PACIFIC RIM COLLEGE OF PSYCHIATRISTS

BULLETIN

APRIL 2007

TSUYOSHI AKIYAMA, EDITOR

ALLAN TASMAN, PRESIDENT

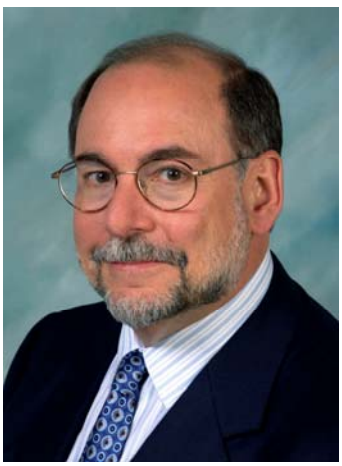
PRESIDENT'S REPORT

Welcome to the newest edition of our bulletin. Those of you who have received our newsletter in the past will notice that we have changed the name. The new title, "bulletin", reflects an increased emphasis on articles of academic interest, and an expansion of our total content. This also marks the initial edition produced by our new bulletin editor, Tsuyoshi Akiyama. He has done an outstanding job of transforming our major communication vehicle, and I know you will find much of interest here.

We continue to work on membership expansion, with new categories available for psychiatrists at all levels of professional development, with fees determined to be affordable no matter what your country. For more information , see our web site, www.prcp.org, or information in this version of the bulletin.

PRCP has been exploring the possibility of starting a new journal to focus on issues related to psychiatry in our membership area. We have approaching several organizations regarding co-sponsorship, and are looking forward to making good progress in the coming months.

If I can be of any assistance, or provide any further information about the PRCP. Please contact me at allan.tasman@louisville.edu , or contact our Secretary General, Chee Ng, at cng@unimelb.edu.au



With best wishes,
Allan Tasman, MD,
PRCP President

Editor's Report

Firstly, I would like to express my appreciation that the PRCP board has given me this wonderful opportunity to serve as editor of the bulletin. Since I am not an eloquent writer like my predecessor, Dr Philip Morris, I will rather focus to be instrumental to make this bulletin an open forum.

I am planning to compose this bulletin with messages from the president, secretary general and editor, award papers, reports on innovative programs, international conferences and collaborative programs in the region. I will also include a young psychiatrists' section and other interesting papers.

In this issue, you will find the excellent award paper by Dr. Jaeuk Hwang and reports on innovative programs: "Chinese Psychiatry Online" by Prof Yizhuang Zou and "Yuli Psychiatric Rehabilitation Model in Taiwan" by Dr Steve Chih-Yuan Lin. I guess these two programs are wonderful examples of creativity and commitment to the consumers. You will also find reports on PRCP Taipei conference, SAARC Katmandu conference and WPA Psychiatry in Developing Countries section conference in Lahore. There are articles on ICER-Asia-Pacific Regional Collaborative Research and young psychiatrists' activities at the PRCP Taipei conference as well. The fascinating addition is the discussion between Dr Philip Morris and Prof Bruce Singh on the mental health system in Australia. The discussion is quite stimulating.

As we know, there are countless progressive projects taking place within the PRCP. I ask every member to provide me with suggestions about these new moves. Please simply notify me akiyama@sa2.so-net.ne.jp the name and the contact information of the key person, I will take care of the rest.

If this bulletin could facilitate the exchange of information, ideas and proposals, and thus PRCP could become more cohesive and practically engaging organization, it would be my utmost pleasure.

Dr Tsuyoshi Akiyama.

The Australian Mental Health Crisis: A Case of Good Intentions Gone Wrong— Dr Philip Morris

Australia has a mental health crisis. Despite two national mental health plans and a decade of changes to public mental health services, individuals, patients, families, carers and support groups from all around Australia are saying that the care of mentally ill individuals is a shame. The causes of this crisis are manifold, but three main factors are important. Over the past 30 years three pervasive influences have affected Australian psychiatry; the process of 'deinstitutionalisation', the 'mainstreaming' of mental health services, and the introduction of new (more liberal) mental health acts. Although often introduced with good intentions, theses forces have had bad unintended consequences. Deinstitutionalisation has left many chronically unwell patients homeless and dispossessed of appropriate residential and rehabilitation care (often leading to these patients occupying acute inpatient beds), mainstreaming has led to the marginalisation of mentally ill patients in our general health services, and new mental health acts, while emphasising patient autonomy and least restrictive care settings, can restrict access to needed treatment. This has led to severe rationing, inadequate provision of appropriately supervised supported accommodation, 'false efficiency' of running psychiatric inpatient units at 100 percent occupancy, the unique needs of individuals suffering mental illness not being fully appreciated, a narrowing of the focus of public mental health services with a lack of emphasis on rehabilitation and recovery, a demoralized workforce, and problems with recruitment and training into a workplace offering limited experience and often perceived as unattractive. The consequences of the crisis have been inadequate care of patients and additional burdens for families and carers.

Having reached this crisis what can be done?

In order to correct this situation a number of important reforms need to be introduced. Mental health services must become accountable primarily to patients, their families and their carers. The treatment needs of the patient must not be inappropriately influenced by the demands of rationing applied by mental health services. Substantial staffing and facility enhancements and additional funding will be required to support this change.

As a method of enhancing this accountability, I have called for a standing commission of inquiry (cont)

The Australian Mental Health Crisis: A Case of Good Intentions Gone Wrong

Continued...

into all suicides to review each suicide and any prior (within six months) contact the person had with treatment services in order to monitor the quality of mental health care and make regular recommendations to improve it. In addition, regular reports should be made public on morbidity and mortality data from patients under psychiatric treatment concerning deaths from natural causes, suicide, homicide, police shootings, and accidents, as well as the numbers of deaths of others caused by individuals suffering from mental illness under care of mental health services. Parallel but integrated services should replace the 'mainstream' model, and a build of clustered supervised accommodation around embedded rehabilitation and recovery services is urgently needed for longer stay or chronically ill patients. An increase in training opportunities beyond public mental health services such as in the private sector and non-government organisation services is required for medical students, registrars, allied health professionals and nurses in order to provide comprehensive knowledge and skills training in psychiatry.

While a major investment of public resources is required to deal with the mental health crisis, the money will not be well spent unless issues of accountability, service direction and training raised above are addressed.

It is unlikely Australia is unique in experiencing these problems in mental health services. Other developed countries have been confronted with similar challenges. Developing nations within the Pacific Rim would be well advised to note these difficulties and devise policies to avoid them.

Dr Philip Morris

Commentary on Dr Philip Morris Article

Prof Bruce Singh

My colleague Dr Philip Morris has written a trenchant criticism of the reforms of the Australian mental health system over the past 2 decades. It is important however that readers have the opportunity to put these comments in perspective. It has been widely acknowledged that Australia has implemented one of the most comprehensive programs of reform anywhere in the developed world. It is also true that there have been considerable criticism of the perceived consequences of these reforms. This is the apparent paradox in that mental health services are getting better (in the sense that more people are being treated more effectively in a less restrictive environment than ever before and many of these are therefore living more productive lives without limitations on their freedom than was the case for those who were treated in mental institutions) but are looking worse (in the sense of receiving the type of criticism that Philip has detailed).

The reasons for this are really quite simple. As mental health services become more accessible and acceptable, demand for them rises, but resources are inevitably finite and therefore rationed and have not been able to keep up with the demand. Given that community mental health services are labour intensive, boundaries have to be drawn around who can be offered these publicly funded services. Some of the solutions offered by Philip are eminently sensible such as the need for more “supervised accommodation around embedded rehabilitation and recovery service” and an increase in training opportunities. Others fly in the face of reality, namely decoupling patient care from the resources required to fund them. The recommendation of a standing commission of enquiry into all suicides might lead some to believe that all suicides are the result of treatment failure and/or inadequacies in care which is manifestly not true. Typically 10% of patients with schizophrenia will die by their own hand but this is more often consequences of the presence of a terrible devastating disorder rather than treatment failure. I would suggest that the reader keep some of these points in mind when they read Phillips article because as he points out many countries are dealing with similar issues as they attempt to modernize their mental health service and while aspirations may be ahead of reality we should not throw the baby out with the bath water.

Prof Bruce Singh

Secretary-General's Report

It is a pleasure to provide this report on the PRCP and the activities of the Secretariat for the inaugural PRCP Bulletin. I would like to thank Prof Allan Tasman and Dr Tsuyoshi Akiyama for their contributions to the refreshed format of our quarterly college publication.

I would also like to thank the members who have finalised their overdue PRCP membership dues recently. The PRCP has recently updated their membership accounts and we appreciate those that have finalised their accounts to date. Membership dues for 2007 have been sent out in March 2007.

In accordance with the PRCP Board approval of the new membership categories at the meeting in Taiwan, all Fellows of the PRCP in 2006 have now been appointed to Distinguished Fellows of the PRCP. The Secretariat is currently reviewing the status of all Members and Fellows, and will advise accordingly.

The Secretariat has requested the services of a taxation firm to address the taxation requirements associated with the PRCP receiving donations and grants to undertake key projects in the future. Such a mechanism would enable the PRCP to pursue future research and educational projects that can benefit the PRCP and enhance our role in the region.

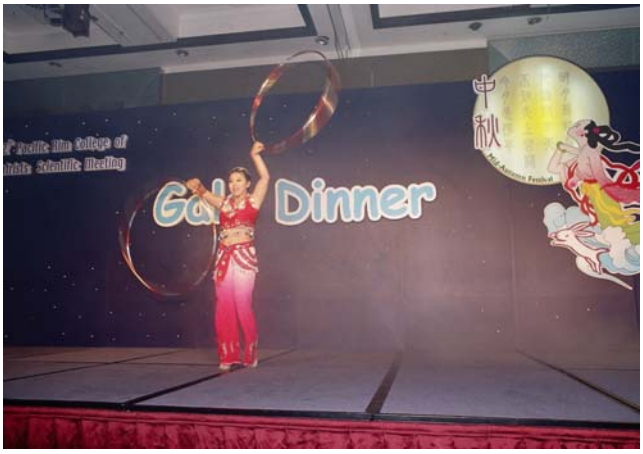
Following the recent success of the PRCP Research Awards offered at the meeting in Taiwan, the PRCP Board would like to secure ongoing funding for Research Awards at the meeting in Japan and beyond. The Secretariat has contacted all Board members requesting for contact details of international pharmaceutical companies and other potential sponsors. If you have information that can assist please email to info@prcp.org .

We are currently updating the PRCP website www.prcp.org. I would like to invite members to promote relevant events on the PRCP website. Requests for uploading of information to the website can be emailed to info@prcp.org.

On behalf of the PRCP Secretariat I would like to wish all our members and their families an enjoyable and successful 2007.

Associate Professor Chee Ng

Photo's from 12th PRCP Scientific Meeting Taipei, Taiwan



Yu Li Rehabilitation Program in Taiwan—Chih-Yuan Lin M.D.

Yuli Psychiatric Rehabilitation Model in Taiwan

To help the long stay inpatients of **Yuli Veterans Hospital (YLVH)**, which resides in Yu-Li a rural town in the midpoint of Eastern Rift Valley in Taiwan, reintegrate into the community. There are four major components of the Yuli model: holistic medical support, vocational rehabilitation, case management, and residential program.

Holistic Medical Support

Most patients in YLVH suffer from schizophrenia, which manifests in positive, negative and disorganized symptoms and, to a great degree, negatively affects neurocognitive, social and vocational functioning. To meet their needs, we offer comprehensive and continuous psychiatric treatment and rehabilitation. In addition to psychiatric services, the patients can rely on medical departments of YLVH, which is also the biggest community general hospital in the area to address their medical needs. Thus, continuous psychiatric and medical care is provided under one administrative roof, which minimizes problems with referral, as well as barriers to care associated with distance and transportation.

Case Management

We apply the principles of case management through multidisciplinary team. This team, except for general medical needs, is directly taking care of all kinds of needs as long as they are concerned with the patients' working, living and learning in the community. It is a shared caseload operation to avoid any colleague working alone and burning out. Now there are 20 team members to take care of 250 patients. The main goals of case management are to mobilize all available resources to help the patients remain clinically stable, get and keep jobs, and enjoy a satisfied life in the community. Therefore, we offer assertive outreach, on-going, round-the-clock services to ensure the continuity of care across time.

Vocational Rehabilitation

According to their function level the patients are assigned to one of three groups in our vocational rehabilitation program: hospital work training, community work training, and supported employment. The patients in the first two categories typically hold part-time, entry-level jobs in hospital and community settings respectively. Currently, 213 patients are in hospital work training programs at 24 worksites, which combine the features of traditional occupational therapy, prevocational training, and sheltered workshop. Community work training is intended for those patients who can work at least 20 hours every week but whose productivity still falls behind the requirements of competitive employment. There are now 29 patients at 8 worksites of community work training. Patients in supported employment work at least 20 hours a week in an integrated community setting, and receive wages that are commensurate with those of a competitive job. At present, 52 patients work part-time at 25 worksites, and 11 patients work full-time (maximum of 40 hours) at 4 worksites.

Residential program

The residential program with very different physical environment and social atmosphere from the inpatient units demands more on personal responsibilities . The residents are responsible for their personal hygiene, social behaviors, daily chores, money management, and participation in vocational rehabilitation programs.

The residents take medication themselves, although supervision is available if needed. There is no regular roll call. In addition to working in the community they can hang out in Yuli town. Further, the emphasis of staff-resident relationship is shifted from custodian-patient relationship to partnership. The staff focuses on not only monitoring changes of physical and mental status but also providing guidance and empowering residents to participate in all the decisions that affect their daily lives. Now the residential program accommodates 203 patients.

In summary, the four components of the Yuli model help the patients recover two essential structure and order of their life in the community: ordinary daily routine and vocational practice. As the recovery progress, we find the patients gradually regain their inner stability, dignity, self-confidence and a sense of control over their lives.

Chih-Yuan Lin M.D.
Deputy-Superintendent
Yuli Veterans Hospital
Taiwan

Award paper
PRCP 12th Scientific meeting

Mood Disorder Award

Abstract Topic - Basal Ganglia Shape Alternations in Bipolar Disorders

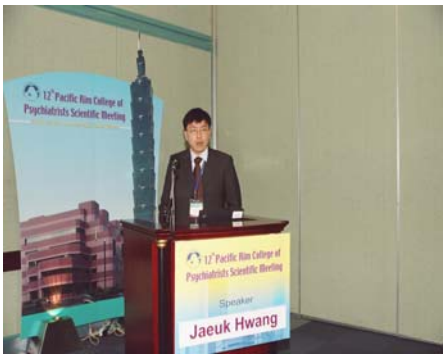
OBJECTIVE: Shape differences in the caudate heads and putamen were compared between drug-naive and drug-treated patients with bipolar disorder and healthy comparison subjects by using spherical harmonic (SPHARM) techniques. On the basis of previous studies, the authors hypothesized that the drug-naive patients would exhibit shape differences of the caudate heads and putamen, especially on the right side, relative to the healthy comparison subjects, and that shape differences, relative to healthy comparison subjects, would differ between drug-naive and drug-treated patients.

METHOD: Brain magnetic resonance images were acquired from 49 bipolar disorder patients (21 drug-naive and 28 drug-treated patients) and 37 healthy comparison subjects. Volumetric measurements were obtained, and SPHARM descriptions were used to measure between-group radius differences in the surfaces of the caudate heads and putamen.

RESULTS: Although no significant between-group volume differences were found in the striatal structures, significant shape differences in the anterior and ventral surfaces of the striatum were observed. Specifically, shape differences, more prominent for the right side, were found for drug-naive bipolar disorder patients, relative to the healthy comparison subjects, but not for drug-treated bipolar disorder subjects.

CONCLUSIONS: The findings suggest that drug-naive bipolar disorder patients have shape differences of the striatum, relative to healthy comparison subjects, and that these differences may be modulated by treatment. The findings more generally demonstrate the sensitivity of the SPHARM analytic technique for detecting subtle anatomical shape differences in small brain regions in the absence of volume differences.

Dr Jaeuk Hwang



Innovative Programs in the Region

Chinese Psychiatry Online

"Chinese Psychiatry Online" is organized by Chinese Society of Psychiatry (CSP), executed by Beijing Huilongguan Hospital. The website opened on Feb. 23rd, 2001.

The main contents of the "Chinese Psychiatry Online" is divided into the public version, professional version and English version. The Chinese versions are updated every day.

Public version includes 4 categories and 24 columns. The categories are: public education, resource searching, self-testing, consultation service. Over 40 professionals run those columns including testing center for self-testing and is very useful for common people to self-evaluate their mental status, consultation center, offers free consultation on 27 topics such as "Depression", "Anxiety" and "Child and Adolescent Consultation", and so on, hosted by psychiatric experts who has replied over 40,500 online consultations, helping many people.

Professional version include 32 columns. There are more than 20 leading psychiatrists in China hold those columns, including CME, medical reference, hospital administration, psychological evaluation, crisis intervention, legal psychiatry, psychiatry in general hospital, neural-image, psychiatry nursing, case discussion, electric medical records, diagnostic classification, and so on.

The "Chinese Psychiatry Online" was designed by psychiatrist and maintained by Beijing Huilongguan Hospital. The website is intelligent, private, friendly, powerful, quickly updated and secured. There are several very useful databases in the website, including database of psychiatry experts, hospitals, glossary, mental disorders, medications, papers and diagnostic systems, ICD-10, DSM-IV, and CCMD-III, psychiatric references, e-journals and electric medical records (EMR).

In 2003, "Chinese Psychiatry Online" obtained the Prize of Beijing health websites and Chinese Society of Psychiatry Outstanding-Contribution-Award. It also received special funding from Ministry of Health, Chinese Association of Science and Technology and sponsorship from public and companies. In the last 6 years, the website had over 100,000 registered population and 8,000 registered physicians. The daily visit is about 12,000 people. The "Chinese Psychiatry Online" has already become the most important resource for obtaining information of psychiatry and mental health in China.

Prof Yizhuang Zou

International Conference Report

WPA International Congress 2007—A Focus on Asia-Pacific

28 November– 2 December 2007
Melbourne, Australia

The 2007 WPA International Congress in Melbourne, Australia will be hosted by The Royal Australian & New Zealand College of Psychiatrists. The theme of the Congress is "Working Together for Mental Health: Partnerships for Policy and Practice". An important aspect of this Congress is the strong focus on the Asia-Pacific region. This will be fostered through the Regional and Cross Cultural Collaboration stream, with leading speakers presenting key lectures and symposia on current trends and research findings from a wide range of psychiatry and mental health areas. The perspectives and experiences of practising clinicians, consumers and carers in the Asia-Pacific will also be interwoven through the program. The Congress will also be assisted by an Asian Advisory Committee consisting of representatives of the relevant WPA zones and the regional psychiatric associations including the Pacific Rim College of Psychiatrists.

One of the main features and a highlight of the scientific program is the Consensus Meeting and Symposium on the Asia-Pacific Community Mental Health Development Project. The aim of this project is to inspire best practice in mental health care in the community through the use of information exchange, current evidence and practical experience in the Asia-Pacific region. Participated by over 10 countries from the Asia-Pacific, this project is supported by the World Health Organisation (WHO) and peak international bodies in the region.

Be involved and participate by submitting papers on mental health in the Asia-Pacific – for information and abstract submission online see www.wpa2007melbourne.com

Assoc Prof Chee Ng

Collaborative Programs or Proposals

ICER—Asia Pacific Regional Collaborative Research

One of the key objectives of the role of PRCP is to promote the exchange of research information and activities between the countries in the Pacific Rim. Although there are existing institutional links between academic departments, having a collaborative network of research centres across the region allows for standardisation of research methodology, replication of studies and generalisation of research findings.

The International Collaborative Ethnopsychopharmacology Research (ICER) group was formed in 2004 at the PRCP biannual meeting in Hong Kong to conduct collaborative research across 7 study centres across Asia-Pacific (Australia, China, Korea, Malaysian, Singapore, Taiwan, Thailand). Most of the principal investigators of the paticipating study sites are Fellows of the PRCP. The main study undertaken by the group has been to examine the clinical response and outcome to antidepressants in relation to the pharmacogenetic polymorphisms for diverse populations across the different countries. The study will hence will provide data from each study site that can be pooled and compared between each site with their respective ethnic groups where distinct inter-ethnic profiles of genotype variations in drug pharmacokinetic and pharmacodynamic have been found.

As this is a multi-site research program across the Asian-Australian region, it would help establish a pharmacogenetic database for the region and will also increase the respective genetic research capacity of the respective study sites, especially in the emerging area of pharmacogenetics. The development and strengthening of such research collaboratively, which has direct translation to local clinical applicability, is vital to optimal practice of psychopharmacology and mental health care in the region. A meeting will be held next month hosted by one of the principal investigators, Prof Keh-Ming Lin (Taipei) on collaborative clinical mental health research in the Asia-Pacific with the ICER group and participants from the United States, making the collaborative group truly Asia-Pacific.

It is hoped that similar collaborative groups will emerge from the Asia-Pacific region in different psychiatric areas like early psychosis, substance abuse, disaster psychiatry, suicide prevention, etc can share research knowledge, data and experience. The PRCP can be a useful organisation to facilitate information exchange and enhance the regional collaboration in research. Research groups with special interest may also consider submitting articles for the PRCP newsletter to inform fellow members of their work that may also help extend their collaborative network.

Assoc Prof Chee Ng

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APPLICATION FORM FOR MEMBERSHIP OF THE PACIFIC RIM COLLEGE OF PSYCHIATRISTS

Please return to:
PRCP Secretariat
University of Melbourne Department of Psychiatry, 1 North, Level 1 Main Block
Royal Melbourne Hospital, Victoria, Australia 3050
Ph: +61 3 8344 5509, Fax: +613 9347 3457, E-mail: info@prcp.org

DATE:_____

TITLE:_____ FIRST NAME:_____ LAST NAME:_____

DATE OF BIRTH: _____ COUNTRY:_____ SEX:_____

MEDICAL SCHOOL GRADUATED FROM:_____

_____ YEAR OF GRADUATION:_____

POST GRADUATE (OR RESIDENCY) TRAINING RECEIVED AT: _____

_____ FROM:_____ TO:_____

ARE YOU A MEMBER OF A NATIONAL PSYCHIATRY ORGANISATION? (PLEASE SPECIFY)

_____

SPECIALIST BOARD: DATE RECEIVED: _____

PSYCHIATRY_____

NEUROLOGY_____

OTHER (PLEASE SPECIFY)_____

CURRENT INTERESTS:

CLINICAL_____

TEACHING _____

RESEARCH _____

CROSS CULTURAL _____

CURRENT POSITION_____

MAILING ADDRESS_____

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HOME PHONE: _____OFFICE PHONE: _____

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PLEASE ATTACH CURRICULUM VITAE (abbreviated version acceptable) AND ONE PASSPORT PHOTOGRAPH.

SIGNATURE **X**_____

PRCP recognizes the World Bank Economic Categories. Please see the PRCP website for details: www.prcp.org/members.html

Category A - Distinguished Fellow / Fellow AUD$135, Member AUD$90

Category B - Distinguished Fellow / Fellow AUD$85, Member AUD$60

Category C - Distinguished Fellow / Fellow AUD$40, Member AUD$25

Category D - Distinguished Fellow / Fellow AUD$20, Member AUD$10