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Sharing Good Practice In Rehab Between The Western Pacific WHO CCs

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Edited by Sheila Purves and Ortal Shamay-Lahat

Helping People with Mental Health Conditions in the Community

This newsletter's theme raised some challenges, the first of which was the scope of our theme.

Mental health conditions, psychiatric disorders, mental disorders, mental illness are used interchangeably in various papers. The World Report on Disability (p.305) defines a mental health condition as "characterized by alterations in thinking, mood, or behaviour associated with distress or interference with personal functions… also known as mental illness, mental disorders, psycho-social disability."

Some community programmes and organizations champion the use of "psycho-social disabilities", to promote the social approaches of CBR. For example, CBM notes on their webpage, that "…disabilities arising from mental health problems are called psychosocial disabilities, which reflect the challenges that people face, as they are often shunned from their communities and face discrimination and abuse as well as finding work and other responsibilities difficult to manage." (Accessed on 24.01.14 from: www.cbm.org/Psychosocial-disabilities-251912.php)

Terminology used by the medical profession, by laws and regulations, by the disability sectors, and by the public may be quite different. It is our responsibility to be aware of the terminology in our own languages, and support and lead the work to diminish stigma, ignorance and discrimination.

This is a very interesting newsletter with articles from national perspectives (China and Korea), covering community support for people with intellectual disabilities (Korea) and with cognitive disabilities after brain damage (Japan), describing the use of "recovery approach" by a community organization (Hong Kong), summarizing a research to measure "recovery" (Australia), and looking at attitudes/knowledge of physical medicine staff in a general hospital. Thank you to all our contributors.

From CRRC, Beijing, China

Prevention, Treatment and Rehabilitation of Mental Health Conditions at Community level in Mainland China

Reported by Ms. Fei Liu and Ms. Hong Zhang

Overview

There are more than 16 million people with severe mental health conditions and 30 million with mild mental health conditions throughout China. The screening of mental health conditions is faced with many difficulties due to social stigma and discrimination. Only 27.5% of people with severe mental health conditions have been admitted to a hospital and received treatment. In some underprivileged families, people have no choice but to stay at home.

The Chinese government has been putting great efforts into the prevention, treatment and rehabilitation of mental health conditions since 1958. The local governments have increased investments in mental health hospitals and listed them in the medical

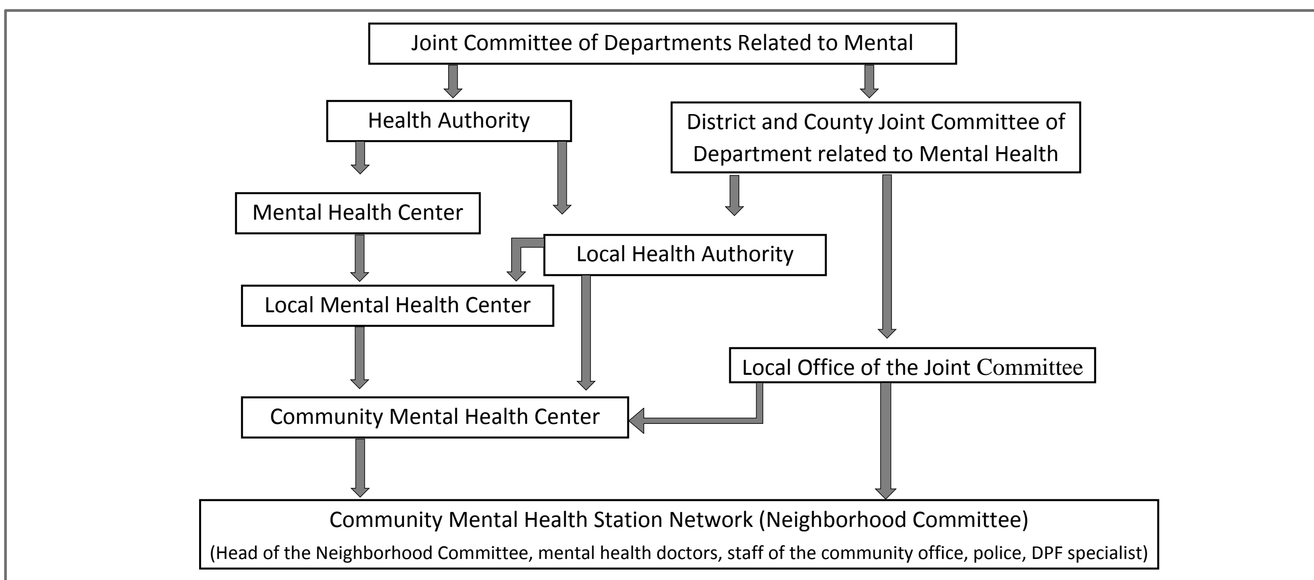
insurance coverage list. However, as hospitals have limited staff and capacity, not all people can be treated in such institutions. Moreover, there are many disadvantages to long-term hospitalization in that it will cause financial burden to the family and is not helpful for improving patient's independence. As a result, the focus of mental health conditions prevention, treatment and rehabilitation has gradually shifted to the community.

Current Status and Challenges

Most of people with mental health conditions live in communities. Community-based medical service (graph 1), which aims to provide convenient and comprehensive care and support for patients and families, is the bridge between local hospitals and families. Physicians working at community hospitals will monitor and follow up on patients' status closely, instruct them to take medications correctly and on time, monitor the adverse events, record rehabilitation evaluation and whether patients are getting better while spreading knowledge among families.

There are mainly three types of community-based rehabilitation programs: medical rehabilitation, functional training and vocational rehabilitation. In medical rehabilitation programs, community doctors visit patients at least once every three months to make sure patients pay regular hospital visits, take medications on time and improve patients' compliance. In functional training, patients' independence, work ability and social skills are enhanced. In vocational rehabilitation, patients are paid to conduct production activities to boost their confidence and sense of accomplishment.

In recent years, prevention, treatment and rehabilitation of mental health conditions at the community level have achieved major success. However, because it has only started very recently we are still faced with many problems, such as lack of specialized medical professionals, lack of project funding and imperfect "Free Medication" policy. What's more important is the social stigma which makes patients and their families conceal their conditions.



Graph 1: workflow of community-based medical service

Opportunities

The Chinese government has realized the importance as well as the challenges of community-based services for people with mental health conditions and launched in the recent years regulations, laws, and national projects to promote the prevention, treatment and rehabilitation at the community level.

(1) *"Plan of prevention, treatment and rehabilitation of mental health conditions for the 'Twelfth Five-year Plan (2011-2015)'"* published by the National Health and Family Planning Commission (NHFPC), Ministry of Civil Affairs, Ministry of Public Security, Ministry of Education, Ministry of Finance and China Disabled Persons' Federation.

According to the plan, "socialized, comprehensive and open" rehabilitation work for people with mental health conditions will be conducted all over the country and 7.8 million people will benefit from the plan.

Medical aid will be provided for 200,000 poor patients, and community and family rehabilitation will be provided for 1.56 million stable patients. Day care will be provided to patients in community rehabilitation centers and other community service facilities where psychological counseling, self-care and social adaptability training, training for family members, and other rehabilitation activities will be conducted. Patients and family members will be familiarized with the social environment of the community, and patients' social life skills will be strengthened.

The grass-root work force should be stabilized. Appropriate subsidies should be provided to community doctors working at the prevention, treatment and rehabilitation of mental health conditions.

According to the experiences of cities and counties, the workflow of prevention, treatment and rehabilitation of mental health conditions should be as follows:
Establish a socialized work system→develop plans→staff training→investigation→establish record → implement measures → review and evaluate.

(2) *The "686 project"*

In 2005, the NHFPC initiated the "686 project" which aims to monitor and treat people with severe mental health conditions in model communities in 60 counties and towns of 30 municipal cities and provinces. The project will strengthen the treatment and management of patients using the power of community medical facilities, family and society to provide an open community service and to help patients return to society. The integrated model of hospital, family and society mainly includes:

(1) "Mental health condition prevention day" system: psychiatrists should go to communities and provide services to patients on a fixed term, such as medication instruction and periodic checkup.

(2) Day-care centres: where discharged patients can receive skill training during the day.

(3) "Mid-way dormitory" in communities: assisted living residence where patients live and take care of themselves to improve their independence under the monitor of staff. Treatment is not provided in such facilities.

(4) "Protective workplace": a pre-job training in which patients are taught to fulfill simple manual tasks and given certain rewards.

(5) "Family member resource center": the center guides family members in providing

services to patients and helps them maintain psychological and physical health. Its main purpose is to ensure smooth transition from hospital to home, and to make sure that patients can receive good care after being discharged from hospital.

(3) *Mental Health Law of People's Republic of China, May 1st 2013*

The Mental Health Law of People's Republic of China is the first law to protect the legal rights of people with mental health conditions and marked a major milestone in the cause of mental health in China. The law has also clarified the responsibilities of relevant sectors.

The central government will strengthen the construction of mental health service system, support poor and remote areas to carry out work related to mental health, and ensure funding for grassroots mental health stations.

The local governments should make plans for and establish community rehabilitation centers for mental health conditions based on the conditions of their administrative area.

The medical institutions should provide medication for patients with severe mental health conditions living at home and provide technical guidance and support for community rehabilitation facilities.

Community rehabilitation centers should provide the necessary facilities and equipment for patients with mental health conditions, and offer rehabilitation training to improve their independence and social adaptability.

Community health centers, township medical centers, and countryside medical stations should establish medical records for patients with severe mental health conditions and visit them regularly to guide patients take medication, conduct rehabilitation training, and spread knowledge among patients' guardians.

Local governments should guide and monitor community health centers, township medical centers, countryside medical stations to conduct the above work.

Conclusion

There is a large population of people with mental health conditions in China; the majority of them live in communities. There are many problems facing community rehabilitation of mental health conditions, such as understaffing, lack of funding, social exclusion and discrimination which might cause unemployment and poverty for recovered patients.

The government has been putting more and more emphasis on community prevention, treatment and rehabilitation of mental health conditions; laws and regulations are published and national projects are carried out to emphasize the important role of community-based services. With the launch of "Mental Health Law of People's Republic of China", it is believed that with powerful policy support and continuous efforts, people with mental health conditions will receive better treatment and rehabilitation, reintegrate to society and enjoy health and well-being.

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From NRC, South Korea

Mental Health in Korea

Reported by Dr. Kim Wan-Ho

The yearly prevalence of mental disorders in Korea is 10.2% between the age of 18 and 64, with total numbers being about 3.68 million. The prevalence of anxiety disorders, affective disorder and psychotic disorders are 10.2% (3.94M) while the rate of alcohol use is 4.4% (1.58M).

The mental health act was enacted in 1995 and the 5-years plan of mental health development was established in 1998. Currently 1,845 mental health institutes and 200 mental health promotion centers, which include mental health clinics and mental recuperation welfare institutions, are being operated nationwide (based on data formulated in December, 2011).

The integrated health promotion programs, which emphasize early detection of mental disorders, counseling, emergency and short-term hospital stay, treatment and residence/occupational rehabilitation, is being executed while psycho-social rehabilitation facilities and social adaptation functions are being reinforced to increase the rate of reintegration into society with no re-admissions into mental clinics or recuperation facilities. In addition, alcohol counseling centers are extended and operated, reinforcing counseling and case service while the Suicide Prevention Act and the enforcement ordinance was enacted, establishing and executing a suicide prevention plan.

Early detection of mental disorders of children and adolescents and provision of personalized post-care service is being promoted recently. In addition, to the provision of comprehensive mental health services in the community, there is a move to connect and integrate mental health promotion centers, social recuperation facilities, alcohol counseling centers, mental clinics, and psycho-social rehabilitation facilities. Such planning and adjustments are being executed by public health centers.

Intellectual Disability

Among Korea's disabled population of 2,683,477, 176,000 are intellectual disabled and 193,026 are those with global development disorder and 16,916 with autism.

Currently, a community-based independence assistance center is being operated to improve independent living of the intellectually disabled and to reinforce social assistance. The center provides various programs such as:
(1) counseling- information, human rights counseling; (2) caretaker support program- caretaker education and support; (3) rights and interests protection program- sexual violence and disability recognition improvement, self-advocacy movement, human rights advocacy activity, self-help group operation; (4) education and life promotion- parents counselor education, independent living support seminar, promotion and publishing, international exchange and cooperation; (5) community resources development and related programs- service desire survey, community resource development, community resource connection, case management service; and (6) culture and sports support program- living sports activities and cultural activities.

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From NRCD, Japan

The Support Systems for Persons with Cognitive Disorder due to an Acquired Brain Injury: A Higher Brain Dysfunction Support Promotion Project in Japan

Reported by Dr. Kumiko Imahashi, Dr. Reiko Fukatsu, Dr. Yasoichi Nakajima, Mr.Yuzuru Kamezawa, and Dr. Kozo Nakamura, WHO CC

It is a known fact that the memory, attention, executive function and social behavior are impaired following a traumatic brain injury (TBI) and cerebrovascular accident (CVA), and as a result, those affected individuals are often excluded from social participation. Since those impairments are not readily apparent, they are sometimes referred to as "invisible disabilities," and patients often have difficulty obtaining public understanding and supports. Younger generation patients especially face a major challenge of returning to school or work.

We have 2.3 such new patients per 100 thousand people each year in Japan, and the total number of the patients is estimated to be approximately 300 thousand nationwide, and among which 70 thousand patients are younger than 65 years of age.

NRCD has been playing a central role in the operation of a Higher Brain Dysfunction Support Promotion (HBDSP) project, which is funded by the Ministry of Health, Labour and Welfare (MHLW), since 2005, and expanding support networks for these patients nationwide through local governments. The purpose of the project is to facilitate their returning to school, work and communities. Some of the project accomplishments include:

- Development of diagnostic criteria
- Development of a standard rehabilitation program
- Establishment of 70 local base support organizations for people with higher brain dysfunction nationwide (for which appropriate existing facilities including university hospitals, municipal hospitals, welfare institutions and health centers were designated by each local government)
- Distribution of approximately 300 support coordinators
- Provision of approximately 70 thousand consultations a year
- Construction of local support networks by each base support organization
- Organization of biannual conferences by NRCD (in which local officials and coordinators gather to report their efforts and study common issues in group work)
- More than 200 publications

Research and Project Partnership

In parallel to the project, NRCD has been conducting several research funded by the MHLW and Health and Labour Sciences Research Grants. Under NRCD, the 70 local base support organizations are grouped into 10 geographical blocks, each of which is headed by a local academic expert, for this project.

National Summary Data

The following information is based on data from the HBDSP National Database:

- Demographic characteristics: average age = 42, male (82%)
- Cause of disability: TBI (54%), stroke (33%), encephalitis or encephalopathy (9%), brain tumor (2%) and others (2%)

- Average time from the date of injury to admission to support centers: 96 days
- Average stay in rehabilitation unit: 97 days
- The most frequently provided services in both inpatient and outpatient settings: occupational rehabilitation services
- The average time of the inpatient occupational rehabilitation: 208 minutes a week for 3 months per person (physical rehabilitation was 190 minutes/week, speech rehabilitation was 174 minutes/week, and psychological rehabilitation including psychological assessments was 142 minutes/week)
- Average duration of mainly provided occupational and speech therapies after discharge: 80 to 120 minutes per week for 4 to 5 months
- Employment: employed one year after injury (24%). 31% of the participants who were employed pre-injury returned to work or found open employment
- The percentage of participants who have returned to work: 47 % provided that performing a household task and studying are also included in the definition of work

For more information:

- NRCD, Japan. Rehabilitation manual 19: Guide to Support for Persons with Higher Brain Dysfunction 1. Tokorozawa.2006. http://www.rehab.go.jp/english/pdf/E19.pdf
- NRCD, Japan. Rehabilitation manual 22: Guide to Support for Persons with Higher Brain Dysfunction 2. Tokorozawa.2008. http://www.rehab.go.jp/english/pdf/E22.pdf

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From Sidney, Australia

Assessing and Measuring Mental Health Recovery

Reported by Dr. Nicola Hancock and Dr. Anne Honey, Centre for Disability Research and Policy, University of Sydney, Australia

Mental illness is the leading cause of non-fatal burden of disease and injury in Australia (24%). Around 7 million Australians experience mental illness during their lifetime, at any point in time there are around 206,000 Australians with mental illness who experience severe or profound limitations to their daily activities.

People with lived experience of mental illness describe recovery not as medically defined cure or amelioration of symptoms, but rather, as a process of attaining a meaningful and satisfying life regardless of the presence or absence of reoccurring symptoms (e.g., (Anthony, 1993; Bellack, 2006; Davidson & Roe, 2007; Onken, Craig, Ridgeway, Ralph, & Cook, 2007). The goal of recovery is increasingly reflected in Australian policy (Department of Health and Ageing 2009) and needs to be reflected in the goals, interventions, and outcomes of services. To do this, a way of measuring recovery is needed.

Whilst a plethora of recovery-based instruments have been developed internationally over the last decade, many of these have remained in early stage development with limited psychometric testing and ongoing development (Burgess, Pirkis, Coombs & Rosen, 2011). The Recovery Assessment Scale (RAS) is one of the more developed, evaluated and used of these measures. However, our study, which

examined the usefulness of this instrument with over 100 Australians living with mental illness, found a number of limitations including: 1) poor category structure (consumers were using it as a 2 point scale rather than a 5 point scale) and 2) a very significant ceiling effect (it was too easy for many consumers and lacked items relating to the later stage of recovery).

We conducted focus groups with consumers who reported being further along their recovery journey to identify 'missing' items by better understanding the goals and achievements of people in later stages of their recovery (Hancock, Bundy, Honey, Helich & Tamsett, 2013). A collaborative and iterative process of working with consumers resulted in a modified instrument called Recovery Assessment Scale – Domains and Stages (RAS-DS).

The RAS-DS is a self-report instrument that uses a 38 item likert-style scale to measure people's own perceptions of their level of mental health recovery under the domains of functional, personal, clinical and social recovery. This scale is designed to be used, not only as an outcome measure, but also as an individual assessment tool to guide intervention. It identifies specific areas of recovery in which a consumer is doing well and any areas of potential enhancement, providing a springboard for discussion between consumer and staff member, and suggesting potential directions to work on together. As an outcome measure, the RAS-DS can be used by consumers to track their own recovery journey by comparing RAS-DS data to previous results, as well as potentially measuring the effectiveness of services. The dual purpose of individual assessment and program outcome measure is critical because Australian studies demonstrate that current rates of completion for outcome measures in Australian mental health services are extremely low (e.g., Kightley, Einfeld & Hancock, 2010). This lack of 'compliance' has been associated with a perceived lack of practical usefulness with staff and consumers reporting a sense of completing forms for the 'bureaucrats' rather than seeing how they are useful for practice.

We trialled the RAS-DS with 3 large Community Managed Organisations (CMOs) in two Australian states, collecting over 120 full data sets. Consumers completed the RAS-DS and both consumers and staff members were asked to complete a questionnaire about its usefulness.

Preliminary analysis of the data indicated good item fit and internal reliability. Further, users reported that they found doing the RAS-DS to be a useful exercise, with the potential to assist in facilitating recovery. However, staff and, more importantly, consumers said that they needed another point in the rating scale between 'unsure' and 'yes '– suggesting that a 4-point, rather than a 3-point scale was required. . We could also see from the quantitative data that an additional point would enhance sensitivity to change properties. We spent some time exploring good scale descriptors given the problems with the original RAS. After trialling our preferred descriptors with a small group of consumers and staff we have now commenced a large scale study using this recently enhanced RAS-DS.

Given the poverty of current recovery measures, the RAS-DS looks incredibly promising. However, it is still in testing stage. While new recovery measures are repeatedly being created internationally, no work has been done on most of them after the initial

development stage where they show moderate measurement properties at best. There are obvious reasons for this - when an instrument is modified, it becomes essentially a new (whilst better informed) instrument and new testing is needed. However, the dividends are clear. Through the long term, iterative process we have engaged in, we have developed what we feel, consumers are saying, and data is indicating, will be a far superior measure of recovery than exists globally. We also hope to develop an online resource to link areas of need, as indicated by the RAS-DS, to evidence based recovery resources.

We look forward to completing the current study and publishing our work. In the meantime, the RAS-DS can be accessed freely at http://hdl.handle.net/2123/9317.

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From Guangzhou, China

Psychiatric Rehabilitation in China Today: A Brief Overview

Reported by Prof. Zhuo Dahong, WHO CC

According to a rough estimate in 2009, there are in mainland China about 100 million people with psychiatric disorders in a broad sense. Among them, ten millions suffer from schizophrenia, and others, from depression, anxiety and other affective disorders.

Since the late eighties of last century, China has included psychiatric rehabilitation (PR) into its various programs of medical and social rehabilitation. During the years 1990~1995, sixty-four counties and cities carried on the pioneering projects on psychiatric rehabilitation-combined with the prevention and treatment of schizophrenia, and with particular trials on community-based psychiatric rehab services.

Currently, China is carrying out a Five-year project (2011-2015) on psychiatric rehabilitation which is recognized as one of the key projects of National Rehabilitation Service Projects. The following features of the Chinese RP projects are noteworthy:

- Various programs for PR have been developed and now in service such as day care center, work-recreation center, family-based medical and rehab care.
- The half-way or sheltered or supported-employment type of vocational rehabilitation for people with psychiatric disorders is increasingly popular in many cities of China. The Shanghai Sunshine model and the Changsha Heartwing Clubhouse model are some of the successful examples for PR, the latter was set up with the technical assistance from the Hong Kong Phoenix Clubhouse model.
- National Guidelines and Standards on the construction and professional services of psychiatric rehabilitation center or hospital are now on the way of drafting. It is expected that the upcoming guidelines and standards to be launched in a couple of years will efficiently improve the quality of PR in China.
- In some Chinese PR centers, such as the Wuxi PR center in Jiangsu Province, exploration and research on the application of behavioral arts therapy for psychiatric patients has been carried out with favorable results.

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From New Life, Psychiatric Rehabilitation Association, Hong Kong

Recovery Initiative: strategies in promoting recovery-oriented practice in Hong Kong context

Reported by Ms. Sania Yau, Ms. Candy Ling, and Mr. Keith Wong

Definition of recovery

Mental health recovery had become an increasingly prominent concept in global mental health services. Compared to the medical model, which focus primarily on symptom reduction and functioning

restoration, recovery-oriented services strive for a personally meaningful life beyond the identity of being mentally-ill. It benefits people in recovery (PIR) by focusing on their hope, strength, personal meaning, potential and full participation in society and community life.

With the reference of Substance Abuse and Mental Health Service Administration's (SAMSHA) recovery model (2005) as well as input from local service users and family members, we have adopted a localized model, including three levels to support recovery, (1) individual level (choice & self-direction, participation, individualized service, responsibility), (2) support level (family participation, respect and anti-stigma, strength-based, and peer support) and global level (non-linearity, holistic and hope). In order to promote recovery-oriented service in the organization, we form the Alliance for Recovery and Care (ARC) with five directional strategies for implementation.

Promoting Participation of Service User

As autonomy and personal meaning is emphasized in recovery model, we consider what is important 'to' the PIRs than merely what is important 'for' them. As thus, we aim to increase the voice from PIRs and their family members inviting them to participate in the three recovery task groups. The expertise knowledge of lived experience from PIRs and the professional knowledge from staffs create a synergy to support the development, planning and implementation as well as advocacy of the recovery-oriented practice in the Association.

A Peer Support Worker project funded by MINDSET is now being conducted in collaboration with other local NGOs. It aims to empower PIRs and advocate recovery-oriented mental health care. PIRs who complete a training course and practicum will be then employed as peer support workers to share their personal experience in living with mental health challenges and to support the recovery journey of other PIRs through recovery groups, programs and individual contacts. They act as ambassadors and work with the staff team to create a recovery-oriented environment.

Training to Enhance Staff's Knowledge and Attitude

In order to education working staff to understand recovery, systematic training on recovery was designed and delivered to both new and existing staffs. For example, a recovery information leaflet and a brief introductory talk on recovery were given to all new staff during orientation period. Half-day and whole-day workshops were organized regularly for frontline and professional staff respectively.

The learning mode combines both lecturing and experiential activities to promote staff knowledge and attitude of recovery. Lastly, regular recovery retreat day was held for all officers-in-charge and supervisors, as well as different services staffs to consolidate recovery knowledge gained, to support the realization of recovery-oriented practices and to share barriers encountered. In the evaluation feedback, different levels of staff reported the trainings and retreats not only built up their knowledge, but also promoted their attitude change and action orientation.

Refining Recovery-Oriented Assessment

Assessment is an important tool in the system

transformation process, which help us to better understand our existing progress for future improvement. We have collaborated with the Chinese University of Hong Kong to develop and validate translated or local recovery assessment tools, such as the Recovery Knowledge Inventory (RKI), Recovery Assessment Scale (RAS), Test Life Satisfaction Scale (TLS) and the self-developed Attitude towards recovery Questionnaire (ARQ) which would be used in our annual service assessment. The development and validation process included the input from PIRs, family and staffs. We have also developed a recovery questionnaire for recruitment purpose to identify applicants who demonstrate the values of the recovery-oriented service.

Research and Evidence-Based Practices

Extensive researches had been conducted to provide a solid empirical base of the service. Various types of researches were conducted which mainly include (1) program evaluation of recovery foundation training, staff training, therapeutic groups (Wellness Recovery Action Plan, hope-based intervention, community navigator, anti-self-stigma group person-centered care planning etc.), and public education activities, and (2) focus groups for staffs, PIRs and family to collect qualitative feedback. With the research results, it gives the direction of future service development.

Knowledge and Experience Share Platform

To increase the awareness of the importance of mental health recovery concept in the mental health field, internal and external sharing platforms were created. Internally, *Recovery Digest* and the intranet were developed to share the most updated information to the Association staffs. Furthermore, a Recovery Glossary was published to facilitate the understanding of different recovery concepts and terminologies. Externally, regular symposiums with invited international and local speakers were organized to facilitate knowledge exchanges, experience sharing as well as open conversations among academia, service providers, PIRs and caregivers in the field of mental health. A Recovery Website was constructed to serve as the first Chinese online platform on recovery knowledge and practice for both local and international readers.

Way Forward

Recovery-oriented service is the global direction of mental health services in Western country while the development in Hong Kong is still at the beginning. In the future, we hope to create partnership with different parties to further promote recovery, and more importantly, PIR's participation and empowerment in the community.

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From Wuhan

Rehabilitation Professionals Attitudes toward Mental Illness of Professionals Working in a Rehabilitation Medicine Department of a University Hospital - an informal questionnaire

Reported by Prof. Lu Min, Prof. Huang Xiaolin, Dr. Li Qiaolin, and Ms. Sheila Purves, WHO CC

The World Disability Report refers to many articles documenting challenges of people with disability to access general health care services, and people with mental illness are even more deeply stigmatized. We acknowledge that our patient population in a physical medicine rehabilitation centre, may include people with hemiplegia after a stroke, diabetes, obesity, chronic lung condition, joint pain, or others, as well as acute conditions, who may also have a mental illness. For the purposes of this newsletter, we decided to undertake a quick survey of our own staff attitudes towards persons with mental illness. This is neither a valid nor reliable survey, but only an initial attempt to increase our awareness of the issues.

There are many attitude and knowledge surveys available from the literature, including those developed for both general and psychiatric health professionals. We decided to select questions from the UK public sample survey "Attitudes to Mental Illness".[1] We identified 15 from the total of 27 attitude statements, translated them into Chinese and invited 20 staff to respond to them, using a five-point Likert scale - Agree strongly/Agree slightly/Neither agree nor disagree/Disagree slightly/Disagree strongly (see Table 2 for statements used). These 15 statements became the third part of our survey, which included also background information of the respondent and their source of knowledge. The survey was given in written format and not discussed.

Findings and Discussion

We asked a representative group to answer the questionnaire as shown in Table 1 (Part I of our questionnaire). Part II presented two questions on general contact with mental illness. The source of knowledge of mental illness came mainly from their medical school training, followed by books, media and the internet. No one stated they had direct contact with people with mental illness. The second question directly asked if the respondent was willing to provide their usual rehabilitation services for a patient with mental illness (e.g. physical disability requiring rehabilitation intervention). Two physicians and five therapists chose "yes", the rest selected "maybe". Those who selected "maybe" said that they would provide usual treatment so long as the patient's mental illness was stabilized.

	Physicians	Therapists
Number	10	10
Male/Female	4 (M) 6 (F)	6 (M) 4 (F)
Junior/Intermed/ Senior Levels	4 / 2 / 4	4 / 6 / 0

Table 1: general information of respondents

Regarding the response to the "attitude statements", while there is little reliability in the actual numbers, there are some interesting issues. Of the fifteen attitude statements presented to respondents in Part III (see Table 2), eight questions were answered very consistently being, (#1, 2, 5, 6, 7, 9 & 10) concerning right and need of people with

mental illness to care, health services and sympathy. However, it is noted that all staff felt that it is easy to identify people with mental illness (#1) perhaps demonstrating their lack of experience with people in quiet periods, or when recovering from mental illness.

Four statements (#3, 4, 8 & 11) provoked small disagreement of 1-2 staff only. In general our staff have a scientific understanding of mental illness being a disease and thus treatable, and not to be regarded as a burden. However, three statements (#12, 13 & 15), relating closely to social and community issues (as opposed to hospital environments), divided the staff equally. These related to: people with mental illness being dangerous, being part of the normal community, and having the right to normal jobs. Among the ten doctors interviewed, most were more open-minded about these statements, than the therapists.

Conclusion

This small sample group of professionals working in a general rehabilitation department of a university hospital, demonstrated open attitudes towards patients who might have mental illness. However, there are also areas for probing, clarification and education, in particular to activity and participation elements, as well as to the popular concerns about violence. If health care staff are not aware of the challenges and rights facing people with mental illness, they may have difficulty accessing usual health care. In addition, professionals may perpetuate the perception that they cannot "recover" and live fulfilling lives in spite of their illness label.

This very quick questionnaire, informs us of the starting point and design of future awareness and education activities for staff in general hospitals, who are not usually in contact with persons with mental illness. As a university hospital, with responsibilities for educating other health care staff, we must be aware of people with mental illness and psycho-social disabilities.

Most importantly, while there are indeed many problems with our attitude questionnaire, but we did not intend it as a rigorous exercise, rather a very initial trial to raise discussion and highlight the need for "access" for all, at least in our own department.

No.	Question	Agree strongly	Agree slightly	Neither agree nor disagree	Disagree slightly	Disagree strongly
1	There is something about people with mental illness that makes it easy to tell them from normal people	0	20	0	0	0
2	As soon as a person shows signs of mental disturbance, he should be hospitalized	1	19	0	0	0
3	Mental illness is an illness like any other	0	18	0	2	0
4	Virtually anyone can become mentally ill	0	19	0	1	0

No.	Question	Agree strongly	Agree slightly	Neither agree nor disagree	Disagree slightly	Disagree strongly
5	We need to adopt a far more tolerant attitude toward people with mental illness in our society	1	19	0	0	0
6	We have a responsibility to provide the best possible care for people with mental illness	0	20	0	0	0
7	People with mental illness don't deserve our sympathy	0	0	0	18	2
8	People with mental illness are a burden on society	0	2	0	18	0
9	Increased spending on mental health services is a waste of money	0	0	0	19	1
10	There are sufficient existing services for people with mental illness	0	0	1	19	0
11	People with mental illness should not be given any responsibility	0	2	0	18	0
12	People with mental illness are far less of a danger than most people suppose	0	10	0	10	0
13	The best therapy for many people with mental illness is to be part of a normal community	0	11	0	9	0
14	As far as possible, mental health services should be provided through community based facilities	0	20	0	0	0
15	People with mental health problems should have the same rights to a job as anyone else	0	6	4	10	0

Table 2: survey responses

Questionnaire Reference

- UK Attitudes towards Mental Illness, 2001. Accessed 12 Dec 2013
http://www.hscic.gov.uk/catalogue/PUB00292
- Other references available on request

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Other Reports

From NRC, South Korea

International Symposium on Rehabilitation

A Meeting for Domestic and International Exchanges Proposing the Future Vision of Rehabilitation

Reported by Dr. Kim Wan-Ho

For domestic and international exchanges proposing the future vision of rehabilitation research, The 2013 International Symposium on Rehabilitation Studies was held in Seoul Olympic Parktel on November 21st by the Korean National Rehabilitation Center. This year's symposium was held to promote domestic and international exchanges and to formulate a cooperative vision regarding rehabilitation studies. More than 200 domestic and foreign scholars, including prominent scholars of rehabilitation from WHO, China and Japan, participated and were able to share international trends on rehabilitation, and fields related to disability including rehabilitation assistant device, exercise/ recognition rehabilitation and rehabilitation services.

Domestic and foreign lecturers were given on variety of topics and exhibition structures for trial manufactured goods and posters were installed to display the research results and R&D activities of the national rehabilitation center.

The National Rehabilitation Center of Korea will try to construct an international research infrastructure that involves active exchange with other rehabilitation centers in China and Japan on areas of rehabilitation and disability.

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