# SUMMARY RECORD OF THE FIFTH MEETING

Indera Kayangan Ballroom, The Empire Hotel and Country Club  
Wednesday, 12 September 2001 at 2 p.m.

**CHAIRPERSON:** Mrs Sandra S. PIERANTOZZI (Palau)

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1. SPECIAL SESSION ON MENTAL HEALTH: Item 19 of the Agenda

1.1 Panel discussion: Item 19.1 of the Agenda

The CHAIRPERSON explained that, in accordance with one of the recommendations of the Working Group on Reform of Sessions of the Regional Committee to make the sessions more “interesting and interactive”, for the first time a panel discussion would form part of the session of the Regional Committee. The panel discussion would highlight issues in preparation for the ministerial round table that would follow.

The first speaker was Professor Norman Sartorius, professor of psychiatry at the University of Geneva, Switzerland, and former Director of the Division of Mental Health at WHO Headquarters. Professor Sartorius presented an overview of the general philosophy of mental health and described its public health importance (Annex 1).

He was followed by Professor Xiao Zeping, Deputy Director of the Shanghai Mental Health Institute, a WHO Collaborating Centre for Research and Training in Psychiatry. She spoke on mental health services in general hospitals in Shanghai (Annex 2).

Sister Iokapeta Sina Enoka, a lecturer in nursing at the University of Samoa, was the next speaker. She discussed the treatment of mental disorders and mental health promotion in a community where specialized services are scarce and collaboration with families and other social support agencies essential (Annex 3).

The final speaker was Mr John McGrath, Chair of the Mental Health Council of Australia. He addressed the family experience of care and the support needs of the families of people with mental disorders (Annex 4).

The CHAIRMAN thanked all four speakers for their interesting and enlightening presentations.

1.2 Ministerial round table: (Item 19.2 of the Agenda)

The panel discussion was followed by a ministerial round table on the subject of mental health.
INTRODUCTORY PRESENTATION

Professor N. Sartorius, MD, Ph.D.

The scope of mental health programmes could be vast. For practical reasons it is necessary to restrict it. This can be done by concentrating on mental health problems of major public health significance that can be resolved by interventions of proven effectiveness. If this premise is accepted the targets of mental health programmes will be to:

1) reduce problems related to selected mental and neurological disorders;

2) promote mental health, i.e. increase its value for individuals, communities and societies; and

3) ensure that mental health knowledge, skills and expertise are used in the improvement of general health care and in social development.

Reduction of problems related to selected mental and neurological problems

Mental and neurological disorders satisfy all the criteria of a major national and international public health problem. They are frequent, ubiquitous and have severe consequences in terms of suffering and disability. There are effective interventions that can be used within the framework of specialist and primary care services. The primary prevention of a significant proportion of these disorders is possible. The treatment of mental disorders is effective and its cost is affordable even for countries in which health services have to work in conditions of great financial scarcity. Its application is simple and can, to a large extent, be entrusted to primary health care personnel with short-term additional training. Rehabilitation of people who have suffered from mental disorders is also possible, but requires an even greater engagement of social sectors (such as welfare, labour and education) than does the prevention and treatment of mental disorders.

Epidemiological surveys carried out in the countries of the Western Pacific Region and in other parts of the world allow a precise estimation of the numbers of people suffering from mental and neurological disorders. In their most severe forms – such as psychosis, dementia, severe mental retardation and severe brain injuries – these disorders affect 2% of the population. Their less severe, but still disabling forms – such as depressive disorders and severe neurotic disorders – affect a further 3%-4% of the population. Problems related to drug
Annex 1

and alcohol abuse and dependence vary among countries, but are reported as a major concern for governments in many countries. There is every likelihood that the frequency of mental disorders will increase in the future. This is due to several factors, including demographic changes (such as increased life expectancy), which increase the size of groups at risk for mental disorders; better chances for survival after brain injury; the increasing numbers of people suffering from chronic disorders, such as diabetes (which are often accompanied by mental disorders); and increasing stress and insecurity.

The consequences of mental and severe neurological disorders are severe. In addition to the suffering that these disorders cause to the individuals who are sick and to their families, they cause a significant amount of disability. In fact, the World Bank and the World Health Organization have both presented data showing that, among the 10 diseases that have the most severe consequences in terms of years of life lost due to disability, four are mental disorders. These figures do not include mental retardation nor neurotic disorders, which make a further contribution to the burden of disease.

Mental disorders are frequent among children and among older persons, as well as among the rest of the adult population. Studies have also shown that these disorders represent a significant burden and expenditure for general health services. A major study carried out in 15 countries, including some in the Western Pacific Region, showed that psychiatric problems are the main reason for contact with general health services in a significant proportion of cases (varying from 4% to more than 30% depending on the location of the service and country). Other studies confirm that these findings hold true for developed and developing countries. Mental disorders are often co-exist with physical disorders, worsening the prognosis of both conditions. They significantly increase the risk for suicide, and increase the number of contacts that the family members living in the same household have with health services.

On the basis of their frequency and consequences it is possible to select as targets those mental and neurological disorders that produce most severe problems.

These are: (1) psychotic disorders, such as schizophrenia; (2) problems related to drug and alcohol dependence; (3) depression and related disorders most commonly seen in general health care; (4) dementia, regardless of cause; (5) epilepsy; and 6) mental retardation. The frequency and severity of these disorders have been confirmed in studies carried out in countries at different levels of socioeconomic development.
Primary prevention of mental and neurological disorders is possible for some disorders, including several forms of mental retardation (for example cretinism due to iodine deficiency), disorders due to brain injury, certain forms of epilepsy, suicide attempts and suicide, problems related to alcohol and drug abuse, and certain forms of depression. In most instances primary prevention of mental disorders will be the main responsibility of general health care services (e.g. those dealing with perinatal care) or of other social sectors (e.g. the authorities responsible for elementary school education).

The treatment of most mental and neurological disorders is possible. Psychopharmacological treatment, combined with other measures, can be learned quickly by personnel who have undertaken simple training and can apply the treatment in the vast majority of cases with only minimal supervision and referral arrangements. Most mental disorders can be treated in outpatient facilities. Inpatient facilities remain necessary, but their use should be restricted to acute forms of the disorders and their consequences. In most instances, it is possible to keep the patients in hospital for a very short time, rarely surpassing a few weeks. Outpatient treatment and the education of families and communities will also reduce the risk of impairments and disabilities that might otherwise follow or accompany the illness.

A major obstacle to early recognition and treatment, and to rehabilitation (as well as to the improvement of the conditions of life for the patients and their families), is the stigma attached to mental illness. Stigmatization is usually accompanied by negative discrimination in matters of housing, employment, access to treatment, and health insurance. Stigma does not harm only the patient: it usually also affects the family and other individuals helping the patient, including health and social service workers. There are effective ways of fighting stigma and discrimination because of mental illness. These can be used in countries at different levels of development and with different cultural backgrounds, as has been demonstrated in a recent major programme against stigma and discrimination carried out by the World Psychiatric Association, a major nongovernmental organization in official working relations with the World Health Organization.

Promotion of mental health

The value that people attach to mental health is, at present, low in most countries. In part this is due to the vagueness of the concept and to the weakness of mental health programmes that have not initiated nor facilitated appropriate health education and other
programmes inculcating attitudes and appreciation of mental health. Mental health can be defined by reference to (1) the equilibrium that individuals establish within themselves, (2) the harmonious relationships they establish with those who are close to them and (3) the tolerance and selfless support offered to society and its members.

Mental health is thus not defined by reference to the absence of mental illness, although it is clear that mental illness affects mental health. Mental health should also not be seen as a set of extraordinary mental capacities given to the lucky few: good mental health will help individuals to develop their mental and physical capacities, but does not depend on their presence.

The promotion of mental health is a task of major importance for society as a whole. It begins at home, where parents should be helped to educate their children in a manner that will make them appreciate mental health and make them eager to achieve it. Schools can and should have a major role in the formation of values, and can make a major contribution to the enhancement of the value that children give to their mental health. Other social actors – for example, the media, social welfare and departments of justice – have important roles in this effort. Mental health programmes can provide the necessary knowledge and advocate the application of measures that will promote mental health.

Contributions to the improvement of health services and social development programmes

The contribution of mental health programmes to the functioning and improvement of general health services can take place at two levels: first, by ensuring that mental health problems - appearing alone or in conjunction with physical illnesses - encountered in general health care are recognized and treated; and second, by providing knowledge and information developed by mental health disciplines - psychiatry, neurosciences, psychology and other behavioural sciences - to health services in order to improve doctor-patient relationships, to facilitate the acceptance of public health measures, to prevent burn-out among health personnel, to increase participation of patients and their families in the process of care, and so forth. In this area, mental health programmes can also provide specific guidance in relation to modern requirements of health care developments – by providing, for example, appropriate technology for the measurement of changes of health-related quality of life following health service intervention.
The tenets of modern and effective mental health programmes

The principles that should govern mental health programmes have been well defined in recent years. They are similar to the tenets that govern health care in general, but give additional emphasis to some of them. They can be formulated as follows:

1) Mental health professionals cannot carry out mental health programmes alone. A productive alliance between people suffering from mental and neurological disorders, their families, health care workers, representatives of other social sectors (such as labour or social welfare) and the health industry is an essential prerequisite for successful programmes.

2) Mental health programmes should not stop at dealing with mental and neurological disorders. The promotion of mental health and collaboration with general health services are also essential components of mental health programmes.

3) In their efforts to control mental disorders, mental health programmes must define specific targets and orient their activities to ensuring the provision of best care for people suffering from those diseases and of support to their families. Offering effective care of demonstrably good quality will diminish the prevalence of mental health problems and contribute to the diminution of the stigma currently attached to people with mental illness and those that surround them.

4) Fighting stigma and discrimination because of mental illness is a central task of mental health programmes.

5) The provision of care to people with mental illness must go hand-in-hand with an effort to correct the problems of the past - by active rehabilitation programmes directed to people with mental impairments or disabilities, by supporting families caring for people with such conditions, and by introducing appropriate legal and administrative provisions that can help care and rehabilitation.

6) Mental health programmes should remain flexible, capable of using new knowledge and able to counteract negative consequences of socioeconomic
Annex 1

development. This implies that they should also invest in the development of appropriate research at country level and strive to facilitate revisions of legal instruments to meet new needs and situations.
MENTAL HEALTH SERVICES IN GENERAL HOSPITALS IN SHANGHAI, PEOPLE'S REPUBLIC OF CHINA

Professor Xiao Zeping, Shanghai Mental Health Center, Shanghai Psychotherapy and Counseling Center, Shanghai Mental Health Institute, People's Republic of China

It is my great honour to have the opportunity to join this important discussion on mental health. I work as a psychiatrist at the Shanghai Mental Health Centre. My focus today is the new challenges of mental health problems in Shanghai which are shared by other cities in China. I will illustrate one important point; to integrate mental health services into general hospital daily work means increasing mental health services in society.

Mental health awareness in China has developed greatly in the past 50 years. In Shanghai, a tertiary mental health delivery system to treat psychosis, was already in place by late 1950s. It was an effective system, providing care for such conditions as schizophrenia, bipolar disorder and mental retardation. However, as in other countries, rapid industrialization and modernization in China resulted in rapid changes to the social environment. Apart from psychosis, the prevalence of mental disorders among adolescents and alcohol and drug abusers has increased significantly. These disorders include depression, suicide, neurosis and psychosomatic disorders, and child neural problems. These are new challenges for us.

Because of a lack of knowledge about mental health, stigma attached to mental problems, and emotional or other psychological problems, patients often prefer to seek medical care in general hospitals first.

Regarding the treatment of mental health in Chinese general hospitals, I wish to mention briefly a well-known WHO study of on mental disorders in public health settings carried out 10 years ago. The study was led by Professor Sartorius and was held in 15 WHO collaborating centres in 14 countries at the same time.

In Shanghai, 1673 patients in general hospitals were investigated. Results showed that physical symptoms were virtually the only reason for patients to visit physicians, but almost a quarter of the disorders they suffered from were non-physical. The prevalence of current mental disorders was nearly 10%, almost half of which were depression. Only 16% of mental disorders were recognized by physicians, and even fewer were given proper psychiatric
Annex 2

treatment. For example, no antidepressants were prescribed by physicians for depression at that time. The results were quite similar among the different WHO centres, reflecting a worldwide problem.

Policies governing health care services were subsequently adjusted in Shanghai as follows.

A wide-ranging campaign to improve mental health in society was carried out through various media, including television, newspapers, and popular magazines. As a result, public awareness of mental health has clearly improved in Shanghai.

Training sessions to re-educate clinicians in general hospitals in psychiatry or mental health knowledge were conducted, leading to significant improvements in recognition and proper treatment.

Psychological or psychosomatic departments or clinics were established in general hospitals, offering counselling or psychotherapy for inpatients and outpatients. In Shanghai, almost all tertiary-level hospitals now have psychosomatic or psychological clinics or departments. One of them has had a psychosomatic ward for several years.

Staff in Shanghai hospitals also cooperate with colleagues in Western countries, such as Germany, in the holding of training courses in different kinds of psychotherapy. The objective of the training is to develop high quality psychotherapists and to offer supervision in different health settings.

Insurance programmes are now more prepared to accept claims from patients suffering from mental disorders. Sometimes, severe psychotics receive almost full recovery of costs of treatment.

Drafting of mental health legislation is being intensified nationwide. In Shanghai, at the end of this year the local mental health legislation will be submitted to the People’s Congress for discussion.

Great progress has been made. However, compared with developed countries, there is still a long way to go. As in other countries, different parts of China are at different stages of development. However, much more attention needs to be paid to mental health by raising awareness among the whole of society.
We all know that the greater the emphasis laid on mental health, the higher the quality of human life, and the more harmonious and stable the whole of society will be.
ANNEX 3

MENTAL HEALTH CARE IN SAMOA

Iokapeta Sina Enoka, RPN, AND, BN
Lecturer, Faculty of Nursing, National University of Samoa
Clinical Nurse Consultant, Mental Health, Department of Health, Apia

As the sole nurse clinician in mental health in Samoa, and having sincere respect for the dignity of the people with mental illness, I initiated a system of care utilizing one of the strengths of our culture known as the “FAA-MATAI” system (Council of Chiefs and Orators). The system weaves cultural values and beliefs into a “family focus” for community-based mental health care.

The strength of our “FAA-MATAI” system contributes greatly to the effectiveness of mental health care in our society. For example, if a family approaches me because people in the village are provoking a mentally ill member of their family and perhaps making derogatory and discriminatory remarks about that person or his or her family, I would approach the meeting of the Council of Chiefs and Orators and indicate to them the issue as related to me by the concerned family. I would also ask the meeting with utmost and deep respect to continue to support the protection of the people with mental illness and their families within their village. It is this continuing collaboration with the “FAA-MATAI” system that has strengthened the “family focus” approach in mental health care, thus making Samoa unique in its system of human care within the Region.

Having recognized the need for the development of human resources in mental health, I facilitated training for senior registered general nurses in mental health, providing them with knowledge and skills to enable early identification of mental health problems, to understand and provide treatment for mental illness, and to work with families in promoting good mental health. Within a period of three years, 65 out of 200 registered general nurses had completed short-term training in mental health, and three registered general nurses had undergone training in the Advanced Diploma in Nursing, specializing in mental health.

This increase in the number of nurses with training in mental health has facilitated the integration of the “family focus” mental health care approach into community health nursing, emphasizing the significance of mental health promotion, prevention of mental health problems and illness, and maintenance of mental health within a holistic framework of care.
Annex 3

The success story of our “family focus” community-based mental health care approach is due to the commitment and dedication of nurses who persevere with minimal resources to provide mental health care services to the people of Samoa. Nurses take the key role in leadership, management and provision of mental health care services. I feel that there is a possibility of transferring this approach to other areas of the Region, by using cultural systems as the major strand in weaving mental health care.

By developing partnerships with government and governmental organizations, nongovernmental organizations, including the church, our ‘FAA-MATAI’ system has therefore maintained and sustained Samoa’s mental health care service for the past 15 years. Nurses have been trained in the management of common mental health problems and prevention of mental illness. So too have families as caregivers and primary care workers in promoting mental health.

To conclude, I believe that with continuous collaboration and partnership of our mental health care approach, the “FAA-MATAI” system, and government support, the fine mat of mental health care (lalaga o le soifua manuia o le mafaufau) remains the treasure of the health care system in Samoa.
THE CARE EXPERIENCE

Mr John McGrath, Chair of the Mental Health Council of Australia

Bad personal experiences can be self-destructive, or they can become the motivating forces behind a push for things positive and constructive.

In the mid-1980s, my second son, Shane, was hospitalized in what was thought of as a severe emotional state. Ultimately, we were informed he had symptoms of schizophrenia. And therein started the tumultuous experiences of mental hospitals, medications, employment and unemployment, depression, anger, and eventually, suicide.

As you can imagine, and some of you will know from first hand experience, this was a very difficult time for the whole family. I carried the added burden of being in the spotlight through my position as a member of the Victorian State Parliament, and in fact Deputy Speaker of the Parliament. I felt my grieving process was under public scrutiny. People were shocked by Shane’s suicide, and were, in their own way, sympathetic. But they were also watching me to see how I coped with tragedy.

I presented to a full Parliamentary Chamber our family experience of mental illness. I discarded my privacy, and allowed them to see this can happen to any family, that we all collectively need to be responsibly informed, not only for our own benefit, but also for the benefit of the thousands of people that we as parliamentary members are elected to represent.

The response to that parliamentary speech was amazing. Many people spoke to me immediately following the speech and during the days and weeks that followed, seeking information, literature, etc. The media also became involved. I had finally found a positive and constructive way to turn Shane’s early death at just 28 years of age into something very positive.

It was after this amazing response to my initial speech I realized I was in a privileged position to do something for people with mental illness and their families. I had the personal experiences, and in my parliamentary role, I had the platform.

After fourteen and a half years, my decision to retire from the Victorian Parliament in September 1999 was to a large extent influenced by my desire to concentrate more on carers in mental health, particularly at national level. This decision led me to involvement in the
continual reform of the Australian mental health sector through my representation on various committees.

Through my involvement in the mental health sector, and particularly through my involvement with the Mental Health Council of Australia, I have seen the progression and continual reform of the Australian mental health sector. The needs of consumers and family carers and the expectations they have of mental health services are being recognized. The time has now come to not just recognize community needs and expectations of mental health services, but to alter policies and practices and actively work towards aligning services to meet identified needs, expectations and standards of the community, resulting in improved health outcomes (see Table).

The aim of consumer and family carer participation is to provide a process to improve the quality of service delivery and increase the level of consumer and family carer satisfaction with mental health services. All participants involved in the mental health sector must display a high level of commitment and belief in the value of consumer and family carer participation, for it to be truly effective rather than just tokenism.

Consumer and family carer participation in determining mental health priorities ensures a sound basis for successful processes, programmes and services to maintain and improve the mental health of all Australians.

For participation to lead to strong partnerships, the input and contributions from all stakeholders, including those of consumers, carers, special needs groups, clinical service providers, private mental health service providers, nongovernmental and governmental organizations, needs to be valued, recognized, respected and appreciated. With such recognition, there is an expectation that all groups will willingly contribute their expertise and knowledge, and provide valid representation. With such collaborative practice and expert input from all key stakeholders, the mental health sector is in a greater position to promote the mental health of all Australians and assist in providing greater health outcomes for consumers and family carers.
**Best Practice Principles**

The following best practice principles have been identified for consideration in the development of a consumer and carer participation policy.

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<th>Practice 1</th>
<th>All mental health systems will promote through practice consumer and carer participation in all processes that affect the lives of consumers and carers.</th>
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<td>Practice 2</td>
<td>All mental health systems will include consumers and carers in every process that affects the lives of consumers and carers, for instance, recruitment, workforce, resource allocation, evaluation, planning, service delivery, research, and evaluation of <em>National Standards for Mental Health Services</em>.</td>
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<td>Practice 3</td>
<td>All mental health organizations will employ consumer and carer experts to participate in all processes and activities that affect the lives of consumers and carers (either as volunteers or on a part-time or full-time basis).</td>
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<td>Practice 4</td>
<td>Consumers and carers will be employed by external agencies as consumer or carer experts to participate in all processes and activities that affect the lives of consumers and carers (consumer consultant model).</td>
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<td>Practice 5</td>
<td>Terms of reference and duty statements will be developed for consumer and carer participation at all committees. This will ensure transparency in the roles and responsibilities of all positions.</td>
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<td>Practice 6</td>
<td>All mental health organizations will have a consumer and carer participation policy that adapts the principles and practices outlined in this policy to suit individual needs and is ‘locally owned’.</td>
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<th>Practice 7</th>
<th>Each State/Territory will have a recognized peak mental health body representing that State/Territory and operating for the benefit of people with mental illness and carers.</th>
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<td>Practice 8</td>
<td>Consumers and carers will receive payment for their participation and reimbursement for expenses (travel and meals) incurred during their recognized participation in mental health activities and processes that affect their lives.</td>
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<td>Practice 9</td>
<td>An evaluation and ongoing review process of consumer and carer participation will occur annually with all mental health organizations, to ensure sound principles and practices are maintained and mental health organizations remain accountable for their actions. This may occur in conjunction with accreditation against the <em>National Standards for Mental Health Services</em>.</td>
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<td>Practice 10</td>
<td>All mental health organizations will ensure adequate feedback mechanisms exist to facilitate information flow between the organization and consumers and carers. For instance, satisfaction and evaluation surveys, focus groups, support groups, regular meetings with local and State/Territory Community Advisory Groups, newsletters, mental health consumer networks, meetings with senior management, websites, consumer and carer representation on steering committees, reference groups, and State/Territory ministerial committees.</td>
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<td>Practice 11</td>
<td>Consumers and carers will participate in staff education/orientation activities in mental health organizations.</td>
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<td>Practice 12</td>
<td>All mental health organizations will provide education and training for consumers and carers on their rights and responsibilities as consumers and carers, and also as key participants/contributors in all processes that affect the lives of consumers and carers.</td>
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<td>Practice 13</td>
<td>When considering consumer and carer participation, the selection process will ensure potential applicants are sought from key consumer and carer groups who are able to provide support and a network for consultation. For example, State/Territory Community Advisory Groups, Network of Australian Community Advisory Groups, Mental Health Council of Australia, Australian Mental Health Consumer Network, State/Territory peak bodies, Mental Health Advisory Councils, locally based reference groups, Carers Association of Australia etc.</td>
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<td>Practice 14</td>
<td>All mental health organizations promoting and practising consumer and carer participation will maintain a database of consumers and carers available for participation once consumers and carers have agreed to have their details recorded on the database. Such a database will ensure a broad network of consumers and carers are easily accessible to contact and are readily available to participate.</td>
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