The **FJPH** is a Fiji based Journal published for Public Health practitioners, public health researchers, clinicians and all allied health practitioners. Our goal is to provide evidence based information and analysis they need to enable them to make the right choices and decisions concerning their health and health services provided to ensure better health for all.

**FJPH** is published quarterly.

The format of **FJPH** accommodates three types of submissions:

1. Original Academic/Scientific Research Papers - Research-based works addressing a specific area of public health or any other general topic in health - between 3,000 and 4,500 words.
2. Structured Abstracts- for original research & systematic reviews of specific public health interest - between 500 and 3,000 words.
3. Perspectives –Reviews, Opinion pieces that analyze or discuss a recent issue or development in public health - between 250 and 2,500 words.
4. Field notes –Journal-style pieces, with a more personal voice, words.

**Submission Procedures**

1. All manuscripts should be prepared according to the guidelines below
2. The call for submissions and a description of the optional theme can be found in the Health Research web page.
3. All manuscripts should be submitted via the online submissions form on the Research web page.

**Publication Eligibility**

1. For each manuscript, at least one of the authors needs to be an undergraduate, medical, or graduate student at a nationally accredited institution.
2. The submitted manuscript has not been published nor will be published in another publication at the undergraduate, graduate or professional level.
3. The manuscript is the author’s own original work, and the authors are the sole authors of the manuscript.
4. The primary author is willing and able to work with FJPH editors in revising the submission if it is selected as a likely candidate for publication.

**Submission Types**

1. Original scientific Research - Research- based works addressing a specific area of public health or any other general topic in health
2. Abstracts – structured abstracts for original research and
3. Perspectives –Reviews, Opinion pieces that analyze or discuss a recent issue or development in public health
4. Field notes –Journal-style pieces, with a more personal voice, based on direct work in the field

**Formatting**

- All manuscripts should be submitted as double-spaced, size 10, Times New Roman font in microsoft Format (.doc or .docx only).
- Do not include the name of the manuscript’s authors any pages except the title page.

**Content Guidelines for Perspectives and Field Notes**

Perspectives are opinion-based pieces. Field Notes take a more personal, informal tone that addresses public health work the author has done in the field. For both Perspectives and Field Notes, we are looking for submissions that address fresh and exciting developments in public health from an interdisciplinary perspective. Perspectives and Field Notes should be grounded in the preexisting literature base. For citations and references, use APA style.

Tables, Figures and Images

- Tables, figures and images should be the original work of the manuscript’s authors and should be included at the end of each manuscript.
- Captions should describe what the table/figure/image shows and the conclusion that should be drawn.
- Labels and axes should be clearly marked and readable, all tables, figures, and images should be submitted in high resolution please.
- References

The views and opinions expressed in **FJPH** do not necessarily reflect those of the Editorial Board, editorial staff, or their support organisations.

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EDITORIAL

Guest Editor

Dr. Ernest Hunter

OPENING SPEECH

Creating Futures Conference

Honourable Rony Sofia Akbar, Minister of Health and Medical Services

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Use of tobacco, alcohol and marijuana among high school students in Honiara, Solomon Islands

Rex Maukera, Florence Muga

A retrospective, quantitative audit of deliberate self-harm and its management at the Sigatoka Sub-Divisional Hospital, 2016.

Nashika Sharma

Evaluation of the leadership mental health: Island Nations course

Fiona Charlson, Michelle Redman-MacLaren, Kate Gossip, Ernest Hunter

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John Howard

Suicide prevention in Fiji - social and clinical issues

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How you can play a role in strengthening your nation’s system of governance affecting mental health outcomes

Allan Dale, Odille Chang, Fiona Charlson

Striving mental health care in primary care in low and middle income countries: the Fiji experience

Sarah Larkins, Saimone Simone Morua Tunt, Nick Kowalenko, Myrielle Allen, Sainimere Gada

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Formation of the Oceania Society for Mental Health Professionals (OSMHP)

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In the drivers seat, but are we on the right road?

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COMMENTARY

Commentary: The implementation of the mental health Gap action plan within the Fijian healthcare system

Fiona Charlson, Odille Chang, Ilisapeci Kubuabola
BACKGROUND
On 18 September 2017, Ms. Rosy Sofia Akbar, Minister for Health and Medical Services, opened the Creating Futures 17: Fiji conference in Suva (CF:17). Having previously been Minister for Women, Children and Poverty Alleviation she was well placed to consider the objectives of the conference and the Leadership in Mental Health: Island Nations (LMH:IN) course, which ran in parallel. Across those portfolio areas she has had responsibility both for key social determinants of mental health and its vicissitudes, and service responses to the consequences. In welcoming delegates she made note of the: “diverse and eminent group, all of whom are united by the goals of building networks, sharing knowledge and experiences, and developing skills with the ultimate aim of ensuring safer, better and more effective care for those in our communities who experience mental illness. That aim is captured well in the theme of your conference - Strengthening Mental Health Capacity in the Pacific” (see Akbar, this issue).

Since the second Creating Futures conference, held in Cairns in 2006, there has been a stream dedicated to Island Nations with delegates drawn from across the Western Pacific. This focus has progressively expanded and CF:17 was the seventh conference in the series and the second held beyond Cairns (Creating Futures 12 was in Port Moresby). It is also the second to be run in conjunction with the LMH:IN course (the first being at Creating Futures 15 in Cairns). The conference and course in Suva incorporated elements of both the 2012 meeting in Port Moresby, which drew on Australian and other international experts to provide a conference for delegates from PNG and the region (Hunter 2012), and the 2015 LMH:IN course (Charlson, Redman-MacLaren et al. 2015). The structure for the CF:17 conference was, as in PNG in 2012, a series of locally nominated workshops delivered by volunteer experts from Australia in conjunction with local colleagues. The LMH:IN course overlapped the conference and, as with the inaugural course in Cairns in 2015, was run in collaboration with colleagues from Sangath, an Indian NGO that developed the course on which the LMH:IN is based.

For CF:17 the overarching framework was set through eleven plenaries delivered by International and Fijian experts, addressing core issues for Global Mental Health and the circumstances of Pacific Island nations. To note only one in relation to the latter, Dr Isimeli Tukana, National Advisor – Non-Communicable Diseases Prevention and Control in the Fiji Ministry of Health and Medical Services, emphasized the need to shift from searching “lap-tops” for solutions, to reinforcing the need for “neck-tops” to take responsibility for their own and others’ wellbeing.

The core content of CF:17 was provided through thirty-two workshops in four concurrent streams across four days, the topics for which were identified through experience in Port Moresby in 2012 but generally positive results (see Charlson et al, this issue).

Approximately 120 delegates from Fiji attended the conference, equally divided across Ministry of Health and NGOs. Importantly, consumer and carer groups were represented, and the Fiji Association for Mental Health and the Psychiatric Survivors Association provided both a plenary session and a designated workshop. In addition, there were some thirty delegates from Pacific Islands other than Fiji (Vanuatu, FSM, Marshall’s, Nauru, Solomon’s, Samoa, Tonga, PNG, Cook Islands and Kiribati).

Within the CF:17 conference one stream was dedicated to participants in the LMH:IN, which continued with additional workshops for three days after the conference itself had concluded. Participants in the LMH:IN were selected through application, and from Fiji included nine nominated by the Ministry of Health, and ten from NGOs, with a further eleven delegates from other Pacific Islands nations. Graduates from the LMH course in Cairns in 2015 (from Fiji, Solomon’s, PNG and Kiribati) provided mentorship for 2017 participants.

This Issue of the Fiji Journal of Public Health
Each previous Creating Futures conference has resulted in a Special Supplement of Australasian Psychiatry with the last, dedicated to Island Nations, available through open access (http://journals.sagepub.com/toc/apya/23/6_supp1). The organizers of CF:17 and the LMH:IN are explicitly committed to building capacity in the region and, consequently, are delighted to be able to publish key papers in the Fiji Journal of Public Health, noting past special issues relevant to the mental health and wellbeing of the residents of Pacific Island nations, specifically, Environmental health and climate change (2015: Volume 4, Issue 1) and Mental Health (2016: Volume 5, Issue 1).

This issue commences with the full text of the opening speech by the Minister for Health and Medical Services noted above. Seventeen papers follow, of which the first authors of six are resident in Fiji and other nations of the western Pacific, with the majority of the remaining papers having coauthors from the region. Three of these papers are original research, with Rex Maukera (Solomon Islands) and Nashika Sharma (Fiji) presenting the results a survey of youth substance use in Honiara and a hospital-based audit of self harm in Fiji respectively. The third research paper (Charlson et al) documents the evaluation of the Leadership in Mental Health course run in conjunction with Creating Futures in Suva with comparison to the findings from the 2015 course run in Cairns.
EDITORIAL

There are seven review papers, the first two complementing the papers of Maukera and Sharma, with John Howard reviewing cannabis use in the Pacific with discussion of brief intervention approaches, and Balram Pandit reviewing social and clinical issues associated with suicide in Fiji. With overlapping themes to the paper by Howard, Weller et al review motivational interviewing approaches to supporting behavioural change among pregnant adolescents.

The three reviews that follow address systems issues with that by Dale et al considering mechanisms to influence higher level governance in support of improving mental health outcomes, the paper by Larkins et al focusing on strengthening mental health in the primary care setting with Fiji (reflecting issues of low and middle income countries), and the contribution from Saxton et al reflecting on the challenges and opportunities of a rights-based approach to mental health in Fiji. Exemplifying some of these issues, cultural considerations in relation to addressing the needs of vulnerable patients with dementia is the subject of the last review paper by Johnston et al.

Four perspectives cover a broad suite of issues with Odille Chang documenting the formation of the Oceania Society for Mental Health Professionals (OSMHP), and Florence Muga reflecting critically on policy and its implementation in the PNG context. Nic Kowalenko and Allister Bush provide perspectives on initiatives out of Australia and New Zealand to support child and youth mental health capacity across the region.

There are two reports, with Jimmy Obed from Vanuatu outlining the development of clinical mental health services in that nation, and George Tuitama from Samoa putting on the table an argument for developing a Pacific Fellowship of the Royal Australian and New Zealand College of Psychiatrists.

The last paper in this edition is a commentary identifying the recent evaluation of the implementation of mhGAP in Fiji (Charlson et al) that will be published in full elsewhere (a link will be provided to that article through the FJPH).

Creating Futures 17: Fiji and the Leadership in Mental Health: Island Nations course form part of a broader trajectory of cooperation between mental health professionals in Australia and New Zealand, and colleagues in the Pacific. In May 2019 the Annual Conference of the Royal Australian and New Zealand College of Psychiatrists will be held in Cairns. The College is committed to supporting mental health capacity development in our neighbor island nations wide representation from across Oceania is anticipated. We hope to host Pacific Island graduates from the 2015 and 2017 Leadership in Mental Health: Island Nations courses to further refine and develop approaches to developing leadership and improving mental health capacity on the ground. This initiative, and others described in this issue of FJPH, are only possible because of the cooperation and goodwill that has developed through hard work and a common commitment to improving the health and wellbeing of the residents of Pacific Island nations. It remains a work in progress. Vinaka Vaka Levu.

REFERENCES

Bula vinaka and good morning to you all. I am pleased to join you this morning to mark the opening of the 7th Creating Futures conference. I would like to welcome the many mental health professionals, social services staff and other experts from across Fiji who are here today. I also extend a special welcome to our many international guests from Australia, New Zealand, India, South Africa and of course our neighbouring Pacific Island Countries. We are honoured to be host to such a diverse and eminent group, all of whom are united by the goals of building networks, sharing knowledge and experiences, and developing skills with the ultimate aim of ensuring safer, better and more effective care for those in our communities who experience mental illness. That aim is captured well in the theme of your conference, “Strengthening Mental Health Capacity in the Pacific”.

Fiji is fortunate in that we currently have a sound legislative basis for our mental health services in the form of the Mental Health Act. That Act sets out a range of principles for care, treatment and support of people with mental illnesses. It also confirms Fiji’s adherence to international agreements and standards concerning the care and treatment of people with mental illness as well as signaling a commitment, subject to available resources, to provide access to basic mental health care for all who need it and to do so in the least restrictive way.

Our main mental health facility is St Giles Hospital here in Suva, which offers inpatient and outpatient care as well as being the main centre for training at both undergraduate and postgraduate levels. The Ministry of Health & Medical Services is also actively engaged in the delivery of community-based mental health. There are Community Mental Health Teams in each of our four Divisions and we have also sought to integrate mental health into the broader concept of ‘wellness’ that underpins our work to tackle the growing burden of non-communicable diseases.

Of course, we could not accomplish what we do as a nation without the support of a wide range of NGOs, faith-based organisations and civil society partners who are engaged across the spectrum of advocacy, prevention and support services. I must also acknowledge the contributions of the many multilateral and bilateral development partners who contribute so generously to our work.

Ladies and gentlemen, I am sure that much of what I have described resonates with the situation in the other countries that are represented here. While we may differ in the levels of resources we have at our disposal, the challenges we face are similar and the aspirations we all have to offer better lives for those experiencing mental illness are what unite us. That is why the exchanges that will take place here over the next few days are so important and valuable.

Ladies and gentlemen, you may be aware that I have now been in my current role as Minister for Health and Medical Services for almost a year. I was previously Minister for Women, Children and Poverty Alleviation. In my former role I was confronted regularly with the realities of domestic violence in our society. In my current role, when I had the privilege of representing Fiji at a recent meeting of Commonwealth Health Ministers, I was again concerned to hear Fiji named as one of the Commonwealth countries with the highest reported levels of domestic violence.

In our defence, I believe those high rates may be a reflection of growing willingness of victims to report domestic violence and a growing commitment on the part of the police and other authorities to investigate. But I still believe that domestic violence is a cause for great concern in Fiji and, I suggest, in many other countries. I also believe that there is a strong link between much of the domestic violence we experience in our society and the challenges we face in the field of mental health. And it is a link that goes in both directions.

We know that domestic violence can often stem from abuse of alcohol and other substances, problems which our mental health services seek to address. At the same time, we know that victims of domestic violence can often experience depression or may see suicide as the only way out of their situation. As a result they may also need the support of mental health services.

Ladies and gentlemen, I am sure you all recall that the theme for World Health Day which we commemorated in April this year was ‘Depression – Let’s Talk’. At that time we were reminded that depression is the leading cause of ill health and disability worldwide. And Fiji is no exception. Despite much work that has been done to raise awareness of depression we know that there are still too many people who do not seek help due to factors such as stigma or a lack of understanding of the condition itself. Indeed, those two factors, stigmatisation and lack of understanding, are themes which echo across much mental illness.

I was recently asked by a journalist what my Ministry planned to do to tackle the issue of (and I quote) ‘mentally ill people living on our streets and begging’. It seemed to me that the journalist in question had assumed that street people must, by definition, be mentally ill and also that anyone with a mental illness who was not hospitalised was likely end up begging on the street. I am sure those misguided views are not confined to journalists.

Needless to say, I sought to correct the misunderstanding of what mental illness means and explained that there are many in our community whose mental illnesses are well managed and who are contributing positively to society as workers, students, parents or carers. The fact they can do so, and no longer face the prospect of life in an institution, speaks volumes for the work you do as mental health professionals as well as the remarkable advances in our understanding of mental illness, its causes and its treatment. Ladies and gentlemen it would, of course, be remiss of me not to note that we recently marked World Suicide Prevention Day here in Fiji. I am sure those of you from overseas did so as well. We know that suicide is a major challenge to all our health systems. I was disturbed to learn that in 2016 there were 102 suicides and 104 attempted suicides in Fiji. Those figures are a wake-up call for us to re-think our approaches to mental health and to treat it with the urgency that it deserves.

Last week the Ministry of Health and Medical Services worked with our partners to promote the message of ‘Take a minute,
es worked with our partners to promote the message of “Take a minute, change a life”. We sought to emphasise the importance of reaching out to those at risk of suicide as well as those affected by suicide. We highlighted the fact that individuals who have lived through a suicide attempt often say that they wanted someone to ask if they were okay. They wanted someone to intervene, but no one did. We cannot let that continue. Last Thursday, was also ‘R U OK Day’ in Australia – the day when Australians are reminded to ask family, friends, workmates and colleagues that simple question, “R U OK?” Perhaps, ladies and gentlemen, we should all commit to make every day an R U OK Day?

I acknowledge that I have focused on just a small part of the many issues that make up the vital field of mental health. A glance at your programme offers a clear insight into the range and diversity of the topics you will be covering. I am confident it will be a rich and rewarding experience for you all but I also hope that those of you who are visiting from overseas will find time in your busy schedules to experience more of our beautiful country and our legendary hospitality.

I commend you all for the great work you do for those who are affected by mental illness and I wish you all the very best for your deliberations. I am confident that there will be much fruitful debate in the sessions and I look forward with great interest to learning the outcomes of those discussions. With those closing words, may I formally declare the 7th Creating Futures Conference open. Thank you.
ABSTRACT:
Prevalence rates of tobacco, alcohol and cannabis use in high schools are increasing in developing countries. This paper presents lifetime prevalence and factors associated with the use of tobacco, alcohol and cannabis, from a cross-sectional survey carried out in fifteen high schools in Honiara, the capital of the Solomon Islands (SI). Male students were significantly more likely to drink alcohol than female students. Students whose friends are smoking have 3.31 times risk of smoking than the students whose friends are not smoking. Students who smoked cigarettes were significantly more likely to smoke cannabis than students who did not smoke cigarettes, with a relative risk of 8.7. Implications for preventive interventions are discussed.

INTRODUCTION
Tobacco, alcohol and marijuana use is increasing in high schools in developing countries where there are no strict policies regulating the market (Bauman & Phongsavan, 1999). Substance abuse is associated with serious social, health, legal and academic problems (Smith, 1995), and despite youth substance use and anti-social behaviours being a major concern for community leaders in the Solomon Islands (SI) (Blignault, Bundie-Birouste Ritchie et al, 2009), robust epidemiological data are scarce.

Tobacco is a public health concern worldwide, the World Health Organisation (WHO) reporting that of 1.22 billion smokers worldwide, 20% of users were 13 -15 years old, with six million deaths annually as a direct result of smoking (WHO, 2013). While alcohol consumption is widespread and culturally accepted across the globe, it results in 2.5 million deaths each year and is associated with many serious social and developmental issues (National Institute on Alcohol Abuse and Alcohol, 2012). According to the 2011 World Drug Report, cannabis is the most widely used illicit drug and it was consumed by 125 to 203 million people worldwide in 2009 (United Nations Office on Drugs and Crime, 2011). The use of cannabis among students is associated with poor academic performance and apathy, and contributes to social problems such as sexual assaults and accidents (Cox, Zhang et al, 2007).

In terms of associated factors, Kwamanga and colleagues (2003) in a Kenyan study among high school students in Nairobi, found that initiating and experimenting with drugs started as early as 5 to 10 years old, with common influences in this age group being parents and teachers. For those commencing around adolescence, the main influences were peers, advertising and accessibility. Studies from Australia reveal early high school as a common period for commencing tobacco and marijuana use and for progression to further drug use (Dunne, Yeo et al, 2000), and that smoking was the best predictor of progression to cannabis use (Lynskey & Hall, 2000). In addition to peer influences, family and developmental factors have been studied with associations demonstrated between parental smoking and adolescents’ use of tobacco and cannabis (Courtois, Caudrelier et al, 2007), and the influence of older siblings and cousins (Wagner, Ritt-Olson et al, 2008).

Protective factors for substance use include family type, parental monitoring and guidance, level of acceptance, and children’s respect for parental values (Piko & Kovacs, 2010; Cleveland, Feinberg & Greenberg, 2010). Other identified protective factors include religiosity, belonging to a group that participated in school activities or sporting clubs, and living in a supportive neighbourhood (Piko & Fitzpatrick, 2004).

Data from SI are limited. The Global Youth Tobacco Survey (Centre for Disease Control and Prevention, 2008) for SI reports documents cigarette use in the last month by 24% of youth aged 13-15 (similar for boys and girls), with 23% using other tobacco products (boys 28%; girls 20%). The report from the Global School-based Student Health Survey (World Health Organization, 2011) in SI revealed that among students 13 -15 years in the previous 30 days the prevalence of tobacco use was 24% (male 28.3%; female 18%) and alcohol use was 18% (male 21%; female 13%) with the proportion admitting to ever having used cannabis being 14% (male 16%; female 11%).

The aims of this study were to, 1) estimate the lifetime prevalence of tobacco, alcohol and cannabis use among high school students in Honiara; and 2) explore factors associated with the use of tobacco, alcohol, cannabis among these high school students.

METHODS
Ethics and sampling
Ethics committee review was through the School of Medicine and Health Sciences Research Committee, University of Papua New Guinea and the Solomon Islands Ministry of Health Research Committee, with permission also obtained from the Ministry of Education in the Solomon Islands.

This study utilised a random sampling, cross-sectional school-based survey. Of the seventeen schools in Honiara, two were excluded because they were not listed in the information provided by the Education Division. In addition, forms three and five were excluded because the survey coincided with exams. From forms one, two, four and six of the remaining fifteen schools one class from each form was randomly selected to participate (allocation to classes is random in SI). Data collection took place from the 10th of October to 30th October 2011.

Research instruments, data collection and analysis
The study utilised the WHO Drug Abuse Epidemiology questionnaire (World Health Organization, 2000), which includes demography questions and sections for tobacco, alcohol and cannabis use. Each section was slightly modified for the setting; for example, sections on other illicit substances were removed, as were questions regarding family cannabis use (which is illegal in SI).
Questions related to other potential associated factors were added to reflect the local context. Data collection was conducted by four trained research assistants and participating students gave consent. Questionnaires were administered free of teacher supervision with an hour allocated for completion before forms were envelope-sealed and returned to the researchers. Data collected were analysed using SPSS v17.0 Software and Microsoft Excel. Students who were absent were excluded and there were no refusals reported.

RESULTS

Socio-demographic characteristics
A total of 1411 students from fifteen schools belonging to four school systems participated, with an equal mix of males and females, ranging from 11 to 21 years old with a mean of 16 years (Table 1).

<table>
<thead>
<tr>
<th>Gender</th>
<th>Number of participants n = 1,411</th>
<th>Sample proportion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>709</td>
<td>51.3</td>
</tr>
<tr>
<td>Female</td>
<td>702</td>
<td>48.8</td>
</tr>
<tr>
<td>School Category</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National High School</td>
<td>142</td>
<td>10.1</td>
</tr>
<tr>
<td>Provincial High School</td>
<td>117</td>
<td>8.3</td>
</tr>
<tr>
<td>Community High School (Government)</td>
<td>762</td>
<td>54.0</td>
</tr>
<tr>
<td>Community High School (Mission)</td>
<td>390</td>
<td>27.6</td>
</tr>
<tr>
<td>Age group (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 - 12 yrs</td>
<td>17</td>
<td>1.2</td>
</tr>
<tr>
<td>13 - 14 yrs</td>
<td>164</td>
<td>25.8</td>
</tr>
<tr>
<td>15 - 16 yrs</td>
<td>580</td>
<td>35.4</td>
</tr>
<tr>
<td>17 - 18 yrs</td>
<td>337</td>
<td>23.9</td>
</tr>
<tr>
<td>19 - 20 yrs</td>
<td>172</td>
<td>12.2</td>
</tr>
<tr>
<td>21 yrs</td>
<td>21</td>
<td>1.5</td>
</tr>
</tbody>
</table>

Age and sex patterns of substance use
Lifetime prevalence rates of alcohol, tobacco and cannabis use among male students were consistently higher than their female peers, across all age groups. Overall, the lifetime prevalence estimates were: tobacco 33% (males 38%; females 28% - p <0.001), alcohol 38% (males 47%; females 29% - p <0.001), and cannabis 21% (males 29%; females 12% - p < 0.001).

<table>
<thead>
<tr>
<th>Tobacco</th>
<th>Alcohol</th>
<th>Cannabis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>11 - 12 yrs</td>
<td>40.0</td>
<td>0.0</td>
</tr>
<tr>
<td>13 - 14 yrs</td>
<td>20.5</td>
<td>20.2</td>
</tr>
<tr>
<td>15 - 16 yrs</td>
<td>36.1</td>
<td>28.2</td>
</tr>
<tr>
<td>17 - 18 yrs</td>
<td>46.1</td>
<td>34.4</td>
</tr>
<tr>
<td>19 - 20 yrs</td>
<td>53.4</td>
<td>39.1</td>
</tr>
<tr>
<td>21 yrs</td>
<td>53.3</td>
<td>50.0</td>
</tr>
</tbody>
</table>

Substance use increased with age across both sexes and all substance types, with alcohol being the most common substance used at all ages. Age of onset for all substances showed a similar pattern with the majority of users commencing between ages 12 and 18 and the mean age of commencement being 15 years (with the single exception of female cannabis use in which the mean age of commencement was 14 years). Students started experimenting with substances from as young as 7 years. Prevalence rates of all substances were highest for students attending provincial high schools.

Frequency of use
Out of the 467 participants reporting ever using tobacco, 83% used within the past month, 17% had not smoked in the past month, 41% had smoked less than 1 roll per day, and 32% had 1-5 rolls per day. There were 2.6% (n=12) of students who reported that they had smoked more than 26 rolls per day during the previous month.

Out of 541 students reporting lifetime alcohol use, 76% had used alcohol in the past month, 26% in the past week, and 7% within a day prior to the study. Of the participants who had ever used cannabis, 61% reported use within the last month.

Associations between smoking and use of alcohol and cannabis
Students who smoked were 4.4 times more likely to consume alcohol than non-smokers (79% vs 18%) and 8.7 times more likely to use cannabis (50.3% vs 5.8%).

Associations with use by others
Substance use by other members of students’ families was sought for tobacco and alcohol (for legal reasons family cannabis use was not enquired about). Significant associations between student substance use status and other family member use were found for both tobacco and alcohol (Table 3), with students reporting use by a sibling (compared to students reporting no sibling use) increasing the likelihood of personal use (odds ratios 1.6 and 1.5 for tobacco and alcohol use respectively), and those with no family members using the substance less likely to be users than those reporting that any family member used (odds ratios 0.8 and 0.4 respectively).
For both tobacco and alcohol use significant associations with use by best friends were found (marijuana use status was not sought). Nearly two-thirds (64.7%, n=913) of respondents reported that their best friends used tobacco (86.1% of smokers; 54.1% of non-smokers (P <0.001)). Just under two-thirds 65.7% of students reported that their best friends used alcohol (91.1% of those who had ever used alcohol and 49.9% of those who had never used alcohol (P <0.0001)). The role of friends is also reflected in initiation, with users reporting that 75%, 77% and 79% had received their first tobacco, alcohol and cannabis respectively from friends.

**REFERENCES**


ABSTRACT:
Deliberate Self Harm (DSH) is a significant issue in Fiji. This retrospective audit of DSH trends and patterns of mental health services at Sigatoka Divisional Hospital over four-and-a-half-years to July 2016 reviews 144 cases, of which 59 (41%) resulted in death. The majority (80%) were of Indo-Fijian descent with nearly two-thirds aged between 11 and 30, and as with other Fijian studies, chemical ingestion was the commonest method of self-harm. Results are supplemented within information from interviews with clinicians working with DSH at Lautoka Hospital with results indicating that there is significant room for improvement in terms of the priority in both resources and training in terms of self harm and, more broadly, mental health.

INTRODUCTION
Defined by the World Health Organization (WHO) as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community, (1) mental health is more privilege than right. Globally, in 2012 some 450 million people suffered from some kind of mental illness and WHO projects that by 2030 mental illnesses will be ranked alongside the top two non-communicable disease categories (cardiovascular and cancer) in low- to middle-income countries. (2) In terms of mortality, approximately 800,000 people die each year by suicide with WHO estimating that rates have increased by some 60% over the last 45 years, with suicide being the second leading cause of global deaths among those aged 15–29 years old after motor vehicle collisions, these deaths being the tip of the self-harm iceberg and a common presentation of mental illness. (3) In this paper health records in a sub-divisional hospital in Fiji (Sigatoka Hospital) are reviewed to: 1) identify the burden of completed and attempted suicide; 2) define demographic features; 3) explore the underlying causes of DSH; 4) assess the roles of medical and legal professionals, and: 5) identify mental health tools used for assessment and management.

In Fiji, mental health services were decentralized in 2010 with the opening of Stress Management Wards in all three divisional hospitals and satellite clinics in sub-divisional hospitals. Sigatoka hospital is the 3rd largest sub-divisional hospital in Fiji catering for the Navosa/ Nadroga district which has a total of fifteen health facilities serving a population of 52,000, two thirds of whom are belong to the indigenous I-Taukei community and the remainder of Indo-Fijian descent. Mental health clinics are conducted in Sigatoka Hospital weekly by a trained mental health nurse with monthly visits conducted by vocationally trained medical personnel from the divisional hospitals.

METHODS
Health records from the mental health clinic and from the mental health register located at the emergency department at the Sigatoka Health Centre (where all new cases of DSH are registered) were reviewed. A retrospective audit of patients classified as completed and attempted suicide was undertaken for the period January 2011 to July 2016. Demographic data included: age, gender, ethnicity, etiology of mental illness. (1) Mental Health was defined by the presence of a psychiatric diagnosis. (2) A mental illness was defined by the presence of a self-harm presentation, (3) A self-harm presentation was defined as an attempt at suicide.

RESULTS
Deliberate self-harm
One hundred and forty-four cases were identified of which 85 (59%) were attempts and 59 (41%) completed suicides (cases admitted at SDH and transferred to Lautoka Hospital could not be established, with presentations of deliberate self-harm, studied in retrospect). The distribution of attempted and completed suicide by year is presented in Figure 1, demonstrating that while completed suicides showed no obvious pattern, there was an increase in attempted suicide with 28% of all attempted cases from 1st January 2014 to 31st July 2016, the overall ratio of attempted to completed suicide being 1.6: 1.

The gender distribution of combined attempted and completed suicide was similar with 75 females (52%) and 69 males (48%) and no consistent pattern from year to year. Of these, 85 (61%) were aged 11 to 30 (equally distributed across 11-20 and 21-30 years), 41 (28%) aged 31-50, 12 (8%) aged 51-70, and 3 (2%) over 71 years, demonstrating an obvious concentration of DSH in younger years. Indo-Fijians constituted 115 (80%) of all cases, with 26 (18%) being I-Taukei and 3 (2%) being other ethnic groups. Among Indo-Fijian cases males and females were equally represented, whereas among I-Taukei some two-thirds were female, with all three of those of other ethnic groups being male. The breakdown of total cases of DSH by means is shown in Figure 2 with chemical ingestion representing over half of all cases. Of these, 16 individuals ingested weed killer, 11 kerosene, 6 Janola (bleach), with other substances reported for 39 and the substances in 3 cases being unknown.

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The breakdown by gender and attempted vs completed suicide is presented in Figure 2 which demonstrates that while there is no obvious trend in complete suicides, both male and female suicide attempts appear to have increased over the five years to 2015.

![Diagram showing cases of DSH by means (January 2011 to July 2016)](image)

**Figure 2: Cases of DSH (attempted and completed) by means (January 2011 to July 2016)**

Comparative data from Fiji:

A retrospective analysis in 2015 on DSH trends among patients at the Nadi sub-divisional Hospital (1st January, 2012 to 31st December, 2014) showed that of 134 cases, one-quarter were completed suicides with 86% of Indo-Fijian descent, 79% under 40 years of age, and chemical ingestion the most common means (55%), but hanging being the most lethal (93%). (4) A 2007 review of attempted suicide in western Viti-Levu of 132 cases referred to the FSEG in Lautoka from January 2004 to December 2005 following attempted suicide were analyzed. Frequency distributions suggested (but without statistical significance) a higher number of Fijians of Indian ancestry, Hindu females, arranged marriage, childlessness and age less than 32 years as being vulnerability factors. A significant cross cutting association was found between social stress and all categories of ethnicity (despite the prevailing views regarding suicide associated with Christianity and Islam) of. (5)

**DISCUSSION:**

Of 144 cases of DSH presenting at the Sigatoka sub-divisional hospital over four-and-a-half years 85 (59%) were non-fatal and 59 (41%) died. While there is no obvious pattern to completed suicides, this evidence points to an increase in non-fatal attempts for both males and females. Of all episodes of DSH the majority were of Indo-Fijian ancestry (80%) with a concentration of DSH in younger age-groups with the common method used across the study being chemical ingestion (51%).
From interviews with the ten doctors and one mental health nurse providing services, a range of service experience is evident with DSH being a common presentation. However, while it appears that mental status examination is commonly (but not universally) done, it is of some concern that clinician perceptions of the salience of mental disorders to DSH with belief that underlying mental disorder was uncommon among presentations. In terms of management there appears to be a range of approaches which may relate to clinician experience and confidence, and resources. In relation to those factors the perceptions of the majority of these informants was that resources (human and space) for the management of these patients are inadequate, a reality compounded by the apparent limited attention to mental health within Continuing Medical Education sessions provided locally.

The role of medical professionals should not be limited to only the medical management but directed holistically, enabling early identification of high risk cases, psychiatric evaluation and management. Much local effort to increase professional knowledge in the conduct of mental health topics in Continuous Medical Educational programs is warranted. 77.8% respondents validated that no Mental Health discussion was conducted within this year. The features of DSH found in this study bear similarities to the findings from Nadi and Viti-Levu – DSH is common and there are clearly common vulnerabilities (people of Indi-Fijian heritage and young people). There are also common findings in relation to means (chemical ingestion) which provide opportunities for intervention and prevention. However, this study has provided additional information relating to clinician experience and practice that suggests that the priority and resources allocated to address DSH are not commensurate with the burden.

REFERENCE:
Nandini Lal. 20152007 study
Evaluation of the leadership mental health: Island Nations course
Fiona Charlson1,2,3, Michelle Redman-MacLaren4, Kate Gossip1,2, Ernest Hunter1,4

ABSTRACT
Quantitative and qualitative findings of an internal evaluation of the second Leadership in Mental Health: Island Nations course are presented. Findings Prominent commonalities across the evaluations of the 2015 and 2017 courses include: the importance of communication and sharing in situations where professional isolation is common; the particular relevance of topics dealing with practice rather than theory with attention to contextual and cultural adaptation, and; the need for ongoing relationships through supervision and mentorship. The article concludes with consideration of the evaluation findings for the future of the course and for mental health capacity building more broadly across Pacific Island nations.

INTRODUCTION
In opening Creating Futures 2017: Fiji, the Honourable Rosy Sofia Akbar, Minister for Health and Medical Services reflected on the national burden of mental disorders and their consequences, including suicide and violence within families (see Akbar, this issue). As demonstrated by recent data for Oceania, this burden is both significant and increasing across the region (Charlson & Erskine, 2015). Clinical resources are limited and budget allocations to health (let alone mental health) are challenged by competing demands. Innovative approaches to meeting mental health needs, and strengthening the workforce to do so, are required. This paper presents an evaluation of the second Leadership in Mental Health: Island Nations (LMH:IN) course which was enabled by and run in conjunction with the Creating Futures 2017 conference (see Editorial).

As outlined in the evaluation of the first LMH:IN course run in conjunction with Creating Futures: 2015 in Cairns (Charlson, Redman-MacLaren, & Hunter, 2015), this course is modelled on the Leadership in Mental Health course run in Goa since 2008 by Sangath, an Indian mental health NGO (www.sangath.com), in collaboration with the London School of Hygiene & Tropical Medicine. The LMH:IN course was designed to: 1) equip participants with methods to develop and scale up mental health interventions for people with mental disorders, and promote approaches that support mental health and wellbeing in low resource settings, and; 2) enhance leadership skills to scale up mental health care programs and promote the human rights of people affected by mental disorders.

As demonstrated in a recent literature review of approaches to building mental health capacity in low- and middle-income countries (LMICs) (Keynejad et al., 2016), published evaluations are few with none included from Oceania. The LMH:IN course does share features with most common models described in that review, including a combination of brief training with longer-term mentorship and network development. However, there are several differences 1) this is the only such initiative in Oceania; 2) a subset of participants completing the course in 2015 engaged in an on-line Implementation Science course run the following year, and; 3) that group are encouraged to participate in subsequent LMH:IN course delivery. The longer-term objective is not only to increase capacity but also to embed capacity building in the region.

The LMH:IN course ran in parallel to, and then extended beyond, the four days of the Creating Futures 2017: Fiji conference, which was designed to ensure all eleven plenaries were relevant to LMH:IN course participants (program at: www.creatingfutures.com.au). Eight workshops within the conference and another seven over the following three days addressed concepts and issues directly related to mental health leadership in Oceania, and were facilitated by tutors from Australia, India, New Zealand and South Africa. To support context relevance and local expertise, each workshop planning group included at least two Pacific Islander (largely Fijian) participants whose purpose was to be involved in both planning and delivery. A workshop for some thirty co-facilitators was held in Suva five months before the conference and ongoing communication within groups was electronic.

Applications for the LMH:IN were sought through national networks with selection providing an appropriate mix of delegates, there being seventeen from Fiji, including nine nominated by the Ministry of Health and nine from a range of NGOs. In addition there were ten delegates from across other Pacific Island Countries and Territories (PICTs), these being Samoa, Solomon Islands, Vanuatu, Tonga, Cook Islands, Federated States of Micronesia, Marshall Islands and Kiribati. There were equal numbers of men and women. The aim of this paper is to: 1) report the mixed methods evaluation of the LMH:IN course; 2) examine how these results can inform future LMH courses in Oceania, and; 3) apply to broader mental health and public health capacity strengthening in Oceania and comparably resourced contexts.

METHODS
The evaluation of LMH:IN followed a mixed methods convergent parallel design, with both quantitative and qualitative data collected at the same time (at the LMH:IN course), analysed separately, and results then merged for comparison and interpretation (Cresswell, 2013). Data include: 1) post-course assessments (qualitative and quantitative information); 2) workshop feedback forms; 3) record of participant round-table at conclusion of LMH:IN course, and; 4) workshop facilitator session reports (qualitative and quantitative information).

Quantitative evaluation
Pre- and post-course surveys covered 13 topic areas derived from the course objectives, in each of which specific questions addressed participants’ 1) knowledge; 2) awareness of applica-
strategies, and; 3) capacity to implement. The resulting 38 questions utilised a Likert scale of 1 (not true at all) to 4 (very true), to measure attendance impact.

**Qualitative evaluation**

The post-course survey contained questions about: 1) most and least useful components of the course; 2) changes for participants as a result of participation, and; 3) anticipated challenges, opportunities and support needs. Additionally, surveys after each workshop sought participants’ views on content and suggestions for improvement; and facilitators’ opinions on concept, planning and delivery.

An inductive thematic analysis approach was used to analyse participant and facilitator responses (Braun & Clarke, 2006). Codes, categories and themes were identified following line-by-line coding of participant responses.

**RESULTS**

All 27 participants commenced and completed the course, and completed both pre- and post-course surveys.

**Quantitative findings**

Overall, participants reported a pre-course average score of 2.6 and a post-score of 3.4 on our 4-point Likert scale, a 30% increase in scores. This equates to an overall increase in awareness and knowledge of the topic areas of 30%; however, the increase in perceived ability to implement their knowledge was less at 25%. All topic areas appeared useful to the participants with ratings ranging between 4.1 and 4.4 on a 5-point Likert scale. The topics with the biggest gains in knowledge were disaster planning (43%), implementation and scaling up of services (38%), Theory of Change (35%), and community-based research (34%).

On a 4-point Likert scale, feedback on five aspects of workshop planning and delivery were obtained from fourteen LIMH:IN facilitators, these ranging from 2.92 to 3.14. Taking into account feedback from thirty other facilitators, covering the workshops within the Creating Futures conference not within the LIMH:IN course, the lowest scores related to binational cooperation in planning and delivery.

**Qualitative findings**

**Evaluation of workshop by participants**

Most participants described all workshop sessions as useful, with sessions: “closely linked and leaving out a topic would not complete the overall component of the course”. Workshops session’s assessed as more useful included: 1) theory of change; 2) developing and sustaining a workforce; 3) community-based research, and; 4) cultural competencies (consistent with the quantitative data reported above). One participant explained, they were now, “…able to design effective strategies for capacity building and professional development within a service.”

Some participants did find the Theory of Change session a challenge. One participant explained that workshop: “was difficult to understand and ‘could’ve been delivered in a better way’”. Some participants would have preferred the sessions to have a more person-centered rather than systems-focused approach. It was suggested that modules on personal leadership, supervision and mentoring could be added to the course.

“Look at the big picture”: Changes resulting from the course

As a result of the workshop, participants reported it had enabled them to: “Look at the big picture,” and: “get out of my ‘silo’”. Although the countries in which the participants work often have limited resources and capacity, the LIMH:IN course helped some participants to identify networks and platforms of care that could improve mental health services. One participant stated: “…we have existing and available resources in our own countries but do not use it as much or are not even aware of it”. The collective workshop experience inspired some to consider how they could, “learn from other organisations and work together in order to look into mental health issues”, including collaboration with Pacific and non-Pacific partners. Self-reflection, along with encouragement to improve leadership, management skills and personal confidence were also appreciated.

A greater understanding of the recovery-focused perspective on mental health care and the important role that families and carers play was reported. One participant emphasised how it is essential: “to understand and show respect to people and their lived experiences and the mental health challenges for their families and loved ones”.

While all PICTs have unique challenges when delivering mental health services, many experience similar cross-cutting issues. With: “culture…still a strong component of our Pacific identity”, the course provided opportunity to: “share issues which are similar and connected”. The participants also felt that they learned a lot from the expertise of the international facilitators and that facilitators had encouraged new ways of thinking about mental health.

Where to next? Recommendations for future LMH courses

Participants recommended future workshops include a broader range of stakeholders, including people with lived experience of mental illness, carers, volunteers, community members and representatives from education and child and youth organisations. Past LMH graduates should be invited back to mentor new delegates; they: “understand what the course seeks to do and who is likely to benefit”. Participants would also like the course to be run in anther PICT in future. Cultural sensitivities should be more closely attended to, including sessions not to be held on a culturally (religiously) important days.

To adequately prepare for the course, future participants could complete a project that required them to identify key issues in their country. During the course, more time to “reflect, discuss, brainstorm and plan on individual country’s mental health work” was recommended, as were more sessions that explored relationships between Pacific culture and mental health. It was also recommended each country deliver a presentation (or prepare a poster) at the wider Creating Futures conference to enhance inter-country learning and networks. “The extent of personal ‘sharing’ of lived experience” was also encouraged.

Some participants would have liked the course to expand on the clinical issues covered during the Creating Futures conference, including clinical and psychosocial interventions. Participants also wished to explore topics including how use of traditional stories could inform a culturally relevant evidence base. Skills to conduct simple yet quality research informed by literature and local contexts to address priority mental health issues is required. With English not the first language, back-translation and para-
phrasing were suggested. A “primary mentor to relate to” was recommended; either a tutor or past course graduate could act in this role. Participants also recommended an in-group facilitator remain with the group throughout the duration of the course. Session materials, including templates, provided a week before the course would enable participants’ time to read and process workshop content.

Challenges and opportunities for implementing learning in local contexts

A perceived lack of organisation and leadership within respective mental health systems was a major challenge identified. With limited structured platforms in mental health systems, improving mental health services requires: “a strong proactive team that utilises existing resources”. Despite there being: “many health workers motivated and willing to contribute to mental health services”, there is a lack of adequately trained staff and limited skills within the workforce. Participants reported some resistance from medical professionals to be trained in mental health, and a lack of political support from within government that is needed to: “change the way people at the “top” look at issues in mental health”. Participants also pointed to a need for assistance to better engage with non-government organisations, communities and individuals to successfully implement sustainable and integrated mental health services. Related challenges include a lack of funding, ongoing stigma towards mental illness, a lack of specialist mental health workforce actors (e.g. psychologists, social workers, doctors and nurses), challenging geographical conditions, and the increasing negative effects of natural disasters.

Despite these identified challenges, participants valued the opportunity to share information and knowledge, and to strengthen collaboration and networks. Partnerships with carers and cultural leaders were identified as key, the point being made that: “Cultural beliefs and mindsets need to be changed if mental health services are to improve”. Increasing education and awareness campaigns was presented as a viable means to provide education for families and carers who: “carry a huge responsibility for looking after loved ones with a mental health condition”.

Specific requests included formal mentoring and increased professional development, both in terms of as-needed support and in relation to expanding leadership skills, with graduates of the LMH:IN course being identified as potential mentors for following groups. Community-based research was noted as an opportunity to inform mental health services in the Pacific and participants appreciated the importance of: “using the evidence based tools available with the theory of change framework to develop effective mental health services” and using “existing data sources to strengthen [the] database for mental health”. The establishment of a regional research project was suggested as a means to support community-based research collaborations in mental health across the Pacific.

**Evaluation of workshop by facilitators**

Comments regarding conceptualisation, planning and delivery were received from all workshop lead facilitators. There was considerable overlap across the areas with, in general, the responses being positive. However, in relation to the key underlying issues – the program logic of the LMH course in PICTs, utilising workshops balancing didactic and interactive components and, critically, seeking to ensure binational collaboration in planning and delivery – responses varied greatly. While involvement of local workers was universally considered a good idea, actual engagement varied from substantial and effective – to nothing. Area of perceived (or potential but not realised) benefit included increasing external facilitator understandings of local issues, ensuring local ownership and improving relevance for delegates. Various issues were raised by those for whom binational collaboration was not effective including: insufficient understanding of the purpose and process; technical matters frustrating communication, and; lack of local leadership in the process. However, for other facilitators the process worked well and several of these noted that having familiarity with PICTs and, for some, the opportunity to visit Fiji before the course, was important. Among suggestions for the future was the following, making the point about binational participatory learning: “For the next offshore conference could we invite local people to put together and deliver a workshop for presenters. I felt like the information sharing/capacity building was a bit one-sided. I would have liked to learn s bit more about how things work in Fiji”.

**DISCUSSION**

As was the case with the evaluation of the inaugural LMH:IN course run in Cairns in 2015 (Charlson et al, 2015), caution is mandatory in interpreting the results of an internal evaluation of an initiative with a small number of participants and no follow-up. However as this is the second course, it is possible to identify some common themes. Further, as there has been an evolution in the approach to delivering this course and to how it complements other LMH initiatives (specifically, encouraging graduates to participate in the Implementation Science course and participate as tutors in subsequent courses), it is possible to consider the broader relevance of the project to improving mental health leadership capacity in Oceania. It is worth noting that eight of the ten Pacific Island delegates who participated in the 2015 LMH course in Cairns attended the Suva conference in 2017.

Three findings stand out as commonalities across the two courses. First, communication and sharing is highly valued; it appears this is a consequence of professional isolation for many mental health workers. Second, topics that appeared to have greatest importance for participants again appear to be related to practice rather than theory (Theory of Change, valued in both, serving as a practice/implementation enabler). Third, delegates identified the need for ongoing relationships through supervision and mentorship, an area of particular need that has been noted elsewhere (Davies & Lund, 2017). In concluding discussions following both courses delegates expanded on this issue, noting their need for support in developing personal capacities to support task shifting and program development – pedagogical, management and supervision skills. They also emphasised that while universally important, ensuring local relevance and attention to cultural considerations is critical.

Indeed, the area of concern most commonly articulated related to context relevance, both in terms of content and process in the workshops. It is noteworthy that the approach taken to binational preparation and delivery in Suva in 2017 was a consequence of similar concerns raised following the inaugural course in Cairns in 2015. This issue remains highly relevant, and the approaches used at both workshops requires refinement.
The findings reported are instructive as we look at the broader trajectory of workshop facilitation over time. The beginning of this journey was with an Island Nations forum at the Creating Futures conference in Port Moresby in 2012 (Hunter, 2012), at which delegates articulated the need for relevant training for Pacific practitioners. The 2015 course in Cairns was a direct result of this recommendation, and while there were delegates from other settings, the focus was on Pacific Island nations (Charlson et al, 2015). Feedback from delegates to that course led to the provision of an on-line Implementation Science course to a subset of delegates in 2016, and informed the design and delivery of the 2017 course located in the Pacific.

CONCLUSIONS

One interpretation of the findings of this evaluation is that the best model for improving capacity in the region has not been found but that the process is, incrementally, moving towards both improving mental health capacity, and embedding mental health capacity building within the region. To that end, following the Suva course, discussions have commenced regarding an ‘enhanced’ LMH:IN course for a selected group of past participants, to provide implementation, evaluation, supervision and systems planning skills that will enable Pacific mental health workers to drive capacity strengthening within their respective Island nations. Increasing mental health capacity in Pacific Island nations remains a work in progress.

REFERENCES


ABSTRACT
Cannabis use among students can negatively impact on education, mental and physical health outcomes. School and health sector counsellors hold trusted positions and can assist students address cannabis use and associated difficulties. Screening, early identification and brief interventions can assist young people regain control of their lives. A motivational enhancement approach can fit well within their roles. This approach can also be used with alcohol and other drugs, and with youth out of school.

Key words: cannabis use, students, brief intervention

INTRODUCTION
Cannabis is the most commonly used illicit drug in the world (UNODC, 2017). Under-recognition of the effects of cannabis use and dependence on health and psycho-social functioning represents missed opportunities for health promotion and early interventions for young people who may already be experiencing cannabis use-related difficulties.

Potential harms associated with cannabis use
Most drug use behaviours are initiated during adolescence, and there is increasing concern about the impact of early onset, regular and heavy cannabis use on the psycho-social development of young people (Copeland & Howard, 2013). Robust findings link early onset cannabis use and poorer educational achievement, and respiratory disease, especially when cannabis is mixed with tobacco (Horwood, Fergusson, Hayatbakhsh, Najman, Coffier, Patton, Silins and Hutchinson, 2010).

Frequent and heavy use of cannabis can exacerbate underlying mental health conditions, including schizophrenia, with increased symptom severity, non-compliance with treatment and more frequent hospitalisations (Large, Sharma, Compton, Slade and Niellsen, 2011; WHO, 2016).

Prevalence of use by young people in Pacific Island Communities and Territories (PICTs):
The majority of data come from two survey instruments, administered to representative samples in selected schools, for students aged 13 to 17 years, and updates the Howard, Ali and Robbins (2011). The surveys are: a) WHO Global Student Health Survey (GSHS)(WHO, 2017) used in many countries around the world, b) Youth Risk Behaviour Survey (YRBS)(CDC, 2017) developed by the Centres for Disease Control and Prevention, and used in the USA and its territories. Australia and New Zealand use their own instruments (Adolescent Health Research Group, 2013; White and Williams, 2016).

While the data presented come from a variety of surveys, the core questions remain essentially similar: ie During your life, how many times have you used marijuana? Some countries only report ‘ever’ used, and, as survey years vary, comparisons require caution.

Table 1: Ever and current cannabis use mong secondary school students PICTs.

<table>
<thead>
<tr>
<th>Country</th>
<th>Year</th>
<th>Survey</th>
<th>Sample</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Samoa</td>
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<td>2811</td>
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<td></td>
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Table 1 demonstrates that rates of cannabis use across the PICTs vary, with data from Australia, New Zealand and the USA for reference. Higher levels of use were reported in: American Samoa, French Polynesia, Guam, Marshall Islands, Northern Mariana Islands, Palau, Samoa, and the USA. Lower rates were reported in: Fiji, Kiribati, Solomon Islands, Tokelau, Tonga, Tuvalu, Vanuatu, Wallis and Futuna.

Assisting secondary school students with cannabis use-related difficulties:
School nurses, community health workers and primary health counsellors (hereafter nurses/counsellors) occupy trusted positions and are ideally placed to assist students with cannabis-use related difficulties. Students who use cannabis rarely present for

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treatment for their cannabis use. However, they may be referred by school staff for behaviour issues, or seek assistance for other problems such as poor sleep, anger, depression, anxiety, relationship issues, or respiratory problems. Early detection of cannabis-related issues is important in reducing preventable escalating problems.

Whilst some students may avoid conversations about their drug use, others will be relieved they did not have to bring it up themselves. At a minimum, nurses/counsellors are encouraged to provide pamphlets, links to appropriate online resources, and basic screening and detection are strongly encouraged. However, screening instruments do not replace an empathic conversation and history taking, and motivational enhancement (ME) approaches have proved to be useful with young people.

Motivational enhancement:

A number of studies have explored brief (2-3 session), opportunistic, motivational interventions, demonstrating reductions in cannabis use (Martin, Copeland, Swift, 2008; Miller and Rollnick, 2012). A ME approach can be utilized in and out of school settings and aims to engage with an adolescent around their cannabis use. If it is within the practitioner’s role, use of evidence-informed therapeutic approaches could follow, and it is likely that they may be more effective with initial attention to engaging with the young person. Alternatively, if not within role, appropriate referrals can be provided.

ME uses a conversational style, ensuring respect, empathy and communicating an understanding that the student’s use of cannabis is and I'm more than able to stop. ‘Do you think that?’ ‘Do you think that you can look at it... OK?’ ‘What do you think about cannabis?’

R: Well – sometimes... like when my head is spinning and I’m thinking it is giving me the shkit!(s)
N/C: Ok, so it helps you to get to sleep too... What else does the dope do for you?
R: I dunno... it’s fun... Better than being bored with nothing to do... and I can relax, chill...
N/C: Sounds using dope gives you something to do, some fun times and then helps you study... Are you more change you like about it?
R: Hey... what idea? I don’t know... I just like it. (Glares)
N/C: Ok, is there any other drug that you don’t like so much about the dope?
R: Hmmm (pause)... Well, umm... it’s existing me a lot
N/C: So, it’s getting a bit expensive...
R: Yep
N/C: What else?
R: Ah... sometimes I don’t like what it does to my head... especially when I use it by myself... (pause)
N/C: That must be tough... are there other things as well?
R: Sort of. Like when I call Mum or Mum (his sister) they keep saying - ‘are you still using dope?’ ‘are you smoking now?’ It makes me angry - upset
N/C: I see
R: Yes – at them and me!
N/C: Like?
R: Like they think I am some sort of loser... they should talk!
N/C: Ok, so there’s the cost, you feel anxious, being a bit worried about what is happening to your head and how your mum and sister are treating you. Other things?
R: Oh, it makes me lazy too... I don’t get homework done... it’s hard to concentrate in class
N/C: Questions, questions... But, are there other things you don’t like so much about the dope?
R: Nah... think they are the main ones - and think the cops are watching me
N/C: So, have you ever tried to cut down or stop?
R: Yeah - but it didn’t work
N/C: What did you try?
R: Just tried to stop...Nu
N/C: What happened?

Role: Dialogue

N/C: [conversation begins during a general ‘chat’...]
R: so you were mentioning about using dope (cannabis) ... I am wondering what YOU like about it – what are some of the things you get from it?
R: I really don’t know what to say... I like the ‘high’...
N/C: Give me some feedback like...
R: Well... it’s something to do – fills the time... ummm... I do it with me friends ... we laugh
N/C: So you have some fun times with friends and it fills the time... what else?
R: I don’t know... umm... it helps me to get to sleep...
N/C: It’s hard for you to get to sleep without it
R: Yep... sometimes... like when my head is spinning and I’m thinking it is giving me the shkit(s)
N/C: Ok, so it helps you to get to sleep too... What else does the dope do for you?
R: I dunno... it’s fun... Better than being bored with nothing to do... and I can relax, chill...
N/C: Sounds using dope gives you something to do, some fun times and then helps you study... Are you more change you like about it?
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N/C: So, it’s getting a bit expensive...
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R: Ah... sometimes I don’t like what it does to my head... especially when I use it by myself... (pause)
N/C: That must be tough... are there other things as well?
R: Sort of. Like when I call Mum or Mum (his sister) they keep saying - ‘are you still using dope?’ ‘are you smoking now?’ It makes me angry - upset
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R: Yes – at them and me!
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R: Like they think I am some sort of loser... they should talk!
N/C: Ok, so there’s the cost, you feel anxious, being a bit worried about what is happening to your head and how your mum and sister are treating you. Other things?
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N/C: Questions, questions... But, are there other things you don’t like so much about the dope?
R: Nah... think they are the main ones - and think the cops are watching me
N/C: So, have you ever tried to cut down or stop?
R: Yeah - but it didn’t work
N/C: What did you try?
R: Just tried to stop...
N/C: What happened?

Role: Dialogue

R: It didn’t work
N/C: What did you want to get from stopping or cutting down?
R: I dunno... Head quieter, some money for things... family... I don’t know...
N/C: Ok... so you have some good ideas about what you wanted - what about things that might be no so good about making a change?
R: Hmmm... well guess my friends... how they will treat me...
N/C: Yes... that is something important... what other things?
R: Well... getting bored... what will I do... nothing to do...
N/C: So, having something to do with your hands – they will be useless for you... anything else?
R: Nah... just being straight and handling things...
N/C: Ok... Let’s see... so you like getting stoned with friends, stop you getting bored, help you relax and sleep. BUT on the other hand you are worried about what the dope might be doing to your head, it costs you lot, makes you lazy your mum and sister hassle you
R: Yes... I guess that’s it
N/C: And, you think that if you cut down you might have more money and get on better with your family. BUT you’re worried that your friends might not be so happy with you... you might then have no friends and you will be bored
R: Yeah
N/C: So what do you think? I have some information here about how you could try to cut down or quit by yourself... and some info on people or programs that could maybe help you if you would prefer... that some even on the web and there are some Apps that you could try...

Option One: willing to change

Role: Dialogue

R: What if I did want to try one
N/C: Ok... and remember we’ll support you with what you choose... will let’s look at this material (gives brochures from appropriate agencies)
N/C: Option two: not so willing to make a change... at this stage
R: Hmmm, I’m not sure... maybe too hard for me... not sure I could do it
N/C: Ok, well at least you have had a good look at your situation... what you like and like less about dope and what might be good about change, but what also might be hard... what don’t you give this info here and you can look at it... OK?
R: Ok, you
N/C: Good, ok, and, one last thing ... I just wanted to leave you with a question... ‘What do you think could happen that might make you think again about making a change?’
R: I don’t know... maybe getting busted by the cops?... I don’t know
N/C: That could be a big thing... OK – it’s hope that does not happen.... if you do think again about what we have been talking about today... you know where we are – and I’m more than happy to have another chat? OK?
R: Ok... thanks...
Themes evident in this scenario include:

• attempting to build motivation for reflection on Ravi’s predicament and easing Ravi to a point where he can make a ‘decision’.
• exhausting ‘good things’ about use, and not over-reacting to ‘less good things’, thus letting Ravi know that he or she understands that Ravi uses cannabis for specific reasons, is not merely engaging in delinquent behaviour, and that he is aware of the impact of his cannabis use. It is important not to attempt to deal with all issues raised; the main task here is engagement and enhancing motivation for change.
• eliciting Ravi’s views about ‘good/less good things’ about reducing or ceasing use.
• summarising and attempting to have Ravi reflect on this, and make a decision about making a change or staying where he is.

If Ravi is concerned or is ready to consider change, then further interventions could be offered. Key components of these might include:

• Providing feedback linking cannabis use with current and potential health problems.
• Elaboration of cannabis use: amount of use alone and with others, times of day, locations, age mix of those Ravi uses with, any coercion, and any risks associated with their cannabis use – eg location, mix of co-users, sharing of means of use – eg bong or joint.
• Discussion aimed at eliciting change talk. For example, Ravi’s level of confidence that he can change his substance use if he wants to. If confidence is low, encourage Ravi to recount other changes he has made, or the personal qualities that would help him to change his cannabis use.
• Raising specific options to assist change (a Menu of options). For example, identifying high-risk situations, triggers and strategies to avoid them. Triggers for use include: moods/feelings, people (family, friends, peers, others); places; odours, for example, room and clothing not cleaned; implements and waste left around; visual stimuli such as posters linked to cannabis, its use, famous cannabis users, or mixing bowls.
• Identifying other pleasurable activities.
• Helping Ravi decide on goals.
• Encouraging Ravi to identify people who could provide support and help desired change.
• Providing self-help resources, youth-friendly written information and web links to reinforce what has been discussed.
• Inviting Ravi to return to discuss progress and offering further help or information as necessary.
• Working with school staff to ensure Ravi can maintain his education – a strong protective factor.
• Considering an appropriate family work approach.

Such approaches fit with the FRAMES approach recommended by WHO, and outlined in detail in their ASSIST package (WHO, 2010). In addition, it is important to discuss symptoms of withdrawal from cannabis use which can trigger relapse. Symptoms typically emerge after one to three of days of abstinence, peak between days two and six, and typically last from four to 14 days with sleep difficulties often taking some weeks to ameliorate. The most common symptoms include nightmares and strange dreams, difficulty getting to and staying asleep, night sweats, irritability, and diminished appetite (Copeland and Howard, 2013). Likewise, craving for cannabis should be addressed. Craving may occur within the consultation and the nurse/counsellor should enquire about the effect that the conversation about cannabis and its use is having on the student. Strategies to manage cravings, such as delaying, de-catastrophising, distracting, de-stressing and drinking water can be discussed.

CONCLUSION:

Nurses/counsellors occupy unique and trusted positions and, by virtue of this, can provide opportunities for students to address substance-using behaviours that have effects at multiple levels – physical and mental health, academic performance, family relationships, sport and other social and recreational activities, and engagement in activities prohibited by law. Being comfortable in engaging in helpful, motivating conversation about cannabis use, and strategies to address student concerns, is one such opportunity. This approach can also be used with alcohol other drugs, and with youth out of school.

REFERENCES


http://apps.who.int/iris/bitstam/10665/44321/1/9789241599399_eng.pdf


http://apps.who.int/iris/bitstam/10665/44322/1/9789241599405_eng.pdf
**ABSTRACT:**
The number of deaths from suicide appears to be increasing worldwide, and the World Health Organization (WHO) has observed that more than 75% of global suicide cases were from resource poor, low-and-middle-income countries (LMICs). This paper draws on relevant literature as well as the discussions during the suicide and self-harm workshop at the Creating Future 2017 conference which identified important clinical and social issues related to suicide in Fiji.

A systemic approach to suicide prevention is highlighted, which incorporates individual clinical risk assessment and treatment, as well as a public health approach to suicide prevention through a whole of government and whole of community approach. The Fiji national mental health and suicide prevention policy is a welcome step that needs to be implemented through a concrete and adequately resourced national mental health and suicide prevention program.

**Key words:** Suicide, Self-harm, Prevention, Fiji

**INTRODUCTION**
Globally, nearly 800,000 people die by suicide every year. Suicide is the second most common cause of death among 15–29 year olds. For each person who died by suicide, more than 20 others attempted suicide. WHO data for 2017 reveal that 78% of the global suicide cases were observed in resource poor low-and-middle-income countries (LMICs) in 2015. (WHO, 2017). The suicide rate in Fiji was reported to be 8.9/100,000 in 2015. The male suicide rate is approximately 3-4 times higher than the rate for females. Longitudinally, the male suicide rate increased from 13.6/100,000 in 2000 to 14.6/100,000 in 2010 and then gradually declined to 13.5/100,000 in 2015. The suicide rate for females has fallen from 5.7/100,000 to 4.3/100,000 over the period 2000 to 2015 (WHO, 2017). A study from Rakiraki, Fiji concluded that there is a higher rate of suicides and attempted suicides among Indo-Fijians youth and in males (Nafiza et al., 2016). While suicide rates appear to have fallen, as Fiji has issues of under-reporting and relatively poor record keeping, real rates are probably higher.

**Characteristics and Causes**
The characteristics of those attempting suicide in Fiji have been observed to be: non-Indigenous Fijian race; female gender; young age; being a student, and; being unmarried and unemployed (Aghanwa, 2000; Henson et al., 2012). Grambeau (2007) raised concern about an apparent increasing trend in the Indigenous Fijian population. Common factors that affect the risk of suicide include: mental disorders; substance misuse; psychological states; cultural, family and social situations, and; genetics. The majority of cases are associated with mental disorders, substance abuse and psychosocial stresses with these factors often co-existing (Aghanwa, 2000).

Henson et al. (2012) identified interpersonal and identity loss, financial instability and family stresses as predominant triggers for Fijians. In their study, over 10% of participants acknowledged previous attempt(s). Other risk factors included: availability of means; family history of suicide; poverty; homelessness, and; discrimination. The path to modernity and Western materialism has caused compromise and compartmentalization of traditional philosophy, religions and culture that, by contrast, often emphasize a simple and austere lifestyle. The emphasis on individualism has also resulted in a reduction of traditional support systems, which increases social isolation.

Rapid urbanization and large-scale migration from rural areas leaves many without community supports (Jacob, 2009). Moreover, intermittent socio-political and, consequently, economic instability is associated with high rates of suicide in corresponding and following years (Lal, 2006). Since the 2000 political crisis there has been a marked increase in the suicide rate, particularly among Indo-Fijian women aged between 16-25 (Lal, 2006; Joseph, 2006). The possibility that discrimination in job-placement, schools and scholarship schemes contributed to stresses during this period has been reported (Joseph, 2006). Police records reveal that some 1749 people attempted or completed suicide between 2002 and 2010, with an average of 194 per year (Nafiza et al., 2016). In the following years several socio-political reforms occurred leading to greater social and economic stability, which likely contributed gradual decline in suicide rate (Nafiza et al., 2016; WHO, 2017).

**Intervention options**
The etiology of suicide is multifactorial and hence requires a multipronged and integrated approach. A public health approach demands a framework that is located within society and politics rather than bio-medicine, reframing public health issues as basic human rights. Although services exist across both government and non-government sectors, much more needs to be done to strengthen capacity at the community level where an action-oriented, community-based systemic and robust approach is required. Ultimately, the real challenge is to integrate public health goals into the diverse disciplinary frameworks (Jacob, 2017).

Primary care doctors, emergency services and other non-health care professionals, including the community sector and certain volunteer and support groups, all have a role to play in suicide prevention. Primary Health Care networks are in a relatively better position to decrease suicide rates by virtue of their links to hospitals, general practice, Non-Government Organisations (NGOs), and the communities which they serve. The Black Dog Institute
in Australia, has advocated a ‘Systems Approach’ and provides guidance about effective strategies in reducing suicide rates and attempts. This approach has nine strategies incorporating population-based measures as well as individual support (Christensen, 2016):

1. **Aftercare and crisis care** – People who talk about suicide or have self-harmed are at increased risk of repeat attempts. Hence the need for a coordinated approach with the primary care sector drawing on links with hospital and other health services to establish local suicide prevention and crisis teams, and to ensure patients are followed up.

2. **Psychosocial and pharmacotherapy treatments** – The main effective therapeutic options to reduce suicidal thoughts and behaviours are psychosocial treatment and pharmacotherapy. The primary care sector has a critical role in ensuring access to these modalities as part of more broadly providing primary mental health care, which may involve partnering with relevant organisations to develop or disseminate treatment guidelines and new approaches to screening for mental illness and/or symptoms.

3. **Primary care capacity building and support** – While suicidal individuals often have visited primary care providers before a suicide, there needs are not always recognised and primary care clinicians may not be aware of the best way to manage any disclosure of suicidal ideation. Psychiatrists/mental health specialists need to educate and support General Practitioners and other primary health providers to upskill them in identifying and managing at-risk individuals presenting through the primary care sector.

4 and 5. **Frontline staff and gatekeeper training** – Gatekeepers (those who come into contact with at-risk individuals) may influence a suicidal person’s decision to access care. Gatekeeper programs focus on increasing mental health literacy and teaching skills to assess, manage, and provide resources for at-risk individuals. Therefore, one of the tasks of mental health specialists is to identify potential gatekeepers across the community, and provide gatekeeper training as appropriate. People with lived experience, carers, volunteers and paid support workers are clearly key ‘frontline’ resources.

6. **School programs** – Schools provide a cost-effective and convenient way of reaching young people. School-based programs are mostly focused on increasing help-seeking, improving mental health literacy and increasing awareness of suicide warning signs and help strategies. The mental health sector in Fiji should strengthen partnerships with schools to encourage the adoption of evidence-based programs within locally acceptable social and emotional wellbeing frameworks.

7. **Community campaigns** – These are best delivered in conjunction with other strategies and may improve mental health literacy in the general population. Mental Health Services are encouraged to work closely with local communities and government organisations to identify existing programs and ensure targeted, consistent consistent messaging.

8. **Media guidelines** – Suicidal behaviour can be influenced positively as well as negatively by the media. Guidelines endorsing responsible reporting of suicide by the media may reduce suicide rates. Mental health specialists are encouraged to work with local media to promote, adapt and utilise the media reporting guidelines developed by ‘Mindframe’ (Australia) or WHO.

9. **Means restriction** – Controlling access to the means is considered to be one of the most effective suicide prevention strategies. Mental Health services in Fiji are encouraged to draw on partnerships with government and community organisations to analyse data on suicide deaths. Data may reveal suicide ‘hot spots’ and means restriction can then be tailored to these areas and means.

**Workshop considerations of the Black Dog recommendations in the Fijian context**

**PRIMARY CARE CAPACITY AND ASSESSMENT**

As discussed in the workshop on clinical issues, for individual clinical risk assessment, nothing replaces a thorough psychiatric assessment, with a comprehensive clinical history and mental status examination. However, rather than focusing solely on psychiatric symptoms and diagnosis, it is important to consider the patient’s broader life circumstances in order to understand the meaning as well as the manifestations of self-harmful ideation and behaviour. For that, a bio-psycho-socio-cultural-lifestyle approach with attention to predisposing, precipitating and perpetuating factors is recommended.

Shea’s CASE (Chronological Assessment of Suicide Events) approach (Shea, 2009) is a flexible, practical, and easily learned interview strategy for eliciting suicidal ideation, planning, and intent. It is designed to elicit ‘intent’, a combination of stated intent, withheld intent and reflected intent. The ‘reflected intent’ is an idea from motivational interviewing theory that the amount of time thinking about, extent of planning, and actions taken may be a more accurate indicator of actual intent than what someone states is their intent (Shea, 2009).

For addressing suicide in a recovery-oriented manner, the SANE Australia guidelines (SANE, 2016) for mental health professionals recommend: building a positive working relationship with the consumer; holistic risk assessment; working collaboratively with family and friends; supporting consumer independence and decision making; supporting the consumer in times of transition; promoting recovery; building resilience; communicating respectfully; providing support after suicide; staying healthy yourself; and; undertaking additional suicide prevention training.

**Restricting access to means**

With respect to means restriction, chemical ingestion and hanging continue to be the predominant methods of suicide in Fiji (Nafliza et al., 2016). Pesticide poisoning cases are common and frequently lethal in Fiji, and Henson et al. (2012) reported intentional self-poisoning (78.4%) as most common method of attempted suicide in the country. Stronger and enforced pesticide regulations can assist in reducing suicide attempt fatality rates, as observed in Sri Lanka (Roberts et al., 2003), in addition to
assist in reducing suicide attempt fatality rates, as observed in Sri Lanka (Roberts et al., 2003), in addition to implementing the WHO guidelines for safer access to pesticides (WHO, 2016).

Media coverage
Comprehensive strategies to influence media representation of issues related to mental illness and suicides, encouraging responsible and accurate and sensitive descriptions, are unavailable in Fiji. WHO recommends that responsible reporting should: take the opportunity to educate the public about suicide; abstain from language which sensationalizes or normalizes suicide, or presents it as a solution to problems; avoid prominent coverage and undue repetition of reports about suicide; avoid explicit portrayal of the method used in a completed or attempted suicide; avoid providing in-depth information about the location of a completed or attempted suicide; word headlines sensibly; be cautious in using photographs or video footage; take special care in reporting celebrity suicides; show due consideration for people bereaved by suicide; provide information about places to seek help, and; be mindful that media professionals themselves may be affected by stories about suicide (WHO, 2008).

National mental health and suicide prevention policy (NMH-SPP), Fiji, 2015
Fiji developed its national mental health and suicide prevention policy (NMHSPPP) in 2015, and the following ten broad policy statements have been formulated to steer the direction of mental health services in Fiji:
1. Mental Health services will be organised in such a way as to provide all Fijians with timely access to high quality, coordinated care appropriate to their condition and circumstances.
2. National policies, strategies, programs, laws and regulations concerning mental health and suicide prevention will be continuously developed, monitored and implemented in line with evidence, best-practice, the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments.
3. Knowledge and skills of general and specialized health care workers will be built to deliver evidence-based, culturally-appropriate and human rights-oriented mental health and social care services.
4. A dedicated mental health budget will be delivered for the successful implementation of this policy, strategic plan and mental health legislation.
5. Necessary psychotropic medications, medical products and technology will be continuously and consistently available at all facilities providing mental health services.
6. Mental Health will be integrated into the routine health information system. This will identify, collate, routinely report and use core mental health data, disaggregated by sex and age (including on completed and attempted suicides) to improve mental health service delivery, promotion and preventive strategies.
7. There will be enhanced research capacity and academic collaboration on national priorities for research in mental health and suicide prevention, particularly for operational research with direct relevance to service development and implementation and the exercise of human rights by persons with mental disorders.
8. Locus of care will be systematically shifted away from long-stay psychiatric hospitals towards non-specialised health settings with increased coverage of evidence-based interventions, using a network of linked community-based mental health services, collaborating with non-government organisations.
9. Stakeholders from all relevant sectors, including persons with mental disorders, carers and family members will be engaged in the development and implementation of policies, laws and services relating to mental health and suicide prevention.
10. People with mental disorders and psychosocial disabilities will be given a formal role and authority to influence the process of designing, planning and implementing policy, law and services.

These broad statements have provision for development of a National Suicide Prevention Program incorporating a systemic multi-sectorial approach involving whole of government, non-government and community approach, bringing together clinical as well as population based strategies. Increasing the ‘knowledge and skills of general and specialized health care workers’ will likely need to be expanded to primary care, emergency services and other non-health care areas, including the community sector. Education and support should also extend to all stakeholders, including persons with mental disorders, carers and family members, and provide them with a formal role to influence the design, planning and implementing policy, law and services.

CONCLUSION
Suicide prevention is a complex and multifaceted process with significant resourcing and education implications in LMICs. Social, economic and political changes and diminishing support networks lead to overwhelming psychosocial distress with suicide becoming a final common pathway for overwhelmed individuals. Much needs to be done to advance public health policy and move the focus to collective inputs across social strata. Individual assessment and tailored treatments to at-risk individuals are important and upskilling primary care doctors and increasing mental health capacity is important. However, preventive health measures are likely to have much higher yield, particularly if applied in a sustained manner. The Fiji national mental health and suicide prevention policy (NMHSPPP) in 2015 incorporates those preventive measures. The challenge now is to implement the vision into practice through a concrete national mental health and suicide prevention program, with adequate provision of resources towards suicide prevention measures.
REFERENCES


ABSTRACT
This paper describes programs using motivational interviewing (MI) approaches to address modifiable risks such as substance use, obesity and spacing of pregnancies, for adolescents who are pregnant. Including fathers and supporting adolescent decision-making, for instance by improving practitioners’ understandings of adolescent development, are discussed. Violence prevention programs that incorporate MI techniques and promote maternal and family safety are also considered.

INTRODUCTION
Access to best practice antenatal care is essential to assist women and families make healthy changes during pregnancy. Motivational interviewing (MI) is an evidence-based counselling method that performs better than providing clients with traditional advice. Healthy pregnancy promotes positive labour and birth experiences. The transition to parenthood is a major developmental period with important implications for the parents, infant-parent relationships and infants’ development. The World Health Organization (WHO) provides recommendations to improve the quality of antenatal care to reduce the risk of stillbirths and pregnancy complications and give women a positive pregnancy experience. The new guidelines recommend that throughout pregnancy, all women should have a minimum of eight contacts with a health provider (WHO, 2016).

During adolescence young men and women negotiate puberty, achieve sexual maturity and begin sexual relationships. They also develop new cognitive skills including more complex abstract thinking in late adolescence and, depending on their social and cultural environments, will move towards autonomy and independence.

Becoming pregnant during adolescence is linked with negative outcomes for both mother and child. For example, adolescent mothers are more likely than older mothers to experience pre-term birth, receive welfare and have children with emotional and behavioural problems. They are more likely to have experienced sexual coercion and have less access to sexual health education and family planning (Hoffman 2008). Adolescent fathers have a high incidence of witnessing violence at home, to have been victims of physical and sexual violence, to have pre-existing serious anxiety, depression and conduct issues, to drink, smoke and misuse substances, and to have disengaged from formal schooling (Australian Institute of Family Studies, 2015). Modifiable lifestyle factors increasing the risk of adverse health outcomes in pregnancy include smoking, substance and alcohol use, diet and exercise. Gender-based violence against women is also preventable and ecological approaches are recommended (Marino, 2016). Priority preventive and promotional activities in adolescent pregnancy include eliminating or reducing:

- smoking
- risky alcohol and drug use
- overweight and obesity
- exposure to violence
- further adolescent pregnancies.

Motivational interviewing
It is essential that health care professionals have the necessary knowledge, attitudes and interpersonal skills to provide confidential non-judgemental and respectful health care to adolescents. MI is a non-confrontational and collaborative communication style designed to promote behavioural change. MI focusses on identifying a participant’s intrinsic motivation. It is helpful for clients who are ambivalent about changing their behaviour. MI is based on four principles: establishing empathy, developing discrepancy, rolling with resistance and supporting self-efficacy (Miller & Rollnick; 1991, 2002).

The ‘stage of change’ model identifies the different stages towards behaviour change. Readiness to change is influenced by interpersonal interaction; for instance, a pregnant woman may have awareness of the need to cease smoking for the baby’s health but finds change difficult when her partner continues to smoke. MI identifies and mobilises the client’s values and goals to facilitate behaviour change. A therapeutic alliance is established through collaborative goal setting and using communication micro-skills including: open-ended questions, reflective listening, affirmations and summarising.

MI has been used to promote positive health behaviours, for instance to increase breastfeeding rates following birth (Elliot-Rudder et al 2014). In a meta-analysis by Cushing et al (2014) of MI for adolescent health behaviour change in areas other than substance use (e.g. sexual risk behaviour, physical activity, diet), MI interventions were found to be effective, with the authors noting variation regarding interventionist training requirements necessary to ensure effectiveness. There is also evidence for MI for cessation and reduction of smoking in pregnancy (Prah, Weinstein, Hammond, Kearney & Emmons, 2008).

Home visiting programs
An example of a program with an emphasis on supporting behaviour change that utilises MI is the Australian Nurse-Family Partnership Program (ANFPP) which is funded by the Australian Government to support pregnant women with an Aboriginal and or Torres Strait Islander child and engage hard-to-reach clients such as adolescent mothers and young fathers. The ANFPP is a licenced adaptation of the Nurse-Family Partnership (NFP) in the United States. The NFP is an evidence-based nurse home visiting program that improves the health, wellbeing and self-sufficiency of low

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control trials of NFP have shown significant short and long-term benefits to children and parents, especially when the mother has low psychological resources. Program benefits include improved antenatal health, reduction in child abuse, accidents and injuries, less mental health problems, increased school readiness and reduction in substance use. The program emphasises maternal life course development to promote economic self-sufficiency and educational pathways such as spacing of subsequent pregnancies (Olds et al 2010). Nurses implementing the NFP model use NFP Visit Guidelines which provide cues for assessment and teaching in six domains: personal health of the mother, life course development, environmental health, service usage, family and friends and maternal role including physical and emotional care of the child. The visit schedule includes up to 65 visits over a two-and-a-half-year period from pregnancy, through infancy to toddlerhood. Three theories guide the implementation of the model and these are reflected in program materials and visit guidelines: Bowlby’s attachment theory, Bandura’s self-efficacy theory and Bronfenbrenner’s Social Ecology theory, the last two of which promote behaviour change.

Bowlby’s attachment theory promotes the development of a secure attachment bond with the baby. Children with secure attachment feel protected by their caregivers. The program promotes sensitive and responsive parenting and assists parents to understand their babies needs, such as why their baby cries, how to interpret their signals and respond to their baby’s needs for food, rest, love and routine.

Bandura’s self-efficacy theory encourages examining an individual’s belief in their ability to accomplish tasks and whether they believe that achieving those tasks will lead to desired outcomes. What a person believes about their self-efficacy is a good predictor of how motivated they will be and which actions will be taken to achieve a goal.

Bronfenbrenner’s human ecology theory acknowledges the influences of an individual on the environment and of the environment on the individual, including family, work/school and community. This guides the home visiting team to be aware of cultural factors, family dynamics and potential sources of support and conflict in the family as well as the community, service care providers, hospital policies, etc.

The home visiting team in the ANFPP receive training in MI. Reflective supervision in the program also provides an opportunity for the home visiting team to strengthen proficiency and develop competency in MI. (Department of Health and Ageing 2012).

Father Inclusion
Young fathers face transition to parenthood while still navigating adolescence. A qualitative research study identified engagement strategies and the benefits to adolescent fathers of being included in home visiting programs. Benefits identified included: better communication and relationship with their partner; improved knowledge of child development; improved anger and stress management, and; employment outcomes. Strategies for engagement included building positive relationships with the grandparents and promoting the importance of father inclusion in home visiting. A culturally-informed staffing structure that connects young men with male role models supports positive identity and respect for elders. Flexibility of home visit content and scheduling includes an understanding of adolescent needs, hands on interactive activities and assistance with transport. (Sandstrom, Healy, Gearing, & Peters, 2015).

Substance Misuse
The brain undergoes significant structural changes during adolescence and this developmental period is also associated with experimentation with licit substance use and, for some, progression to illicit drug use. The evidence for the negative impact of substance use on physical and mental health status and social functioning is overwhelming, as is the evidence for the impact of all substance use during pregnancy.

Alcohol exposure during pregnancy may result in Foetal Alcohol Spectrum Disorders (FASD) – and is entirely preventable. FASD is a leading cause of mental retardation, birth defects and neurodevelopmental disabilities in children exposed to alcohol prenatally. It is important to identify risky exposure to alcohol use to provide effective interventions such as MI, that can assist with healthier decisions and behaviours (Osterman et al 2017).

The New Zealand Ministry for Health (2010) funded the development of a ‘Pregnancy and Alcohol Cessation Toolkit’, accessible in an online E-learning format) to prompt and support health professionals to assess alcohol and other drug use with women who are planning pregnancy or who are pregnant. The toolkit modules provide brief advice about not drinking alcohol when planning a pregnancy or when pregnant, explains why this is important, assists women who are having difficulty stopping or whose use is problematic to access specialist services, provides information on cultural considerations and how to use MI. The Australian Integrated Mental Health Initiative (AIMHi) program has developed a range of culturally-adapted resources for Aboriginal people such as the Stay Strong App, which incorporates a brief intervention and motivational approach for use in care planning with Aboriginal people experiencing mental health and alcohol and drug misuse (Dingwall et al 2015).

Spacing of Pregnancy
Outcomes are further compromised for adolescent mothers who experience rapid repeat pregnancies (within 18 months of the prior birth), who are less likely to receive prenatal care and more likely to experience a stillbirth, a preterm birth, or a child with a low birthweight. They are also less likely to stay in or complete school, work or maintain economic self-sufficiency, and have children that exhibit school readiness when older. (WHO, 2005). They also recommended birth spacing of 2-3 years between pregnancies to reduce infant and child mortality (WHO 2005).

The Teen Options to Prevent Pregnancy Program (TOPP Program) is an evidence-based intervention that aims to reduce rapid teenage pregnancy, providing adolescent mothers with monthly visits over an 18-month period. The TOPP program incorporated: access to a personalised contraceptive counselling with nurses trained in motivational interviewing; access to a contraceptive clinic; transport assistance, and; social worker support. The TOPP program featured rigorous training in MI with ongoing supervision to ensure fidelity to the five-point global MI spirit scale with the MI treatment Integrity code (Moyers et al 2016). The five dimensions of the MI spirit scale include: Evocation; Collaboration; Autonomy/support; Direction, and; Empathy.
Maternal Obesity

Maternal obesity increases the risk of adverse perinatal outcomes for mothers and their babies including gestational diabetes, miscarriage, stillbirth and pre-eclampsia in the antenatal period. (McIntyre, Gibbons, Flenady & Callaway, 2012) MI has been found to be a useful method for Health Care Professionals when communicating with pregnant women who are obese and when managing difficult workloads (Linhardt et al, 2015).

Exposure to Violence

Mental health outcomes are particularly adverse for girls who experience victimisation in adolescence (WHO, 2013). An increasing body of research identifies transgenerational transmission of trauma including epigenetic mechanisms (Yehuda et al, 2002). Negative perinatal and childhood experiences can interact with genetics to change the structure and function of the brain and exposure to violence in childhood can increase vulnerability to revictimization in adolescence. For some adolescent populations in countries that have experienced the effects of colonisation there are negative long-term effects. Trauma-informed approaches to care provide a framework for supporting clients who have experienced violence and: can be viewed as a universal design for serving trauma survivors; the entire system is used as a vehicle for in-‘tention’ (de Candia and Guarino, 2015).

In promoting ‘Women-centred Care’ the WHO recommends health-care providers discuss options and support women who have experienced intimate-partner violence (IPV) in their decision-making. The relationship should be supportive and collaborative, while respecting women’s autonomy. Health-care providers should work with the women, presenting options and possibilities, as well as providing information, with the aim to develop an effective plan and set realistic goals, but the woman should always be the one to make the decisions (WHO, 2013).

Prochaska and DiClemente’s Trans-Theoretical Model of Change (1984) – often referred to as the Stages of Change Model, postulates that individuals move through six stages of change: pre-contemplation, contemplation, preparation, action, maintenance, and termination. This model provides a framework for evaluating and supporting readiness and ability for change in the context of IPV and promotion of safety. The number of violence prevention programs and interventions incorporating MI approaches have been expanding. Reisenhoffer and Taft (2013) reviewed the literature and identified many programs that used the stages of change model. Saftlas et al (2013) studied the use of motivational interviewing (MI) to improve self-efficacy, depressive symptoms, and stage-of-readiness-to-change among women experiencing IPV. Their study found a beneficial effect on the reduction of depressive symptoms. MI was implemented to guide women in identifying feasible individual goals and small steps that they could safely take to increase self-efficacy and feelings of control. MI relies on reflective listening and is well suited to provide an individualised approach for women living with IPV. Over time, victims of IPV lose their autonomy and self-efficacy, often becoming increasingly isolated. This intervention was developed to empower the women to make choices for themselves and their families, encouraging active steps toward healthy behaviours by helping individuals to clarify and resolve their ambivalence about behaviour change and promote personal and family safety.

CONCLUSION

MI is a way of helping adolescent clients to recognise and do something about their current or potential problems. There is increasing evidence for the efficacy of MI approaches to tackle preventable and treatable adolescent behaviours and promote positive behaviours during the perinatal period. With greater understanding of adolescence and adolescent brain development, there exists an opportunity to promote evidence-based MI approaches for use in behaviour change programs.

REFERENCES


Saftlas A. Motivational interviewing and intimate partner violence: a randomized trial. Annals of Epidemiology 24 (2014) 144-150


ABSTRACT
The governance of mental health is complex. Clients and people working in front line services often experience frustration about the things that may not be working within their mental health governance system (e.g. limited resources, service duplication, top-down policies or poor communication arrangements). Something going wrong in any part of the system can also affect what happens elsewhere (e.g. poor policy can affect those who are delivering services while poor service delivery may mean good policies are not achieved). Whether you are a politician, a policy maker, a service provider or a client of your nation’s mental health system, everybody has a unique role to play to make the system work better. This paper provides simple tools to support understandings of how healthy governance systems work, and to explore and analyse the strengths and weaknesses (and at any level) within national mental health systems.

INTRODUCTION
In any nation, mental health outcomes for individuals and communities are determined by the health of the wider system of governance. Anyone within those systems, however, has potential agency in seeking to analyse system strengths and weakness and to contribute to positive change. While many think that improving the system of governance as it influences mental health outcomes is solely the business of politicians and bureaucrats, the reality is that such systems are shaped by thousands of every-day decisions and actions taken by people from every level. Change is often brought about through the culmination of smaller decisions and actions taken by individuals, and strong alliances of individuals throughout the system. We provide simple tools to help those within the mental health system; to analyse it from within and to determine and effect priorities for change; to help people consider the most appropriate and feasible approach possible for positive intervention within the system, and, to apply these skills in their own governance context.

In what follows, we take a society-wide and broad view of governance as the “intentional shaping of the flow of events so as to realise desired public good” (Parker and Braithwaite:119). Using this definition, it is clear that all and any of us can exert some influence within the wider system of governance, and the resultant outcomes as they relate to mental health. At all levels, system reformers include:

- Politicians, law-makers and law-keepers or tribal chiefs setting the cultural and legislative foundations for national, provincial or local/village societies;
- Public servants developing policies, programs and strategies for mental health;
- Administrators, clinicians and nurses allocating resources within the mental health system;
- Faith-based and community leadership and service organisations providing leadership in and care for communities from national to local scales;
- Families and friendship groups supporting individuals in society; and
- Clients of the mental health system, who make daily decisions and take actions influencing their own mental health outcomes.

Key Features of Any Governance System
Any complex governance system can be defined through the following descriptors (drawn from heavily from sources such as Dale et al. 2013 and Boex & Simatupang 2015) which are the foundations that need to be analysed for change.

Mental Health Outcomes Rely on the Health of the Overall Governance System
Mental health outcomes of a population are influenced by the overall governance system. For example, a nation’s social and development policies could lead to societal conflict, resulting in stress, trauma and poor mental health. In short, unhealthy governance systems lead to negative mental health outcomes for communities and individuals. Hence the need for everyone to focus their efforts on making the overall system work more effectively. In this context, improving small and localised decisions and actions can be just as important as improving higher level decisions about diverse government policies and programs.

Mental Health Outcomes Rely on Multiple Governance Domains
Sub-systems (domains) of any national governance system that influence mental health outcomes cannot be viewed in isolation (Plummer & Armitage, 2007). For example, problems in domains related to labour markets or education can underpin mental health problems or solutions, and need to be examined. However, contemporary governance analysis frequently examines the mental health system in isolation from other domains, and vice versa, policy and programs within such alternative governance domains may be arrived at without consideration of mental health issues. Finally, within the wider health governance system, there may be important activity-based governance domains of critical importance to mental health outcomes (e.g. communicable disease responses, non-communicable disease treatment, etc.). These domains tend to represent distinct governance activities that draw in particular expertise sets and distinct stakeholders and communities. Consequently, these governance domains have a tendency to build their own cultures and eventually to operate in isolation as silos of activities. Critically, in undertaking governance analysis for mental health, we must be acutely aware that different governance domains need to be highly inter-connected.

Most Governance Systems Are Polycentric
Within any domain of governance, decision making extends
Systems Have Structural Characteristics

The concept of structure, referring to a configuration of purpose-oriented activities that make up the overall system (Pullan & Bhadreshia, 2000), provides an account of any governance system’s key components. Indeed, well-defined structural components with a key role in the system may be represented as a network; outcomes from one structural component continually feeding into outcomes from others. Governance structures within society are often represented as being the institutions (e.g., governments, corporations, families, etc.) or alliances of institutions with particular roles in the system; for example, policy-making institutions. While traditional thinking would emphasize the structural importance of government agencies versus local government, industry, the not-for-profit sector and other civil institutions, governance systems are better understood by acknowledging that many different institutions are often collectively carrying out structured governance roles.

To facilitate the analysis of governance systems, Dale et al. (2013) refer to structural aspects of governance by drawing on the policy, planning and management literature (e.g., Althaus et. al., 2007). The following describes the standard structural activity components of most governance systems that could be reliably applied to analysing mental health systems:

- **Vision and objective setting**: Setting higher level visions/objectives (policies);
- **Analysis**: Research and assessment to underpin decision-making;
- **Strategy development**: Determining the best strategies for securing objectives, inclusive of an appropriate solutions mix (i.e., funding programs, education activities, regulatory, collaborative and capacity building approaches);
- **Implementation**: Implementation and delivery of broader strategies, and;
- **Monitoring, evaluation and review**: Monitoring, evaluating and reviewing and implementation against the original vision and objectives.

Linear analysis of institutions operating within governance systems constrains how we think about possible new alliance-based pathways for decision making. Visionary decision-making, for example, is not the sole preserve of government agencies, but could be conducted by an alliance of government, industry, community and not-for-profit institutions. Equally, monitoring and evaluation is not the sole domain for research institutions, but could be achieved through collaborative ventures among researchers and mental health services. This should encourage anyone involved in governance system analysis not to be too deterministic about who should be doing what in any given part of the governance system, so long as the basic structural components of good decision-making are functioning.

Governance Systems Have Functional Characteristics

In addition to ensuring the key structural elements of governance systems are in place, it is equally important to consider how well things are working within and across these structural elements. Great integration of effort in vision/objective setting (or policy making) structures, for example, can be undone by poor integration of effort within and across strategy development and implementation structures. This provides a focus for analyzing how the system works, against all the key or important structural elements of the system.

Dale and Bellamy (1998) suggest there are three cornerstone functional elements of healthy governance systems:

- **Knowledge Application to Improve Governance Systems**: Improving the functionality of any governance system requires integrated use of knowledge from many sources (Leys & Vanclay, 2011), with creative use of appropriate knowledge delivery systems (e.g., through databases, mapping programs and decision support systems) (Cundill & Fabricius, 2009). As knowledge improves within the system, this new knowledge also must be regularly linked to decision-making within the system’s structural arrangements (Bouwen & Taillieu, 2004);
- **Securing Connected Effort Within Governance Systems**: Power relationships drive connections within and between structural components of governance systems (Haider & Rao, 2010). Many systems consist of isolated activities within and between different structural components (Margerum, 1995). Several institutions in a particular nation, for example, may be setting national visions and targets for mental health effort without connecting; at best duplicating effort and at worst working at cross-purposes. Securing effective connectivity within a system is difficult as many institutions and sections within institutions operate in isolation (Morrison et al., 2004). For collaborative and integrated effort to work, leadership and investment is needed to drive connectivity. Well-designed arrangements encouraging fair bargaining and negotiation within and between institutions are required, but are rarely resourced. This leads to ineffective governance and unresolved conflict; and
- **Improving the Decision-Making Capacity of System Participants**: Anything that develops the decision-making capacity of institutions and individuals within a governance system will help improve system vitality (Dorsey, 1986). Attention to building the capacity of all system participants should include: (i) building their understanding of and access to information concerning relevant issues; (ii) motivating them to engage well in the system; (iii) securing the appropriate technical, skill and financial resources needed; (iv) leaders developing a clear mandate from their constituents and maintaining feedback and communication, and; (v) increasing the negotiation capacity of those involved in structured bargaining. Again, capacity development needs to occur in a way that is fair.
**Applying Common Evaluative Principles**

Describing the structural and functional aspects of systems also requires use of a common and robust set of evaluative criteria. Based on Dale and Bellamy (1998), a wide ranging set of views on common evaluation principles have been consolidated into core evaluative criteria that are useful in describing how well governance systems work. The evaluative principles outlined below are designed to measure the health of structural/functional components of the system through exploring the following questions:

- **Sustainability** - Will governance activities be able to be sustained?;
- **Equity** - Are governance activities fair for all stakeholders?;
- **Accountability** - Could those leading governance systems be held accountable by their constituents?;
- **Adequacy** - Are governance activities sufficient to solve the problem?;
- **Effectiveness** - Will governance actions solve problems effectively?;
- **Efficiency** - Will governance actions solve problems efficiently?;
- **Adaptability** - Can governance arrangements adapt if circumstances change?, and;
- **Subsidiarity** - Are different types of decision making occurring at the right level?

With such a set of evaluative criteria in mind, consistency can be secured in analysing priority lines of inquiry about how to improve the system. These common evaluative principles can be applied as a checklist in considering the health of the system and potential areas for reform. Applying this rigorous, principles-based approach against line of inquiry questions also enables a more comprehensive assessment.

**Some Typical System Failures**

Dale et al. (2013) published the Governance Systems Analysis method (from which the above analytical descriptors are drawn) to support individuals, institutions or collaborations within systems to work with analysts to consider priorities for system reform and to work together to effect change. This type of approach has been applied in several practical contexts (e.g. see Dale et al. 2017) in governance themes and domains as diverse as environmental, social and economic development. From empirical evidence, there are some typical system challenges, requiring innovative solutions. Some of the most commonly experienced governance system challenges include:

- **Great Policy but Poor Delivery or Monitoring**: A tendency to centralise power to politicians and bureaucrats means that there can be excellent policies that are poorly delivered, resulting in initial policy enthusiasm from the community, followed by disenchantment and dismay. Those who deliver policies are the foundations for success, but they are often cut out of policy making processes because of a notional and flawed separation between policy making and delivery systems. This is often exacerbated by a lack of monitoring of the outcomes arising from policy implementation, and an over-focus on the collection of data about inputs (e.g. the measurement of numbers of mental health consultations held without reference to the effectiveness of those consultations);
- **Great Initiatives are Limited to Pilots**: Within a wide and lumbering governance system, there may be limited beacons of good practice within a sea of mediocrity. All too often, successful pilot projects are designed, implemented, measured and then discarded. In other cases, successful pockets of activity (e.g. a local mental health clinic) might be in operation, but seemingly in spite of the policies driving the bigger governance system. This can happen because getting things right might require more resources or a more flexible policy environment. Flexible decision-making locally might conflict with the priorities at higher levels in the system. Building opportunities for local excellence and a capacity to scale up success is important;
- **Service Duplication and Poor Coordination**: Complex governance systems engender specialist skills and roles. Policy makers might be great at developing policies, but poor at researching the issues at hand. Specialists in clinical mental health may be isolated from those involved in community mental health. All have a role to play in the system, but their specialist focus and the cultures within their institutions might diverge over time, leading to poor coordination and effort duplication; and
- **An Over-reliance on Government Services**: In governance systems that are looking to influence outcomes at multiple scales, there is a need to support detailed effort at all scales. In the mental health context, securing good mental health outcomes relies on a chain of coordinated and effective effort from the individual client, their families, their friendship circles, their community associations and churches, to first-responders (e.g. nurses or police) service delivery agents (e.g. doctors) bureaucrats, politicians and lawyers. Often resources can be devolved down to the service agent level, but few resources and supports get further (to community organisations, families and to individuals). Consequently, problems can be quite advanced before they become identified in the formal service system. This is often also related to an over-focus on responsive versus preventative interventions.

**Things We Can Do To Analyse Our Systems and Effect Change**

Because of their wide scope, it may seem that the analysis of complex governance systems might be best left to specialists. While working in partnership with expert systems analysts will be helpful, outsourcing analysis and reform to specialists may compromise the capacity of those within the system to secure change. Consequently, with the right partnerships and tools, everyone in the system committed to achieving change can contribute to analysing key parts of the system of concern to them, be they clients, clinicians, administrators and service providers, and may take particular steps as follows.

**Decide the Scope of Analysis**

Think through the scope or scale of the governance problems to be addressed. While clinicians may be interested in improving the evidence-base for current clinical approaches, administrators at the provincial level may be invested in making the system work more effectively at that scale. Either way, first deciding very clearly on the scope of system improvement to be achieved is important, as is starting small on reform, building confidence for change and then growing effort. Once the initial scope is clear, it will become easier to decide the best tools and approaches to be applied to analysis and leading reform.
Seek to Understand the System

Before venturing into the business of reform, make a structured if not thumb-nail sketch of how well the system is working. Someone leading a remote clinic network might start by mapping their context; their part of the overall system. This might mean: (i) understanding the basic outcomes for mental health at that scale; (ii) mapping the various scales of governance relevant to the context (this might mean understanding other scales of governance including village, provincial and national scales); (iii) understanding other systems of governance that might affect outcomes (e.g. policies and programs related to housing, economic development, primary health, etc.); (iv) examining structural aspects of governance at that scale (e.g. are there clear objectives and targets or is there any monitoring and evaluation?), and; (v) considering how things are functioning in that system (e.g. the connections between parts of the system and the policing system, whether local village communities have the capacity to deal with mental health issues, etc.). Using such a checklist approach may provide clarity about where the biggest risks in the system affecting mental health outcomes can be found, and facilitate prioritisation.

Partner With Others for System Reform

Once it is clear that there are significant system risks (or opportunities to expand good parts of the system), then it will be important to find suitable partners within the system. This can be difficult as people in any system can be occupied with their own system’s problems. However, by and large, there are likely to be people invested in making it work more effectively, particularly when there are win-win opportunities. Supporting police to recognise and better respond to mental health issues for example, might deliver better outcomes for their officers as well as for clients and clinicians. Building stronger alliances from the grass roots often rallies others towards improvement.

Build a Commitment to Analysis and Reform

With good approaches to system reform, success can lead to further success if there is a commitment to scale up improvements. Wider momentum can be built upon by gathering evidence of success from emerging reform partnerships. Building on early wins helps build the evidence-based foundations needed to call for higher levels of institutional commitment for more substantive reform.

Towards a Longer Term System of Continuous Improvement

There will always be a need for ongoing continuous improvement and it can be quite demoralising when systems that are starting to improve collapse when a single key leader supporting the reform leaves. Consequently, building local partnerships and securing higher level commitment to ongoing reform is crucial. This buffers the system from loss of key players as more people from within the system feel invested in making the system work better. Finding a research-based advocate to work with as a longer term partner in the system’s improvement process will help. In placed-based approaches in Australia, for example, there is an increasing use of a research-based “back-bone organisations” to assist in the longer term process of systemic improvement. Such individuals and institutions can help partner the leaders for analysis and reform, and ensure there is a wider network of drivers in the system improvement agenda.

CONCLUSIONS

This paper seeks to provide guidance to those invested in improved governance within national mental health governance systems, and we emphasise that everyone has a role in making the system work more effectively and efficiently. Success in progressing reform provides opportunities to ensure sustainability and to explore scalability – nationally and beyond. By including discussion about governance system improvement in the Leadership in Mental Health: Island Nations course (run with Creating Futures 2017), and with ongoing discussion of the tools outlined in this paper, we hope to contribute to building and networking strong leadership in the mental health sector across South Pacific nations.

REFERENCES

Dale, A.P. (2015). If you have a pulse you are a politician. TEDx JCU Talk. https://www.youtube.com/watch?v=ZdSWFe89grk


Saftlas A. Motivational interviewing and intimate partner violence: a randomized trial. Annals of Epidemiology 24 (2014) 144 -150


ABSTRACT
This article explores responses to the shortfall in mental health service capacity in Fiji and other Pacific Island nations at both policy and health system level, and at the individual clinician level. It is based on the proceedings of a workshop delivered by the authors at the Creating Futures conference in Suva. It concludes by exploring the factors that might make a primary health service accessible and acceptable to its clientele when it comes to meeting the needs of those with mental health issues.

INTRODUCTION
There is increasing recognition globally of the importance of mental illness as a lead contributor to the global burden of disease (Patel et al., 2015; Whiteford et al., 2013), where it now contributes one in every ten lost years of health. This is so throughout the lifespan, but a particularly high contributor to morbidity (as measured in Disability Adjusted Life Years) in the adolescent and young adult age group, with 75% of adult mental health conditions arising by the age of 25 (Christiana et al., 2000). There is evidence that investment in treating the most common of these mental health disorders in community and primary health care settings would be cost-effective (Chisholm et al., 2016) and prevent much of the additional morbidity that arises through delayed access to care (Reavley et al. 2010; Thompson et al., 2012; Wang et al., 2007). Research demonstrates that delayed access to care is associated with worsening of mental illness, as well as increased likelihood of recurrence, interruption of education and vocational opportunities and related increased social disadvantage (Reavley et al., 2010).

In many parts of the world, mental health assessment and management guidelines are still predicated on the availability of easy access to a specialised mental health workforce. Yet in low and middle income countries (LMIC), including in Fiji, there is a marked shortage of psychiatrists and specialised mental health nurses (and inpatient facilities) and those that are present are heavily concentrated in major urban centres and capital cities. For example, in Fiji there are just four fully qualified psychiatrists to service the whole population. All are fulltime academics who provide consultative services and support the Ministry of Health (MoH) registrars and only one is based outside Suva, with one psychiatric hospital and a small number of mental health beds (“stress wards”) in the three large subdivisional hospitals. Similar shortages in the specialist mental health nursing workforce occur in Fiji and throughout the Pacific. An additional pressure on mental health services in Fiji is the lack of psychology specialists including clinical psychologists (especially child and adolescent) and counsellors with adequate training in both psychology and counselling fields. A rapid improvement in these figures is unlikely to occur in the short-to-medium term, and may indeed not be the most efficient use of scarce health system resources (Freeman, 2016).

Addressing the issue: policy and health system responses
In response to some of these issues, in 2008 the WHO published a report advocating the integration of mental health care into primary care globally (WHO/WONCA, 2008). This was done on the grounds of increasing access and affordability, promoting human rights, good outcomes and cost effectiveness. The frequently co-morbid nature of physical and mental illness, and the interwoven nature of both with the social determinants of health (or more accurately lack of access to the social determinants of health) strengthens the case for an integrated approach to care provision. Reducing the stigma and discrimination experienced by people with mental health conditions is another likely benefit (WHO/WONCA, 2008). Case studies of nations and regions that have done this allowed the synthesis of ten key principles for successful integration of mental health care into primary care (Table 1). Furthermore, in 2008 WHO launched the Mental Health Gap Action program (mhGAP) to scale up care for priority mental and substance use disorders by non-specialist health care providers with an expanding range of comprehensive training materials to help in upskilling these general nurses and doctors to provide primary mental health care (WHO, 2016).

Table 1: Principles for successful integration of mental health care into primary care (from WHO/WONCA 2008).
1Policy and plans need to be incorporate primary care for mental health;
2Advocacy is required to shift attitudes and behaviour;
3Adequate training of primary care workers is required;
4Primary care tasks must be limited and doable;
5Specialist mental health professionals and facilities must be available to support primary care;
6Patients must have access to essential psychotropic medications in primary care;
7Integration is a process not an event;
8A mental health service coordinator is crucial;
9Collaboration with other government non-health sectors, non-governmental organizations, village and community health workers and volunteers is required;
10Financial and human resources are needed.

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Addressing the problem: clinician responses

These policy level responses are logical, based on some degree of evidence and likely to deliver more accessible mental health care at lower cost to the community, particularly beyond the urban centres. However, particularly in LMIC where demand is high and time-pressures intense, many primary health care professionals still feel uncomfortable and underprepared for dealing with patients with mental health issues. Upskilling and demystification is required to overcome this reluctance to provide mental health services. In particular, the delivery of mental health services in primary health care requires primary care health workers to have high-level mental health triage skills, to be able to assess severity of mental health issues and in particular immediate risk to self or others, usually in the form of suicide risk before providing appropriate health care responses.

In terms of frequency, depression and anxiety are the most prevalent conditions globally and some experts have recommended the delineation of a few targeted mental health conditions to be initially treated in primary care with expansion as capacity increases. Indeed, the Fiji Minister of Health announced a focus on depression on World Health Day in 2017 and specifically included supporting non-governmental organisations working in schools to increase awareness of youth depression. Although the vast majority of mental health issues can be (and usually are) managed successfully in primary care, it is important to be able to identify those at the most severe end of the mental health spectrum or whose condition poses an immediate risk to themselves or others. Various tools are available to help with this process (WHO, 2016), but health system redesign to ensure that specialised support and higher levels of care are available in a timely fashion for those who need it is critical to long term success.

Accessible primary care services

Globally, there have been bi-modal spikes of interest in strengthening primary health care services to deliver better health for all at lower cost: around the time of the Alma Ata declaration in the late 1970s, and more recently in the last decade or so, as described in the Primary Health Care: Now, more than ever report (WHO, 2008). Despite this, until recently very little has been written about what makes an accessible and acceptable primary care mental health service, with the exception of youth-friendly services. Due to the morbidity patterns of their users, these focus on mental health concerns, along with sexual health and other primary health care and social support. Here there is a considerable body of work, mostly from high income countries, focussing on what young people value in health care services (Tylee et al., 2007; Cohen et al., 2009; Hetrick et al., 2017). Given the close association between trauma and mental health difficulties in later life, recent guidelines on trauma-informed care (stressing similar principles) are also likely to be useful (Kezelman and Stavropoulos, 2012). All of these resources stress the importance of gaining a holistic understanding of the young person in their context, and a welcoming, friendly environment and staff. Guidelines emphasise the importance of the following factors for a youth friendly health service: flexible appointment systems; friendly, skilled and non-judgemental health care providers; a one-stop shop for health and social needs; shared decision making; and a holistic approach focusing on overall health and wellbeing, rather illness (Tylee et al., 2007).

Tools of use in mental health assessment in primary care?

As mentioned earlier, the comprehensive suite of training materials and tools provided through the mhGAP materials is of considerable use, both for training primary health care providers in mental health treatment and as a resource for health care providers in daily clinical practice.

Other tools for conducting a mental health assessment might also be useful in the Fijian primary care setting. The so-called HEADSS assessment is a graded approach to interviewing a young person to gain a holistic understanding of them in their broader context. It suggests that after discussing confidentiality and its limits and forming some rapport, the health worker asks age-appropriate questions exploring the home situation; education and employment; activities; drugs and alcohol; sexuality and spirituality and depression or suicide risk (Headspace, no date). The HEADSS tool has been adapted to be culturally sensitive and locally relevant, for example a version for Aboriginal and Torres Strait Islander young people is in use in Australia (NACCHO/RACGP, 2012). Workshop participants proposed that this may be helpful as a tool, with contextual modifications to account for the importance of extended family links and the church in support networks in the Fijian context.

What are the implications for Fiji?

The health system in Fiji has a strong foundation, with its traditional focus on primary care-lead health service provision and excellent in-country health professional education programs, particularly in medicine and nursing. Most Fijians still believe in communal living and so the adage that “it takes a village to raise a child” is still true for Fiji. Therefore, there is likely to be a considerable untapped resource in the community for mental health care and support. If the appropriate community gatekeepers can be identified and empowered through government training and support to strengthen the protection of mental health and wellbeing of community members, then the national burden of poor social and emotional wellbeing may be lessened.

The challenge for the Fiji Health Systems is to strengthen and integrate the existing Community Mental Health system that was established at divisional and sub-divisional level between 2007 and 2010. There was a shift in mindset and perceptions of the nation about the provision of mental health services at that time. However, there are considerable pressures on the Fiji health system, particularly in terms of health workforce migration, population ageing, the double burden of growing rates of non-communicable diseases together with still high infectious disease burden and growing urbanisation. In addition, the effect of climate change in small island states across the Pacific continues to threaten the homes and livelihoods and contribute to mental ill health in the region.

In this context, it is vital that generalism continues to be supported, amidst moves towards siloed subspecialisation unhappily adapted from wealthy countries, and proving economically non-sustainable even in those settings. Fiji Ministry of Health in partnership with the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and St Vincent’s Fund has initi-
lege of Psychiatrists (RANZCP) and St Vincent’s Fund has initiated such workforce development for primary mental health care for young people. This requires system strengthening, mentoring and supervision, expanded training and improved access to more intensive levels of mental health support (through building subspecialty capacity at secondary and tertiary levels) to become sustainable. The support provided needs to be sustained (including funds for training partnerships with RANZCP and others), and also monitored and evaluated. Strengthening a mental health system with a strong foundation in primary care will require committed leadership from policy makers and professional bodies, in partnership with international organisations, to deliver integrated systems with appropriate support and training to deliver appropriate mental health services for all Fijians.

REFERENCES


Headspace.org.au (no date). Headspace Psychosocial Assessment for Young People


Mental health as a human right: challenges and opportunities in Fiji

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ABSTRACT
In the last decade, there has been a clear acknowledgement of high suicide rates and increasing mental health issues in Fiji. The Mental Health Decree 2010 (the Decree) is a welcome step towards better mental health care, as it is based on the contemporary human rights framework and emphasizes prevention as well as high quality and least restrictive treatment of people with mental illness. The Decree brings with it opportunities for mental health reform, paving the way for protecting and promoting the human rights of people with mental illness. This article draws on relevant literature as well as perspectives of participants who attended a workshop pertaining to ‘human rights and social change’ as part of Creating Futures Conference 2017 in Suva, Fiji in September 2017. The challenges and opportunities for a human rights-based mental health reform are discussed focusing on a systematic approach to implementation of the Decree, with commitment from the government and input from various stakeholders including the patients, carers, health professionals and the community at large. While it is important to follow international principles and directions on mental health reform and human rights, it is imperative that the reform is contextualized and respects the social and cultural capital of Fiji.

Keywords: Mental Health, Human Rights, Fiji Mental Health Decree

INTRODUCTION
In the last decade there has been growing awareness of the increase in suicide and mental health needs in Fiji (Chang, 2011). Although Fiji does not have an ongoing nationally-collated database regarding the prevalence of mental disorders, figures suggest that the suicide rate in Fiji is exceedingly high compared to other Pacific Islands Nations (Chang, 2011; Nafiza N, 2016). Whilst suicide represents one of the more socially and morally contentious elements of mental health, it is an indicator of the overall mental health and wellbeing of a population. Global estimates suggest that mental disorders are common in all countries and across all age groups, however 80% of people affected live in low income countries which are allocated less than 10% of global mental health resources (Jacob & Patel, 2014). In Fiji less than 10% of the population requiring mental health care is able to readily access appropriate support and intervention (Chang, 2011). This raises concerns about the equity of mental health care service provision, particularly when considering mental health and wellbeing as a core human right.

The World Health Organisation (WHO) has long argued that there is ‘no health without mental health’ (Prince et al., 2007). This is supported by contemporary international human rights discourse as adopted by the United Nations Convention on the Rights of Persons with Disabilities (CRPD) 2006 and the WHO Quality RightsProject 2012 (United Nations, 2006; World Health Organization, 2012), which emphasise the right to the highest attainable standards of physical and mental health as a basic human right. The other human rights recognised by the CRPD for all the persons with disabilities, and endorsed by the WHO QualityRights project for persons with mental disabilities are the right: to an adequate standard of living and social protection; to exercise gal capacity and the right to personal liberty and the security of person; to freedom from torture or cruel, inhuman or degrading treatment or punishment, and from exploitation, violence and abuse, and: to live independently and be included in the community (United Nations, 2006; World Health Organization, 2012).

This article is informed by perspectives of participants who attended a workshop pertaining to ‘human rights and social change’ as part of the Creating Futures 201’ held in Suva, Fiji in September 2017. It highlights the opportunities for implementing the Fiji Mental Health Decree 2010 (Government of Fiji, 2010), which adopts the rights framework of CRPD, to protect and promote the human rights of people with mental illness, while respecting the cultural diversity and social capital. By drawing on the experiences and knowledge of those involved in the front line of mental health service delivery and uptake, a space can be created to promote tangible, practical and thoughtful solutions to the challenges of mental health care in Fiji.

The Fiji Mental Health Decree 2010 and human rights protection mechanism
The Decree, endorsed by the Government of Fiji on 15 October 2010 (Government of Fiji, 2010), embraces a modern human rights framework. It emphasizes a number of rights of the individuals experiencing mental health issues, including the right: to receive high quality and timely care; to participate in treatment which encourages their educational, vocational and recreational needs, and: to have gender, age, religious, language and cultural requirements recognized (Part 5 sections 34 a, b, c, d, h). In addition, the Decree sets out the patients’ right to be informed about their assessment, diagnosis, treatment options, side effects and treatment alternatives and to be involved wherever possible in decision-making processes that impact on them (part 5 sections 34 g, i). It encourages least restrictive treatment and puts into place safeguards to ensure that involuntary treatment is not used arbitrarily (Part 4, sections 23-33). The rights of family members and carers are emphasized (Part 5, section 34k) and part 5, Section 35 states that a patient has the right to a copy of their treatment order, is entitled to request a review and must be informed of his/her rights in an explanation that is ‘in a language, style and manner that the patient is readily able to understand’. The
Decree also outlines the functions of a national Mental Health Review Board which must periodically review the treatment and care of voluntary patients, patients on Community Treatment Orders and the detained patients. (Part 9, sections 95-100). Such protections align with the human rights agenda, which views the rights to an inherent dignity, mental wellbeing and quality health-care as fundamental civil liberties.

Implementing the Mental Health Decree – the challenges
The Decree of 2010 has replaced the 1940 Mental Treatment Act which was outdated due to its focus on restrictive and institutionalized care (Chang, 2016). The Decree seeks to adhere to international human rights and conventions and encourages preventive community care models (Chang, 2016). With an emphasis on decentralized care, the Decree directs a service structure that promotes rights to treatment in the community and least restrictive treatment within an appropriate cultural context. These concepts provide a solid basis on which to enact rights-based care and community-based recovery models within Fiji.

A key positive to come out of Mental Health reform in Fiji is the establishment of stress management wards (short term admission to a small general ward with and oversight by a psychiatrist) in three general hospitals. Previously the only provision of psychiatric care in Fiji was from St Giles Hospital in the capital city, Suva (Chang, 2011). While there have been recent upgrades of this facility including restructing of wards and provision of outpatient services along with increasing awareness of human rights and welfare issues, stigma associated with admission to old stand-alone psychiatric hospitals remains (Singh S & N., 2013). Having mental health services within the general hospital or primary care settings not only makes mental health care more accessible, but also aids in reducing stigma (World Health Organization, 2008). Unfortunately, the availability of beds and privacy in these wards is limited, and staffing numbers and training are variable. As nurses are the primary point of contact for many patients and their families, specific mental health training is required if nurses are to adequately respond to patient needs (Foster, Usher, Gadai, & Taukei, 2009).

Despite an emphasis on decentralizing care, mental health services and facilities tend to be concentrated in the large urban areas of Suva and Lautoka. Having all the mental health services concentrated in major metropolitan areas creates issues of equity for those unable to travel due to financial or geographical constraints. Moreover, whilst the community-based treatment has been emphasized in policy, on the ground this has not been accompanied by appropriate transfer of administrative authority to the peripheral service centers, and therefore it has been argued, that the benefits of decentralisation for users and providers are likely to be limited (Mohammed, North, & Ashton, 2016).

Whilst these equity issues are not new, some positive resolutions have been outlined. These include the Community Recovery Outreach Program, consumer groups such as Psychiatric Survivors Association and Youth Camps for Mental Health, and advocacy groups such as Fiji Alliance for Mental Health (Singh S & N., 2013). The establishment of these networks promotes consumer-led community-based recovery-oriented practices, which may offer a more culturally appropriate context to mental health care. Representatives from these groups include those who identify themselves as having mental illness, carers, family members, medical practitioners and other mental health professionals. However, these programs are also centrally-based in Suva and were heavily reliant on volunteer staff, with no secured ongoing funding source. Moreover, there was a certain degree of disconnect between such community-based groups focusing on mental health awareness; and the specialized psychiatric treatment still concentrated in St Giles Hospital or the three stress management wards.

Reframing challenges as opportunities
The idea of human rights was discussed and debated in the context of Fiji and the Pacific Islands in the Human Rights and Social Change workshop at the Creating Futures 2017 conference. Some participants felt that the concept of human rights was aligned to Western individualism and was not entirely appropriate to Pacific Islander contexts. Others identified that hierarchy and cultural norms could at times be a barrier to enacting human rights within the context of mental health care. Most, however, felt that patient and carer rights were at the core of their work and/or personal experiences of mental health. It was also acknowledged that health care providers as well as the consumer groups played a vital role in upholding and promoting human rights. Part of this discussion acknowledged that the position of the doctor tends to be privileged in discussions regarding patient care, as the cultural beliefs support a hierarchical decision-making approach. Similarly, the view of certain family members involved in patient care may traditionally be prioritized and thus dissuade patients from asking questions or challenging decisions regarding their own body and mind. In such a context, supporting health care professionals to understand their role within a local and contextualized human rights framework is vital.

Awareness of the rights of people with mental illness is one of the central issues in the field of human rights and mental health. For those in rural areas, awareness of mental health remains low, despite the risk of suicide and self-harm being elevated (Nafiza N, 2016). There are also further challenges of stigma and cultural taboos, which may compromise uptake of mental health care. Consequently, those who already face geographical isolation and social exclusion are further marginalized and excluded from quality care. Recognition of this inequity is the first step in moving towards equitable distribution and allocation of mental health care. Adequate resourcing and a clear timeline of action would solidify this commitment to meet the objectives of the Decree.

Given the restricted availability of quality mental health care in rural and remote areas, and the limited uptake of existing services in the urban areas, the role of carers, family members and community groups is paramount. It is also important to value and recognize their role as a scaffold to existing support structures rather than a substitute for quality mental health care. Many carers and their families talked of the incredible physical, emotional and financial stress involved in supporting a loved one with mental illness. Efforts to strike a balance between individual autonomy and family input need to respect the collectivist cultural context of close-knit family units in the Fijian context. Family and community groups are an incredible resource when seeking to raise the profile of mental health and work collaboratively to reduce stigma. Supporting families and communities to better respond to
issues may maximize the opportunity to strengthen decentralization efforts and community-based care. Any efforts which foster cultural inclusion, reduce stigma, encourage treatment and promote rights fit well with the implementation of the Decree aligned with human rights and social justice.

Whilst discussion in the workshop focused on challenges, there was also an opportunity to acknowledge Fijian cultural and social capital, which has previously filled the treatment gap in the absence of quality medical care. Building on social networks, sharing knowledge, drawing on spirituality, improving mental health literacy and being involved in the decision-making processes are the strengths which may be used to enable positive mental health outcomes in the community. The recognition of these strengths is already enshrined within the Decree, which provides support for family members, consumers, and health care practitioners and promotes inclusion, transparency and collaboration. The impetus now must be to ensure the Decree becomes a living, breathing, human rights-driven approach to mental health care, through relentless efforts by all the stakeholders as well as a clear commitment by the government.

The way forward
Decentralisation of services from stand-alone mental hospital to community-based recovery-oriented accessible services is paramount for protection and promotion of human rights of people with mental health issues as highlighted in the WHO Mental Health Action Plan 2013-2020 (World Health Organisation, 2013). The new models of care need additional training and upskilling of health care professionals. Mental health literacy of the broader community must be improved via information sharing and awareness campaigns to promote positive mental health and to reduce stigma and discrimination. International collaborators must be mindful to ensure their contribution is consistent with the cultural goals and ambitions of the Fijian people. The implementation of the Decree must be accompanied by robust systems to ensure that all parties, including patients and carers are appropriately aware of their rights. Collaboration among health care professionals, government, community groups, NGOs, carers and consumers needs to be strengthened to find culturally and contextually appropriate human rights responses to issues of mental health and wellbeing. Decentralisation, education, consultation and collaboration are all practical strategies to promote good mental health care in Fiji. All four components have been identified and a plan of action detailed within the Decree. The final component of this equation is motivation. Motivation should include an injection of action detailed within the Decree. The final component of this equation is motivation. Motivation should include an injection of funding to meet the objectives clearly outlined in the Decree.

The Ministry of Health 2016-2020 Strategic Plan has identified mental health as a priority area (Ministry of Health and Medical Services, 2016). It is hoped that given the Ministry of Health’s commitment to mental health, the pressing need to respond to issues of suicide and mental illness and the willingness of both health care providers and community services to collaborate, the government will find renewed motivation to uphold the commitments detailed in the Decree. Arguably this paves the way for an approach to mental health care which values cultural diversity, and provides space for dialogue which does not devalue existing cultural practices but draws on their most positive aspects to improve the health and wellbeing of community. Such an approach upholds the undeniable premise of enjoyment of highest attainable standards of physical and mental health as a basic human right.

REFERENCES:
Foster, K., Usher, K., Gadai, S., & Taukei, R. (2009). There is no health without mental health: Implementing the first mental health nursing postgraduate program in Fiji: Taylor & Francis.
ABSTRACT
Dementia is a growing public health priority globally. Both Fijian and Australian Aboriginal and Torres Strait Islander peoples face barriers to seeking timely care for dementia. Factors include lack of knowledge and resources, and low accessibility of services. Access to accurate dementia diagnosis in Australian Indigenous communities is facilitated through culturally appropriate and validated tools such as the Kimberley Indigenous Cognitive Assessment which can be modified for use in other indigenous populations. As the population ages, health system responses to dementia will be required in the coming years in Fiji and other Pacific Island countries. Culturally appropriate awareness raising and education may be effective for supporting caregivers and understanding contextual factors including pathways to diagnosis, diagnostic assessment and beliefs and experiences of dementia, will be important in developing a sustainable response to dementia in Fiji.

INTRODUCTION
Dementia currently affects an estimated 46.8 million people worldwide with numbers expected to double in high income countries, and treble in low and middle income countries (LMIC) by 2050. Dementia is a leading cause of disability in older adults with the ability to manage activities of daily living and personal care quickly diminishing as cognitive impairment increases. Known risk factors include age, genetics, cardiovascular disease and diabetes, and lifestyle factors such as smoking, obesity and depression. Potential protective factors include higher levels of education, physical activity and social integration. At an estimated annual cost of US$818 billion a year, dementia has a devastating impact not only on those affected but also their families and carers who provide the majority of informal care, and wider society through the costs of care and lost productivity. Yet, up to a third of dementia cases could be delayed by modifying lifestyle risk factors (World Health Organization, 2015).

In Pacific Island countries (PIC), population ageing is occurring at an increasing rate. In Fiji, the number of people aged over 60 years is expected to increase from 9.7% of the population currently to 19% in 2050 (UNFPA Pacific Sub-regional Office Fiji, 2014). Following global trends, population ageing in Fiji has future implications in terms of higher dementia prevalence. High rates of cardiovascular disease, obesity and diabetes in Fiji could add to the issue. Whilst there is an absence of published reports, recent data indicate that 1.53% of total deaths in 2016 may be attributed to dementia (IHME, 2016). Given limitations in reporting of health data and under-diagnosis of dementia this figure likely underrepresents the true extent of dementia in Fiji. Experiences from Indigenous populations in Australia may offer insight in cultural aspects of dementia in Fiji, although circumstances are clearly different, and these lessons cannot be uncritically generalised.

Dementia in Indigenous Australians: Lessons learnt
Aboriginal and Torres Strait Islander people comprise 3% of the Australian population but have more complex health needs, higher rates of chronic disease and lower life expectancy than the general population. Dementia prevalence is disproportionately higher and occurring earlier (e.g. 45 years and over) (Smith et al., 2008; Russell et al., 2016). Indigenous people with dementia, their families and carers are less likely to access dementia services than the wider community. Cultural factors around how dementia is perceived and understood in these communities likely influences service use, although such factors are not well understood. Dementia knowledge is limited in the Australian population and is even lower in Indigenous communities (Garvey et al., 2011). Misunderstanding or ignoring symptoms results in a delay in help seeking until dementia is advanced or a crisis occurs.

Until recently, the timely and accurate diagnosis of dementia in Aboriginal and Torres Strait Islander communities was hindered by a lack of culturally appropriate, validated assessment tools. To address this gap, the Kimberley Indigenous Cognitive Assessment (KICA) was developed for older Indigenous Australians living in remote regions of Australia (LoGiudice et al., 2006). The KICA uses simple English to facilitate translation into other languages and items include culturally appropriate pictures (e.g. emu, aboriginal people, boomerang) and commonly used objects (matches, comb, cup). The KICA can be easily adapted and has since been modified for use in urban Aboriginal communities and for Torres Strait Islanders. Work is also underway with overseas indigenous populations.

Dementia in Fiji: Challenges ahead
Health systems in PIC are currently inadequate to support the health needs of an ageing population (Anderson & Irava, 2017) and unprepared to meet the needs of people with dementia and their families. In the Pacific Islands, extended family tradition provides care for older people, although care arrangements for people with dementia are unreported to date. There is growing concern about challenges to traditional care systems in the Pacific including rural-urban drift, a trend towards more nuclear family units, emigration and disability in old age (UNFPA Pacific Sub-regional Office Fiji, 2014). Moreover, although traditional care systems in less resource settings buffer negative aspects of caring to some extent, caring for people with dementia is still associated with high levels of caregiver strain, loss of income and increased financial burden (Prince & 10/66 Dementia Research Group., 2004).

Formal dementia care in Fiji is predominantly provided through

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public mental health services and primary health care. St Giles Hospital is the only specialist psychiatric hospital and is the major referral centre for mental health issues in Fiji. People with dementia may also access mental health in-patient services (stress management units) at divisional hospitals. Out-patient services and mental health clinics are provided regularly, at various locations, by community mental health outreach teams, and through primary health care at health centres. Importantly for dementia care, domiciliary services are provided by mental health nurses and district nurses. Primary health care for dementia may also be accessed through private general practice. Dementia diagnosis is made using mainstream cognitive assessment tools as culturally appropriate measures such as the KICA are not available in Fiji. This has important implications for accurate diagnosis of dementia in Fiji (and other PIC) where there is a diversity of cultures.

People with dementia and their families face substantial barriers to accessing care in Fiji. Structural barriers include distance to health services, transport availability, cost of travel and availability of medications. Beliefs and low knowledge of dementia among caregivers and family also hinders return to health services for review appointments, and access to care in the first instance. People with dementia often present late to health services and in response to relatives’ concerns about behavioural symptoms such as aggression and profound forgetfulness. Many families believe they lack the knowledge and resources to care for a family member with dementia, and request admission to a care facility. To reduce the burden on families, some people with dementia are admitted at St Giles Hospital or at aged care facilities. However, there is a lack of facilities equipped for dementia care in Fiji.

**The way forward**

In response to shifting demographics, Fiji established a National Policy on Ageing (Fiji Ministry of Social Welfare, 2011). The National Council for Older Persons was formed in line with this policy in 2013 with the role to advocate and inform policy on the perspectives of older people (Government of Fiji Gazette., 2012). These initiatives represent a national approach and commitment to the wellness of older people. Importantly, the National Policy on Ageing references the need for training of health personnel in dementia care (Fiji Ministry of Social Welfare, 2011). Health system responses to dementia will be required in the coming years in Fiji and PIC. Developing a sustainable response to dementia requires an understanding of contextual factors (Ferri & Jacob, 2017). In PIC, as for Indigenous Australians, this includes investigation of pathways to diagnosis; diagnostic assessment; prevalence; impacts; perceptions, beliefs and experiences of dementia; workforce and resources. Drawing on experiences from other countries, culturally appropriate awareness raising and education for communities and caregivers may be effective for supporting caregivers in caring for people with dementia at home, for as long as possible.

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**REFERENCES**


INTRODUCTION

For many years, mental health issues such as suicide and substance abuse have been a concern in the Pacific. The problems associated with natural disasters, unemployment, domestic violence, child abuse and rapidly changing cultures have also contributed to the mental distress experienced by the people of this region. However, despite the evidence of the mounting burden of mental health disorders, there continues to be a dearth of mental health professionals in the Pacific to address these issues. In response to this longstanding reality, the Fiji National University (FNU) developed a clinical training program for nurses and doctors in the Pacific which has resulted in first-line mental health practitioners in all regions of Oceania. Many of these graduates are leaders in their country’s mental health service and recognize the value of developing a regional mental health association that is based and operated by its members in the Pacific. As such, discussions with mental health practitioners from Fiji, Vanuatu, Kiribati, Palau, Federated States of Micronesia and Tonga have occurred and the outcomes have been overwhelmingly positive with regards to the formation of a regional mental health organization that can provide clinical support, training and education to its members.

PROCESSES UNDERTAKEN FOR ESTABLISHMENT OF A REGIONAL MENTAL HEALTH ASSOCIATION

Most Pacific Island Countries (PICs) have at least one medical professional trained in mental health through the FNU postgraduate diploma programme and several countries had mental health nurses trained in either Fiji or PNG. Drawing on this network, the establishment of the Oceania Society for Mental Health Professionals (OSMHP) started with discussions amongst interested and like-minded mental health professionals from countries in the region and was facilitated by the SSCSiPs (Supporting Specialized Clinical Services in the Pacific, funded by the Australian Government Department of Foreign Affairs and Trade) programme during a two day workshop for a select working group.

While the majority of the health professionals were doctors, it was immediately and broadly realized and agreed that nurses and other allied mental health professionals should be included as members of the proposed professional association. During the workshop, the working group was able to develop a Constitution and commenced the process for registering the association. Further, as there has been a shift amongst PICs to having health professionals (especially for nurses and doctors) registered regularly based on continuing professional development activities, a focus of discussion was developing a continuing professional development framework for mental health professionals (see below).

Table 1: Draft Oceania Society of Mental Health Professionals, CPD Framework

<table>
<thead>
<tr>
<th>Educator</th>
<th>Activities</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teaching</td>
<td>Medical students</td>
<td>1 point per hour</td>
</tr>
<tr>
<td></td>
<td>Nurses</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Allied Health workers</td>
<td></td>
</tr>
<tr>
<td>Supervising</td>
<td>Junior staff</td>
<td>2 points per year</td>
</tr>
<tr>
<td>Presentations</td>
<td>Grand rounds</td>
<td>2 points</td>
</tr>
<tr>
<td></td>
<td>Conferences</td>
<td>5 points</td>
</tr>
<tr>
<td>CME</td>
<td>Activities</td>
<td>Points</td>
</tr>
<tr>
<td>Conferences</td>
<td>Mental Health Conferences</td>
<td>10 points</td>
</tr>
<tr>
<td></td>
<td>Other Medical conferences</td>
<td>5 points</td>
</tr>
<tr>
<td>Short courses - Essential</td>
<td>Basic Counseling Skills</td>
<td>10 points</td>
</tr>
<tr>
<td></td>
<td>Crisis Intervention</td>
<td>10 points</td>
</tr>
<tr>
<td></td>
<td>SPEC Training</td>
<td>10 points</td>
</tr>
<tr>
<td></td>
<td>Adult Critical Life Support</td>
<td>10 points</td>
</tr>
<tr>
<td></td>
<td>Psychological First Aid</td>
<td>10 points</td>
</tr>
<tr>
<td></td>
<td>Cognitive Behavioural Therapy</td>
<td>10 points</td>
</tr>
<tr>
<td></td>
<td>Instructor on course</td>
<td>20 points</td>
</tr>
<tr>
<td>Non-essential Short courses</td>
<td>5 points</td>
<td></td>
</tr>
<tr>
<td>Supervised clinical attachments for more than 2 weeks</td>
<td>5 points</td>
<td></td>
</tr>
<tr>
<td>Other training</td>
<td>Eg Medical Education, leadership, management etc</td>
<td>3 points</td>
</tr>
<tr>
<td>Departmental CME</td>
<td>1 point per session</td>
<td></td>
</tr>
<tr>
<td>Practice Review</td>
<td>Activities</td>
<td>Points</td>
</tr>
<tr>
<td>Audit</td>
<td>Attendance at presentation</td>
<td>1 point</td>
</tr>
<tr>
<td></td>
<td>Conducted Audit and presents findings</td>
<td>10 points</td>
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<td>Review of Clinical practice guidelines</td>
<td>Adopting guidelines to the pacific context</td>
<td>5 points</td>
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<tr>
<td>Development of clinical practice guidelines</td>
<td>10 points</td>
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<tr>
<td>Clinical Incidents</td>
<td>Root cause analysis - conducted</td>
<td>8 points</td>
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<td></td>
<td>Attendance at presentation</td>
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<tr>
<td>Morbidity and mortality, complex cases review meetings</td>
<td>1 point</td>
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<tr>
<td>Self-Education</td>
<td>Activities</td>
<td>Points</td>
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<td>BMU Learning</td>
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<td>Other</td>
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<td>Distance Learning including Health on Air *Remote areas</td>
<td>1 point per program</td>
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<td>Research</td>
<td>Published article - International</td>
<td>30 points</td>
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<td>- Pacific</td>
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<td></td>
<td>Unpublished</td>
<td>15 points</td>
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<td>Other</td>
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<td>Mental Health working group/consultancy</td>
<td>e.g. Conference organizing committee, sub committees, active member of professional mental health bodies</td>
<td>5 points per year</td>
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</table>

*Documented evidence must be produced

Annual points requirements: Doctors: 30 points; Nurses: 20 points.

Odille Chang
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Jimmy Obed
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ABSTRACT
Papua New Guinea’s health policies aim to provide accessible quality mental health care for all. This paper compares the policy statements to the practice on the ground and makes suggestions to help the country attain its mental health care goals.

INTRODUCTION
“We leaders and people must know where we want to go before we can decide how we should get there. Before a driver starts a motor car, he should first decide on his destination. Otherwise his driving will be without purpose, and he will achieve nothing. We Papua New Guineans are now in the driving seat. The road which we should follow ought to be marked out so that all will know the way ahead.” (Constitutional Planning Committee (CPC) Report, 1974, Chapter 2, Section 4)

These bold words were proclaimed by Papua New Guinean leaders (National Strategic Plan Taskforce Papua New Guinea, 2009) prior to the country attaining Independence in 1975. Have we decided on the destination and is the road to be followed marked out so that all will know the way ahead, or are we, despite having been in the driver’s seat for more than forty years, driving ‘without purpose’, doomed to ‘achieve nothing’?

Papua New Guinea (PNG) is a Pacific nation just north of Australia. The country is divided into 4 regions made up of a total of 22 provinces. With a population of 8 million, the country has one psychiatric hospital, the 60 bed Laloki Psychiatric Hospital outside the capital city Port Moresby. There are 11 psychiatrists working in PNG. Only 0.02% of people with severe mental illness receive treatment, i.e. there is a treatment gap of 99.98% (Adu Krow, et al., 2013).

This brief paper will seek to discuss two questions with regard to mental health care in PNG:
1. What is the mental health care destination in Papua New Guinea?
2. What is the road to mental health care in Papua New Guinea and is this road clearly marked out so that we all know the way ahead?

While recognizing that mental health care provision also involves financing, drugs, equipment, political goodwill and so on, this paper confines itself to the health workforce providing mental health care service and, in particular, doctors. In PNG ‘residency’ refers to the period between completing medical school and being registered as a fully-fledged doctor, ‘registrar’ refers to the doctors undertaking specialist M.Med training and ‘physician’ refers to a specialist doctor in internal medicine.

The destination
The current overarching national strategic vision is the PNG Vision 2050 (National Strategic Plan Taskforce Papua New Guinea, 2009) which states: “We will be a Smart, Wise, Fair, Healthy and Happy Society by 2050”. It explains that: “Being happy means our people will be healthy, wealthy and safe.” Vision 2050 further describes itself as: “the aspiration of every Papua New Guinean to fulfill the dreams of our founding fathers and to ensure that the correct mechanisms are in place for our country’s future.” All future medium to long-term strategies and plans in the country must now align themselves to Vision 2050.

The current National Health Plan 2011-2020 (Government of Papua New Guinea, 2010) envisages: “a healthy and prosperous nation that upholds human rights and our Christian and traditional values and ensures affordable, accessible, equitable and quality health services for all citizens”. It lists as priorities eight Key Result Areas including: Child Survival, Maternal Health, Communicable Diseases and Healthy Lifestyles. Mental health is listed under Key Result Area 7, Promoting Healthy Lifestyles, with the objective: “to reduce morbidity and mortality from non-communicable diseases and a strategy to improve and expand the standards in mental health service delivery.”

Even prior to Vision 2050, the health destination in PNG had been consistent over the years. Earlier National Health Plans emphasized the need to improve services to the population, and mental health care got increasing mention over time: the 1993 Mid-Term Review of the 1991-1995 National Health Plan (Department of Health Papua New Guinea, 1993) stressed the need for psychiatrists (there was only one in the country); the National Health Plan of 1996-2000 stated an objective of establishing 4 regional psychiatric centres by the year 2000, and; the 1998 Mid-Term Review of the 1996-2000 National Health Plan (Ministry of Health Papua New Guinea, 1998) targeted an increase in psychiatrists to 4 by the year 2000.

The National Health Plan 2001-2010 (Ministry of Health Papua New Guinea, 2000) set out a specific mental health goal – to reduce the number of people who become ill and die from mental illness. Its strategies included increasing the number of staff and training positions and supporting training; establishing and maintaining psychiatric units in all public hospitals and the four regional hospitals; improving mental health services available at provincial and district level, and; upgrading and maintaining Laloki Mental Hospital. Crucially, this Plan also specified: “All physicians caring for adult patients in public hospitals shall be responsible for hospital-based psychiatric units in the absence of psychiatrists.” That policy still holds.

The National Mental Health Policy (Department of Health, Ministry of Health Papua New Guinea, 2010), re-iterated that goal as the National Health Plan 2001-2010 and its first objective was improving the access and quality in delivery of mental health services.

The Mental Health Destination can therefore be summarized as a position where all Papua New Guineans are able to access affordable, equitable, quality mental health services, with psychiatrists at the four regional psychiatric units and with physicians providing mental health care in all hospitals that do not have psychiatrists.

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The road and the marking on the way to the destination:

Any clearly marked road should not only include milestones but should also warn of hazards ahead. It is also important that road signs not contradict each other. The Health Sector Human Resource Policy Vision (National Department of Health Papua New Guinea, 2014) states: “By 2020, the health sector shall have a well-managed, highly qualified, skilled and sustainable health workforce that delivers quality health services to meet the country’s population needs...”. This means that just two years from now, the country should have sufficient, highly qualified mental health workers to meet the country’s population need, including psychiatrists in all four regional hospitals as per the National Health Plan of 2001-2010. The year 2020 is therefore a clearly marked milestone that the driver will need to reach if the car is to arrive at its destination on time. However, at present only two of the four regions have psychiatrists. More psychiatrists are clearly needed.

The road to becoming a psychiatrist involves several consecutive milestones, namely the successful completion of the MBBS programme (5 years), residency (2 years), service years (1-2 years) and the MMEd programme (4-6 years). Each leg of the journey comes with its own challenges and hazards that can influence when, or even if, the destination will be reached.

MBBS:

In PNG, the School of Medicine and Health Sciences (SMHS) of the University of Papua New Guinea (UPNG) has been training doctors for over 50 years and produces between 40 and 45 graduates each year. A newer university, the Divine Word University, had its first intake of medical students in 2016 and those students are currently in the third year of the five year MBBS programme. The MBBS students at SMHS have a few seminars in psychiatry in their 2nd, 3rd and 4th years, but the bulk of the training in psychiatry takes place in the 5th year, including 8 weeks of seminars during which there is a 4 week clinical rotation in the course of which they are required to attend clinics and ward rounds both at the Port Moresby General Hospital and the Laloki Psychiatric Hospital, and to clerk and present a minimum of 3 patients. The 4 week psychiatry clinical attachment is too short for students to follow acutely ill patients from admission through to discharge, so students may therefore leave with the impression that psychiatric patients don’t recover much. However, an evaluation done by the author at the end of the rotations has consistently shown that the students report a substantial (two or threefold) increase in their knowledge of psychiatry and their confidence in managing psychiatric patients, as well as a sharp decrease in their fear of psychiatric patients. The students attributed the positive changes to hands-on exposure to psychiatric patients, and increased understanding of their conditions, which they reported reduced the stigma they had previously harboured. Student suggestions for improvement of the rotation have included requests for longer clinical exposure.

About four years after completing their psychiatry rotation, I see several of these enthusiastic students return to SMHS as trainee registrars – in disciplines other than psychiatry. While it is true that the majority had never intended to become psychiatrists, a few did during their MBBS training, but this small minority had shrunk to almost zero by the time applications were received for M.Med training. What had taken place, or not taken place, in the interval that effectively extinguished the enthusiasm these doctors had once had for psychiatry? Part of the answer may lie in the residency and service years and the lack of training positions in psychiatry.

Residency and service years:

Residency lasts two years during which time residents undergo fixed rotations in various disciplines. Unfortunately, there is no rotation in psychiatry. Doctors thus complete residency without any further training in psychiatry, so when a year or two later they apply for postgraduate studies, their MBBS psychiatry being but a remote memory, it becomes a case of out of sight, out of mind, and they apply for specialties to which they’ve had more recent exposure.

Compounding this recency effect, with the exception of Lae and Port Moresby, the psychiatric clinics and units in the hospitals in which residents and service medical officers work are run by psychiatric nurses, not by psychiatrists. Although these nurses have certain practice restrictions (forensic assessments, court reports, legal admissions, prescription of certain medications...) they have undergone a one year degree course at SMHS and are capable of managing most mental disorders, managing the units and referring on complex cases. However, nurses’ obvious competence in providing mental health services is not likely to motivate junior doctors to pursue psychiatry, as they model themselves after fellow doctors. Expecting a doctor to maintain his initial interest in psychiatry without further input during the residency and service years is akin to expecting a driver to complete a long journey on a half tank of petrol with no more service stations to refuel en route. Residency as it is currently conducted thus poses a major hazard on the road to increasing the number of psychiatrists trained and thus to implementing the country’s noble health policies.

Postgraduate (M.Med) training in psychiatry:

The problems above notwithstanding, a few determined doctors do apply to specialize in psychiatry, but fail to get training positions from the National Department of Health. Since the M.Med Psychiatry programme began in the 1990s, has trained thirteen psychiatrists, including two from the Solomon Islands and one from Timor Leste. However, while the medical school is able to increase its intake into psychiatric training, it is the National Department of Health, not the medical school, that offers training positions. Despite the explicit intention to have psychiatrists at all four regional hospitals and psychiatric units in all provincial hospitals, the Department of Health has not provided sufficient training positions – with obvious consequences for salary and accommodation. The Department of Health has also, over the past few years, tended to recycle the training positions within the different specialties. For instance when a registrar in surgery graduates, thus releasing the training position, it does not go back into a general pool but is given to an incoming registrar in surgery. Thus specialties that have several registrars such as paediatrics and obstetrics, end up with even more incoming trainees, while those with few or no graduating trainees miss out. Psychiatry has had some years with no graduates, resulting in a lack of training positions to be passed down to intending applicants, some of whom,
tions to be passed down to intending applicants, some of whom, as a result, switched to other specialties where training positions were readily available such as emergency medicine and surgery. Expecting a doctor to train for four years without salary or accommodation is similar to expecting a driver to get to his destination without a car.

This presents a significant hazard; half the current psychiatrists are close to retirement age and there is currently only one national psychiatric registrar in the M.Med programme and the incoming registrars in 2019 will not graduate till 2023.

The role of physicians:
The distribution of specialists in the country varies from specialty to specialty. Excluding Port Moresby General Hospital, which is the national referral and teaching hospital, and Laloki Psychiatric Hospital, which is the country’s sole psychiatric hospital, there are 21 hospitals at regional or provincial level across the country. As of June 2017, of these 21 hospitals, 16 hospitals had at least one physician, while only one of the hospitals (Angau Hospital in Lae) had any psychiatrists (National Department of Health Papua New Guinea, 2017), leaving 5 hospitals with no physician and 20 hospitals with no psychiatrist. Physicians are therefore more equitably distributed and more accessible to the population than are psychiatrists.

The Health Department’s solution to this severe shortage of psychiatrists is to task physicians with the care of the mentally ill in all the hospitals where there is a physician but no psychiatrist (Ministry of Health Papua New Guinea, 2000), which effectively means in 15 of the 21 regional and provincial hospitals. This assumes that physicians have adequate training and skills in psychiatry. However, the reality is that they do not, because their M.Med training in internal medicine does not include any time at all in psychiatry. They therefore qualify as very proficient physicians but with only their undergraduate training and skills in psychiatry acquired ten or more years earlier. And yet, on graduating as physicians they are expected to take on the dual role of physician-cum-psychiatrist. This is akin to asking a driver who has the skills and license to drive the family sedan to take on the job of driving long-distance heavy goods vehicles.

Contradictions between policy statements and reality on the ground:
I note three contradictions between policy statements and the reality on the ground:
1) The objectives of the Health Sector Human Resource Policy (National Department of Health Papua New Guinea, 2014), is to ensure that: “for all health cadres, pre-service and in-service training, continuing education, and professional development are appropriate, cost effective and of an acceptable standard.” While it may be cost effective to have physicians perform the role of psychiatrists, those physicians are not receiving training of an acceptable standard for them to perform those roles.
2) The policy adds that the government, through the Department of Health, will support and coordinate all health workforce training activities undertaken by both public and private health training institutions. However, the M.Med in Psychiatry training is not being supported through training positions.
3) Although it is acknowledged that: “The success of Vision 2050 is contingent upon the competencies of the country’s workforce. A well educated, healthy, appropriately skilled, and honest workforce that is committed, proactive and innovative is the kind of workforce required to implement Vision 2050” (National Strategic Plan Taskforce Papua New Guinea, 2009), the reality is that PNG is not training sufficient psychiatrists and physicians are not being trained to manage.

Which way forward?
What is the mental health destination in Papua New Guinea? The destination, clearly articulated in many documents, is the equitable provision of efficient and effective quality mental health care for all.

What is the road? The road to providing this care involves having psychiatrists in all the regional hospitals and having physicians standing in for psychiatrists in hospitals where the latter are not available.

What are the markings? This road is currently strewn with obstacles that militate against reaching the mental health destination in reasonable time. Without clear markings, neither the Health Department nor the doctors working within it are able to anticipate or prepare for the inevitable hazards. Given the current situation in PNG, were those markers in place they would read:
“Look out! Drivers released after only one month of clinical exposure!”;
“Danger! Two years of no psychiatric input ahead”;
“Hazard around the corner! No training position for applicants in psychiatry!”; and:
“Warning to physicians! Treacherous road ahead requiring engagement of four-wheel drive!”

CONCLUSIONS
PNG’s mental health destination remains a noble one, and those in the driver’s seat are not ‘driving without purpose’ – neither are they ‘achieving nothing’. However, in order to get “on track” to the destination the problems listed above have to be addressed. This could be achieved by making a few basic changes:
1) Lengthening the clinical attachment in psychiatry during MBBS. Although studies across the world, including in PNG (Muga & Hagali, 2006), Kenya (Ndetei, Khasakha, Ongecha-Owuor, Kuria, & Syanda, 2008), India (Tharayan, John, & Braganza, 2001) have shown that psychiatry is not a popular specialty, studies in Czechoslovakia (Dvoracek, et al., 2013), in Italy (Pascucci, et al., 2016) and in Pakistan (Aslam, et al., 2009) have also shown that increasing exposure to psychiatry results in a more positive attitude. A longer MBBS attachment could encourage more students to specialize in psychiatry.
2) Introducing a compulsory rotation in psychiatry during residency. This should be possible now that there are psychiatrists in both Lae and Port Moresby to supervise the residents. The rotation would help maintain the interest in psychiatry that students have at the end of their MBBS attachment.
3) Availing psychiatry training positions for the M.Med (psychiatry) programme. This would prevent the loss of potential psychiatrists to other disciplines that were not their first choice.
4) Introducing a psychiatric attachment of several weeks into the training, continuing education, and professional development are appropriate, cost effective and of an acceptable standard.” While it may be cost effective to have physicians perform the role of psychiatrists, those physicians are not receiving training of an acceptable standard for them to perform those roles.
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3) Availing psychiatry training positions for the M.Med (psychiatry) programme. This would prevent the loss of potential psychiatrists to other disciplines that were not their first choice.
4) Introducing a psychiatric attachment of several weeks into the M.Med (internal medicine) programme to equip the physicians to manage psychiatric patients in their hospitals. The onus here is on...
the SMHS, which sets the curriculum, to work with the Department of Health to ensure the training offered is not that of a pure physician but of a hybrid physician-psychiatrist. Only then can the country hope to fulfill the aspirations of our founding fathers declared prior to Independence and still valid today.

REFERENCES


PERSPECTIVE

ABSTRACT
Aims: To describe the work of psychiatrists in Australia, New Zealand (ANZ) and Fiji in recent years aimed at building child and adolescent mental health capacity.

Methods: Building on the success of Pasifika Study groups (PSGs), Fiji’s participants invited ANZ child psychiatrists to work with them to expand child and adolescent mental health workforce capacity. This was established under the auspices of the Faculty of Child and Adolescent Psychiatry (FCAP).

Results: A series of visits were undertaken to Fiji to offer workforce training opportunities for the mental health workforce, the primary care workforce, NGO staff, FNU students, hospital staff, support NGO clients and work with a school community affected by Cyclone Winston.

Conclusions: Partnerships to enhance workforce capacity in child and adolescent mental health in Fiji have shown initial promise. To further realise the potential of such partnerships, child psychiatrists in the region are developing their strategic directions to progress this conjoint work in Fiji and in other Pacific nations.

INTRODUCTION
Since 2013, the Royal Australian and New Zealand’s College of Psychiatry’s Faculty of Child and Adolescent Psychiatry (FCAP) has been working closely with mental health providers in the Pacific region. This paper reports on ANZ psychiatrists working together with Pacific islands psychiatry, health and community staff, focusing on Fiji, to further upskill and support both the mental health and the primary care workforce in their work with children, young people and families. Other authors in this series of publications have established the significance of mental disorders in youth as a lead contributor to the global burden of disease (see Larkins S et al, 2018 this edition).

In Fiji, significant mental health workforce shortages are described (Singh et al, 2013) and capacity building initiatives, such as those based at Fiji National University (FNU), are well underway although there are significant challenges in sustaining them (Chang, et al 2015). A limited mental health workforce is available consisting of medical, nursing and remarkably few allied health staff (WHO, Mental Health Atlas 2011-country profiles) highlighting the relative scarcity of available human resources commonly seen in low and middle-income countries (LMICs). The key mental health services in Fiji are presented in Tables 1 and 2.

There is a lack of available data in Fiji about mental health services for children and adolescents (World Mental Health Atlas 2011). Approximately 30% of the population is aged under 15 years (Singh et al, 2013). Specialist Child and Adolescent mental health (CAMH) services utilise psychiatric registrars from the Fiji Ministry of Health and Medical Services (FMoHMS) based in the three divisional hospitals and Fiji’s only child and adolescent psychiatrist operating from Suva. In the Central Division (Suva), of each month. No regular specialist clinics currently exist in the Western and Northern Divisions. CAMH services are provided together with general adult mental health services. Common cases seen are those with Autism Spectrum Disorders, ADHD, Epilepsy, Intellectual Disabilities and physical and sexual Abuse, including those referred by the judiciary and social welfare services.

The treatment gap identified in Fiji is considerable (see Figure 1). A significant contribution to the treatment gap arises in children and adolescents where their access to appropriate services and treatment is very limited (Morris et al, 2011). Measures recommended to address this include integration of primary mental health care (Fisher et al, 2011).

Table 1: MH and CAMH in FIJI: Services

<table>
<thead>
<tr>
<th>Hospital based:</th>
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<tbody>
<tr>
<td>St Giles Hospital, Suva (services centralised)</td>
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<td>Stress management units (Lautoka, Suva, Labasa)</td>
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<table>
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<th>Community Mental Health - Primary health</th>
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<td>(District nurse, health worker)</td>
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<table>
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<tr>
<th>Non-Government Organisations (NGO’s)</th>
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<tr>
<td>Psychiatric Survivors Association</td>
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<tr>
<td>Youth Champs 4 Mental Health</td>
</tr>
<tr>
<td>Community recovery outreach program</td>
</tr>
<tr>
<td>Fiji Alliance for Mental Health</td>
</tr>
<tr>
<td>Others (Lifeline)</td>
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</tbody>
</table>

<table>
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<tr>
<th>Faith-based organisation provide counselling</th>
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</thead>
<tbody>
<tr>
<td>No private care</td>
</tr>
<tr>
<td>Limitations to medication, access and monitoring</td>
</tr>
</tbody>
</table>

Table 2: MH in FIJI: Clinicians

Challenges
- Primarily urban services (village access difficulty; yet 50% live in non urban)
- Limited numbers and training of health professionals

Education
- Nursing MH education: basic MH Cert since 2006
- Medical MH education: Post-grd dip in mental health since 2011
  - Psychiatric study disseminated

Psychiatry 3

Child and Adolescent Mental Health
- Service started in 2011, 1 C&A psychiatrist (academic role)
- No uni very few < 18 admitted to St Giles, few clinicians
- Large youth population, 30% <15 (gradually changing)

Weaving the strands together: child and adolescent mental health, psychiatry and public health.

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Volume 7, Issue 1, 2018
Building Capacity for Child and Adolescent Mental Health

In 2013, the first Pasifika Study Group (PSG) in child and adolescent psychiatry was convened as a two-day pre-conference meeting on leadership, partnerships, training and service provision with participants from eight (8) Pacific Island nations held in Melbourne, Australia. (Omigbodun, O, 2013). Since then, they have been regularly held in Pacific Island nations and the most recent is described in detail (Bush A et al, 2018, this edition) Similar initiatives have had a track record of success. (Fung et al, 2015., Blignault, I et al, 2015)

Since 2013 Fiji’s child and adolescent psychiatrist, general psychiatrists and their trainees have been actively engaged with ANZ child psychiatrists in educational, networking, capacity building, consultancy and leadership activities with a view to expand mental health service provision for children, adolescents and their families.

This has included the active participation of Fiji’s civil society mental health organisations such as the Fiji Alliance for Mental Health (FAMH). In addition, FMoHMS, FNU, hospital staff and the local service directors have worked together to progress this work.

FAMH supports a wide range of mental health activities in the community and in 2016 auspiced activities for volunteer psychiatrists from ANZ, including addressing youth at the Psychiatric Survivors Association, an NGO providing psychosocial recovery services. There were presentations to medical and nursing staff at Colonial War Memorial Hospital, Suva, including to paediatricians, medical students and nurses on mental health topics, and a school visit to consult with teachers, students and their parents on the island of Koro, to assist with managing the impact of disaster in the classroom and in the community, which was devastated by Cyclone Winston in February 2016.

This was followed by attracting external grant funding for training in child and adolescent mental health (iCAMH) for 16 participants, a program initially piloted by the International Association of Child and Adolescent psychiatrists (IACAPAP) (Rathnayaka,K 2016). This included psychiatrists, paediatricians and their trainees, mental health nurses, psychologists and university academics(Hoadley & Kowalenko, 2017). It was held at Namosi House in the Ministry of Health Headquarters in Suva. Key resources to support such training are freely available, such as the e-textbook on CAMH (IACAPAP editor Rey, J, 2015, and Eapen et al, 2012), but, are not sufficiently adapted to Pacific populations. Key issues in the development of programs include that there is (some) local development; they are culturally relevant and sensitive, and; delivered in settings and with resources similar to the graduates’ place of practice (Chang et al, 2015). Problem-based learning can assist with this, and efforts have been made to collaboratively develop problem-based teaching resources. Such a collaboration of FNU, Fiji MoHMS and FAMH hosting training exemplifies the scope for cooperation that can be achieved locally. CAMH training for primary care staff in the western region was coordinated by the Fiji MoHMS with some external funding support, with key Fiji leaders in the field, such as Dr. Myrielle Allen, actively participating. Arrangements are being made to provide mentoring to assist the implementation of skills learnt. These initiatives add to the foundation training for CAMH in mhGAP (http://www.who.int/mental_health/mhgap/en/), previously delivered to the majority of primary care providers in Fiji. Full implementation of mhGAP skills has, anecdotally, been limited for children and adolescents and further support is being planned to address this. This is in keeping with findings in the global mental health field where sustainability of primary care programs responding to mental health needs requires staff supervision by specialist mental health workers (Davies & Lund, 2017). Training alone is insufficient, if referral platforms for severe cases and availability of specialist care is inadequate (Davies & Lund, 2017).

Active participation in Creating Futures 2017, also held in Suva, has allowed ANZ psychiatrists to enrich their understandings of Fiji’s mental health environment and facilitate extensive contact.
with colleagues, a range of local NGO’s, faith-based organisations and other services involved in mental health service provision in Fiji, including health promotion and early intervention activities in schools.

In Fiji there are many key players in these activities, actively involved in leveraging available resources to secure staff development to support mental health initiatives including in the MoHMS, civil society, in the professions, in the primary care workforce and more broadly.

Setting Strategic Directions

Recently, the RANZP Faculty of Child and Adolescent Psychiatry established an International Relations Subcommittee with co-opted Pacific Island nations members, and established a part time project officer role within RANZCP to continue promoting work in the Pacific. A strategic plan was developed with the following aims:

1. Support mental health workforce development in the delivery of CAMH services in the Pacific region;
2. Encourage mental health leadership in the CAMH Pacific workforce through facilitated educational activities and networking;
3. Support the clinical development of primary mental health care workers delivery of CAMH services in the Pacific region;
4. Support the development of clinical mental health skills in the existing specialist (paediatrician, general psychiatrists/mental health nursing and allied health) workforce to deliver CAMH services in Pacific through iCAMH (an educational resource);
5. Develop collaborative relationships with regional health influencers in the Pacific to improve CAMH services and workforce development (including advocacy, research, service and policy development).

While this represents a broad set of aims that reach beyond clinical child psychiatry it does address some key elements identified in the WHO Mental Health Action Plan (WHO Draft comprehensive mental health action plan 2013).

Over the course of the Faculty’s three Pasifika Study Groups mental health leadership skills have remained a constant, and have been a key component of the CAMH elements of Creating Futures. Requests for specific skills development has broadened, in consultation, to include acute psychiatry, youth and forensic psychiatry, drug and alcohol problems and case management. An important theme has been the importance of the eight (8) Pacific nations’ mental health leaders comparing local solutions to their CAMH needs.

For ANZ psychiatrists and trainees, working together with their colleagues in the Pacific with Pacific peoples can expand their clinical horizons (NiaNia, W et al 2017), build skills in working cross culturally, and develop their capacity to contribute meaningfully to service development in regional settings.

CONCLUSIONS

While the initiatives to date have demonstrated the capacity of RANZCP members to start a range of activities in a collaborative network, consolidating these efforts and scaling up can now be considered. How this can best occur and continue to be supported will require much closer partnerships that can better address resource issues to realise shared aims.

The role of volunteering in RANZCP members is being carefully considered. The College’s role in such a broad agenda may be circumscribed, but its success in its core function of educating and training professionals and ensuring standards of practice in ANZ could be exploited in the Pacific (with appropriate adaptation) to expand service capacity, both for children, young people and their families, and across the life-span.

The RANZCP also has considerable experience in promoting human rights, designing services, system strengthening, addressing stigma, promoting awareness and in mental health leadership that might assist Pacific nations, if appropriately adapted.

The RANZCP Congress in Auckland in May 2018 will highlight education and training partnerships in the Pacific by hosting a Pacific Forum with a large number of Pacific Nations’ participants and representatives of regional mental health organisations to review progress to date and consider what further role the RANZCP might have in the region in coming years as it weaves together child and adolescent mental health, clinical psychiatry and public health in a regional network. Participants from Fiji have been key to supporting this work and are seeking innovative responses to shape how we can all best work together to improve mental health services in Fiji.

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REFERENCES


Davies, T and Lund, C (2017) Integrating mental health care into primary care systems in low and middle income countries lessons from PRIME and AFFIRM Global Mental Health 4, 7 1-6 doi:10.1017/gmh.2017.3


Pacific Island Countries. Australasian Psychiatry, 23, 218-221.


This paper describes the 3rd Pasifika Study Group (PSG), held in conjunction with the Pasifika Medical Association (PMA) Conference in Noumea in late September 2017. The PSG brought together doctors and other health professionals from Samoa, Cook Islands, Fiji, Tonga and Vanuatu for case based learning sessions, sharing of service contexts and dilemmas from each Pacific nation setting and other collaboration and networking. There was a call from participants for further PSG workshops with future involvement of other Pacific mental health professionals.

INTRODUCTION
It is acknowledged that there is a marked disparity between the capacity of different nations across the South Pacific to provide mental health care to their communities. As one response to this situation, since 2013 the Royal Australian and New Zealand College of Psychiatrists (RANZCP) Faculty of Child and Adolescent Psychiatry (FCAP) have hosted a biennial two day Pasifika Study Group (PSG) for doctors providing mental health care in their Pacific nations of origin. The aims of the PSG include promoting development of effective and sustainable mental health capacity, particularly in child and adolescent mental health, within the Pacific region; as well as relationship building and fostering collaboration between mental health professionals in this region through networking and educational activities.

While the initial PSG was held in conjunction with the RANZCP FCAP conference in Melbourne, Australia in 2013, participants then suggested looking at Pacific settings for future meetings. Since 2015 the Pasifika Study Group has been hosted jointly with the PMA who convene annual conferences for doctors in Pacific nations. The PMA have a background of strong relationships with Pacific Nations’ governments, doctors and other health professionals and focus on addressing the unique challenges that doctors face in Pacific communities. Since 2015 there has been a strong contribution from RANZCP trainee psychiatrists including trainees with Pacific ethnicity.

METHODS
The 2017 Pasifika Study Group (PSG) was planned as a two day workshop to coincide with the 2017 PMA conference in Noumea, New Caledonia which was hosted by The Pacific Community (SPC). Participants were invited to attend if they were recommended as the appropriate mental health doctor from their nation by their Ministry of Health. Funding was sought to cover accommodation and travel expenses for all participants. The study group included an opportunity for each participant to present the services and context for mental health care in their nation, and to share differences in culture and the range of challenges faced in each country. The majority of the Pasifika Study Group sessions consisted of case based small group discussion focused on three topics identified previously by participants: a) childhood trauma and trauma informed care; b) neuropsychiatric emergencies and how these might be managed in low resource settings; and; c) acute psychiatric care for young people with psychosis in Pacific contexts. The case scenarios were drawn from relevant Pacific nation’s settings and contributed by participants. The scenarios were discussed and then each small group fed back their assessment findings and management recommendations to the larger group. Discussion was followed by a presentation on the relevant topic by a Pacific psychiatry RANZCP trainee or one of the facilitators. Further teaching sessions from senior child and adolescent psychiatrists on topics requested by participants were included, for example, a session on assessment and principals of management of young people with co-morbid intellectual disabilities and mental health difficulties.

RESULTS
Participants in the 2017 PSG included doctors from Samoa, Tonga, Cook Islands, Vanuatu and Fiji. They included three medical officers who were the sole doctors in charge of mental health in their Pacific nation, two paediatricians and one obstetrician who was also her nation’s chief medical officer. Psychiatrists from Papua New Guinea and Solomon Islands were invited but unable to attend at the last minute due to health reasons and travel disruption.

There were child and adolescent psychiatrists, adult psychiatrists and two trainee psychiatrists of Pacific origin affiliated with RANZCP facilitating the programme and supporting the small group discussions. An experienced psychiatric nurse with Fijian background added an important nursing perspective to the PSG. In addition, three child and adolescent psychiatrists from Noumea joined the group for some sessions.

A local airline strike resulted in significant disruption of delegates’ travel arrangements and the programme was altered each day to take account of the needs of participants who arrived later than anticipated. The programme was opened by the SPC Director General, Dr Colin Tukuitonga. The adjusted program took place over four half days, including a symposium presentation on the final day of the Pasifika Medical Association conference.

Feedback from participants was positive. Participants indicated the program was informative and relevant and were confident the material could be adapted to local settings. Specifically, there was positive feedback about the small group case discussion, group facilitation, opportunity for participants to communicate about their setting and respect for culture. One participant commented that a special feature of the PSG in Noumea was the presence of the two RANZCP psychiatry trainees.

Allister Bush
Child and Adolescent Psychiatrist, Health Pasifika, Capital Coast District Health Board, Porirua, New Zealand

Jimmy Obed
Senior Registrar Mental Health, Vila Central Hospital, Vanuatu

Paul Robertson
Director of Advanced Training, Child and Adolescent Psychiatry, University of Melbourne

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“The Noumea group was different because of the Psych registrars added to the group. That changed the whole dynamic of the group as we were able to relate more to them, sharing resources and spending more time with them in discussing cases and other things at the level of registrars. After the PSG Noumea, we created a Facebook Messenger chat group and we have been able to talk about cases and share registrar stories/challenges thereby maintaining these relationships forged during the PSG.”

Participants called for a focus on workforce development, particularly pathways for psychiatric training of doctors based in the Pacific, career pathways for psychiatrists and development of a broader mental health workforce approach for the PSG, especially pertaining to the nursing workforce in Pacific nations.

DISCUSSION
The 2017 PSG provided an opportunity for doctors delivering mental health care in their Pacific nations to engage with their colleagues across the Pacific as well as psychiatrists and psychiatric trainees from New Zealand and Australia. It built further on the success and momentum of the previous two PSGs. Benefits identified by participants included the fostering of professional relationships and networks providing opportunities for communication and sharing of advice and collegial support outside of the limited timeframe of the PSG. In addition, the educational focus of the program around specific themes identified prior by participants was considered a valuable component of the programme, as was the opportunity to compare and discuss the various health systems, novel solutions and constraints across different Pacific countries. Participants particularly appreciated the role of RANZCP trainee psychiatrists in the PSG in Noumea.

New Zealand and Australian psychiatrists and trainees identified considerable mutual learning from the PSG especially related to cultural insights and formulations shared by Pacific colleagues, and the challenges faced by doctors managing with scant resources in a range of Pacific settings.

Since the first PSG in 2013 there has been an evolution from an initial leadership focus to more emphasis on small group discussion around culturally and context-relevant case scenarios. These discussions have been popular with participants and resulted in wide ranging discussions around unique challenges faced by participants in their Pacific nations. While previous PSG’s have used more child and adolescent case scenarios, this time there were a majority of acute psychiatry cases relating to young adults, in response to the request of participants.

In the broader context the PSG continues to support the place of mental health as one focus in broader health service planning and development within the Pacific Region.

CONCLUSIONS
The PSG has been a useful model for supporting the development of sustainable mental health services within the Pacific region, particularly through networking and training. Participant feedback has been positive. Future PSG’s will include other Pacific island nations with recently trained doctors providing mental health care, broaden the selection of participants to include mental health nurses and continue to foster relationship building and collaboration between mental health doctors and other clinicians across the Pacific.

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BACKGROUND
Nearly 250,000 ni-Vanuatu live on more than eighty islands making up the Republic of Vanuatu. There are six provinces and two major centres – Port Vila and Luganville – with health service administration and the major hospital (Vila Central Hospital - VCH) in the former. As with other Pacific Island countries, the population is young (40% under 15 years of age) and reliant on primary production. Mental health service provision in Vanuatu was, until 2014, inconsistent and concentrated at VCH. At that time the Mental Health Clinic operated one afternoon per week and services for those requiring inpatient treatment were grossly inadequate, particularly those who required seclusion. The first ni-Vanuatu doctor with mental health training was Dr Jimmy Obed who graduated in 2013 with a Post-graduate Diploma in Mental Health from the Fiji National University (FNU). On return to Port Vila Dr Obed took on the role of team leader for Mental Health Services at VCH, and focal person for broader services across the country with the Mental Health Unit (MHU) at VCH serving as the ‘hub’ for providing support to provincial hospitals.

THE TURNING POINT FOR MENTAL HEALTH CLINICAL SERVICES
From March 2014 the MHU at VCH has functioned with its own, dedicated nurses. From the outset the newly formed team sought to address widespread stigmatizing practices. For instance, what had colloquially been known as the ‘psycho ward’ is now the MindCare clinic, a term which is now used to refer to mental health clinics in all provincial hospitals across the country. However, mental health services remained within the Internal Medicine Department and the Senior Registrar (JO) was required not only to run the mental health clinics and be the first on-call for the mental health unit, but to participate in internal medicine ward rounds and be on the medical on-call roster.

Towards the end of 2015, it was agreed that the non-mental health demands of the mental health team compromised its primary purpose and those responsibilities were wound back. Subsequently, specific clinics have been commenced, including Forensic Clinics, Child and Adolescent Mental Health Clinics, and Community Mental Health clinics and activities. With serious and persisting challenges in terms of Infrastructure and human resources, there has been a shift towards more community mental health, including home visits. The impression from service providers and the limited data available is that this has resulted in a reduction in patient admissions for inpatient management, and less relapses for those with serious mental disorders.

Needless to say, mental health service capacity building is a top priority with a particular focus on training nurses. Three nurses from the MindCare team at VCH were supported to study Mental Health Nursing at FNU. At the time of writing one has returned to work as Nurse in Charge of the MHU at VCH (and assists in running mental health clinics) and the other two are completing their studies.

In 2016 the Mental Health Unit initiated a mentoring program – the Vanuatu Psychiatry Mentorship Program (VPMP) – in collaboration with volunteer consultant Psychiatrists from New Zealand and Australia to provide clinical support, teaching and overall mentoring for the Senior Registrar. To provide support and experience in the assessment and management of common mental disorders to provincial nurses, a one-month placement with the MHU at VCH has been initiated. The first participant to complete that placement (in August 2017) is now conducting mental health clinics in the Northern Provincial Hospital (NPH).

With stability and growing capacity in the MindCare Clinic at VCH the focus of capacity building effort has shifted to the NPH, which was the first provincial hospital to send a mental health nurse for training under the Mental Health Nursing program at FNU. In addition to running hospital-based mental health clinics, this nurse is also providing mental health support to Vanuatu’s Northern Health Care group.

It was not until April 2017 that Mental Health was officially recognized under the Vanuatu Ministry of Health Structure as a department in its own right. The current structure now has responsibilities for Consultants, Registrars and dedicated Mental Health Nurses. However, while much has happened in the last four years, the challenges of limited human resources and the negative perceptions of mental health by those working in other health areas persist. That has consequences for attracting and retaining staff and, consequently, the work is far from finished.
ABSTRACT
With the significant and increasing burden of mental disorders in island nations across the Pacific, the need for psychiatric expertise is pressing. In this paper the author considers options for linkages with the Royal Australian and New Zealand College of Psychiatrists with view to enhancing training opportunities without contributing to the loss of a scarce and precious human resource.

INTRODUCTION
The South Pacific is a diverse region with many countries, ranging in population from Papua New Guinea with 8 million down to smaller countries such as Tonga with 110,000. The general GDP per capita is low by Australian and New Zealand standards, as is resource base available to doctors in the region. Historically, the major investments from outside the region are from Australia, New Zealand, and France, and to some extent the United States, with China a recent and significant player, and the WHO as the main regional multilateral organization. Training programs in psychiatry are available within the region but they do not have the same status and credibility as could be provided by the more developed neighbouring nations, specifically through the Royal Australian and New Zealand College of Psychiatrists (RANZCP). These were issues considered at the Annual Conference of the RANZCP which was, appropriately for the issues considered here, held in Auckland which may be considered the de facto capital of the South Pacific.

THE TRAINING DILEMMA
In 2013, I joined the mental health department in Samoa under the supervision of RANZCP Fellow, Dr Ian Parkin; with further support provided by our visiting psychiatrists and Fellows Dr Lisi Petaia and Professor Roger Mulder. Samoa’s career structure for medical doctors, esteem fellows as the highest level. However, few fellows continue to work in Samoa once they have gained their Fellowship, with the personal and professional attractions of Australia and New Zealand usually irresistible. The situation is compounded when Pacific Fellows obtain citizenship or permanent residence and become accustomed to the lifestyle of their new home. While those in Samoa regret their departure, their decisions are understood and respected. However, if we continue down this path, we will never have adequate numbers of fellows working full time in Samoa and the Pacific.

A PACIFIC FELLOWSHIP PROGRAM
A meeting of the Health Ministers in the South Pacific over a decade ago urged the creation of a WHO sponsored professional network – PIMHNet. Through subsequent meeting and networking it became clear that, in some countries, the selection of mental health staff was not based on interest or capacity. What we in Samoa wish to foster is a training program that will provide world-class psychiatrists who will be close if not completely up to the standard of Fellows of the RANZCP.

Six months into my work in the mental health department, Dr Parkin proposed approaching the RANZCP to allow Pacific Island trainees to join the College training scheme without first becoming a citizen or resident of New Zealand or Australia. For reasons outlined below, that was problematic but we subsequently used every opportunity to advance the idea with College representatives.

The ideal, of course, would be to train registrars in the Pacific to the RANZCP Fellowship level and to examine them locally. However, that is not possible, given the current training regulations which require trainee experience in large teaching hospitals with multiple registrars as part of the mental health team, rotations through subspecialty areas, and supervision from senior College Fellows. The nature of the Pacific is such that there may be only one or two registrars in a particular country, who are supervised by psychiatrists who, for the most part, are not Fellows of the College. Those registrars are likely to be working in all fields at the same time. Thus, their child and adolescent experience will be in the course of the general day-to-day work rather than being in a dedicated CAMH service. Similarly, forensic and old-age psychiatry experience will occur during their daily work rather than through specific rotations.

In terms of supervision, while the Internet capacity is increasing and videoconference supervision is now feasible, there remains the issues of who is clinically responsible for the care of the patients discussed and how this can be managed in a way which allows supervision but does not expose the supervisor or the hospital that they are working in liability. As noted above, the alternative, taking these registrars out of the country to work in a metropolitan setting under senior College psychiatrists for extended periods is counter-productive to the service needs of their country of origin. At the present time there appear to be three potential directions:
1.Maintaining the current status quo where there is some degree of supervision and training that comes from overseas by interested parties on an ad hoc basis. In Samoa this has occurred with resident psychiatrist, Dr Ian Parkin as well as significant input from visiting psychiatrists including Professor Roger Mulder and Dr Lisi Petaia;
2.Developing a training program that provides a College accreditation with lower standards than would be required to be a full Fellow of the College. This is likely to be achieved by upgrading the degree of supervision and including some overseas experience working in hospitals in Australia or New Zealand, and;
3.Embarking on a full training program to provide for Fellows of the college at a standard equivalent to those in Australia and New Zealand.

While option three may not be feasible at the present time, it may be a realistic aspiration. Option two, however, is realistically possible if goodwill and hard work are there to create it.
mental health services in Australia and New Zealand could form partnerships with the mental health services in each of the countries in association with the College. Memoranda of Understanding could be signed, and supervision provided to trainees in their own country as well as providing access to direct training in their partner service, either in New Zealand or Australia.

One of the major obstacles will be the visa status of Pacific doctors working in New Zealand and Australia. If they are given quick access to moving to those countries, then many will do so. They need to be able to work as doctors in those countries but remain restricted to training under supervision so that they do not get a fast track to full medical registration. This will need to be worked out by the respective registration bodies and departments of immigration. Such arrangements will require government to government agreements and Pacific Island ministerial involvement will likely be necessary, and will require careful attention to cross-ministerial considerations including trade practices. The Royal Australasian College of Surgeons has a model which may provide directions from experience.

CONCLUSIONS

Fellowship of a medical professional College is the highest level of achievement that most doctors in the Pacific aspire to. However, regulations and current policies make it almost impossible for most trainees, regardless of passion and drive, to stay and work full time in our respective homelands. Most Pacific countries are now pushing for the Master’s degree to be the highest level necessary for professional accreditation. But psychiatric registrars should not settle for less than having some form of accreditation from the RANZCP. Ongoing negotiations with the College will not only contribute to improvements in training, but will result in improvements of mental health treatment outcomes across the Pacific. Many years ago, the College removed the transitional “Member” status. Perhaps it is time to revive this in the form of “Pacific Member” with these Pacific Members having access after time and experience to a pathway to full Fellowship.
Fiji’s Mental Health Decree (2010) has set the direction for deinstitutionalisation and provision of community mental health services (Chang, 2016). This process commenced with the establishment of Stress Management Wards in Divisional Hospitals and Mental Health Clinics at selected primary healthcare facilities. To facilitate this scale-up of services, Fiji’s Ministry of Health and Medical Services (MoHMS) has committed to implementing the World Health Organization’s (WHO) mental health Gap Action Programme (mhGAP). Launched in 2008, the World Health Organizations (WHO) mhGAP aims to address the lack of care, especially in low- and middle-income countries, for people suffering from mental, neurological, and substance use (MNS) disorders. mhGAP provides health planners, policy-makers and donors with a set of clear and coherent activities and programmes for scaling up care for priority conditions. mhGAP is a very important global initiative and Fiji is one of the first Pacific Island nations to systematically train its workforce using this program. At the core of mhGAP is the mhGAP intervention guide (mhGAP-IG) – a tool for use by health-care providers working in non-specialised health-care settings. Training of Fiji health workers in mhGAP has been prolific; however, it has been unclear how this training has impacted on the delivery of decentralised mental health services.

An assessment of the implementation of mhGAP in Fiji is a crucial step in assisting MoHMS to assess progress in its commitment to the decentralisation and scaling-up of mental health services. More broadly, the implementation of mhGAP in a multicultural, middle-income, island nation is considered with the view to offer lessons regarding implementation process to other contexts with similar needs and challenges and contributing to a much-needed evidence-base for best practice. With this in mind, WHO and MoHMS recently commissioned an evaluation of the implementation of mhGAP in Fiji.

Relative implementation successes were found in that mhGAP was considered valuable and easy to use, and the health workers who deliver mental health services had a reasonable level of knowledge and willingness to change. However, several significant weaknesses and opportunities for implementation and mental health system strengthening were identified in the health services and the broader mental health system, including the need for improved planning, governance and leadership. To generate change will require creative and bold approaches.

In recent years training of Fiji health workers in mhGAP has been prolific; however, as anticipated at the time of the commissioning of this evaluation, several implementation challenges have been identified that have hampered the full potential of mhGAP. This evaluation has highlighted that whilst training of health workers is a necessary pre-requisite to translate evidence into practice, alone it is not sufficient to produce change. Implementation strategies need to be designed and operationalised, and health systems strengthened to address the barriers in implementation.

Fiji is taking a regional lead in implementing the World Health Organization’s mental health Gap Action Programme (mhGAP). If Fiji is able to consider and act upon the findings of this evaluation with a high level of commitment, it has the opportunity to not only develop effective mental health services in Fiji but to be a role model for other countries in the Pacific and beyond in how to successfully implement mhGAP within a strong mental health system.