



World Health Organization



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Situational analysis of mental health needs and resources in Pacific Island countries

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1. EXECUTIVE SUMMARY

1.1 Introduction

This report overviews information gathered and analysed as part of a preliminary phase in the development of a technical support programme for the organisation of mental health services in countries in the Western Pacific region. The targeted countries are Commonwealth of Northern Mariana Islands, Cook Islands, Federated States of Micronesia, Fiji, Guam, Kiribati, Republic of Marshall Islands, Nauru, New Caledonia, Niue, Palau, Papua New Guinea, Samoa (Western), Solomon Islands, Tokelau, Tonga, Tuvalu, Vanuatu, and Wallis and Futuna.

This programme is being co-ordinated by the Mental Health Policy and Service Development Team in the Department of Mental Health and Substance Abuse at World Health Organization (WHO), in conjunction with WHO's Western Pacific Region Office. Partnering WHO is The University of Auckland, through the Centre for Mental Health Research, Policy and Service Development in the Faculty of Medicine and Health Sciences.

1.2 Programme Outline

The overarching goals of the programme are to build the capacity and capability of key people, and thereby their countries, and to support participants in planning for the development of mental health services in their countries. More specific objectives are:

- To identify and engage with individuals who have responsibilities for the organization and development of services for mental health.
- To work with participants to design country-based plans of action for developing an optimal mix of services.
- To design and implement projects that contribute to those plans and which improve mental health services development, organization and delivery.
- To provide coordinated and structured technical support to participants around developing and implementing the plans of action and associated projects.
- To create a network in the region made up of people who have responsibilities and/or expertise in relation to the organization and development of services for mental health that will serve as support for programme participants.

It is anticipated that the programme benefit both the participating individuals and the countries they represent by enhancing the ability of countries in the Western Pacific region to undertake mental health reform and planning by providing key people in those countries with training and support around mental health service organisation and delivery.

1.3 Process

The information presented and analysed in this report was gathered using three main approaches: a desk-based audit of various forms of documentation; interviews with, or surveys completed by, key informants; and a workshop run at the South Pacific Nursing Forum. Information from these sources was collated in an ongoing fashion into country profiles that were the basis of a gap analysis/needs assessment. The profiles were also analysed across subject areas to provide a regional or issue based assessment.

While all care has been taken to ensure the validity and reliability of sources and information various limitations are inherent in the report content: Firstly, the available documents come from a variety of sources and span a number of years. Secondly, we cannot vouch for the validity and reliability of the original material. Thirdly, while the interview process was intended to balance documentary material with current information, for various reasons only a small number of interviews were conducted. That said, these interviews took in nearly half of the countries under consideration and were generally undertaken with already well established contacts thereby helping to encourage involvement and enhance the depth and quality of the information gathered. Finally, there are wide variations in the level of information and detail available for different countries. While detail is quite scant for some, data in other countries is reasonably comprehensive.

Even with these limitations, it is argued that the report represents a reasonably detailed overview of the situation across the region and in the selected countries and is adequate for this phase of the programme.

1.5 Programme Pilot

Piloting was seen by country representatives as a vital element in the development process so that a programme can be tested and reviewed to ensure that the most effective and appropriate approach is adopted for each country. It was always intended that the next stage of the programme would involve just such a piloting process. Based on a range of criteria and the information and analysis contained in this report a shortlist of pilot sites from the larger group of 19 countries is offered:

- Cook Islands
- Fiji
- Samoa
- Tonga
- Papua New Guinea
- Vanuatu
- Solomon Islands

Once the exact nature of the initial pilot programme is known, further consideration will need to be given to selecting the most appropriate countries from this group (or perhaps expanding or altering the make up of the shortlist).

While the exact nature of the programme is yet to be finalised, a broad overview and suggested outline can be presented. Firstly, it is important that whatever technical support is provided is done so in partnership with countries and in a culturally appropriate manner. In this vein, the support programme will follow the principles laid down in the WHO document *WHO Multi-country project to improve policy, systems and services for mental health – Implementation phase of the policy project* which focuses on: country needs, evidence, partnerships, human rights, continuity and sustainability, and evaluation. Areas that might be considered for action within countries are also identified in that document.

The support programme will assist countries in formulating a mental health policy and strategic implementation plan. This will involve a comprehensive and detailed assessment of mental health services in each country such as is outlined in the WHO document – *Rapidly assessing mental health in countries – A tool for use at country level*. The information gathered in this report for each country is but a starting point in such a process as accurate and comprehensive information will be needed at this stage. National workshops will need to be organized in each country in order to support countries in the process of developing and implementing such a plan. A number of detailed steps for this process are outlined elsewhere in the report. From such a plan it is then suggested that projects could be developed that are themselves the subject of support activities and which contribute incrementally to the overall implementation of the plan.

Technical support during this process will likely take two forms: Firstly there will be direct, in-country support by consultants with relevant expertise and experience. In addition, it will also be necessary to provide ongoing distance support for countries. This latter form of support will need to be based on modes that are appropriate to and preferred by each country as signalled in this report.

Given that this is a pilot programme, it is suggested that a two-pronged evaluation be undertaken. This would focus evaluating both the country based projects and the approaches, processes and activities associated with the programme. The latter will allow for ongoing improvements to be made to the programme with the long term goal of developing a practical, effective, efficient and sustainable generic model of technical support that can be adapted to the needs and circumstances of other countries in the region.

1.4 Overview

This final section provides an overview of the information and analysis contained in the report and which should be taken into account in the development and implementation of the pilot programme. In light of the limitations outlined earlier, however, it is important to note that interventions in any country should be prefaced by the gathering of accurate and up-to-date information.

The goals of this programme are very important. Mental health services are the means by which effective interventions for mental health are delivered and through which the burden of disease can be reduced or ameliorated. However, the success that mental health services have in fulfilling this function often

depends, in large part, on certain conditions such as the legislative and policy frameworks that those services operate in, and how they are planned for, funded, organized and delivered. Hence this programme seeks to target these areas by equipping people with the expertise to determine the exact mix of different types of mental health services that their country should have, and to develop and implement a plan to deliver that optimal mix of services.

Many obstacles and issues confront the programme however. Chapter 4 outlines the mental health context that the programme will face in the target countries and in doing so highlights many of these challenges. Broad issues include the fact that mental health is often not perceived as a major health priority by many country governments as they address other, more pressing, health needs. As well, mental illness is often seen as a difficult subject for people to talk about and people often experience stigma and discrimination.

As was evident from the overview and analysis presented in Chapter 4, most Pacific countries have a health structure that lends itself to an optimal mix model – that is, they already have a system orientated towards primary health care. However, mental health care does not necessarily fit easily or well into this structure. Reasons for this include the broader issues as noted above. Other factors concern the infrastructure needed to develop and support an optimal mix of mental health services and Chapter 4 addresses these. They are governance; financing; health services delivery and organisation; legislation; policies, plans and programmes; workforce; services and facilities; and the involvement of non-governmental organisations (NGOs). The complex inter-relationship between areas and issues is evident in countries where facilities and services are developed but cannot be staffed because of workforce problems, or where staff exist but there is insufficient expertise or funding to develop services/facilities.

Although governance is not always clear from available data all countries have a government ministry or department responsible for health, though not necessary a dedicated mental health section, staff or focus within it. Many countries do not have a dedicated mental health budget and often spend very small percentages of their overall health budget on this area. Addressing these two areas will be important aspects of the programme in several countries.

There is variation across the region in the nature, comprehensiveness and quality of legislation in relation to mental health. While a small number of countries with legislation are engaged in a review and updating process, or have done so in the last decade, many have legislation that is dated. Thus, a key function of the programme will involve supporting countries in reviewing legislation to produce legal frameworks that, while reflecting the unique circumstances and culture of each country, are comprehensive, contemporary in nature, and mindful of international obligations.

There is inconsistency across the region in relation to the presence, make up and status of mental health policies, plans and programmes. It would seem that not only the development but the operationalisation and often the actual implementation of policies, plans and programmes can be highly problematic for countries. This is clearly an area where skilled technical assistance and

support may be crucial. Current priorities in the planning of many countries include:

- Increasing the size and expertise of specialist workforces (almost universal).
- Improving training for the general health workforce (very common).
- Improving understanding and awareness of mental health in the community.
- Improving the organisation and management of mental health services.
- Developing mental health policies and legislation.
- Developing/improving community based care.

Regardless of their status, content and coverage, the existence of policies, plans, programmes and other such initiatives in various countries can be built upon for this programme.

The skewing of health services towards primary health care means that training and development around mental health of the associated workforce is clearly important to improving care and outcomes. As is evident in the report, this is perceived as a high priority by countries. However, while much can be achieved through the training of general health staff in mental health, an optimal mix of services also requires a specialist workforce. The small size of such workforces in most countries raises a number of issues such as those around recruitment and retention (including the loss of specialist staff when training occurs overseas) and providing appropriate and ongoing training for this group. In relation to these issues, a more co-ordinated and co-operative approach among groups of countries may be useful. Similarly, ongoing distance learning and support programmes in specialist staff development are clearly important but these need to be carefully structured. These last two points are considered in more detail shortly.

Workforce issues must also consider the best utilization of staff. Thus, the organisation and structure of services and facilities must be considered in close relationship with workforce issues and along with the wider country context and the place and fit of mental health more generally.

The often limited and frequently variable nature of information regarding services and facilities has implications for analysis in those areas. From the available data some general observations can be made about services and facilities can be made:

- Large dedicated institutions often only provide less than optimal care and place a heavy drag on resources.
- Despite strong primary health care orientated systems, for a variety of reasons many countries do not integrate mental health into those systems
- The involvement of, and reliance on, primary health care workers, outside agencies, communities and families necessitates a strong education programme.
- Delivery of services is often hampered by the geography of countries (e.g. widely dispersed islands) and limited resources (e.g. reliable, maintained transport). Thus, developing services and facilities needs to incorporate considerations well beyond those centred around mental health and be open to innovative thinking.

- Geography can also influence mental health service and facility development directly – e.g. the need to replicate services and/or facilities when transport makes centralisation problematic.
- There is the need to consider provision for particular groups (e.g. children and adolescents) and needs (e.g. around suicide) as well as generic services and facilities
- As well as providing support, networking and sharing among Pacific countries may highlight similar problems and throw up innovative solutions.

NGO involvement is variable across countries and, again, precise information is limited by data available for analysis. In a number of countries there is expressed interest by NGOs and governments in expanding the roles and involvement of such organisations.

In terms of responding to these issues, the report offers an overview and analysis of education and training in the countries under consideration (Chapter 5), and from a regional perspective (Chapter 6). These chapters look at health education more broadly across various areas (e.g. clinical and management), and with a particular focus on mental health.

As clinical training, especially in terms of health workers, nurses and doctors, is seen as a high priority in all countries, it is positive that most have, at the least programmes around nursing. However, there is variation in the nature and significance of mental health content in these and efforts in addressing this need to be made. It is argued that this programme will make a valuable contribution to extending the interest in clinical training to management, policy and leadership areas. Also considered important by countries were more general programmes around mental health education, promotion and prevention for workers and the public.

Reflecting the situation outlined earlier in this summary section and in more detail in Chapter 4, the primary health care system is important in relation to mental health care. However, the mental health training for this workforce varies considerably in terms of existence, type, frequency, coverage, and quality and again this is an area that needs attention. Any clinical training around mental health should take account of the predominance of nurses and health workers in the specialist and generic workforces.

It is apparent that many countries use courses run in neighbouring countries for basic and/or specialist training and there is a clear and expressed desire for more collaboration of this kind. Such networks and collaborative approaches are obviously of value and interest since they can play an important role in training and support initiatives. Indeed, improved and expanded networks are a key goal in this programme. Existing Pacific education collaborations, networks and relationships vary in size, nature and structure and one country can belong to a number of these for a variety of different motivations or purposes. Apart from SPC, networks and organisational collaborations tend to be associated with smaller regional sub-groupings.

As is the situation in some cases already, future collaborations could be made up of a set of countries grouped around a key provider, based on more local

relationships and particular needs. Each collaborative centre of training or learning would provide a focus for shared and concentrated investment of human and financial resources to ensure quality training. It could also develop a 'train the trainers' approach and encourage a flow on effect to other groups of workers. Collaborations would allow for training to reflect the cultural and other needs of Pacific nations and could well reduce the loss of staff that often happens when training is made available in Australia or New Zealand.

Technical support in various forms would clearly be beneficial in developing and maintaining collaborations of this sort and in promoting shared and ongoing training and education. Most countries have developed external or strategic partners (in Australia and New Zealand), but there still needs to be more linkages at regional level with efforts made to utilise, support and develop the leadership roles of existing providers. For instance, although USP is the leading distance education provider in the Pacific, it does not teach health or medicine programmes. Thus, it needs to link productively with providers that have such an orientation. Ongoing support should favour models that contribute to the goals of building capacity and capability and a lasting infrastructure in the region through viable and sustainable networks and organisations.

It is clear that the internet and other electronic media, including telehealth initiatives, offer some potential in relation to collaborations and networking around education and training. However, those interviewed placed heavy emphasis on the oral culture in Pacific countries, the preference for a face-to-face approach for training, and the need for close engagement with neighbouring countries. Ongoing support and mentoring was recognised as important but the approaches adopted needed to be appropriate and reflect the above factors. Thus, electronic media should be viewed as an adjunct rather than mainstay of any programme, though consideration must still be given to availability, access, reliability, costs, skills, knowledge, experience and preferences. Even if technology is available in countries, in-country variability could mean that more mundane approaches such as ordinary mail and the like may still be necessary.

Finally, it was evident from interviews that any proposed programmes be well piloted. In addition, in order to give credibility and ongoing support to particular training programmes, significant members of the community and church (e.g. elders or leaders) should be involved alongside administrators, managers, clinicians and workers. This will ensure greater buy in and sustainability of programmes.

2. INTRODUCTION

2.1 Background

In committing to mental health as a global priority, the World Health Organisation (WHO) recognises that the impacts of illness are not evenly distributed. For instance, as is noted in their *Regional Strategy for Mental Health*¹, the Western Pacific Region of WHO has had improvements in physical health over the last 50 years but the situation has worsened in respect of mental health over that same time frame. As well, the Region experiences a higher burden of mental and neurological disorder compared to other parts of the world. The *Strategy* also recognises that, as elsewhere, services in this region are often scarce and poorly distributed and resourced.

Mental health services are the means by which effective interventions for mental health are delivered and through which the burden of disease can be reduced or ameliorated. However, the success that mental health services have in fulfilling this function often depends, in large part, on factors such as the legislative and policy frameworks that those services operate in, and how they are planned for, funded and organized. Those who have responsibilities in relation to such conditions need expertise in a range of areas so as to be able to determine the exact mix of different types of mental health services that their country should have, and to develop and implement a plan to deliver that optimal mix of services.

In order to assist those who are responsible for the planning, organisation and delivery of mental health services, WHO has developed the *Mental Health Policy and Service Guidance Package* which is a series of user-friendly inter-related modules designed to canvas various issues in relation to policy and service development and implementation. However, WHO is aware that in addition to such materials, those charged with the task of service planning and management – government officials, policy makers, and senior health or mental health professionals such as doctors and nurses – require support and training to enable them to develop and implement an optimal mix of mental health services in their country.

In response to this perceived need, WHO is partnering with the University of Auckland to develop a programme of technical support for countries in the Western Pacific region. This will incorporate elements of direct as well as ongoing distance support. It is intended that the programme will initially be piloted with a small number of countries before becoming more widely available.

¹ World Health Organization – Western Pacific Regional Office (2002). *Regional Strategy for Mental Health*. Manila: WHO/WPRO

2.2 Report Outline

This report presents information and analysis gathered as the initial phase in developing just such a pilot programme. The remainder of this chapter overviews the evolution, organisation and rationale for the programme. Chapter 3 outlines the processes used in gathering, collating and analysing the information presented in this report. Importantly it also notes limitations inherent in the production of the report.

The next three chapters provide overviews of the information and analysis in relation to the mental health context (Chapter 4), and education. The former canvasses key mental health issues and areas such as: health services delivery and organisation; governance, financing and legislation; policies, plans and programmes; workforce, services and facilities; and the involvement of non-governmental organisations. The latter is examined from a country perspective (Chapter 5) and a regional viewpoint (Chapter 6). Finally, Chapter 7 offers a conclusion that summarises the key findings and, in sketching out the shape of the proposed pilot, considers the relevance and implications of these findings to the pilot programmes and process.

2.3 Programme Overview

2.3.1 Organisation

This project is being co-ordinated by the Mental Health Policy and Service Development Team in the Department of Mental Health and Substance Abuse at WHO. It is being lead by Dr Michelle Funk, with the technical assistance of Ms Natalie Drew. Dr Tom Barrett has provided further technical input. Representing the region from WHO's Western Pacific Region Office (WPRO) are Dr Wang Xiangdong and Kathlyn Fritsch.

Partnering the WHO is The University of Auckland (New Zealand), through the Centre for Mental Health Research, Policy and Service Development in the Faculty of Medicine and Health Sciences. This group is lead by the Centre Director, Dr Frances Hughes, and is made up of Dr Mary Finlayson and Patrick Firkin. Dr Francis Agnew is also part of the team. Dr Agnew is a psychiatrist with considerable experience working in the Pacific and is Clinical Leader of Pacific Mental Health and Drug and Alcohol Services with Waitemata District Health Board (Auckland, New Zealand).

2.3.2 Goals

The overarching goals of the programme are:

1. To build the capacity and capability of key people, and thereby their countries, and
2. To support participants in planning for the development of mental health services in their countries.

2.3.3 Objectives

More specifically, the objectives of the programme are:

- To identify and engage mental health workers and policy makers in Ministries of Health and other government departments who have

responsibilities for the organization and development of services for mental health.

- To work with participants to design country-based plans of action for developing an optimal mix of services.
- To design and implement projects that contribute to developing an optimal mix of services and which improve mental health services development, organization and delivery.
- To provide coordinated and structured technical support to participants around developing and implementing the plans of action and associated projects.
- To create a network in the region made up of people who have responsibilities and/or expertise in relation to the organization and development of services for mental health that will serve as support for programme participants.

2.3.4 Benefits

It is anticipated that the programme will have benefits for both the participating individuals and the countries they represent. In general terms the capability and capacity of countries in the Western Pacific region to undertake mental health reform and planning will be enhanced by the training and support of key representatives around mental health service planning and organisation. More specifically, countries will benefit from the development of a situation assessment on current mental health service organisation; a plan for the organisation of mental health services; and from the development and implementation of projects associated with the plan.

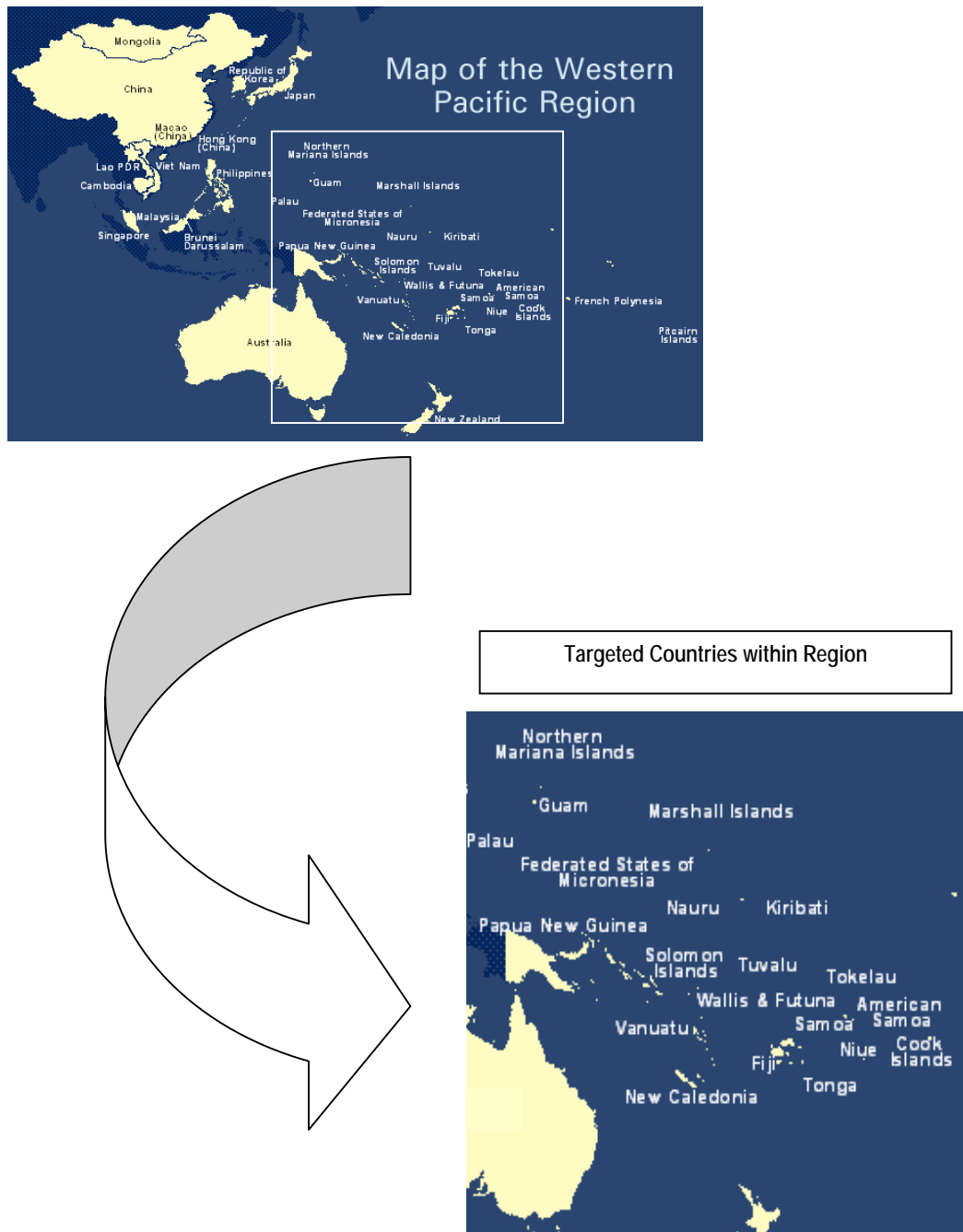
2.3.5 Western Pacific Region

The Western Pacific Region for WHO comprises a large number of countries spread across a large geographical area as seen in Figure 1. This report contains information and analysis around a subset of countries as shown in the enlarged area of that figure and listed in Table 1.

Table 2.1 Targeted Countries from WHO Western Pacific Region

| | |
|--|-----------------|
| Commonwealth of Northern Mariana Islands | Cook Islands |
| Federated States of Micronesia | Fiji |
| Guam | Kiribati |
| Marshall Islands | Nauru |
| New Caledonia | Niue |
| Papua New Guinea | Palau |
| Samoa (Western) | Solomon Islands |
| Tokelau | Tonga |
| Tuvalu | Vanuatu |
| Wallis and Futuna | |

Figure 2.1 WHO Western Pacific Region and Targeted Countries



3. PROCESS

3.1 Introduction

The overarching purpose of the initial phase of the programme has been to gather and collate country based information into a gap analysis/needs assessment for the development of the pilot support programme. Associated with the information gathering process is the development of a contact list.

It should be noted that a regular dialogue has been maintained between WHO and the University of Auckland team during the process and this has been influential in developing and guiding the information gathering and analysis and, as outlined in section 2.3.1, in the evolution of the programme.

This chapter briefly outlines the means by which information and contacts have been built up. Three approaches have been adopted in this process: a desk-based audit of various forms of documentation; interviews and surveys with key informants; and a session run at the South Pacific Nursing Forum. The chapter ends with a brief discussion of the limitations inherent in this process and the implications this has for the findings and analysis.

3.2 Contacts Development

A list of contacts has been developed for each Pacific country, from a regional perspective, and for WHO, Australia and New Zealand. These comprise key individuals in relevant areas such as government, medicine, nursing, health (more generally), education, NGOs, and the community. The process drew on the existing relationships and networks of those associated with the programme. It also sought to build and develop new contacts and relationships.

3.3 Information Gathering and Analysis

3.3.1 Overview

Information has been sought in terms of individual countries and across the region within three broad areas:

1. Mental health services organisation and provision:
 - a. *Health and mental health legislation, policy and programmes.*
 - b. *How healthcare, especially mental health care, is organised and delivered.*
 - c. *Overview of health and mental health workforce.*
 - d. *Description of services and facilities dedicated to mental health.*
 - e. *Outline of involvement by non-governmental agencies in mental health.*
 - f. *Identification of specific mental health issues.*
2. Health/Mental Health Education and Training:

- a. *Description of any training programmes in health and especially mental health at any level.*
- b. *Overview of availability of ongoing and advanced health/mental health training (in-country or overseas) – not confined to clinical practice.*
- c. *Overview of capacity within countries and institutions to provide new educational programmes.*

3. Distance Learning:

- a. *Overview of existing distance learning courses, providers & relationships – these could be in relation to mental health, health, or more generally.*
- b. *Overview of distance learning capacity and capability within and between countries and institutions.*
- c. *Review of experiences of distance learning.*
- d. *Review of technical possibilities and problems around distance learning.*

Information around the above has been collected via documentary collection and review, surveys and personal interviews, and a group forum.

3.3.1.1 South Pacific Nursing Forum (SPNF)

The South Pacific Nursing Forum (Rarotonga, 15-19 November, 2004) presented a valuable opportunity for members of the project team to engage with country and regional representatives in a number of ways:

- Engage in detail discussions with country participants about general issues around health/mental health in Pacific countries.
- Conduct interviews with country representatives for completion of questionnaires and obtaining information for project (as per Section 3.3.2).
- Conduct a two hour workshop with representatives from Pacific nations.

The Forum also provided a valuable opportunity for Dr Hughes and Dr Finlayson to meet with regional and local representatives of WHO and to meet and work with Dr Tom Barrett of WHO, Geneva.

The SPNF member countries are listed in Table 3.1

3.3.2 Documents

Documents were primarily sourced from WHO – mission reports, commissioned reports, meeting reports, as well as strategic, training and other documents. A range of other documents were sourced via database and Internet searches. A review of website material was also conducted.

Table 3.1 South Pacific Nursing Forum: Member Nations & Associations

| | |
|---------------------------------|------------------|
| American Samoa | Niue |
| Australia | Papua New Guinea |
| East Timor | Samoa |
| Cook Islands | Solomon Islands |
| Fiji | Tokelau |
| Kiribati | Tonga |
| Nauru | Tuvalu |
| New Zealand | Vanuatu |
| <i>Associated with:</i> | |
| Commonwealth Nurses Federation | |
| International Council of Nurses | |

3.3.3 Interviews and Surveys

Interviews were conducted with key informant in selected countries to verify and augment the information gathered via documents. This mostly occurred during the SPNF. Some representatives completed their country surveys after returning home and also sent on further information (*Samoa and Papua New Guinea*). Dr Tom Barrett also conducted a visit to *Fiji* for this purpose.

In addition to meeting representatives from various countries during the SPNF, Drs Hughes, Finlayson and Barrett were able to meet with the Minister of Health and Secretary of Health from the Cook Islands during this time. Also present was the WHO country representative.

Interviews or completed surveys were obtained from representatives of the following countries: *Cook Islands, Fiji, Niue, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu*.

The interview schedule used in this process was developed in conjunction with Dr Tom Barrett (WHO, Geneva). Staff from the Maori and Pacific Health Unit at the University of Auckland provided a review of the questions. Appendix A contains a summary of the questions canvassed in these interviews.

3.3.4 South Pacific Nursing Forum Mental Health Workshop

As noted, a workshop was conducted during the Forum. This allowed the project to be explained in some detail including its rationale and goals. Importantly, participants were invited to engage in group work that provided further valuable information in the development of the project. Areas canvassed are outlined in Table 3.2.

Table 3.2 Issues Covered in SPNF Mental Health Workshop

- Critical mental health issues/needs
- Legislation & Policy
- Services (& Facilities)
- Service Organisation & Delivery
 - who does what, where, when, why and how
- Workforce
 - education & training
- Existing MH education programmes
- what, where, who when, how
- Unmet learning needs
- Learning approaches
- Positives & Strengths
- Challenges & Issues
- Questions

3.4 Analysis

Information from these various sources was collated in an ongoing fashion into country profiles. These profiles detail the available information on the current circumstances and capability/capacity of countries in respect of the key areas outlined in Section 3.3.1 (items 1, 2 and 3). These in turn served as the basis for a gap analysis/needs assessment in each country around those same areas. The profiles were also analysed across subject areas to provide a regional or issues based assessment.

The full country profiles are provided in Appendix B.

3.5 Limitations

Before proceeding with the report it should be noted that the information and analysis contained in it are limited in various ways. Firstly, the available documents come from a variety of sources and span a number of years. Thus they may not always be entirely up to date and sometimes different reports present contradictory views. While only reputable sources have been used the authors cannot vouch for the validity and reliability of the original material. Secondly, while the interview process was intended to balance documentary material with current information, only a small number of interviews were conducted and these were, in turn, limited to countries attending the South Pacific Nursing Forum. Some effort was made to conduct interviews by phone in other countries prior to the Forum but various difficulties did not allow this.

Finally, there are wide variations in the level of information and detail available for different countries.

3.6 Conclusion

Even with these limitations, the report represents a reasonably detailed overview of the situation across the region in the selected countries. Although the available data is quite scant in some cases – notably in respect of *New Caledonia* and *Wallis and Futuna* – in many other cases quite rich and comprehensive information is provided. While limited in number, the interviews that were conducted greatly enhanced the information base for individual countries and the project as a whole. Importantly, interviews and requests for information were undertaken with already well established contacts which helped to encourage involvement and enhance the depth and quality of the information gathered. These were an invaluable contribution to the ongoing evolution of the programme.

4. COUNTRY-BASED MENTAL HEALTH OVERVIEW

4.1 Introduction

This chapter provides an overview of mental health in Pacific countries in respect of the following areas:

- Health Services Delivery and Organisation
- Governance
- Financing
- Legislation
- Policies, Plans and Programmes
- Workforce
- Services and Facilities
- Non-Governmental Organisations (NGOs)

Before examining each of these areas a short overview is presented of mental health issues raised during group work in the session conducted as part of the South Pacific Nursing Forum.

4.2 Mental Health Issues

As noted in Chapter 2, a workshop that focused on mental health was conducted as part of the South Pacific Nursing Forum. While each country will have its own issues many shared similar concerns. Some of the key mental health issues to emerge from the group work are summarised in Table 4.1.

In addition to those issues listed, other concerns were identified in discussions. Key amongst these was that:

- Mental health in Pacific countries is a difficult subject for people to talk about. Thus, although the health system is heavily reliant on families and communities, these are groups that often struggle to understand and provide appropriate care. Issues such as stigmatisation and neglect are sometimes mentioned as a result.
- Mental health was often felt to not be a priority in many countries at government level given the many other pressing health issues.
- Health professionals were reported as being not particularly interested in mental health and they did not have skills in this area. It was also felt that many did not want to get involved in this field.

A variety of other information, including that gathered via interviews and surveys, confirmed the prominence of issues around alcohol and other drugs, and of concerns around suicide rates, often but not always in relation to youth. The impact of violence and trauma was also seen as a significant issue in many countries.

Table 4.1 South Pacific Nursing Forum: Mental Health Session – Feedback on Mental Health Issues

| |
|---|
| <p><i>Training of Doctors and Nurses</i></p> <p><i>Unavailability of psychologists for in-patient and community services</i></p> <p><i>Growing AOD problems, especially among students/youth</i></p> <p><i>Growing rate of suicide</i></p> <p><i>Lack of legislation and policy</i></p> <ul style="list-style-type: none"> ○ Around services ○ Around medications & treatments ○ Roles of stakeholders (police, magistrate, family, physician etc and around custody) <p><i>Medications</i></p> <ul style="list-style-type: none"> ○ Nurse prescribing ○ Lack of new medications ○ General lack <p><i>Services</i></p> <ul style="list-style-type: none"> ○ Lack of facilities ○ Lack of proper facilities ○ Lack of follow up capability <p><i>Budget restrictions</i></p> <p><i>Lack of political will and support</i></p> |
|---|

4.3 Situational Overview

4.3.1 Health Services Delivery and Organisation

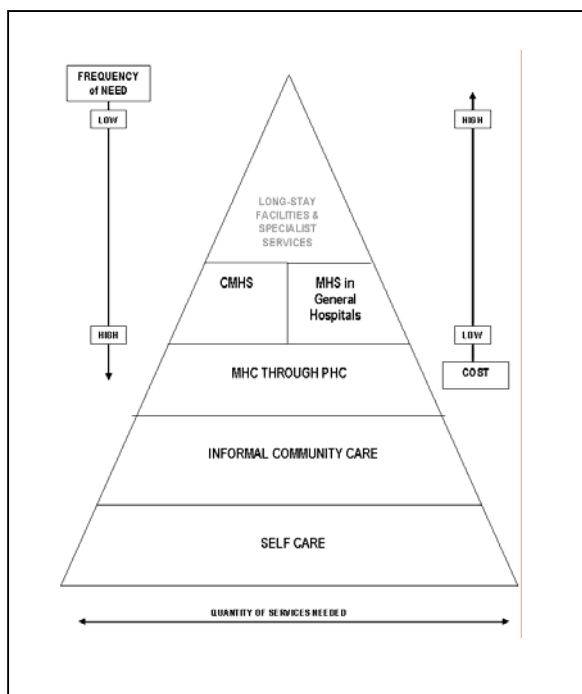
In general terms health care in Pacific countries is organised around a pyramid system with a wide primary health care orientated base. The most common organisational pattern, described in generic terms, is a number of village or community level health clinics or services that are connected with a smaller number of larger sub-regional or regional health centres. These are in turn connected to regional or national hospitals. The numbers of tertiary facilities and layers of community services differs between countries. The most common services may be built around visiting teams or shared residential staff.

Though it, too, differs between countries, the distribution of the health workforce across this type of structure can also be generically described. The most common services are often staffed by health workers and traditional healers. Nurses may also staff this level but are more commonly attached to wider regional centres, or tertiary facilities and/or provide visiting services. Doctors are more likely attached to the last two.

Clearly the structure of health care service organisation and delivery in general terms has implications for provision of mental health care. As can be seen from Figure 4.1 this structure mirrors the model for an optimal mix of mental health services. While the absolute requirement for, and the ability to provide and deliver, various services differs greatly between countries as the result of a range of factors, the relative needs for different services in any optimal mix are roughly the same. Thus, as is evident from Figure 4.1, the most numerous services should be informal community mental health services and mental health services provided in primary health care, followed by psychiatric services in general hospitals and formal community mental health services, and lastly specialist mental health services.

However, there are a number of issues in relation to the successful integration of mental health into existing general health structures in Pacific nations, many of which are canvassed throughout this chapter.

Figure 4.1 Modelling an Optimal Mix of Mental Health Services



Notes: CMHS = community mental health services; MHS = mental health services; MHC = mental health care; PHC = primary health care. Faded text indicates little justification for such services.
Source: WHO (2003) Organization of Services for Mental Health – Mental Health Policy and Service Guidance Package, Geneva: WHO - p 32

4.3.2 Governance

The governance of mental health services is not always clear from the available data. All countries have a health ministry or department for administering services, but a large number have no identifiable division or specified senior role dedicated to mental health (*Cook Islands, Nauru, Niue, Samoa, Solomon Islands, Tokelau, and Vanuatu*). *Tonga* is in this group but has a mental health committee. *Wallis and Futuna* also likely falls into this category as well but the situation is unclear. Information is also uncertain in respect of *New Caledonia*.

The remaining countries have either a specific mental health section or division within the larger health or human services department/ministry (*Palau, Northern Mariana Islands, and Guam*) or have identified mental health as being part of other health and human service divisions:

- *Papua New Guinea* within the Social Change and Mental Health section of the Technical and Health Services Division
- *Kiribati* within the Hospital Services Division
- *Fiji* within the Hospital Services Divisions. It is noted that a shift to a regional-based organisation in the Fiji health service poses both opportunities and challenges for mental health.
- *Marshall Islands* within the Bureau of Primary Health Care in the Division of Human Services
- *Micronesia* within the Preventive Health Division
- *Tuvalu* within the Curative Health Services

Like *Tonga, Marshall Islands, Micronesia* and *Palau* have Mental Health Councils.

4.3.3 Financing

As outlined in Table 4.2, ATLAS provides the following information about the financing of services for mental health.

Table 4.2 Mental Health Financing by Country

| Country | ? Budget allocations for mental health | % of total health budget allocated to mental health | Sources of mental health financing (in descending order of prominence) |
|------------------|--|---|---|
| Cook Islands | NO | N/A | Tax |
| Fiji | YES | 1.7 | Tax Private Insurance |
| Guam | YES | N/A | Tax Private Insurance Grants Personal or family payments Social Insurance |
| Kiribati | NO | 1.6 | Tax |
| Marshall Islands | YES | 0.4 | Social Insurance |
| Micronesia | YES | 7.3 | Grants Social Insurance Personal or family payments Tax |
| Nauru | NO | N/A | Tax |
| New Caledonia | YES | N/A | Social Insurance |

| Country | ? Budget allocations for mental health | % of total health budget allocated to mental health | Sources of mental health financing (in descending order of prominence) |
|---------------------|--|---|---|
| | | | Private Insurance Personal or family payments |
| Niue | NO | N/A | Tax |
| Northern Mariana Is | YES | N/A | Tax Social Insurance Grants Private Insurance Personal or family payments |
| Palau | NO | 2.0 | Tax Grants |
| Papua New Guinea | YES | 0.7 | Tax |
| Samoa | NO | N/A | Tax |
| Solomon Islands | YES | 1.4 | Tax |
| Tokelau | NO | N/A | Tax [NZ Aid] |
| Tonga | YES | 0.5 | Tax |
| Tuvalu | NO | N/A | Tax Personal or family payments |
| Vanuatu | NO | N/A | N/A |
| Wallis and Futuna | NO | N/A | Grants |

Notes: N/A = information not available

4.3.4 Legislation

A majority of Pacific countries have legislation in relation to mental health. However, *Wallis and Futuna* together with *Tokelau* apparently do not have mental health legislation. Available data make the situation in *New Caledonia* unclear. Although *Guam* appears to have legislation the precise details are not known. Legislation in *Niue* is very limited and, as is the case in the *Cook Islands*, both countries also employ New Zealand legislation. Interestingly, in *Niue* a situation exists where the involuntary detention and treatment of the mentally ill with family consent is by practice not law.

Over and above the presence or absence of legislation relating to mental health there is also variation in its comprehensiveness and coverage. Few countries have what could be described as comprehensive legislation. More often available laws are fragmented and restricted, dealing with specific issues such as involuntary commitment. Other legislation may be implicated in some countries. For instance, in the *Cook Islands* mental health legislation is embedded in the Crimes Act while in *Guam* aspects of the Health Act may be relevant. Legislation in the *Marshall Islands* is in the form of National Mental health Planning Council By-Laws.

A great deal of existing legislation in Pacific countries was originally enacted in the 1960s and 1970s (*Micronesia*, 1970; *Nauru*, 1963; *Niue*, 1969; *Papua New Guinea*, 1960; *Samoa*, 1961; *Solomon Islands*, 1970; *Tuvalu*, 1978; and *Vanuatu*, 1965). Some legislation in other countries even predates this timeframe but was revised during the same period (*Fiji*: legislation enacted 1940 and reviewed 1978; *Kiribati*: legislation enacted 1927 and reviewed 1977).

A trio of countries have had much more recent legislative reviews: *Marshall Islands* (1997), *Northern Mariana Islands* (1993), and *Tonga* (1992). Another small group of countries are currently engaged in reviewing their legislation. *Samoa*, since 2003, and *Vanuatu* are actively engaged in this process with WHO assistance. Each country has an established legislative process in this regard. *Fiji* is also engaged in a review and had been hoping for new legislation to be in place in 2004.

Solomon Islands recognised the need for review and consultants conducted this and advised on amendments in 1995. These involved consolidating the law relating to persons of unsound mind as well as making further and better provision for the care of persons suffering from mental disorders, for the custody of persons, and for the management and control of mental hospitals. There is now an attempt to get community and primary health care facilities incorporated into the act in Solomon Islands as well. The revised act forms part of the mental health programme in that country. It was hoped that the amendments would be enacted in 2002 but it is unclear if this has occurred.

4.3.5 Policies, Plans and Programmes

This rather broadly titled section considers what national policies, plans or programmes are in place around mental health in Pacific countries. ATLAS has been drawn on for some of the following information regarding programmes and policies. Other data has been used regarding plans and to augment, where possible, the rather scant details present in ATLAS. Six countries (*Cook Islands*, *Nauru*, *New Caledonia*, *Niue*, *Tokelau* and *Wallis and Futuna*) do not have any initiatives in place in these categories. The *Cook Islands* has expressed an interest in developing a plan. In six other countries a mental health policy is also absent but each of these countries has been active, to varying degrees, around related initiatives.

- *Solomon Islands* has had a national mental health programme in operation since 1999. A draft strategic plan has been developed since 2001 and revised in 2004 covering policy development, awareness training, facilities improvement, workforce growth and training increases.
- *Tonga* has no national programmes or plans in relation to mental health. It does have a Social Plan which acknowledges the “vulnerable”. Generic workforce development issues, which are also relevant to mental health have been acknowledged in a Ministry of Health Report. Importantly, Tonga has set six health priority areas, one of which is better management of chronic psychiatric patients through improving the mental health component of training for all public health care nurses. They are also interested in encouraging NGO involvement. Tonga has a Mental Health Council.
- *Vanuatu* has neither national plans nor programmes for mental health and their health policy does not specifically mention mental health. However, a 1999 Ministry of Health report raises the issues of mental health management and treatment of disability. This country is apparently making optimal use of a WHO consultancy to develop a national programme and recruit support from local planners. The service development goals in this country are based on a gradual transition from traditional hospital-based psychiatric treatment to

community-based services. There is also a desire to develop educational collaborations with local and international universities around education and training.

- *Samoa* has a broad five year Strategic Health Plan and, while references to workforce development in this are relevant to mental health, there is not specific incorporation of mental health. A National Policy for Mental Health Services is in development with a first draft near completion.
- *Marshall Islands* has no formal government plans or programmes but there is a stated desire to undertake a five year plan around developing a community based mental health service, building an inpatient facility, creating information systems, strengthening family training and support groups, and hiring professional staff. Marshall Islands has a Mental Health Council.
- *Fiji* does not have an official mental health policy and the National Advisory Council in Mental Health is currently developing one. A National Mental Health Programme ran between 1998 and 2002 but currently this has been incorporated into the public health and promotion category of the Ministry of Health's National Corporate Plan. A reorganisation of the health services structure to a regional basis poses challenges and opportunities for mental health services.

The remaining countries have mental health policies that are often, but not necessarily, associated with programmes and plans.

- *Papua New Guinea* has conflicting information available regarding its situation. While ATLAS notes that a mental health policy is present (though there are no details about the year of formulation) which covers advocacy, promotion, prevention, treatment and rehabilitation, interview data counters this. A national mental health programme is identified as being present since 1962. It is also noted that there is a Mental Health and Social Change Program 2001-2010 which has among its priorities: increased staffing and training of psychiatric nurses; the establishment of psychiatric units at all public hospitals; the establishment of four regional referral and supervising units at level-two hospitals; an upgrade for Laloki Mental Hospital; improved inter-sector collaboration in forensic psychiatry, domestic violence against women and the control and prevention of substance abuse; improved community knowledge and skills to support community mental health programmes; expanded community mental health programmes; and improved monitoring and reporting. This is also reference to a five year plan to develop training packages for doctors and nurses, create a diagnosis and treatment manual for health professionals, train more specialists in mental health, and improve post-graduate psychiatric training to international standards. This has not yet been accepted or approved.
- *Guam* has a policy formulated in 1983 which has prevention, treatment and rehabilitation incorporated into it. It canvasses issues such as promoting a least restrictive environment and integrated care with a community orientation, including outreach to people with serious mental illness. ATLAS indicates that there is not a mental health programme or plan.

- *Kiribati* has a mental health policy around advocacy, promotion, prevention, treatment and rehabilitation, and a national programme dating from 1999. No other details are available. Key health priorities announced by the government in 1999 make no specific mention of mental health but objectives around primary health care, health education, and human resource development are relevant.
- *Micronesia* has had a national mental health policy around advocacy, promotion, prevention and treatment since 1986, with an associated programme since 1989. No other information is available. Some mention is made of a proposed five year plan to develop/maintain an organized community based system, improve community awareness and develop an active prevention programme. Micronesia has a Mental Health Council.
- *Tuvalu* has conflicting information with ATLAS identifying the presence of a mental health policy formulated in 1978 but interview data identifying the need for mental health related policy and legislation. There is no national programme. Mention is made of a five year plan to train a specialist psychiatrist and send more nurses to Fiji for mental health training as well as seeking partners in a community mental health programme and developing a public education programme.
- *Palau* also has conflicting information with ATLAS noting that a policy is absent but that “the components of the policy are advocacy, promotion, prevention, treatment and rehabilitation”. The executive summary of the Mental Health Plan 2001 outlines programmes for adults, children and technical assistance needs. Palau has a Mental Health Council.
- *Northern Mariana Islands* has had a mental health policy since 1976 that covers areas such as advocacy, promotion, prevention, treatment and rehabilitation. It has also had a national mental health programme since the same year.

Finally, a number of plans, at varying stages of development (conceptual, draft and implementation) have been identified within many countries. Similarly, a range of needs have been recognized by countries as important in terms of future planning and service development and organization. Such plans and needs are summarized in Table 4.3. They cover various areas and issues dealt with in this chapter. More detailed plans regarding workforce development are given in Table 4.4.

4.3.6 Workforce

This section explores workforce issues in relation to mental health and overviews the specialist or dedicated mental health workforce. However, as will be apparent, that workforce is often quite limited. When this is put together with the heavy skewing of health services in general towards primary level care, clearly doctors, nurses and health workers involved at that level need to also be involved in providing mental health services and care. There is, however, wide variation in the attitudes, skills and knowledge as well as the training and education of these primary health care workers in relation to mental health. Section 5.2.3 in the next chapter outlines education and training in each country for this group.

Table 4.3 Facilities and Services Summary – Overview of Plans & Needs

| Country | | Plans | Needs |
|---------------------|-----|--|--|
| Cook Islands | | Increase specialist workforce Develop an awareness campaign Develop an alcohol & other drugs service Develop targeted programmes for suicide and depression | National plan and/or policy |
| Fiji | | Strengthen advocacy Improve mental health information systems | Decentralisation Better institutional care Assistance with planning and organising Develop, improve, increase community based programmes Improved clinical training for specialist staff |
| Guam | N/A | | |
| Kiribati | | Develop mental health awareness programme Improve care/services for families/caregivers | Improved clinical training for specialist staff |
| Marshall Islands | | 5y PLAN Develop community based service Build inpatient facility Create mental health information system Strengthen family training and support Increase specialist workforce | |
| Micronesia | | 5y PLAN Maintain a well organised community based service Improve community awareness Develop an active intervention programme | |
| Nauru | N/A | | |
| New Caledonia | N/A | | |
| Niue | | | Increased focus on mental health at all levels of society Clinical training for general health staff |
| Northern Mariana Is | N/A | | |
| Palau | | | Plan for community services (based on recent research) |
| Papua New Guinea | | DRAFT Clinical training and manual for specialist staff Increase specialist workforce (Doctors) Improve post-grad training standards | Increase community awareness Improved clinical training (especially in outlying areas) for specialist staff Improve rehabilitation services Improve counselling services |

| Country | | Plans | Needs |
|-------------------|-----|---|---|
| | | | Reduce stigma etc |
| Samoa | | Reform mental health legislation (in action) Co-ordinate aid Create a mental health board or council Increase and develop specialist workforce Improve educational opportunities in mental health Improve incentives for working in mental health Build secure inpatient facility within hospital | Greater visibility and priority for mental health Mental health policy (in draft) Improved training and education around <ul style="list-style-type: none"> • Strategic leadership/management • Clinical skills • Teaching • Health promotion |
| Solomon Islands | | PROPOSED Integrate mental health into primary health care system Clinical training for general health staff Formulate mental health policy and review legislation Develop mental health policy Mental health awareness programme Improve existing facilities Better funding of inpatient unit | Better transport between islands Training facilities (as well as programmes) |
| Tokelau | N/A | | |
| Tonga | | | Develop a mental health plan Improved clinical training for specialist staff Training in mental health service organisation Awareness campaign Community/family training in care around mental health |
| Tuvalu | | 5y PLAN Develop community based mental health programme Develop community education programme | Develop specific mental health legislation and policies Clinical training for general health staff |
| Vanuatu | | Increase specialist workforce Set up appropriate administrative systems Develop draft mental health policy Increase community awareness | Clinical training for general health staff Build relationships between School of Nursing & other educational providers |
| Wallis and Futuna | N/A | | |

Table 4.4 gives some indication of the size of the specialist or dedicated mental health workforce. The figures are obviously approximate and thus indicative only. Staff are included if they are viewed as working exclusively in the mental health field. In addition they may or may not have some sort of specialist training and/or expertise. As is clear, the specialist workforces in all countries are very small and nurses predominate in each country. Even where larger workforces are evident this does not necessarily translate to a better service. For instance, in Fiji indications are that the specialist workforce is concentrated around the central hospital. Similarly, the medical specialist workforce in Papua New Guinea is centred in the capital. Table 4.4 also gives some indication of any plans or intentions regarding the development of each country's specialist mental health workforce. These are relevant to any programmes being considered by outside agencies. Indeed they have often been arrived at through targeted efforts by such agencies.

Table 4.4 Specialist/Dedicated Mental Health Workforce by Country

| | Specialist Doctors | Specialist Nurses | Other Notes | Workforce Plans or Expressed Intentions |
|------------------|--------------------|-------------------|---|--|
| Cook Islands | # | 1 | 1 Social Worker 1 Community Worker | Want to employ a full time support worker for outer islands as well as three additional mental health nurses and social workers |
| Fiji | 7 | 32 | Plus Orderlies | Plans to establish post-graduate medical training; develop regional links for mental health training; and form a regional association for mental health professionals. |
| Guam | ~7 | ~12 | Heavy reliance on social workers in community services Has forensic services (with psychiatric and medical technicians, a nurse, and counsellor) Has a developed private sector of mental health providers (psychiatrists, psychologists, therapists) | |
| Kiribati | 1 | 5 | Plus Orderlies & Medical Assistants | Described plans to increase mental health experience of nursing workforce (in Fiji or PNG); train more nurses in community mental health nursing; and train a medical officer in psychiatry. |
| Marshall Islands | | 1 | 2 Mental health Co-ordinators 1 Social Worker | Five year plan includes intention to attract more professional mental health |

| | Specialist Doctors | Specialist Nurses | Other Notes | Workforce Plans or Expressed Intentions |
|--------------------------|--------------------|-------------------|---|---|
| | | | | staff |
| Micronesia | - | ~2 | Plus social workers and psychologists | |
| Nauru | - | - | | |
| New Caledonia | ~10 | ~60+ | Plus others | |
| Niue | - | - | | |
| Northern Mariana Islands | 2 | 10 | 2 Psychologists | |
| Palau | 1 | 10 | Plus Support staff | |
| Papua New Guinea | 9 | 30 | 4 Occupational Therapists or Rehabilitation Officers 1 Social Worker | Five year plans includes intentions to train more mental health specialists. |
| Samoa | 1 | 3 | | Has expressed desire to increase and develop mental health workforce as part of broader mental health strategy |
| Solomon Islands | 1 | 6 | | Recognition of need to enhance specialist nursing workforce and plan formulated for 2004 includes funding for 12 extra positions. Trying to focus current efforts on training nurses for provinces where specialist staff not currently available |
| Tokelau | - | - | | |
| Tonga | 1 | 7 | 8 Psychiatric Assistants 1 Welfare Officer 1 Social Worker | Recognition within broader health workforce planning of need to develop and maintain mental health workforce but no plans as yet re this. |
| Tuvalu | - | 1 | Plus Social Workers | Five year plan includes desire to have a medical officer trained in psychiatry and to grow mental health nursing workforce by sending more off-shore for specialist training. |
| Vanuatu | | 1* | | General recognition of health workforce issues |
| Wallis and Futuna | - | - | 7 Generic Mental health Workers Plus Psychologists & Social Workers | |

Notes: *indicates a staff member with "interest" in field
visiting medical officer only
? has a dedicated workforce but details unavailable
~ indicates an estimate based on ATLAS figures

4.3.7 Services and Facilities

This section outlines current services and facilities. Only very limited information on services and facilities via ATLAS is available for:

- *Nauru*: Mental health is not a part of the primary health care system, though actual treatment of severe mental disorders is available at the primary level. Treatment is provided as part of curative services. There are no community care facilities for patients with mental disorders. It is noted that although there is a lack of community services, mentally ill persons are absorbed into the community.
- *Tokelau*: Mental health is a part of the primary health care system although actual treatment of severe mental disorders is not available at the primary level. Tokelau has a telemedicine arrangement with New Zealand that has a mental health component and so when necessary specialised opinion is received from New Zealand and local doctors treat accordingly. There are community care facilities for patients with mental disorders but only stable patients are treated by community doctors and nurses.
- *Wallis and Futuna*: Mental health is a part of the primary health care system and actual treatment of severe mental disorders is available at the primary level. There are, however, no community care facilities for patients with mental disorders.

The following section examines facilities and services using the categories outlined in the optimal mix pyramid (Figure 4.1). At the upper levels of that pyramid are specialist inpatient facilities. Then there are specialist community services, followed by mental health services as part of the primary health care system. The latter are the most common type of formal care.

Facilities of varying sizes and types are present in a number of countries. These are described as a means for then exploring their inter-relationships with other mental health services in those countries.

- *Fiji* has the largest regional facility in St Giles Psychiatric Hospital with around 190 beds that cater for a diverse patient group – those with mental illness, substance abuse issues and developmental disabilities, as well as those with chronic conditions or who have been ‘abandoned’. St Giles appears to be the centre of mental health services in Fiji with outpatient, day centre, occupational therapy and forensic services associated with it. A community psychiatric nursing service operates from the hospital to surrounding areas. Services and access for outlying islands and areas appears problematic. The hospital is also the venue for teaching through the Fiji School of Medicine.

ATLAS reports that mental health is a part of the primary health care system but that actual treatment of severe mental disorders is not available at the primary level. Follow up can be provided at this level however. Although there are community care facilities for patients with mental disorders these operate within the restrictions noted above around the centripetal effect of St Giles Hospital.

There have been initiatives in Fiji to increase consumer empowerment – through encouraging the active participation of consumers and families in decision making – as well as a destigmatisation and awareness campaign through community groups visiting St Giles.

- *Kiribati* has a mental health Wing as part of the Central Hospital. The bed state of this is unclear, but total inpatient beds for the country, based on ATLAS calculations, are around 70. The Wing is being renovated with two new wards to be added.

ATLAS notes that mental health is a part of primary health care system but that actual treatment of severe mental disorders is not available at the primary level and there are no community care facilities for patients with mental disorders.

- *Guam* has two inpatient units, each with 16 beds. One serves the adult population and the other is part of child and adolescent services. In addition, there are two supported residential programmes catering for 12 adults and four children/adolescents respectively. A forensic service, staffed by a specialist team, is also provided albeit under the Department of Corrections.

ATLAS reports that mental health is not a part of the primary health care system and that actual treatment of severe mental disorders is not available at the primary level. There is, instead, a referral process to appropriate government or private services. In keeping with its philosophical position of integrated care in the least restrictive environment with community care that includes outreach to people with serious mental illness, Guam has a well developed array of community services. These include:

- Emergency Intake Service
 - Adult Counselling Service
 - Day Treatment Facility
 - Community Support Service
 - Prevention and Training Programme
 - Medication Clinic
 - Sexual Abuse and Domestic Violence Unit
 - Child and Adolescent Community Services
- *Papua New Guinea* has a number of inpatient facilities. A 38 bed psychiatric hospital is located in Laloki (Port Moresby). This is described as ‘prison like’ and is very institutionalised with limited therapy. Problems are experienced in transporting patients to this facility and then getting them back home. Laloki does not have its own mental health medical staff but receives visits from psychiatrists who are part of the mental health ward at Port Moresby General Hospital. This is a 10 bed unit of fairly rudimentary make up apparently. A new ward in the hospital was lost to other services and redevelopment plans have been foiled by lack of money. There are also a number of smaller regional units with very limited specialist staffing:
 - Lae, Morobe: 8 beds (4 each sex) includes provision for seclusion – 2 mental health nurses and a psychiatrist
 - Madang, Madang: 4 beds
 - Wewak, East Sepik: 8-10 beds – 2 mental health nurses
 - Goroka, Eastern Highlands: 2 beds – 1 mental health nurse
 - Simbu, Central Highlands: 3-4 beds – 2 mental health nurses

Inpatient units in Abaul, East New Britain and Mount Hagen, Western Province have been closed.

The Bomano Correctional Facility also apparently provides care for people with milder mental illness.

A psycho-social rehabilitation centre is available in the community at Port Moresby which has provision for 10 outpatients and focuses on work and life rehabilitation, family support, education and awareness, and mental health promotion. It is heavily reliant on philanthropy.

ATLAS reports that there are no community care facilities for patients with mental disorders and community care is provided only for known patients on medications prescribed by a psychiatrist. ATLAS also notes that mental health is not a part of the primary health care system but that the actual treatment of severe mental disorders is available at the primary level. Other information indicates that the level and nature of local care depends on the nurse in the area as psychiatrists apparently have little presence and impact in the community. Families provide community based care with churches and the like being the next level of care.

- *Solomon Islands* has a 24 bed (14 male/10 female) ward at Kilu'ufi Hospital, Malaita Province that serves the entire country. Transporting patients for inpatient care in this country has always been difficult and demanding for patients, family, staff and the system in general.

A national mental health referral centre outside the capital Honiara that used to serve the entire country was closed in 2002. This now runs as a small outpatient clinic but is not part of the general hospital services.

ATLAS indicates that mental health is a part of the primary health care system but that actual treatment of severe mental disorders is not available at the primary level and there are no community care facilities for patients with mental disorders. A basic continuum of care exists with the availability of some acute inpatient and outpatient care along with outreach services, but this is uneven and erratic. Other information indicates minimal rural services.

A system of regional psychiatric nurse co-ordinators has been established but not all provinces have these yet. These roles are used to manage minor cases and refer severely ill people to inpatient units, though there are regional variations on how these co-ordinators fulfil their roles. "Care tours" within a province are often used to do assessments, manage treatment, provide advice, and run education/awareness initiatives.

There is a strong emphasis on traditional approaches at village level for mental health care, with close knit communities and strong family bonds.

- *Tonga* has a 16 bed mental health unit annexed to the Vailoa Public Hospital. Six of these beds are designated "security".

There is an emphasis on managing mental health at the primary health care level in Tonga. This is evident in the remit of mental health services which are run by a Psychiatric Unit within the Ministry of Health. Functions include: treat and contain acute/emergency cases; treat and rehabilitate chronic cases; care for institutionalized and promote deinstitutionalization; treat and contain forensic cases; follow up out-patients; provide open door care for respite and drop in care; and provide regular 24/7 transport for patient care. As ATLAS notes, actual treatment of severe mental disorders is available at the primary level and there are community care facilities for patients with mental disorders.

Churches, community leaders and traditional healers play important roles at the primary health care level.

- *Northern Mariana Islands* has a 10 bed unit on the island of Saipan. Reports indicate that six of these beds are for long term care.

ATLAS reports that mental health is a part of the primary health care system, that actual treatment of severe mental disorders is available at the primary level and that there are community care facilities for patients with mental disorders. However, primary health care is available only for stabilised patients after hospital treatment is over. Other sources indicate that the community care facilities include an outpatient service for people with serious mental health problems that is run from the inpatient unit. No other details are available.

There is also a Community Guidance Centre (CGC) that provides a range of services around psychiatric mental health, behavioural mental health, and substance abuse/addiction. More specifically it provides crisis and medium-term therapeutic services to individuals and families. It works on a multi-agency model and also has education and prevention roles. Although based in Saipan, the CGC is tasked with providing outreach services to public and private schools and agencies elsewhere in the Commonwealth.

- *Palau* provides an inpatient mental health service for up to eight patients at the Belau National Hospital. Four beds in this facility are described as “secure”. This inpatient unit appears to be the basis for an outpatient service, a psychiatric day-programme and other outreach services. Specific details are not available, however.

Palau operates their mental health services within a philosophy of least restrictive treatment and relies on the extended family system. ATLAS indicates that mental health is a part of the primary health care system and actual treatment of severe mental disorders is available at the primary level. In addition, there are community care facilities for patients with mental disorders. As before, no further information is available on these services or facilities.

- *Tuvalu* has a two bed ward in their main hospital. It is reported that they do not have any community services and this is supported by

ATLAS noting that there are no community care facilities for patients with mental disorders. However, ATLAS also reports that mental health is a part of the primary health care system and actual treatment of severe mental disorders is available at the primary level.

- *Vanuatu* had developed a new mental health inpatient unit but a lack of specialist staff meant that it could not run and this is now used for the quarantine of patients with tuberculosis. Currently inpatient care is provided by families only in a very poorly provisioned room and is available to only one person at a time. There are no inpatient facilities in outlying islands.

ATLAS notes that mental health is not a part of the primary health care system and actual treatment of severe mental disorders is not available at the primary level. As well, there are no community care facilities for patients with mental disorders. Other information indicates a heavy reliance on traditional or religious approaches to mental health care at the village level.

- *New Caledonia's* information is extremely limited. It appears from ATLAS that this country has both psychiatric hospital beds and inpatient beds within general hospitals. ATLAS also reports that mental health is a part of the primary health care system. Actual treatment of severe mental disorders is available at the primary level and there are community care facilities for patients with mental disorders. There are four centres for medico-psychiatry and for alcohol.

The remaining countries do not have inpatient facilities or services of any type. However they have community services.

- *Cook Islands* services reflect the ATLAS summary that mental health is a part of the primary health care system. Actual treatment of severe mental disorders is available at the primary level and there are community care facilities for patients with mental disorders. In addition to community care being the responsibility of public health nurses, a community-based programme has been started by a NGO with the agreement of the Ministry of Health.

This programme is the mental health well being centre run by Richmond Fellowship – Are Pa Taunga (APT). It offers:

- diagnosis and treatment of mental illness
- psychological support and counselling
- follow up of clients
- respite and support for caregivers
- care of the elderly
- advocacy
- assessment and treatment of prisoners

In addition an unfunded service has been developed by former staff of APT. This is Te Kainga – Mental Health and Family Services, a mobile service which provides:

- mental health services around crisis, assessment and treatment

- a counselling service
 - a drugs and alcohol programme
 - family and children services around education and support
 - other support services such as respite and supported accommodation
- *Samoa* has a community mental health programme run out of the mental health unit at Tapua Tamasese Meaole Hospital. There are no allocated inpatient beds in the hospital for mental health – these were deliberately closed about 10 years ago to focus on a community based service – but in some instances patients might be admitted to general hospital beds. In emergencies or where violence is involved, police cells are used.

ATLAS reports that mental health is a part of the primary health care system with actual treatment of severe mental disorders available at the primary level. Community care facilities are available for patients with mental disorders. Nurses working in the field received focused short term (three weeks) training sessions in 1998/99. There is a family focus to the community based mental health service.

Other information provides more detail regarding the structure and organisation of care. Traditional healers are usually invited by families to come to their homes to heal or treat someone deemed to be mentally ill. Where necessary, clinics refer patients to the main hospital for care by the mental health unit. There they receive intensive treatments/therapy for up to two weeks (this appears to involve some inpatient care at times) and are then discharged for care at home and follow-up by unit staff. If longer term continuing care or supervision is needed then the community health nurses take over. They only refer back to the mental health unit if reassessment or further help is needed.

In general, it seems that members of the mental health team (primarily nurses, who can prescribe in Samoa) try to do monthly visits to the various health centres on the two main islands to do new assessments and monitor/follow up. This is hampered however by transportation problems (e.g. breaks down) and is very demanding. Care and treatment is delegated to senior nurses, most of whom have some training in recognizing and treating mental illness and who are based in district hospitals and rural health centres. They, in turn, work with other nurses and the women's committees (a very important part of the health system) in health sub-centres at the village level. Family care and involvement is promoted. Primary health care providers are keen for training in management and treatment of mental illness. The augmentation of mental health provision within the primary health care system alongside an enhanced specialist service has been previously raised as a desired model.

The view that a lot of approaches to care previously used in Samoa were culturally inappropriate has seen the development of *Aiga – A Partnership in Care through Continuous Collaboration*. This is a culturally appropriate perspective that appreciates cultural beliefs, values, traditions and the nature of the Samoan being – that is, the Samoan

person does not exist as an individual, but in a collective context of identity and belonging, genealogical lineage, roles, responsibilities and heritage. *Aiga* serves as a foundation for a culturally appropriate family-focused community based mental health care service in Samoa.

A national symposium to increase mental health awareness has been run in Samoa.

- *Niue* has an approach to mental health care that involves close co-operation between the police and health services. ATLAS notes that mental health is not a part of the primary health care system, there is no actual treatment of severe mental disorders available at the primary level, and there are no community care facilities for patients with mental disorders. Families and the general community are heavily involved and traditional approaches are often used at this level. In severe cases, prison is sometimes used to contain people with major psychotic episodes and in the extreme people can be transferred to New Zealand for care and treatment. The involuntary detention and treatment of people with mental illness with family consent is by practice not law.

The situation in Niue is exacerbated by the loss of the hospital in a cyclone (as beds there were sometimes used for depressed patients, for instance). The only health facility is the health centre. It is intended that the hospital be rebuilt using aid money but what implications this has for mental health are unclear (thereby offering challenges and opportunities).

- *Marshall Islands* has no hospital beds designated to mental health – although there are plans to build such a facility – but provides home based services in mental health and substance abuse. ATLAS notes that mental health is a part of the primary health care system and actual treatment of severe mental disorders is available at the primary level. As well, there are community care facilities for patients with mental disorders and outreach prevention and treatment programmes are provided to communities around the country.
- *Micronesia* also has no inpatient beds, though it is noted that jail is used for safe care on occasions. It adopts a community orientation to the provision of mental health care. This is translated into different forms in various states.
 - Pohnpei State

Has an active community mental health centre with weekly clinics, outreach services, a day programme, counselling and crisis phone services, and education. One patient can stay there on a short term basis. Community health aides case find and supervise compliance
 - Chuuk State

Has a team of 20 mental health workers who provide weekly treatment and out-patient clinics. The general hospital on the main island also has an outpatient clinic and outreach services
 - Yap State

Has an island wide system of outpatient services. Four staff from the substance abuse and mental health unit provide patient care and family counselling sessions

- Korsae State

Has a multi-disciplinary team of counsellors and nurses who also partner with the police to do case finding, assessment and referral to hospital

The involvement of the police in Korsae State reflects a view of mental health in Micronesia that sees responsibilities span various groups: the community action agency, public defender, police, schools, hospitals, and courts as well as specialist groups/agencies.

ATLAS notes that mental health is a part of the primary health care system and actual treatment of severe mental disorders is available at that level. In addition, there are community care facilities for patients with mental disorders. Community based care system is located in the villages.

4.3.8 NGO Involvement

Non-Governmental Organisations are involved in mental health services to varying degrees across many but not all countries.

The *Cook Islands* represents an NGO sector actively involved in advocacy, treatment and rehabilitation. Firstly there is a community-based programme started and run by Richmond Fellowship with the agreement from the Ministry of Health (and with overseas aid support). This is built around a mental health well-being centre: Are Pa Taunga (APT) started in 2000. It supports a variety of functions:

- diagnosis and treatment of MI
- psychological support and counselling
- assessment and treatment of prisoners
- follow up of clients
- care of elderly
- respite and support for caregivers
- advocacy

It also runs a course in mental health for nursing students

In addition a locally run non-governmental service has evolved. This is Te Kainga – Mental Health and Family Services, a service which provides:

- mental health services around crisis, assessment and treatment
- a counselling service
- a drugs and alcohol programme
- family and children's services around education and support
- other support services such as respite and supported accommodation

Both mobile and centre based approaches are envisioned for this service. In addition it seeks to be involved in education, information provision and research.

ATLAS identifies that NGOs are not involved in *New Caledonia, Niue, Nauru, Tokelau, and Wallis and Futuna*. This is also true of *Solomon Islands* but it is indicated that NGOs have expressed an interest in having some involvement there. Although ATLAS classifies NGOs as not involved in mental health in *Samoa*, they are seen as engaged in counselling and suicide awareness programmes.

ATLAS also reports that NGOs are classified as not involved in mental health services in *Vanuatu* but Foundation of the Peoples of the South Pacific International (FSPI) is running a complex mental health related programme for youth (especially males). Another NGO is also involved in youth counselling services. Other NGOs (e.g. Vanuatu Society for Disabled Persons and Vanuatu Women's Centre) have expressed an interest in being more active in the mental health arena.

Other countries where NGOs are reported to be engaged in mental health are:

- *Papua New Guinea* – predominantly in advocacy, but also in relation to promotion, prevention, treatment and rehabilitation. The Mental Health Foundation is one of these NGOs. One of its foci is family violence prevention and there is also a Centre for Domestic Violence. A related programme on youth suicide, common to many countries and run by the FSPI, is operating here. There is also a private company providing counselling services.
- *Fiji* – mainly in advocacy, promotion, prevention, and rehabilitation. An FSPI programme on youth mental health is operating here. There is also a Fiji Women's Crisis Centre.
- *Kiribati* – mainly in rehabilitation. The related programme on youth suicide run by the FSPI is also operating here.
- *Micronesia* – mainly in promotion, prevention, treatment and rehabilitation. It is noted that one NGO in Pohnpei State is involved in work around youth delinquency and substance abuse.
- *Guam* – reported to have a strong NGO sector. One organisation provides a crisis hotline service. The main roles of NGOs relate to advocacy, promotion and prevention.

Only the most limited ATLAS based information is available for this last group of countries:

- *Tonga* – mainly in advocacy, promotion, prevention, treatment and rehabilitation.
- *Marshall Islands* – mainly in promotion, prevention, treatment and rehabilitation.
- *Northern Mariana Islands* – mainly in advocacy, promotion and prevention.
- *Tuvalu* – mainly in promotion, prevention and rehabilitation.
- *Palau* – mainly in advocacy.

4.4 Summary

Issues

Clinical training of doctors and nurses was a key issue for countries at the SPNF. Other issues revolved around:

- Mental health in Pacific countries being a difficult subject for people to talk about. Thus, although the health system is heavily reliant on families and communities, these are groups that often struggle to understand and provide appropriate care.
- Mental health not being a priority in many countries at government level given the many other pressing health issues. There was a perceived lack of political will and support in this area. Also lacking were legislation and policy as well as adequate services and facilities.
- Health professionals reportedly not being particularly interested in mental health and not having skills in this area. It was also felt that many did not want to get involved in this field.

For these and other countries further matters of concern were around the growth in misuse of alcohol and other drugs, and over rising suicide rates, often but not always in relation to youth. The impact of violence and trauma was also seen as a significant issue in many countries.

The complex inter-relationship between areas and issues is evident in countries where facilities and services are developed but cannot be staffed because of workforce problems, or where staff exist but there is insufficient expertise or funding to develop services/facilities.

Healthcare Organisation and Delivery

In general terms health care in Pacific countries is organised around a pyramid system with a wide base of primary health services. In terms of staffing, the most common services are often staffed by health workers and traditional healers. Nurses may also staff this level but are more commonly attached to wider regional centres, or tertiary facilities and/or provide visiting services. Doctors are more likely attached to the last two.

Governance

All countries have a health ministry or department for administering services, but *Cook Islands, Nauru, Niue, Samoa, Solomon Islands, Tokelau, Vanuatu* and *Tonga* have no identifiable division or specified senior role dedicated to mental health. The situation is unclear for *Wallis and Futuna* and *New Caledonia*.

The remaining countries have either a specific mental health section or division within the larger health or human services department/ministry (*Palau, Northern Mariana Islands, and Guam*) or have identified mental health as being part of other health and human service divisions (*Papua New Guinea, Kiribati, Fiji, Marshall Islands, Micronesia, and Tuvalu*). *Tonga, Marshall Islands, Micronesia* and *Palau* have Mental Health Councils.

Financing

There are specific budget allocations to mental health in 9 of the 19 countries. The percentage of health expenditure allocated to mental health ranges from 0.4% to 7.3%. Sources of mental health funding vary between countries but taxed based funding is most common playing a role in all but three countries

where data is available. All other forms of financing were far less represented across countries but of about equal prominence. Some countries relied on a mix of sources.

Legislation

A majority of Pacific countries have legislation in relation to mental health though there is wide variation in its comprehensiveness and coverage. Few countries have what could be described as comprehensive legislation and available laws are often fragmented and/or narrowly applicable. A great deal of existing legislation in Pacific countries was originally enacted in the 1960s and 1970s. Some legislation in other countries even predates this timeframe but was revised during the same period.

A trio of countries have had relatively recent legislative reviews: *Marshall Islands* (1997), *Northern Mariana Islands* (1993), and *Tonga* (1992). *Samoa*, *Solomon Islands*, *Fiji* and *Vanuatu* are currently engaged in reviewing their legislation, though this is at various stages.

Legislation in *Niue* is very limited and, as is the case in the *Cook Islands*, both countries also employ New Zealand legislation. *Wallis and Futuna* together with *Tokelau* apparently do not have mental health legislation. Available data make the situation in *New Caledonia* unclear as are the exact details regarding *Guam*.

Policies, Plans and Programmes

Cook Islands, *Nauru*, *New Caledonia*, *Niue*, *Tokelau* and *Wallis and Futuna* do not have any initiatives in place in these categories, though the *Cook Islands* has expressed an interest in developing a plan. The situation is unclear in *Palau*.

Solomon Islands, *Tonga*, *Vanuatu*, *Samoa*, *Marshall Islands* and *Fiji* do not have a mental health policy but each of these countries has been active, to varying degrees, around related initiatives. These include draft mental health initiatives, social or broader health initiatives, and health workforce initiatives.

The remaining countries (*Papua New Guinea*, *Guam*, *Kiribati*, *Micronesia* and *Tuvalu*) have mental health policies that are often, but not necessarily, associated with programmes and plans.

Various plans and needs have been identified within many countries around mental health. The plans are at various stages of development and implementation. These plans and identified needs canvass many of the areas covered in this chapter such as policy, legislation, workforce, services, facilities and other more broad or general issues such as mental health awareness. Increasing the size and expertise of specialist workforces is a common plan or recognised need, as is improved training for the general health workforce. Increasing understanding and awareness of mental health in the community is another frequently cited priority. Other common plans or needs are around organisation and management of mental health services; policies and legislation in this area; and the development/improvement of community based care.

Regardless of their status, content and coverage, the existence of policies, plans, programmes and initiatives in various countries can be built upon for this programme.

Workforce

The specialist workforces in all countries are very small and are predominantly made up of nurses. This signals a heavy dependence on the primary health care workforce for delivering of mental health care. Nurses and health workers make up the bulk of the primary health care workforces.

Even where larger specialist workforces are evident this does not necessarily translate to a better service. For instance, in Fiji indications are that the specialist workforce is concentrated around the central hospital. Similarly, the medical specialist workforce in Papua New Guinea is centred in the capital.

Given that most countries are keen to increase their specialist workforce it is unsurprising that many initiatives are planned for or targeted at this goal. However, training and workforce development does not sit in isolation from the wider country context and the place and fit of mental health more generally.

Services and Facilities

Little information is available on services and facilities in *Nauru, Tokelau and Wallis and Futuna*.

Fiji, Kiribati, Guam, Papua New Guinea, Solomon Islands, Tonga, Northern Mariana Islands, Tuvalu, Vanuatu, and New Caledonia have inpatient facilities of varying types, sizes and quality. Some have more than one facility. Those on Fiji and Papua New Guinea (Laloki) appear to be of the large institutional style that provide less than optimal care and place a large drain on resources.

The facility on *Kiribati* is also large but attached to the general hospital. *Vanuatu* developed a new ward attached to the general hospital but lack of staff saw this turned to other uses and now only a very rudimentary single bed space is available. Various factors have worked against development of further facilities in *Papua New Guinea*.

Cook Islands, Samoa, Niue, Marshall islands, and Micronesia do not have inpatient facilities.

Outside of specialist facilities countries provide varying levels and types of community services. Given the small specialist workforces described earlier, it is unsurprising that specialist community services are very limited in many countries. Different models of service delivery are employed to address this issue with varying degrees of success.

Mental health is not always integrated into primary health care. Communities, churches and families are important elements of care arrangements, as are traditional approaches in some cases, though there are concerns – as noted earlier – around community attitudes and beliefs about mental illness. Table 4.5 summarises data on whether mental health is part of the primary health care system, if treatment of severe mental disorders is available at that level, and on the presence/absence of community facilities and services.

Table 4.5 Facilities and Services Summary – Primary & Community Health Care

| Country | Is mental health part of primary health care system? | Is treatment of severe mental disorders available at primary health care level? | Are community care facilities and/or services available? |
|---------------------|--|---|---|
| Cook Islands | YES | YES | YES Good service run by NGOs |
| Fiji | YES | NO but follow up care available | YES but geographically limited |
| Guam | NO | NO | YES especially well developed services |
| Kiribati | YES | NO | NO |
| Marshall Islands | YES | YES | YES these outreach services cover outlying islands |
| Micronesia | YES | YES | YES has a village based orientation |
| Nauru | NO | YES | NO |
| New Caledonia | YES | YES | YES |
| Niue | NO various agencies involved in mental health however | NO | NO |
| Northern Mariana Is | YES | YES but only for stabilised former inpatients | YES range of community mental health services with outreach to other islands |
| Palau | YES | YES | YES |
| Papua New Guinea | NO | YES | YES though limited (both geographically and to established patients) |
| Samoa | YES | YES | YES specialist community services hampered by transportation problems |
| Solomon Islands | YES | NO | YES but only at a very basic service level and with wide variations |
| Tokelau | YES | NO | YES but only for stable patients |
| Tonga | YES emphasised | YES | YES has an integrated approach to care with primary care emphasis |
| Tuvalu | YES | YES | NO |
| Vanuatu | NO | NO | NO |
| Wallis and Futuna | YES | YES | NO |

NGO Involvement

NGOs are involved in mental health services to varying degrees and in different ways across many but not all countries. They appear not to be involved in *New Caledonia, Niue, Nauru, Solomon Islands, Tokelau, and Wallis and Futuna*. The remaining countries have some level of engagement with NGOs. The *Cook Islands* represents an NGO sector actively involved in advocacy, treatment and rehabilitation. In some countries organisations and/or governments have expressed a desire for NGOs to become involved in mental health in various ways (if not currently active) or to increase their involvement (if currently active).

5. COUNTRY-BASED HEALTH EDUCATION OVERVIEW

5.1 Introduction

This chapter outlines information around education and training in the targeted countries. It begins by overviewing and then commenting on health related programmes and providers. Also considered in the commentary are any country-based capabilities for internal communication that may be useful in education and training (e.g. radio telephone networks). As well, identified training and education priorities for eight of the nine countries that were part of the SPNF interview/survey process are presented. Finally, education and training around mental health in relation to the primary health care workforce is overviewed.

5.2 Overview

5.2.1 Introduction

The programmes considered here are those run on a recurring basis as opposed to one-off courses. These are mostly associated with health more generally, as there are very few courses dedicated to mental health. The majority of programmes are around nursing as many countries have such a programme in some form (*Nauru, Tokelau, Tuvalu* and *Niue* do not provide such programmes – the last trains their nurses in Fiji; the status of *Wallis and Futuna* is unknown from available data). Table 5.1 consolidates this data identifying the relevant programmes in each country in terms of nursing, medicine, other health, or generic programmes. The type and nature of programmes and who provides them are indicated where possible. For those countries that are attached to the University of the South Pacific this is identified as a generic education provider (see Section 6.2.2.3 in the next chapter for an overview of this organisation). The commentary following Table 5.1 provides additional detail regarding these programmes and providers as well as other relevant information for each country.

Table 5.1 Health Related Training by Area within Countries

| Nursing | Medicine | Other Health | Generic |
|---|---|---|--|
| Cook Islands | | | |
| School of Nursing - 3y certificate programme - Post-Grad → Fiji | No | No | USP Centre |
| Fiji | | | |
| Fiji School of Nursing - 3y Diploma - 1y bachelors - Masters - Post-grad Certificates (no MH) - Bachelors degree with James Cook University in Australia | Fiji School of Medicine - undergraduate and post graduate medical education & training | Fiji School of Medicine - certificate, diploma, undergraduate & post-grad programmes - allied health (paramedics, lab techs, X-Ray technicians, dieticians, physiotherapists, pathology technicians) - dentistry - pharmacy via WHO and NZ university | Fiji School of Medicine - undergraduate and post-grad health services management Fiji Institute of Technology - no health related programmes USP Campus and Centres |
| Guam | | | |
| School of Nursing, Social Work and Health Sciences @UoG - 3y degree - degree completion programmes for LPN & RNs | No | UoG - Degrees in health and physical education and social work Guam Community College - medical assisting programme | University of Guam (UoG) - runs health services and public administration programmes Guam Community College - nature of other courses U/K Professional Development and Lifelong Learning Centre |
| Kiribati | | | |
| Kiribati Nursing School - 3y basic programme - Post basic courses x2 (midwifery & public health) - Medical Assistant programme | No | U/K | Tarawa Technical Institute - only relevance may be in computing capability USP Centre |
| Marshall Islands (Republic of the) | | | |
| College of Marshall Islands - Associate of Science Degree with Nursing major | No | U/K | College of Marshall Islands - nature of other courses U/K USP Centre |
| Micronesia (Federated States of) | | | |
| College of Micronesia - pre-nursing course | No | College of Micronesia - medical assistants - health assistants | College of Micronesia - nature of other courses U/K |
| Nauru | | | |
| No | No | No | USP Centre |

| Nursing | Medicine | Other Health | Generic |
|--|---|---|---|
| New Caledonia | | | |
| U/K <i>but likely given size and other tertiary facilities</i> | U/K | U/K | University of new Caledonia - nature of other courses U/K |
| Niue | | | |
| No | No | No | USP Centre |
| Northern Marianas Island (Commonwealth of) | | | |
| Northern Marianas College - associate degree in nursing - cert. in nursing assist NB: University of Guam offers BSN for those with associate degrees | No | No | Northern Marianas College - nature of other courses U/K |
| Palau | | | |
| School of Nursing @ Palau Community College - no details | No | U/K | Palau Community College - nature of other courses U/K |
| Papua New Guinea | | | |
| School of Nursing @ University of PNG - Diploma in Nursing - 1y Ad. Dip in MH Nursing Pacific Adventist University Lutheran School of Nursing Highlands Regional College of Nursing Uunapopa School of Nursing | College of Medicine University of PNG - 4y Masters programme - Post-grad psychiatry | University of PNG - management - pharmacy Six schools run community health worker programmes (= E/N) Laloki Psychiatric Hospital - Training for rural health workers (since 2000) - WHO programme with primary care workers/Drs | University of PNG - a range of broadly relevant courses |
| Samoa | | | |
| School of Nursing @ NUS - Diploma (enrolled) - Bachelors (registered) - Post-grad 1y diplomas includes MH speciality focused on clinical practice and service | No | National University of Samoa (NUS) - Diplomas in dental therapy & environmental science - Health Leadership & Management Development Programme | NUS offers various other programmes, some of which may be relevant USP Campus & Centre |
| Solomon Islands | | | |
| School of Nursing & Health Studies @ Solomon Islands College of Higher Education - no details | No | U/K | Solomon Islands College of Higher Education - nature of other courses U/K USP Centre |
| Tokelau | | | |
| No | No | No | USP Centre |
| Tonga | | | |
| Queen Solate School of Nursing - 3y general programme | | | USP Centre |

| Nursing | Medicine | Other Health | Generic |
|--|----------|--------------|--|
| + 9 m post basic clinical programme - post basic courses 6m (no MH) - AUT collaboration | | | |
| Tuvalu | | | |
| No | No | No | USP Centre |
| Vanuatu | | | |
| Vanuatu Centre for Nurse Education - 3y general nurse programme - post grad programmes of 9m (no MH) | | | Vanuatu Rural Development and Training Centres Assn - broad curriculum - some health related - works with local nurses & health workers open learning orientation USP Campus & Centre |
| Wallis and Futuna | | | |
| U/K | U/K | U/K | U/K |

5.2.2 Commentary

Over and above the tabulated data presented in Table 5.1, some observations can be made regarding many of the programmes and providers. Included here are training and education priorities identified in eight of the nine countries which completed interviews/surveys.

Cook Islands

Doctors usually train via Fiji School of Medicine (FSM)

Cook Islands School of Nursing:

- Two tutors only.
- Shortage of resources (one computer, VCR and TV).
- Courses recognized by NZ universities for credit but not University of South Pacific (USP).
- Keen to link with open learning opportunities elsewhere (with clinical time off-shore).
- Keen to link with mental health programme at National University of Samoa (NUS).
- Are Pa Taunga (NGO Provider) runs mental health course for nursing students.

Fiji

Fiji School of Nursing (FSN)

- Mental health component conducted with St Giles Hospital and community facilities.
- Students at FSN have extremely limited access to computers (nurses at divisional hospitals also have a difficult time getting access).
- Even printed resources are in short supply.

- New nurses want learning opportunities, and FSN has been attempting to provide these through its postgraduate programmes (WHO has helped FSN establish postgraduate nursing programmes in midwifery, nurse practitioner, and public health; FSN also has a postgraduate program in healthcare management; other identified areas of need for nurses are trauma, cardiology, oncology, and operating theatre).
- WHO funds FSN nursing management audio teleconferences with nurses at three sites: Suva, Lautoka, Labasa.
- FSN also broadcasts weekly continuing education programs for nurses on Radio Fiji but no handouts or other documents accompany the programs.

Fiji School of Medicine (FSM)

- Serves a regional as well as local role and is involved in distance education (see Section 6.2.2.4 in the next chapter).

Fiji Institute of Technology

- Does not provide health related programmes but could provide teaching training for instructors (has been suggested as useful for FSN Tutors).

Identified Training Priorities

- Doctors and nurses require basic clinical training especially around follow up.
- Midwives need training in problem recognition.
- Others such as police and school teachers need awareness training and the like.
- Assistance is needed for planning, organizing and prioritising mental health services.
- Community based promotion, prevention and particularly treatment services are also needed.

Guam

University of Guam (UoG)

- Has provided some distance education courses and continuing education via PEACESAT since 1993 under a US federal grant and a grant from the Sasakawa Foundation. Courses were provided to US affiliated countries and the Commonwealth of the Northern Mariana Islands. May no longer be running.
- Also a key organisation in the Pacific Basin Telehealth Consortium (see Section 6.2 in the next chapter)
- Is associated with Pacific Resources for Education and Learning – PREL (see Section 6.2.2.7 in the next chapter) an NGO serving the educational community in US affiliated Pacific islands

Healthcare professionals in Guam have identified a number of valuable uses for telehealth initiatives. These include:

- Teleconferencing for continuing medical and nursing education, with CME and CEU credits;
- Telemedicine consultations to reduce off island referrals; and

- Teleradiology capabilities for remote consultation.

Kiribati

School of Nursing

- Basic programme has overhead projectors and TV/VCR, two computers and one printer, a photocopy machine, and no Internet access.
- Students have no access to computers.
- The post-basic program has an overhead projector and a TV/VCR, three computers and printers, a photocopy machine, fax machine, and no Internet access.
- Students have access to the computers through the tutors' offices.

It is intended that the Medical Assistant programme be merged with the post-basic programmes and upgraded to a nurse practitioner level. Work is just beginning on this merger.

In addition to the programmes run through the School of Nursing, nursing assistants receive on-the-job training. The Clinical Nurse Specialist has developed a basic training programme for the nursing assistants, and has provided this training once. As well, Village Welfare Groups receive on-the-job training from medical assistants and community health nurses.

The government has established a medical library.

Marshall Islands

College of Marshall Islands (CoMI)

- Distance learning capable (PEACESAT).
- Associated with PREL (see Section 6.2.2.7 in the next chapter).
- Affiliated with UoG and University of Hawaii.

Micronesia

College of Micronesia (CoM)

- Currently developing their web-based potential.
- Associated with PREL (see Section 6.2.2.7 in the next chapter).

New Caledonia

Currently has distance learning capability through their Distance Learning Centre (no other details available).

Niue

Identified Training Priorities

- Policy makers need greater awareness as well as training and support regarding mental health.
- There is a need for an identified person with this focus in the Ministry of Health.
- Doctors and nurses need training in recognition and management of mental health.
- Nurses also need to be able to do promotion and prevention work.

- Health workers require education to help them understand mental health problems and treatment.
- Others (e.g. community members with interest in mental health) also need education.

Northern Marianas Islands

Northern Marianas College (NMC)

- Has online component to programme.
- Connected with distance learning offered through UoG's College of Nursing and Health Sciences.
- Developing distance learning capability.
- Associated with PREL (see Section 6.2.2.7 in the next chapter).

Papua New Guinea

University of Papua New Guinea (UPNG)

- Has a sub-regional role in nursing (especially in post-graduate mental health) and medical education
- Provides short courses in mental health and sponsors a biennial mental health conference.
- The Post-Graduate clinical nursing programme is moving from face-to-face to mixed mode delivery, with the transition occurring between 2006 and 2008.

The *HEALTH NET Radio Telephone Network* is a relatively new and very sophisticated radiotelephone set up based at the Laloki Hospital. This has been supplied by AUSAID to most hospitals and some clinics in PNG. It is similar but more sophisticated than those in other Pacific nations. However, it has only been used in a very limited way for mental health related queries from the provinces. With psychiatric nurses working in isolation in many parts of the country this almost cost-free radio-telephone network has huge potential for both consultation and training. In this way it could enhance the quality of care and provide valuable support for mental health staff facing difficult problems in care.

Identified Training Priorities

- Doctors need clinical training.
- Nurses and health workers need clinical training and training in behavioural management.

Samoa

National University of Samoa (NUS)

- Has a sub-regional provider role (see Section 6.2.2.5 in the next chapter).
 - *Regional Postgraduate Certificate on Pacific Health Leadership and Management Development* is run at NUS with the support of the Pacific Regional Consortium, which includes University of Guam, and the National University of Samoa. The programme is co-funded by the SPC and WHO.
- Developing a 'Virtual Classroom' mode to allow distance learning
- Videoconference facility also being installed at the hospital and there are plans for one at the university as well.

- The university has set up a committee to develop a plan for the use of distance learning.
- The campus in Apia is connected to USPNet's videoconferencing and data network. Provides access for email and Internet.

School of Nursing at NUS

- Limited mental health component in undergraduate nurse training.
- One year specialist mental health post-graduate programme.
- There is a computer laboratory for nursing school faculty and students to use.
- Some use of CD-Roms by the faculty.
- There are plans to provide a videoconference unit and Internet access for the nursing school.
- None of the faculty is taking part in any on-line course at present but one member has experience with on-line training.

NUS is collaborating with Ministry of Health to provide a data and videoconference link to the PEACESAT network in American Samoa to enable students to access online courses from either the college or from the LAN at the Ministry. It will also provide the opportunity to use telemedicine to improve health services in Samoa. This is seen as providing opportunities to improve in-service training for health care workers as well as increased use of telemedicine to assist in diagnoses and referral.

Discussions have also been initiated between the Ministry of Health, University Without Walls in Sydney, FSM, and Australian Medical Schools to develop Internet based training for health care professionals.

Identified Training Priorities

- Strategic leadership and management/organization training required.
- Clinical skills training needed.
- Training in diagnosis/early recognition, treatment/management is important.
- Teaching and health promoting skills training also needed

Solomon Islands

Solomon Islands College of Higher Education – School of Nursing & Health Studies

- Undergraduate nursing course has 50 hours theory and one month practical placement in mental health.

The Solomon Islands have a good radio-telephone system for health consultation, but this is apparently underutilised for mental health.

Identified Training Priorities

- Doctors and nurses need clinical training.
- Government personnel need policy related training.

Tokelau

While not strictly an educational programme, Tokelau has access to a telemedicine programme with a mental health component that connects with specialist advice in New Zealand.

Tonga

Queen Solate School of Nursing

- Two computers – no internet access.
- Nurses at the school or in the field generally don't have access to computers and do not have computer skills.
- Nine month post basic clinical programme.
- Six month post basic programmes in ICU, Obstetrics, Public Health
- WHO and Auckland University of Technology collaboration (can get BHSc with an extra year).
- The Open Polytech of New Zealand also associated.
- Provides 30 minute radio update every two weeks but not every clinic has radio.
- Only occasional in-service training (travel and attendance are problems).

The Ministry of Education is working with New Zealand Open Polytechnic University to develop an Open Learning model with the goal of developing a virtual university. It has also developed a Distance Education and Communications Centre. The Centre has a non-operational PEACESAT terminal, offices and two computer laboratories. However, when this information was gathered there was no Internet connection and, as a result, training was provided on computer applications and software as well as on CD-ROM based materials. In the past, it has trained personnel from Tonga Communications Corporation and the Ministry of Health as well as Ministry of Education staff in basic computer skills.

Identified Training Priorities

- Clinical skills training needed.
- Management and organisational skills training needed.
- Training for families and communities in awareness and coping skills required.

*Tuvalu*Identified Training Priorities

- Doctors and nurses require clinical skills and training in mental health.

Vanuatu

Vanuatu Centre for Nurse Education (VCNE)

- Computers but no internet access.
- Mental health curriculum in undergraduate nursing programme involves 50 hours theory only.
- Nine month post-graduate programmes for midwifery or nurse practitioner (not mental health).

Vanuatu Rural Development & Training Centres Assn (VRDTCA)

- NGO with 34 learning centres in primarily remote centres.
- Broad curriculum – some health related.
- Video based (may require hiring generators etc).
- Works with local nurses and health workers.
- Foundation for open learning.

Health care workers trained by AUSAid project to train trainers.

There is a radio telephone network for health consultations specifically designed to overcome the problems of distance and isolation of health professionals. However, there is conflicting information on how well this is working. It is seldom used for mental health.

Other reports have identified relevant needs for ongoing and distance education of health professionals:

- An audio network to connect health care professionals at hospitals, health centres, and dispensaries – health care professionals need to interact with one another.
- A technology learning center for health care professionals.
- Distance learning postgraduate courses for nurses and other health care workers.
- Delivery of up-to-date information on medical topics on video on a regular schedule to health care workers.
- Provision of training in reproductive health, family planning, STDs, cervical cancer detection, malaria, TB, heart disease and diabetes as well as obstetrics and gynecology, and internal medicine for doctors.

Agence Universitaire de la Francophonie (AUF).

Although AUF is not currently providing any services in health education, the director believes there is a major need for in-service education for Francophone health care workers in Vanuatu and the director would like to explore the possibility of offering courses from the medical school in Dakar, Senegal. Essentially, AUF provides a distance-learning centre that helps facilitate distance learning courses delivered by the University of New Caledonia, University of Paris, and other French higher education institutions. All instruction is in French. AUF is hoping to work with USP and tie into USPNet.

- Vanuatu campus has two computer laboratories available for students and a small scientific library.

Institut National de Technologie de Vanuatu (INTV)

INTV was originally a French training centre focusing on vocational education. It has linkages to other training organizations including the Open Learning Institute in Queensland, Australia and the Fiji Institute of Technology.

- Two computer labs, one francophone and one Anglophone, for a total of 80 computers available for student use.
- Faculty also have access to computers with one or two assigned to each department as well as a small computer room for teachers.

- The organization is open to allowing others to use their resource centre and VCNE staff report that they have worked well with INTV in the past.

The Vanuatu government is currently considering a plan to create a Ministry of Training to assume the training responsibilities for all government training including health care workers. Under this scheme, responsibility for the VCNE would move from the Ministry of Health to the new Ministry of Training and be administered by INTV who would be required to expand by opening five additional campuses in the other provinces. It is planning to have one or two of these operational in the next four years.

Identified Training Priorities

- Doctors and nurses need clinical training.

5.2.3 Mental Health Related Training of the Primary Health Workforce

As well as education and training for health workers, and for mental health workers especially, some comments can be offered regarding the development of the primary health care workforce in relation to mental health.

- *Cook Islands* recognise the lack of mental health knowledge and expertise among the wider nursing community. As well, ATLAS reports that regular training of primary health care professionals is not conducted in relation to mental health. However, primary health care providers are keen for training in management and treatment of mental illness and some initial training around this and community awareness and education has begun with the assistance of a New Zealand psychiatrist.
- *Fiji's* Ministry of Health recognises the importance of mental health awareness and promotion for all health staff. This may not yet have filtered through into the training the Ministry provides for community and healthcare workers which includes radio and TV programmes. It is observed that the training of primary healthcare workers in mental health has begun. For instance, WHO has trained two dozen nurses in early detection of symptoms of mental illness as well as improving their confidence in tackling problems and their ability to treat patients in the local environment. ATLAS notes that regular training of primary health care professionals is carried out in the field of mental health. While in the last two years about 140 personnel were provided with training, it seems that such training is organised on an ad-hoc basis. It is hoped that training in awareness and early recognition can be extended to police and teachers. Midwives are also singled out as an important target group.
- *Solomon Islands* has made a commitment to integrate mental health into the existing primary health care system (both legislatively and practically) as advocated by earlier external reports. Consequently, ATLAS reports that about 13 personnel were provided training over two years. As well, some psychiatric health coordinators have been trained. While the plan is to train all registered nurses and nursing aides throughout the country over a five year period, only a small number have received this training. There is also a plan to provide follow up training via refresher training/workshop every two years.

- *Samoa's* situation according to ATLAS is that regular training of primary health care professionals is not carried out in the field of mental health. However, it also notes that family care givers are receiving training and that community nurses working in the field received focused short term (three weeks) training sessions in 1998/99. Other information indicates that primary health care providers are keen for assistance and upskilling in management and treatment. An earlier situation report suggests supporting primary healthcare in larger roles around mental health alongside the development of specialist services.

Countries where ATLAS provides a limited amount of additional information and where regular training of primary health care professionals is carried out in the field of mental health include:

- *Marshall Islands* where there have been particular workshops and training programmes – for instance *The Crisis Prevention and Intervention Training*, and the *Partners in Mental Health Performance Outcome Workshop*.
- *Micronesia* where about 21 personnel were provided with training in the two preceding years. Hawaii State Hospital is the primary site/provider for teaching clinical psychiatry to the Pacific Basin Medical Officer Training Program. Part of this involves transcultural issues.
- *Papua New Guinea* is active in this regard with regular training for groups such as Health Extension Officers. They also provide formal training around mental health in primary health care for district workers.
- *Tonga* has provided around 14 people with training over the last two years. An earlier WHO Mission Report recommended that mental health care revolve around primary health clinicians having the available skills to diagnose and manage most mental disorder and mental disability.

Those countries where the only available information is via ATLAS, and which is limited to reporting that regular training of primary health care professionals is not carried out in the field of mental health, include *Guam, Kiribati, Nauru, New Caledonia, Niue, Northern Mariana Islands, Palau, Tokelau, Tuvalu and Wallis and Futuna*.

Vanuatu also falls into this category but there is a desire to develop the general health workforce and some recognition that this should also include the area of mental health. An earlier WHO Mission Report on Vanuatu calls for a greater role for community health services in relation to mental health.

5.3 Summary

As clinical training in mental health for health workers, nurses and doctors is seen as a high priority in all countries, it is positive that many have, at the least, programmes around nursing. However, there is variation in the nature, significance and quality of mental health content in these. Facilities and resourcing are also often limited. Also considered important in some countries are more general programmes around mental health education, promotion and prevention for workers and the public.

The proposed programme will make a valuable contribution to extending the interest in clinical training to management, policy and leadership areas.

Reflecting the situation outlined in the previous chapter, the primary health care system is important in relation to mental health care but is not always utilised effectively or appropriately resourced for a range of reasons. One of these is around education of the workforce. Wide variation in this is evident across countries in terms of the existence of such training, and its type, frequency, coverage, and quality.

Clinical training around mental health should take account of the predominance of nurses and health workers in the specialist and generic workforces.

It is apparent that many countries use courses run in neighbouring countries for basic and/or specialist training. Such collaborative approaches are obviously of value and interest. Given their regional/sub-regional orientation, the next chapter considers this issue in more depth.

6. REGIONAL EDUCATION & COMMUNICATION OVERVIEW

6.1 Introduction

The overview presented in this chapter outlines education and communication services, providers and issues that are common to, or shared by, countries in the region. Few, if any services, providers or issues apply to every country. Rather they tend to be associated with regional sub-groupings. In addition a summary of relevant material gathered from the workshop conducted at the SPNF and from interviews and surveys associated with the Forum is also presented as they relate to regional education and training.

6.2 Telehealth

In addition to the obvious use of telemedicine for remote consultations and to reduce the need for off island referrals, this medium also has potential for continuing medical and nursing education. As noted in the previous chapter, various countries are engaged in their own telehealth projects. For instance, *Tokelau* has access to telemedicine programme with a mental health component that connects with specialist advice in New Zealand. Other projects have regional implications such as that by the *Fiji School of Medicine* which is engaged in developing a telehealth/telemedicine project (with aid funding) that will involve a number of countries.

Pacific Basin Telehealth Consortium (which involves initiatives through WPHNet, PACNET, the Akamai Pacific Island Health Care Project, PEACESAT, and PREL) is staffed and co-ordinated through the University of Guam. Health Resources and Services Administration (HRSA at the United States Department of Health and Human Services) funds the consortium and its associated initiatives which has various functions:

- Develop the Pacific Basin Telehealth Consortium
- Deploy telehealth technologies
- Support human telehealth infrastructure development

In turn the Consortium has been:

- Conducting an inventory of existing telecommunications and telehealth resources in the region
- Developing a road map for joint telehealth initiative in distance learning, clinical telemedicine and public health
- Developing and supporting existing web-based tools such as distance education web pages and listservs for information sharing.

6.3 Regional Education and Training

6.3.1 Introduction

This section outlines regional educational networks and relationships among countries in the region, and relationships between those countries and New Zealand and Australia. Table 6.1 outlines these. A commentary then discusses in more detail the key components identified in the tabular overview.

Table 6.1 Regional Relationships and Networks by Country

| Partner/Service | In-country Contact or Area of Operation | Description |
|--|---|---|
| Cook Islands | | |
| Richmond Fellowship | Mental Health Services | Establishing services and training staff |
| POLHN USP PEACESAT | | |
| Intra-island connectivity | Telecom & Ministry of Health | Looking to develop telehealth network for information, telemedicine and distance learning |
| SPC | | |
| Fiji | | |
| University of Otago | Fiji School of Medicine | Distance Learning Course in Health Informatics |
| James Cook University, Australia | Fiji School of Nursing | Provides Bachelor status for nursing programme |
| University of NSW, Australia: School of Medical Education | Public Health | Delivered distance education programme on public health (with difficulties). |
| POLHN USP SPC | | |
| Guam | | |
| Pacific Basin Telehealth Consortium | University of Guam | Includes some distance education responsibilities/activities |
| Pacific Islands Continuing Clinical Education Programme – University of Washington | University of Guam | Runs programmes, and does needs assessments and workforce analyses |
| PREL University of Hawaii | University of Guam | Educational support |
| WPHNet, PACNET, PEACESAT SPC | | |
| Kiribati | | |
| POLHN USP SPC | | |
| Marshall Islands (Republic of the) | | |
| University of Auckland Faculty of Medicine & Health Sciences | Pacific Basin Medical Assn | Developed a distance learning post-graduate programme for medical practitioners |
| University of Guam | Nursing programmes | Part of a long-standing Micronesia initiative |

| Partner/Service | In-country Contact or Area of Operation | Description |
|---|--|--|
| School of Nursing | | (1993) via PEACESAT (now suspended due to lack of funds) |
| PREL Universities of Guam & Hawaii | College of Marshall Islands | Educational support |
| POLHN USP PEACESAT SPC | | |
| Micronesia (Federated States of) | | |
| University of Auckland FMHS | Pacific Basin Medical Assn | Developed a distance learning post-graduate programme for medical practitioners |
| PREL Universities of Guam & Hawaii | College of Micronesia | Educational support |
| POLHN SPC | | |
| Nauru | | |
| USP SPC | | |
| New Caledonia | | |
| SPC | | |
| Niue | | |
| USP SPC | | |
| Northern Marianas Island (Commonwealth of) | | |
| University of Auckland FMHS | Pacific basin Medical Assn | Developed a distance learning post-graduate programme for medical practitioners |
| University of Guam School of Nursing | Northern Marianas College Nursing Programme | Part of a long-standing Micronesia initiative (1993) via PEACESAT (now suspended due to lack of funds) |
| PEACESAT SPC | | |
| Palau | | |
| University of Auckland FMHS | Pacific Basin Medical Assn | Developed a distance learning post-graduate programme for medical practitioners |
| University of Guam School of Nursing | School of Nursing | Part of a long-standing Micronesia initiative (1993) via PEACESAT (now suspended due to lack of funds) |
| POLHN SPC | | |
| Papua New Guinea | | |
| University of Technology (Sydney, Australia) | College of Health Sciences, University of PNG | Have collaboration around nursing |
| Newcastle University (NSW, Australia) SPC | Medical School, University of PNG | Undefined links |
| Samoa | | |
| University of Auckland Faculty of Medicine & Health Sciences | National University of Samoa (NUS) | Health leadership and management development programme |
| University of Technology Sydney | NUS | Consultant from UTS facilitated training which helped increase human resources for mental health care. |
| University Without Walls (Sydney, Australia) + Fiji School of Medicine + other Australian Medical Schools | Ministry of Health | Discussions initiated around developing Internet based training for health care professionals. |

| Partner/Service | In-country Contact or Area of Operation | Description |
|---|---|--|
| POLHN USP PEACESAT – VTC SPC | | |
| Solomon Islands | | |
| POLHN USP SPC | | |
| Tokelau | | |
| New Zealand | Clinical staff | Has telemedicine programme with a mental health component that connects with specialist advice in New Zealand. |
| USP SPC | | |
| Tonga | | |
| Auckland University of Technology, New Zealand | School of Nursing | WHO and AUT collaborate to turn nursing diploma into degree with extra study |
| The Open Polytechnic of New Zealand | Ministry of Education | To develop open learning model → virtual university |
| Swinburn University, Australia | Ministry of Education | As below |
| POLHN USP PEACESAT - ?non operational TONGASAT SPC | | |
| Tuvalu | | |
| USP SPC | | |
| Vanuatu | | |
| Open Learning Institute in Queensland, Australia & Fiji Institute of Technology | Institut National de Technologie de Vanuatu | |
| Agence universitaire de la Francophonie | Training organisation with overseas links | Distance learning centre for courses run out of University of New Caledonia and University of Paris. (French) |
| USP SPC | | |
| Wallis and Futuna | | |
| SPC | | |

6.3.2 Commentary

6.3.2.1 Secretariat of the Pacific Community (SPC)

Since it has a relationship with all countries in the region, SPC is an important and highly relevant group. SPC is a technical and development organisation within the Pacific that covers 22 nation and territories. It seeks to contribute to the development of the technical, professional, scientific, research, planning and management capability of people and countries across the region. Within this wide mandate there are two existing activities of the Secretariat that are of particular interest in this context.

1. The Secretariat website has a *Distance Education in Health* page that is a database of programmes and courses with a health orientation from

around the world that are available in distance learning modes. This also includes telehealth, and has links to many sites with library and other information resources. In addition the site has links to programmes at Fiji School of Medicine, University of Guam, POLHN, and the SPC's own courses (in epidemiology), and the Pacific Islands Continuing Clinical Education Programme through the University of Washington (though this programme has concluded).

2. The Secretariat has been active in putting together a *Health Leadership and Management Development Programme* in conjunction with the National University of Samoa (servicing the southern Pacific area) and the University of Guam (serving the remaining Pacific area). See Section 6.2.2.5 for more on this.

6.3.2.2 Pacific Open Learning Health Network (POLHN)

Support from WHO and the government of Japan has led to computer learning centres being established in 10 Pacific countries (see Table 6.2) for the purpose of distance education of health professionals. Each centre has computers with internet connections and videoconferencing capability. Staff have been trained in each centre to maintain the system and to guide and teach users in necessary skills (using computers, basic software and CD-ROMs, accessing internet etc). The central hub is located in Suva, Fiji.

Table 6.2 POLHN Participating Nations

| | |
|--------------------------------|------------------|
| Cook Islands | Fiji |
| Kiribati | Marshall Islands |
| Federated States of Micronesia | Palau |
| Samoa | Solomon Islands |
| Tonga | Vanuatu |

Also associated with the POLHN network is the *Commonwealth of Learning* a separate searchable web-based system for identifying, collating and accessing a variety of resources relevant to those using POLHN. It is organised into four categories of resources, all of which can be searched by keyword on the site. The first two, related to health and POHLN course resources, have been screened for relevance to POLHN and referenced from the Internet via URLs. The other two include a library of special publications that are local documents on health related matters and a library of health-related resources that are available by fee for access (abstracts are free).

Interviews and surveys suggest that the POLHN system is experiencing problems in the following countries:

- In the *Solomon Islands* there is concern that this is not working and that there is no-one who appears able to fix the problems and keep training potential users.

- In *Fiji* comments indicate that this system is apparently not functioning well but reasons for this are unknown.

The status in other countries is unknown.

6.3.2.3 University of the South Pacific (USP)

USP is the leading provider of tertiary education in the Pacific. USP has a memorandum of understanding with 12 member countries (see Table 6.3), and with colleges in the Pacific which it cross-credits courses with. Headquartered in Fiji, USP has three major campuses and 13 centres (2 in Fiji and one in each other participating country). Campuses and centres are located as per Table 6.3. Each centre has a programme assistant, a librarian, and a support person. USP provides distance and flexible learning (DFL) for around half of its student population via satellite communications (USPNet). This equates to about 15,000 students per semester. Most USP certificate, degree, and diploma programs are available via distance learning. DFL students get a mix of printed materials, audio and video cassettes, Internet based learning, and live access to lectures and tutorials via video conferencing and broadcasting.

Centres provide the following facilities:

- Connection to USPNet's videoconferencing and data network.
 - this network provides videoconferencing with other USP campuses and extension centres as well as access for email and Internet access.
- Audio conferencing and videoconferencing to support USP's open learning courses.
- Videoconferencing system for two-way point to point connections to one other site at a time or for one way broadcast of lecture courses from campuses at Fiji, Vanuatu, or Samoa.
- Online courses provided via WebCT.
- Internet access for faculty and students at different times to conserve bandwidth.
- A computer laboratory available for student and faculty use.

USP does not teach health or medicine programmes though single courses may have some relevance. It does teach management related programmes and its certificate in leadership management may be useful in health.

Even with its technological innovation, the nature of countries where USP operates means that ordinary mail and the like may still be necessary to get assignments to outlying islands (as happens in Kiribati for instance). In such circumstances the success of courses depends on the reliability of these services.

Table 6.3 USP Participating Countries, Campuses and Centres

| | |
|--------------|------------------|
| Cook Islands | Fiji |
| Kiribati | Marshall Islands |
| Nauru | Niue |
| Samoa | Solomon Islands |
| Tokelau | Tonga |
| Tuvalu | Vanuatu |

| USP CAMPUSES | | |
|--|--|--|
| Alafua Campus in Apia, Samoa | Emalus Campus in Port Vila, Vanuatu | Laucala Campus in Suva, Fiji |
| USP CENTRES | | |
| USP Centre in Cook Islands Rarotonga, Cook Islands. | USP Centre in Fiji (Northern) Labasa, Fiji. | USP Centre in Fiji (Western) Lautoka, Fiji. |
| USP Centre in Kiribati Tarawa, Kiribati. | USP Centre in Tuvalu Funafuti, Tuvalu. | USP Centre in Tonga Nuku'alofa, Tonga |
| USP Centre in Nauru Republic of Nauru. | USP Centre in Tokelau c/- Tokelau Apia Liaison Office, Apia, Samoa. | USP Centre in Solomon Islands Honiara, Solomon Islands. |
| USP Centre in Vanuatu Port Vila, Vanuatu. <i>Santo (Sub-Centre)</i> <i>Tanna (Sub-Centre)</i> | USP Centre in Samoa Apia, Samoa. | USP Centre in Niue Alofi, Niue. |
| | USP Centre in Marshall Islands Majuro, Marshall Islands. | |

6.3.2.4 Fiji School of Medicine (FSM)

FSM is developing expertise in designing and delivering courses by distance mode that includes paper-based materials, teleconferencing, and using other advances in information technology. This is an ongoing area of development for FSM, especially in relation to telehealth and telemedicine, as a mechanism to overcome the isolation that health professionals endure in the region. FSM reports that Internet based technologies play a major role in medical referral processes and continuing medical education. In addition, computers are now an integral part of the learning process at FSM and this organisation has built up expertise in the role of computers in the education of health professionals through networking, the use of CD-Rom technology, and Internet access to information.

FSM is looking to promote itself as a “one stop shop” for medical education and flexi-learning. Professional doctors are needed in the field and, as they often can’t be released from their posts to come to Fiji for many months or years of training, open learning programmes are needed at the postgraduate level in medicine. It is conceived that doctors could spend just brief periods of time in Fiji for their programmes and, via open learning and visiting tutors, study from their posts.

The Hezel Report² places FSM as “the future of the Pacific” in medical education. However, it is also noted that building a strong open learning program at FSM would require that it receive guidance from another university. It is suggested that closer alignments with USP or with a university that has expertise in open learning would enable FSM to achieve this with limited impact on its internal operations. FSM already contracts training workshops from USP. In addition to other developments, FSM needs to have learner support and coordination in each country. Also, Hezel believes that FSM could collaborate with nursing schools in countries to obtain an efficient use of open learning coordinators. Any learning centre and coordinator needs to be tailor-made for each country. Despite the actual and potential connections between FSM and USP, at the time of the Hezel Report there were still gaps between the two institutions. For instance, although FSM graduates received their diplomas from USP, the latter did not appear to see FSM as one of its schools and consequently did not permit FSM to use USPNet. Access to USPNet would give FSM access by satellite to all of the doctors in the South Pacific.

6.3.2.5 National University of Samoa (NUS)

NUS provides, among a range of other programmes, nursing education up to post-graduate level. The latter has just been extended to include a mental health specialty. This alone makes it a valuable resource for the WHO programme. It also provides some distance learning capability though this is not articulated in much detail beyond noting that it is developing a ‘Virtual Classroom’ mode for such purposes.

The Hezel Report indicates that NUS and the Samoan Ministry of Health are collaborating to provide a data and videoconferencing link to the PEACESAT network in American Samoa. Apparently, videoconferencing is not used as frequently as audioconferencing.

NUS has computing facilities, some of which are dedicated to nursing students. Faculty have access to computers at the nursing school and there is some use of CD-Roms by staff.

NUS is the provider of a *Health Leadership and Management Development Programme* for a southern Pacific consortium of countries. This programme was based on a consortium model and developed using a collaborative and partnership approach through SPC. The Directors of Health in the participating countries were actively involved in this project. It brings together six Pacific countries in the Southern Pacific region and five countries in the Northern region, each forming a consortium with a local provider (which in the case of the Southern

² Hezel Associates (2001) *Expanding the Professional Healthcare Education Resources in Pacific Countries – An Assessment of Open Learning Needs for the World Health Organisation Western Pacific Regional Office*. Syracuse, NY, USA.

region is augmented by a strategic partner) – see Table 6.4. While limited to these countries, documentation around this project acknowledges that other countries may wish to join at some point (e.g. in the Southern region: Kiribati, Cook Islands, Niue and Tokelau).

Table 6.4 Health Leadership & Management Development Programme – Participating Countries and Sub-Regional Groupings

| <u>Southern Pacific Region</u> | <u>Northern Pacific Group</u> |
|---|--|
| Fiji | Guam |
| Tuvalu | Palau |
| Samoa | Fed. States of Micronesia |
| Solomon Islands | Marshall Islands |
| Tonga | Nauru |
| Vanuatu | |
| <i>Provider:</i> National University of Samoa | <i>Provider:</i> University of Guam |
| <i>Strategic Partner:</i> University of Auckland | |

The regional demarcations used in developing and providing this programme allow for a distinctive sub-regional character and imperatives to infuse the programme while the use of local providers builds capacity and ensures more appropriate local delivery. The specific role of the University of Auckland, which has a formal relationship with the NUS via a Memorandum of Understanding, is strategic and related to continuing education pathways, capacity development and identified opportunities for collaboration.

The programme was based on a training needs analysis conducted in 2000 that informed the curriculum and delivery. Its overall aim is to update and enhance the knowledge and skills of mid-level managers, and to broaden the scope of their management practice. Those taking part could come from a range of disciplines and backgrounds thereby giving the course a fertile cross disciplinary character. Bringing together participants from a number of countries also allows regional networks to be built. A recognised qualification is provided. Education and training occurs while individuals are located in workplaces, though all must attend a compulsory residential course, and the programme includes an applied project so that classroom knowledge and skills are employed in real life circumstances. The programme covers 13 modules within four core themes – managing in an organisation and a changing environment, as well as managing programmes and people. Each participant has a workplace mentor and an academic supervisor (who were trained as part of the initial phase of the programme). Background documentation suggests that this is an effective model for capacity development and institutional

building in all aspects of health services management and has the potential to be expanded throughout the Pacific.

6.3.2.6 University of Guam (UoG)

UoG plays a diverse role across the region. As noted above it is the provider for the northern region in relation to the *Health Leadership and Management Development Programme*. Similarly, as outlined earlier, it co-ordinates and staffs the *Pacific Basin Telehealth Consortium*. It also provides full training and degree completion programmes for nurses trained elsewhere in local US affiliated territories. Although they have been suspended, UoG has also provided distance learning and continuing education initiatives around nursing education for the same group of countries. While it too has now come to an end, UoG was also associated with the University of Washington's *Pacific Islands Continuing Clinical Education Program (PICCEP)*

6.3.2.7 Pacific Resources for Education and Learning (PREL)

PREL is a not-for-profit corporation serving the educational community in the US-affiliated Pacific islands. As such, its coverage is limited for the purposes of this programme but it is worthwhile being highlighted as it has connections to educational providers in Commonwealth of Northern Mariana Islands, Federated States of Micronesia, Guam, Republic of the Marshall Islands, and Republic of Palau as well as with Hawaii based universities and colleges.

6.3.2.8 University of Papua New Guinea

Provides general preliminary medical and nursing training on a sub-regional basis. Also provides post-graduate mental health training for medical and nursing staff in a small group of countries.

6.4 Workshop, Interview and Survey Overview

6.4.1 Workshop Feedback on Education and Training

The mental health workshop conducted at the SPNF considered education and training around mental health. A summary of feedback from the group work is provided in Table 6.5. This is relevant for not only the development of individual country programmes but also for regional and sub-regional approaches.

6.4.2 Programme Design, Modes of Learning and Support

Finally, interviews and surveys, supported by workshop feedback, provided important information on the design of a programme such as being proposed by WHO, and the preferred modes of learning and support that could be incorporated into it. Table 6.6 outlines which modes of education and support are favoured by representatives from the countries sampled through SPNF. Some additional, cautionary or supportive comments relating to these are also included. Those forms of communication considered to be best for ongoing communication and support among the SPNF group are outlined in Table 6.7.

**Table 6.5 Forum Workshop on Mental Health – Group Discussion
Feedback: Education & Training**

| |
|---|
| <p>Existing Programmes</p> <ul style="list-style-type: none"> - <i>All of the countries have mental health components in their basic programme (nursing)</i> - <i>PNG and Samoa have post-basic mental health programme</i> <p>Unmet Learning Needs</p> <ul style="list-style-type: none"> - <i>Need for specialist mental health education</i> <p>Learning Approaches</p> <ul style="list-style-type: none"> - <i>Face to face teaching = oral cultures</i> - <i>Group learning → health professionals AND local community leaders</i> - <i>Print material</i> → <i>NOT preferred (no onsite support for latter)</i> - <i>Internet learning</i> - <i>Training & Education needs to occur <u>within</u> Pacific</i> <p>Positives & Strengths</p> <ul style="list-style-type: none"> - <i>Commitment to improve services</i> - <i>Cultures</i> - <i>Strong role of churches</i> - <i>NNA's</i> <p>Challenges</p> <ul style="list-style-type: none"> - <i>Foreign Aid = restrictive timeframes</i> - <i>Cultural Barriers and Issues</i> <ul style="list-style-type: none"> o <i>Develop NUS MH programme for mixed mode delivery</i> o <i>Expand NUS programme for other nations</i> - <i>Scholarships (flight of professionals if trained overseas)</i> <ul style="list-style-type: none"> o <i>Suggest providing scholarships based on requirement to return and work (WHO Fellows)</i> o <i>Provide locum nurses from NZ while any training being undertaken</i> |
|---|

Table 6.6 Preferred Modes for Distance Education by Country

| | Study guides (books of readings and like) | Audio materials and teaching | Video material and teaching | CD-Rom (computer) based materials & teaching | Internet based materials and teaching | Summer Schools & Workshops | Group Discussion (with other Pacific countries) | Face-to-face contact with mentor or tutor | Ongoing support once course is over | Other and Additional Comments |
|------------------|---|------------------------------|-------------------------------------|--|---|----------------------------|---|--|-------------------------------------|---|
| Cook Islands | | | ✓ | | | ✓ | ✓ | ✓ | | Little experience with open learning Prefer face-to-face methods/approaches (e.g. workshops) Strong support for visual modes of learning |
| Fiji | ✓ "most feasible" | | | | ✓ "OK when available but not widely available" | ✓ | ✓ | ✓ "Definitely needed" | ✓ | Would like a train the trainers/educators approach Uneven availability of technology |
| Niue | ✓ "in English" | | ✓ "DVDs are VERY common" | ✓ "via USP" | | ✓mix "very positive" | | ✓ | ✓mix | mix = these combined approaches (very positive about both) Limited computer availability (mainly in hospitals/Dept. of Health) Internet access is affordable and reliable but struggle with weather |
| Papua New Guinea | ✗ "literacy poor" | ✗ "prefer visual" | ✓mix "especially if locals used" | ✗ "few computers" | ✗ "poor access" | ✓mix "like role plays" | ✓mix "enjoy sharing experience" | ✓ "needs to be pitched at right levels" | ✓ | mix = these combined approaches Piloting and pre-testing important Many languages, and while English is common, there are varying competencies |
| Samoa | | ✓ combine audio-visual | ✓ combine audio-visual | ✓ | ✓ "email as well" | | | | | |
| Solomon Islands | ✓ | | | | ✓ | | ✓ | ✓ | ✓ | Emphasises place of mentoring |
| Tonga | | | | | | | | | | Internet based approaches not considered appropriate: access is "limited" and skill levels vary considerably |
| Vanuatu | ✓ | | | | ✓ | | ✓ | ✓ | ✓ | Internet access is good |

Table 6.7 Preferred Modes for Ongoing Support by Country

| | Telephone Support | Mail Support | Discussion Board (Web-based) | Email Support | Comments |
|------------------|--|--|------------------------------|---------------------|--|
| Cook Islands | | | | | High Internet costs |
| Fiji | ✓ | ✓ | | ✓ "limited" | Internet capability is limited Uneven availability of technology |
| Niue | ✓ "most people have these but connections unreliable" | ✓ "not as regular as once the case; also has courier service" | ✓ | ✓ "quite common" | Fast internet connections Internet access is affordable and reliable but struggle with weather |
| Papua New Guinea | ✗ "often cut-off" | ✓ "but must be return post paid" | | | Challenging environment. Internet-based communication not reliable |
| Samoa | | | | | |
| Solomon Islands | ✓ | ✓ | ✓ | ✓ | |
| Tonga | | | | | Internet access described as limited. Internet skills levels are highly variable (many people have no skills) |
| Vanuatu | ✓ | ✓ | ✓ | ✓ | Internet access is good |

There was a strong sense among some of those interviewed that the presence and dominance of an oral culture in Pacific nations needs recognising and integrating into any training and support programme. So too does a preference for face-to-face delivery. Thus, even print material needs to be delivered initially in person. Similarly, it was felt that a successful programme would need to involve others outside those directly being trained or supported. For instance, involving community leaders and the like gives programmes and their associated flow on activities a credibility and influence that might otherwise not eventuate. It also means that participants are supported by the community. The piloting of any programme was signalled as important.

Countries expressed the desire for the training of staff not to occur in Australia or New Zealand as participants often do not return and potential benefits are lost. Bonding was raised as one solution. Alternatively, the idea of shared or collaborative training located in Pacific countries was frequently raised in both the interviews and other material, and was very positively viewed as a way to increase expertise with less risk of losing staff. Some representatives identified other Pacific countries that they might like to engage in a support programme with:

A Pacific Approach/Collaboration

Marshall Islands
Papua New Guinea
Tuvalu
Fiji
Vanuatu
Solomon Islands

Specific Preferences

Papua New Guinea with Solomon Islands
Niue with Cook Islands or Samoa

Over and above any technological difficulties and problems noted in Tables 6.6 and 6.7, a range of other issues emerged from the data.

- There is wide variation in computing skills among individuals and groups in countries so any programme would need careful assessment of the target population in this regard.
- In Tonga USP found that some students did not enjoy distance learning as they found it hard to understand the accents of trainers.
- The Cook Islands have little experience with distance/open learning
- The large number of languages and variable English competency raises additional challenges in Papua New Guinea
- University of New South Wales found a series of issues when running a distance programme in Fiji: cultural issues; difficulties multiplexing work, study, and family; and students' preferences for face-to-face education. The criteria for distance education they found essential were high intellectual capacity and a good knowledge of the English language.

6.5 Summary

Reflecting the Pacific collaborative approach spoken of in the previous chapter, it is clear from the preceding discussion that a number of networks already exist between countries. These vary in size, nature and structure and one country can belong to a number of these for a variety of different motivations or purposes. They could be drawn on in any support programme for practical and other purposes. Certainly, an awareness of these networks and relationships is important when considering how to connect countries for support and training. With this in mind the following points are worth highlighting:

- Apart from SPC, networks and organisational collaborations tend to be associated with regional subgroupings
- USP was the leading provider in the Pacific, but does not teach health or medicine programmes. Thus, it needs to link productively with providers that have such an orientation.

In terms of building Pacific collaborations, as is already often the case, these could be made up of a set of countries grouped around a key provider, based on more local relationships and particular needs within the larger region. Each collaborative centre of training or learning would provide a focus for shared and concentrated investment of human and financial resources to ensure quality training. It could also develop a 'train the trainers' approach. A flow on effect might be created by more skilled/qualified practitioners such as nurses being trained to educate other health or support workers. Such an approach would allow for training to reflect the cultural and other needs of Pacific nations as well as reducing the likelihood that staff would not return as often happens when training is made available in Australia or New Zealand.

Technical support in various forms would clearly be beneficial in developing and maintaining collaborations of this sort and in promoting shared and ongoing training and education. Efforts should be made to utilise, support and

develop the leadership roles of existing providers. Most countries have developed external or strategic partners (in Australia and New Zealand), but there still needs greater linkages at regional level. Ongoing support should favour models that contribute to the goals of building capacity and capability and a lasting infrastructure in the region through viable and sustainable networks and organisations.

It is clear that the internet and other electronic media offer some potential in relation to collaborations and networking around education and training. Telehealth initiatives, which a number of countries have or are interested in developing, can also be included here. These provide an opportunity for training and ongoing supervision and are particularly useful for overcoming the isolation of sole practitioners, providing support and guidance, and for preventing skills depletion over time. However, any involvement of such media needs to consider that those interviewed placed heavy emphasis on the oral culture in Pacific countries, the preference for a face-to-face approach for training, and the need for close engagement with other local countries. Ongoing support and mentoring was recognised as important but the approaches adopted needed to be appropriate and reflect the above factors. Thus, electronic media should be viewed as an adjunct rather than mainstay of any programme. Even as an adjunct, consideration must be given to availability, access, reliability, costs, skills, knowledge, and preferences around electronic media. For instance, whilst acknowledging the importance of POLHN, some countries were experiencing problems. Even if technology is available in countries, more mundane approaches such as ordinary mail and the like may still be necessary to get assignments to outlying islands (as happens in Kiribati for instance). These can be very unreliable and uncertain.

Finally, as well as careful piloting of any programmes, it is important that, in order to give credibility and ongoing support to particular training programmes, significant members of the community and church (e.g. elders or leaders) be involved alongside clinicians and workers. This will ensure greater buy in and sustainability of programmes.

7. CONCLUSION

7.1 Introduction

This report is an overview and analysis of country-based mental health related data from 19 Western Pacific nations as part of the preliminary phase in the development of a technical support programme for the organisation of mental health services. The data has been collected from various sources – documents, interviews and surveys (completed by country contacts), and a workshop. As outlined in Section 3.5, the report is subject to certain limitations around the availability and quality of that data.

This final chapter is intended to draw together the various threads of the report. In doing so it performs two more specific functions. Firstly, as the next stage of this programme involves a piloting process, some observations are made regarding the possible structure and approach that the pilot and process might adopt. Some criteria that may be useful in selecting a shortlist of countries where the pilot programme can be trailed are then presented and one such shortlist is offered. Obviously, further work will need to be done around any shortlist before a final decision is made on what is intended to be, at this stage, the two countries where the programme of technical support will be piloted. Secondly, this chapter will summarise the key points from the preceding three chapters, indicating where these have implications for the proposed programme.

7.2 Piloting the Programme

7.2.1 Piloting Overview

While the exact nature of the programme is yet to be finalised, a broad overview can be developed. It is important that whatever support is provided is done so in partnership with countries and in a culturally appropriate manner. The support programme will follow the principles laid down in the WHO document *WHO Multi-country project to improve policy, systems and services for mental health – Implementation phase of the policy project* which focuses on country needs, evidence, partnerships, human rights, continuity and sustainability, and evaluation. Areas that might be considered for action are also identified in that document and include: policy development; legislation and human rights; financing; organisation and development of services; human resources and training; quality improvement; essential psychotropic drugs and their distribution; promotion, prevention, treatment and rehabilitation strategies; inter-sectoral collaboration; advocacy; information systems; and research and evaluation of mental health systems and services.

The support programme will help countries to develop a mental health policy and strategic implementation plan. This will firstly involve a comprehensive and detailed assessment of mental health services in each country such as is outlined in the WHO document – *Rapidly assessing mental health in countries – A tool for use at country level*. The information gathered in this report for each country is but a starting point in such a

process as it will be necessary to ensure the accuracy, relevance and comprehensiveness of information at that point. The programme will then entail:

1. Developing a mental health policy:
 - Gathering information and data for policy development.
 - Gathering evidence for effective strategies.
 - Consultation, negotiation, and exchanging information with other countries.
 - Setting out the vision, values, principles and objectives of the policy.
 - Determining areas for action and the major roles and responsibilities of different sectors.
2. Developing a mental health plan:
 - Determining the strategies and time frames and setting indicators and targets.
 - Determining the major activities and associated costs, available resources and budget.

It is suggested that these activities might be structured into discreet projects that can become the subject of support activities and which contribute incrementally to the overall implementation of the plan.

Since successful programmes of development need to involve significant others, specifically community or church leaders, national workshops will need to be organized in each country as part of the support process for developing and implementing a mental health policy and plan. This will ultimately generate greater buy in and sustainability of programmes.

Support will likely take two forms: Firstly there will be direct, in-country support by consultants with relevant expertise and experience. In addition, it will also be necessary to provide ongoing distance support for countries. This latter form of support will need to be based on modes that are appropriate to and preferred by each country as signalled in this report.

Given that this is a pilot programme, it is suggested that a two-pronged evaluation be undertaken. This would involve evaluating both the country based projects and the approaches, processes and activities associated with the pilot programme. The latter will allow for ongoing improvements to be made to the programme with the long term goal of developing a practical, effective, efficient and sustainable generic model of technical support that can be adapted to the particular needs and circumstances of countries.

7.2.2 Criteria

A number of issues can be considered when selecting pilot countries. As has been outlined earlier, considerable effort has been put into gathering some baseline data about each country in terms of their:

- Mental health infrastructure (i.e. legislation, policies, programmes, facilities, services and workforce);
- Health and mental health related educational infrastructure (including around distance learning); and
- Other relevant issues.

This has been presented in the report and serves as the first means by which potential pilot sites were identified. It is not only the nature of the information that is relevant here, but the wide variation in amounts and quality of information that also proved useful in this process. Prior involvement in programmes of this type as well as relationships among countries and between countries and education providers were also factored in. In addition, the make up of contacts – in number and nature – were another consideration regarding the selection of pilot countries. As it formed an important role in relation to informing and engaging with country representatives, information gathering, and contact building, attendance at the South Pacific Nursing Forum was a further factor. Finally a broad range of miscellaneous issues were also considered and significant among these were the matters of language and access.

7.2.3 Shortlist

As a result of the above considerations the following countries have been identified as suitable for piloting the programme.

- Cook Islands
- Fiji
- Samoa
- Tonga
- Papua New Guinea
- Vanuatu
- Solomon Islands

Once the exact nature of the pilot programme is known, further consideration will need to be given to selecting the most appropriate countries from this group (or perhaps expanding or altering the make up of the shortlist). The information contained in the country profiles will need to be checked for current validity and reliability and will obviously need to be closely considered in light of the goals and precise make up of the pilot programme. Current practical and other issues in each country – for instance security in the Solomon Islands – will also need to be given weight in the final decision making process.

7.3 Report Summary

The goals of this project are very important. Mental health services are the means by which effective interventions for mental health are delivered and through which the burden of disease can be reduced or ameliorated. However, the success that mental health services have in fulfilling this function often depends, in large part, on factors such as the legislative and policy frameworks that those services operate in, and how they are planned for, funded, organized and managed. Those who have responsibilities in relation to such influences need expertise in a range of areas so as to be able to determine the exact mix of different types of mental health services that their country should have, and to develop and implement a plan to deliver that optimal mix of services. While recognising the high importance and demand for clinical training, this programme is intended to balance that with developing the necessary expertise in these other areas.

Effort in these areas will contribute to broad issues and concerns that often impede the successful development of mental health services in countries. As noted in the report these include the fact that mental health, and particularly mental illness, is often a difficult subject for people to talk about. Similarly, stigmatisation is still a major issue to address globally and this region is not immune. Finally, mental health is often not perceived as a major health priority by many country governments as they combat other pressing health needs.

As was evident from the overview and analysis presented in Chapter 4, most Pacific countries have a health structure that lends itself to an optimal mix model – that is they already have a system skewed towards primary health care systems. However, as was also evident in that analysis, there are many obstacles that need to be overcome. These include, as noted above, the knowledge, attitudes and beliefs of community. Other challenges concern the infrastructure needed to develop and support an optimal mix of mental health services and these were outlined in Chapter 4 in areas such as governance; financing; health services delivery and organisation; legislation; policies, plans and programmes; workforce; services and facilities; and the involvement of non-governmental organisations (NGOs). The complex inter-relationship between areas and issues is evident in countries where facilities and services are developed but cannot be staffed because of workforce problems, or where staff exist but there is insufficient expertise or funding to develop services/facilities.

Although governance is not always clear from available data, all countries have a government ministry or department responsible for health. However, this does not necessarily mean that there is a dedicated mental health section, staff or focus within it. Many countries do not have a dedicated mental health budget. Those that do often spend very small percentages of their overall health budget on mental health. Thus, addressing governance and financing issues will be an important component of the programme in several countries.

There is variation across the region in the nature, comprehensiveness and coverage of legislation in relation to mental health. A few countries are without mental health legislation and some employ a piecemeal approach to laws in this area. While a small number of countries with legislation are engaged in a review and updating process, or have done so in the last decade, many have legislation that is dated. Thus, a key function of the support programme should be to assist in the review of legislation to produce a legal framework that is comprehensive and contemporary in nature, and that fulfils international obligations, while reflecting the unique circumstances and culture of each country.

Across the region there is also some inconsistency in relation to the presence and make up of mental health policies, plans and programmes. Countries are at various points in developing initiatives in one or other of these categories, with some only at the conceptual stage. It would seem that not only the development but also the operationalization and often the actual implementation of policies, plans and programmes can be highly problematic. This is clearly an area where skilled technical assistance and support may be crucial and which the programme is focused on.

Various new plans and needs have been identified within many countries around mental health. The plans are at various stages of development and implementation. Common needs or plans are around:

- Increasing the size and expertise of specialist workforces (almost universal).
- Improved training for the general health workforce (very common).
- Improving understanding and awareness of mental health in the community.
- Improving the organisation and management of mental health services.
- Developing mental health policies and legislation.
- Developing/improving community based care.

Regardless of their status, content and coverage, the existence of policies, plans, programmes and other such initiatives in various countries can be built upon for this programme.

The skewing of health services towards primary health care means that training and development around mental health of the associated workforce is clearly important to improving care and outcomes. Indeed it perceived as a high priority by countries. However, while much can be achieved through the training of general health staff in mental health, an optimal mix of services requires a specialist workforce. The small size of such workforces in most countries raises a number of issues. For instance, there is the problem of first attracting and then retaining staff in the mental health field. Then there are challenges around providing this group with appropriate and ongoing training. The latter would seem to be an area where a more co-ordinated and co-operative approach among groups of countries may be best employed. Ongoing distance learning and support programmes in specialist staff development may be useful but these need to be carefully structured. These last two points are considered in more detail shortly. Countries also have concerns regarding the loss of specialist staff when training occurs overseas (particularly in Australia and New Zealand).

Workforce issues are not solely about numbers, however. They also involve how staff are utilised. Thus, the structure of services and facilities must be considered in close relationship with workforce issues. As well, it needs to be remembered that training and workforce development around mental health does not sit in isolation from the wider country context and the place and fit of mental health more generally.

From the available data some general observations can be made about services and facilities. In summary:

- Large dedicated institutions often only provide less than optimal care and place a heavy drag on resources (people and money).
- Despite have strong primary health care orientated systems, for a variety of reasons many countries do not integrate mental health into those systems.
- The involvement of, and reliance on, primary health care workers, outside agencies, communities and families necessitates a strong education programme.
- Delivery of services is often hampered by the geography of countries (e.g. widely dispersed islands) and limited resources (e.g. reliable, maintained transport). Thus, developing services and facilities needs to incorporate considerations well beyond those centred around mental health and be open to innovative thinking.
- Geography can also influence mental health service and facility development directly – e.g. the need to replicate services and/or facilities when transport makes centralisation problematic.

- There is the need to consider provision for particular groups (e.g. children and adolescents) and needs (e.g. around suicide) as well as generic services and facilities.
- As well as providing support, networking and sharing among Pacific countries may highlight similar problems and innovative solutions.

NGO involvement is variable across countries and, again, precise information is limited by the data available for analysis. In a number of countries there is expressed interest by NGOs and governments in expanding the roles and involvement of such organisations.

In terms of responding to these issues, the report offers an overview and analysis of education and training in the countries under consideration (Chapter 5), and from a regional perspective (Chapter 6). These chapters look at health education more broadly across various areas (e.g. clinical and management), and with a particular focus on mental health.

As clinical training, especially in terms of health workers, nurses and doctors, is seen as a high priority in all countries, it is positive that most have at least programmes around nursing. However, there is variation in the nature and significance of mental health content in these and efforts to address this need to be made. It is argued that this programme will make a valuable contribution to extending the interest in clinical training to management, policy and leadership areas. Also considered important by several countries were more general programmes around mental health education, promotion and prevention for workers and the public.

Reflecting the situation outlined earlier in this summary, and in more detail in Chapter 4, the primary health care system is important in relation to mental health care but is not always utilised effectively for a range of reasons. One of these is around education of the workforce and there is wide variation across countries in terms of the existence of this, and its type, frequency, coverage, and quality.

Any clinical training around mental health should take account of the predominance of nurses and health workers in the specialist and generic workforces.

It is apparent that many countries use courses run in neighbouring countries for basic and/or specialist training and there is a clear and expressed desire for more collaboration between countries. Such collaborative approaches are obviously of value and interest since they can play an important role in training and support initiatives. Indeed, improved and expanded networks are a key goal in this programme. Of course Pacific education collaborations, networks and relationships already exist, though these vary in size, nature and structure and one country can belong to a number of these for a variety of different motivations or purposes. Apart from SPC, networks and organisational collaborations tend to be associated with smaller regional subgroupings.

As is the situation in some cases already, future collaborations could be made up of a set of countries grouped around a key provider, based on more local relationships and particular needs within the larger region. Each collaborative centre of training or learning would provide a focus for shared and concentrated investment of human and financial resources to ensure quality training. It could also develop a ‘train the

trainers' approach. A flow on effect might be created by more skilled/qualified practitioners such as nurses being trained to educate other health or support workers. Such an approach would allow for training to reflect the cultural and other needs of Pacific nations as well as reducing the likelihood that staff would not return as often happens when training is made available in Australia or New Zealand.

Technical support in various forms would clearly be beneficial in developing and maintaining collaborations of this sort and in promoting shared and ongoing training and education. Most countries have developed external or strategic partners (in Australia and New Zealand), but there still needs greater linkages at regional level with efforts made to utilise, support and develop the leadership roles of existing providers. For instance, although USP is the leading distance education provider in the Pacific, it does not teach health or medicine programmes. Thus, it needs to link productively with providers that have such an orientation. Ongoing support should favour models that contribute to the goals of building capacity and capability and a lasting infrastructure in the region through viable and sustainable networks and organisations.

It is clear that the Internet and other electronic media offer some potential in relation to collaborations and networking around education and training. Telehealth initiatives, which a number of countries have or are interested in developing, can also be included here. These various approaches (Internet, telehealth, other electronic media and so on) provide an opportunity for training and ongoing supervision and are particularly useful for overcoming the isolation of sole practitioners, providing support and guidance, and for preventing skills depletion over time. However, any involvement of any such media needs to consider that those interviewed placed heavy emphasis on the oral culture in Pacific countries, the preference for a face-to-face approach for training, and the need for close engagement with other local countries. Ongoing support and mentoring was recognised as important but the approaches adopted needed to be appropriate and reflect the above factors. Thus, electronic media should be viewed as an adjunct rather than mainstay of any programme, though even then consideration must still be given to availability, access, reliability, costs, skills, knowledge, and preferences. For instance, whilst acknowledging the importance of POLHN, some countries were experiencing problems. Even if technology is available and accessible in a country, national variability and limitations may mean that support programmes could still have to rely on more mundane approaches, such as ordinary mail.

Finally, it was evident from interviews that any proposed programmes be well piloted. In addition, in order to give credibility and ongoing support to particular training programmes, significant members of the community and church (e.g. elders or leaders) should be involved alongside administrators, managers, clinicians and workers. This will ensure greater buy in and sustainability of programmes.

APPENDIX A

Interview / Survey Questions

1. What is your role in relation to mental health services planning, organisation and delivery?
2. What background and experience do you bring to that role?
3. Who are the key people responsible for the development and organisation of mental health policy and services in your country?
4. How are each of these providers and facilities delivering mental health care in your country?
 - Informal community mental health agencies/providers
 - traditional healers, family members, religious organizations, etc
 - Primary care facilities
 - medical clinics, hospitals, etc
 - Community mental health agencies
 - mental health centres and clinics; NGO services; private offices for psychiatrists, psychologists, social workers and psychiatric nurses
 - these may be both public and private, so differentiate
 - Psychiatric units in general hospitals
 - Long stay psychiatric hospitals
5. What are the key mental health issues and needs in your country in terms of:
 - policy and implementation
 - organisation and delivery
 - funding
6. What training and support needs around mental health are most needed in your country to aid the implementation of mental health policy and services?
7. Who are the people who would benefit most from this training and support?
8. What are the important training needs in your country for mental health professionals and workers?

Training needs might be around the following (but don't be limited to them):

 - *clinical skills (diagnosis/ recognition, treatment/ management)*
 - *management/ organisation skills*
 - *teaching/ training (of others) skills*
9. What training in mental health is currently available in your country – for clinical practice and/or service organisation?
10. What existing education/training arrangements does your country have?

i.e. with organisations and with other Pacific countries

The sorts of organisations we are thinking of are Polytechs & Universities (such as University of South Pacific) and networks such as POLHN and the Secretariat for the Pacific Community's Distance Learning Network. But please don't be limited to these
11. What approaches to distance learning would be best suited to your country's circumstances?

Some approaches you might consider are:

 - *Study guides (Readings and like)*
 - *Audio materials and teaching*
 - *Video material and teaching*
 - *CD-Rom (computer) based materials and teaching*
 - *Internet based materials and teaching*
 - *Summer Schools*
 - *Group discussions for people who are dealing with the same issues in other Pacific countries*
 - *Face-to-face contact with a tutor or mentor*
 - *Ongoing support once the course is over*
12. What are the means of communication available in your country for distance teaching/learning?
13. Would your country prefer to take part in a programme like this with other Pacific nations or independently?
14. Do you have any other suggestions or comments?

APPENDIX B

Country Profiles

COUNTRY PROFILES for GAP/NEEDS ANALYSIS

[Cook Islands](#)

[Fiji](#)

[Guam](#)

[Kiribati](#)

[Marshall Islands](#)

[Micronesia](#)

[Nauru](#)

[New Caledonia](#)

[Niue](#)

[Northern Mariana Islands](#)

[Palau](#)

[Papua New Guinea](#)

[Samoa](#)

[Solomon Islands](#)

[Tokelau](#)

[Tonga](#)

[Tuvalu](#)

[Vanuatu](#)

[Wallis and Futuna](#)

| COOK ISLANDS | |
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| Health Policy | |
| MH Law | No capacity to treat involuntarily (1998 Law Report) |
| MH Policy | No MH policy or plan at national level have asked for this to be developed by Francis Agnew psychiatrist in NZ |
| Health Structure | 90 bed Rarotonga Hospital (main referral hospital) → 5 smaller hospitals (25 to 4 beds) → Health clinics on other islands = all health care on outer islands (including MH) managed by nurse practitioners |
| Health Workforce | Doctors assigned to all hospitals; nurses provide clinic care 216 medical staff (2000) = 17 Drs, 39 nurses and assistant nurses |
| MH Workforce | <p>APT has:</p> <p><u>As at Dec 2003</u></p> <ul style="list-style-type: none"> 1 F/T specialist psychiatrist (visits from NZ 3/12) 1 P/T MH Nurse 1 F/T MH social worker 1 community support worker 1 P/T office support <p><i>NB: Press reports = MH nurse resigned from APT 2004</i></p> <p><u>Plan:</u></p> <ul style="list-style-type: none"> Hire F/T MH Support worker for outer islands + 3 MH nurses and social workers Develop awareness programmes Develop AOD service Develop assessment and counseling to reduce suicide, depression etc |
| Health & Other Education | <p>Secretary of Health aims to use improved telecommunications for consultation and education for health care professionals as well as public education.</p> <p>Limited inservice and on-going education.</p> <p>Doctors generally trained via FSM No ongoing education</p> <p>Cook Islands School of Nursing</p> <ul style="list-style-type: none"> 2 tutors 3y certificate program Shortage of resources Courses recognized by NZ universities for credit but not USP Post-graduate training via Fiji SoN Keen to link with open learning opportunities elsewhere (with clinical time off-shore) 1x computer, VCR and TV Keen to link with MH programme at NUS Hospital Nurses need training, only one nurse with specialist MH training <p>APT Provides a course in MH for nursing students</p> |
| MH Education | <p>Richmond Fellowship providing training for local medical personnel. MOU signed 2003</p> <p>This needs to be further investigated re how this is operating???</p> <p>Training for primary care nursing staff provided by Dr Francis Agnew</p> <p>Also runs community awareness programmes</p> |
| MH Programmes & Services | <p>Richmond fellowship (MoH NZ; British High Commission; Cook Is govt.; Overseas Development Fund)</p> <ul style="list-style-type: none"> - AOD detox centre plus counseling/support services - Have a mental health well-being centre Richmond: Are Pa Taunga (APT) - fund raising for new transport options to outer islands <p>Are Pa Taunga (APT) 2000</p> <ul style="list-style-type: none"> - diagnosis and treatment of MI - psychological support and counseling - assessment and treatment of prisoners - follow up of clients - care of elderly - respite and support for caregivers - advocacy <p>Provides a course in MH for nursing students</p> <p>Programmes do not seem to be being offered as at Nov 04</p> <p>TE KAINGA – Mental Health and Family Services</p> <ul style="list-style-type: none"> ■ Programs and services are focused along prevention, promotion and early intervention ■ Service delivery is culturally sensitive and consistent with community environment ■ Client/caregivers participation in planning and implementation of services. ■ Partnership with frontline agencies in programme delivery <p>Core Services</p> <p><i>Mental health services</i></p> <ul style="list-style-type: none"> ■ Crisis, assessment and treatment ■ Counselling service ■ Drugs and Alcohol Program <p>Information/awareness campaign</p> |

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| | <p>Community Facilitators Training Alcohol Education Program</p> <p><i>Family services</i></p> <ul style="list-style-type: none"> ■ Family support <ul style="list-style-type: none"> Parenting education program Stopping violence program ■ Children services <ul style="list-style-type: none"> Counselling service in schools Advocacy for victims of abuse Alternative program for truant children and offending <p><i>Support services</i></p> <ul style="list-style-type: none"> ■ Respite Care -a service to support caregivers ■ Supported Accommodation a service for individuals who are unable to take care of themselves and does not have a family able to accept responsibility for their care. <p><i>Information, education and research</i></p> <p>Service delivery model</p> <ul style="list-style-type: none"> ■ Mobile delivery -this model facilitates the ability to take the service where it is needed. It is also utilize to respond to request for assistance such as crisis intervention, treatment and follow-up. ■ Centre-based delivery- this model is utilise to deliver counselling and maintenance type of services as well as information and education programs. <p>Challenges</p> <ul style="list-style-type: none"> ■ Challenge for nurses to be multi-skilled, for example in counselling, assessment, fund raising, writing proposal, lobbying, etc ■ Incorporating traditional medicine into health practice – creating a shift in thinking from dependency in western medicine to using existing indigenous resources. ■ Development of mental health human resource capacity in the Cook Islands. ■ Incorporate mental health into the national health policy and budget. |
| MH Issues | |
| Other Resources | <p>Member nation of the University of the South Pacific</p> <ul style="list-style-type: none"> - extension campus is located in Rarotonga and is connected to USPNet's videoconferencing and data network. - this network provides compressed 128 kbps videoconferencing with other USP campuses and extension centres as well as 64 kpbs data access for email and Internet access. - the current network is utilized for audio conferencing and videoconferencing to support USP's open learning courses. - the videoconferencing system allows for two-way point to point connections to one other site at a time or for one way broadcast of lecture courses from either Fiji, Vanuatu, or Samoa. - Internet access is provided for faculty and students at different times to conserve bandwidth. - There is a computer laboratory available to student and faculty use. <p>POLHN Computer lab .(based at Hospital)</p> <p>NGO – Richmond Fellowship active presence. (no nurses employed, issues re staffing and also another proviers has set up in opposition)</p> <p>High internet costs</p> <p>MoH used: PEACESAT – voice traffic to be replaced by phone network MoH has compuers – some internet access</p> <p>Telecom CI is seeking \$ to develop telehealth network to connect isolated health providers. MoH wants this to include distance education to health professionals. Hezel notes this could be basis of health portal for information/education/telemedicine/etc</p> <p>MoEd – providing WAN and internet to all primary/secondary schools but high\$\$ MoEd also uses radio</p> <p>VCR and TVs in most hospitals and many schools 6 computers (5 in capital) – just 2 email capable</p> |
| Other Issues/ Information | <p>Prefer face-to-face learning; workshops Little experience with open/distance learning Strong support for visual modes of learning (videos)</p> |
| WHO ATLAS | <p>POLICIES AND LEGISLATION</p> <p>Mental Health Policy A mental health policy is absent.</p> <p>Substance Abuse Policy A substance abuse policy is absent.</p> <p>National Mental Health Programme A national mental health programme is absent.</p> <p>National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1992.</p> <p>Mental Health Legislation Mental health legislation is a part of the Crimes Act.</p> |

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| | <p>The latest legislation was enacted in 1969.</p> <p>MENTAL HEALTH FINANCING There are no budget allocations for mental health. Details about expenditure on mental health are not available. The primary source of mental health financing is tax based.</p> <p>MENTAL HEALTH FACILITIES The country has disability benefits for persons with mental disorders. A monthly monetary benefit is made on recommendation of a physician to the social welfare department. Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. Medications are provided by doctors and nurses. Regular training of primary care professionals is not carried out in the field of mental health. There are community care facilities for patients with mental disorders. Community care is the responsibility of public health nurses. A community-based programme has been started by a NGO with the agreement with Ministry of Health.</p> <p>PSYCHIATRIC BEDS AND PROFESSIONALS Total psychiatric beds per 10 000 population 0 Psychiatric beds in mental hospitals per 10 000 population 0 Psychiatric beds in general hospitals per 10 000 population 0 Psychiatric beds in other settings per 10 000 population 0 Number of psychiatrists per 100 000 population 0 Number of neurosurgeons per 100 000 population 0 Number of psychiatric nurses per 100 000 population 5.3 Number of neurologists per 100 000 population 0 Number of psychologists per 100 000 population 0 Number of social workers per 100 000 population 0 General physicians deal with psychiatry.</p> <p>NON-GOVERNMENTAL ORGANIZATIONS NGOs are involved with mental health in the country. They are mainly involved in advocacy, treatment and rehabilitation.</p> <p>INFORMATION GATHERING SYSTEM There is mental health reporting system in the country. The country has no data collection system or epidemiological study on mental health. Information on known patients are collected.</p> <p>PROGRAMMES FOR SPECIAL POPULATION There are no special services available.</p> <p>OTHER INFORMATION ADDITIONAL SOURCES OF INFORMATION 1. Government document (2000). Cook Island Essential Drug List.</p> |
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| FIJI | |
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| Health Policy | Five health priorities – no mention of MH but has health promotion and workforce components |
| MH Law | Mental Health Act 1940, last amended 1978 <i>Some support for review and actively commenced in 2003 with WHO assistance</i> Needs updating |
| MH Policy | Have a National Mental health Program (MoH, 1998-2002) <i>Dr Shisram Narayan: Fiji MH Service</i> <i>Plans: intensify advocacy for MH, establish post-grad M.O. training, improve MH information system, develop regional links for training, form Pacific Assn for MH professionals</i> <i>Recognition in MoH of importance of promotion, awareness and training of staff</i> <i>Plans to split health into geographical divisions may be opportunity to build MH capacity but some concern that MH will still not get prominent position it deserves</i> MoH has established MH priorities, priority is emergency response MH planning and organization training is needed at appropriate levels MoH depends on guidance from St Giles and Director of Nursing for MH guidance Need for assistance in planning and organizing and prioritising MH services Need community based promotion, prevention and particularly treatment services |
| Health Structure | 3 Divisions with hospitals (Central & Eastern; Northern; Western) |
| Health Workforce | Approx. 1700 nurses |
| MH Workforce | Dec 2003 2x psychiatrists 1x F/T, 1x P/T) 3x Psychiatric Registrars with post-basic training 2x Psychiatric Registrars without post-basic training 24x R/N 6x R/N with 1 month attachment in Australia 1x Matron, 1x Sister with 4 month attachment in Australia 69x Orderlies <i>WHO Sit Rep indicates 1000 general nurses in MH area - ????? if this is correct</i> |
| Health & Other Education | Fiji School of Medicine Various medical, allied health and health related bachelor degrees, diplomas and certificates. |

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| | <p>Post Graduate programmes also available Has distance learning capability (trialing this with post-graduate training for doctors (Hezel)) Tele-health and tele-medicine capability Computer-aided learning capability Technician training is conducted by FSM for paramedics, lab technicians, X-ray technicians, dietitians, physiotherapists, and pathology technicians. FSM also offers an undergraduate certificate and diploma program in allied health. WHO supported a pharmacy program offered by a New Zealand university via distance education and with a teacher traveling to Fiji. Most technicians are trained in Fiji, but some are sent away for training not available in the country</p> <p>FSM promotes “one stop shopping” and flexi-learning. Open learning programs are especially needed at the postgraduate level in medicine. Professional doctors are needed in the field, and they can’t be released from their posts to come to Fiji for many months or years of training. It is conceived that doctors could spend just brief periods of time in Fiji for their programs and, via open learning and visiting tutors, study from their posts.</p> <p><i>Dr Shisram Narayan: Fiji MH Service</i> <i>Plans: intensify advocacy for MH, establish post-grad M.O. training, improve MH information system, develop regional links for training, form Pacific Assn for MH professionals</i></p> <p>Fiji School of Nursing FSN has twinned with James Cook University in Australia. 3y Diploma – Nursing Post Graduate Certificates</p> <ul style="list-style-type: none"> - Nurse Practitioner - Midwifery - Public Health - Management <p>1y Bachelor Nursing (James Cook University) Masters Nursing Science</p> <p>Nursing education conducted with St Giles Hospital and community</p> <p>FSN tutors have identified the need for human resource development: more tutors who have been trained as instructors. Tutors are currently selected for teaching by their area of clinical expertise. All have advanced study but not necessarily teaching qualifications. Teacher training could be offered through Fiji Institute of Technology, USP, or via open learning from another organization.</p> <p>Students at FSN have extremely limited access to computers, and nurses at divisional hospitals also would have a difficult time getting access. Even printed resources are in short supply: FSN students share course textbooks at a ration of 50 books per 150 students.</p> <p>New nurses want learning opportunities, and FSN has been attempting to provide those opportunities through its postgraduate programs. WHO has helped FSN establish postgraduate nursing programs in midwifery, nurse practitioner, and public health. FSN also has a postgraduate program in healthcare management. Other areas of need for nurses are trauma, cardiology, oncology, and operating theater.</p> <p>WHO funds FSN nursing management audio teleconferences with nurses at three sites: Suva, Lautoka, Labasa. FSN also broadcasts weekly continuing education programs for nurses on Radio Fiji. No handouts or other documents accompany the programs.</p> <p>Community Nursing Training via NZ</p> <p>MoH’s Health Promotion trains community and healthcare workers within each district. The staff has an interest in using distance learning to train staff about health promotion. Each Sunday Health Promotion broadcasts a program on four radio channels in Fijian and Hindi. They also produce TV spots on dengue, leptospirosis, tobacco and outbreaks. Health Promotion could develop materials for FSN. They have a social marketing officer as well as a research officer, who conducts formative and summative evaluation. The representative of Health Promotion says a health promotion officer is needed in each division to work with public health nurses.</p> <p>Fiji Institute of Technology</p> <ul style="list-style-type: none"> - no relevant programmes |
| MH Education | <p>Undergraduate medical and nursing have theory and practical placement at St Giles. Need for greater clinical training in basic programmes No post grad psychiatric training for medical or nursing Post grad training is needed</p> <p>WHO Programme</p> <ul style="list-style-type: none"> - trained 24 nurses in early detection of symptoms of MI, confidence in tackling problems and ability to treat patients in own environment; NGOs were involved them in the care of mentally ill persons in community (sic) (Manila Report) <p>Need for more specialized MH nursing training Training for Community nurses in MH</p> |

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| | <p><i>Training of primary health care workforce in MH is beginning</i></p> |
| MH Programmes & Services | <p><i>Dr Shisram Narayan: Fiji MH Service = "illness orientated, centralized, neglected, inaccessible, fragmented orientated to long-term care" WPRO Report</i></p> <p><i>Poor outcomes for wider communities due to centralisation</i></p> <p><i>Plans: intensify advocacy for MH, establish post-grad M.O. training, improve MH information system, develop regional links for training, form Pacific Assn for MH professionals</i></p> <p><i>Currently looking to decentralize services with St Giles having a national role.</i></p> <p><i>Training of primary health care workforce in MH is beginning</i></p> <p>St Giles Psychiatric Hospital 190 beds St Giles has complex mix of patients (ID, MI & AOD) Need for improved care at St Giles Nurses requesting more training</p> <p>In patient Outpatient Services Community psychiatry Day centre OT Forensic Service Teaching venue for FSM 2-3 month average stay (some for years) Community Psychiatric Nursing (1997) Available from hospital to surrounding areas Nurse, doctor and orderly</p> <p>No community based MH just health care generally</p> <p>NGOs Advocacy, promotion, prevention, rehabilitation</p> <p>FSPI Project on male youth mental health Fiji Women's Crisis Centre (FWCC)</p> <p>Spiritual and traditional healers are first line of treatment for majority of Fijians (80%)</p> |
| MH Issues | <p>St Giles has complex mix of patients (ID, MI & AOD)</p> <p>Stigma</p> <p><i>WHO report indicates many opportunities and some constraints. Also identifies initiatives underway to overcome barriers and issues.</i></p> |
| Other Resources | <p>POLHN Computer lab. Not functioning and doesn't know why</p> <p>Member nation of the University of the South Pacific USP based in Fiji USP serves 12 countries through USP Centers. It connects those centers via a private network, USPNet, on Intelsat with funding from the Japanese govt. USP uses Polycom conferencing devices, at 64k for data and 128k for video. For its online courses USP uses WebCT. USP offers pre-degree and degree programs. Most of USP certificate, degree, and diploma programs are available via distance learning. USP serves 15,000 students per semester via distance learning with a priority on addressing the government manpower plan within each country. Each center has a program assistant, a librarian, and a support person. The distance education unit has instructional designers and program developers. AusAID has funded a design team to work with USP to help strengthen its centers. USP offers a certificate in leadership management, which could be useful for health management. USP has a memorandum of understanding with countries and colleges in the Pacific and it cross-credits with those colleges. (H)</p> <p>FSM and USP FSM is viewed as "the future of the Pacific" in medical education. To build a strong open learning program, FSM must receive guidance from another university to build a strong open learning program. Closer alignments with USP or with a university that has expertise in open learning would enable FSM to build an open learning program with minimal impact on its internal operations. USP has instructional designers, and FSM contracts training workshops from USP. FSM needs to have its own staff in instructional design, learner support, and it needs coordination in each country to provide support to each distance learner, but that could come at a later time. Also, FSM could collaborate with nursing schools in countries to obtain an efficient use of open learning coordinators who would work for FSM as well as the national school of nursing. Any learning center with a coordinator would be tailor-made for each country. Despite the actual and potential connections between FSM and USP, there still exists a gap between the institutions. Although FSM graduates receive their diplomas from USP, USP does not appear to consider FSM as one of its schools. As a result, USP does not permit FSM to use USPNet. That resource would give FSM access by satellite to all of the doctors in the South Pacific. (H)</p> <p>Perceived barriers to open learning include cost of technology and materials production cost. Several respondents observed that open learning systems must be sustainable if they are to be successful. (H)</p> |

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| | <p>AusAID has supported a postgraduate medical education program at FSM with two-year posts in curriculum development and teaching and distance learning. The goals are (1) design of curriculum in obstetrics and gynecology, pediatrics, internal medicine, surgery, and anesthetics; and (2) delivery of postgraduate programs via distance learning. The program will be extremely important in the development of new initiatives in open learning.</p> <p>The New Zealand High Commission is funding the FSM telehealth project, but aid has been cut in half since the coup, and New Zealand currently has no aid liaison with the Fiji government. (H)</p> <p>The School of Medical Education at the University of New South Wales (UNSW) delivered a public health program via distance education:</p> <ul style="list-style-type: none"> - but experienced cultural issues with distance education. - Students found it difficult to multiplex work, study, and family. - They found that students prefer face-to-face education. - The criteria for distance education they found essential were high intellectual capacity and a good knowledge of the English language. <p>It costs A\$15,000 per student for the 18 month MPH program. The UNSW program had 3500 students, half on site and half participating via distance learning. (H)</p> <p>AusAID sponsored a project that envisaged centers with computers for student access (1) within Fiji, and the Lautoka center was developed; (2) in other countries. However, only three people are currently enrolled, it is reported. It is also said that the distance learning postgraduate students lack supervision. The project envisaged creating a lifelong education capacity within FSM on behalf of doctors, but staff is lacking. The project has a link to the University of Papua-New Guinea in Port Moresby. (H)</p> <p>Nursing and Computer Access Students at FSN have extremely limited access to computers, and nurses at divisional hospitals also would have a difficult time getting access. Few subdivisional hospitals have computers that nurses could use for learning. Computer literacy is generally low among nurses. That could change, however, as the MoH is driving toward the collection of public health data by computer. As MoH rolls out its implementation, we would expect to see more computer literacy among nurses. Some 100 nurses (of 1700 in the country), however, are posted to locations without electricity, and, without solar power supplies, no amount of technology will be useful. (H)</p> <p>MoH's Health Promotion trains community and healthcare workers within each district. The staff has an interest in using distance learning to train staff about health promotion. Each Sunday Health Promotion broadcasts a program on four radio channels in Fijian and Hindi. They also produce TV spots on dengue, leptospirosis, tobacco and outbreaks. Health Promotion could develop materials for FSN. They have a social marketing officer as well as a research officer, who conducts formative and summative evaluation. The representative of Health Promotion says a health promotion officer is needed in each division to work with public health nurses. (H)</p> |
| Other MH Observations | Consumer empowerment: active participation of patients and families in decision making, an anti-stigma and awareness campaign based on inviting many community groups to visit the mental hospital |
| WHO ATLAS | <p>POLICIES AND LEGISLATION</p> <p>Mental Health Policy A mental health policy is present. The policy was initially formulated in 1994. The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. The National Advisory Council in Mental Health is in the process of reviewing the National Mental Health Policy.</p> <p>Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1998.</p> <p>National Mental Health Programme A national mental health programme is present. The programme was formulated in 1999.</p> <p>National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1994.</p> <p>Mental Health Legislation There are the Laws of Fiji – Chapter 113 – Mental Treatment Act. The latest legislation was enacted in 1978.</p> <p>MENTAL HEALTH FINANCING There are budget allocations for mental health. The country spends 1.7 % of the total health budget on mental health. The primary sources of mental health financing in descending order are tax based and private insurances.</p> <p>MENTAL HEALTH FACILITIES The country has disability benefits for persons with mental disorders. They are able to apply for social welfare assistance. Mental health is a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level. There is a lack of sufficiently trained doctors or facilities to treat severely ill patients in the primary health centres, but they are able to follow-up. Regular training of primary care professionals is carried out in the field of mental health. In the last two years about 140 personnel were provided training. Training to primary health care workers are provided on an ad-hoc basis. There are community care facilities for patients with mental disorders. A community psychiatric nursing team has been established in the central division which operates to provide community care.</p> <p>PSYCHIATRIC BEDS AND PROFESSIONALS Total psychiatric beds per 10 000 population 2.4 Psychiatric beds in mental hospitals per 10 000 population 2.4 Psychiatric beds in general hospitals per 10 000 population 0</p> |

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| | <p>Psychiatric beds in other settings per 10 000 population 0 Number of psychiatrists per 100 000 population 0.1 Number of neurosurgeons per 100 000 population 0.1 Number of psychiatric nurses per 100 000 population Number of neurologists per 100 000 population Number of psychologists per 100 000 population Number of social workers per 100 000 population There is one occupational therapist.</p> <p>NON-GOVERNMENTAL ORGANIZATIONS NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention and rehabilitation.</p> <p>INFORMATION GATHERING SYSTEM There is mental health reporting system in the country. An annual report is compiled and submitted to the Ministry of Health by the St. Giles Hospital at Suva. The country has data collection system or epidemiological study on mental health. Statistics department collects information from hospitals.</p> <p>PROGRAMMES FOR SPECIAL POPULATION The country has specific programmes for mental health for disaster affected population. A trauma counselling team was formed in 2000.</p> <p>OTHER INFORMATION ADDITIONAL SOURCES OF INFORMATION 1. Government document (1978). Laws of Fiji. Mental Treatment, Chapter 113 2. Government document (1998). Substance Abuse Advisory Council Act. 3. Khan, S. (1998). Community Psychiatric Nursing Annual Report. 4. Medical Superintendent. (1998). Report on the St. Giles Staff Activities in the Western Division. 5. St. Giles Hospital Annual Report (1999). Mental Health, Non-Communicable Diseases. 6. St. Giles Hospital Annual Report (1997). Community Mental Health Team.</p> |
| | <p>Most likely to benefit: Nurses and physicians but community also need education Important training needs: doctors and nurses – basic clinical training especially around follow up; midwives – training in problem recognition; others (police and school teachers) – awareness etc; NGOs Educational Preferences Modes</p> <ul style="list-style-type: none"> - study guides = most feasible - internet based learning – ok where available but not great availability - summer schools - Group discussions with other Pacific participants - Face-to-face contact with mentor/tutor definitely needed - Ongoing support - ADD train educators <p>Make training compulsory Communication support</p> <ul style="list-style-type: none"> - Telephone - Mail - Email – limited <p>Internet capability is limited Would like to be involved with other Pacific nations Wants other clinical course e.g. midwifery</p> |

| GUAM | |
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| Health Policy | Has health priorities but MH not mentioned (but DOA prevention is). Health promotion, access and availability, and workforce issues are relevant. |
| MH Law | Aspects of the Health Act specifically related to MH (1998 Law Report) |
| MH Policy | Integrated care, least restrictive environment with community care, including outreach to people with serious MI |
| Health Structure | Public/Private mix US military has sizeable military health service/facility 200 bed Main Hospital; 4 private primary care and specialty clinics; 12 private practice clinics Guam Department of Mental Health and Substance Abuse in Tamuning, Guam Territory Protection and Advocacy Agency - each State and selected Territories have a protection and advocacy agency that receives funding from the Federal Center for Mental Health Services There is a Dept of Integration of Services for Individuals with Disability (includes MH) |
| Health Workforce | 150 Drs ? nurses |
| MH Workforce | 4 p/t psychiatrists (1998 Law Report) <i>see in services section for detail of staffing</i> |
| Health & Other Education | University of Guam - bachelors degree in Nursing UoG associated with PREL (Pacific Resources for Education & Learning an NGO serving educational community in US affiliated Pacific islands) The University of Guam (UOG) College of Nursing and Health Sciences offers a BSN degree as well as a degree completion program for LPNs and RNs. The college had been offering distance education courses and continuing education via PEACESAT since 1993 under a US federal grant and a grant from the Sasakawa Foundation. Courses were provided to US affiliated countries and the Commonwealth of the Northern Mariana Islands. (H) |

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| | <p><u>Pacific Basin Telehealth Consortium</u> UOG staffs the consortium and coordinates activities with WPHNet, PACNET, the Akamai Pacific Island Health Care Project, PEACESAT, PREL Star, and the distance education workgroup established at Noumea. PICCEP also conducts healthcare workforce analyses and needs assessments. HRSA also funds the Pacific Basin Telehealth Initiative, under which the Pacific Basin Telehealth Consortium was developed, telehealth technologies were deployed, and support was provided for the human telehealth infrastructure development. The Consortium has been:</p> <ul style="list-style-type: none"> - Conducting an inventory of existing telecommunications and telehealth resources in the region; - Developing a road map for join telehealth initiative in distance learning, clinical telemedicine and public health; and - Developing and supporting existing web-based tools such as distance education web pages and listservs for information sharing. <p>The consortium piloted videoconferencing with American Samoa and store and forward technologies in Palau. The consortium also conducted a web based distance education project to support Maternal and Child Health programs. (H)</p> <p>Guam Community College - Medical Assisting Course GCC associated with PREL (Pacific Resources for Education & Learning an NGO serving educational community in US affiliated Pacific islands)</p> <p>Professional Development and Lifelong Learning Centre Lower key programme base but may be relevant</p> |
| MH Education | |
| MH Programmes & Services | <p><i>ALL Sourced from 1998 Law Report</i> Philosophy: Integrated care, least restrictive environment with community care, including outreach to people with serious MI Emergency intake service (4 S/W) Crisis Hotline (NGO) Adult Counselling Service (5 S/W) Day Treatment Facility (4 staff) Community Support Service (9 S/W) Prevention and Training Programme (6 S/W) Medication Clinic 16 Bed Adult In-patient Unit (21 Staff) 16 Bed Child & Adolescent In-patient Unit (18 staff) Sexual abuse & Domestic Violence Unit (6 staff) Child and Adolescent Community Services (8 S/W) Supported residential programmes - adults (12 beds) - children (4 beds)</p> <p>Forensic care: Under Dept of Corrections Staff: 2 psych. Techs//1 staff nurse//1 medical tech.//1 AOD counsellor Private Sector: 5x Psychiatrists 5x Psychologists 38x licensed therapists</p> <p>Strong NGO sector</p> |
| MH Issues | |
| Other Resources | <p>UoG is committed to providing health/medical information resources</p> <p>The University of Washington's Pacific Islands Continuing Clinical Education Program (PICCEP) in the Center for Health Workforce Studies receives HRSA funding. PICCEP emphasizes primary care continuing education for practicing local health care providers in the US-affiliated areas of the Pacific. PICCEP was a facilitator of the Pacific Basin Medical Officers Training Program (PBMOTP) and continues to support graduates of the program. PICCEP also conducts healthcare workforce analyses and needs assessments. HRSA also funds the Pacific Basin Telehealth Initiative, under which the Pacific Basin Telehealth Consortium was developed, telehealth technologies were deployed, and support was provided for the human telehealth infrastructure development. The Consortium has been:</p> <ul style="list-style-type: none"> - Conducting an inventory of existing telecommunications and telehealth resources in the region; - Developing a road map for join telehealth initiative in distance learning, clinical telemedicine and public health; and - Developing and supporting existing web-based tools such as distance education web pages and listservs for information sharing. <p>UOG staffs the consortium and coordinates activities with WPHNet, PACNET, the Akamai Pacific Island Health Care Project, PEACESAT, PREL Star, and the distance education workgroup established at Noumea. The consortium piloted videoconferencing with American Samoa and store and forward technologies in Palau. The consortium also conducted a web based distance education project to support Maternal and Child Health programs. (H)</p> <p>The needs for telehealth identified by Guam healthcare professionals include:</p> <ul style="list-style-type: none"> - Teleconferencing for continuing medical and nursing education, with CME and CEU credits; - Telemedicine consultations to reduce off island referrals; - Teleradiology capabilities for remote consultation. <p>The University of Guam (UOG) College of Nursing and Health Sciences offers a BSN degree as well as a degree completion program for LPNs and RNs. The college had been offering distance education courses and continuing education via PEACESAT since 1993 under a US federal grant and a grant from the Sasakawa Foundation. Courses were provided to US</p> |

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| | <p>affiliated countries and the Commonwealth of the Northern Mariana Islands. Those courses have been terminated, however, due to lack of both funding and human resources. (H)</p> <p>Distance education could succeed in the Pacific countries only with an investment of more resources, agreements with countries to provide distance education, more communication among nurses, and distribution of web courses in print. (H)</p> |
| | Is a commonwealth of the USA so receives major benefits as a result |
| WHO ATLAS | <p>POLICIES AND LEGISLATION</p> <p>Mental Health Policy A mental health policy is present. The policy was initially formulated in 1983. The components of the policy are prevention, treatment and rehabilitation.</p> <p>Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1983.</p> <p>National Mental Health Programme A national mental health programme is absent.</p> <p>National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is absent.</p> <p>Mental Health Legislation Law on parity in health insurance for mental illness and chemical dependency. The latest legislation was enacted in 1998.</p> <p>MENTAL HEALTH FINANCING There are budget allocations for mental health. Details about expenditure on mental health are not available. The primary sources of mental health financing in descending order are tax based, private insurances, grants, out of pocket expenditure by the patient or family and social insurance.</p> <p>MENTAL HEALTH FACILITIES There are disability benefits for persons with mental disorders. An individual must be certified by a licensed doctor. Mental health is not a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level. Psychiatric patients are referred to government psychiatric setups or private psychiatrists. Regular training of primary care professionals is not carried out in the field of mental health. Details about community care facilities in mental health are not available. The psychiatric department abides by the legislation PL 17-21 to provide community-based out patient mental health, alcohol and drug abuse programs and services for the people.</p> <p>PSYCHIATRIC BEDS AND PROFESSIONALS Total psychiatric beds per 10 000 population 2.2 Psychiatric beds in mental hospitals per 10 000 population 2.2 Psychiatric beds in general hospitals per 10 000 population 0 Psychiatric beds in other settings per 10 000 population 0 Number of psychiatrists per 100 000 population 5 Number of neurosurgeons per 100 000 population 0 Number of psychiatric nurses per 100 000 population 8 Number of neurologists per 100 000 population 1.3 Number of psychologists per 100 000 population 5 Number of social workers per 100 000 population 39</p> <p>NON-GOVERNMENTAL ORGANIZATIONS NGOs are involved with mental health care. They are mainly involved in advocacy, promotion and prevention.</p> <p>INFORMATION GATHERING SYSTEM There is no mental health reporting system. There are no data collection system or epidemiological study on mental health. The University of Guam conducted in 2000 a prevalence study on the islands senior citizen population.</p> <p>PROGRAMMES FOR SPECIAL POPULATION There are specific programmes for mental health for disaster affected population and children. DMHSA follows the 'territorial emergency plan' when serving disaster affected population. DMHSA's child and adolescent unit serves the mental health needs of the youth.</p> <p>OTHER INFORMATION</p> <p>ADDITIONAL SOURCES OF INFORMATION 1. Official Mental Health and Substance Abuse Policy, P.L. 17-21: 83-92. (Government document) 2. Parity in Health Insurance for Mental Illness and Chemical Dependency. Most Recent Law in the Field of Mental Health, P.L. 24-303. (Government document)</p> |

| KIRIBATI | |
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| Health Policy | |
| MH Law | Mental Health Treatment Ordinance Cap 56 Enacted 1927. Not changed since 1977. Needs reviewing. 1993 new public health Acts drafted not enacted. |
| MH Policy | 1999 - key health priorities cited by govt. No mention of MH specifically but objectives re primary care, health education, human resource development are relevant |
| Health Structure | Tangura Central Hospital (TCH) 140 bed main referral hospital → Btio, 10 bed referral hospital + Kirimati 10-15 beds referral hospital → 85 health centres and dispensaries (medical asst or nurse). |
| Health Workforce | 22 doctors |

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| | 170 nurses Doctors mostly from China and Philippines |
| MH Workforce | 1x Psychiatrist (2003) 1x Medical Asst. 5x Qualified Nursing Staff (2 – had 3/12 MH attachment in Fiji; 1 – NZ trained) 24x Orderlies |
| Health & Other Education | <p>Govt. targeting middle level healthcare workers for outer islands Govt targeting improving nursing competencies Drs train overseas</p> <p>Kiribati Nursing Program (KNS)</p> <ul style="list-style-type: none"> - basic program is now 3 years in length. - most nurses have graduated from this program.; students attend year round, and the program is divided into theoretical and clinical practice = 12 week out-island community health experience the last term of the program. - currently 7 tutors in the program, including the Principal who also teaches courses. All tutors have at least 8 years of experience as a nurse, but 4 of the 7 tutors have 2 or less experience in teaching. Several tutors have had in-country or out-of-country courses beyond basic education, usually from Fiji, Australia, and New Zealand. The tutors are very eager to increase their teaching knowledge. <p>Kiribati Post-Basic Program has two sections.</p> <ul style="list-style-type: none"> - Public Health portion is four months in length, including a four-week outer island attachment. - Midwifery portion is 7 months in length, equally divided between theory and clinical practice. The midwifery program was founded three years ago. With six months of training in obstetrics, nurses and medical assistants prepare for midwifery, with a priority for placement in the outer islands. - The post-basic coordinators have both extensive clinical practice and nursing education experience. Both have out-of-country experience. The clinical tutor is has been teaching for one year. She has a baccalaureate degree in nursing, a midwifery certificate, and is a medical assistant. <p>Medical Assistant Program (MA)</p> <ul style="list-style-type: none"> - 1-½ year program for initially qualified nurses. - program is offered according to needs - not been delivered since 1999. - Current plans by the MoH are to merge the MA program with the post-basic programs and upgrade the program to a nurse practitioner level. Work is just beginning on this merger. <p>Other</p> <ul style="list-style-type: none"> - Nursing assistants receive on-the-job training. The Clinical Nurse Specialist has recently developed a basic training program for the nursing assistants, and has provided this training once. - Village Welfare Groups receive on-the-job training from medical assistants and community health nurses. <p>The KNS program has two classrooms with overhead projectors and TV/VCRs that can accommodate 30-40 students each. Classrooms are almost always occupied during the day. They have two computers and one printer, a photocopy machine, and no Internet access. The students have no access to computers.</p> <p>The post-basic program has one classroom with an overhead projector and a TV/VCR that can accommodate approximately 12 students. They have three computers and printers, a photocopy machine, and fax machine. They have no Internet access. Students have access to the computers through the tutors' offices.</p> <p>Education Support via Federation for the South Pacific (FSP), UNICEF, Peace Corp, AUSAid, USP, NGOs</p> <p>No distance learning initiatives but some positive regard for them to solve issues Many nurses are said to be aware of distance education as a tool for continuing education, but few have direct experience with it.</p> <p>Tarawa Technical Institute</p> <p>Tarawa Technical Institute's 1999 study year started on 1 February with further growth in courses and student numbers. The institute has been in existence for more than 20 years catering for post-school in-country demand for education and training in several areas. Recently it has undergone major improvements led by the new principal Temaia Ereata and sponsored in cash and kind by several overseas agencies. Two areas that have benefited from overseas support are the computing department and secretarial skills department. Both are fully equipped with the latest in computer hardware and software thanks to the EU and South Korea. The British have also weighed in with personnel and cash to resume courses in management development, and accounting and financial management. In addition, they are also backing courses about to start in electrical engineering. Courses in English, Mathematics, Engineering and Carpentry are also taking off or benefiting from a facelift, with support from Australia and the Commonwealth. Along with more and better courses, improvements have also been carried out to the college campus in Betio, on the lagoonside adjacent to the new wharf. New classrooms, offices and a maneaba are the main aspects, and the library is also expanding.</p> |
| MH Education | <p><i>Plans to continue to send nurses to Fiji or PNG for MH experience</i> <i>Plans to train nurses in community MH nursing</i> <i>Suggests nursing exchange programme</i> <i>Plans to train an MO in MH</i></p> |
| MH Programmes & Services | Mental Health Wing, Central Hospital, Tarawa Under renovation with addition of two new wards and a fence |

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| | Plans to develop awareness programmes for MH Plans to improve care and services for families and caregivers |
| MH Issues | FSPI Project on male youth suicide |
| Other Resources | <p>POLHN computer lab Member nation of the University of the South Pacific USP has provided some courses through distance education. Assignments are sent by mail to outer island nurses. → USP and Tarawa Technical Institute (TTI) provide computer classes on Tarawa.</p> <p>Govt has established medical library</p> <p>Telemedicine is viewed as a useful diagnostic tool within the referral system to reduce referral costs and improve clinical knowledge among healthcare professionals.</p> <p>Computers are still relatively rare in healthcare facilities, except in the hospitals. Email, available two years ago within the MoH, is no longer available, except in the Permanent Secretary's office. Nurses are learning how to use computers on the job. A few nurses have access to audiocassette recorders, VCR/TVs are available in only one or two clinics. The KNS program has two classrooms with overhead projectors and TV/VCRs that can accommodate 30-40 students each. Classrooms are almost always occupied during the day. They have two computers and one printer, a photocopy machine, and no Internet access. The students have no access to computers. The post-basic program has one classroom with an overhead projector and a TV/VCR that can accommodate approximately 12 students. They have three computers and printers, a photocopy machine, and fax machine. They have no Internet access. Students have access to the computers through the tutors' offices.</p> |
| WHO ATLAS | <p>POLICIES AND LEGISLATION Mental Health Policy A mental health policy is present. The policy was initially formulated in 1999. The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. Substance Abuse Policy A substance abuse policy is absent. National Mental Health Programme A national mental health programme is present. The programme was formulated in 1999. National Therapeutic Drug Policy/Essential List of Drugs Details about the national therapeutic drug policy/essential list of drugs are not available. Mental Health Legislation There is no mental health legislation. Details about the year of enactment of the mental health legislation are not available.</p> <p>MENTAL HEALTH FINANCING There are no budget allocations for mental health. The country spends 1.6 % of the total health budget on mental health. The primary source of mental health financing is tax based.</p> <p>MENTAL HEALTH FACILITIES The country does not have disability benefits for persons with mental disorders. There are no social benefits. Mental health is a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level. Regular training of primary care professionals is not carried out in the field of mental health. There are no community care facilities for patients with mental disorders.</p> <p>PSYCHIATRIC BEDS AND PROFESSIONALS Total psychiatric beds per 10 000 population 7.3 Psychiatric beds in mental hospitals per 10 000 population 7.3 Psychiatric beds in general hospitals per 10 000 population 0 Psychiatric beds in other settings per 10 000 population 0 Number of psychiatrists per 100 000 population 1 Number of neurosurgeons per 100 000 population 0 Number of psychiatric nurses per 100 000 population 0 Number of neurologists per 100 000 population 0 Number of psychologists per 100 000 population 0 Number of social workers per 100 000 population 0</p> <p>NON-GOVERNMENTAL ORGANIZATIONS NGOs are involved with mental health in the country. They are mainly involved in rehabilitation.</p> <p>INFORMATION GATHERING SYSTEM There is mental health reporting system in the country. Details can be obtained from the Health Information and Statistics Centre of the Ministry of Health. The country has no data collection system or epidemiological study on mental health.</p> <p>PROGRAMMES FOR SPECIAL POPULATION There are no special services available.</p> <p>OTHER INFORMATION ADDITIONAL SOURCES OF INFORMATION 1. Mental Health. Annex 1 (Government document).</p> |

| MARSHALL ISLANDS (Republic of) | |
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| Health Policy | |
| MH Law | Public Health, Safety and Welfare Act – only ever used in case of insanity in court proceedings |
| MH Policy | No govt. plan for MH |
| Health Structure | Division of Human Services → MH & DOA services and S/W support |
| Health Workforce | |
| MH Workforce | 2x MH coordinators (1 each for Majuro and Ebeye) 1x S/W in Majuro 1x MH Nurse 1x Counsellor on substance abuse |
| Health & Other Education | College of the Marshall Islands Associate of Science Degree with Nursing Major NB Associated with PREL (Pacific Resources for Education & Learning an NGO serving educational community in US affiliated Pacific islands) Distance learning capable Affiliations with University of Guam and Hawaii |
| MH Education | |
| MH Programmes & Services | No hospital beds designated for MH Patients seen at home Mental health, alcohol and substance abuse services as well as social work programmes Doctor has to authorize treatment <i>Plan – 5y to develop community based MH service, build an inpatient facility, create MH information system, strengthen family training and support groups, hire professional staff.</i> <i>Would like co-operative Pacific approach</i> |
| MH Issues | Suicide is a major issue: rate = 0.77 per thousand (usually 15-44, 89% male) |
| Other Resources | POLHN computer lab. Member nation of the University of the South Pacific CoMI Associated with PREL (Pacific Resources for Education & Learning an NGO serving educational community in US affiliated Pacific islands) CoMI continues to expand distance learning capabilities (PEACESAT) |
| WHO ATLAS | <p>POLICIES AND LEGISLATION</p> <p>Mental Health Policy A mental health policy is absent.</p> <p>Substance Abuse Policy Details about the substance abuse policy are not available.</p> <p>National Mental Health Programme A national mental health programme is present. The programme was formulated in 1982.</p> <p>National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is absent.</p> <p>Mental Health Legislation There are National Mental Health Planning Council By Laws. The latest legislation was enacted in 1997.</p> <p>MENTAL HEALTH FINANCING There are budget allocations for mental health. The country spends 0.4 % of the total health budget on mental health. The primary source of mental health financing is social insurance.</p> <p>MENTAL HEALTH FACILITIES The country has disability benefits for persons with mental disorders. Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. The Ministry of Health and Environment offers mental health programs under the auspices of Bureau of Primary Health Care, but all medical supplies and drugs are for curative health care. Regular training of primary care professionals is carried out in the field of mental health. There have been some workshops and training programs namely – The Crisis Prevention and Intervention Training, Partners in Mental Health Performance Outcome Workshop, etc. There are community care facilities for patients with mental disorders. Usually community based system of care is provided. Outreach prevention and treatment programs are provided to communities around the country.</p> <p>PSYCHIATRIC BEDS AND PROFESSIONALS Total psychiatric beds per 10 000 population 0 Psychiatric beds in mental hospitals per 10 000 population 0 Psychiatric beds in general hospitals per 10 000 population 0 Psychiatric beds in other settings per 10 000 population 0 Number of psychiatrists per 100 000 population 0 Number of neurosurgeons per 100 000 population 0 Number of psychiatric nurses per 100 000 population 0 Number of neurologists per 100 000 population 0 Number of psychologists per 100 000 population 3 Number of social workers per 100 000 population 3 Only one medical doctor works with the mental health program.</p> |

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| | <p>NON-GOVERNMENTAL ORGANIZATIONS NGOs are involved with mental health in the country. They are mainly involved in promotion, prevention, treatment and rehabilitation.</p> <p>INFORMATION GATHERING SYSTEM There is mental health reporting system in the country. Monthly reports are sent to the office of the Director, annual reports are sent to the office of the Assistant Secretary of the Primary Health Care and the Planning and Statistics Office. The country has data collection system or epidemiological study on mental health. The Ministry of Health and Environment have collected data from 1992-2000.</p> <p>PROGRAMMES FOR SPECIAL POPULATION The country has specific programmes for mental health for minorities, elderly and children. Mental health program and community outreach prevention and treatment program provide the services.</p> <p>OTHER INFORMATION The purposes of the National Mental Health Planning Council are 1) to serve as advocate for chronically mentally ill persons, 2) to monitor, review and evaluate not less than once a year, the allocation and adequacy of mental health services with the republic and 3) to carry out other activities that might be related to the purpose of the council.</p> <p>ADDITIONAL SOURCES OF INFORMATION 1. Government document (1997). By-laws of the RMI Mental Health Planning Council (a Standing Committee of the RMI Health Advisory Board)</p> |
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| MICRONESIA (Federated States of) | |
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| Health Policy | |
| MH Law | There is existing but 1970 based legislation for treating involuntary patients |
| MH Policy | |
| Health Structure | |
| MH Structure | MH & Sub. Abuse Management → Four States – each has Substance Abuse and Mental Health Council → MH service |
| Health Workforce | |
| MH Workforce | 53 positions paid for by USA 5 = national office; 14 = Chuuk; 3 = Kosrae; 11 = Yap; 10 = Pohnpei; 10 = NGO Pohnpei |
| Health & Other Education | College of Micronesia Provides a pre-nursing course (associate of liberal arts) Certificates in health Assisting & Assistant Medical Officers Currently developing their website potential NB Associated with PREL (Pacific Resources for Education & Learning an NGO serving educational community in US affiliated Pacific islands) |
| MH Education | |
| MH Programmes & Services | Community focus No inpatient facilities (jail used for safe care) No long-term care facility MH responsibilities span various groups: community action agency; public defender; police; schools; hospitals; courts. Drs and staff in state hospital have little MH expertise. Pohnpei State Active community MH centre <ul style="list-style-type: none"> - One patient can stay short term there - weekly clinic and outreach services - day programme - counseling and crisis phone services - education - Community health aides case find and supervise compliance Chuuk State <ul style="list-style-type: none"> - 20 MH workers provide weekly treatment and out-pt clinics - hospital on main island also has outpt clinic and outreach services Yap State <ul style="list-style-type: none"> - island wide system of outpt services - 4 staff of substance abuse and mental health unit provide patient care and family counseling sessions Kosrae State <ul style="list-style-type: none"> - multi-disciplinary team of counselors, nurses and police who do case finding, assessment and referral to hospital NGO in Pohnpei → youth delinquency and substance abuse <i>Plan</i> 5y - Maintain an organized community based system, improve community awareness re MH, develop an active prevention programme. |
| MH Issues | |
| Other Resources | POLHN computer lab. CoM Associated with PREL (Pacific Resources for Education & Learning an NGO serving educational community in US affiliated Pacific islands) |
| WHO ATLAS | POLICIES AND LEGISLATION Mental Health Policy A mental health policy is present. The policy was initially formulated in 1986. The components of the policy are advocacy, promotion, prevention and treatment. Substance Abuse Policy |

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| | <p>A substance abuse policy is present. The policy was initially formulated in 1989.</p> <p>National Mental Health Programme A national mental health programme is present. The programme was formulated in 1989.</p> <p>National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1991.</p> <p>Mental Health Legislation Details about existing mental health legislation are not available. However, there is a tobacco law, all four states of Micronesia have passed the law making it illegal to sell tobacco to minors. This was formulated in 1994. Details about the year of enactment of the mental health legislation are not available.</p> <p>MENTAL HEALTH FINANCING There are budget allocations for mental health. The country spends 7.3 % of the total health budget on mental health. The primary sources of mental health financing in descending order are grants, social insurance, out of pocket expenditure by the patient or family and tax based.</p> <p>MENTAL HEALTH FACILITIES The country has disability benefits for persons with mental disorders. Mentally ill children of a state/federation employee are provided with a small benefit of \$50 if the parent dies. Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. Regular training of primary care professionals is carried out in the field of mental health. In the last two years about 21 personnel were provided training. The Hawaii State Hospital is the primary site for teaching clinical psychiatry to the Pacific Basin Medical Officer Training Program. Transcultural issues are discussed. There are community care facilities for patients with mental disorders. Community based care system is located in the villages.</p> <p>PSYCHIATRIC BEDS AND PROFESSIONALS Total psychiatric beds per 10 000 population 0.7 Psychiatric beds in mental hospitals per 10 000 population 0 Psychiatric beds in general hospitals per 10 000 population 0.7 Psychiatric beds in other settings per 10 000 population 0 Number of psychiatrists per 100 000 population 0 Number of neurosurgeons per 100 000 population 0 Number of psychiatric nurses per 100 000 population 2 Number of neurologists per 100 000 population 0 Number of psychologists per 100 000 population 1 Number of social workers per 100 000 population 4 There is 1 occupational therapist, 4 hospital administrators, 5 medical assistants, 12 medical officers and 4 other kind of staff.</p> <p>NON-GOVERNMENTAL ORGANIZATIONS NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention and rehabilitation.</p> <p>INFORMATION GATHERING SYSTEM There is mental health reporting system in the country. Quarterly and annual reports are made. The country has data collection system or epidemiological study on mental health. There is a mental health information system. This uses EPI and epidemiological surveillance system called MHIS.</p> <p>PROGRAMMES FOR SPECIAL POPULATION The country has specific programmes for mental health for minorities, disaster affected population, indigenous population, elderly and children. The whole population is composed of minorities and indigenous people (as per SAMHSA definitions).</p> <p>OTHER INFORMATION</p> <p>ADDITIONAL SOURCES OF INFORMATION 1. Bernstein, D., Young, D.M. (1996). Shrinking the Western Pacific: psychiatric training for medical students from Micronesia. Hawaii Medical Journal. 55(4), 70-1. 2. Government document (1994). Third Pohnpei Legislature, Fourteenth Special Session. 3. Rubenstein, D. H. (1992). Suicide in Micronesia and Samoa: A Critique of Explanations. Pacific Studies. 15(1), 51-75.</p> |
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| NAURU | |
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| Health Policy | |
| MH Law | |
| MH Policy | |
| Health Structure | |
| Health Workforce | |
| MH Workforce | |
| Health & Other Education | |
| MH Education | |
| MH Programmes & Services | |
| MH Issues | |
| Other Resources | Member nation of the University of the South Pacific |
| WHO ATLAS | <p>POLICIES AND LEGISLATION Mental Health Policy A mental health policy is absent. Substance Abuse Policy</p> |

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| | <p>A substance abuse policy is absent.</p> <p>National Mental Health Programme A national mental health programme is absent.</p> <p>National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1997.</p> <p>Mental Health Legislation The Mentally Disordered Persons Ordinance is the latest legislation. The latest legislation was enacted in 1963.</p> <p>MENTAL HEALTH FINANCING There are no budget allocations for mental health. Details about expenditure on mental health are not available. The primary source of mental health financing is tax based.</p> <p>MENTAL HEALTH FACILITIES The country does not have disability benefits for persons with mental disorders. Mental health is not considered a disability. Mental health is not a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. Treatment is available as part of curative services. Regular training of primary care professionals is not carried out in the field of mental health. There are no community care facilities for patients with mental disorders. Though there is a lack of community services, mentally ill persons are absorbed into the community.</p> <p>PSYCHIATRIC BEDS AND PROFESSIONALS Total psychiatric beds per 10 000 population 0 Psychiatric beds in mental hospitals per 10 000 population 0 Psychiatric beds in general hospitals per 10 000 population 0 Psychiatric beds in other settings per 10 000 population 0 Number of psychiatrists per 100 000 population 0 Number of neurosurgeons per 100 000 population 0 Number of psychiatric nurses per 100 000 population 0 Number of neurologists per 100 000 population 0 Number of psychologists per 100 000 population 0 Number of social workers per 100 000 population 0 There are no mental health personnel in the country. There are no specified beds for psychiatry.</p> <p>NON-GOVERNMENTAL ORGANIZATIONS NGOs are not involved with mental health in the country.</p> <p>INFORMATION GATHERING SYSTEM There is no mental health reporting system in the country. The country has no data collection system or epidemiological study on mental health.</p> <p>PROGRAMMES FOR SPECIAL POPULATION There are no special services available.</p> <p>OTHER INFORMATION Suicide rates are on the increase in these islands and there is a need for mental health personnel.</p> <p>ADDITIONAL SOURCES OF INFORMATION</p> |
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| NEW CALEDONIA | |
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| Health Policy | |
| MH Law | |
| MH Policy | |
| Health Structure | |
| Health Workforce | |
| MH Workforce | |
| Health & Other Education | |
| MH Education | |
| MH Programmes & Services | |
| MH Issues | |
| Other Resources | |
| WHO ATLAS | <p>POLICIES AND LEGISLATION</p> <p>Mental Health Policy A mental health policy is absent. Legislation is also a component of the policy.</p> <p>Substance Abuse Policy A substance abuse policy is absent.</p> <p>National Mental Health Programme A national mental health programme is absent.</p> <p>National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is absent.</p> <p>Mental Health Legislation Details about the mental health legislation are not available.</p> <p>MENTAL HEALTH FINANCING There are budget allocations for mental health. Details about expenditure on mental health are not available. The primary sources of mental health financing in descending order are social insurance, private insurances and out of pocket</p> |

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| | <p>expenditure by the patient or family.</p> <p>MENTAL HEALTH FACILITIES There are disability benefits for persons with mental disorders. Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. Regular training of primary care professionals is not carried out in the field of mental health. There are community care facilities for patients with mental disorders. There are four centres for medico-psychiatry and for alcohol.</p> <p>PSYCHIATRIC BEDS AND PROFESSIONALS Total psychiatric beds per 10 000 population 16.8 Psychiatric beds in mental hospitals per 10 000 population 12.9 Psychiatric beds in general hospitals per 10 000 population 3.7 Psychiatric beds in other settings per 10 000 population 0 Number of psychiatrists per 100 000 population 5 Number of neurosurgeons per 100 000 population 0 Number of psychiatric nurses per 100 000 population 31 Number of neurologists per 100 000 population 1 Number of psychologists per 100 000 population Number of social workers per 100 000 population</p> <p>NON-GOVERNMENTAL ORGANIZATIONS NGOs are not involved with mental health care.</p> <p>INFORMATION GATHERING SYSTEM There is no mental health reporting system. There are no data collection system or epidemiological study on mental health. The Central Hospital carried out a study.</p> <p>PROGRAMMES FOR SPECIAL POPULATION There are specific programmes for mental health for disaster affected population and children.</p> <p>OTHER INFORMATION ADDITIONAL SOURCES OF INFORMATION</p> |
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| NIUE | |
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| Health Policy | |
| MH Law | Omnibus legislation situation but nothing for MH |
| MH Policy | <p>No policy and only one mention in a clause of existing Act. No recognition or understanding (needs promotion) No plans for MH policy review but there is recognition of growing AOD problems and depression. However no links made between AOD & MH Problems No ring fenced funding Need to involve Crown Counsels of Niue who are involved with legislation, policies etc – Senior Crown Counsel: Peleni Talagi; Crown Counsel: Sinahemana Hekau</p> |
| Health Structure | |
| Health Workforce | |
| MH Workforce | No MH trained professionals |
| Health & Other Education | <p>Nurses train in Fiji Has links with NZ nurse training</p> |
| MH Education | Nurses train in Fiji |
| MH Programmes & Services | <p>Police and health services work closely on MH</p> <p>Families and general community heavily involved. Only Health facility is the health centre. Cyclone devastated hospital, plans through NZaid to rebuild. Unclear what this means for mental health. Traditional means are used in these situations but not considered or encouraged medically Prison sometimes used to contain major psychotic episodes; general hospital bed may be used for depression. Serious cases sometimes transferred to NZ No community MH services No facilities nor inpatient beds</p> <p>Involuntary detention and treatment of MI with family consent is by practice not law</p> |
| MH Issues | |
| Other Resources | <p>Member nation of the University of the South Pacific USP Centre in Niue Not health related</p> <p>DVD very popular medium (players readily available)</p> <p>Workbooks, print material. Internet link is through the health centre to staff</p> <p>Internet access is affordable and reliable but computers struggle with weather</p> |
| WHO ATLAS | <p>POLICIES AND LEGISLATION Mental Health Policy A mental health policy is absent. Substance Abuse Policy A substance abuse policy is absent.</p> |

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| | <p>National Mental Health Programme A national mental health programme is absent.</p> <p>National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1998.</p> <p>Mental Health Legislation There is a Mental Health Act. New Zealand's mental health act is also used in the country. The latest legislation was enacted in 1969.</p> <p>MENTAL HEALTH FINANCING There are no budget allocations for mental health. Details about expenditure on mental health are not available. The primary source of mental health financing is tax based.</p> <p>MENTAL HEALTH FACILITIES The country has disability benefits for persons with mental disorders. There is a government budget support for disability benefits. Mental health is not a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level. Regular training of primary care professionals is not carried out in the field of mental health. There are no community care facilities for patients with mental disorders.</p> <p>PSYCHIATRIC BEDS AND PROFESSIONALS Total psychiatric beds per 10 000 population 0 Psychiatric beds in mental hospitals per 10 000 population 0 Psychiatric beds in general hospitals per 10 000 population 0 Psychiatric beds in other settings per 10 000 population 0 Number of psychiatrists per 100 000 population 0 Number of neurosurgeons per 100 000 population 0 Number of psychiatric nurses per 100 000 population 0 Number of neurologists per 100 000 population 0 Number of psychologists per 100 000 population 0 Number of social workers per 100 000 population 0</p> <p>NON-GOVERNMENTAL ORGANIZATIONS NGOs are not involved with mental health in the country.</p> <p>INFORMATION GATHERING SYSTEM There is mental health reporting system in the country. Mental health reporting is available only as a statistical information. The country has no data collection system or epidemiological study on mental health.</p> <p>PROGRAMMES FOR SPECIAL POPULATION There are no special services available.</p> <p>OTHER INFORMATION</p> <p>ADDITIONAL SOURCES OF INFORMATION</p> |
| | <p><u>Greatest Needs</u></p> <ul style="list-style-type: none"> - Policy makers need greater general awareness of MH and necessary and training and support. Need identified MH person in MoH - Clinical training (update on current medication and treatment) <p><u>WHO Project benefits:</u></p> <ul style="list-style-type: none"> - policy makers (Minister and Director of health, Public Service Commissioners responsible for health) <p><u>Most important Training needs:</u> doctors – recognition and management of MH; nurses – MH promotion + recognition and management of MH; health workers: understanding of MH problems and treatment; other (community members with interest in MH) – need education</p> <p><u>Educational preferences</u></p> <p><u>Modes</u></p> <ul style="list-style-type: none"> - study guides (English) - DVDs = very common!!!! - CD-Rom - Internet based material (via USP) - Summer schools (very positive) MIX - Group discussions with other Pacific participants (very positive) MIX - Face-to-face contact with tutor/mentor - Ongoing support once course is over (very positive) MIX - NOTES <ul style="list-style-type: none"> o Suggests includes NZ based Niuean in teaching o Policy level people often not computer literate o Limited computer availability (mainly in hospitals/Dept of Health) <p><u>Contact</u></p> <ul style="list-style-type: none"> - telephones (most have but problems with connections) - mail not as regular as previously (also have courier service) - internet discussion (fast connection) - email (quite common) <p>DVD very popular medium (players readily available)</p> <p><u>Workbooks, print material. Internet link is through the health centre to staff</u></p> <p><u>Internet access is affordable and reliable but computers struggle with weather</u></p> <p><u>Would like to participate with Cook Islands and Samoa in such a programme</u> <u>Need to canvas support from Dept. of Health, government and Public Service Commission</u></p> |

| NORTHERN MARIANA ISLANDS (Commonwealth of) | |
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| Health Policy | |
| MH Law | Involuntary Civil Commitment Act of 1993 (inpatient – no compulsory out patient treatment legislation) (Law Report, 1998) |
| MH Policy | |
| Health Structure | Department of Public Health Division of Mental Health and Social Services (Herbert Yamada) Community Guidance Centre CGC |
| Health Workforce | |
| MH Workforce | See below for CGC staff Inpatient Unit has 14 staff – C/N, 8 R/N, 4 A/N, 1 practice nurse Other Division Staff: (Law Report, 1998) 2x Psychiatrists 2x Clinical Psychologists 1 Psycho-metrician 1 S/W |
| Health & Other Education | Northern Marianas College NMC associated with PREL (Pacific Resources for Education & Learning an NGO serving educational community in US affiliated Pacific islands) Has online component to programme Associate Degree – Nursing Certificate – Nursing Assistant The University of Guam (UOG) College of Nursing and Health Sciences offers a BSN degree as well as a degree completion program for LPNs and RNs. The college had been offering distance education courses and continuing education via PEACESAT since 1993 under a US federal grant and a grant from the Sasakawa Foundation. Courses were provided to US affiliated countries and the <u>Commonwealth of the Northern Mariana Islands</u> . |
| MH Education | |
| MH Programmes & Services | Community Guidance Centre: - Psychiatric Mental Health - Behavioral Mental Health - Substance Abuse/Addiction Community Service (individuals and families) Outlying islands (Rota & Tinian). Outreach services to public/private schools and agencies The team of health care providers and counselors includes psychiatrists, a psychologist, outpatient nurse, substance abuse/addiction counselor, and mental health counselor, social worker and support staff. From Law Report 1998 10 bed Inpatient Unit (Saipan) [6 beds = L/T patients; 2 beds OOS] Outpatient Service for those with Serious MI from there CGC is from Division Offices |
| MH Issues | Drugs – Meths |
| Other Resources | |
| WHO ATLAS | POLICIES AND LEGISLATION Mental Health Policy A mental health policy is present. The policy was initially formulated in 1976. The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. Substance Abuse Policy A substance abuse policy is present. The policy was initially formulated in 1976. National Mental Health Programme A national mental health programme is present. The programme was formulated in 1976. National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is absent. Mental Health Legislation In addition to the Involuntary Civil Commitment Act of 1993, there is also an existing legislation regarding the family (in particular, the Domestic Violence Protection Act - Public Law 12-19 of 2000). There are also various laws on patient's rights. The latest legislation was enacted in 1993. MENTAL HEALTH FINANCING There are budget allocations for mental health. Details about expenditure on mental health are not available. The primary sources of mental health financing in descending order are tax based, social insurance, grants, private insurances and out of pocket expenditure by the patient or family. MENTAL HEALTH FACILITIES There are disability benefits for persons with mental disorders. An individual must be certified by a licensed psychiatrist to receive disability benefits. Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. Primary care is available only for stabilised patients after hospital treatment is over. |

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| | <p>Regular training of primary care professionals is not carried out in the field of mental health. There are community care facilities for patients with mental disorders. A community mental health service was established and funded under local and US grants.</p> <p>PSYCHIATRIC BEDS AND PROFESSIONALS Total psychiatric beds per 10 000 population 1.4 Psychiatric beds in mental hospitals per 10 000 population 0 Psychiatric beds in general hospitals per 10 000 population 1.4 Psychiatric beds in other settings per 10 000 population 0 Number of psychiatrists per 100 000 population 4 Number of neurosurgeons per 100 000 population 0 Number of psychiatric nurses per 100 000 population 8 Number of neurologists per 100 000 population 0 Number of psychologists per 100 000 population 5 Number of social workers per 100 000 population 9.7 Occupational therapists provide services to children and youth with development disabilities. Recreational activities are also present.</p> <p>NON-GOVERNMENTAL ORGANIZATIONS NGOs are involved with mental health care. They are mainly involved in advocacy, promotion and prevention.</p> <p>INFORMATION GATHERING SYSTEM There is mental health reporting system. There are data collection system or epidemiological study on mental health. Data collection on inpatients and outpatients is done.</p> <p>PROGRAMMES FOR SPECIAL POPULATION There are specific programmes for mental health for disaster affected population and children. The American Red Cross helps disaster affected population. Children and students with special needs are provided services under the public school system special education program.</p> <p>OTHER INFORMATION ADDITIONAL SOURCES OF INFORMATION 1. Commonwealth Health Centre (2000). Purpose and Philosophy.</p> |
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| PALAU | |
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| Health Policy | |
| MH Law | 72 Hour Detention and Evaluation Act and Chapter 5, Mental Illness of Title 34 of Palau National Code |
| MH Policy | <p>Not a MoH priority Reliant on external funding and technical assistance.</p> <p>Does promote least restrictive treatment.</p> <p>Has a 10 member govt. appointed MH Council – advocates, plans, promotes, monitors, evaluates, and advises</p> |
| Health Structure | Outlying areas served by dispensaries – health assistants trained in Primary care, but no phone/radio contact with hospital |
| MH Structure | Ministry of Health → Bureau of Public Health → Division of Behavioral Health = responsible for MH services: provide treatment for MI and SA, promote MH, prevent SA |
| Health Workforce | |
| MH Workforce | 1x psychiatry MO 1x public health nurse supervisor 3x outpt nurses 7x Inpt nurses 2x S/W 1x Addiction Tx supervisor 2x Addiction Tx counselors 1x counselor asst. |
| Health & Other Education | |
| MH Education | |
| MH Programmes & Services | Belau National Hospital <ul style="list-style-type: none"> - Inpt service with 24h nursing 8 patients, including 4 secure) - Out-pt service - Psych day programme - Outreach services <p>Does promote least restrictive treatment.</p> <p>Relies on extended family system</p> <p><i>Recently conducted community assessment has data for improving service Plan for this needs developing</i></p> |
| MH Issues | |

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| Other Resources | POLHN computer lab. |
| WHO ATLAS | <p>POLICIES AND LEGISLATION</p> <p>Mental Health Policy A mental health policy is absent. The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. The executive summary of the Mental Health Plan 2001 outlines programs for adults, children and technical assistance needs.</p> <p>Substance Abuse Policy A substance abuse policy is absent.</p> <p>National Mental Health Programme A national mental health programme is present. Details about the year of formulation of the programme are not available.</p> <p>National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is absent.</p> <p>Mental Health Legislation There are different legislation in the field of mental health of which RPL 349 amends a previous legislation by adding provisions for non-judicial, involuntary 72-hour detention period for purposes of evaluation, diagnosis and treatment of mental illness and for other purposes. The latest legislation was enacted in 1991.</p> <p>MENTAL HEALTH FINANCING There are no budget allocations for mental health. The country spends 2% of the total health budget on mental health. The primary sources of mental health financing in descending order are tax based and grants.</p> <p>MENTAL HEALTH FACILITIES The country does not have disability benefits for persons with mental disorders. Until now there are no benefits, but soon a bill will be passed which will provide for disability benefits for mentally ill as well as others. Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. Regular training of primary care professionals is not carried out in the field of mental health. There is some training facilities for the areas of substance abuse but none for other mental health services. There are community care facilities for patients with mental disorders.</p> <p>PSYCHIATRIC BEDS AND PROFESSIONALS Total psychiatric beds per 10 000 population 4.7 Psychiatric beds in mental hospitals per 10 000 population 0 Psychiatric beds in general hospitals per 10 000 population 4.7 Psychiatric beds in other settings per 10 000 population 0 Number of psychiatrists per 100 000 population 5 Number of neurosurgeons per 100 000 population 0 Number of psychiatric nurses per 100 000 population 10 Number of neurologists per 100 000 population 0 Number of psychologists per 100 000 population 0 Number of social workers per 100 000 population 10</p> <p>NON-GOVERNMENTAL ORGANIZATIONS NGOs are involved with mental health in the country. They are mainly involved in advocacy.</p> <p>INFORMATION GATHERING SYSTEM There is mental health reporting system in the country. There are monthly reports to the Ministry. The country has data collection system or epidemiological study on mental health. Data are compiled every month. Details about patients and service utilization are available from the Behavioural Health Division's report.</p> <p>PROGRAMMES FOR SPECIAL POPULATION Free medicines and counselling are provided to prisoners. A program for substance abuse exists.</p> <p>OTHER INFORMATION</p> <p>ADDITIONAL SOURCES OF INFORMATION 1. Government document (2001). Mental Health Plan. Executive Summary.</p> |

| PAPUA NEW GUINEA | |
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| Health Policy | |
| MH Law | 1960 Mental Health Law not revised since promulgation |
| MH Policy | <p>5y plan:</p> <ul style="list-style-type: none"> - develop training package for doctors and nurses - create a diagnosis and treatment manual for health professionals - train more specialists in MH - improve post-grad psychiatric training to international standards <p>Not yet accepted or approved.</p> <p>No plans or strategies around MH Not a health priority (priorities are HIV, TB, malaria, maternal mortality) Lip service Lock and detain policy (custodial care model) No rights for patients World Bank has financed health initiative and MH not mentioned</p> <p><i>Suggests collaborative approach between countries, training of trainers approach, HR for training be shared among Pacific countries, regular short-term training for MH specialties be available. WHO HR Report</i></p> |

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| Health Structure | Department of Health → Technical & Health Services → Principal Advisor Social Change & Mental Health → Mental Health Services (<i>one of most active sections in Dept. with strong recognition and priority given to MH – Dr Goiba Tienang</i>) |
| Health Workforce | District hospitals and clinics made up of 400 Drs 1000 nurses |
| MH Workforce | 6x qualified Psychiatrists (concentrated in PM with limited reach into other areas) located in hospital only 3x psychiatrists in training 90x trained psychiatric nurses BUT only about 30 doing MH work 4x OT and rehabilitation officers 1x MH S/W 2x staff with Masters in MH 1x staff in final stage of PhD in MH 50% of nurses have little or no MH post basic qualifications 50% do have some such training |
| Health & Other Education | University of Technology Sydney and College of Health Sciences (PNG) have collaboration in nursing. AusAID sponsored a project that envisaged centers with computers for student access (1) within Fiji, and the Lautoka center was developed; (2) in other countries. However, only three people are currently enrolled, it is reported. It is also said that the distance learning postgraduate students lack supervision. The project envisaged creating a lifelong education capacity within FSM on behalf of doctors, but staff is lacking. The project has a link to the University of Papua-New Guinea in Port Moresby. (H) <u>Health related educational institutions</u> UPNG Pacific Adventist Uni (very good) 3 y diplomas provided by: Lutheran School of Nursing Highlands Regional College of Nursing Uunapopa School of Nursing 6x schools running community health worker (=E/N) programmes |
| MH Education | Lots of activity in HR development – training psychiatrists and nurses Emphases on - community awareness of MH - training of general medical staff in provincial/district hospitals - psycho-social rehabilitation Need greater emphasis on counseling skills but culturally is difficult Need greater post basic training around communication, stigma/fear reduction University of Papua New Guinea 1y course in psychiatric nursing – Advanced Diploma in MH Nursing (teaches for other countries also) 4y Masters in Medicine Doctors leave country for specialist Link with Newcastle University (Australia) Psychiatry post-grad for Doctors (but staffing problems are issues) Plus regular short courses in MH Biannual MH conference Laloki Psychiatric Hospital Training for rural health workers (since 2000) WHO programme with primary care workers/Drs |
| MH Programmes & Services | Approx. 100 beds in country Capital Services Laloki Psychiatric Hospital (Port Moresby) 38 beds; no outpts services prison like No F/T Drs and staff by visiting Psychiatrists from PM General Hospital Fairly institutionalized arrangements and limited therapy. Issues of transport and costs to get patients to this unit (and ensure they can get back home!) Port Moresby General Hospital Wd 6: 10 inpt beds; outpt services = just a dormitory and desk for nurse <i>NB new ward lost to other services, plans for redevelopment of comprehensive facilities but lack of \$\$</i> Child Guidance Unit just starting Bomano Correctional Facility Provides temp. care of milder MI PNG Psychosocial Rehab Centre in the Community (Port Moresby) Care for 10 outpts Heavily reliant on philanthropy an MHF support Work and life rehab; family support; education and awareness, MH promotion Provincial Services Lae, Morobe = 8x beds (4 each sex) + seclusion with 2 MH Nurses and 1x psychiatrist in admin Madang, Madang = 4 beds with 1 MH nurse |

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| | <p>Wewak, East Sepik = 8-10 beds with 2 MH nurses Goroka, Eastern Highlands = 2 beds with 1 MH nurse Simbu, Central Highlands = 3-4 beds with 2 MH Nurses Abaul, East New Britain & Mount Hagen, Western Province = closed units</p> <p>3x NGOs involved in MH advocacy MHF (family violence prevention) Centre for Domestic Violence</p> <p>Private company – PNG Counselling and Care (public and commercial clients)</p> <p>MH not openly discussed at local level but community supportive to a point Family provide community level care Local care depends on nurse in area Psychiatrists have no impact (and don't directly assist nurses) only based in hospital Next level up is church and such organizations Hospital or prison if severe 4 regional hospitals have MH ward but very prison like Nurses, midwives, child health workers deliver care – 90% of care overall</p> |
| MH Issues | <p>FSPI project on male youth mental health Current security situation is factored heavily into MH Alcohol Drug abused, domestic violence big issues HIV consumers have inadequate psychosocial support or counselling</p> |
| Other Resources | <p>Private company – PNG Counselling and Care (public and commercial clients)</p> <p>AusAID sponsored a project that envisaged centers with computers for student access (1) within Fiji, and the Lautoka center was developed; (2) in other countries. However, only three people are currently enrolled, it is reported. It is also said that the distance learning postgraduate students lack supervision. The project envisaged creating a lifelong education capacity within FSM on behalf of doctors, but staff is lacking. The project has a link to the University of Papua-New Guinea in Port Moresby. (H)</p> <p>Radio Telephone Network – HEALTH NET New and very sophisticated radiotelephone set at the Laloki hospital. = part of the Healthnet supplied by AUSAID in the past year to most hospitals and some clinics in PNG. It is similar but more sophisticated than those in other island nations of the Pacific. However, it was used only about 4 or 5 times in the past year for mental health related queries from other provinces. With psychiatric nurses working in isolation in many parts of the country the almost cost free radio-telephone could be used for tele-psychiatric consultation and training to enhance the quality of care and provide valuable support for mental health staff facing difficult problems in care.</p> |
| WHO ATLAS | <p>POLICIES AND LEGISLATION Mental Health Policy A mental health policy is present. Details about the year of formulation are not available. The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. Substance Abuse Policy A substance abuse policy is absent. National Mental Health Programme A national mental health programme is present. The programme was formulated in 1962. There is also a Mental Health and Social Change Program 2001-2010 which has the following priorities: review and update of the Public Health Act; increase staffing and training of psychiatric nurses; establish psychiatric units at all public hospitals; establish four regional referral and supervising units at level 2 hospitals; upgrade Laloki Mental Hospital; improve intersectoral collaboration in forensic psychiatry, domestic violence against women and the control and prevention of substance abuse; improve community knowledge and skills to support community mental health programs; expand community mental health programs and improve monitoring and reporting. National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1950. Mental Health Legislation There is a Public Health Act with certain sections on mental health. The latest legislation was enacted in 1985. MENTAL HEALTH FINANCING There are budget allocations for mental health. The country spends 0.7 % of the total health budget on mental health. The primary source of mental health financing is tax based. MENTAL HEALTH FACILITIES The country does not have disability benefits for persons with mental disorders. Mentally ill patients are cared for by their relatives with no support from the government. Mental health is not a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. Regular training of primary care professionals is carried out in the field of mental health. Training of primary care professionals such as Health Extension Officers is part of their curriculum. Formal training of mental health in primary health care for workers in districts are in place. There are no community care facilities for patients with mental disorders. Community care is provided only for known patients on medications prescribed by psychiatrist.</p> |

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| | <p>PSYCHIATRIC BEDS AND PROFESSIONALS Total psychiatric beds per 10 000 population 0.24 Psychiatric beds in mental hospitals per 10 000 population 0.17 Psychiatric beds in general hospitals per 10 000 population 0.07 Psychiatric beds in other settings per 10 000 population 0 Number of psychiatrists per 100 000 population 0.09 Number of neurosurgeons per 100 000 population 0 Number of psychiatric nurses per 100 000 population 1.2 Number of neurologists per 100 000 population 0 Number of psychologists per 100 000 population 0 Number of social workers per 100 000 population 0.04 There is a lack of trained staff. Psychiatric facilities are limited. There are inpatient psychiatric facilities in only three hospitals. Since 1999, all hospitals have got psychiatric services. In seven provinces psychiatric services are provided by psychiatric nurses and in the remaining nine provinces by general physicians or general health workers. Formal training conducted in 1999 and 2000 have produced a minimum of one physician in each hospital (total 19) with sufficient skills to handle mental health problems.</p> <p>NON-GOVERNMENTAL ORGANIZATIONS NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation.</p> <p>INFORMATION GATHERING SYSTEM There is no mental health reporting system in the country. National Department of Health's forms on reporting have no provision for mental health. The country has no data collection system or epidemiological study on mental health.</p> <p>PROGRAMMES FOR SPECIAL POPULATION There are services for prisoners and also for other forensic services. Special programmes for armed forces/ Defence Force of Papua New Guinea are ongoing (2001). Rehabilitation programmes for chronic mental illness are in place. Programmes for school children are ongoing.</p> <p>OTHER INFORMATION Promoting materials such as posters, video, community awareness tape are available, street awareness programs, newspaper articles, radio talk shows are some of the array of success funded by National Department of Health.</p> <p>ADDITIONAL SOURCES OF INFORMATION 1. Noble, F. (1997). Long-term psychiatric care in Papua New Guinea. <i>Psychiatric Bulletin</i>. 21, 113-116.</p> |
| | <p>Nurses would benefit most from training as they provide bulk of care Resident doctors also Important training needs: doctors – clinical training; nurses (and health workers) – clinical training, behavioural management Educational Preferences Modes</p> <ul style="list-style-type: none"> - XX study guide = literacy low - XX audio – prefer visual - ++ MIX Video – successful especially if locals are used - XX internet and computing – few computers and poor internet access - ++ MIX Summer schools – good with role plays - ++ MIX Group discussions – enjoy sharing experiences - ++ Face-to-face mentor/tutor but needs to be pitched at appropriate levels - MIX ongoing support/contact <p>Communication for support</p> <ul style="list-style-type: none"> - Mail (but lack of money to pay postage) - XX telephones often cut off - Internet based systems not reliable <p>Internet poor Piloting and pre-testing vital Would like to undertake with Solomon Island as linked culturally and best fit 850 languages – prefer in English but varying competencies</p> |

| SAMOA | |
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| Health Policy | <p>5y Strategic Health Plan but no MH plan as such Interview</p> <ul style="list-style-type: none"> ➤ A National Policy for Mental Health Services is still in the developmental stage and a first draft is being completed at this point. ➤ Funding is an issue, as Mental Health has to compete with other services that are defined as priority by government e.g. diabetes. <p>Needs MH policy MH needs place at strategic level Has goals relating to appropriately trained workforce</p> <ul style="list-style-type: none"> - post graduate training for Drs and nurses - management - IT training <p><i>Goals to reform MH legislation, gather political and aid agency support, create a MH Bd Want to increase/develop workforce, plus study opportunities (scholarships and accessible courses) and create motivation in field via rewards/incentives. WHO HR Report</i></p> |
| MH Law | Mental Health Ordinance 1961 |

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| | <p>Needs reviewing (NB Att. Gen. Believes that this could be technically amended as interim to account for outreach/primary care Policy should inform this Needs to account for international obligations</p> <p>2003 M/R identifies that plan for developing MH policy and reviewing MH legislation already underway as part of Health Sector Reform Health Legislative Work Programme (MoH + Att. Gen. = Samoa Health Sector Management Project (funded by World Bank; WHO seeking to collaborate) 2003 M/R provides comprehensive assessment of Samoan MH law and examines necessary revisions and process Pacific Islands Project PIP funded by AusAID psychiatrist to visit 2/52 for service development and education Interview</p> <ul style="list-style-type: none"> ➤ The Mental Health Legislation is currently under review as part of health legislation reviews for the REFORMS. |
| MH Policy | <p>5y Strategic Health Plan but no MH plan as such (as above) Interview</p> <ul style="list-style-type: none"> ➤ A National Policy for Mental Health Services is still in the developmental stage and a first draft is being completed at this point. ➤ Funding is an issue, as Mental Health has to compete with other services that are defined as priority by government e.g. diabetes. <p>Needs MH policy MH is neglected</p> <p>2003 M/R identifies that plan for developing MH policy and reviewing MH legislation already underway as part of Health Sector Reform Health Legislative Work Programme (MoH + Att. Gen. = Samoa Health Sector Management Project (funded by World Bank; WHO seeking to collaborate) Pacific Islands Project PIP funded by AusAID psychiatrist to visit 2/52 for service development and education</p> <p>MH SitRep suggests need for comprehensive MH Strategy, Policy and Service/Care Framework. Says that a Draft MH Policy is being consulted on by MH staff</p> |
| Health Structure | <p>Highly developed primary health care system Health system in the process of being restructured and organizational realignment occurring. Plan is to build a unit in main hospital for MH clients which is secure Community MH model which is family based is working well Upolo = 1x Main Referral Hospital + 2 district hospitals // Suvai'i → 1x referral + 1x district hospital → District Health Officers and Nurses (few in no.) Drs responsible for 7 health centres (serving 2-3 sub-centres) = 2-3 R/N/2-3 E/N and 14 sub-centres (serving 6-10 villages) = E/N → Komiti Tumama (Women's Committees) [& traditional healers] set up a health sub-centre in every village (visited daily by nurse/weekly by Dr)</p> <p>Private health sector developing</p> |
| Health Workforce | <p>56 Dr 248 RNs 100 E/N 50 midwives</p> <p>Critical nursing shortage</p> |
| MH Workforce | <p>M.O 3x MH nurses (MH trained) (2003) No specialist psychiatrist</p> <p>Staff reluctant to work in MH No trained staff, poor knowledge of care, MI abused</p> <p>Visiting psychiastract 2/52 year</p> |
| Health & Other Education | <p>National University of Samoa Diploma in Nursing (Enrolled) Bachelor of Nursing (Registered) (includes MH component) Has a Virtual Classroom mode available for distance learning NUS is collaborating with MoH to provide a data and videoconference link to the PEACESAT network in American Samoa to enable students to access online course from either the college or from the LAN at the Ministry. It will also provide the opportunity to use telemedicine to improve health services in Samoa. NUS has two computer laboratories available for students upon request. Plans are to provide each student with their own email account in the near future. There is also a computer laboratory at the National University of Samoa (NUS) for nursing school faculty and students to use. Faculty have access to computers at the nursing school and there is some use of CDs by the faculty. In addition, there are plans to provide a videoconference unit and Internet access to the school. None of the faculty are taking part in any on-line course at present but one member has experience with on-line training. The university has set up a committee to develop a plan for the use of distance learning.</p> <p>A videoconference facility is also being installed at the hospital and there are plans for one at the university as well (see below).</p> <p>Offers the regional postgraduate certificate on Pacific Health Leadership and Management Development, with the support of the Pacific Regional Consortium, which includes University Of Guam, and the National University Of Samoa. The program is co-funded by the SPC and WHO.</p> <p>Many of the medical professionals in leadership in the MoH are looking to the new videoconference network (VTC) and the increased Internet access through the PEACESAT link as opportunities to improve in-service training for health care workers as</p> |

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| | <p>well as provide for increased use of telemedicine to assist in diagnoses and referral.</p> <p>The Director General of Health has already used the VTC to conduct meetings with personnel from the LBJ Tropical Medical Center in Pago Pago, American Samoa. His vision is to use the newly available technologies for continuing medical education beginning with postgraduate education as well as for telemedicine applications. Discussions have been initiated with the University Without Walls in Sydney, FSM, and Australian Medical Schools to develop Internet based training for health care professionals.</p> <p>Party of the University of the South Pacific</p> |
| MH Education | <p>National University of Samoa School of Nursing <u>Post-Graduate Diploma in MH.</u> Practitioners working without Drs</p> <ul style="list-style-type: none"> - diagnose and manage (within competencies) - teach and supervise - work with MO to provide best care - promote MH and prevent MI - Focus on clinical practice and service <p>Ms Iokapeta Enoka is the Lecturer in Mental Health and Nursing in the Faculty of Nursing, National University of Samoa.</p> <p>Little MH component in training</p> <p>Pacific Islands Project PIP funded by AusAID psychiatrist to visit 2/52 for service development and education</p> <p>DEVELOPMENT OF MENTAL HEALTH EDUCATION</p> <ul style="list-style-type: none"> ◆ A course in Mental Health & Mental Ill Health for the undergraduate degree program is included in the curriculum. ◆ Mental Health is one of specialty area in nursing. ◆ Postgraduate Diploma in Mental Health was offered this year 2004 by Faculty. ◆ Competency standards have also been developed for specialist practice. <p>Interview Training needs</p> <ul style="list-style-type: none"> ➢ Strategic Leadership and management/organization training; ➢ Clinical skills; diagnosis/early recognition, treatment/management; ➢ Teaching ➢ Health promoting skills |
| MH Programmes & Services | <p>Community Programme run by staff of MH Unit, Tapua Tamasese Meaole Hospital, Apia (no inpatient service – use general hospital beds or police cells; closed 10y ago to deliberately focus on community based care) does run some daycare. Occasionally severe cases may be admitted to general hospital (or police cells).</p> <p>From Interview</p> <ul style="list-style-type: none"> ➢ Traditional Healers, are usually invited by families to come to their homes to heal or treat someone deemed to be mentally ill. ➢ Clinics refer patients to main hospital under the care in the mental health unit for: Intensive treatments/therapy for up to 2 weeks and then discharged for care at home and followed-up by unit staff. ➢ If longer term continuing care or supervision is needed the community health nurses take over and only refer to mental health unit for reassessment or if further help is needed. ➢ There is no long-term psychiatric hospital. <p>M.O + 2 nurses (not MH trained) + 0.5 specialist psychiatrist (2003) do rounds on 2 main islands for f/u and new referrals (visit each centre every month BUT Drs there are stretched) Assess, treat and follow up in homes. Network and delegate ongoing care to a team of senior R/Ns (most have some training in recognizing and treatment of MI; treatment protocols available) in district hospitals and rural health centres who in turn work with nurses and women committees in sub-centres Nurses can prescribe Promotes family care and involvement. Transport for outreach programme broken down. Care mostly custodial. Psychotic emergencies and violent behaviours → locked up in jail Little support from other health professionals Therapies are culturally inappropriate</p> <p>Primary care providers keen for assistance and upskilling in management & treatment NGOs: Komiti Tumama (Women’s Committees) and churches keen to be upskilled in basic MH support Traditional Healing Organisation also keen to be involved</p> <p>FLO – Faataua le Ola – suicide prevention/awareness gp and international lifeline</p> <p>MH Sit Rep suggests supporting primary healthcare in larger roles with MH and development of specialist services</p> |
| MH Issues | <p>Keen for this to be given greater priority Inaccessibility: Transport for outreach programme broken down. Limited availability of medicines Lack of training for drs and nurses Suicide AOD</p> |

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| | <p>Little support from other health professionals Therapies are culturally inappropriate Stigmatisation Family neglect</p> |
| Other Resources | <p>POHLN Computer lab Member nation of the University of the South Pacific The campus in Apia is connected to USPNet's videoconferencing and data network. Provides access for email and Internet access. The current network is utilized for audio conferencing and videoconferencing to support USP's distance learning courses.</p> <p>The videoconferencing system allows for two way point to point connections as well as point to multi-point connections. Courses can be broadcast from Samoa to multiple other sites and the campus can engage in multipoint videoconferencing. In addition, Internet access is provided for faculty and students. There is one computer laboratory with 10 computers to serve the 100 students faculty at the USP campus. Videoconferencing is not used as frequently as audio conferencing. Currently, a few 400 courses are being delivered through a combination of face-to-face instruction over a period of four weeks with follow up support on student projects being delivered at a distance. USP is also experimenting with a software platform for on-line learning, WebCT.</p> <p>Current Samoa Health Project Team (AUSAid project) developing health policy etc is interested in integrating MH into process</p> <p>AUSAid funding and managing HIS Staff need more training</p> <p>The hospital in Apia has a basic Local Area Network (LAN) providing network and internet access to health care providers at the hospital. There is a PC located in the doctors' common room at the hospital and there are nine to ten PCs in the training room.</p> <p>There are 102 computers in the Ministry of Health.</p> <p>A videoconference facility is also being installed at the hospital and there are plans for one at the university as well. The videoconferencing (VTC) service is a low cost service that ties into the PEACESAT network in American Samoa. The Ministry is excited about connecting to this network because it will allow videoconferencing to any other facility with videoconferencing capability through a bridge in Honolulu. Most of the medical centers in Hawaii are on this network and low cost connections are available to VTC sites in American Samoa, Saipan and Rota in the Commonwealth of the Northern Mariana Islands, Fiji, the states of Chuuk, Kosrae, Pohnpei, and Yap in the Federated States of Micronesia, Guam, Palau, and Majuro in the Marshall Islands.</p> <p>Many of the medical professionals in leadership in the MoH are looking to the new videoconference network (VTC) and the increased Internet access through the PEACESAT link as opportunities to improve in-service training for health care workers as well as provide for increased use of telemedicine to assist in diagnoses and referral.</p> <p>The Director General of Health has already used the VTC to conduct meetings with personnel from the LBJ Tropical Medical Center in Pago Pago, American Samoa. His vision is to use the newly available technologies for continuing medical education beginning with postgraduate education as well as for telemedicine applications. Discussions have been initiated with the University Without Walls in Sydney, FSM, and Australian Medical Schools to develop Internet based training for health care professionals.</p> |
| Other MH Observations | <p>Has run a national symposium to increase MH awareness</p> <p>Interview Distance learning approaches</p> <ul style="list-style-type: none"> - CD-Rom - Internet - Email - Audio Visual |
| WHO ATLAS | <p>POLICIES AND LEGISLATION Mental Health Policy A mental health policy is absent. Substance Abuse Policy A substance abuse policy is absent. National Mental Health Programme A national mental health programme is absent. National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1994. There is a drug policy approved in 2001 and awaiting an implementation plan. Mental Health Legislation There is a Mental Health Law. The latest legislation was enacted in 1961. MENTAL HEALTH FINANCING There are no budget allocations for mental health. Details about expenditure on mental health are not available. The primary source of mental health financing is tax based. MENTAL HEALTH FACILITIES The country does not have disability benefits for persons with mental disorders. There are no disability benefits for mental illness or disabilities.</p> |

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| | <p>Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. Community based mental health service is family focussed.</p> <p>Regular training of primary care professionals is not carried out in the field of mental health. However, family care givers are receiving training. Community nurses working in the field have received focused short term (3 weeks) training sessions in 1998/99.</p> <p>There are community care facilities for patients with mental disorders. Community mental health care is family focussed and is completely provided by nurses.</p> <p>PSYCHIATRIC BEDS AND PROFESSIONALS</p> <p>Total psychiatric beds per 10 000 population 0.2</p> <p>Psychiatric beds in mental hospitals per 10 000 population 0</p> <p>Psychiatric beds in general hospitals per 10 000 population 0</p> <p>Psychiatric beds in other settings per 10 000 population 0.2</p> <p>Number of psychiatrists per 100 000 population 0</p> <p>Number of neurosurgeons per 100 000 population 0</p> <p>Number of psychiatric nurses per 100 000 population 0.5</p> <p>Number of neurologists per 100 000 population 0</p> <p>Number of psychologists per 100 000 population 0</p> <p>Number of social workers per 100 000 population 0</p> <p>NON-GOVERNMENTAL ORGANIZATIONS</p> <p>NGOs are not involved with mental health in the country. NGOs are involved in counselling and suicide awareness groups.</p> <p>INFORMATION GATHERING SYSTEM</p> <p>There is mental health reporting system in the country. There was an Annual Report by the Department of Health in 1997 & 1998.</p> <p>The country has data collection system or epidemiological study on mental health. A report is prepared every month and sent to the health planning and information section.</p> <p>PROGRAMMES FOR SPECIAL POPULATION</p> <p>The country has specific programmes for mental health for indigenous population, elderly and children. There are programmes to look after dementias in elderly and mental retardation and developmental problems in children and also victims of abuse and suicide.</p> <p>OTHER INFORMATION</p> <p>ADDITIONAL SOURCES OF INFORMATION</p> |
| | <p><u>Aiga – A partnership in Care through Continuous Collaboration</u></p> <p>A culturally appropriate perspective especially appreciating cultural beliefs, values, traditions and the nature of the Samoan being, that is, the Samoan person does not exist as an individual, but as in a collective context of identity and belonging, genealogical lineage, roles, responsibilities and heritage</p> <p>→ foundation of the culturally appropriate “family-focus community based mental health care service in Samoa.</p> <ul style="list-style-type: none"> ◆ AusAid and WHO funded two training sessions for RNs in mental health care. ◆ Mr. K. Kellehear – Consultant from UTS facilitated training which helped increase human resources for mental health care. ◆ Continuous in-service training conducted for small staff working in mental health care. <p>Model essentials:</p> <ul style="list-style-type: none"> – Knowledge of the beliefs, traditions, customs and values of the AIGA. – Strong understanding in the cultural background of the client and AIGA. – Willingness to go to the homes and be committed to the work. – Ability to communicate effectively and listen attentively to AIGA. <p>AIGA model influenced by systems theory and philosophy of nursing in Samoa:</p> <ul style="list-style-type: none"> – the AIGA model operates from the heart – true care begins at home – striving to help a Samoan person in the presence of the whole family to express what he or she is experiencing is “doing it the Samoan way” through sharing experiences and stories. <p>THE STRANDS OF MENTAL HEALTH CARE</p> <ul style="list-style-type: none"> ◆ Strand 1: Recognizing the need to change ◆ Strand 2: Use of AIGA (family) as strength of culture to facilitate care ◆ Strand 3: Integration of mental health care into community health nursing services ◆ Strand 4: Specialist mental health care <p>DEVELOPMENT OF MENTAL HEALTH EDUCATION</p> <ul style="list-style-type: none"> ◆ A course in Mental Health & Mental Ill Health for the undergraduate degree program is included in the curriculum. ◆ Mental Health is one of specialty area in nursing. ◆ Postgraduate Diploma in Mental Health was offered this year 2004 by Faculty. ◆ Competency standards have also been developed for specialist practice. <p>INTEGRATION OF MENTAL HEALTH INTO COMMUNITY HEALTH NURSING</p> <ul style="list-style-type: none"> ◆ Implementation of the AIGA model is expressed through specific roles characterizing Samoan nurses: <ul style="list-style-type: none"> – “pae ma auli” (peacemaker) counseling and advocating for families; problem-solving; – “faioa” (wealthmaker) collaborate with families promoting well-being and health; – “ositaulaga” (leader in worship) offer comfort through being there, encouragement during spiritual distress; – “taulasea” (healer) heal the physical, psychological and spiritual needs to achieve holistic care |

SOLOMON ISLANDS

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| Health Policy | Minister/Ministry of health has full responsibility for MH |
| MH Law | Have the Mental Health Ordinance 1970. Comprehensive but now needs reviewing (only plans no action) Covers visitors, voluntary patients, reception orders, temporary detention, discharge/transfer/removal of patients, judicial power |

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| | <p>over people with unsound mind.</p> <p>This act consolidates the law relating to persons of unsound mind and makes further and better provision for the care of persons suffering from mental disorders and for custody of persons and the management and control of mental hospitals. There is now an attempt to include community and primary care facilities incorporated into the act. The Act was amended in 1995 by two consultants and attempts are being made to get it passed by the parliament by 2002. It is a part of the mental health programme.</p> |
| MH Policy | <p>Draft document prepared 2001 – “Future Directions for Development of Mental Health in Solomon Islands – Situation Analysis and Future Plans (covers human resources, prevention/treatment/rehab objectives, MH promotion, law and policy development) towards a proposed MH Policy, Strategies and Action Plans</p> <p><i>5y Plan is to integrate MH into primary health care system via training general health personnel + formulating a national MH strategy and reviewing Mental Treatment Act.</i></p> <p><i>Suggests a regional institute for MH and ongoing support for training from aid agencies. WHO HR Report</i></p> <p><i>Very small MH budget in overall budget</i></p> <p>2004 plan MH Policy – (WHOS) MH Awareness training Pamphlets Internet Printing capability Renovate existing facilities Fund 12 extra positions Access some specialist training Funding of inpatient unit</p> |
| Health Structure | <p>National Referral Hospital + 5 regional hospitals → 14 area health centres → 123 health clinics → village health (61 nurse aid posts + 128 village health workers)</p> <p>Key is good radiotelephone links</p> <p>75% network = govt. run//25% church and industry.</p> <p>MH Services centralized in Kilu’ufi Hospital. Minimal rural services.</p> |
| Health Workforce | <p>26 Drs (15 in Nat. Ref. Hosp. and others widely dispersed)</p> |
| MH Workforce | <p>2003</p> <p>1x Dr (training to be Psychiatrist in PNG University)</p> <p>6x MH Nurses (3x Post Basic Psychiatric Nursing Cert. 3x Post-Grad Dip in Nursing with MH major)</p> <p>Interview indicates only 2 qualified MH nurses. Later 8 qualified (2 groups of 3xhospital and 2x in provinces)</p> <p>Need more qualified MH nurses</p> <p>1x nurse doing training at PNG University</p> <p>No MH support staff (OT/SW)</p> |
| Health & Other Education | <p>Undergraduate Nursing training in Honiara and Malaita</p> <p>No education linkages in health education except for PNG as below</p> <p>Regular training of primary care professionals is carried out in the field of mental health. In the last two years about 13 personnel were provided training. Some psychiatric health coordinators have been trained and the plan is to train all registered nurses and nursing aides throughout the country over a five year period. Only four personnel were provided training. The others still discharge some minimal health services. They need a follow up training as refresher training/workshop every two years. It is also included in the national mental health programme.</p> |
| MH Education | <p>MH component in undergraduate nurse training (50h theory & 1m practice)</p> <p>Specialist 1y-18m MH degree training in PNG → nurses sent (uses PNG for nurse training)</p> <p>Psychiatric medical training in PNG also</p> <p>Currently training nurses in MH for provinces without them</p> <p>Lack of money and suitable institutions. WHO HR Report</p> <p>Need training in counseling and also clinical assessment</p> |
| MH Programmes & Services | <p>There is some basic continuum of therapy from the acute care at the outpatient hospital clinics of some centres along with outreach services but they are erratic.</p> <p>Capital of Honiara has only a small outpatient clinic NOT associated/attached to National Referral Hospital</p> <p>MH Services centralized in Kilu’ufi Hospital in Malita Province.</p> <p>??? Closed down late 2002 due to lack of medicines. Continues with O/P service Interview indicates this is now open again</p> <p>This has a MH ward with 24 beds (14 male/10 female) to serve entire country</p> <p>National MH referral centre - Outside capital: 1951 = inpatient unit//1971 = MH unit (15 beds) added to new provincial hospital//1994 = 12 female beds added (27 total)// 2002 = unit closed! (Inpatient care often required arduous transport.)</p> <p>No long term inpatients</p> <p>Minimal rural services.</p> <p>Traditional approaches at village level to deal with MH care organized around aroa (spirit)</p> <p>MH Nurse coordinators appointed in provinces (manage minor cases, refer severely ill to unit) – system required WHO input in 1999 to reinvigorate (now in place in 7 of 9 provinces)</p> <p>Regional Variations/Initiatives:</p> <p>Choiseul: Care “tours” around provinces doing assessments, treatment, education and awareness and advice. Clearly shows need for more input.</p> <p>Temotu: Can admit to general hospital occasionally</p> <p>Care tours</p> |

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| | <p>No NGOs involved in MH care No elderly, child, adolescent AOD services No psycho-social rehab</p> <p>Problems with medication supplies</p> <p>MH SitRep suggested training of primary health team nurses in MH (just as they are in various others forms of healthcare)</p> <p>Strong emphasis on traditional means (and use for close knit communities and strong family bonds) for MH care especially for neurosis</p> <p>Nurses deliver bulk of care as no fully trained psychiatrists and only 1 doctor in training</p> |
| MH Issues | <p>?AOD (alcohol and cannabis for youth) Some problems with supply of drugs</p> <p><u>Issues</u> Drug abuse (alcohol, marijuana, home brew) Neurosis (pacing)\Depression Schizophrenia Bi-polar</p> |
| Other Issues | Transport among widely dispersed islands with small population |
| Other Resources | <p>Member nation of the University of the South Pacific</p> <p>Good radio-telephone system for health consultation (but underutilised for MH) 9 internet cafes with goal of 25 by the people first network. POLHN computer lab. This is not working – no-one who can fix problems or train potential users – concerned by this</p> |
| WHO ATLAS | <p>POLICIES AND LEGISLATION</p> <p>Mental Health Policy A mental health policy is absent. There are plans of drafting a mental health policy.</p> <p>Substance Abuse Policy A substance abuse policy is absent. There is no substance abuse programme, although it is a part of the national mental health programme.</p> <p>National Mental Health Programme A national mental health programme is present. The programme was formulated in 1999. It is a six year plan. Part of it was incorporated in the Ministry of Health's National Health Policies and Development Plans 1999-2003.</p> <p>National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. Details about the year of formulation are not available. The national drug policy was drafted in 1999 but has still not been ratified. However, it is being applied in functions related to essential drug program, dangerous drugs and psychotherapy, administration and reporting, poison registration and pharmaceutical personnel development and training.</p> <p>Mental Health Legislation There is a Mental Treatment Act. This act consolidates the law relating to persons of unsound mind and makes further and better provision for the care of persons suffering from mental disorders and for custody of persons and the management and control of mental hospitals. There is now an attempt to include community and primary care facilities incorporated into the act. The Act was amended in 1995 by two consultants and attempts are being made to get it passed by the parliament by 2002. It is a part of the mental health programme. The latest legislation was enacted in 1970.</p> <p>MENTAL HEALTH FINANCING There are budget allocations for mental health. The country spends 1.4 % of the total health budget on mental health. The primary source of mental health financing is tax based.</p> <p>MENTAL HEALTH FACILITIES The country does not have disability benefits for persons with mental disorders. There is no public disability benefit. The insurance system does not insure against mental illness. Mental health is a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level. There is some basic continuum of therapy from the acute care at the outpatient hospital clinics of some centres along with outreach services but they are erratic. Regular training of primary care professionals is carried out in the field of mental health. In the last two years about 13 personnel were provided training. Some psychiatric health coordinators have been trained and the plan is to train all registered nurses and nursing aides throughout the country over a five year period. Only four personnel were provided training. The others still discharge some minimal health services. They need a follow up training as refresher training/workshop every two years. It is also included in the national mental health programme. There are no community care facilities for patients with mental disorders. There is no proper therapeutic system. Nurses give injections to patients in rural areas.</p> <p>PSYCHIATRIC BEDS AND PROFESSIONALS Total psychiatric beds per 10 000 population 0.6 Psychiatric beds in mental hospitals per 10 000 population 0.6 Psychiatric beds in general hospitals per 10 000 population 0 Psychiatric beds in other settings per 10 000 population 0 Number of psychiatrists per 100 000 population 0 Number of neurosurgeons per 100 000 population 0</p> |

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| | <p>Number of psychiatric nurses per 100 000 population 1.5 Number of neurologists per 100 000 population 0 Number of psychologists per 100 000 population 0 Number of social workers per 100 000 population 0 There is a lack of specialists because of difficulties in getting through the advertisement and recruitment process.</p> <p>NON-GOVERNMENTAL ORGANIZATIONS NGOs are not involved with mental health in the country. However Richmond Fellowship has expressed a willingness to help in mental health services.</p> <p>INFORMATION GATHERING SYSTEM There is no mental health reporting system in the country. Currently mental health is not included in the Monthly Clinic Report System (Health Information System) but it would be reported in future and is a programme under the mental health programme. There is an annual mental health report by the Mental Health Division Heads which use standard reporting systems. The country has no data collection system or epidemiological study on mental health. A prevalence survey was tried unsuccessfully and would be retried again.</p> <p>PROGRAMMES FOR SPECIAL POPULATION There are no special services available.</p> <p>OTHER INFORMATION ADDITIONAL SOURCES OF INFORMATION</p> |
| | <p>People most benefit: Nurses, Physicians, MoH Critical training needs: doctors – clinical; nurses – clinical; govt. – MH policy Need facilities for training Education preferences Modes:</p> <ul style="list-style-type: none"> - written material; - internet based materials and teaching - group discussion with other Pacific participants - face-to-face contact with tutor/mentor - ongoing support once course over - mentoring re-identified as critical <p>Communication</p> <ul style="list-style-type: none"> - telephone - mail - internet discussion - email <p>Want to participate with other Pacific nations</p> |

| TOKELAU | |
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| Health Policy | |
| MH Law | |
| MH Policy | |
| Health Structure | There are 3 hospitals that help in primary and secondary treatment. There are no specific mental hospital or any specific psychiatric beds. |
| Health Workforce | There is only one medical officer and 4 general nurses to man each of the 3 hospitals on the 3 islands. |
| MH Workforce | |
| Health & Other Education | |
| MH Education | |
| MH Programmes & Services | |
| MH Issues | |
| Other Resources | Has access to telemedicine programme with MH component Member nation of the University of the South Pacific |
| WHO ATLAS | <p>POLICIES AND LEGISLATION</p> <p>Mental Health Policy A mental health policy is absent.</p> <p>Substance Abuse Policy A substance abuse policy is absent.</p> <p>National Mental Health Programme A national mental health programme is absent.</p> <p>National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1998.</p> <p>Mental Health Legislation There is no mental health legislation. Details about the year of enactment of the mental health legislation are not available.</p> <p>MENTAL HEALTH FINANCING There are no budget allocations for mental health. Details about expenditure on mental health are not available. The primary source of mental health financing is tax based. Funding for mental health is supported by New Zealand.</p> |

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| | <p>MENTAL HEALTH FACILITIES There are no disability benefits for persons with mental disorders. Mental illness is not considered as a criteria for disability. Mental health is a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level. Specialised opinion is received from New Zealand and local doctors treat accordingly. Regular training of primary care professionals is not carried out in the field of mental health. There are community care facilities for patients with mental disorders. Only stable patients are treated by community doctors and nurses.</p> <p>PSYCHIATRIC BEDS AND PROFESSIONALS Total psychiatric beds per 10 000 population 0 Psychiatric beds in mental hospitals per 10 000 population 0 Psychiatric beds in general hospitals per 10 000 population 0 Psychiatric beds in other settings per 10 000 population 0 Number of psychiatrists per 100 000 population 0 Number of neurosurgeons per 100 000 population 0 Number of psychiatric nurses per 100 000 population 0 Number of neurologists per 100 000 population 0 Number of psychologists per 100 000 population 0 Number of social workers per 100 000 population 0 There is only one medical officer and 4 general nurses to man each of the 3 hospitals on the 3 islands. There are 3 hospitals that help in primary and secondary treatment. There are no specific mental hospital or any specific psychiatric beds.</p> <p>NON-GOVERNMENTAL ORGANIZATIONS NGOs are not involved with mental health care.</p> <p>INFORMATION GATHERING SYSTEM There is mental health reporting system. There are no data collection system or epidemiological study on mental health.</p> <p>PROGRAMMES FOR SPECIAL POPULATION No specific programme exists for any special population group.</p> <p>OTHER INFORMATION ADDITIONAL SOURCES OF INFORMATION 1. Department of Health (2000). Bulk Store Drug Inventory, Drug Order Form. Government of Tokelau- Department of Health.</p> |
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| TONGA | |
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| Health Policy | <p>Ministry of Health's report, <i>Tonga's Health 2000</i> (Dec. 2000) identifies "...the maintenance of an appropriate skill base as one of the greatest challenges facing the Ministry currently." This includes MH clinicians and those working with MI. There is no plan for the training of healthcare professionals. The ministry does provide some short-term workshops and some scholarship funding has been available to send students overseas for both preservice and in-service training.</p> <p>Through a process that began in June 1999, five management and six health priority areas were identified for the Ministry of Health. The five management priority areas are 1) To significantly improve the efficiency and effectiveness of management in the Ministry of Health; 2) To improve and strengthen workforce management in the Ministry of Health; 3) To provide the Tonga Health System with an efficient and effective financial management system; 4) To provide the Tonga Health System with improved facilities and equipment and maintain them well; 5) To strengthen informed decision-making within the ministry through the provision of appropriate information management.</p> <p>The six health priority area plans include: 1) Preventing or delaying the onset of and complications from cardiovascular disease and diabetes; 2) Decreasing motor vehicle injuries in Tonga and improving the services available to manage them. 3) Improving health by ensuring equitable access to, and the rational use of, safe and effective, quality drugs. 4) Reducing dental decay. 5) Improving the management of chronic psychiatric patients. This area involves improving the mental health component training for all public health care nurses. 6) Identifying existing cancer cases and increasing the early detection of cancer.</p> <p>The Ministry primary foci are non-communicable diseases and health promotion.</p> |
| MH Law | <p>Mental health Act 1992. This is the only law enacted regarding "disability" as all other types are expected to be cared for at home by family/community.</p> <p>2004 bill passed to amend act problems with English translation.</p> |
| MH Policy | <p>Has Mental Health Committee No policies or strategies, structures, Ministries, co-ordination/collaboration re disability Draft social plan makes vague mention of assistance to "vulnerable" but no specific MH</p> <p style="color: red;">A plan would be most useful</p> <p>WHOMR – Mellsop (2001) Suggests the need for a National MH Policy & Strategy <u>Aims</u> to develop and maintain a culturally relevant, effective mental health promotion programme, decrease the prevalence of mental illness and mental health problems and reduce the impact of mental disorders and disability on patients, their families, and the general community <u>Strategies:</u> A. Increasing the skill base and availability of mental health relevant clinicians: available budget, health workforce structure & population → revolve around primary care health clinicians having the available skills to diagnose and manage most mental disorder and mental disability (A planned base for this was foreshadowed in the 1994 Puloka proposal). There also need to be a small nidus (critical mass) of specialised mental health workers to provide ongoing mental health clinical support, advice and occasional brief clinical management. I.e. Specialised secondary services should operate in a consultation liaison</p> |

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| | <p>model as well as running their own “secondary” services. B. All mental health services need to be developed within the Best Practice model and other aspects of a quality plan need to be developed. C. An appropriate cultural and family context, which balances personal rights with the public good, and takes account of the strong contributory role of the churches. D. Integrates a national drug and alcohol policy.</p> <p><u>Suggests:</u> As Tonga’s own small size, economical and geographical positions, will not allow the development and maintenance of large secondary, or any tertiary mental health expertise, it needs to develop an ongoing relationship with a body which can.</p> <p>(i) Supporting critical staff brief interchanges both ways, (ii) A “distance learning” staff development and supervision program could be developed using a video link.</p> |
| Health Structure | <p>4 hospitals including national referral centre in capital (MoH located there)</p> <p>All specialist services thru’ there.</p> <p>Other 3 hospitals = 61, 28, 16 beds</p> <p>→ 14 community health centres (CHC) with health officer + public health nurses → 34 maternal and child health clinics (MCH) with public health nurse</p> <p>MH is represented by a Psychiatric Unit within MoH with responsibilities as below. Other objectives include:</p> <ul style="list-style-type: none"> - Strengthen HR management and staff competencies (in-service/study abroad) - Active in all matters relating to mental health - Upgrade security for better patient management - Upgrade equipment - Amend/replace Mental Health Act, 1992 |
| Health Workforce | <p>74 doctors (some undertake specialty training overseas)</p> <p>339 nurses</p> <p>41 dental, 122 technical, 47 clerical, and 150 other personnel</p> <p>12 public health staff</p> |
| MH Workforce | <p>All attached to MH Unit (within MoH):</p> <p>1x Senior MO;</p> <p>7x psychiatric nurses</p> <p>8x psychiatric assts</p> <p>1x MH Welf. Officers</p> <p>1x MH S/W</p> |
| Health & Other Education | <p>Ministry of Health’s report, <i>Tonga’s Health 2000</i> (Dec. 2000) identifies “...the maintenance of an appropriate skill base as one of the greatest challenges facing the Ministry currently.” There is no plan for the training of healthcare professionals. The ministry does provide some short-term workshops and some scholarship funding has been available to send students overseas for both preservice and in-service training.</p> <p>The Acting Chief Nursing Officer indicated nurses are important to the education efforts of the MoH. They are often required to speak to patients and local community groups on family planning, immunization, childcare and other health issues. As a result, she believes they need additional training particularly in the areas of reproductive health, counseling skills, and public speaking.</p> <p>No dissemination strategy or plan</p> <p>Queen Solate School of Nursing</p> <p>3y general programme</p> <p>9m post basic clinical programme</p> <p>6m post basic programmes in ICU, Obstetrics, Public Health</p> <p>WHO + AUT Collaboration (can get BHSc +1y)</p> <p>Open Polytech also associated</p> <p>2 computers – no internet access</p> <p>30 minute radio update every 2 weeks but not every clinic has radio</p> <p>Occasional inservice only ongoing training (travel and attendance are problems)</p> <p>Attendance is often a problem.</p> <p>Need to ensure that community leaders (often = church leaders) are included in education programmes with others as this makes the courses acceptable/validated and provides ongoing support for participants</p> <p>Do not want clinicians being trained in NZ or Australia as they do not return to Tonga</p> |
| MH Education | <p>Government qualifies MH Drs and nurses (unlike other specialties)</p> <p>Six completed overseas attachments to NZ in general and forensic psychiatry</p> <p>Proposals for further attachments in fields of psycho-geriatrics and substance abuse.</p> <p>Regular and continuous in-service education for nurses and psychiatric assistance.</p> <p>Do not want clinicians being trained in NZ or Australia as they do not return to Tonga</p> <p>Need:</p> <ul style="list-style-type: none"> - Clinical skills - Management and organizational skills <p>Also need training for families and communities to understand and work with those who have MI</p> |
| MH Programmes & Services | <p>16 bed (6 security; 10 general) MH unit annexed to Vailoa Public Hospital</p> <p>MH is represented by a Psychiatric Unit within MoH with responsibilities to</p> <ul style="list-style-type: none"> - Treat and contain acute/emergency cases - Treat and rehabilitate chronic cases - Care for institutionalized and deinstitutionalize - Treat and contain forensic cases - Follow up out patients |

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| | <ul style="list-style-type: none"> - Open door care for respite and drop in care - Provide regular/24/7 transport for patient care <p>MH usually managed at Primary Care level</p> <p>Disability related services usually left to NGO – but lack money, equipment, medicines and trained staff. Do a variety of programmes some with vague MH relationship</p> <p>Churches, community leaders and traditional healers play important roles</p> |
| MH Issues | <p>Substance abuse View of MI as biological issue alone (and not inter-related) Families do not like to discuss MH issues (unpleasant)</p> |
| Other Resources | <p>POLHN computer lab. Member nation of the University of the South Pacific</p> <p>Internet access described as “limited” and most people have no computing skills with only a few having limited abilities. Oral culture = print and computer materials need to first be delivered personally Internet not felt to be appropriate</p> <p>The Ministry is working with New Zealand Open Polytechnic University to develop an Open Learning model with the goal of developing a virtual university, to serve the Kingdom. It is also working with Swinburn University in Australia and has received some assistance from the Commonwealth of Learning in planning for post secondary degrees programs in agriculture, accounting, and tourism.</p> <p>The Ministry of Education has developed a Distance Education and Communications Centre. The Centre has a non-operational PEACESAT terminal, offices and two computer laboratories and includes a principal, Mr. Viliami Takau, a senior computer programmer, Piveni Piukala, and a distance learning coordinator, Mrs. Siatukimoana Vaea. There is currently no Internet connection. As a result, training is provided on computer applications and software as well as on CD-ROM based materials. The Centre offers a certificate and diploma in Information Technology as well as short courses for the public. In the past, it has trained personnel from Tonga Communications Corporation and the Ministry of Health as well as MOE staff in basic computer skills. The charge for training courses is T\$2.50 per person, per hour. The computer laboratories are heavily booked.</p> <p>The MOE also uses radio to provide current information to teachers. Each morning, a one-hour radio program provides information to teachers and students. The program is produced by the Ministry and sent to the radio station on tape. Through print, mail, and radio, the Ministry is providing a diploma of education for teachers in the outer islands.</p> <p>University of the South Pacific (USP). The campus outside Nuku’alofa on Tongatapu is connected to USPNet’s videoconferencing and data network. This network provides compressed 128 kbps videoconferencing with other USP campuses and extension centres as well as 64 kbps data access for email and Internet access. The current network is utilized for audioconferencing and videoconferencing to support USP’s distance learning courses. The videoconferencing system allows for two way point to point connections to one other site at a time or for one way broadcast of lecture courses from either Fiji, Vanuatu, or Samoa. In addition, Internet access is provided for faculty and students at different times to conserve bandwidth. There is one computer laboratory with 6 computers. Students have access to this laboratory from 1300 to 1800. Videoconferencing is used for approximately 2 to 4 classes per day and audio conferencing is used for approximately 10 classes per day. Most of these classes are held in the evenings (from 1600 to 2000) since most of the participants are continuing education students. The only health courses are regional educational courses in nutrition that lead to a Community Nutrition Certificate. USP’s experience with distance learning courses in the Kingdom has been that print based courses are the most effective because of the unreliability of power, especially in the islands of Vava’u and Ha’apai. In addition, most students report they do not enjoy distance-learning courses because they find it hard to understand the various accents of the instructors. USP has offered a series of nutrition courses over a 3-semester period using voice conferencing for nutrition workers.</p> <p>Technology & Open Learning Technology facilities in health care settings is minimal. Hospitals have power and phone service and most have VCRs. There are only three computers at Vaiola with Internet access. Few of the Health Centres have TVs or VCRs. Two of the 14 Health Centers have phones. The remaining twelve centers don’t have a direct phone. In some cases, there is only one phone for the entire island and it often doesn’t work. 31 of the 34 Maternal Health Centres do not have phone service. There is a need for a workable communication and consultation system. The QSSN only has two computers. Nurses at the school or in the field generally don’t have access to computers and do not have computer skills. In the Ministry of Health, division heads have computers but very few of these computers have Internet connections. Only 3 computers at main hospital so limited use by staff. Most of the health care staff have no experience with open learning and information technology. The exceptions are doctors, tutors at QSSN, and some nurses. The majority of these workers are familiar only with print, audiocassette, videocassette, and radio. Some doctors and a few nurses have experience with computers, including email and web access although most of these health care professionals have only basic computer skills.</p> <p>Also need training for families and communities to understand and work with those who have MI</p> |
| WHO ATLAS | <p>POLICIES AND LEGISLATION Mental Health Policy A mental health policy is absent. Substance Abuse Policy A substance abuse policy is absent.</p> |

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| | <p>National Mental Health Programme A national mental health programme is absent.</p> <p>National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 2000. The National Drug Policy has three principal objectives: to ensure the consistent availability within the country of medicinal drugs which are of acceptable quality, safety and efficacy; to provide equity of access to medicinal drugs and to ensure that medicinal drugs are used rationally by prescribers, other health professionals and consumers.</p> <p>Mental Health Legislation There is a Mental Health Act. It details the powers of the minister, the mental health welfare officer. It also provides guidelines for compulsory admission, detention and release of mentally ill patients. The latest legislation was enacted in 1992.</p> <p>MENTAL HEALTH FINANCING There are budget allocations for mental health. The country spends 0.5 % of the total health budget on mental health. The primary source of mental health financing is tax based.</p> <p>MENTAL HEALTH FACILITIES The country does not have disability benefits for persons with mental disorders. There is no state disability benefit. Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. Regular training of primary care professionals is carried out in the field of mental health. In the last two years about 14 personnel were provided training. There are community care facilities for patients with mental disorders.</p> <p>PSYCHIATRIC BEDS AND PROFESSIONALS Total psychiatric beds per 10 000 population 2.6 Psychiatric beds in mental hospitals per 10 000 population 0 Psychiatric beds in general hospitals per 10 000 population 2 Psychiatric beds in other settings per 10 000 population 0.6 Number of psychiatrists per 100 000 population 1 Number of neurosurgeons per 100 000 population 0 Number of psychiatric nurses per 100 000 population 1 Number of neurologists per 100 000 population 0 Number of psychologists per 100 000 population 0 Number of social workers per 100 000 population 6 There are ten psychiatric assistants and one mental health welfare officer.</p> <p>NON-GOVERNMENTAL ORGANIZATIONS NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation.</p> <p>INFORMATION GATHERING SYSTEM There is mental health reporting system in the country. The country has data collection system or epidemiological study on mental health.</p> <p>PROGRAMMES FOR SPECIAL POPULATION The country has specific programmes for mental health for indigenous population, elderly and children.</p> <p>OTHER INFORMATION Efforts have been made to study mental disorders in the country from the transcultural perspective.</p> <p>ADDITIONAL SOURCES OF INFORMATION 1. An Act to deal with mental health in Tonga and matters related there to. No 18 (1992) (Government document) 2. Jilek, W. (1988). Mental health, Ethnopsychiatry and traditional medicine in the kingdom of Tonga. Curare. 11, 3, 161-176. 3. Ministry of Health (2000). Kingdom of Tonga National Drug Policy. 4. Ministry of Health (1998). Standard Drug List Revisited.</p> |
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| TUVALU | |
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| Health Policy | |
| MH Law | |
| MH Policy | <p><i>5y Plan to training a specialist in psychiatry, sending more nurses to Fiji for experience, seeking out stakeholders to develop community based MH programme, and educate public on mental health.</i></p> <p><i>Suggests academic institutions in region collaborate to establish regional network to help build HR in poorly staffed countries. Suggests a region fund be established to help support MH services. WHO HR Report</i></p> <p>Need for specific MH policy/legislation</p> |
| Health Structure | Health Ministry → Curative Health Services → Mental Health Service |
| Health Workforce | |
| MH Workforce | 1x R/N who has completed 3m attachment to Fiji (St Giles) General doctors treat MH patients (no specialist training) |
| Health & Other Education | Nurses trained at Fiji School of Nursing with some support from WHO |
| MH Education | Doctors and nurses need specific MH clinical training (don't send to NZ or Aust as don't come back) = keep in Pacific |
| MH Programmes & Services | 2 bed ward in main hospital No community services |
| MH Issues | Families wont accept members with MH issues back into homes |

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| | <p>No drug abuse People with alcohol problems → jail</p> |
| Other Resources | Member nation of the University of the South Pacific |
| WHO ATLAS | <p>POLICIES AND LEGISLATION Mental Health Policy A mental health policy is present. The policy was initially formulated in 1978. Substance Abuse Policy A substance abuse policy is absent. National Mental Health Programme A national mental health programme is absent. National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is absent. The essential drug list and the national therapeutic drug policy have not been officially adopted. Mental Health Legislation There is a Mental Treatment Law. The latest legislation was enacted in 1978. MENTAL HEALTH FINANCING There are no budget allocations for mental health. Details about expenditure on mental health are not available. The primary sources of mental health financing in descending order are tax based and out of pocket expenditure by the patient or family. MENTAL HEALTH FACILITIES The country does not have disability benefits for persons with mental disorders. Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. Regular training of primary care professionals is not carried out in the field of mental health. There are no community care facilities for patients with mental disorders. PSYCHIATRIC BEDS AND PROFESSIONALS Total psychiatric beds per 10 000 population 1.8 Psychiatric beds in mental hospitals per 10 000 population 0 Psychiatric beds in general hospitals per 10 000 population 1.8 Psychiatric beds in other settings per 10 000 population 0 Number of psychiatrists per 100 000 population 0 Number of neurosurgeons per 100 000 population 0 Number of psychiatric nurses per 100 000 population 0 Number of neurologists per 100 000 population 0 Number of psychologists per 100 000 population 0 Number of social workers per 100 000 population 0 Psychiatric patients are managed by medical officers. NON-GOVERNMENTAL ORGANIZATIONS NGOs are involved with mental health in the country. They are mainly involved in promotion, prevention and rehabilitation. INFORMATION GATHERING SYSTEM There is no mental health reporting system in the country. The country has no data collection system or epidemiological study on mental health. PROGRAMMES FOR SPECIAL POPULATION There are no special services available. OTHER INFORMATION ADDITIONAL SOURCES OF INFORMATION 1. Government of Tuvalu (2000). Tuvalu Essential Drug List.</p> |

| VANUATU | |
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| Health Policy | <p>Does not have a formal mental health policy but there is a general health policy (MH not mentioned in this) National Health Conference 2003 identifies MH as priority MoH Annual report in 1999 refers to related issues (H)</p> <ul style="list-style-type: none"> • Prevention and control of mental health problems and the reduction and management of mental and physical disabilities • Development and strengthening of health workforce planning process with special attention the planned expansion of services and programs including faculty improvement of the Vanuatu Centre for Nursing Education (VCNE) and the implementation of the medical workforce plan • Improvement of hospitals • Improvement in the quality of health care in rural health services • Development of appropriate infrastructure • Greater levels of community participation in health activities • Consideration of options for outsourcing health services to non-government and other organizations <p><i>Plan: increase numbers of trained/qualified staff; set up separate administrative structure to facilitate appropriate care; increase community awareness; draft policy as safeguard WHO HR Report</i></p> <p>Ministry of Health has lead role in MH</p> |

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| | <p>- but only funds one inpatient bed NGOs make plans and submit to MoH Foundation for South Pacific also collect data - provides some funding</p> |
| MH Law | <p>Mental Hospital Act (Law 38 of 1965) – never been implemented and hardly ever used. Anyway, it is considered inadequate (focused on hospital admissions; no community treatment capacity; lack of protections. Govt. has timetable for new MH legislation and well developed processes (MoH prepares policy statement → approval by Council of Ministers → MoH gives drafting instructions to State Law Office (SLO) → SLO prepare Bill → MoH for review → SLO redrafts (iterative process till all parties happy) → final draft is piloted through parliament by SLO. WHOMR Pathare: Agreement over need to prioritise MH. Need someone identified as responsible Needs technical assistance for developing and implementing MH policies, staff training, and developing MH legislation. Suggests they request outside assistance for this.</p> |
| MH Policy | <p>Does not have a formal mental health policy but there is a general health policy MH not mentioned in this (as above) National Health Conference 2003 identifies MH as priority BUT MH not part of any Ministry directorate WHOMR Pathare: As above PLUS: Should include training MH professionals in the Work Force Training Plan currently being developed. Strategic plan = development of mental health services, especially at the community level + existing MH facilities at Villa Central Hospital upgraded and strengthened by providing training to existing staff as well as more appropriate facilities for inpatient care. Involve NGOs.</p> |
| Health Structure | <p>Based on 3 provinces: Central Referral Hospital → four small and 1 large provincial hospitals → 30 health centres (nurse practitioner, staff nurse, midwife, aide) → 120-130 dispensaries (1 or 2 nurses, aide) → village aid posts (local aides and carers) 2 private hospitals</p> |
| Health Workforce | <p>23-30 medical Drs – 70% in VC hospital Nurse practitioners work as senior health care providers, especially in absence of doctor (and some with NP status may prescribe) 700 healthcare workers (various levels) → 300 nurses (these are the primary healthcare providers for population, 60 midwives, 70 nurse practitioners, 170 aidpost workers. Some can prescribe if no M.O. available (but none competent in MH prescribing). Health Workforce Plan is in place but does not address MH and WHOMR Pathare: suggests this include training MH professionals.</p> |
| MH Workforce | <p>No MH trained professionals No MH Nurses No MH Dr's 1 nurse who has developed an interest in mental health</p> <p>Care provided by physicians and nurses Need more nurses with MH training/expertise Training needs are around clinical staff – doctors, nurses, psychologists</p> |
| Health & Other Education | <p>Vanuatu Centre for Nurse Education 3y General Nursing program 9m post-grad programs for midwifery or nurse practitioner Computers but no internet access No MH curriculum (except for 50h theory in normal programme) Health care workers trained by AUSAid project to train trainers</p> <p>Vanuatu Rural Development & Training Centres Assn (VRDTCA) NGO with 34 learning centres in primarily remote centres Broad curriculum – some health related Video based (may require hiring generators etc) Works with local nurses and health workers Foundation for open learning</p> <p>Identified relevant needs for health professional ongoing distance education:</p> <ul style="list-style-type: none"> • An audio network to connect health care professionals at hospitals, health centres, and dispensaries. Health care professionals need to interact with one another. • A technology learning center for health care professionals • Distance learning postgraduate courses in Obstetrics and Gynecology and Internal Medicine for Doctors • Distance learning postgraduate courses for Nurses and other health care workers • Delivery of up-to-date information on medical topics on video on a regular schedule to health care workers • Provide training in reproductive health, family planning, STDs, cervical cancer detection, Malaria, TB, heart disease and diabetes |
| MH Education | <p>Limited MH component in basic nursing training No post-grad programmes in MH No MH specialist tutors</p> <p>WHOMR Pathare – suggests training arrangements/relationships via Fiji or PNG</p> |
| MH Programmes & Services | <p>New hospital had psych unit but lack of MH staff means this is now used for quarantine of tuberculosis patients. Now = One bed platform in dilapidated room. Family care only. Interview identifies 1 room in hospital with stays of up to 4 months but mostly around 3 days No MH facilities in outer islands. No MH care or treatment via various community clinics & programmes. Satisfactory supply of psychotropic meds. but poor management due to untrained staff</p> |

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| | <p>No private MH providers. Some NGOs provide very basic MH services and are interested in expanding repertoire (e.g. Vanuatu Society for Disabled).</p> <p>Little coordination between govt. and NGO in service provision. NGOs make plans and submit to MoH</p> <p>Care provided by physicians and nurses</p> <p>NGOs Foundation for the Peoples of South Pacific Vanuatu (FSPV) is a local not-for-profit NGO focusing on sustainable development, particularly in the sectors of health, youth, good governance, small business and community capacity building. FSPV has recently started a Masculinity, Mental Health and Violence project to address youth depression and associated violence = baseline community survey, establishing peer support networks, implementing drama workshops, support workshops, an information, education and communication (IEC) campaign and partnership building and collaboration with national key stakeholders to establish a national mental health network. Wan Smol Bag Theatre group runs a drop-in centre for youth and also has trained nurses who provide generic counselling services. Vanuatu Society for Disabled Persons provides services mainly to persons with physical handicaps and intellectual disability (mental retardation). They have a community-based programme and have indicated an interest in developing a programme to support persons with mental disorders in the community. UNICEF not govt. funded. The Vanuatu Women's Centre was started in 1992 by the National Council for Women to provide assistance for women victims of domestic violence. The centre provides counselling both by telephone and face to face and does public education through the media, posters and pamphlets. The centre works closely with village chiefs, police and church pastors, who are its main sources of referrals. The centre also refer needy cases to the hospital or the police. The counselling provided may be religious, legal or by traditional chiefs who hold considerable power in Vanuatu.</p> <p>Limited interest in/recognition of MH in wider community health services</p> <p>80-90% of MH care is at village level and by traditional and religious means</p> |
| MH Issues | <p>MH has been neglected and MH issues on increase Suicide is crucial issue, especially among young females plus AOD abuse (Marijuana) Teenage pregnancy – some planning being done Child abuse Lack of any dedicated and trained MH staff is crucial</p> |
| Other Resources | <p>POLHN computer lab This is working well Internet access is good</p> <p>Member nation of the University of the South Pacific</p> <ul style="list-style-type: none"> - Emalus campus of USP in Port Vila - connected to USPNet's videoconferencing and data network. This network provides compressed 128 kbps videoconferencing with other USP campuses and extension centres as well as 64 kbps data access for email and Internet access. However, the current network is under utilized and the network does not reach the USP campus on Santo. The slow speed of the Internet connection limits the ability to utilize on-line courses. In addition, students lack basic computer skills resulting in a need for training before they can effectively use technology. The Port Vila campus primarily uses print with some videotapes and audiotapes for their distance learning courses. <p>Agence universitaire de la Francophonie (AUF).</p> <ul style="list-style-type: none"> - has built a distance-learning centre that provides facilitation for distance learning courses delivered by the University of New Caledonia, University of Paris, and other French higher education institutions. - Vanuatu campus has two computer laboratories available for students with a dedicated 64 kbps Internet access, and information centre, and a small scientific library. - All instruction is in French. - The university currently is not providing any services in health education and the director believes there is a major need for in-service education for Francophone health care workers in Vanuatu and the director would like to explore the possibility of offering courses from the medical school in Dakar, Senegal. - AUF is hoping to work with USP and tie into USPNet. - MOE has asked AUF to focus on foundation courses for students. <p>Institut National de Technologie de Vanuatu (INTV).</p> <ul style="list-style-type: none"> - INTV was originally a French training centre focusing on vocational education. - has linkages to other training organizations including the Open Learning Institute in Queensland, Australia and the Fiji Institute of Technology. - has two computer labs, one francophone and one Anglophone, for a total of 80 computers available for student use. Faculty also have access to computers with one or two computers assigned to each department as well as a small computer room for teachers. - The organization is open to allowing others to use their resource centre and VCNE staff report that they have worked well with INTV in the past. <p>The government is currently considering a plan to create a Ministry of Training to assume the training responsibilities for all government training including health care workers. <i>Under this scheme, responsibility for the VCNE would move from the Ministry of Health to the new Ministry of Training and be administered by INTV.</i> The organization would be required to expand by opening 5 additional campuses in the other provinces and is planning to have one of two of these operational in the next four years.</p> <p>Conflicting information on telecommunications</p> |

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| | <p>Hezel: Telecommunications is a problem for many health facilities. Not all facilities have phone service and in many rural communities, there is only one phone available for the entire village. In order to improve communications, the Ministry has purchased tele-radios for use by remote facilities. However, the tele-radio at the Ministry is currently not operable.</p> <p>MR: Good radio-telephone system for health consultation (but seldom used for MH)</p> <p>Overview.doc: radio-telephone network</p> |
| Other Issues/ Information | <p>Language</p> <ul style="list-style-type: none"> - English but also local = Bislama and French <p>The feeling among ni-Vanuatu is that projects come and go but are never sustainable. Foreign countries do not take into account the budget of a country. For a project to be sustainable, it cannot increase costs. AUSAID is heavily supporting the CRM which attempts to push some of the costs of healthcare and training on the individual. Currently, the Ministry of Health sees VCNE as a cost (burden) to them. For open learning to be effective, there needs to be a local open learning coordinator in Vanuatu.(H)</p> <p>The Human Resources and Development Unit has been established and has assumed responsibility for training of MoH staff. Prior to the establishment of the HRD, the VCNE was the main provider of training for the MoH. The HRD now includes 7 VCNE staff and a manager.(H)</p> |
| Other MH Observations | <p>Making optimal use of a WHO consultancy to develop a national programme and recruit support from local planners (Vanuatu) with support of service development of collaborations with local and international universities and a gradual transition from traditional hospital-based psychiatric treatment to community-based services.</p> <p>One Dr engaged in FSM distance learning program but negative re this on support etc and is withdrawing</p> <p>Look up WHO ICD X PHC training kit for doctor/nurse training</p> |
| WHO ATLAS | <p>POLICIES AND LEGISLATION</p> <p>Mental Health Policy A mental health policy is absent.</p> <p>Substance Abuse Policy A substance abuse policy is absent.</p> <p>National Mental Health Programme A national mental health programme is absent.</p> <p>National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1999.</p> <p>Mental Health Legislation There is no mental health legislation. Details about the year of enactment of the mental health legislation are not available.</p> <p>MENTAL HEALTH FINANCING There are no budget allocations for mental health. Details about expenditure on mental health are not available. Details about sources of financing are not available.</p> <p>MENTAL HEALTH FACILITIES Details about disability benefits for mental health are not available. Mental health is not a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level. Patients are sent to referral hospitals. Regular training of primary care professionals is not carried out in the field of mental health. There are no community care facilities for patients with mental disorders.</p> <p>PSYCHIATRIC BEDS AND PROFESSIONALS Total psychiatric beds per 10 000 population 0.2 Psychiatric beds in mental hospitals per 10 000 population Psychiatric beds in general hospitals per 10 000 population Psychiatric beds in other settings per 10 000 population Number of psychiatrists per 100 000 population Number of neurosurgeons per 100 000 population Number of psychiatric nurses per 100 000 population 0 Number of neurologists per 100 000 population Number of psychologists per 100 000 population Number of social workers per 100 000 population There are no specific psychiatric nurses, general nurses handle patients.</p> <p>NON-GOVERNMENTAL ORGANIZATIONS NGOs are not involved with mental health in the country.</p> <p>INFORMATION GATHERING SYSTEM There is mental health reporting system in the country. Mental disorders are usually reported in the health information. The country has no data collection system or epidemiological study on mental health.</p> <p>PROGRAMMES FOR SPECIAL POPULATION The country has specific programmes for mental health for disaster affected population. There is a government disaster management department. All essential services are under it.</p> <p>OTHER INFORMATION</p> <p>ADDITIONAL SOURCES OF INFORMATION</p> <p>Most benefit from WHO programme</p> <ul style="list-style-type: none"> - nurses, doctors, counselors <p>Most important training needs: Doctors – clinical; nurses – clinical; NGSs (not further specified)</p> <p>No educational relationships etc outside own school of nursing</p> <p>Need scholarship system for training</p> <p><u>Educational Preferences</u></p> <p>Modes</p> <ul style="list-style-type: none"> - study guides - internet based materials and teaching |

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| | <ul style="list-style-type: none"> - group discussions with other participants - face-to-face support and teaching with tutor/mentor - ongoing support once course is over <p>Communication</p> <ul style="list-style-type: none"> - telephone - mail - internet discussion - email <p>Internet access is good Would like to participate in a programme like this with others. Emphasises the need to train more nurses</p> |
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| WALLIS & FUTUNA ISLANDS | |
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| Health Policy | |
| MH Law | |
| MH Policy | |
| Health Structure | |
| Health Workforce | |
| MH Workforce | |
| Health & Other Education | |
| MH Education | |
| MH Programmes etc | |
| MH Issues | |
| Other Resources | |
| WHO ATLAS | <p>POLICIES AND LEGISLATION</p> <p>Mental Health Policy A mental health policy is absent.</p> <p>Substance Abuse Policy A substance abuse policy is absent.</p> <p>National Mental Health Programme A national mental health programme is absent.</p> <p>National Therapeutic Drug Policy/Essential List of Drugs A national therapeutic drug policy/essential list of drugs is absent.</p> <p>Mental Health Legislation There is no mental health legislation. Details about the year of enactment of the mental health legislation are not available.</p> <p>MENTAL HEALTH FINANCING There are no budget allocations for mental health. Details about expenditure on mental health are not available. The primary source of mental health financing is grants.</p> <p>MENTAL HEALTH FACILITIES There are no disability benefits for persons with mental disorders. Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. There is one doctor in each primary health centre. Regular training of primary care professionals is not carried out in the field of mental health. There are no community care facilities for patients with mental disorders.</p> <p>PSYCHIATRIC BEDS AND PROFESSIONALS Total psychiatric beds per 10 000 population 0 Psychiatric beds in mental hospitals per 10 000 population 0 Psychiatric beds in general hospitals per 10 000 population 0 Psychiatric beds in other settings per 10 000 population 0 Number of psychiatrists per 100 000 population 0 Number of neurosurgeons per 100 000 population 0 Number of psychiatric nurses per 100 000 population 0 Number of neurologists per 100 000 population 0 Number of psychologists per 100 000 population 7 Number of social workers per 100 000 population 107 There are 7 other mental health workers.</p> <p>NON-GOVERNMENTAL ORGANIZATIONS NGOs are not involved with mental health care.</p> <p>INFORMATION GATHERING SYSTEM There is no mental health reporting system. There are no data collection system or epidemiological study on mental health.</p> <p>PROGRAMMES FOR SPECIAL POPULATION There is no specific programmes for the special populations.</p> <p>OTHER INFORMATION</p> <p>ADDITIONAL SOURCES OF INFORMATION</p> |