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# Developing Community Mental Health Services

*Report of the Regional Workshop  
Bangkok, Thailand, 11-14 December 2006*



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Organization**

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## 1. Introduction

The World Health Report 2001 clearly pointed out that mental and neurological conditions cause a significant amount of morbidity all over the world. It is estimated that about 450 million people are affected by mental, neurological and substance-abuse disorders. A large proportion of these people live in developing countries, including the WHO South-East Asia Region. It is estimated that the burden of disease from neuropsychiatric conditions measured by DALY's will increase from 9% of the total disease burden in 1990 to 14% in 2020.

It is also known that a substantial proportion of people with neuropsychiatric conditions, particularly in developing countries, do not get appropriate treatment. This is referred to as the mental-health gap or treatment gap for mental health. It is very unfortunate that the treatment gap in developing countries can be as high as 80-90%.

Traditionally, neurological and psychiatric services have been concentrated in tertiary-care hospitals. Thus, large segments of the population, particularly those who live in rural and remote areas, have been deprived of such services. This is despite the fact that both neurological and psychiatric conditions are common in these communities.

To meet the mental health needs of the community, The Mental Health and Substance Abuse Unit (MHS) of the WHO Regional Office for South-East Asia (WHO/SEARO) has concentrated on a two-pronged strategy: one is to promote mental well-being taking a positive approach to mental health promotion and prevention of mental illnesses; and the other is to assist Member States in developing community mental health services which reach out to the community.

The MHS Unit is making efforts to develop programmes capable of delivering at least the basic minimum level of services for neuropsychiatric conditions to everyone, everywhere. Ideally, such services should be delivered within the community rather than expecting people to travel long distances to tertiary-care hospitals. For this purpose, primary health care system should be utilized. Those delivering health care in the community

should be trained to identify and manage these conditions. In addition, affordable and appropriate medications should be made available in the community. Finally, the programmes should address psychosocial issues such as stigma and rehabilitation.

Broadly speaking, community mental health care programmes imply that ALL mental health and well-being needs of the community are met in the community, using community resources and the primary health care system. It goes MUCH BEYOND ONLY TREATMENT and includes:

- Promotion of well-being and mental health promotion
- Stigma removal
- Psychosocial support (such as the monks programme in Thailand, the Imam programme in Bangladesh, meditation, spirituality, etc.)
- Rehabilitation of those in need (such as intellectually impaired, recovering substance abusers, chronically-ill patients, management of learning and behavioural problems in children through parents and teachers)
- Prevention of harm from alcohol and substance use
- Treatment of the ill using the primary health care system (focusing specifically on the most common and disabling illnesses in the community).

Although it may not be possible to implement all these components in every community, whichever component is relevant and accepted by the community should be implemented using community resources. The MHS Unit is developing and has already developed culturally appropriate technical material for most of these components. These have been developed and tested in Member States in the WHO South-East Asia Region (WHO/SEAR).

The present workshop was one in a series of activities which started in Bangkok in November 2001 in which all Member States participated. The experts recommended that Member States be assisted in the development of strategies to identify and manage common mental health problems in the community. As a follow-up of this workshop, a series of consultations have been held (Yangon in August 2002, Bangkok in August 2003, and an

Intercountry workshop on developing country-specific strategies for reduction of treatment gap in November 2004 in New Delhi, India). Based on the recommendations of these workshops, WHO/SEARO, with the help of experts in Member States, has made substantial progress on models and strategies to close the treatment gap for common mental health conditions.

These programmes have been successfully tested in Maldives, Myanmar, DPR Korea and some states of India. These models now need to be adapted where they have not been tested and integrated into the primary health care system in order to ensure sustainability in the long term.

The workshop was jointly organized by WHO/SEARO and the Department of Mental Health, Ministry of Public Health, Government of Thailand. Delegates from Bhutan, Bangladesh, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste participated. The WHO Secretariat consisted of technical staff from its headquarters and the Regional Office. The programme of the meeting and the list of participants are given at Annexes 1 and 2.

## **2. Objectives of the workshop**

### **2.1 General objective**

The overall objective of the workshop was to discuss with Member States the development of community-based mental health services by enhancing the capability of the existing primary health care system.

### **2.2 Specific objectives**

- (1) To review the existing status of community mental health services in Member States;
- (2) To review the global and regional concepts and models of community mental health services;
- (3) To develop a framework for culturally appropriate community mental health services in resource-scarce settings.

### 3. Summary of proceedings

The workshop was inaugurated by Dr Prat Boonyawongvirot, Permanent Secretary, Ministry of Public Health, Thailand. The message from the WHO Regional Director was read out by Dr P. T. Jayawickramarajah, WHO Representative to Thailand. (Full text of the Regional Director's address is placed at Annex 3). Professor Doctor Prasop Ratanakorn delivered the keynote address in which he traced the history of the mental health programme in Thailand. He also released the WHO/SEARO advocacy material on stigma removal and prevention of harm from alcohol.

Dr Apichai Mongkol, Deputy Director-General, Department of Mental Health, Thailand, was elected as the Chairperson, Dr Kapil Dev Upadhyay, Nepal, as Co-chairperson, and Dr Smita Deshpande, India, as the Rapporteur of the Workshop.

Dr Vijay Chandra, Regional Adviser, Mental Health, WHO/SEARO, made two presentations, one on the concept of community mental health, and, two, operationalizing this concept for application in the community.

He pointed out that the current situation of community-based mental health care in Member States needed to be urgently reviewed. There were many commonalities in the issues involved:

- Limited trained manpower
- Uneven distribution of existing manpower
- Low priority with corresponding low budget for mental health
- General medical practitioners (GPs) not comfortable with managing persons with mental illness
- Lack of awareness about the medical nature of mental illness in the community
- Poor access to care (travel time, convenient availability of services)
- Poverty
- Poor availability of medications
- People preferring to go to faith healers, religious healers or traditional healers.

Dr Chandra mentioned that what is needed to go forward is a clear definition of what is community mental health (CMH). CMH must aim to reach every individual who needs mental health care. More than treatment, it needs to include promotion of well-being and mental health as well, removal of stigma, psychosocial support and rehabilitation for those in need, prevention of harm from alcohol and substance use, and treatment of those who are sick, using the primary health care system as near to the user community as possible.

As new and innovative programmes are developed, these should be systematically evaluated by assessing the impact of these programmes in meeting the mental health needs of the community, i.e. impact indicators need to be developed. Examples of such indicators include:

- Reduction of treatment gap
- Reduction of stigma
- Patient satisfaction with treatment
- Reduction of harmful use of alcohol
- Reduction of violence in schools.

Unfortunately, impact indicators are not commonly used in mental health. These must be used in all future activities so as to take timely corrective actions to achieve the objectives of the programme.

Dr B. Saraceno, Director, Department of Mental Health and Substance Abuse, WHO/HQ, said that while “treatment gap” (the difference between service availability and number of people who need these services) is present in both developing and developed countries, the gap in developing countries is significantly larger. The number of serious cases receiving no treatment during the last 12 months in developed countries varies from 35.5% to 50.3%. In developing countries this gap extends from 76.3% to 85.4%. All countries in the South-East Asia Region fall in the latter category.

He described the presence of negative trends such as absent or insufficient resources, non-adherence to the human rights of the mentally ill, predominance of acute and mid-term medical care with disregard to long-term and psychosocial needs, and increasing influence of industry, which also darken the picture. People often prefer to approach faith healers for primary treatment due to wrong notions and health practices. But on the brighter side, the negative trends have been countered by positive

trends such as evidence-based improvement in both biological as well as social models of care, increasing consumer awareness in the form of user and family groups, and movement towards community-based services.

Dr Saraceno summarized the current urgent priorities globally for mental health:

- To enhance the status of mental health within public health;
- Increase resources allocated to mental health;
- To use allocated resources to strengthen community based rather than hospital- based services;
- To protect human rights of the mentally ill more effectively.

For these changes to occur, paradigms must shift from exclusion to inclusion. Henceforth, the biopsychosocial approach (social dimension as key component of treatment) should predominate rather than the biomedical, thus taking psychiatric care from a hospital bed to family setting, from hospital to community, from short-term to long-term care i.e. rehabilitation, from individual work to team work, thus finally bridging the span from treatment to service.

### **3.1 Country presentations: Are existing mental health services reaching out to the community?**

A common point in all country presentations was the inadequacy of mental health personnel and mental health care in the Region.

#### ***Bangladesh***

The National Institute of Mental Health in Dhaka has recently conducted a national survey on mental disorders in the community. This has shown that 16.1% of the adult population was suffering from mental disorders. Information from this survey will be used for national-level planning.

Recently, training programmes in basic mental health care have been conducted for civil surgeons (25), primary health care physicians (2871), health workers at *upazilla* level (5300) and *Imams* (172). Through these programmes it is hoped that mental health care will become available at the grass-root level. Steps have been taken to develop four model upazillas for community awareness in mental health around Dhaka city.

### ***Bhutan***

Tertiary care psychiatric services are provided at the Jigme Dorji Wangchuck National Referral (JDWNR) Hospital where there is a specialized OPD and an eight-bedded ward.

Recently, medical officers and staff nurses have been trained in mental health care. There has also been emphasis on training health workers in mental health. Topics on mental health have been included in the Standard Treatment Manual for health workers. The teaching curriculum of trainees of the Royal Institute of Health Sciences (RIHS) in the subjects of psychosociology and mental disorder has been revised. A two-week clinical attachment course for the trainees of the Royal Institute of Health Sciences with the Psychiatry Department of the JDWNRH has been established. RIHS has collaborated with the education sector for student counselling services including parent awareness and education programme. They have also developed linkages with the welfare and law enforcement sectors working with problems of drug dependence and juvenile delinquency.

Recording and reporting of mental disorders have been revised in the general health information system. This will provide valuable data for future planning.

### ***India***

There were five presentations from India on various aspects of mental health. The most important aspects of mental health care in India are:

- Large talent pool, but uneven distribution;
- Rapidly emerging private sector which provides upto 80% services;
- Vast unorganized sector providing mental health care;
- People seeking unconventional treatment.

**Role of Central and State Mental Health Authority:** The detailed working of these agencies are described on the Government of India web site. In summary, these agencies do the following:

- Provide a network in mental health for the whole country.
- Coordinate, monitor and supervise mental health programmes and other activities.

- Collect data about implementation of mental health services from all states on a regular basis.
- Determine the priorities at the centre/state level.
- Promote intersectoral collaboration and linkages with other national programmes.

**Re-strategized National Mental Health Programme:** This programme, which has been implemented in India for many years, has been gradually scaled up. Community-based activities are implemented through the District Mental Health Programme. It now covers 94 districts in 29 states/Union Territories. The main objective is to provide basic mental health services to the community and integrate these with other health services.

**Mental Health Services of Central Institute of Psychiatry (CIP), Kanke, Ranchi, India:** The wide variety of clinical services provided by CIP were described.

**Mental health care project, Gujarat:** The Mission Report 2003 of this project suggests ways to achieve the extremely complex and challenging needs of the mental health sector in an integrated manner with active involvement of the community, integration with existing activities, capacity strengthening and developing linkages with various stakeholders.

**Yoga and psychiatry – well-being or treatment option?** Yoga has been practised in many Member States for centuries. Yoga helps people to maintain tranquility of mind, keep mentally and physically fit, observe ethical and moral values and grow spiritually. A research project has been initiated which will evaluate the beneficial effects of yoga among ill individuals and their caregivers, and the factors which may be associated with such response.

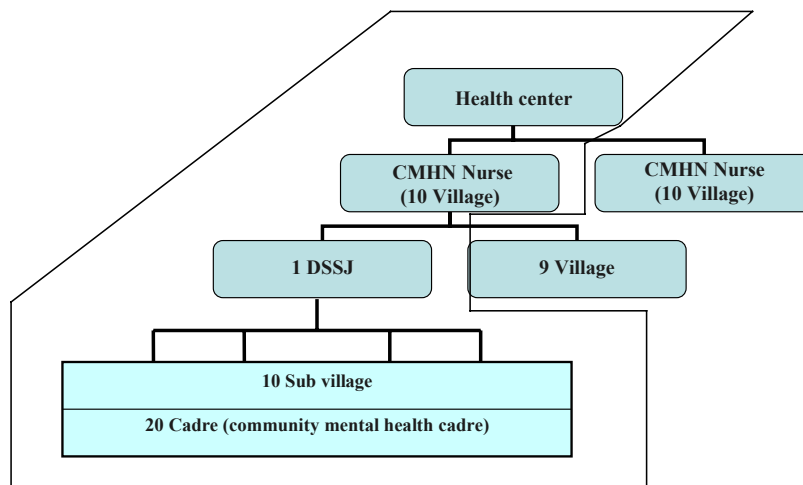
### **Indonesia**

The Community Mental Health Service consists of trained general practitioners who are based at the health centre. They are trained in early detection and treatment of mental disorders, supervision of paraclinical staff, and in monitoring/evaluation of programmes. Community Mental Health Nurses are based at the health centre but they also provide outreach services to the community. They can be trained either by a basic or intermediate course. An advanced course is being developed. This is a new

approach called the Professional Nursing Practice Model, which is a management approach focused on patient care delivery based on family care.

A figure of their concept of “mentally healthy village” is presented below:

***Mentally Healthy Village (Desa Siaga Sehat Jiwa)***



***Maldives***

The population of Maldives is spread over numerous islands which are very far apart, thus making travel between islands difficult and expensive. Specialized mental health care is available only in the Capital, Male.

Each island has a medical centre which is staffed by an expatriate doctor. WHO has developed a video-based teaching module for mental health which can be used as a learning tool even in outlying islands by the doctors.

There are six NGOs actively involved in mental health-related work, including rehabilitation of children with learning disabilities, awareness programmes for parents with mentally and physically disabled children, outreach programmes for substance abusers, teaching life-skills to students, conducting programmes for the well-being of the elderly, provision of psychosocial support, and resilience building around social issues.

Maldives has developed a national mental health policy which will soon be finalized and submitted to the government.

### **Myanmar**

Myanmar has an excellent public health care delivery system which reaches out to the community. Local experts have conducted a community-based programme to close the treatment gap for epilepsy and psychosis. They have shown that with adequate training of existing health staff, the treatment gap can be reduced to zero. They have also shown that the main limitation is affordability of medication.

The government-sponsored primary health care system aims to achieve better mental health care for the community by providing at least 80% of basic health staff with training to enable them to diagnose, administer necessary treatment and proper referral, by the year 2007. They will also attempt to map the prevalence of psychosis, epilepsy and mental retardation in the community.

The specific activities planned include:

- Train the trainers (Township Medical Officers)
- Train Basic Health staff
- Conduct multiplier courses
- Encourage community participation
- Link with and cooperate with other sectors
- Deploy NGO help and participation (Red Cross Association and Fire Brigade also participate in community mental health activities at present).

### **Nepal**

Community mental health is being promoted through the following activities:

- There are mobile clinics in several districts outside Kathmandu.
- Training manuals for doctors, nurses and paramedics and for lower level of health workers have been prepared and used. Doctors (2 groups of 10 each) and one group of nurses have

been trained. Training of health workers to diagnose Generalized Tonic Clonic Seizures (GTCS) as per WHO guidelines have been carried out in 2 districts. A follow-up assessment will be carried out in 6 months.

- Awareness-raising activities through radio and television. Booklets for patients, guardians and for common people on depression, epilepsy and schizophrenia are being prepared.
- A draft of mental health legislation has been prepared and should be finalized soon.
- Maryknoll Nepal and Asha Deep are the NGOs dealing with the rehabilitation of chronically-ill patients with mental illness. They have a 40-bedded facility and a day-care centre.

### ***Sri Lanka***

Immediately after the tsunami, there was much greater awareness and emphasis on the mental health and psychosocial needs of the community. There was support from the highest level of the government.

The government of Sri Lanka has developed a new National Mental Health Policy. This was formally approved in October 2005. It includes a time-bound plan for extending mental health services all over the country within 10 years which is based on the following principles:

- Psychiatric hospital should not be the mainstay of mental health services
- Alternatives to institutional care must be developed at the local community level
- Prioritize the needs of severely mentally ill
- Develop an integrated system of care.

The implementation will be through:

- Medical Officers Mental Health (MOMH) and nurses
- A new cadre of staff grade doctor/diploma holders to be appointed in districts with no psychiatrists

- Develop new wards and services in various parts of the country
- Review the role of community level workers and if possible create a new cadre for them
- Develop a new cadre of psychiatric nurse
- Return of long-stay patients to their district of origin with the needed social support
- A new national referral centre to be established at the National Institute of Mental Health
- All MOMHs to be supported by nurses, psychosocial trainers, community mental health education officers and full multidisciplinary teams in all districts
- Establishing a community support centre in every district consisting of outpatients, day care, family education and community outreach.

Despite the availability of qualified mental health care, some people still seek help from traditional or religious healers or practitioners of indigenous systems of medicine such as Ayurveda. There are some special groups needing mental health care such as immigrant workers, especially women working abroad: while they go abroad due to economical reasons, some of the husbands become alcoholic and their children suffer from attachment or emotional problems. A significant problem in Sri Lanka is the migration of qualified talented mental health professionals to Western countries.

### ***Thailand***

The Department of Mental Health, Ministry of Public Health, Thailand, has been implementing the community mental health programme since 1982. The community network has established linkages among concerned organizations. At present, the linkage with local authorities is being expanded as they have realized the importance of mental health of local communities. A significant plus point in Thailand is the strong religious beliefs of the community.

The Department of Mental Health defines community mental health as follows:

**Community mental health**

- Community mental health are these services
  - Mental health promotion
  - Prevention of mental health problems
  - Treatment for psychiatric patients
  - Rehabilitation of psychiatric patients in the community

Department of Mental Health, Ministry of Public Health, Thailand

*Innovative programmes*

There are many examples of innovative programmes introduced in community mental health:

- Monks programme: In this programme, monks have taken the leadership of the mental health programme. They have been trained to recognize and refer mentally-ill patients for professional care. This programme is so successful that in this community, the treatment gap is zero
- The Village Health Volunteer programme which reaches out to every village
- Mobile mental health teams
- Prevention of harm from alcohol: One community realized the harm from alcohol; for example, during funerals, people got drunk. They decided that in future no alcohol would be served during funerals. This was accepted by everyone, and this menace was reduced.

*Mental Health Indicators*

The Thai Department of Mental Health evolved indicators of mental health comprising of various domains.

Domain 1 (Mental state)

- General well-being positive effect
- General well-being negative effect
- Perceived ill-health and mental illness

Domain 2 (Mental capacity)

- Interpersonal relationship
- Expectation achievement congruence
- Confidence in coping
- Inadequate mental mastery

Domain 3 (Mental quality)

- Kindness and altruism
- Self-esteem
- Faith
- Creative thinking and enthusiasm

Domain 4 (Supporting factors)

- Social support
- Family support
- Physical safety and security
- Health and social care

*Strategies for mental health promotion*

Strategies for mental health promotion include:

- (1) Developing network with
  - Public health service system
  - Education system
  - Religious institutions
  - Media institutions
  - Village Health Volunteers (VHV)
- (2) Developing appropriate technology
- (3) Activities to strengthen mental health networks
- (4) Develop additional mental health services
- (5) Establish mobile mental crises teams
- (6) Telephone counselling
- (7) Stress-reduction clinic

*Knowledge and development of appropriate technology*

- Tools for evaluation: stress and suicide
- Tool and developmental programme for EQ, CQ
- Develop MQ, AQ and mental skills
- Mental Health Indicators for community and family
- Guidelines for psychosocial care for special high-risk groups
- Develop technology and guidelines for:
  - mental health of the family
  - mental health of the community
  - Increased capability of youth in the community to stay away from drugs
  - Increased mental immunity of children on the lines of medical immunity.

*Treatment and rehabilitation techniques*

- Community mental health project run by Village Health Volunteers
- Mental health projects in schools
- Mental health in the workplace
- To be Number One Project aiming at the high-risk group for drug use
- Case-finding by health personnel at health station and in the community by VHV
- Training of GPs
- Skill training to patients to stay in the community and to family members for home care of the patient
- Home visits by mental health staff.

### **3.2 Are Western models appropriate for developing countries?**

The participants discussed the appropriateness of Western models of mental health care to the Member States of the Region. There was general agreement that there is no one perfect model for community mental health and that mental health care is closely linked to the culture of the community. The following points were specifically noted:

- The existence of close family ties and extended family structure (which is undergoing change but remains the main caregiver in times of need).
- The joint decision-making by the family sometimes involving the entire community in health care-seeking behaviour (e.g. in taking a person to a faith healer rather than a doctor). This contrasts with Western models in which patients have the right to decide.
- Western models of care are heavily dependent on mental health experts, but these are scarce in the Region. So, PHC will have to be used.
- Cost is a major consideration for most people, as they have to pay the expenses from their own earnings or savings. In Western countries insurance usually covers the expenses.
- Even if Western-type services are made available to the community in the Region, these may not be acceptable to them because of their lack of awareness of the medical nature of mental illness. Thus, a lot of advocacy and education of the community is required.
- Communities generally have faith in traditional methods of care and treatment, and will usually go to these care-providers first.
- Availability and accessibility of mental health care remains a significant problem, particularly in rural and remote areas. These are not a major problem in Western countries.

In summary, the participants concluded that Western models should be closely studied, adapted to suit the local culture, and tested for their appropriateness prior to their application in the Member States of the Region.

### **3.3 Field visit to community mental health programme at Bangkhun Gong sub-district, Bang-Kruay district, Nonthaburi**

The delegates were taken for a field visit to a primary health care centre where they were able to interact closely with community leaders, health staff, village health volunteers, NGOs, teachers, older people, a family with a mentally ill patient and the local monk.

Notable observations of the delegates were:

- A strong sense of ownership of the mental health programme by the community. The village leaders felt that mental health was as important as physical health.
- The PHC health staff seemed to have been very well trained by the Department of Mental Health, as they were comfortable and confident of dealing with issues related to mental health.
- There was a great sense of caring and sharing among the community; for example, there is a senior citizens group. They help each other and if anyone is ill, they all go and pay a visit to the person.
- The village health volunteers consider it a matter of pride to donate their time to community welfare. One volunteer was a second-generation Village Health Volunteer.
- Teachers are very aware of the mental health needs of young children and growing teenagers. They have been trained to address these needs.
- The family remains the main caregiver for persons who have mental illness. They continue to be loved and kept at home with all their needs met. The family greatly appreciated the help of the health staff and the Department of Mental Health.
- The village temple remains a centre of activity for the village. The monk is greatly respected and his help and advice is actively sought.

In summary, the delegates noted the warm community and family relationships and support. When needed the health staff was easily available to help them.

### **3.4 Presentations from groups on developing community mental health services: new ideas**

Countries were divided into groups during which they prepared a draft of a proposed project on community mental health which they wished to implement in the next 12 months. Each programme must have impact indicators built into the planning process.

## **Bangladesh**

### **(1) Community-based intervention to reduce re-admission rates in patients discharged from Mental Hospital, Pabna, Bangladesh.**

The Pabna Mental Hospital has a large catchment area of surrounding districts. The re-admission rates are high; and sometimes patients are not taken home by relatives for fear of not being re-admitted when necessary. PHC-level workers in and around Pabna have been trained in the detection of mental health problems, but no repeat or booster training has occurred. The proposal suggested the following:

#### *Methods*

- (1) Identify all admissions from a defined area surrounding the hospital from the hospital register.
- (2) Develop a patient discharge and information sheet for handing over to the PHC worker.
- (3) At discharge of a patient from the designated area, contact the PHC worker of that area trained in mental health.
- (4) The trained PHC worker will follow up the patient, ensure treatment compliance and even take the patient once a month to the nearby medical college hospital for follow-up.
- (5) This PHC worker, thus becoming more aware of mental health problems in his area, might also detect, take for treatment and ensure follow-up of other new patients in his area.
- (6) The PHC worker will also keep in touch with families and educate them about illness issues.
- (7) These strategies will reduce the treatment gap as well as reduce readmission rates.

#### *Impact indicators*

- Functional ability of the patient
- Treatment compliance
- Treatment efficacy (by occupation and rehabilitation indicators)
- Readmission rates from the identified area after one year.

**(2) Enhancement of adolescent mental health through life-skills training**

*Objectives*

- (1) To reduce drug abuse in adolescents
- (2) To reduce antisocial and other undesirable behaviours
- (3) To enhance mental well-being

*Methods*

- (1) Approach schools in the catchment area for inclusion in the programme.
- (2) Assess level of targeted behaviour at baseline.
- (3) Use WHO life-skills training manual to deliver life-skills education either directly to adolescents or through teachers and counsellors.
- (4) Identified areas for training would include sexuality, self-esteem, life skills, social skills, peer counselling, and drug/alcohol abuse.
- (5) Lectures or interactive sessions would be held for one hour every week for three months.
- (6) Offer and ensure treatment programmes for those who need them.
- (7) Assess programme at the end of one year.

*Impact indicators*

- Enhanced educational performance
- Enhanced sports performance
- Improved school attendance
- Enhanced well-being behaviours
- Reduced bullying, fighting, etc.

***Bhutan***

Bhutan felt that before proceeding with developing another project, they should evaluate the impact of all the mental health activities conducted in the last five years. Also a prevalence survey of mental disorders in Paro district had been conducted in 2002. It would be desirable to study the

outcome of these patients since identification in order to determine compliance with the treatment and the outcome.

*Impact indicators*

- Outcome of training programmes
- Remission of symptoms in patients.

**India**

Encouraging positive mental health among women, children and adolescents in the community through culturally and socially acceptable yoga-based health practices:

A community with minimal health services and lower socioeconomic status will be identified. Initially, a random survey of a statistically-determined representative sample of households will be carried out to identify felt mental health problems and needs of the community. The medical needs identified will be dealt with by referrals to appropriate departments in a hospital. This will not only provide immediate medical help, but should also win the confidence of the community and increase cooperation.

Intervention will be through regular interactions, especially focusing on women and children of the community, that will be carried out weekly. In these interactions, issues such as psychoeducation for the purpose of improving health, reducing morbidity as well as encouraging positive mental health by means of Patanjali yoga practices will be taught. Throughout, the focus will be on women, children and adolescents as opinion-makers and future citizens.

*Impact indicators*

The success of the programme will be evaluated by six-monthly KAP surveys to assess if knowledge changes attitudes and if it is translated into practice. The number of referrals for treatment to the hospital and informal interactions among community groups, etc., will also be recorded as measures of performance.

**Maldives**

A community-based mental health programme will be piloted in three islands. Different models of providing care will be tested.

### *Methods*

Existing/new nurses or community health workers with a diploma-level education will be trained in mental health. These personnel will function as Mental Health Coordinators (CMHCs) (duration of training: 2 weeks to 6 months). Back-up technical support will be provided by general duty doctors who will also be trained in mental health.

#### Main functions of CMHCs

- Work in the community (identification, treatment and referral)
- Visit islands and organize follow up of patients in the islands
- Distribute psychotropic medication, including anti-epileptic medication
- Implement long-term rehabilitation programmes, including occupational activities
- Promote income-generation activities, sheltered employment and social activities.

#### *GPs training*

A majority of the GPs, working specially in the islands, are expatriates, with a rapid turnover. Although they need training in mental health, the government cannot spend too much on training them and also they cannot be away from the islands for extended periods of training. Thus, they will be trained using a video/CD-based self-learning training material developed by WHO/SEARO.

#### *Support workers*

Support workers based on the islands will implement programmes under the supervision of the CMHC and GPs. Support workers will work with people with serious mental illness and will concentrate on the following activities:

- Prioritize those people with ongoing problems
- Provide regular and practical support
- Provide support with daily living, supporting them to live their lives
- Help people gain access to resources/allowances, etc.
- Support the family.

### *Impact indicators*

- Number of patients identified
- Number of patients identified and treated
- Number of patients identified and referred.

### **Nepal**

The focus will be on development of a comprehensive community mental health care delivery system. Four key priorities will be addressed:

- Developing and adopting new mental health legislation and policy
- Training one medical officer and one or two nurses in mental health. They will be deployed at 75 district hospitals
- Make psychotropic drugs available at the district level
- Training manuals to be made available for auxilliary health workers at village/sub-health posts

### *Impact indicators*

- Government to accept a new mental health policy and legislation with support of the Finance Ministry
- Training plans accepted for mental health personnel
- Training of health personnel commenced within 18 months with focus on underserved areas (far west of the country).
- Availability of international NGOs' donor funding for training including, auxilliary health worker training
- There are an estimated 21,000 fighters in 7 large and 21 smaller sub-camps whose rehabilitation needs to be addressed.

### **Sri Lanka**

Assessment of harmful use of alcohol in Kalutara district.

### *Methods*

A community-based survey will be conducted which will focus on the assessment of:

- Alcohol use
- Harm from alcohol use
- Suggestions for prevention of harm

The WHO/SEARO instrument for the assessment of harmful use of alcohol will be used. All adults  $\geq 18$  (estimated  $n=2500$ ) will be included. The study population will be a random sample from one division and one PHM area.

*Expected outcomes*

- Adaptation of the WHO instrument; identification of methodological obstacles
- Crude estimation of magnitude of use
- Estimation of harmful use
- Suggestions from the community for the reduction of harm from alcohol use (community ownership)
- Recommendations for additional programmes to address harm from alcohol use.

*Action points*

- WHO to provide instrument
- Director Mental Health Services (DMHS) approaches agencies for financial resources (UNFPA)
- DMHS to organize translation, pre-test (reliability, validity and acceptability)
- District psychiatrist to organize psychological workers (PSW) for data collection
- Data analysis provided by WHO

***Timor-Leste***

Training of general practitioners and general duty nurses of national hospitals in the identification of psychosis.

*Methods*

- Two-weeks' training for GPs
- Two-weeks' training for general nurses
- Use of WHO manual for identification of psychosis.

*Impact indicators*

Number of psychosis cases identified.

### **3.5 Launch of neurosciences section of disease control priorities in developing countries project**

The Disease Control Priorities Project (DCPP) is a joint project of WHO, the National Institutes of Health, USA, and the World Bank. It has been funded by the Bill and Melinda Gates Foundation.

The underlying principle of the project is: to provide the most cost-effective health care services in developing countries using select interventions for select conditions which should be systematically evaluated. Governments should be encouraged to prioritize conditions which are proven to be most cost-effective.

The findings of all chapters have been published in one document. The Department of Mental Health and Substance Abuse, WHO/HQ, has published the chapters dealing with neurosciences (including substance abuse) in a separate document. To create more awareness about this book, country launches have been planned. It had been launched in India, and was launched in Thailand during the workshop.

The launch was chaired by Dr Somchai Chakraband, Director-General, Department of Mental Health, Ministry of Public Health. Presentations were made by Drs Saraceno and Chandra, Regional Adviser, MHS, WHO/SEARO. There were also two country presentations (by India and Thailand) on current practices in setting priorities for disease control.

Dr Somchai officially released the book.

## **4. Conclusions**

The meeting came to the following conclusions:

- (1) Currently, mental health services are extremely limited in some Member States, particularly in rural and remote areas.
- (2) The treatment gap for mental illnesses is huge, leading to substantial preventable morbidity in the community. Given the availability of knowledge and appropriate medications, this needs urgent attention.

- (3) Even though there is a scarcity of mental health services in Member States, even existing mental health services are not being optimally utilized.
- (4) A substantial proportion of mental health care is provided by the private sector, mostly by the informal sector (faith healers, religious healers, traditional healers). This issue needs to be addressed by governments, professionals and civil society. A sensitive issue is: can this sector be constructively engaged as limited partners?
- (5) The existing mental health services in most Member States need to be improved. The quality of service is poor and there are numerous human rights violations.
- (6) Community mental health care is the optimum direction for future development of mental health services by Member States. This is based on the following observations:
  - (a) Evidence that community-based mental health care is superior to psychiatry hospital-based care.
  - (b) Great scarcity of qualified mental health professionals to meet all the needs of the community.
  - (c) Problems in transportation of patients from their homes to tertiary-care hospitals.
  - (d) Preference of people to seek health care locally in the community.
- (7) Community mental health service should be integrated into the existing primary health care delivery system to ensure its long-term sustainability.
- (8) The capacity of staff at the primary health care level should be enhanced through appropriate training. Care should be taken not to over-burden the PHC staff with too many details which are not essential at the primary care level. Different countries may use different models, e.g. dedicated mental health worker (Sri Lanka) or enhancing the capacity of general PHC staff (Indonesia).
- (9) Countries should consider whether the successful Thai model of Village Health Volunteers can be replicated, or paid workers are needed.

- (10) Mental health care is closely linked to the culture of the community, thus culturally-sensitive programmes should be developed, e.g. the deeply religious beliefs, strong family ties of the regional countries, etc.
- (11) Community mental health services should meet all the mental health needs of the community, including mental health promotion, prevention of mental illness, psychosocial needs of the community, needs of special groups (adolescents, elderly, refugees, etc.), prevention of harm from substance abuse, etc.
- (12) Community awareness programmes are urgently needed focusing on issues such as:
  - (a) Medical nature of mental illness
  - (b) Changing the health-seeking behaviour of the community
  - (c) Stigma removal
  - (d) Removal of myths and misconceptions
  - (e) Ensure community ownership of the programme
  - (f) Communities and families need to be prepared to care for persons with mental illness.
- (13) Traditional methods and practices (traditional healers, faith healers, religious healers) should be scientifically evaluated. If appropriate and effective, they should be promoted.
- (14) New programmes being developed should be evidence-based and periodically evaluated for their impact.

## **5. Recommendations**

- (1) WHO should provide technical support to Member States to develop/adapt community mental health programmes.
- (2) WHO should assist experts in Member States to advocate with governments on the concept of community mental health and its role as compared to tertiary-care psychiatry hospitals.
- (3) To meet the scarcity of PHC workers trained in mental health, appropriate training programmes are needed. Training

programmes for training of trainers in the Region should be set up with WHO assistance, and should involve other local experts.

- (4) An association of nurses interested in mental health should be formed in the Region. Initially, it will be established only by e-mail. It will help promote this under-served speciality in the Region.
- (5) A list of training centres in the Region be compiled and more centres could be considered as WHO Collaborating Centres.
- (6) The proceedings of the workshop should be widely disseminated, preferably in a special issue of an international journal. WHO/SEARO should negotiate with the editors for such an issue.
- (7) Each Member State should develop and pilot-test a model for community mental health in the next 12 months. These experiences can be discussed in a follow-up meeting to be hosted by the Department of Mental Health, Ministry of Public Health, Thailand.

## Annex 1

# Programme

### Monday, 11 December 2006

#### Inaugural Session

- 1700 – 1710 hrs Welcome address  
Dr Prat Boonyawongvirot, Permanent Secretary,  
Ministry of Public Health
- 1710 – 1720 hrs Welcome by  
Dr Somchai Chakrabhand, Director-General,  
Department of Mental Health
- 1720 – 1730 hrs Message from WHO Regional Director  
Dr P. T. Jayawickramarajah, WHO Representative to Thailand
- 1730 – 1750 hrs Concept of community mental health services -  
Dr Vijay Chandra, Regional Adviser, Mental Health, WHO/SEARO
- 1750 – 1820 hrs Mental Health – Global Action Programme (MHGAP)  
Dr Benedetto Saraceno, Director, Department of Mental Health and  
Substance Abuse, WHO/HQ
- 1820 – 1850 hrs Development of community mental health services in Thailand  
Dr Somchai Chakrabhand, Director-General, Department of Mental  
Health
- 1850 – 1920 hrs Keynote address  
Professor Doctor Prasop Ratanakorn
- 1920 – 1930 hrs Launch of SEAR advocacy material on stigma removal and  
prevention of harm from alcohol -  
Professor Doctor Prasop Ratanakorn

### Tuesday, 12 December 2006

- 0830 – 0900 hrs Registration
- 0900 – 0915 hrs Introduction of delegates  
Election of Chairperson, Co-Chairperson, Rapporteur

- 0915 – 0945 hrs Operationalizing the concept of community mental health services  
Dr Vijay Chandra, Regional Adviser, Mental Health, WHO/SEARO
- 0945 – 1030 hrs Discussion
- 1100 – 1300 hrs Country presentations: Are existing mental health services reaching out to the community?
- 1400 – 1430 hrs Country presentations: Are existing mental health services reaching out to the community? (Continued)
- 1430 – 1500 hrs Discussion

Programme for Launch of Neurosciences Section of Disease Control Priorities in Developing Countries Project

- 1500 – 1510 hrs Welcome by  
Dr Somchai Chakrabhand, Director-General,  
Department of Mental Health
- 1510 – 1530 hrs Disease Control Priorities Related to Mental, Neurological,  
Developmental and Substance Abuse Disorders: Global Perspective  
Dr Benedetto Saraceno, Director, Department of Mental Health and  
Substance Abuse, WHO/HQ
- 1530 – 1550 hrs Disease Control Priorities Project: Setting priorities  
Dr Vijay Chandra, Regional adviser, Mental Health, WHO/SEARO
- 1550 – 1610 hrs Setting priorities for disease control by the Department of Mental  
Health in Thailand  
Dr Benjamas Prukkanone, Psychiatrist, Galyarajanakarindra Institute
- 1610 – 1625 hrs Setting priorities for control of neurological disorders  
Dr Vijay Chandra, Lead Author, Chapter on Neurological Disorders
- 1625 – 1655 hrs Setting priorities for disease control in India –  
Rajesh Sagar, Secretary, Central Mental Health Authority, India
- 1655 – 1700 hrs Release of book:  
Dr Somchai Chakrabhand, Director-General,  
Department of Mental Health

**Wednesday, 13 December 2006**

- 0900 – 1030 hrs Country presentations: Are existing mental health services reaching out to the community? (Continued)
- 1100 – 1200 hrs Country presentations: Are existing mental health services reaching out to the community? 30 minutes each country: (Continued)
- 1200 – 1300 hrs Discussion: Are we on the right track?  
Drs Chakrabhand, Saraceno, Chandra

- 1400 – 1430 hrs Models for community mental health services: SEAR experience  
Dr Chandra
- 1430 – 1500 hrs Models for community mental health services: Global experience  
Dr Saraceno
- 1500 – 1600 hrs Are Western models appropriate for developing countries?  
Roundtable discussion
- 1630 – 1700 hrs Adaptation of models developed in other countries -  
Round table discussion
- 1700 – 1730 hrs Discussion: How should we go ahead?  
Drs Chakrabhand, Saraceno, Chandra

**Thursday, 14 December 2006**

- 0800 – 1200 hrs Field visit to community mental health programme.  
At Bangkhun Gong Sub-district, Bang-Kruay District, Nonthaburi
- 1300 – 1530 hrs Group work on developing community mental health services:  
New ideas
- 1600 – 1700 hrs Presentations from groups
- 1700 – 1730 hrs Way forward and closing -  
Drs Chakrabhand, Chandra

## Annex 2

### List of participants

#### Bangladesh

Prof. Dr. Md. Ahasanul Habib  
Director  
Mental Hospital  
Pabna

Dr. Md. Abdul Mohit  
Associate Professor  
National Institute of Mental Health  
Research & Hospital  
Sher-e-Bangla Nagar  
Dhaka

#### Bhutan

Dr Damber K Nirola  
Psychiatrist  
National Referral Hospital  
Thimphu

#### DPR Korea

Unable to attend

#### India

Prof. V.K. Sinha  
Central Institute of Psychiatry  
Ranchi, Jharkhand

Dr R.H. Bakre  
Programme Officer (Mental Health)  
Gandhinagar, Gujarat

Dr Smita N. Deshpande  
Head of Department, Psychiatry  
Dr Ram Manohar Lohia Hospital  
New Delhi

Dr Rajesh Rastogi  
Sr. Consultant, Psychiatry  
Safdarjang Hospital  
New Delhi

#### Indonesia

Dr Prima Siwi Waluyati  
Chief, Section of Non-Communicable Disease  
Jakarta Provincial Health Office  
Jl. Kesehatan No. 10  
Jakarta Pusat

Dr Arida Oetami, MKes.  
Chief, Section of Basic Medical Care  
and Referral  
Provincial Health Office Yogyakarta,  
Central Java  
Jl. Tompean TR III 201 - Yogyakarta,  
Central Java

Dr Budi Anna Keliat, SKp., MAppSc  
Psychiatric Nurse  
Faculty of Nursing, University of Indonesia  
Kampus Baru UI Depok

Dr Evalina Asnawi, Sp KJ  
Psychiatrist  
Jakarta Mental Hospital  
RSJ Dr Soeharto Heerdjan  
Jl. Prof. Dr Latumenten No. 1  
Jakarta Barat

#### Maldives

Mr Abdul Hameed  
Senior Administrative Officer  
Health Promotion Unit  
Department of Public Health  
Male

#### Myanmar

Dr Khin Ko Ko Thu  
Senior Consultant Psychiatrist  
General Hospital  
Mawlamyaing  
Mon State

Dr San San Hla  
Consultant Psychiatrist  
General Hospital, Patheingyi  
Ayeyarwaddy Division

#### **Nepal**

Dr Mahendra Neupane  
Bharatpur District Hospital  
Nepal

#### **Sri Lanka**

Dr Hiranthi de Silva  
Director, Mental health  
Ministry of Healthcare & Nutrition  
Colombo

Dr John Mahoney  
Consultant in mental health  
WHO Representative's Office  
Colombo

Ms Berit Keiselbach  
United Nations Volunteer (UNV)  
WHO Representative's Office  
Colombo

Dr D P D Wijesinghe  
Psychiatrist  
Kalutara  
Sri Lanka

#### **Thailand**

Dr. Apichai Mongkol  
Deputy Director-General

Dr. Sujarit Suvannashiep  
Senior Advisor to the Department of  
Mental Health

Dr. Kiattibhoom Vongrachit  
Director  
Srithunya Psychiatric Hospital

Dr. Wichian Deepentham  
Director of Mental Health Center 4

Dr. Pitakpol Boonyamalik  
Psychiatrist, Advisory Group

Dr. Apisamai Srirangsan  
Psychiatrist  
Srithunya Psychiatric Hospital

#### **Timor-Leste**

Mr Teofilo Julio K Tilman  
Unit Officer for Mental Health  
Ministry of Health  
Timor-Leste

#### **Temporary Adviser**

Dr Rajesh Sagar  
Associate Professor  
Department of Psychiatry  
All India Institute of Medical Sciences  
New Delhi, India  
&  
Secretary  
Central Mental Health Authority  
India

#### **WHO Secretariat**

Dr Vijay Chandra  
Regional Adviser  
Mental Health and Substance Abuse (MHS)  
WHO/SEARO

Dr Benedetto Saraceno  
Director  
Department of Mental Health and  
Substance Abuse  
WHO/Geneva

### **Annex 3**

## **Address by Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region (Read by WR Thailand)**

Distinguished Participants, Colleagues, Ladies and Gentlemen,

It is with great pleasure that I welcome you all to the Inter-country Workshop on Development of Community Mental Health Services. This workshop, I am sure, will be of great help as we embark on a programme to provide mental well-being services to one and all.

Before suggesting some action points, I would like to highlight the current situation of mental health services in our Region.

The WHO study on Burden of Disease clearly shows that mental, neurological and substance abuse disorders impose a huge burden on Member States of the South-East Asia Region. Neuropsychiatric disorders account for 12% of total DALYs. It is important to note that this burden is much greater compared to some other public health problems; for example, HIV, which accounts for 3% of DALYs.

The WHO Mental Health Atlas shows that specific policies on mental health are absent in nearly half of the countries in the South-East Asia Region. In addition, countries for which data are available, half of them spend less than 1% of the total health budget on mental health. Qualified manpower for mental health is very scarce; for example, the median number of psychiatrists in the WHO South-East Asia Region is only 0.2 per 100,000 population compared to a global figure of 1.2. Another issue is that patients are taken to faith healers rather than bonafide doctors.

All these factors lead to a huge mental health gap in the countries of our Region. This manifests itself in the community as, for example, poor well-being, high treatment gap, rampant stigma, high prevalence of alcohol abuse, etc. Of particular relevance to this workshop on community mental

health services is the high treatment gap, which has been reported to be 80-90% for epilepsy and nearly 70-95% for psychosis.

The fact that such large numbers of people are not getting appropriate, affordable and effective treatment should be a matter of great concern to all policy-makers and public health specialists. We need to introspect why this situation has arisen.

Distinguished participants, one of the problems has been the belief that mental health care is best delivered in large psychiatric hospitals. There is clear evidence that community mental health care is not only more effective but is also cheaper and more acceptable by the community.

We not only need new ideas, but also need to operationalize them.

I notice from the agenda that this workshop will focus on the development of community mental health services. Broadly speaking, community mental health care programmes imply that ALL the mental health and well-being needs of the community are met in the community, using community resources and the primary health care system. It goes MUCH BEYOND TREATMENT and should include:

- Promotion of well-being and mental health
- Stigma removal
- Psychosocial support
- Rehabilitation of those in need (such as intellectually impaired, recovering substance abusers, chronically-ill patients, and management of learning and behavioural problems in children through parents and teachers)
- Prevention of harm from alcohol and substance use
- Treatment of those who are sick using the primary health care system (focusing specifically on the most common and disabling illnesses in that community).

Although it may not be possible to implement all these components in every community, whichever component is relevant and accepted by the community should be implemented using community resources. The WHO Regional Office has already developed culturally appropriate technical

material for most of these components, which has been tested in Member countries of the Region.

There are many success stories in our Region; for example, the community mental health programme run by monks in Thailand. This is the only community in the Region and perhaps in the world where the treatment gap is zero. The community mental health programme in Myanmar has clearly shown that training public health workforce can effectively reduce the treatment gap. We should also capitalize on the inherent strengths of our communities. The strong bonds of the joint family system, the sense of camaraderie in communities, particularly in rural areas, and the religious beliefs of our people can be used more effectively.

An important issue in our Region is the scarcity of community-based health workforce in mental health. The relevance of such a force has clearly been established in the recent tsunami disaster and the outbreak of avian flu in some countries of the Region, where village health volunteers, for example, in Thailand, were used very effectively to support the medical services. Training such a workforce in mental health could make a substantial impact on the mental health status of the community.

I look forward to see new and innovative ideas emerging from this workshop. Any new idea, however, needs assessment for its appropriateness and impact. So, as you proceed, please build into your programmes the element of impact evaluation. Appropriate measures of impact should be developed so that the burden of suffering in the community can be reduced. This is our ultimate goal.

I hope this workshop will further strengthen WHO's initiative to assist Member States to deliver community-based mental health care to all those who need it.

In conclusion, I wish you success in your deliberations and a very pleasant stay in Bangkok.

Thank you.