

SEA-Ment-128
Distribution: Restricted

Development of Strategies for Community-Based Neuropsychiatric Services

*Report of an Intercountry Consultation
Bangkok, Thailand, 19-22 November 2002*



World Health Organization
Regional Office for South-East Asia
New Delhi
June 2002

(C) Word Health Organization (2002)

The contents of this restricted document may not be divulged to persons other than those to whom it has been originally addressed. It may not be further distributed nor reproduced in any manner and should not be referenced in bibliographical matter or cited.

CONTENTS

| | <i>Page</i> |
|---|-------------|
| 1. INTRODUCTION | 1 |
| 2. OBJECTIVES OF THE CONSULTATION | 2 |
| 3. COMMUNITY NEEDS IN TERMS OF NEUROPSYCHIATRIC SERVICES | 2 |
| 4. SUMMARY OF PROCEEDINGS | 5 |
| 5. EPILEPSY | 10 |
| 5.1 Country Reports on Epilepsy | 10 |
| 5.2 Report of International League Against Epilepsy 'Out of the Shadows'- A Global Campaign Against Epilepsy | 12 |
| 5.3 Treatment of Epilepsy in the Community..... | 16 |
| 5.4 Summary of the Report of the Working Group on Epilepsy..... | 17 |
| 6. PSYCHOSES | 17 |
| 6.1 Country Reports on Psychoses..... | 17 |
| 6.2 Summary of the Report of the Working Group on Psychoses..... | 19 |
| 7. CONCLUSIONS | 20 |

Annexes

| | |
|--|----|
| 1. Agenda..... | 22 |
| 2. Programme..... | 23 |
| 3. List of Participants..... | 24 |
| 4. Opening Remarks by WHO Representative, Thailand..... | 27 |
| 5. The Choice of Antiepileptic Drugs | 30 |
| 6. Revised Draft of the Screening Instrument for Major Fits..... | 33 |
| 7. Intercountry Consultation on Development of Strategies for Community- Based Neuropsychiatric Services – Resolution | 37 |
| 8. Intercountry Consultation on Development of Strategies for Community- Based Neuropsychiatric Services – Resolution | 38 |

1. INTRODUCTION

Traditionally, neurological and psychiatric services have been concentrated in tertiary care hospitals which are usually located in urban areas. Large segments of the population in SEAR Member Countries, particularly those who live in rural and remote areas do not have the resources to travel to urban areas to seek such services and are thus deprived of care, despite the common occurrence of both neurological and psychiatric disorders.

The priority of the Regional Office is to concentrate on community-based projects and programmes. Thus, every effort must be made to develop projects and programmes which are capable of delivering at least the basic minimum level of services for neuropsychiatric disorders to everyone regardless of where they live. Ideally, such services should detect cases in the community, and provide services at the community level, using the primary health care system. Such services should also include education of the community to address issues such as stigma attached to neuropsychiatric disorders and rehabilitation.

A strategy is needed which will enable at least basic minimum neuropsychiatric services to be delivered to the entire community including rural and marginalized communities.

Development of such a strategy which aims to reach out to the community raises several important questions:

- (1) What is the basic minimum level of service for neuropsychiatric disorders which must be available to every one in the community?
- (2) Who will deliver this basic minimum level of service?
- (3) How will the health care providers be trained to deliver these basic minimum services?
- (4) What medications will be used in the treatment of these disorders?
- (5) Who will bear the cost of these medications?

- (6) Other issues to be addressed, are stigma, myths, social support, and rehabilitation etc

The concept of developing community-based neuropsychiatric services has been approved by the High Level Task Force. Discussions were also held during the 38th CCPDM in Yangon, Myanmar (30 August to 1 September 2001) and the concept was supported by Member countries. The RC54 resolution has also supported development of community-based services to be implemented in Member Countries.

2. OBJECTIVES OF THE CONSULTATION

- (1) To review the experience of Member Countries in community-based neuropsychiatric services for priority conditions;
- (2) To develop a broad strategy for implementation of community-based neuropsychiatric services, and

To develop guidelines for pilot testing the strategies in select countries.

See Annex 1, 2 and 3 for Agenda, Programme and List of Participants.

3. COMMUNITY NEEDS IN TERMS OF NEUROPSYCHIATRIC SERVICES

What is the basic minimum level of service for neuropsychiatric disorders which must be available to everyone in the community?

Ideally, complete and comprehensive services for all neuropsychiatric disorders should be available to all members of the community. However, such comprehensive services cannot be delivered to all within the community, especially in rural and remote areas. Thus, projects and programmes for delivery of such services must address select disorders. Selection of disorders could be guided by the following principles:

- (1) High prevalence of the disorder in the community;
- (2) High morbidity from the disorder;

- (3) Easy to diagnose with resources available in the community;
- (4) Availability of effective and low cost medication, and
- (5) Good prognosis with treatment.

Many neuropsychiatric disorders such as epilepsy, psychosis, and depression meet the above criteria. Some communities may have their own unique problems which meet the above criteria. Although it would be ideal to develop projects to deal with all major neuropsychiatric disorders and implement them at one time, this is not practical or possible. Thus it is proposed to target two disorders in the first phase of this project to reach out to the community.

Who will deliver this basic minimum level of service?

Different countries could use different health care providers as long as the health care provider is based in the community and is willing to serve rural and remote areas. Some countries have made available qualified doctors at primary health care centres even in rural areas supported by a field team of trained health care providers who provide door to door service in the community.

The government or the community leaders could nominate those who would take the courses developed for this project.

In some countries (e.g. Nepal and Indonesia), faith healers provide the bulk of treatment specially in neuropsychiatric disorders. Efforts have already been successfully made in these countries to educate such providers.

How will the health care providers be trained to deliver these basic minimum services?

The health care providers will be trained using a structured written manual and video-based demonstration of patients with major fits and psychosis (based on several existing modules developed by National Institute of Mental Health and Neuro Sciences, Bangalore, and HQ). These modules will address the identification, differentiation from similar conditions, when and whom to

refer for further management, myths and misconceptions about fits, care, rehabilitation, community education (to remove stigma), treatment and follow-up of patients. It will be targeted towards the community health care provider.

What medications will be used in the treatment of these disorders?

Many medications are available for the treatment of epilepsy. However, phenobarbitone which has been used for over 50 years is probably the most inexpensive and optimum drug for widespread use in the treatment of epilepsy in developing countries. The global campaign against epilepsy jointly launched by WHO and NGOs also advocates the use of phenobarbitone. However, phenobarbitone is banned in certain countries and some people may be allergic to it, so at least one alternative should be available.

The optimum medication for treatment of psychosis is either phenothiazine or haloperidol. However, there is some evidence that the toxicity profile of these medications is high. Although much more expensive, the newer antipsychotics are more effective and less toxic. The relative cost versus benefits and toxicity needs to be discussed.

Who will bear the cost of these medications?

Ideally, patients should pay for the medication they use. However, in some countries patients are too poor even to pay small sums of money for medication. Thus, each country will have to decide on a mechanism of funding medications to the patients.

Other issues to be addressed

Other important issues in the care of patients with neuropsychiatric disorders are stigma, myths, social support, schooling, marriage, sports, job and rehabilitation. These should be addressed, so that the project deals with the comprehensive needs of patients with neuropsychiatric disorders.

4. SUMMARY OF PROCEEDINGS

During the discussion, the delegates supported the concept of providing basic minimum services to the community, in the community, no matter where the community is located. There was general agreement that new and innovative solutions need to be considered.

There was a detailed discussion on who would provide neuropsychiatric care to the community. Many examples were cited of government health workers working in primary health care centres who have been trained to identify major mental disorders. However, most delegates felt that PHC staff are already over burdened with numerous and diverse health programmes and would have little time to deliver neuropsychiatric care. Many examples were given in which PHC staff are trained for new projects. Whereas, the training is usually very successful, practice of the training in the community is usually extremely limited. Some delegates felt that training primary health care workers must be one of multiple strategies to be developed in order to cover communities as extensively as possible.

The role of community-based health care providers was discussed. Many examples were given in which village health volunteers have been successfully trained. It was also pointed out that almost all villages in all Member Countries have a community health care provider. This person is usually "a self-proclaimed medical practitioner". His qualification is very variable, however, he is respected by the community and sought after for medical advice and health. In most cases, this is the only medical health available to the community. This health care provider provides medical care on a "fees for service" basis, thus, the community is paying for the care that they receive, including for medications dispensed by the health care provider. There was general agreement that attempt should be made to involve these health care providers into a training programme for delivery of neuropsychiatric services particularly in rural and remote areas. How such workers will be trained, remains a challenge.

Some delegates also pointed out that as the number of medical practitioners increases and opportunities for private practice in cities are limited, many physicians are moving to small towns and even large villages. One of the strategies to be considered for delivery of neuropsychiatric services should be to train these general practitioners (GPs).

The role of faith healers was discussed. In some countries, faith healers are highly sought after in the care of patients with neuropsychiatric disorders, as the community believes these disorders are caused by evil spirits. The faith healers are also not aware of the medical nature of neuropsychiatric disorders. Examples were cited in which faith healers have been trained to identify neuropsychiatric disorders, refer them for medical treatment while continuing to encourage patients to engage in rituals which acts as psychosocial support. Examples were given of medical doctors and faith healers working together for the benefit of the patients.

There was general agreement that any programme developed, should be under the overall supervision of psychiatrists and neurologists who must form the backbone of a support system for rural and remote health workers.

An important component of community-based mental health programme must be demystification of mental health. The programme must emphasize the medical nature of neuropsychiatric conditions and emphasize the need for taking appropriate medication. Stigma removal and rehabilitation must also be included. The attitude of people needs changing.

There was extensive discussion on the conditions to be included in Phase I. Although, there was general agreement on including epilepsy and psychosis, some delegates felt that depression should be considered. However, other people felt that treatable depression would be hard to differentiate from depressive symptoms which do not require treatment. Also, the psychosocial factors which contribute to depression may be hard to control. It was decided that depression should be considered in the next phase of programme development.

It was brought out that about 80% of outpatient care is provided by the private sector. Thus, any programme must include the private sector and utilize the existing health care delivery system.

The discussion concluded with the observation that the vast majority of people who need neuropsychiatric services are not getting appropriate services. This reality must be acknowledged and efforts made to remedy the situation as soon as possible.

Bangladesh

There are very few trained psychiatrists in Bangladesh with only about one psychiatrist for about 19 lakh people. Majority of the people think that doctors have no role to play in the management of neuropsychiatric disorders and thus seek treatment from "Ojha", "Kabiraj" or religious leaders. Imams and health care providers in villages can be trained to identify and refer patients. Village based health care providers are already prescribing many medications. In a community survey conducted in Bangladesh, depression was a leading cause of morbidity.

Bhutan

There are village health volunteers in Bhutan. These could be trained to identify and refer patients with neuropsychiatric disorders, also to convince people to seek treatment. The community often seeks treatment from faith healers. In a small survey conducted in Bhutan, depression was the number one cause of morbidity. A large survey of the morbidity from neuropsychiatric disorders is planned for March 2002.

India

Representatives from India made detailed presentations on epilepsy and psychosis. Of particular interest were the community-based programme and the comprehensive rural health services project at Ballabgarh, Haryana, and the experience of the National Institute of Mental Health and Neuro Sciences with working in the community.

DPR Korea

The government provides all mental health care which is available to every one. There is a medical university in every province. Schizophrenia is an important condition and should be prioritized. The main problems are difficulty of transportation, lack of medication and lack of updated instruments.

Indonesia

There are 33 000 islands of which five are big islands. With a population of 200 million, there are only 450 psychiatrists. This shortage of psychiatrists, plus the large number of islands make delivery of neuropsychiatric services difficult. The government has decided to prioritize five conditions for management at the primary health care level, and epilepsy and psychosis are included in this list. Attempts were made to train faith healers in West Java but their dominant personality and their belief that they are extremely wise, made it difficult to train them. In Bali, faith healers are much more amenable to training.

Myanmar

The local faith healers are called "*payawga sayas*". They often use laxatives. Basic health workers and community health workers could be used in the identification and referral of patients with neuropsychiatric disorders. Many training programmes are already in existence. Epilepsy is the third commonest neurological disorder in Yangon General Hospital.

Nepal

About 95% of patients with neuropsychiatric disorders go to faith healers, particularly in rural areas. Faith healers are available almost everywhere and charge fees in cash or kind. Some government programmes have been developed to train them. Because of their influence in the community, it would be very desirable to work with them. However, they should be trained to identify cases rather than treat them.

Sri Lanka

Sri Lanka has a very well developed health care system with very extensive coverage. A qualified doctor is available within 4.8 kms to any one in the island. This availability of doctors along with an extensive network of paramedical staff can make delivery of neuropsychiatric services relatively easy and expensive.

Thailand

In rural areas, there are village health volunteers who provide initial care for major and minor mental disorders and epilepsy. They also provide psychosocial care for patients with HIV and terminally ill patients. They also promote mental health in schools and work place. It would be very desirable to train and cooperate with traditional healers and monks.

Neuropsychiatric conditions for management in Phase 1

The Consultation discussed in detail and at length various neuropsychiatric conditions of importance to Member Countries. It was unanimously decided that the two conditions which meet the criteria defined in Section 3 are epilepsy and psychosis.

Epilepsy (major fits)

Epilepsy is a common disorder in all parts of the world. In the SEA Region, it affects between 2-10 per thousand population. It is believed that there are 35 million persons with epilepsy in developing countries, with 8-10 million people in India alone.

Epilepsy has high morbidity from injuries during a seizure and also from the social stigma attached to the disease which affects both patients and their families.

The diagnosis of epilepsy is complex and requires a high level of sophistication on the part of a physician specializing in neurosciences, supported by high technology laboratory tests such as CT and MRI scans and EEG. On the other hand, identification of grand mal seizures which are commonly called "major fits" by the common man are easy to identify by simple observation. These major fits have the highest morbidity and a good outcome if treated with easily available and effective anti-convulsant medication.

Major fits will be the focus of this project.

Psychoses

Psychotic disorders also occur all over the world. Schizophrenia, one of the major types of psychotic disorders affects about 1% of the world's population. It commonly occurs in the most productive age group of 15-35 years. If left untreated or partially treated, schizophrenia can cause significant and long-lasting impairment and disabilities, encompassing all aspects of human functioning. It makes heavy demands on hospital care, and may require prolonged medical care, rehabilitation and support services. The social costs and burden on the family can be enormous.

The broad category of psychotic disorders are relatively easy to diagnose and treat. It is not necessary to make a detailed diagnosis of the exact type of psychotic disorder as generally the treatment is the same for all. With adequate treatment, the prognosis is good.

5. EPILEPSY

5.1 Country Reports on Epilepsy

Bangladesh

Misdiagnosis of epilepsy patients is quite common. Epileptic patients are often considered to have hysterical fits till they suffer a serious injury such as a burn or fracture of limbs. On the contrary, many non-epileptic patients are put on anti-convulsant medications for extended periods. There is a major stigma attached to epilepsy, much more for women than for men.

Bhutan

No nationwide survey on the prevalence/incidence of epilepsy has been conducted. An OPD survey of 717 patients conducted between 1999 –2000 found that 8% of cases had epilepsy. Amongst those less than 20 years of age, 20% of people attending OPD had epilepsy. Epilepsy is included in the reporting format from all health care centres. All primary health care workers have been trained to manage epileptic emergencies (such as, status epilepticus). Compliance with medications is a problem amongst patients.

Most medications are available, but radiological tests and EEG are not available. Patients are referred to India for treatment.

Indonesia

Epilepsy should be considered a public health problem and thus a comprehensive programme on its identification and management should be a government responsibility. With the new decentralization policy, the district health office should be the focal point.

Myanmar

Epilepsy is the third commonest neurological disorder. An epilepsy centre was started in Yangon on 1997. There is widespread lack of knowledge about the true nature of epilepsy. About 35% of patients do not receive proper treatment. There is no special education or sheltered work for epilepsy.

Nepal

Epilepsy is quite common in Nepal, but a majority of people go to faith healers and never reach a physician. There is widespread negative attitude and social stigma attached to epilepsy. Lack of qualified manpower further adds to the problem of inadequate treatment.

Sri Lanka

Epilepsy is the commonest chronic neurological disorder in Sri Lanka. The first tertiary care centre for epilepsy was established at the National Hospital in Colombo in February 2001. An epilepsy task force has also been established by the Ministry of Health, which is a multidisciplinary team and will provide comprehensive services to the entire community.

Thailand

There appears to be substantial underestimation of the number of people with epilepsy in Thailand, particularly in rural areas. Some patients with epilepsy still use old traditional treatments such as witchcraft and unknown herbs. Now

the Thai government has launched a policy for improving medical services, particularly in rural areas using well trained health workers and an efficient referral system.

5.2 Report of International League Against Epilepsy 'Out of the Shadows'- A Global Campaign Against Epilepsy

Introduction

Worldwide there are 50 000 000 people with epilepsy. Some 40 000 000 people, 80% (!) of people with epilepsy are not properly diagnosed and do not receive adequate treatment.

Furthermore, all over the world, people with epilepsy experience psychosocial difficulties, be it that these may vary from country to country, based on cultural differences and economical circumstances.

What is the global campaign?

The ILAE/IBE/WHO Global Campaign against Epilepsy "Out of the Shadows" is a partnership of three global organizations, active in the area of health care: it is a joint initiative of the World Health Organization, the International League against Epilepsy the global society for professionals and the International Bureau for Epilepsy, the global association for people who have the condition, their carers and non-medical professionals.

Its mission statement is:

"To improve the acceptability, treatment, services and prevention of epilepsy worldwide" after all 60-70% of people with epilepsy could live normal lives if appropriately treated."

Epilepsy, not only presents people with health problems, they also have to cope with a wide range of difficulties that affect almost every aspect of their lives. Many of these difficulties are a consequence of the misconceptions, the prejudice and the stigma. In many countries including in the western world, epilepsy is still the hidden disease.

Together IBE, ILAE and WHO are trying to raise epilepsy to a level of awareness that has not been achieved yet, despite all efforts from each of the separate organizations and their affiliates: To bring epilepsy out of the shadows!

The global campaign strategy

The Global Campaign Strategy includes two parallel and simultaneous tracks. It provides a platform for general awareness and understanding of epilepsy by organizing the launch of the second phase of the Campaign in the year 2001 and regional conferences on public health aspects. The Campaign will assist the Departments of Health in identifying the needs and promoting education, training, treatment, services, research and prevention by providing information and support for national initiatives and initiating demonstration projects

The launch of the 2nd phase of the campaign

It is four years since the campaign was first launched and the experience of this phase had created the rationale for the suggestion of a second phase with new and even more ambitious goals: to improve the health care services and treatment, identify and assess the potential for prevention and social acceptance of epilepsy world-wide.

The Director-General, Dr Gro Harlem Brundtland and the Cabinet of WHO therefore decided to boost the status and the activities of the campaign within the context of the new WHO health priorities, which also include epilepsy.

The second phase of the campaign was launched in Geneva on 12 February 2002 in the presence of Dr Gro Harlem Brundtland, Director-General of WHO, Dr Derek Yach, Executive Director of the Cluster on Noncommunicable Diseases and Mental Health, Dr Benedetto Saraceno, Director of the Department on Mental Health and Substance Dependence, regional advisors from all six Regions of WHO, the presidents and representatives of Executive Committees, members and representatives of IBE and ILAE.

Raising Awareness

During the past few years, the campaign essentially focused on raising awareness and on advocacy. The main tools to do so were the organization of regional conferences on epilepsy as a public health priority and the development of regional declarations on epilepsy.

The main players in the global campaign are the national members of IBE and ILAE, and the WHO regional offices, who know best the local problems, needs and solutions for people with epilepsy in their own countries. To date, in over 70 countries, activities have been performed or are being planned to take place under the global campaign from every part of the world.

What has been achieved

In 1998, the first regional conference took place in Heidelberg, Germany and the first regional declaration was unanimously adopted.

In 2000, four more regional conferences took place, in Senegal, Africa; in Chile, Latin America; in India, South-East Asia and in the USA, North America.

Over 1200 representatives from WHO, ILAE and IBE, from other nongovernmental organizations and UN agencies, from governments, universities and health care providers from well over 100 countries, representing millions of people with epilepsy were involved in the development and adoption of these regional declarations.

In February 2001, the launch of the second phase of the ILAE/IBE/WHO Global Campaign against Epilepsy took place in Geneva. In March 2001, the European White Paper was launched in the European Parliament in Brussels.

Demonstration Projects

The campaign now moved from raising awareness to the implementation of demonstration projects, into the second phase of the campaign.

Demonstration projects are set up to support departments of health in identifying the needs, and promoting education, training, treatment, services, research and prevention on a national level.

Achievements

In April 1999, the Secretariat met with representatives of countries involved in the organization of demonstration projects. The progress and the prospects of the projects were reviewed and discussed and it was acknowledged that assurance was needed that epilepsy interventions would be sustainable and able to provide appropriate care over the long-term including the availability of essential antiepileptic drugs.

In China, the demonstration project has already been implemented: epidemiological research was undertaken and the outcomes are remarkable. The first training activities are already taking place. In India, the possibilities for projects are being investigated. In Senegal and Zimbabwe, the protocols are being finalized. In Argentina, preparation work on the protocol is progressing.

Recommendations for the future

- Intensify and boost the status and activities of the Campaign
- Develop a partnership with WHO Regional Offices in all regions
- The development and implementation of demonstration projects in all regions
- Organize Regional Conferences on public health aspects of epilepsy in all regions,
- Organize meetings with appropriate United Nations agencies and relevant WHO departments
- Jointly with WHO representatives, organize meetings with possible donors
- Continue efforts in priority setting for research in epilepsy, including epidemiology and prevention
- Organize technical consultative meetings and workshops on various topics

Conclusion

The entire success of the Campaign is in the partnership: in the first place the partnership between IBE, ILAE and WHO, but also and as important the

partnership with the national chapters of IBE and ILAE and with the Regional Offices and national representatives of WHO, the partnership with the other NGO's, especially those in neurology and neuroscience and the partnership with the industry.

Finally another quote from Dr. Brundtland:

"The collaboration between the International Bureau for Epilepsy, the International League Against Epilepsy and WHO has shown that when people with different backgrounds and roles come together with a shared purpose, creativity is released and expertise is used in innovative and constructive ways".

Bring EPILEPSY 'Out of the Shadows'!

Hanneke M. de Boer,
Secretariat ILAE/IBE/WHO Global Campaign against Epilepsy
Stichting Epilepsie Instellingen Nederland
Heemstede, The Netherlands

5.3 Treatment of Epilepsy in the Community

Dr William Theodore, Chief, Clinical Epilepsy Branch, National Institutes of Health, USA reviewed the status of old and new anti convulsant medication available for treatment of epilepsy.

He emphasized that phenobarbitone does not have a high abuse potential. Abuse is more with short acting barbiturates. Also despite the widespread views on the availability of phenobarbitone in Nepal, there are no addicts. It has hardly ever been used for suicide. The hyperactivity observed in children is usually transient. Phenobarbitone is usually of high quality, whereas phenytoin and carbamazepine have significant quality problems.

Dr Theodore emphasized that whereas the newer anti-convulsants may be preferred in a clinic based practice, the requirements of use on a mass scale, dealing with very large number of patients, are different.

Regarding the choice of anti-convulsant medication for large community based programmes he opined that no AED has a perfect combination of high

efficacy, low toxicity and cost, and a good pharmacologic profile. In fact, each of the drugs has advantages and disadvantages that make it the best choice for particular situations and patients. For large-scale programmes in developing countries, where medical monitoring and backup treatment facilities are limited, it is unwise on therapeutic grounds to use new AEDs. Knowledge of their toxicity is incomplete. Among the older drugs, PB appears to have the best combination of advantages, and the fewest disadvantages.

5.4 Summary of the Report of the Working Group on Epilepsy

The epilepsy working group was able to revise the draft questionnaire which was circulated for screening for identification of generalized tonic clonic seizures in the community. The working group recommended that the term "Major Fits" be used for this condition as non-medical lay health workers would be identifying cases. The group also recommended that the screening instrument be pilot tested first at sites where large numbers of epilepsy patients were available. All India Institute of Medical Sciences, New Delhi; National Institute of Mental Health and Neurosciences, Bangalore, and the National Hospital of Sri Lanka, Colombo were identified as the sites for first step testing. After appropriate modification, this instrument would be tested in the community in as many Member Countries as willing to participate.

6. PSYCHOSES

6.1 Country Reports on Psychoses

Bangladesh

Unfortunately, symptoms of resembling psychotic disorders are termed as "madness" or "insanity" in the community. They also do not consider psychosis as a medical illness and believe that these are caused by evil spirits or supernatural power.

Bhutan

No countrywide data are available, but in OPD based survey of 717 patients, identified 5% of cases as having psychotic behaviour. Basic training in mental

health skills have been conducted for all district medical officers and health workers.

India

Studies conducted in India have clearly shown that psychotic disorders are prevalent all over the country in both rural and urban areas. Unfortunately, more than two-third of patients suffering from psychosis do not receive any treatment. There are widespread misconceptions about the cause and management of psychotic disorders. The morbidity from psychosis both among the patients and the family is very high. Currently, the main treatment for patients is available in large mental hospitals with virtually no community-based services. It would be ideal to integrate the services into the existing health care delivery system.

Indonesia

Psychosis is common condition in Indonesia with serious morbidity to the patient and the family. The focal point for programme should be the district health officer under the new decentralization policy.

Myanmar

Psychosis is a major cause of morbidity in Myanmar and it is estimated that about 0.5 million people are suffering from psychosis. This has substantial negative consequences on the lives of the patients and a burden for the family, society and country. Often the patient is unwanted by the family. WHO sponsored the decentralization of psychiatric services and launching the community-based mental health programme by integration of mental health services into primary health care was started in 1990. This greatly assisted in the care of patients, particularly since qualified psychiatrists are few. The programme has been very successful.

Nepal

It has been estimated that about 2% of the general population could be suffering from psychotic disorders. It is encouraging to note that social support

is still strong, but lack of medication is a major problem. Most psychotic patients are taken to faith healers and a majority of them never see a physician or psychiatrist because of the strong community belief that these illnesses are caused by evil spirits.

Sri Lanka

A programme dealing with psychotic disorders designed and developed by local experts would be very appropriate to incorporate into the primary health care services of Sri Lanka.

Thailand

Care of psychotic patients is gradually moving from mental hospital to community-based programme. The success of such programmes depends on mutual understanding between the psychiatry specialist and the community organization. Mental health professionals have become more responsive to the needs of general practitioners and community workers. Case identification of psychotic patients is done by trained village health volunteers with confirmation by community health workers. Final diagnosis is made at a district hospital by a physician. Usually, for the first episode and to treat refractory patients, patients are referred to psychiatrists. Psychotropic medication and continuity of care is provided in the community at home. With the current national health insurance policy the quality of care in the community is expected to be strengthened.

6.2 Summary of the Report of the Working Group on Psychoses

Background

- (1) Psychoses are universal illnesses. Schizophrenia is a type of psychosis. Due to their symptoms these psychoses are easily identifiable.
- (2) Although the rates of incidence of schizophrenia are low, because of chronicity of the illness, prevalence rates can be quite high.
- (3) The shorter the duration of untreated prodrome, better is the long-term outcome of schizophrenia. Thus early identification of cases is important.

- (4) Schizophrenia is easily treatable with medication although psychological support also plays a role in its management.
- (5) The economic costs and burden of schizophrenia are huge.

Management issues

- (1) In a community setting, psychoses can be identified by trained personnel and adequate treatment can be given by providers. It is not important to differentiate between types of psychoses.
- (2) Providers can vary from country to country depending upon accessibility and availability of health workers.
- (3) Providers and identifiers can be both easily trained to provide basic services.

Plan for community care

The first step is to select potential identifiers who can be any member of the community including teachers, police, health workers, and midwives. The individual suffering from psychosis can be identified depending upon symptoms and the duration of symptoms. The training of identifiers must be local, decentralized, ongoing and happen in a cascading manner. Technical support to lay health workers should be made available. Training manuals should be available to primary workers. Depending upon the country, drugs can be selected and the provider trained in the use of drugs, their side effects and other sources of help. Piloting of the project is essential. Sites for testing should be carefully selected. The system and the service needs to be evaluated periodically, based on a number of parameters related both to providers and cases of major mental disorder.

7. CONCLUSIONS

The Consultation agreed that multiple strategies need to be developed to deliver neuropsychiatric services to the community in order to ensure widest possible coverage. At least three strategies were identified:

- (1) Training of general physicians;
- (2) Training of lay health workers at the primary health care level, and
- (3) Training of community-based health care providers who already live and practise in the community.

The epilepsy working group developed a revised draft of a screening instrument for Major Fits, and recommended that the screening instrument be pilot tested first at sites where large numbers of epilepsy patients were available (see Annex 4). All India Institute of Medical Sciences, New Delhi; National Institute of Mental Health and Neurosciences, Bangalore, and the National Hospital of Sri Lanka, Colombo were identified as the sites for first step testing. After appropriate modification, this instrument would be tested in the community in as many Member Countries as were willing to participate.

The psychosis working group recommended that a similar screening instrument as for epilepsy be developed to identify cases of psychosis in the community. Dr Nimesh Desai from the Institute of Human Behaviour and Allied Sciences, Delhi and Dr Dinesh Bhugra, London, UK will develop the first draft of the screening instrument.

The meeting concluded with a strong support for the WHO project to deliver essential services for select neuropsychiatric disorders to the community in the community.

Annex 1

AGENDA

Day 1: Monday, 19 November 2001

1. The rationale for development of strategy for community-based neuropsychiatric services
2. Strategy for community-based neuropsychiatric services project
3. Country presentations
4. Global epidemiology and morbidity of epilepsy to include:
 - Epidemiology
 - Morbidity
5. Treatment of epilepsy

Day 2: Tuesday, 20 November 2001:

1. Epilepsy in South-East Asia: Medical perspective, to focus on:
2. Epilepsy in South-East Asia: Community perspective
3. Epidemiology of psychosis: Western and trans-cultural perspective.
4. Epidemiology of psychosis: Eastern perspective

Day 3: Wednesday, 21 November 2001:

1. Working groups
 - Complete the strategy for community-based services for major fits
 - Develop the outline of a strategy for community-based services for psychosis.
2. Report and conclusion of the consultation.

Day 4: Thursday, 22 November 2001:

The Department of Mental Health of the Government of Thailand is arranging a field trip to mental institutions and community services in Surat, Thailand

Annex 2

PROGRAMME

Monday, 19 November 2001

| | |
|----------------|---|
| 0830-0900 hrs | Registration |
| 0900-1000 hrs | Inauguration |
| 1030-1045 hrs | Introduction to community based neuropsychiatric services project Dr Vijay Chandra |
| 1045-1130 hrs | Discussions on community-based neuropsychiatric services project |
| 1130-1300 hrs | Country presentations addressing (20 minutes each country): |
| 1400-1500 hrs | Country presentations continued |
| 1500- 1530 hrs | Global campaign against epilepsy – Ms Hanneke de Boer and Dr L. Prilipko |
| 1530-1610 hrs | Global epidemiology and morbidity of epilepsy – Dr Martin Rossor |
| 1630-1700 hrs | Treatment of epilepsy – Dr William Theodore |
| 1700-1730 hrs | Discussion |

Tuesday, 20 November 2001

| | |
|----------------|--|
| 0800- 0820 hrs | Epilepsy in South-East Asia: Medical perspective – Dr Satish Jain |
| 0820- 0840 hrs | Epilepsy in South-East Asia Community perspective – Dr Suresh Kapoor and Dr Anand |
| 0840- 0900 hrs | Discussion on Epilepsy |
| 0900- 0940 hrs | Epidemiology of Psychosis: Western and Trans-cultural Perspective – Dr Dinesh Bhugra |
| 1000- 1040 hrs | Epidemiology and Treatment Practices of Psychosis: Eastern Perspective – Dr Mohan Isaac |
| 1040- 1130 hrs | Discussion |
| 1130- 1300 hrs | Two working groups : Epilepsy and Psychosis |
| 1400-1700 hrs | Working groups continued |

Wednesday, 21 November 2001

| | |
|---------------|------------------------------|
| 0800-1100 hrs | Two working groups continued |
| 1100-1300 hrs | Report of working groups |
| 1400-1500 hrs | Report and conclusion |

Thursday, 22 November 2001

| | |
|---------|---|
| All day | Field visit to mental institutions in Surat, Thailand |
|---------|---|

Annex 3

LIST OF PARTICIPANTS

Bangladesh

Dr Nazmul Ahsaan
Director-cum-Professor
National Institute of Mental Health
and Research (IMHAR)
Sher-e-Bangla Nagar
Dhaka

Dr Md. Rezaul Karim
Director, Mental Health Hospital
Pabna

Bhutan

Dr Purushottam Bhandari
District Medical Officer
Dagana

DPR Korea

Dr Pak Chun Taek
Director,
Department of Treatment and Prevention,
Ministry of Public Health
Pyongyang

Dr Ri Yong Un
Chief, Chair of Mental Medicine
Pyongyang Medical University
Pyongyang

Dr Pak Song Il
Researcher (cum interpreter)
Population Centre,
Ministry of Public Health
Pyongyang

India

Dr Suresh Kapoor
Professor, Centre for Community Medicine
All India Institute of Medical Sciences
Ansari Nagar
New Delhi 110 019

Dr K. Anand
Assistant Professor of Community Medicine
Centre for Community Medicine
All India Institute of Medical Sciences
Ansari Nagar
New Delhi 110 019

Dr Satish Jain
Additional Professor of Neurology
All India Institute of Medical Sciences
Ansari Nagar
New Delhi 110 019

Dr Bela Shah
Senior Deputy Director-General
Indian Council of Medical Research
Ansari Nagar
Post Box 4911
New Delhi 110 029

Dr Mohan Isaac
Professor and Head
Department of Psychiatry, NIMHANS
Bangalore 560 029

Indonesia

Dr Rusdi Maslim
Dte of Community Mental Health
Ministry of Health and Social Welfare
Jalan HR Rasuna Said Kav. X5 No. 4-9
Jakarta 12950

Dr Idris Yusmansyah
Dte of Community Mental Health
Ministry of Health and Social Welfare
Jakarta 12950

Myanmar

Dr Nyan Tun
Consultant Neurologist
Neurological Department
Yangon General Hospital
Yangon

Dr Win Aung Myint
Consultant Psychiatrist
Magway General Hospital
Yangon

Nepal

Dr Niarakar Man Shrestha
Director of Mental Hospital
Lalitpur

Dr Surendra Sherchan
Psychiatrist – Koshi Zonal Hospital
Biratnagar

Sri Lanka

Dr (Mrs) Ranjani Gamage
Consultant Neurologist
National Hospital of Sri Lanka
Colombo 10

Dr WL Wickramasinghe
Consultant Psychiatrist
General Hospital
Kandy

Mr Herath
Special Grade Nursing Officer
Mental Hospital
Angoda

Thailand

Dr Bhakhaporn Pirommai
Director, Mental Health Centre Region 5
Nakorn Ratchasima Province

Dr Boonchai Nawamongkolwatana
Director
Prasimahabhodi Psychiatric Hospital
Ubonratchatanee Province

Dr Prawate Tantipiwatnaskul
Director
Institute of Child and Adolescent Psychiatry
Rama 6 Road
Bangkok

Dr Suparat Ekasawin
Director, Mental Health Centre Region 4
Bangkok

Mrs Seekeow Disariyakul
Director
Mental Health Centre Region 9
Nakornsawan Province

Dr Ketchai Suavansri
Medical Officer
Prasart Neurological Institute
Bangkok

Temporary Advisers

Dr William Theodore
Chief Clinical Epilepsy Branch
National Institute of Neurological Disorders
and Stroke, NIH, Bethesda
Maryland, USA

Professor Martin Rossor
Department of Neurology
National Hospital for Mental Diseases
Queens Square
London, UK

Dr Dinesh Bhugra
Reader in Cultural Psychiatry
Health Services Research Department
Institute of Psychiatry
De Crespigny Park
London, SE5 8AF

Dr Nimesh G. Desai
Professor and Head, Department of Psychiatry
Institute of Human Behaviour
and Allied Sciences
Post Box 9520, Jhilmil
Delhi

Observers

Dr Hanneke de Boer
International League against Epilepsy
Epilepsy Zentrum Bethel
Mara 1 – Maraweg 21, Bethel 33617 Bielefeld
Germany

Ms Suchada Sakornsatien
Director, Psychiatric Service Development
Section
Department of Mental Health
Ministry of Public Health
Tiwanond Road, Nonthaburi
Thailand

WHO Secretariat

Dr Bjorn Melgard
WHO Representative
Thailand

Dr Leonid Prilipko
Programme Leader
Neuroscience & Neurological Disorders
Department of Mental Health and
Substance Dependence
WHO/HQ

Dr Vijay Chandra
Regional Adviser-Health and Behaviour
WHO/SEARO

Ms Bina Luthra
Administrative Secretary
Health and Behaviour

Annex 4

STRATEGIES TO DELIVER BASIC NEUROPSYCHIATRIC SERVICES TO THE ENTIRE COMMUNITY OPENING REMARKS BY WHO REPRESENTATIVE, THAILAND

Distinguished colleagues, ladies and gentlemen,

Recognizing the magnitude of mental and neurological disorders, WHO is paying increasing attention to create awareness about these conditions and to develop suitable strategies to manage them. This year, several important events sponsored by WHO focused on mental health. For example, World Health Day on 7th April 2001 focused on mental health while the World Health Assembly during its session in May, also discussed issues related to mental health. The World Health Report 2001 was also devoted to mental health.

The reason for WHO's focus on mental health is the fact that currently, about 450 million people worldwide suffer from these disorders. Seen from another perspective - one in four people will be affected at some point during their life time. Depression is a leading cause of disability worldwide. In the South-East Asia Region of WHO, 27 per cent of the disability is due to neuropsychiatric disorders.

Mental health is of particular importance to the South-East Asia Region. There is an acute shortage of trained manpower. For example, there is only one psychiatrist in Bhutan, while there are 65 psychiatrists for over 115 million people in Bangladesh, 420 psychiatrists for over 200 million people in Indonesia, only 3500 psychiatrists for 1 billion people in India and about 400 psychiatrists for a population of about 63 million in Thailand. Suicide rates are unacceptably high with Sri Lanka ranking 7th in the world. Appropriate drugs are not widely available. Very frequently, they are unaffordable. Vast segments of the population are deprived of recent advances in neurosciences. In addition, there are serious problems about stigma and discrimination linked to mental disorders. In this context, it is worth quoting from a speech by Dr Gro Harlem Brundtland, the Director-General of the World Health Organization who said, "Many of them suffer silently, and beyond the

suffering and beyond the absence of care lie the frontiers of stigma, shame, exclusion and, more often than we care to know, death.”

Mental health programmes in the countries of our Region have generally concentrated on hospital-based psychiatry. However, there is increasing awareness of the need to shift the emphasis to community-based mental health programmes.

The WHO Regional Committee for South-East Asia at its 54th session in Yangon resolved “to strengthen community based prevention and control programmes on mental health ...” and also “to enhance human resource development in mental health for appropriate levels of health care workers”. In keeping with this recommendation, the Regional Office is organizing this very important workshop on Strategies to Deliver Basic Neuropsychiatric Services to the Entire Community. Reaching out to the entire community may be extremely difficult but we have a moral obligation to reach this objective.

We are very happy that Thailand is playing a particularly important role in assisting the Regional Office in developing its community based mental health programmes. Thailand has substantial expertise in mental health, which the Royal Thai Government has graciously made available for training of mental health professionals, not only from our Member countries, but also from countries in the Western Pacific Region.

I see in the programme that the workshop will discuss many important questions such as what is the basic minimum level of service which must be available to everyone in the community? Who will deliver this basic minimum level of service? How will the community health care providers be trained? How will the programme be financed? Another important issue to be addressed is the shame and stigma attached to mental illnesses which remains a major obstacle to the development of effective mental health programmes in our Region.

In conclusion, I would like to quote from a recent speech by Dr Uton Muchtar Rafei, our Regional Director. He said, and I quote:

“Mental health care, unlike many other areas of health, does not generally demand costly technology. Rather, it requires the sensitive deployment of personnel who have been properly trained in the use of

relatively inexpensive drugs and psychological support skills on an outpatient basis. What is needed above all, is for all concerned to work closely to address the multi-faceted challenges of mental health." Unquote

I am delighted that we have delegates from nine Member countries present. On behalf of the WHO country office, I welcome you all to Thailand and wish the meeting every success.

Thank you

Annex 5

THE CHOICE OF ANTIPILEPTIC DRUGS

William H Theodore MD, Chief, Clinical Epilepsy Section, National Institutes of Health, Building 10 Room 5N-250, 9000 Rockville Pike, Bethesda MD 20892-1408, USA

The proper choice of antiepileptic drugs (AEDs) depends on several factors, including efficacy, toxicity, and ease of use. Effective therapy requires compliance, which is influenced by all of these. Pharmacokinetic variables, such as Half-life and Drug interactions, must be considered as well. Finally, drug cost has to be accounted for.

There are relatively few studies comparing AED efficacy. Among the 'older' drugs, the US Veteran's Administration Cooperative Study (Mattson et al NEJM 1985), showed that phenytoin (PHT) and carbamazepine (CBZ) had comparable effectiveness, as measured by a combination of seizure control and toxicity, while phenobarbital was slightly, and primidone definitely, less effective. In contrast several other studies performed in the developing world comparing these drugs showed no difference between CBZ and PB in children or adults (Placencia et al Epilepsy Research 1993), PB and PHT (Pal et al Lancet 1998; Mani et al Lancet 2001). A trial comparing CBZ and VPA (Mattson et al NEJM 1992 show a slight superiority for the former for both complex partial and generalized tonic-clonic seizures, but the differences were small.

Comparisons of 'new' and 'old' drugs showed in general that comparably effective doses for seizure control lead to comparable toxicity (Brodie et al 1995; Chadwick et al 1998). However, long-term studies have shown a disappointing tendency of patients to abandon new AEDs: only 30% of patients continued on topiramate or lamotrigine (LTG), and 10% on gabapentin after three years, due to toxicity or lack of efficacy (Lhattoo et al Epilepsia 2000).

Side effects of AEDs include (usually dose-related) neurologic toxicity, such as lethargy, impaired thinking, sleepiness, depression, diplopia, dystaxia,

or peripheral neuropathy. Systemic side effects, potentially more dangerous, are often related to hypersensitivity reactions, and include hematologic, hepatic, ophthalmologic, and endocrine complications. The most severe of these, such as aplastic anemia, can occur without warning, and may not respond to stopping the drug. They can lead to prolonged illness, require complex medical interventions, and can be fatal.

Limited data suggest that some but not all of the newer AEDs may have slightly less cognitive toxicity than older drugs. Lamotrigine and possibly gabapentin may have 5-10% less cognitive toxicity than CBZ, VPA PHT at comparably effective doses (Meador et al 1991, 1995, 1999, 2001; Aldenkamp et al 2000). On the other hand topiramate may lead to greater cognitive impairment. Systemic and idiosyncratic side effects are harder to evaluate, as they usually do not appear among the limited number of patients enrolled in clinical trials. Older AEDs have had more time for side effects to be discovered and described. Several dramatic side effects of new AEDs have appeared recently, such as rash due to LTG, felbamate-induced aplastic anemia, vigabatrin-related visual field constriction, and topiramate-induced glaucoma.

Pharmacokinetic considerations can also affect the choice of AEDs. Phenytoin, for example, shows interpatient metabolism differences between slow and rapid metabolizers. It has rate-limited metabolism, which is close to saturation at therapeutic dose. Thus, blood level monitoring is more important than with other drugs. The short half-life of CBZ and VPA make multiple daily dosing imperative.

AED formulations may vary, and manufacturing problems may create differences among batches of the drug even in different lots of branded drugs from the same factory. This is particularly true of drugs that are hard to make, like phenytoin. Dissolution and absorption can vary, leading to changes in peak concentration, and Area under the concentration time curve.

Overall, the 'old' AEDs are still used much more than the 'new' ones in developed as well as developing countries. The choice of AEDs may vary from region to region, depending on traditions of medical practice; phenytoin is the most commonly prescribed drug in the US, but is used much less extensively in Europe. CBZ and PB, for example, are the most common drugs

in Denmark. This may in part be related to cost; the new drugs are much more expensive. In the US, for example, the monthly cost of LTG is approximately \$120, PHT \$6, and PB \$2.

In addition to its low cost, what are the advantages of PB for epilepsy treatment? It can be given once daily. It has simple, well-understood kinetics, and there is little evidence for interpatient variability. Thus, blood level monitoring plays a small role in clinical practice. There are few serious systemic side effects, and they are well known. All of these factors will increase compliance, which is the sine qua non of an effective epilepsy treatment.

The disadvantages of PB include a slightly increased incidence of cognitive side effects than some other AEDs. Hyperactivity can be a problem in children. These side effects usually respond to a decrease in the dose. PB is a hepatic enzyme inducer, which can lead to drug interactions if a patient is taking other medications (such as treatment for cysticercosis), as their metabolism may be increased, and effectiveness reduced. PB, like other barbiturates, benzodiazepines, and drugs such as carbamazepine, can cause a transient increase in seizures if the drug is stopped abruptly.

No AED has a perfect combination of high efficacy, low toxicity and cost, and a good pharmacologic profile. In fact, each of the drugs has advantages and disadvantages that make it the best choice for particular situations and patients. For large-scale programs in developing countries, where medical monitoring and backup treatment facilities are limited, it is unwise on therapeutic grounds to use new AEDs. Knowledge of their toxicity is incomplete. Among the older drugs, PB appears to have the best combination of advantages, and the fewest disadvantages.

Annex 6

REVISED DRAFT OF THE SCREENING INSTRUMENT FOR MAJOR FITS

Site Study No.: _____

Survey For Major Fits: Community Questionnaire

Section – A. Family demographic details

Head of Family:

Caste:

Address:

Respondent:

Family enumeration:

| No. | Name | Age | Sex | Yes, more than once, to questions below | | |
|-----|------|-----|-----|---|-----|-----|
| | | | | Q.1 | Q.2 | Q.3 |
| 1. | | | | | | |
| 2. | | | | | | |
| 3. | | | | | | |
| 4. | | | | | | |
| 5. | | | | | | |
| 6. | | | | | | |

Screening questions to be administered to responsible respondent:

| No. | Questions | Yes, once/ No Do not Know | Yes, more than once |
|-----|--|------------------------------|------------------------------|
| 1. | Has any one of your current family members, listed above, ever in their life suffered from an episode in which they were disoriented/unaware of surroundings/partially unconscious? | | |
| 2. | Has any one of your current family members, listed above, ever in their life suffered from an episode of complete loss of consciousness? | | |
| 3. | Has any one of your current family members, listed above, ever in their life suffered from an episode in which the body became stiff/had thrashing movements of the limbs/had jerky movements of the whole body? | | |

If the answer to the above questions is, "do not know", then use another responsible respondent in the family, to a maximum of three respondents. If none available, or three respondent reply "do not know", exclude the family. (Make a note that the family has been excluded and why).

If the answer to any of the questions is yes, ask:

Has such an episode occurred more than once / at least twice in their life? Yes / No.

If yes, i.e. two or more episodes of any of the three questions in any family member, note this information in the second column above and proceed to Section B.

If the answer to all the three questions is No, terminate the interview with Thanks.

Signature of Interviewer

Site Study No.: _____

Date:

Central Study No.: _____

Section B– The question MUST be administered to somebody in the family who has witnessed an attack.

Relationship of respondent to patient: _____

Information about episodes:

| No | Questions | Yes/No/ Don't Know* |
|------|---|---------------------------|
| 1 | Events before the episode | |
| 1.1 | Were the attacks preceded by stressful events such as, quarrels, conflict with mother-in-law, or other stressful events? | |
| 1.2 | Were there any warning symptoms before the attack, such as, strange feelings, by which the person would become aware that the attack is going to occur? | |
| 2 | <i>Events during the episode</i> | |
| 2.1. | Did he/she have vomiting during or after any episode? | |
| 2.2 | Did he/she pass urine or stool in his/her clothes during that episode? | |
| 2.3. | Did he/she ever injure him/herself (including tongue bite) during such an episode? | |
| 2.4. | Were the eyes shut tightly during any episode? (imitate tightly shut eyes) | |
| 2.5. | Were the eyes rolled up or turned to one side during any episode? | |
| 2.6. | Did the pattern of movement remain exactly the same in all episodes? | |
| 2.7. | Could the person respond to your commands during the episodes? | |
| 2.8. | Was there any frothing from the mouth during any episode? | |
| 3. | <i>Events after the episode</i> | |
| 3.1 | Did he/she remember any thing about the events later? | |
| 3.2. | Did he/she have weakness, drowsiness/headache after such an attack? | |

| No | Questions | Yes/No/ Don't Know* |
|------|---|---------------------------|
| 4 | <i>Other details of the attack</i> | |
| 4.1 | Did he/she ever have such an attack during sleep? | |
| 4.2. | Did any episode ever occur outside the home? | |

- If too many (50% or more) “do not know”, change the respondent to a maximum of three, till you get a person who knows better.
- Many of this would have happened in one episode but not in others. It will be taken as yes, if it is so even in one episode.

Annex 7

INTERCOUNTRY CONSULTATION ON DEVELOPMENT OF STRATEGIES FOR COMMUNITY-BASED NEUROPSYCHIATRIC SERVICES, BANGKOK, 19-22 NOVEMBER 2001

RESOLUTION

We, the participants of the SEAR Intercountry Consultation Group on Development of Strategy for Community-Based Neuropsychiatric Services agree that the disorders to be the focus of Phase I of the programme are Epilepsy and Psychosis, being of high prevalence and high morbidity in the Region.

Dr Nazmul Ahsaan; Dr Md. Rezaul Karim (Bangladesh); Dr Purushottam Bhandari (Bhutan); Dr Pak Chun Taek; Dr Ri Yong Un; Dr Pak Song Il (DPR Korea); Dr Suresh Kapoor; Dr K Anand Dr Satish Jain; Dr Bela Shah; Dr Mohan Isaac; Dr Nimesh Desai; (India) Dr Rusdi Maslim; Dr Idris Yusmansyah (Indonesia); Dr Nyan Tun; Dr Win Aung Myint (Myanmar) Dr Niarakar Man Shrestha; Dr Surendra Sherchan (Nepal); Dr (Mrs) Ranjani Gamage; Dr WL Wickramasinghe; Mr Herath (Sri Lanka) Dr Bhakhaporn Pirommai; Dr Boonchai Nawamongkolwatana, Dr Prawate Tantipiwatnaskul, Dr Suparat Ekasawin Mrs Seekeow Disariyakul Dr Ketchai Suavansri (Thailand)

* * *

Dr William Theodore, Chief Clinical Epilepsy Branch National Institute of Neurological Disorders and Stroke, NIH, Bethesda Maryland, USA

Professor Martin Rossor, Department of Neurology National Hospital for Mental Diseases Queens Square London, UK

Dr Dinesh Bhugra, Reader in Cultural Psychiatry Health Services Research Department Institute of Psychiatry De Crespigny Park London, SE5 8AF UK

Annex 8

INTERCOUNTRY CONSULTATION ON DEVELOPMENT OF STRATEGIES FOR COMMUNITY-BASED NEUROPSYCHIATRIC SERVICES, BANGKOK, 19-22 NOVEMBER 2001

RESOLUTION

We, the participants of the SEAR Intercountry Consultation Group on Development of Strategy for Community-Based Neuropsychiatric Services strongly support the global campaign against epilepsy.

Dr Nazmul Ahsaan; Dr Md. Rezaul Karim (Bangladesh); Dr Purushottam Bhandari (Bhutan); Dr Pak Chun Taek; Dr Ri Yong Un; Dr Pak Song Il (DPR Korea); Dr Suresh Kapoor; Dr K Anand Dr Satish Jain; Dr Bela Shah; Dr Mohan Isaac; Dr Nimesh Desai; (India) Dr Rusdi Maslim; Dr Idris Yusmansyah (Indonesia); Dr Nyan Tun; Dr Win Aung Myint (Myanmar) Dr Niarakar Man Shrestha; Dr Surendra Sherchan (Nepal); Dr (Mrs) Ranjani Gamage; Dr WL Wickramasinghe; Mr Herath (Sri Lanka) Dr Bhakhaporn Pirommai; Dr Boonchai Nawamongkolwatana, Dr Prawate Tantipiwatnaskul, Dr Suparat Ekasawin Mrs Seekeow Disariyakul Dr Ketchai Suavansri (Thailand)

* * *

Dr William Theodore, Chief Clinical Epilepsy Branch National Institute of Neurological Disorders and Stroke, NIH, Bethesda Maryland, USA

Professor Martin Rossor, Department of Neurology National Hospital for Mental Diseases Queens Square London, UK

Dr Dinesh Bhugra, Reader in Cultural Psychiatry Health Services Research Department Institute of Psychiatry De Crespigny Park London, SE5 8AF UK