municators, leaders and members of the health care team, life-long learners, and professionals committed to excellence and ethically accountable to patients. In the current curriculum, psychiatry is allotted 19 topics and 112 core competencies and has a more ubiquitous presence in every stage of learning.[4] However, still there are no skill-based certifiable competencies in psychiatry.[5]

There is a definite gap in the quantity and quality of mental health services and their distribution in the country.[6] According to a survey conducted by the Indian Psychiatry Society within a week of the start of the nationwide lockdown in India, the number of reported cases of mental illness in the country had risen by 20%.[7] This pandemic, other than its direct consequences, has ubiquitous ripple effects on people's psyche as a whole. Adverse psychiatric consequences such as fear of infection, anxiety, stress, depression, post-traumatic stress disorders, suicide,[8] and stigma are on the rise among the general public as well as health workers.[9,10] There is pouring evidence of an imminent, massive mental health crisis that can further worsen health outcomes, increase burden on health care systems, impair functioning, and cause loss of productivity.[11]

In this juncture, when incorporating mental health to primary health care has been the tenets for all national health policies, MCI's decision is unfortunate. Serious consideration should be made to incorporate mental health aspects of the pandemic in the UG curriculum. Furthermore, the Indian Psychiatric Society must attempt to bring to MCI's notice the urgent need to include mental health in the pandemic management module.

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Seshadri Sekhar Chatterjee[1], Sheikh Shoib[2]

[1]Dept. of Psychiatry, Diamond Harbour Government Medical College and Hospital, Diamond Harbour, West Bengal, India. [2]Dept. of Psychiatry, Jawahar Lal Nehru Memorial Hospital (JLNMH), Rainawari, Srinagar, Jammu and Kashmir, India.

Address for correspondence:

Sheikh Shoib, Dept. of Psychiatry, Jawahar Lal Nehru Memorial Hospital (JLNMH), Rainawari, Srinagar, Jammu and Kashmir 190003, India. E-Mail: sheikhshoib22@gmail.com

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Telepsychiatry: The Tool to Revive National Mental Health Program of India?

In 1982, India became one of the earliest developing countries to frame and implement the National Mental Health Program (NMHP). The program was envisaged to address the existing burden of mental disorders and the lack of treatment facilities. Subsequently, after the successful implementation of the Bellary Model, the District Mental Health Program (DMHP) was launched in 1996, under the broader ambit of NMHP.[1] Both NMHP and DMHP have been revised multiple times since their inception, in order to scale up their services.[2] However, even recent assessments of the programs have found that they are only partially successful.[3–5]

The major issues that seem to be affecting the program are a non-uniform

implementation, lack of utilization of funds, and lack of clarity in the initial plan.[5] Additionally, experts have also pointed out that issues pertaining to human resources have consistently been proving detrimental to the program. Inadequate recruitment, unappealing compensation, poor training initiatives, overburdened community health workers, lack of supervision, and weak leadership at the district level have been a few consistent sources of complaints about NMHP. Attempts have been made to circumvent this issue by relaxing the recruitment criteria, increasing the number of feeder courses, and creating a specialized cadre of community health workers trained in identifying mental illnesses.[5] But still, the outcome desired from the NMHP has not been achieved.

Telepsychiatry is a mode of using "information and communication technologies to provide psychiatric care from a central or nodal site to a peripheral, distant, or remote site."[6] In India, our experience with telepsychiatry is limited, though it has been in vogue for at least the last two decades. But, the importance of telepsychiatry has come to the forefront in the current testing times of novel coronavirus (COVID-19) pandemic.[7] Several reports have shown the immense potential that telemedicine has during the COVID-19 pandemic.[7–9] It has been able to mitigate the immense pressure that this pandemic has put on the healthcare systems. It has been successful in providing psychiatric care in sectors where traditional close-contact healthcare was disrupted. Using telepsychiatry as a mode of training has also been shown to be successful and operationally viable.[10] Telepsychiatric modes of consultation have also been shown to be economically feasible and cost-effective.[11]

A major concern about telepsychiatry has been the lack of guidelines regarding its legal aspects and scope of applicability. However, recently, even those issues have been ironed out after guidelines were published by the Medical Council of India[12] and National Institute of Mental Health and Neurosciences, Bengaluru.[13]

Concerns have also been expressed about the potential pitfalls of telepsychiatry. The appeal of a technology-intensive approach like telepsychiatry in the rural areas has been questioned, especially because broadband internet service may not be available in such settings. Issues pertaining to the confidentiality of the clients and archiving of data have to be kept in mind. The restrictions in terms of choices of drugs that can be prescribed and the possibility of abuse of certain drugs (e.g., benzodiazepines) are also important issues. But, none of these should deter us from exploring the potential of telepsychiatry in expanding NMHP.

A closer introspection will tell us that the answer to a lot of the maladies of NMHP lies in telepsychiatry. It has the potential to decrease the distance traveled to seek treatment, remove the barrier of unavailability of trained staff at remote locations, and mitigate the absence of central monitoring. In the last few years, India has undergone a digital revolution, and high-speed internet is available in most places of the country, with further upgradation being planned in the immediate future. This can also be helpful in quick and effective training of healthcare professionals for the implementation of NMHP. The provision of mental health apps should also be explored. Recent evidence from India has revealed the various promises and possible challenges of building an app.[14] Researchers fear that trying to build an app with a "one size fits all" approach will not be sufficient in a country with such diversity in terms of languages spoken and sociocultural milieu. But that should not deter us from exploring this path.[14]

The lessons we have learned from the current pandemic are going to change the way we approach any challenges the future may pose to us. If we learn from our experience, we should be able to appreciate that the effectiveness of telepsychiatry also came to the fore-front when India faced a natural disaster in the form of a tsunami in 2004.[15] But, as we recovered, the interest in telepsychiatry waned off. This may have been due to logistical limitations and the relatively high cost of internet connection at that time. But now, India has a vastly improved technological outreach. This is the time we should realize the immense potential telepsychiatry has and invests our efforts into building on it.

Arghya Pal[1]

[1]Dept. of Psychiatry, Himalayan Institute of Medical Sciences, Swami Rama Himalayan University, Dehradun, Uttarakhand, India

Address for correspondence:

Arghya Pal, Dept. of Psychiatry, Himalayan Institute of Medical Sciences, Swami Rama Himalayan University, Dehradun, Uttarakhand 248016, India. E-mail: drarghyamb@gmail.com

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Impact of Celebrity Suicide on Population Mental Health: Mediators, Media, and Mitigation of Contagion

Sir,

Celebrity suicide has a negative impact on public health, chiefly by its potential to trigger suicide contagion (Werther effect) among vulnerable individuals. These effects are accentuated by detailed and imbalanced media portrayals of celebrity suicide, a prevalent and concerning practice in Asia.[1]

Questions remain on the potential drivers of this observed vulnerability to imitative suicidal behavior. Below, we offer some insights into mediators of suicide contagion following a celebrity suicide and propose suggestions from a preventive standpoint.

Possible Mediating/ Moderating Mechanisms in the Impact of Celebrity Suicide on Population Mental Health

1. *Pre-existing psychiatric morbidity or maladaptive cognitions*: Pre-existing vulnerability could be due to a combination of biological and psychosocial factors. Evidence from both retrospective[2] and prospective[3] studies suggest that prior psychological distress, depression, or anxiety symptoms and history of negative life events, such as being abused or having interpersonal conflicts, may moderate the effects of celebrity suicide. Other factors that may mediate the vulnerability include severe mental illness, substance use disorders, and chronic pain disorders; the latter has been associated with both suggestibility and suicidality.[4]
2. *Excessive identification and idealization*: Celebrities enter the public psyche through many forms of media and networking. All these contribute to their larger than life image and may result in their idealization by certain subgroups. When such individuals die by suicide, it becomes a deeply triggering event, and explicit media portrayals of suicide can further increase the emotional impact and trigger suicide contagion.[5] This is particularly the case for individuals who excessively identify themselves with the deceased. However, idealization is neither necessary nor sufficient for suicidality. As an example, suicides in celebrities whom one might not necessarily like or admire can also trigger a contagion.
3. *The role of peer integration*: Following a celebrity suicide, increased discussion with peers and misinformation may ensue; this may amplify feelings of loss, particularly for those who closely identify themselves with the deceased. These assertions are indirectly supported by evidence from retrospective studies[2] and the Foxconn suicides,[6] in which temporal clustering of suicides occurred in a single organization. This suggests that contagion could occur even in highly cohesive environments.
4. *Public image and influence of the celebrity*: A study that examined the effects of news