14th Pacific Rim College of Psychiatrists
Scientific Meeting

Brisbane Convention Centre, Australia from 28th – 30th of October 2010.

Advancing together in Psychiatric Treatment, Research and Education

Firstly I acknowledge and pay my respects to the Turrbel people the Traditional Owners of the land on which we gather together and to their Elders past and present.

Secondly I thank you for inviting me to speak at this Scientific Meeting which I note is to bring together leading mental health practitioners in the fields of clinical work (psychiatrists, general practitioners, mental health nurses, and psychologists), academic psychiatry, and public and private mental health services stretching from the west coasts of North America and South America to East Asia and South-East Asia and Oceania. A big area.

This brings me to the first question I ask myself and that is why am I here as I am not by any stretch of the imagination one of those to which the Meeting is directed. I am certainly not a scientist. I have been invited as the President of the World Federation for Mental Health and I would like to speak to you briefly about the Federation,
World Mental Health Day and my involvement in the Federation.

The Federation was formerly called the International Committee for Mental Hygiene. As a layperson I find this name somewhat strange. Others may have thought similarly because in 1947 it was agreed to change the name to what it is today and to accept as a new purpose “to promote among all peoples and nations the highest possible level of mental health in its broadest biological, medical, educational and social aspects”

The Federation was officially founded as a legal entity on 19 August 1948 and began with members consisting not of individuals or countries but of societies from forty six different countries. Today with members and contacts in over one hundred a fifty countries the founding principles of the Federation still hold true and are reflected in current activities including World Mental Health Day, a Biannual World Congress, Collaborating Centres in different parts of the World and ongoing initiatives to improve awareness and remove prejudice about mental disorders.

In part the work of the Federation is through regions and Australia is part of the Oceania Region which includes New Zealand, Papua New Guinea, Fiji, Samoa, Cook Islands and New Caledonia. Each Region has a Vice-President and for Oceania this is Helen Herrman who is well known to you and your organization. Helen and I are hopeful that the Federation will become more active in this region through
local organizations such as yours and the Mental Health Council of Australia.

World Mental Health Day was first observed on 10 October 1992. It was started as an annual activity of the Federation by the late Dick Hunter who was as a volunteer Deputy Secretary General for the Federation from 1983 until 2002. Dick’s vision was that World Mental Health Day should be a global and unified effort to promote greater public awareness and understanding of mental health and mental illness. This vision continues to be realized each year on 10 October and is now celebrated in over one hundred countries.

Over a period of years I came to know Dick quite well. A very calm and peaceful man. He was a Quaker at the time of the second World War and registered in the United States as a conscientious objector. As a result he qualified for alternative service and during the war he was assigned along with other similar objectors to work in psychiatric hospitals for the duration of the war. He worked in several different hospitals in the US both state and private for the duration of the war and at the end of the war he and a number of his fellow objectors came together to share their concerns and experiences of the poor quality of the facilities and of the standard of care that was provided in them. They formed an organization called the National Mental Health Foundation as an effort to spur a reform movement to improve services and the human rights abuses that were
very prevalent at the time. Dick served as the Director for the Foundation and one of his major achievements was to get an expose of the condition in mental health institutions published in the Life Magazine. This had a great impact but was short lived! In 1983 he took on as a volunteer the role of Deputy Secretary General for the Federation a role that he held until his death in 2007 at the age of eighty nine. A truly remarkable man!

The Federation has suffered quite severely as a consequence of the Global Financial crisis and because of limited finances has minimal staff and is largely a volunteer organization. There are no funds to cover the cost of Board Members attending conferences or Board Meetings which means they have to cover these themselves. They are often called upon to represent the Federation at international conferences.

In the early days World Mental Health Day did not have a specific theme and its aims were to generally promote mental health advocacy and education of the general public on relevant issues. Since that time however the Federation has chosen a particular theme to be promoted in its planning kit each year. The theme for this year is a continuation of the previous one from last year on integration of physical and mental health, with a specific focus on the relationship of mental health with chronic physical illnesses.

A position that the World Federation for Mental Health is promoting in international forums is the need for inclusion of mental health in the emergent and growing emphasis being
given to non-communicable diseases. We believe mental health is intimately tied to the Millennium Development Goals. In 2000, the then Australian Prime Minister John Howard, along with 188 other world leaders, signed the United Nations Millennium Development Goals (MDGs) Declaration. Australia's signature on this declaration was a commitment to help the world's poorest of the poor.

In a historic sign of solidarity with the world's most vulnerable communities, world leaders committed to a global action plan to eradicate extreme poverty and hunger by 2015 — a commitment that Australian aid agencies robustly applaud.

For the world leaders who signed the declaration in 2000, poverty was not defined by the boundaries of states and regions. Needless human suffering is prolific, and as a leading international donor, the Australian Government is obliged to respond accordingly.

As these goals are reformulated, we will try to ensure that mental health is prominently represented. The burden of mental illnesses is well documented. This year on World Mental Day we underlined the intimate and bi-directional relationship between mental illnesses and chronic physical illnesses including diabetes, cancer, heart disease, respiratory diseases, and obesity.

WFMH is currently developing a program – the Great Push for Mental Health – to ensure that mental health is given priority in all countries. The connections between physical and mental illnesses, and the relationship between these
illnesses and human productivity and mortality, are key to such prioritization. The Federation often gets confused with the World Health Organisation but the two organizations are quite distinct although we do work in co-operation. WHO is financially supported by country donations but the Federation relies in a small part upon membership contributions from national organisations most of which have also suffered as a result of the Global Financial Crisis. The main financial support for the Federation is from Corporate bodies which again have experienced financial downturn especially in the United States where the Federation is based.

I need to mention at this point a report launched by WHO on 16 September this year on mental health and development called “Targetting people with mental health conditions as a vulnerable group” as this fits in with the Great Push. It is not surprising that the report states the challenge is enormous. An estimated one in four people globally will experience a mental illness condition in their lifetime. Mental health conditions are responsible for a great deal of mortality and disability, accounting for 8.8% and 16.6% of the total burden of disease due to health conditions in low and middle income countries respectively. Depression will be the second highest cause of disease burden in middle income countries and the third highest in low income countries by 2030. The report calls for action to address these needs by:-

- Recognising the vulnerability of this group and including them in development initiatives
- Scaling up services for mental health in primary care
• Including people in income generating programmes and providing social and disability benefits
• Involving people themselves in the design of development programmes and projects
• Incorporating human rights protections in national policies and laws
• Including children and adolescents with mental and psychosocial disabilities in education programmes
• Improving social services for people with mental and psychosocial disabilities

This is a big challenge for organization’s that work internationally and highlights the need to work co-operatively to achieve better outcomes for those in developing nations.

This brings me to the second question I am constantly forced to ask myself and that is how on earth did I become the President of the Federation. I have been involved in the Federation for about ten years and about three years ago I was thinking I had done my stint and should retire gracefully. Out of the blue I received an email from the Federation’s Nomination Committee asking if I would accept a nomination to be President Elect and when I showed this to my wife she said “Do they know how old you are?” Not very helpful but I responded to the email thanking them for the confidence they had in me but suggestion they should think about someone who was a little younger. The Nomination Committee were however convinced I was the right person for the position and in the end I accepted the nomination as the first non medical person and family carer to do so. I had
nothing to gain personally as I did not have a career in front of me with a need to expand my CV. My motivation for involvement in mental health is because of family circumstances and had they not happened I like a lot of other people would probably not be particularly interested in mental health or illness. My first personal contact with mental illness was back in the early eighties when I was studying part time to become a lawyer as a mature aged student working full time. My eldest daughter was working as a nurse and contracted glandular fever but was persuaded by the staff doctor at the hospital where she worked not to take time off despite her inability to cope. This in the end developed into very severe depression which was something very new to me and about which I had no understanding. She started off receiving medical attention from the family GP who fortunately had a strong interest in depression but despite trying several medications the depression got worse and the GP referred her to a psychiatrist. He then went overseas and she was referred to other well known psychiatrists in Perth when a whole range of medications were tried without success. The illness got worse to the extent that she was hospitalized several times. She was literally fading away because she was not eating or drinking. One of my most vivid recollections is of seeing my daughter curled up in a hospital bed in the foetal position virtually dying. The treating psychiatrist at the time discussed the situation with my wife and myself and told us the only remaining thing that could be tried was ECT which he explained to us as it was all unknown to us. Whilst our daughter was over the age of consent he was seeking our agreement to proceed because she was unable to give that consent herself and was being
treated as a voluntary patient. It was all very strange to us but agreed to the procedure out of desperation. She did respond to the extent she started eating and drinking again but remained very depressed requiring many ECT treatments and I virtually had to rescue her several times from life threatening situations where she had self harmed. Time does not permit me to expand on these but in the end she was referred to another psychiatrist who at the time was regarded as the top psychiatrist in Perth who prescribed a MAO Inhibitor which began to stabilise my daughter. It was a long and difficult battle but eventually my daughter decided to wean herself off this medication. She was able to resume work and now has a responsible nursing position and is married with two daughters. She remembers very little of this which is a fortunate thing in many ways but I can still see vestiges of the illness. A success story and an example of recovery as opposed to a complete cure. My third child a son had a very difficult life. As a child at school he was always on the fringe because he was different and had co-ordination and dyslexia problems. He was a very intelligent person and gained a place at university but unfortunately dropped out mainly because of an involvement with a very attractive but demanding young lady. He married her. without anyone in the family knowing but that marriage failed fairly quickly. Whilst married he developed testicular cancer resulting in him having extensive chemotherapy and extensive operations to have cancerous tissue removed from various parts of his anatomy. This left him in a very low emotional state resulting in him on one occasion taking a large amount of medications which had been prescribed for me. I was out with my wife when we received a telephone call from him. We went home and
found him almost unconscious. I drove him to the emergency department of a hospital where his stomach was pumped out and he was discharged on the following day. He believed his family was in some way responsible for his problems and decided to move to Sydney where he came in contact with psychiatric services and was given a diagnosis of bi-polar disorder. He adopted an alternative life style and became involved in the drug scene including heroin. Unfortunately there was no quality control over the heroin and because of the strength of it on one occasion he became unconscious. He was intensive care for many weeks and had long periods of rehabilitation because of irreversible brain damage which affected his mobility. He was in a wheel chair. You may have noticed I have referred to my son in the past tense and this is because he died in November of last year as a result of a heroin overdose.

This leads me to the need to involve families or others in a caring close relationship with a person with a mental illness in the assessment, treatment and recovery processes.

The 1991 United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care include:-

- The right to the best available mental health care which shall be part of the health and social care system [Principle1.1]
- Every person with a mental illness shall have the right to live and work, as far as possible, in the community [Principle 3]
In order to achieve the above families who are an integral part of the community often have an important role to play. The concept of the family, however it is defined, is important to the general wellbeing of the world population. It is however a rapidly changing concept and the nuclear family [mother father and their children] is rapidly disappearing. The “family” relationships that now exist are myriad and can range from the single parent family to the extended family as often exists in developing countries. Friends and even pets can now be regarded as part of the family. In the developed parts of the world with all the technology that is readily available families can however become isolated even in the urban environment and this urbanization can lead to many social problems including mental illness. People often do not know their neighbours who in years gone past would have been part of what could be called the community family and willingly available to offer help and support. No matter how the family is defined “families” can still offer the support, nurture and encouragement to those that are part of them.

This is particularly important in caring for people with mental illness which is now clearly recognised as contributing heavily to the burden of ill health throughout the world. Often the responsibility for caring falls upon the family of the person that has the mental illness and yet this important role is commonly overlooked. In the determination of what is the “family” allowance should be given for the person who has a mental illness to define their family. This caring role can be assumed for different reasons including the lack of services but often the family will regard it as their responsibility although sometimes it is forced upon them because there is nothing else available.
This can have a flow on effect with the family carers becoming physically and mentally unwell because of the lack of support they receive in this caring role. In addition they can become socially isolated and experience the stigma that mental illness attracts and in some cultures the mental illness within the family can remain hidden because of shame. It must be acknowledged that each family will face a different set of circumstances and that not all families require the same level of support. Some may not even see the need for support because it is accepted as the family's responsibility to provide the required care.

The family caring role is in itself diversified. The overwhelming majority care for one person but those caring for someone with a mental illness or learning disability are more likely to be caring for more than one. This often places a particular burden on the mother in the family who accepts the primary responsibility as part of her role when it is a child that needs the care.

In addition to the caring role families have an important role in the assessment and treatment of their family member. Mental health clinicians working alongside families can help support and empower families to assist in the treatment, care and recovery process for their family member as well as dealing with their own trauma and distress. The losses, grief and adaptations that families usually face are different to those where there is a congenital or birth related condition, or one which is evidenced in early childhood. They are different again from the losses associated with care of an ageing parent or partner. Due to this different age
of onset and the unpredictable course of mental illness, roles and relationships need to be changed and re-formed on an ongoing basis. There is a profound sense of grief experienced, which can be compounded by the professional attitudes encountered and the long search for help.

A quote in 2006 by the National Alliance for the Mentally Ill as an objective

*To develop a partnership with mental health care providers is vital to the success of families in caring for their loved ones – to their providing crisis intervention, case management, counseling, basic needs support, socialization, advocacy and insight into their loved one’s illness [National Alliance for the Mentally Ill 2006]*

Families have clearly been involved in health care for centuries but their involvement in mental health care in the way envisaged by this quote is a fairly recent development and one that is progressing slowly. It is at varying stages of implementation throughout the world and it must be acknowledged that it will not always be possible because of family conflict and disengagement from the family.

Family involvement at all levels is a global issue that the World Federation for Mental Health [WFMH] is concerned about in its endeavors to improve the wellbeing of all peoples throughout the world and to make mental health a global priority for everyone.

It should be noted that in its resolution 52/81 of 12 December 1997 the UN General Assembly recognized that the basic objective of the follow up on the International Year
of the Family [1994] should be to strengthen and support families in performing their societal and developmental functions and build upon the their strengths and in particular at the national and local levels.

Whilst there is a need to support families globally it is particularly important for there to be a strong focus on the least developed and developing countries to reinforce family related concerns in respect of mental illness and the promotion of mental health.

What needs to be done is the development of:-

- Increased awareness of family issues around mental health among Governments as well as the private sector
- Strengthened capacity of local organizations to formulate, implement and monitor mental health policies particularly as they relate to or affect families
- Efforts to respond to problems affecting and affected by mental health issues in families
- Reviews at all levels of the situation and needs of families and
- Improved collaboration among national and international non-government organisations for the support of families and identifying specific mental health issues and problems

I think I have made it clear why I am involved in mental health issues and my plea is that we as a total global community work together to achieve better outcomes for those that experience mental illness and I would like to conclude with a story which you may have heard before.