and to work across diverse healthcare settings.

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Given the growing demands related to mental health, it is essential to invest in the qualification of professionals and strengthen medical residency programs. Such measures are necessary to ensure more effective, humane, and accessible psychiatric care for the Brazilian population.

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Shaping Mental Health Education in the UAE: The Al Amal Clinical-Academic Experience

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Introduction

Mental health workforce shortages remain a major global challenge. The World Health Organization (WHO) and the World Psychiatric Association (WPA) continue to emphasise pre-service and postgraduate education as essential strategies for addressing treatment gaps and strengthening mental healthcare systems (WHO, 2021; WHO, 2025). Across the Middle East, shortages remain particularly evident in child and adolescent psychiatry, addiction psychiatry, and specialist mental health nursing (Clausen et al., 2020; Findling & Stepanova, 2018).

Within this context, the United Arab Emirates has increasingly invested in locally based specialist training pathways and academic mental health infrastructure. Al Amal Psychiatric Hospital, under Emirates Health Services, has evolved from a tertiary psychiatric referral centre into a national clinical-academic platform supporting education, workforce development, and academic growth.

Established in 1983 and relocated in 2018 to a modern purpose-built facility, the hospital now integrates education, research, quality improvement, and clinical care within everyday institutional practice. Supported through partnership with Maudsley Health, collaboration with international academic partners and reputable local and international universities, Al Amal hosts one of the largest mental health training environments in the UAE.

Al Amal as a Clinical-Academic Training Platform

As the only stand-alone public psychiatric hospital in the UAE, Al Amal provides a broad multidisciplinary training environment across adult psychiatry, child and adolescent psychiatry, addictions, forensic psychiatry, intellectual disability services, rehabilitation, emergency psychiatry, outpatient care, and community psychiatry.

Through collaboration with Maudsley Health and South London and Maudsley NHS Foundation Trust, the hospital adopted a Clinical Academic Group structure across specialist services. Educationally, this allows trainees to experience psychiatry through integrated specialist pathways with embedded supervision, governance, reflective practice, and scholarly engagement rather than through a single generic model of psychiatric training.

Education is therefore embedded within the clinical operating model rather than functioning as a parallel academic activity. Trainees participate directly within multidisciplinary teams and are exposed to collaborative decision-making, patient-centred care, and specialist psychiatric practice.

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Undergraduate and Multidisciplinary Clinical Education

The hospital currently hosts more than 1000 trainees annually across medicine, nursing, psychology, pharmacy, family medicine, and allied disciplines. Clinical placements emphasize experiential learning, supervised patient exposure, communication skills, professionalism, and multidisciplinary collaboration.

Educational activities are embedded within multidisciplinary teams and supported through small-group teaching, case-based discussion, simulation, and workplace-based learning approaches consistent with experiential education models (Kolb, 1984; Parmelee et al., 2020). The hospital-wide weekly academic programme further supports this environment. In 2025 alone, more than 230 academic sessions generated over 10,000 attendances across trainees and staff.

Importantly, trainees participate within the same academic environment as qualified clinicians, strengthening interprofessional learning and reinforcing psychiatry as an intellectually engaging and clinically meaningful discipline. The hospital has also increasingly expanded placements into emerging disciplines including healthcare management and bioengineering, recognising that future mental health systems will require collaboration between clinicians, administrators, and technological experts.

Trainee Wellbeing and Psychological Safety

Recognising that effective clinical education requires psychologically safe learning environments, Al Amal introduced a structured trainee wellbeing programme through the Committee for Academic and Professional Advancement (CAPA). Trainees receive orientation regarding supervision pathways, wellbeing resources, and psychological safety principles, and are allocated named supervisors throughout placements and training programmes.

The model encourages reflective practice, open discussion of uncertainty, and professional support during emotionally demanding clinical experiences. This approach aligns with wider evidence regarding psychological safety and compassionate leadership within healthcare education (Edmondson, 2019; West, 2021).

Psychiatry Residency Training

The Psychiatry Residency Programme represents one of the hospital's major educational developments. Established to support the UAE's growing need for locally trained psychiatrists, the programme received Arab Board accreditation in 2019 and NIHS accreditation in 2024, becoming the first NIHS-accredited psychiatry residency programme in Dubai and the Northern Emirates.

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The four-year competency-based programme currently trains 38 residents and has graduated 18 psychiatrists, the majority of whom now practise within UAE healthcare institutions. Training includes rotations across adult psychiatry, child and adolescent psychiatry, addiction psychiatry, consultation-liaison psychiatry, emergency psychiatry, neurology, internal medicine, and community psychiatry.

Educational activities include protected academic teaching, psychotherapy supervision, reflective practice groups, simulation-based learning, and workplace-based assessments. Recent curriculum developments have also incorporated teaching on digital psychiatry and emerging healthcare technologies, reflecting the evolving nature of psychiatric practice.

Child and Adolescent Psychiatry Fellowship

Recognising the major regional shortage in child and adolescent psychiatry, Emirates Health Services established the first NIHS-accredited Child and Adolescent Psychiatry Fellowship in the UAE at Al Amal Psychiatric Hospital.

The fellowship provides advanced subspecialty training in outpatient, inpatient, developmental, neurodevelopmental, emergency, addiction, and consultation-liaison psychiatry. Training integrates supervised clinical responsibility with structured academic teaching in developmental psychopathology, psychotherapy, psychopharmacology, family interventions, and complex formulation.

Mental Health Nursing Residency

Mental health nursing has similarly become a central component of workforce development at Al Amal. In line with the UAE National Strategy for Nursing and Midwifery (UAE Government, 2021), Al Amal hospital established the first NIHS-accredited Specialty Training in Mental Health Nursing Programme in the UAE.

The programme integrates supervised psychiatric clinical practice with leadership development, academic learning, reflective practice, and quality improvement across emergency psychiatry, addictions, rehabilitation, child and adolescent psychiatry, forensic psychiatry, and community mental health settings.

Research, Academic Culture, and Scholarly Engagement

Research and academic culture increasingly support the hospital's educational mission. Participation in research projects, scholarly activities, conference presentations, and peer-reviewed publications is vital for trainee development across programs.

Al Amal adopted a bottom-up approach to enhance academic culture, alongside a top-down institutional strategy. A hospital-wide strategy forum identified education and research as core pillars, integrating research key performance indicators into operational planning across Clinical Academic Groups.

Initiatives included multidisciplinary workshops in scientific writing, research ethics, systematic reviews, and critical thinking; open "Research Café" meetings for peer mentorship; and "Al Amal Fairs" for collaborative project development. The Al Amal Scientific Research Award evolved into a national platform, with the 2023 event attracting 60 abstracts and 150 participants, and the 2026 edition receiving 114 submissions, including 85 scientific posters, with categories for students and trainees. These efforts increased peer-reviewed publications and international academic participation, enhancing the hospital's academic role.

These initiatives have significantly increased the number of peer-reviewed publications and participation at international academic events, solidifying Al Amal Psychiatric Hospital's academic role as a center for research and academic excellence in mental health.

Discussion and Future Directions

The Al Amal experience illustrates how specialist psychiatric hospitals can evolve into integrated clinical-academic ecosystems that combine service delivery, education, trainee wellbeing, and scholarly engagement. Several features appear central to this model: broad multidisciplinary exposure, accredited postgraduate pathways, protected academic activity, named supervision, and practical research engagement linked directly to clinical education.

Importantly, the Al Amal model reflects adaptation rather than replication. International collaboration has supported educational governance and curriculum development while remaining aligned with local leadership, national accreditation systems, and UAE workforce priorities. Future priorities include expanding subspecialty fellowship pathways, strengthening simulation-based learning, and further integrating digital competencies into training curricula.

Conclusion

The Al Amal experience demonstrates how specialist mental health institutions can function not only as centres of care, but also as platforms for developing future generations of clinicians, educators, researchers, and healthcare leaders. By integrating clinical service delivery, accredited training, trainee wellbeing, multidisciplinary learning, and scholarly engagement within a unified institutional vision, Al Amal Psychiatric Hospital offers a practical example of how the UAE is shaping the future mental health workforce.

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Figures and References

Figure 1. Al Amal Hospital Journey

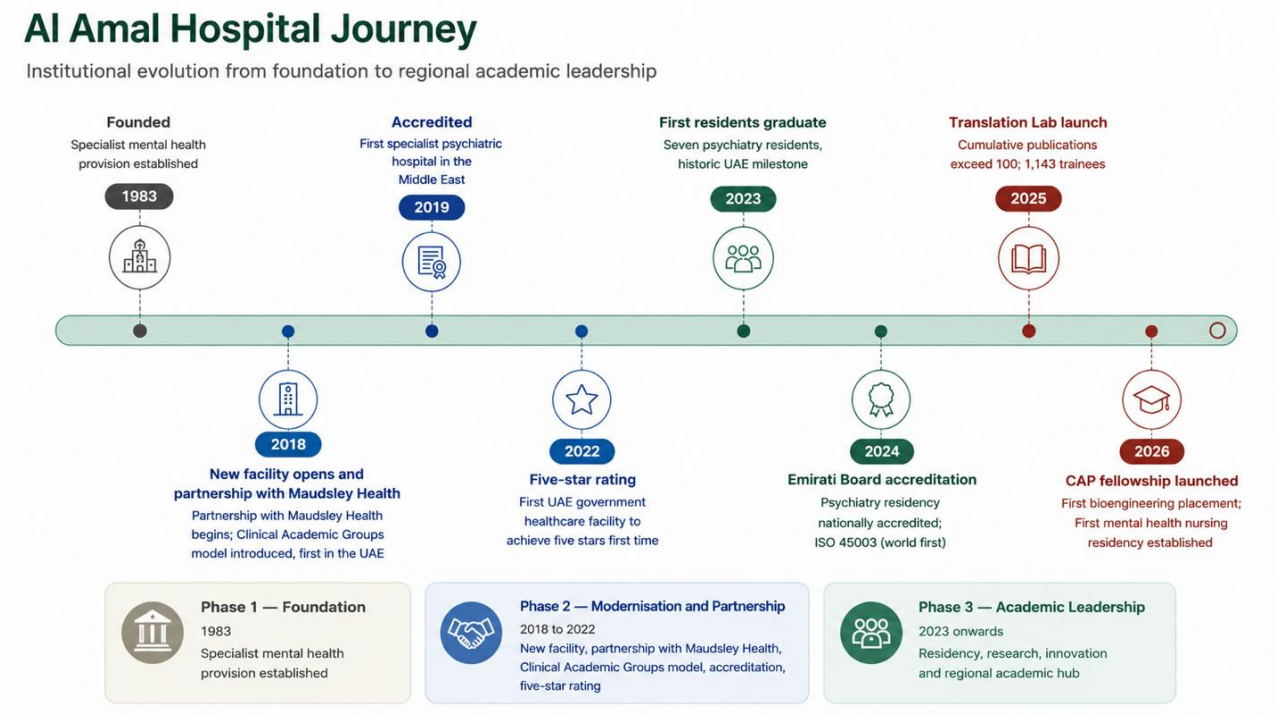

Figure 1. Institutional evolution of Al Amal Psychiatric Hospital from foundation in 1983 through three phases of development: foundation, modernisation and partnership (2018 to 2022), and academic leadership (2023 onwards). Key milestones include the new facility and Maudsley Health partnership in 2018, JCI accreditation in 2019, the first psychiatry residency cohort graduating in 2023, NIHS Emirati Board accreditation and ISO 45003 certification in 2024, the Translation Lab launch and cumulative publications exceeding 100 in 2025, and in 2026 the launch of the Child and Adolescent Psychiatry Fellowship, the first bioengineering placement, and the establishment of the Specialty Training in Mental Health Nursing Programme.

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Figure 2. Trainee Growth at Al Amal Psychiatric Hospital

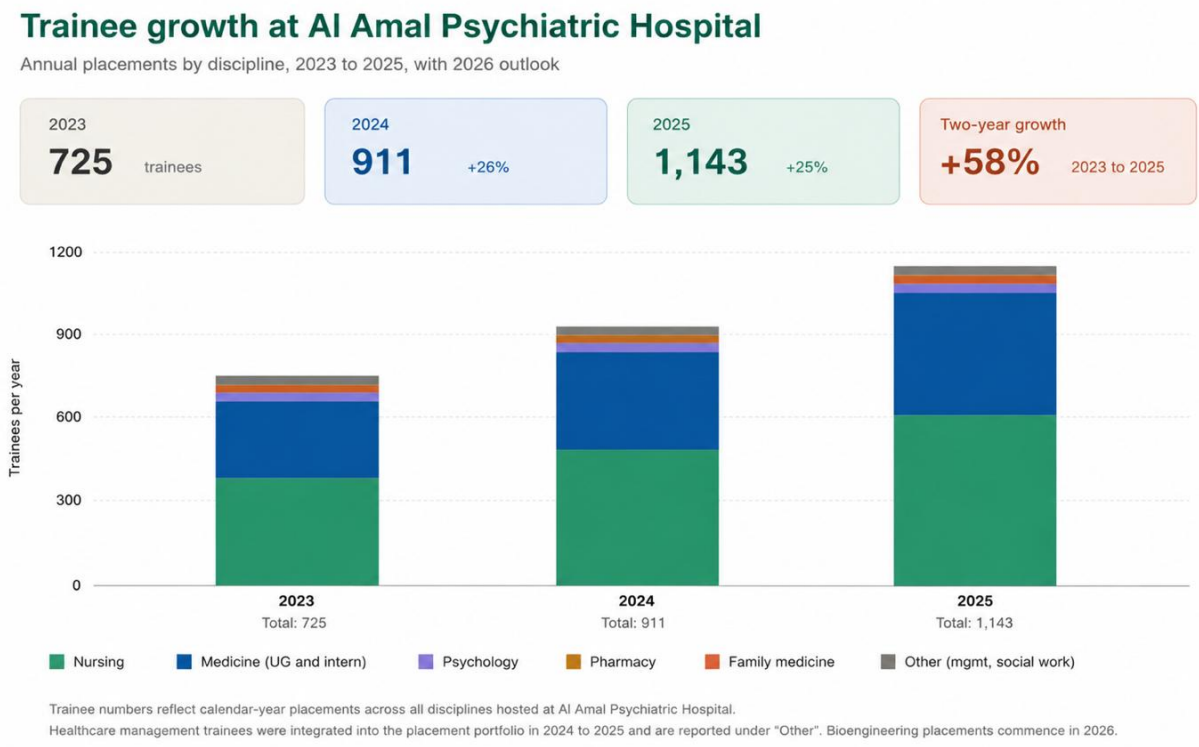

Figure 2. Annual trainee placements at Al Amal Psychiatric Hospital by discipline, 2023 to 2025, with 2026 outlook. Total trainee numbers grew from 725 in 2023 to 911 in 2024 (+26%) and 1,143 in 2025 (+25%), representing a 58% increase over two years. The composition of the trainee body has broadened, with the first healthcare management trainees completing placements between January and April 2026. The first bioengineering placement commences in June 2026.

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Ara. A Māori guidebook of the Mind

Dr Hinemoa Elde. Te Aupōuri, Te Rarawa, Ngāti Kurī, Ngāi Takoto. Ngāpuhi. New Zealand

How do we think about thinking? A question at the heart of our work as psychiatrists. The workings of our minds hold such fascination. Not only our own minds, other peoples' minds, how our minds connect and our collective sense of Mind. We want to make meaning, identify patterns, we want to learn faster and more easily, we want tricks and tips that make us succeed in life, help us "acheive", feel at ease, experience mastery or perhaps wisdom, or even happiness. We want to stop making the same mistakes, we want to heal our pain and suffering, we want to make better choices, we want to remember, we want to prevent diseases of the mind, we want to feel in control.

Another challenge we face is to provide resources that enhance mental wellbeing and protect against risks of developing mental illness to large groups of people, as well as to the smaller groups we might see in clinics and services. In Māori society, as in many other cultures, we are used to being trained in and then providing resources developed in english speaking cultures, often the cultures which originally colonised us and continue to colonise us today in various ways. We do not have ready access to the tools which originate from our own world view, from our own methodologies and evidence base.

My latest book is an ambitious attempt as a mother, descendent, ancestor of the future, and psychiatrist to address these challenges and provide Māori resources that address the idea of how we think about thinking in a uniquely Māori way. My goal is to bring some expanding insight, growing understanding and even comfort in the terrifying times that we live in, to our global community. The book is called Ara. A Māori guidebook of the Mind. Ara is our word for pathway, quest, direction. This signals that the book takes us on a vivid, transformational journey. A travel guide, if you will, through 23 caves created and curated by Hinengaro, our goddess of the Mind. A specific itinerary with time and space to explore these priority areas identified by our ancestors. The names of these caves and the order in which we must explore them comes from teachings I was privileged to be part of in 2008, in the Hokianga, a sacred harbour in Te Tai Tokerau, Northland, Aotearoa, New Zealand. Ara, is my interpretation of what I was taught and my way of safely handing on the knowledge that have given to me.

Ara is a book to help us with modern life. We are awash with information, on screens, data flooding us. It is almost impossible to escape the internet with our phones a constant companion and the portals they carry invading our spaces, taking over our lives. I use this journey through the caves of Hinengaro in my work. The journey provides a safe way for tamariki mokopuna, children and families, together and as individuals, to process what is happening in a new way. These are not only Māori people. Families from a diverse range of cultures have found their

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Ara journey fruitful. Māori resources can work for those from other cultures too. I have also voiced an audiobook for those who prefer to listen rather than reading. Here is a whirlwind tour of the quest we traverse in Ara. By travelling deep into Papatūānuku, our Earth Mother and back to the surface again we find our way through Hinengaro's caves. How fitting that we should be taken inside our planet. Into her rocks and layers, the strata of ancient times as a way to cut out the noise of daily life and embrace the fear of shadows, through these ever descending series of caves down to the bowels of the earth and then slowly and steadily back up to the surface again. Our mental processes and mental health, intrinsically linked to that of our world.

Rua i te horahora. Awareness of the vast expanse of wairua is our entrance into this underground treasure trove. Wairua, the unique connection between people and the universe, our spiritual connectivity. We are wairua in physical form. This focus on wairua awareness and knowledge returns us to the essence of ourselves, reminding us that wairua is critical to our wellbeing, to our view of the world and our place in it. To our perspectives about others. To our decisions and to our behaviour. To how we feel. Here we breathe wairua. The thrill and awe of learning is next in rua i te wanawana. The tingle we feel when we meet our passions in life, and give ourselves the freedom to pursue this drive. Rua i te wanawana fuels the way we pay attention to the juice of learning. Rua i te pūkenga, a focus on shared abilities that we are growing skills together, is our next stop. When we join up our skills, we are more than the sum of our parts. We are not be alone on the quest, many others take the same journey and we can invite others to share this path. The sweet fragrances that trigger memories in rua i te mahara are next. Hinengaro has this special place for connecting with the power of memory. Fostering our memory gifts with learning and laughter. Rua i te pupuke reminded us about patience in building our strengths over time and how that feels emotionally. The simplicity and stability of rua i te taketake o Io is a formal recognition of the footsteps we follow and those we create for others. We have been reminded of our tiny part in a much bigger story. Next, we enter rua i te atamai. Readiness of the mind, quick wit, intellect. This is the territory of rapid response, of lightning-speed choices. Brevity is inherent in this kind of quick thinking. Keeping it short and sweet. We can be confident enough to trust Hinengaro's unexpected lessons through playfulness.

Rua matua taketake o Tāne. Parenting mind. Our whakapapa, genealogy, is our focus, with this much needed parenting angle. A unique place where the resources for parenting are stored. It should not surprise us that our ancestors recognised parenting as a fundamental aspect of Hinengaro's concerns. Without skilled and loving intergenerational parenting of our babies the tribe would die. Here in this rua we are dedicated to experiences of structured progress in our parenting and caregiving roles. Rua i te whaihang Creativity. There is a crackle of static on our skin. An electric charge ignites the air. A place dedicated to creativity. We feel such freedom of expression and the intense drive to create. In our rushing, distracted, overstimulated lives we can struggle to find our creativity. To rediscover the ease we had as youngsters in making a leaf and stick into a waka, a boat, in building a fort with cushions and a tarpaulin, scratching elaborate designs from our dreams into the wet sand. Next we enter rua i te kōrero, Hinengaro gave us the power of words. Words can instantaneously take us around the world, back in time

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and into the future, all in the same moment. Here is a place to remember the extraordinary freedom words can bring us. Rua i te whakaako is where we enter the place of learning and teaching. Blood, sweat and tears flowed as we neared the deepest part of the journey. Next we arrive at the bowels of the earth. Te whatumanawa. Now we set foot in our most intimate and profoundly emotional arena. The warmth rapidly intensifies. A thundering lava river grinds through the chasm far below. Chunks of crushed rock jostled by the streams of dazzling orange and yellow. Flames spiking up from the serpentine body of living fire. We are in the depths of Papatūānuku. The crucible of emotion. Te Whatumanawa is a place to come to stand in the blast furnace of our own feelings and to begin to recognise what they are about. Our emotions are another superpower.

Beginning to move up again, we enter rua i te whai whakaaro, a fitting place to review and reassess in order to develop plans that deliver the results we are looking for. Then, rua i te whai mātauranga where we were reminded that the search for knowledge is another priority. Trust, enshrined in rua i te whakapono, comes next. We are invited to pick up Hinengaro's challenge in our lives, remembering the responsibilities that come with building trusting relationships. Curving ever upwards, the power of prayer echoed in the vast hall of rua i te karakia. Each of us comes with different histories of prayer and what that means. Next we explore rua i te matakite, the ancient gateway opening up our awareness of intuition. Hinengaro reminded us to trust our gut instincts. Rua i te mōhio asked us to begin to take on board the possibility of wisdom. We move on to the place of humility, rua i te mahaki. A reminder from Hinengaro to let go of pride and arrogance, to remember our origins. Next on our spiral circuit we visit rua i te hauora tangata, where resources in enhancing health are stored. Rua i te whakapakari tinana follows, where Hinengaro provided the lesson that our minds and bodies are not separate. They are intimately intertwined. We need growth in the mind to grow strong and healthy bodies. Rua i te aroha is our penultimate storeroom of the mind. Loving connection and compassion. Love given is love returned. Love is a reciprocal energy. Aroha is an ancient Māori word and concept, describing a deeply felt emotion and a way of thinking that encompasses love, compassion, sympathy and empathy. We consider aroha something that comes from within our core *and* from all around us. An inexhaustible source, a divine wellspring. Fierce protection, rage at injustice, smouldering passion and desire, the abyss of loss and grief. A central source of how we experience aroha comes from our experiences of the deaths of those we love and the aroha we carry forward as their legacy. Rua i te āta whakaaro. Deep thought. Hinengaro leads us up a series of stony steps to our last refuge. We are rested, our hearts awakened by the aroha legacy of loss we share. The aroha effect remains strong. Pondering the lessons from our caving trip through ngā rua a Hinengaro. This kind of contemplation is not always something we make time or space for. Not something we might feel too comfortable about. And yet this is an essential aspect of our wellbeing. This last rua is here for a reason. Hinengaro has provided this last cavern in her system to sit back and see this journey as a whole, forming one great complex of learning opportunities for fresh ways to approach life. A chance to gather up our highlights

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perhaps. The re-discovery of our stories, our imaginative new perspectives invigorated by Hinengaro.

Ara. A Māori Guidebook of the Mind, a compelling map with which to discover more about ourselves and others as we explore the deepest treasures of our own minds. A Māori cultural resource for families and for psychiatrists around the world.

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One Standard Model for Understanding Human Beings: Toward a "Model of Everything"

Dr. Cho Soochurl Seoul National University

Introduction

Throughout history, scholars have repeatedly asked a fundamental question: *What is a human being?* From Hippocrates to modern neuroscience, from philosophy and religion to psychiatry, many have approached this question from different perspectives. Yet despite remarkable scientific advances, the human being remains both magnificent and mysterious.

Throughout my professional life, I have attempted to understand patients not simply as diseases but as whole human beings. The purpose of this paper is to describe the intellectual journey that led me to develop what I call the *Model of Everything*—an integrative framework that seeks to understand the whole person through biological, psychological, social, spiritual, historical, artistic, scientific and cosmological perspectives.

Early Professional Development

My early academic career was devoted primarily to child and adolescent psychiatry, particularly autism and developmental disorders. During my fellowship at Yale University (1986–1988), I was exposed to advanced research methodologies in psychopharmacology, developmental biology, biochemistry and clinical research. Upon returning to Korea, I applied these approaches to studies of childhood psychopathology, epidemiology, neuroimaging, psychopharmacology and biological psychiatry.

This period, which I call the **First Period of Externalization**, was characterized by the application of established scientific methods. Numerous studies and textbooks were produced, and important assessment instruments for childhood depression and anxiety were developed. Yet despite academic productivity, I gradually experienced increasing dissatisfaction and began questioning the fundamental meaning of my work.

A Period of Conflict and Reflection

During the late 1990s, several questions became central to my thinking:

- What is research?
- What is the purpose of psychiatry?
- What is the psyche?
- What is a human being?

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- Am I treating patients as whole persons?
- Do biological discoveries genuinely improve the lives of suffering children and adolescents?

To explore these questions, I temporarily stepped away from conventional research and turned toward introspection. I immersed myself in philosophy, religion, classical literature and music. I studied Eastern and Western traditions, including the Bible, Buddhist scriptures, Confucian classics, Laozi, Zhuangzi and the works of Beethoven.Through this process, I concluded that much of my earlier work had focused on research itself rather than on understanding human beings and meaningful human lives.

Principles of Power, Control and Survival

This period resulted in my first integrative model, which I called Principles of Power, Control and Survival in Interpersonal Relationships.The model was based on a simple extension of the WHO bio-psycho-social perspective. It proposed that survival depends upon both power and control, each of which may be expressed through physical and psychological, internal and external dimensions.

Several conclusions emerged:

1. Human beings cannot exist independently of relationships.
2. All relationships are reciprocal.
3. Development unfolds toward effective survival.
4. Survival depends upon power and control.
5. Both power and control may be constructive or destructive.
6. Individual and interpersonal characteristics are shaped by these dynamics.

This framework led to a new understanding of normality, abnormality and interpersonal development.

Return to Psychiatry

Having achieved a partial answer to the question of human nature, I returned to mainstream psychiatric research. During this **Second Period of Externalization**, I conducted studies on depression, obsessive-compulsive disorder, school violence, internet addiction, post-traumatic stress disorder, environmental toxins, neuroimaging, genetics and psychopharmacology.

Research became increasingly integrative, combining genetics, neuroimaging and pharmacological approaches. Nevertheless, my interest in broader questions concerning human existence continued to develop.

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Psychiatry, Humanities and Spirituality

A second period of introspection followed, during which I explored the relationships between psychiatry, music, religion and philosophy. Publications examined figures such as Beethoven, Freud, Jung and Hermann Hesse, as well as themes related to religion and psychiatry.A common theme emerged: the integration of seemingly opposing values. I became increasingly convinced that a comprehensive understanding of human beings required attention not only to biological, psychological and social dimensions, but also to spiritual dimensions.

This led to the development of the **Consilience Model**, which expanded the WHO framework into a **Bio-Psycho-Socio-Spiritual Model**. Inspired by Edward O. Wilson's concept of consilience, I viewed the humanities, social sciences, natural sciences and medicine as sharing a common goal: understanding and promoting meaningful human life.

Toward a Model of Everything

Following retirement from Seoul National University and subsequent work in military mental health, I recognized additional limitations in existing models. Successful treatment alone did not necessarily lead to well-being, and mental health required active cultivation of purpose, responsibility, meaning and personal growth.

To address this challenge, I incorporated several complementary perspectives:

- Positive perspective
- Historical perspective
- Scientific perspective
- Artistic perspective
- Religious and philosophical perspective
- Cosmic perspective

The historical perspective emphasizes understanding individuals across time. The scientific perspective emphasizes objectivity and research. The artistic perspective seeks truth, goodness and beauty. The religious and philosophical perspective recognizes the depth and value of human existence. The cosmic perspective emphasizes that human beings exist within the broader context of the universe.

The Final Model

The resulting framework consists of four dimensions:

Structure
- Body
- Mind

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- Social Relationships
- Spirit

Time
- Past
- Present
- Future

Space

- Self
- Family
- Society
- Nation
- World
- Cosmos

Attitude
- Positive
- Historical
- Scientific
- Artistic
- Religious/Philosophical

Combining these dimensions yields 360 possible elements for understanding human beings.

This model was inspired by cosmology. Just as physicists seek a unified theory capable of integrating the fundamental forces of nature, I sought a framework capable of integrating diverse forms of human knowledge. For this reason, I called it the **Model of Everything**.

Conclusion

Over the course of my career, three successive models emerged:

1. Principles of Power, Control and Survival
2. Consilience Model (Bio-Psycho-Socio-Spiritual Model)
3. Model of Everything

The final model does not claim to provide fundamentally new knowledge. Rather, it seeks to integrate insights that already exist across medicine, philosophy, religion, science, history and the arts. A comprehensive understanding of human beings remains largely theoretical because our knowledge of each element remains limited.

In this respect, the wisdom of earlier thinkers remains relevant. Hippocrates reminded us that it is more important to know what sort of person has a disease than what sort of disease a

person has. Confucius taught that much of what we know is inherited from earlier generations. Socrates emphasized the limits of human knowledge. Pascal observed that what we know is only a drop compared with what remains unknown.

Nevertheless, the effort to understand human beings remains one of humanity's greatest challenges. As Sophocles wrote in *Antigone*:

"There are many wonders in the world, but none is more wondrous than human being."

Indeed, the human being remains both wondrous and mysterious. The task of understanding that mystery continues.

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Twenty Years of Child and Adolescent Psychiatry Workshops in Slovenia

Prof. Hojka Gregorič Kumperščak Faculty of Medicine, University of Maribor, Maribor, Slovenia.Child and Adolescent Psychiatry Unit, University Medical Centre Maribor, Maribor, Slovenia

This April marked the 20th consecutive workshop on child and adolescent psychiatry, a gathering that has traditionally been held in Maribor, Slovenia's second-largest city. In recent years, Maribor has gained recognition as one of the more compelling and authentic urban destinations in the world – a city that seamlessly combines a rich historical and cultural heritage with close proximity to the natural environment.The workshops in Maribor were first organized in 2006; however, the history of child and adolescent psychiatry in Slovenia dates back to 1954, when the Psychohygienic Dispensary for Children and Adolescents was established in Ljubljana, the country's capital. This was followed, in 1955, by the establishment of the first Counselling Centre for Children and Adolescents.

A major aspect of the twenty-year development of the workshops has been their thematic evolution, reflecting both clinical priorities and broader societal changes in child and adolescent psychiatry. Early workshops (2006–2012) focused primarily on core diagnostic categories and everyday clinical practice, whereas later years increasingly addressed psychiatric emergencies, personality disorders, genetic and neurobiological perspectives, as well as the organisation, accessibility, and effectiveness of mental health services. In recent years, the focus has shifted toward broader systemic and societal issues, as illustrated by the title of the 20th workshop: *Changes, Challenges, and Opportunities of the Past Two Decades*.

The 20th workshop, held in April 2026, was dedicated to an in-depth discussion of the changes observed in the field of child and adolescent psychiatry over the past two decades. Prof. Norbert Skokauskas delivered a plenary lecture on developments in Norway alongside the challenges posed by the integration of digital tools in child and adolescent psychiatry. Prof. Branko Aleksic presented changes in the clinical expression of mental disorders in Japan, with particular attention to the hikikomori phenomenon. Prof. Milica Pejović Milovančević outlined developments in Serbia, while national speakers addressed the situation in Slovenia.

Over the past two decades, child and adolescent psychiatry globally – as evidenced by data from Slovenia, Norway, Japan, and Serbia – has witnessed not merely a quantitative increase in mental disorders, but, more significantly, a profound transformation in their clinical

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presentation and psychopathological expression. Anxiety disorders, depressive disorders, and trauma-related conditions have become increasingly prominent, while the relative proportion of classical behavioural disorders has declined. This shift from externalising to internalising psychopathology is accompanied by considerably greater clinical complexity. The clinical expression of mental disorders is dominated by overlapping, comorbid presentations in which symptoms do not cluster into a single diagnostic category.

A particularly noteworthy phenomenon is the **blurring of the boundary between normative development and psychopathology.** Children and adolescents are increasingly being referred for assessment for responses that, until recently, would have been understood as part of normative development – sadness in the face of failure, conflicts with parents or peers, behavioural outbursts within the context of normal adolescent development. We are facing a reduced tolerance for frustration in children and adolescents alongside with societal imperative for perpetual happiness. The psychiatrisation of everyday distress is thus occurring in parallel with a genuine rise in serious mental disorders.Concurrent with these increasing demands, significant changes in institutional functioning are also apparent. There is a frequent shifting of responsibility between different systems. Children and adolescents are increasingly referred for specialist child and adolescent psychiatry assessment, even though many would benefit primarily from more stable and higher-quality relationships within their immediate environment – in the family and at school.

At the same time, the field has recorded meaningful progress: the development of specialised psychotherapeutic and other approaches to mental disorders, the growth of parenting programmes, a greater emphasis on preventive interventions, and increased involvement of families in the treatment process. The stigma associated with mental illness has diminished over the past two decades. Nevertheless, it is becoming increasingly clear that, in order to achieve a lasting impact on the mental health of children and adolescents, broader societal changes will be necessary – greater stability, predictability, trust, and accountability in sociaty, institutions and family as well as more acceptance for developmentally normative experiences, including exposure to frustration.

Twenty years of workshops on child and adolescent psychiatry in Maribor represent an important professional continuum that extends well beyond an educational remit. Over the years, the workshops have served as a space for reflection, the exchange of experience, and the critical appraisal of clinical practice. At the same time, they have functioned as a mirror of the field’s development – both in Slovenia and in the wider international context.

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From Asia to the World: ASCAPAP 2026 as a Growing Global Platform for Youth Mental Health

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Dr. Johanna Inhyang Kim
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Chair of the General Affairs Committee of ASCAPAP 2026

The 12th Congress of the Asian Society for Child and Adolescent Psychiatry and Allied Professions (ASCAPAP, President Takashi Okada) was held from April 2 to 4, 2026, at COEX in Seoul, Korea. Hosted by the Korean Academy of Child and Adolescent Psychiatry (KACAP, President Hee Jeong Yoo), this congress marked the second time that Korea has hosted the ASCAPAP congress since 1999.

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Beyond Asia: ASCAPAP's Growing Role as a Global Platform for Youth Mental Health

While rooted in the Asia-Pacific region, this year's congress clearly demonstrated ASCAPAP's growing role as a global platform, bringing together 820 participants from 30 countries across Asia, North America, and Europe. The meeting reflected not only geographic diversity, but also the increasingly interconnected nature of child and adolescent mental health challenges and solutions worldwide.

ASCAPAP 2026 featured a comprehensive scientific program, including six plenary sessions, 42 symposia, two workshops, six research sessions, five poster sessions, and a grand forum. A total of 391 presentations were delivered across 66 sessions, during which participants actively shared cutting-edge research findings and clinical insights. The presence of distinguished international leaders, including Dr. Tammy Benton and Dr. Luis Rohde, further enriched the academic exchange and strengthened global partnerships. Furthermore, the congress fostered dynamic discussions on critical issues in child and adolescent mental health.

In line with its expanding global scope, the congress also featured a symposium on capacity building in child and adolescent psychiatry, led by Professor Norbert Skokauskas, Secretary for Education and Scientific Publications of the World Psychiatric Association (WPA). The session addressed the critical global shortage of child and adolescent psychiatry specialists and the resulting inequities in access to mental health services for young people. By bringing together perspectives from South Korea, the United States, and Norway, the symposium highlighted both shared challenges and context-specific training approaches. Discussions focused on innovative strategies to strengthen workforce capacity, including digital and blended learning, international collaboration, and cross-institutional partnerships. The session underscored the urgent need for scalable and adaptable training models to meet the growing and increasingly complex mental health needs of children and adolescents worldwide.

Capturing Both Agony and Positive Energy of Our Global Community: NSSI and K-Culture Influence

A central highlight of the congress was the Grand Forum, which addressed the rising global concern of adolescent suicide and non-suicidal self-injury (NSSI). This forum brought together perspectives from clinical practice, research, social systems, and policy, underscoring the urgent need for integrated and coordinated responses. These discussions reflected the shared challenges faced by youth worldwide and emphasized the responsibility of the global mental health community to respond collectively.

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In parallel, ASCAPAP 2026 also explored the positive forces shaping youth mental health. A special symposium on Korean popular culture (K-culture) examined how cultural influences can support identity formation, resilience, and emotional connection among young people. Featuring the participation of a well-known Korean actor who shared personal insights and experiences, the session provided a unique perspective on how contemporary cultural phenomena can contribute to mental well-being.Together, these programs offered an opportunity to capture both the agony and the positive energy of our global community, while demonstrating ASCAPAP's deep academic insight.

Bridging Tradition and the New Generation: Honoring Excellence and Empowering Young Professionals Worldwide

This congress was also particularly meaningful in bridging tradition and the new generation. At the Opening Ceremony, the ASCAPAP Contribution Award was presented to Professor Kang-E Hong (Professor Emeritus, Seoul National University College of Medicine, Korea) in recognition of his lifelong dedication and outstanding contributions to the advancement of child and adolescent psychiatry and to the development of ASCAPAP. In addition, the Prof. Ahn's Travel Grant, generously established by Professor Dong Hyun Ahn (Professor Emeritus, Hanyang University College of Medicine, Korea), was awarded to 15 participants to support attendance by professionals from low- and middle-income countries. Furthermore, the Research and Poster Sessions, where the latest findings were presented, particularly highlighted the outstanding contributions of young researchers and professionals, whose active engagement formed a vibrant "young wave."

The next congress, ASCAPAP 2027, will be held in Taiwan under the leadership of Professor Susan Shur-Fen Gau, who introduced the upcoming congress at the Closing Ceremony and extended a warm invitation to participants to reconvene in Taiwan.

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WPA Webinar "Wars in the 21st Century: Mental Health Impacts, Intervention Strategies, and the Cost to Our Humanity"

Sulaima Elkhalife – Combating Violence Against Women & Children Commission
Sadie Hamid – Hope & Haven for Refugees Organisation
Mohammed Abumughaiseeb – Social Science Unit, Médecins Sans Frontières (MSF-UK)
Ruth-Kari Ramleth – Norwegian Aid Committee (NORWAC), Oslo University Hospital, Oslo, Norway
Peter McGovern – Norwegian Aid Committee (NORWAC), Modum Bad Traumepoliklinikken, Oslo, Norway
Rodrigo Ramalho – WPA Disaster Psychiatry Section
Nikos Christodoulou – WPA Disaster Psychiatry Section
Dinesh Bhugra – WPA Geo Psychiatry Special Interest Group
Rabih El Chammay – National Mental Health Program (NMHP), Lebanon
Armen Soghoyan – Secretary for Scientific Sections, World Psychiatric Association (WPA)
Josyan Madi-Skaff – Immediate Past Chair, WPA Section on Women's Mental Health
Ann Faerden – Past Chair, WPA Section on Public Policy and Psychiatry

This webinar was held under the umbrella of the World Psychiatric Association (WPA) after a personal initiative of Dr Josian Madi-Skaff and Dr Ann Faerden who was later joined by secretary for WPA section s Armen Soghoyan, later on professor Dinesh Bughra from the WPA Geopolitical interest group, WPA ACRE representative Rodrigo Ramalho and professor Nikos Christodoulou chair for Section for WPA Disaster Psychiatry.

The webinar came about more than 2 years ago as the current wars continued to devastate communities around the world where we as psychiatrists felt compelled to act and give voice to the profound pain and helplessness and create a space for the voices of the severely traumatized populations. The situation in two of the current wars; Sudan and Gaza, were given a voice.

From the Sudan war Dr Sulaima Elkhalifa and Dr Sadeia Hamid gave examples from their different projects under the theme of "We are still humans: mental Health, Survival and Hope in the Sudan war". Dr Elkhalifa talked about her work in the project "Combating violence against women and children commission". She emphasized that the strong resilience of the Sudanese people cannot carry the burden of crisis, that mental health needs to be integrated into the humanitarian help given and that women where the center of the rehabilitation work. One "good" thing coming out of the war was the reduction of stigma for mental health in that the people understood the need for psychosocial support and asked for it. She voiced the stress felt by the carers, their need for mentor support and that mental health support cannot come from imported clinical framework detached from the local living.

Dr Hamid talked about the project "Hope and Haven for Refugees Organization" and how the

numbers for suffering can make us unhuman and does not tell about the suffering behind the numbers, the invisible wounds behind the wars and how these invisible wounds need to be core components to humanitarian response. She discussed how humanitarian and mental health responses must be integrated, as psychological wellbeing cannot be separated from access to safety, food, healthcare, education, and dignity. Drawing on field experience, she highlighted the importance of community-based and culturally grounded approaches that build on local coping mechanisms, social networks, and collective resilience. Dr Hamid also emphasized the impact of the conflict on children and young people, many of whom have experienced displacement, loss, interrupted education, and repeated exposure to violence. She noted that mental health workers themselves are often affected by the same crisis conditions, leading to compassion fatigue, secondary trauma, and burnout. She also stressed how mental health cannot be separated from humanitarian needs and that mental health support starts with meeting basic needs such as safety, food, dignity and learning. food. She showed how community-based approach of group meetings where listening is central and local communities possess knowledge of coping mechanisms. She concluded by calling for greater international attention to the crisis in Sudan, increased support for locally led organizations, and a humanitarian response that recognizes the dignity, resilience, and humanity of affected communities while helping them build hope for the future. Lastly, she asked the international community not to look away, and the people need humanity, dignity and hope to build a better future.

Two different aspects were covered concerning the war in Gaza. First Dr Mohammed Abumughaiseeb, who has been working for the Medicines Sans Frontiers (MSF-UK) inside Gaza, talked on the “Continuous traumatic stress in Gaza: when caregivers and communities share the same crisis”. He started with stressing the shortcoming of the notion of Post Traumatic Stress Disorder (PTSD) as there is no post-traumatic stress since the trauma has not ended. This leads to children learning to survive instead of building trust and they all a high degree of PTSD symptoms, depression, anxiety and suicidal thoughts. He especially described the situation for carers who are also displaced, hungry and grieving; while trying to do their best. Helpers feel they provide inadequate care leading to chronic stress, for some burn out and psychosomatic symptoms. Lastly, he raised ethical questions for global psychiatry about how we provide mental health when basic needs remain unmet and can meaningful interventions exist without safety?

Dr Ruth-Kari Ramleth and Dr Peter McGovern from the Norwegian Aid Committee (NORWAC) followed up on “Helping the helpers”. Dr Ramleth talked about the support of surgical teams that were sent in from NORWAC to Gaza after the war started. From former surgical collaboration building up service the situation was changed into massive trauma exposure with ethical dilemmas, resource shortage and relational and existential stress. This led to increased mental preparation for the deployment, ongoing support during mission and follow-up afterwards. As a necessary part of the mission.

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Dr McGovern gave insight into how to understand the reactions under extreme stress with affective flattening, cognitive rigidity and survival mode which is not pathology but adaptive response to an unnatural situation. He used Bion`s and psycho analytical thinking on how to understand changes under pressure for the individual and the groups and how they used this in the collegial support. This experience can be used for other extreme conditions and how we can hold on to cope.

The discussion following the four speakers' presentations was facilitated by Dr Rodrigo Ramalho and Dr Nikos Christodoulou. Participants were invited to reflect on existing guidelines and related resources for mental health professionals working in conflict areas. The discussion focused on three key questions: What has worked for mental health professionals in these settings? What are the current needs? What recommendations can inform the development of future resources? Participants noted that current guidelines are often insufficient in contexts where trauma is continuous rather than time-limited. They suggested that much of the existing evidence focuses on recovery after disasters, with less attention to the response phase during ongoing conflict. They also highlighted that many resources focus primarily on individual-level interventions, with less attention to the wider systems that shape mental health and wellbeing. Similarly, existing guidelines tend to focus on how best to address trauma, psychological distress, and mental health disorders, paying less attention to resilience and mental health promotion. Drawing on examples from Sudan and Gaza, participants emphasised the importance of basic needs, including food, safety, and dignity, as foundational for any mental health response. The discussion also raised the need for psychiatry and mental health professionals to take a more active role in advocating for the social and political conditions required to support mental health. Participants concluded that future guidelines should learn from current conflict situations and better prepare professionals and systems.

The last part of the webinar was set to reflections by Dr Dinesh Bhugra and Rabih Chammay about "What are the wars doing to us all?". Dr Bhugra informed of the work of Geopsychiatry Special Interest Group within the WPA that explores the transnational challenges and their mental health. He, as the formal discussant, pointed to the need for psychiatrists to engage in all levels of the specialist pyramid, starting at the bottom and turning the pyramid upside down.

Dr Rabih El Chammay gave words to something many of us feel but struggle to name: the world as we knew it has ended. The current transition in the global order — accelerated by war, displacement, and compounding crises — is not just a geopolitical shift. It is a psychological one, and it is shattering for all of us. He argued that mental health professionals have a distinctive role in this moment — not to pathologize these reactions, but to make sense of them. To resist the pull of the consulting room and the tendency to individualise what are, in fact, collective experiences. To bring psychological insight into public life, into policy, into the spaces where the inner world and the outer world meet.The task, as he framed it, is to help

people feel less alone in what they are living through — and to build the bridge between what is happening in the world and what it does to us inside.

The goal of the seminar was not only to bear witness but to help to build conditions in which people can remain human and get support in the ongoing wars. There was five themes common to all the eight speakers: the trauma for the children of the war, that PTSD does not make sense in a continuous stress and traumatic situation as wars, the need for integration of mental health to all humanitarian work starting with support for basic needs that support human dignity, the need for support of the carers and the need for psychiatry and mental health to take a more central and political role in the current world situation so that we have a better chance to remain human. The different talks are planned to be published in the International Review of Psychiatry edited by Professor Dinesh Bhugra.

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