

approach and to take a better balance with the existing, powerful needs-based approach. Arts are one of the assets of individual and community which can be used as a driving force of the assets-based approach. For example, art therapy has been already established in many hospitals and is commonly used there to improve the mental health of patients. However, the use of arts is less established in primary health care in many parts of the world. Since the late 1980s, arts have been sporadically used as part of health projects in UK. In *Arts Development in Community Health* published in 2009, Mike White defines 'arts in health' as 'creative activities that aim to improve individual/ community health and healthcare delivery using arts based approaches, and that seek to enhance the healthcare environment through provision of artworks or performances.' The arts-in-health activities were later implemented in Australia and South Africa, too. However, evaluation still remains a challenge. In Asia, arts have been frequently used in primary health care projects. As part of donor agencies' health development projects in developing countries, arts-in-health approach has been taken, too; for example, street dramas, picture contests, song contests have been used for health promotion activities in schools and communities. However, they tend to be local, sporadic and less sustainable. Though arts have been taken up frequently to these projects, they are not well perceived as arts-in-health activities. Their performance has not been well evaluated as such, either. This is because the concept of arts-in-health itself is not well known in Asia. Moreover, we tend to look at only outcome rather than process; to expect only short-term results rather than long-term results; to seek only scientific evidences rather than emotion-provoking success stories and anecdotes. Now, a balance of focus might be sought so that a pendulum moves more from the former to the latter. People centered approach and their participation can be highly valued by mobilizing arts as assets and by evaluating process, long-term effects, and success stories and anecdotes.

SY15-04

"Every Family a Family Doctor" Movement in Taiwan

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Objective: Since July 2003, post 921-earthquake and SARS endemic era, National Health Insurance Bureau in Taiwan has been carrying out novel services of 「Family Physician Integrated care project」 (FPICP) to highlight community medical group-based practice in primary care sector. Evidence-based progress of this primary care project in community health was investigated.

Methods: Regarding the update quantity and quality of "every family a family doctor" movement, we used systematic literature review and statistical reports to evaluate the current situation of FPICP.

Results: Until Dec 2008, the FPICP has only covered 6.6% of Taiwan population, 17.8% of primary care physicians and 20.0% of community hospitals and clinics joined to form 324 community medical groups in six national health insurance regions. Total 29 papers selected from 81 papers reviewed in literature during 2004-2008 to analyze service of quality versus five FPICP components. Most of papers belonged to cross-section studies. The satisfaction rate of family members was 71.1% and 76.3% of primary physicians. Continuity of care and preventive services was better in FPICP patients. There were lacks of preventive service outcome studies.

Conclusion: Further development is not only the increasing number of new founded medical groups but also more new allied health professionals participated; meanwhile, each individual community medical group could promote its successful experience as a role model for more primary physicians to learn. More participants will minimize the inequality and improve primary care quality in different NHI regions. Facing rapid increasing elder population and aging society in Taiwan, long term care insurance is proposed for legalization by government at this moment. It is urgent to assure well functioning shared care services and promote propaganda to attract more people to register in FRICP especially older adults.

Symposium 16- Mental Health and Public Health

SY16-01

Leadership for Mental Health System Development **Harry Minas**

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Objective: Mental disorders are a major component of the non-communicable disease burden in all countries, including low- and middle-income countries. Despite this fact mental disorders are relatively neglected by governments and public health systems, and most people with mental disorders receive no treatment or care. This paper will describe some recent initiatives that aim to improve population mental health by strengthening capacity of mental health systems.

Methods: An outline will be given of several international initiatives that aim to strengthen capacity of mental health systems in low- and middle-income countries.

Results: Preliminary information suggests that a number of mental health system capacity-building initiatives in low- and middle-income countries, particularly in Asia, are having a positive impact and that scaling up of

mental health services will be possible despite substantial under-investment in such services by governments. Conclusion: Mental health system development efforts need to be substantially increased if improved population mental health is to be achieved in low- and middle-income countries.

SY16-02

Mental Health and Suicide after Natural Disaster

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Objective: The purpose of this study is to clarify the issue concerning mental health and suicide after natural disaster. Earthquakes, floods, tsunamis cause deaths and injuries of many people around the world every year, which subsequently result in mental health problems, such as depression, post-traumatic stress disorder. However, whether or not mental health problems would exaggerate suicide remained uncertain. Using earthquakes as the example, we address the question: do suicide rates increase after natural disaster?

Methods: Using earthquake and suicide as the keywords, we searched Medline from 1980 to 2008 to identify relevant articles. Only those studies which were dealing with suicide mortality rate were included in our analysis.

Results: Seven papers were included in this analysis, namely, 4 papers related to 1999 Nan-tou earthquake in Taiwan and 2 papers were regarded to 1995 Kobe earthquake in Japan. One paper reported by US CDC. Most of Taiwanese studies reported increased suicide rate after Nantou earthquake, except study by Lu, who found no association between the degree of damage and the increase in suicide rate. Otherwise, Chou et al found that victims were 1.46 times more likely than non-victims to commit suicide following earthquake. Yang reported higher suicide rates were observed over a 10-month period following disaster. Liaw reported that suicide rate for all age groups all increased, but only group of age 45-64 reached statistically significant. The studies from Japan and US did not support that suicide rates increase after earthquake.

Conclusions: In Taiwan, the suicide rate increased since 1994, and further became one of the leading causes of mortality in 1997 that was reported by Department of Health, Executive Yuan (the Cabinet). The suicide rate escalated persistently and reached the peak in 2006 by 19.3 per 100 thousands people. Not only earthquake in Nantou in 1999, but also tremendous impact of socioeconomic and political events, precipitated suicide rate increased during this period. For example, migration-out of traditional industries to foreign countries since early 1990, and amendment of the Labor Standards Act in 1996 and 1998, which causes drastically increased unemployment of many working labors. It is already known that the unemployment rate is closely related to suicide rate. We concluded that

natural disaster may raise mental health problems among the affected people, but may not directly cause increased suicide rate. We highly agree that diverse contextual effects should be taken into consideration when issue of suicide rate after natural disaster is dealt with.

SY16-03

Prevalence of Mental Disorders in the General Population: Is there A Gender Difference?

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Objective: This paper examined the gender differences in common mental disorders in the general population in Malaysia.

Methods: This population-based household study utilized a multistage cluster sampling based on ethnicity and geographical location in Malaysia, covering 5 states. A male and a female, were chosen in each household with the aid of random selection tables. A one-to-one structured interview was carried out in homes using the iPAQ or pocket computers. Diagnoses of common mental disorders were made based on the Clinical Interview Schedule-Revised (CIS-R). A cut-off score of 12 indicates the presence of a mental disorder. A score of 2 or more for each of the CIS-R 14 symptoms indicate the presence of prominent symptoms.

Results: 3666 respondents (89% response rate), consisting of 61% females and 39% males, above 16 years old participated. There was a significant difference in gender in the prevalence of common mental disorders ($p < 0.001$). 208 (6%) met the criteria for ICD-10 diagnosis of mental disorders with the CIS-R. The primary CIS-R diagnoses were: mixed anxiety and depressive disorder-mild (54.3%, $n=113$); mixed depressive episode (8.2%, $n=17$); generalized anxiety disorder (8.6%, $n=18$); mixed anxiety and depressive disorder (19.7%, $n=41$); social phobia (7.7%, $n=16$); social (isolated) phobia (1%, $n=2$); agoraphobia (0.5%, $n=1$). Females were 1.8 times more likely to have common mental disorders than males.

Conclusion: Knowledge on the prevalence of mental disorders and the gender group, who are at risk, would be essential for clinical management, policy decisions and mental healthcare utilization.

Lunch Symposium

JECM and 21st Century Medicine

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