Mental health was identified as a top health priority at the Ninth Meeting of Ministers of Health for the Pacific Island Countries in Honiara, Solomon Islands, in 2011. Ministers agreed that mental health issues, if not addressed appropriately and immediately, will continue to grow, with a significant adverse impact on health and socioeconomic development.

Progress has been achieved over the last two years in a variety of areas, including awareness, needs assessment, policies and laws, services, capacity-building and networking for mental health. WHO Mental Health in Development Country Profiles have been completed for seven Pacific island countries and areas (PICs) documenting needs, challenges, resources and services. The WHO Suicide Trends in At-Risk Territories (START) project supported PICs in establishing baselines, monitoring suicide behaviours and implementing prevention strategies.

Through the Pacific Island Mental Health Network (PIMHNet) support by the New Zealand Aid Programme, most PICs have begun drafting a national mental health policy or plan. Various training initiatives are addressing human resource constraints, including a one-year post-graduate diploma in Mental Health (PGDMH) established at Fiji National University, fellowship programmes on community mental health and depression provided by WHO collaborating centres in Australia and the Republic of Korea, technical support visits by mental health professionals, and national workshops. Health and legal professionals from various PICs have received support for study, and a technical officer post in the WHO Representative Office for the South Pacific/Division of Pacific Technical Support in Fiji, has been established. The integration of mental health services into general and primary health care has progressed.

Health ministers may wish to discuss effective strategies and concrete actions to overcome common barriers to the development and utilization of mental health services in the Pacific, including the serious shortage of trained professionals, the lack of population-based epidemiological data, and challenges in implementing mental health care in primary care.
1. BACKGROUND

Globally, an estimated 450 million people suffer from mental disorders. Surveys indicate that at least 2%-3% of the global population suffer from severe forms of mental disorders, such as schizophrenia, manic-depressive disorders, and severe depression. Other disabling forms of mental disorders, such as mild and moderate depressive disorders, anxiety, obsessive-compulsive disorders, and alcohol abuse, affect a further 5%-10% of the global population. Depressive disorders alone are responsible for 5.73% of the overall disease burden in the WHO Western Pacific Region. Mental disorders affect people of all ages, classes and cultures. Pacific island countries and areas (PICs) are no exception. Despite the lack of population-based epidemiological data for most PICs, health service statistics, case registrations and school health surveys all indicate that mental disorders and mental health problems are common in PICs. The disease burden from mental health is expected to increase greatly in the future—the result of dramatic social change, rapid population ageing and the increasing gap between socioeconomic groups.

Many PICs report higher suicide rates than the global average. Suicide behaviour among young people has become a major concern in the Pacific. The median age of suicide deaths is notably lower in Guam (27 years), Tonga (22 years) and Vanuatu (21 years), than in countries such as Australia (41 years). The proportion of male suicides is higher than female suicides in some PICs, for example, the Commonwealth of the Northern Mariana Islands, French Polynesia, Guam, the Marshall Islands, New Caledonia and Tonga. There was greater equality in the sex ratio of male-to-female deaths in some other PICs, for example Fiji, Papua New Guinea, Samoa and Solomon Islands. Hanging was the most common method of suicide in most PICs, including Fiji, French Polynesia, Guam and Tonga. Consumption of paraquat, a toxic herbicide, had been a leading method for suicide in some countries, including Samoa.

Substance abuse, in particular alcohol and marijuana, is cited among the most common causes of morbidity and as the cause of a variety of social issues, including violence and other criminal behaviours. A number of countries reported a high proportion of drug-induced psychosis in people seeking mental health services. Based on data derived from the Youth Risk Behaviour Survey and the Second-Generation Behaviour Surveillance Survey, the proportion of young people (aged 15–24 years) having ever used alcohol in PICs ranged from 43.9% to 83.8%, and marijuana use ranged from 5.5% to 67.1%. Mental disorders often affect and are affected by other diseases such as cancer, cardiovascular disease, diabetes and
HIV/AIDS. For example, there is evidence that depression predisposes people to myocardial infarction and diabetes, both of which conversely increase the likelihood of depression. Many risk factors, such as low socioeconomic status, alcohol use and stress, are common to both mental disorders and other noncommunicable diseases (NCDs).

A vast gap exists between the need for the treatment of mental disorders and the services available. Service data reported in several PICs indicate that substantially more than 90% of people with mental disorders had received no care or treatment in the previous 12 months. Among many other constraints, lack of services and trained mental health professionals are major barriers for the delivery of mental health services.

Mental health had been identified as one of the top health priorities in the Pacific at the Ninth Meeting of Ministers of Health for the Pacific Island Countries in Honiara, Solomon Islands, in June 2011. The health ministers agreed that mental health issues, if not addressed appropriately and immediately, will continue to grow, with a significant adverse impact on the health of people in the Pacific and overall socioeconomic development.

2. ACHIEVEMENTS AND PROGRESS

The establishment of the Pacific Islands Mental Health Network (PIMHNet) in 2007 marked the beginning of an increased focus on mental health. The prioritization of PIMHNet during the meeting of ministers in Honiara in 2011 was welcomed as it provided additional impetus for work promoting mental health and protecting the rights of people with mental disorders. Since 2007 there has been notable progress in relation to the development of comprehensive situation analyses, the development of policies and laws, service provision, capacity-building, and networking for mental health. The recent relocation of the PIMHNet secretariat to the WHO Representative Office to the South Pacific/Division of Pacific Technical Support in 2011 brought better opportunities for networking and the provision of timely technical support to PICs due to the central location of the office in Suva, Fiji, as well as enhanced opportunities for integration with ongoing NCD activities and programmes in the Pacific. Funding from the New Zealand Aid Programme has been gratefully acknowledged.
WHO Mental Health in Development Country Profiles (WHO proMIND) are being finalized for seven PICs, while others are in progress. Each profile provides, among other things, information on contextual factors that impact mental health needs and services in the country; the national legal, policy and human rights framework; prevalence data on mental health problems and the burden of disease; treatment and service utilization; the mental health information system; resources for mental health, including financing for services and the availability of psychotropic medicines; the human resource context, including the number of staff members trained and the level of training in mental health; and the different types of mental health services available at each health-care level, including long-stay facilities and specialist services, psychiatric services within general hospitals, formal community mental health services, mental health services in primary health care and informal community services. In addition, other countries, such as Samoa, integrated mental health into their STEPwise Approach to Surveillance of Risk Factors for NCDs (STEPS) survey in 2013.

While only a few PICs have enacted mental health legislation in recent years, for example, Samoa and Tonga, many of PICs are in the process of drafting a mental health policy or national plan that is either a stand-alone plan or is linked to a plan for NCDs. The plans or policies usually are multisectoral and focus on mental health promotion more than treatment, with mainly the health sector driving and overseeing implementation.

There are approximately 15–20 qualified psychiatrists providing services for the more than 11 million people in the Pacific, which is a far-from-ideal ratio and most of them work in Fiji, Papua New Guinea and areas administered by France or the United States of America, making intercountry disparities quite significant. One of the first milestones for PIMHNet was the development and implementation of human resource plans to improve the number and capacity of health workers to deliver mental health treatment, care and support. An additional and significant milestone for improving human resource capacity had been the establishment in 2012 of the Fiji National University Post-Graduate Diploma in Mental Health (PGDMH). Eight candidates from the Pacific are participating in the course in 2013, with numbers expected to increase in the future. This initiative ultimately should result in better country capacity once the graduates return to work in their respective countries.

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1 Fiji, Kiribati, Nauru, Niue, Papua New Guinea, Tokelau and Vanuatu
Five mental health professionals and lawyers from four PICs\textsuperscript{2} have participated in the diploma programme on mental health, human rights and legislation in Pune, India. The course builds the capacity of participants to advocate for human rights and to influence national legislative and policy reform in line with the United Nations Convention on the Rights of Persons with Disabilities and other key human rights standards.

Although systems are in place to build long-term sustainable human resource capacity for mental health, several service provision needs also require immediate attention, with a particular focus on reducing the treatment gap and improving the quality of services provided. These challenges will be addressed through the introduction of training programmes based on the WHO Mental Health Gap Action Programme (mhGAP), which is an evidence-based package of mental health interventions for non-specialized health workers and settings and through the mobilization of a network of psychiatrists and mental health workers from countries in the Pacific, including Australia and New Zealand. Approximately 25 external providers have shown interest. Between 2012 and 2013, WHO technical officers and consultants undertook short-term missions to 11 countries\textsuperscript{3} for analysis, short-term training and the provision of clinical services. The network of providers referred to above will build on these previous missions to provide long-term support (one to three months) to select PICs. In addition, in order to provide long-term systematic support to PICs, a technical officer position in mental health has been established in the WHO Representative Office in the South Pacific/Division of Pacific Technical Support to facilitate this work, with PIMHNet funding from the New Zealand Aid Programme.

The decentralization of mental health services, including community-based mental health services in Cook Islands, Fiji, Kiribati, Solomon Islands and Vanuatu, has been initiated with the intention of making mental health services more accessible and reducing stigma associated with mental disorders. In several countries, this effort has mainly involved the establishment of mental health outpatient units within general hospitals (including stress management wards), community counselling centres serviced by nongovernmental organizations, the training of health staff in primary care centres to deliver mental health interventions, and the inclusion of mental health as part of health service outreach activities.

\textsuperscript{2} Vanuatu, Palau, Papua New Guinea and Solomon Islands
\textsuperscript{3} Cook Islands, Fiji, the Federated States of Micronesia, Kiribati, the Marshal Islands, Palau, Papua New Guinea, Samoa, Solomon Islands, Tokelau and Vanuatu
The WHO Suicide Trends in At-Risk Territories (START) project, initiated by the WHO Regional Office for the Western Pacific, is an international multi-site initiative intended to enhance capability and establish a database for suicide surveillance and prevention across the Western Pacific Region and globally. The project has supported French Polynesia, Guam, Tonga, Vanuatu and other countries in establishing baselines and monitoring mechanisms for fatal and non-fatal suicide behaviours and has contributed to initiatives for effective management and prevention of suicidal behaviours in these PICs. The representatives of participating countries have met regularly for capacity-building and the sharing of experiences since the project was launched in 2006.

3. CHALLENGES AND ISSUES

Most PICs are facing similar challenges despite differences in overall development. The main challenges include:

1) myths about the nature and causes of mental illness;
2) human rights violations, stigma and discrimination towards people with mental disorders;
3) lack of legislative frameworks for promoting quality health care and human rights;
4) insufficient local epidemiological data for mental disorders to inform policy actions;
5) lack of investment in mental health in terms of the financial and human resources required to address the burden;
6) artificial separation of mental health from physical health and the neglect of psychological needs of people living with chronic diseases, for example diabetes, heart disease and HIV/AIDS;
7) serious shortages of professional workers trained in mental health and the insufficient use of effective interventions for mental disorders;
8) centralization of limited resources; and
9) lack of integrated comprehensive mental health services and care, in general.
The high burden and disability associated with mental disorders are the result of the high prevalence of mental disorders, the early age of onset of the disorders and its chronic course, together with the fact that people are denied timely and appropriate services and support, including health care, social services, education and opportunities for income generation.

4. FUTURE DIRECTIONS

The Sixty-sixth World Health Assembly in 2013 adopted the global Comprehensive Mental Health Action Plan 2013–2020. Health ministers around the world committed their governments and themselves to work for a world in which mental health is valued and promoted and in which mental disorders are prevented. They also committed to work towards a world in which people affected by these disorders are able to exercise the full range of human rights and have access to high-quality, culturally appropriate health and social care in a timely way to promote recovery—all in order to attain the highest possible level of health and participate fully in society and at work, free from stigma and discrimination.

Health ministers are invited to discuss following issues.

1) What are the major information gaps for mental health service planning and delivery, and how can these be addressed?

2) How can mental health services be made available and accessible to entire populations?

3) What can be done to overcome stigma and discrimination against people with mental disorders and mental health service providers?

4) How to overcome the difficulties in recruiting and retaining mental health professionals within the health care system?

5) What are priority areas for intercountry and subregional collaboration for the promotion of mental health?