Strengthening Mental Health Systems through Community-based Approaches

Report of an Informal Consultation
Bali, Indonesia, 19-22 December 2010
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### Acronyms

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<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tr>
<td>AIMS</td>
<td>Assessment Instrument for Mental Health Systems</td>
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<td>mhGAP</td>
<td>Mental Health Global Action Programme</td>
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<tr>
<td>mhGAP-IG</td>
<td>mhGAP Intervention Guide</td>
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<tr>
<td>NGO</td>
<td>nongovernmental organization</td>
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<tr>
<td>PHC</td>
<td>primary health care</td>
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<td>SEA</td>
<td>South-East Asia</td>
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<td>SEARO</td>
<td>Regional Office for South-East Asia</td>
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<td>WHO</td>
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Executive summary

The World Health Organization (WHO) is advocating that governments consider according greater priority to mental health services and review their mental health systems in totality. Governments and experts should consider the important role community-based programmes can play in mental health when delivered through the primary health care (PHC) system. The importance of such programmes for outreach and service delivery in the community should be reiterated, since they are less stigmatizing, facilitate reintegration of patients into mainstream society, and are cost-effective when compared to tertiary-care mental hospitals.

In the past decade, there have been numerous changes in the approach to mental health care delivery. In keeping with these changes, WHO Regional Office for South-East Asia (SEARO) is developing a programme to empower existing PHC systems to deliver essential mental health care. The Mental Health Global Action Programme (mhGAP), launched by the WHO Director-General in 2008, and the evidence-based mhGAP Intervention Guide (mhGAP-IG), published in 2010, provide normative support for delivery of mental health services through non-specialized health care systems.

Nine Member States of WHO South-East Asia (SEA) Region participated in the consultation. Dr Irmansyah, Director of Mental Health, Ministry of Health of Indonesia, inaugurated the meeting and welcomed delegates. Dr Apichai Mongkol, Director-General, Department of Mental Health, Ministry of Public Health, Thailand was elected Chair of the meeting, and Dr Irmansyah was elected Co-chair.

The objective of the meeting was to develop strategies for strengthening mental health care delivery through the existing PHC system in Member States of the SEA Region.

Dr Chandra, WHO-SEARO and Dr Yasamy, WHO-HQ made presentations on the transition in delivery of mental health care from tertiary care specialized centres to community-based care and the development of technical material to support this transition. Each participating country made a presentation on developments in their mental health systems in the past decade. Successful models of mental health care
delivery through the PHC system in countries were reported. The second
day was devoted to group work on possible reorientation of mental health
systems within countries, based on the experience of other countries. The
group work was followed by presentations of a proposed project to be
implemented in each country to further enhance PHC to deliver essential
mental health care.

The participants recommended that WHO provide technical material
and support to the projects being implemented at each participating site. A
mid-term evaluation of ongoing projects was recommended. It was
suggested that a workshop of all investigators to discuss the findings be held
by the end of 2011.
1. Introduction

In the past decade there have been numerous changes in the approach to mental health care delivery. There is now increased awareness among policy-makers and technical experts globally on the following issues:

- Mental health is more than psychiatry: it is a multidisciplinary approach that includes promotion of mental health and well-being and prevention of mental illness.

- Despite tremendous progress in the field of psychiatry, including the availability of numerous new psychotropic medications, the treatment gap (i.e. the number of people not getting appropriate care) is as high as 90% in some parts of Member States. Thus, there is a need to develop new ideas and approaches to the delivery of mental health care.

- The optimal method of delivery of mental health care to the patient is not through tertiary-care mental hospitals alone, but through the PHC system supported by secondary and tertiary-level health care.

- The PHC system can be enhanced to deliver essential mental health care to the community, in the community, thus reaching out even to remote and rural areas.

In keeping with the above observations, SEARO is developing a programme to revitalize PHC systems. This programme aims to provide essential care (including mental health) to the community through the PHC delivery system.

Governments of most Member States need to be sensitized on the need to prioritize mental health. Advocacy with governments is needed on developing approaches to mental health care delivery that are cost-effective and community-based.

The mental health care delivery system is very broad and is closely affected by planning and budget at the central and state government levels,
roles and responsibility of tertiary-care mental hospitals, availability of services in general hospitals, capacity of primary health care delivery systems to deliver essential care, community outreach programmes and very importantly, the severe scarcity of trained manpower in the Region. Thus the entire mental health system needs to be reviewed and each component modified as appropriate to each country.

WHO is advocating that governments accord greater priority to mental health services in countries, and also advocating with governments and technical experts to review the totality of their mental health systems. The Mental Health Global Action Programme (mhGAP), launched by the WHO Director-General in 2008, and the evidence-based mhGAP Intervention Guide (mhGAP-IG), published in 2010, provide normative support for delivery of mental health services through non-specialized health care. Governments and experts should consider the important role that community-based programmes in mental health can play when delivered through the PHC system. Their importance in terms of reaching out and delivering services in the community should be reiterated, as they are less stigmatizing, facilitate reintegration of patients into mainstream society and are cost-effective compared to tertiary-care mental hospitals.

The focus of the consultation was to discuss innovative ways to strengthen the existing PHC delivery system to deliver essential mental health care.

2. Proceedings

2.1 Opening session

Dr Vijay Chandra, Regional Adviser, Mental Health and Substance Abuse, WHO-SEARO, welcomed the participants to the Regional Consultation on Strengthening Mental Health Systems through community-based approaches. He thanked the Government of Indonesia for hosting this important consultation that would contribute to the development of mental health care and thereby the overall well-being of the people. He mentioned that the importance of this consultation to governments could be judged from the fact that 9 out of 11 countries in the Region were participating.
Dr Samlee Plianbangchang, WHO Regional Director for South-East Asia, in his address (delivered by Dr Vijay Chandra, see Annex A) thanked the Government of Indonesia for hosting the consultation. He said that it was extremely important not only for WHO but also for the respective Member States of the SEA Region to formulate policies to more appropriately address issues in the future development of mental health programmes.

Dr Irmansyah, Director of Mental Health, Ministry of Health of Indonesia, inaugurated the meeting and welcomed the delegates. He outlined the importance of mental health in the overall well-being of a person. He mentioned that Indonesia has developed community-based programmes that are being implemented through the PHC system.

Dr Apichai Mongkol, Director-General, Department of Mental Health, Ministry of Public Health, Thailand was elected Chair of the meeting and Dr Irmansyah, Director of Mental Health, Ministry of Health, Indonesia was elected Co-chair. Dr R. Hettiarachchi, Deputy Director, Mental Health, Sri Lanka was elected Rapporteur.

The participants introduced themselves. The delegates were both technical experts and policy-makers from within the government.

### 2.2 Objectives of the consultation

Dr Vijay Chandra introduced the objectives of the consultation. The general objective was to develop strategies for strengthening mental health care delivery systems in Member States of the SEA Region.

The specific objectives were:

1. sharing experiences on the efficacy of existing mental health systems among Member States;
2. advocacy with policy-makers on the importance of prioritizing mental health services;
3. developing a conceptual framework for further strengthening mental health systems in Member States integrated into the PHC delivery system; and
4. identifying operational research issues to bridge the gaps in mental health service delivery.
2.3 Background of the consultation

Dr Vijay Chandra made a presentation on the transition in delivery of mental health care over the last several decades in the Region. He mentioned that both scientific and technological advances have taken place. There is also greater awareness of the need to take a broader approach to mental health care, beyond psychiatry and medications. Dr Chandra introduced the concept of mental well-being. He traced the revised focus in the development of the mental health programme of WHO that started with the World Health Report of 2001 (Mental Health: New Understanding, New Hope), and was followed by the Mental Health Atlas of 2005, and the publication of the WHO Assessment Instrument for Mental Health Systems (WHO AIMS) that allowed countries to reflect on and assess for themselves the level of service availability and utilization. This assessment instrument has been completed by eight Member States. He pointed out that despite these developments, there is still a large treatment gap (i.e. 80%-95% of people who need treatment were not receiving it). He went on to describe the programme being developed in SEARO to train village-based health workers to identify the most common causes of neuropsychiatric morbidity and for PHC-based medical staff (nurses or doctors) to treat the patients. He described some examples of the success of this programme (e.g. in Myanmar) in reducing the treatment gap.

Dr Mohammed Taghi Yasamy, Department of Mental Health and Substance Abuse, WHO-HQ outlined the development of the mhGAP. He mentioned that WHO had selected nine priority conditions that were the most common causes of morbidity worldwide. Experts from around the world had reviewed the scientific literature and come up with evidence-based conclusions for the management of these nine conditions. The interventions recommended are comprehensive and include both medical and psychosocial interventions. These findings were summarized in the document “mhGAP-IG”.

2.4 Country presentations

Bangladesh

Dr Md. Waziul Alam Chowdhry made a presentation on the status of mental health care in Bangladesh. A national sample survey had been
conducted in 2005 that documented the prevalence of neuropsychiatric disorders. He pointed out the limited facilities in terms of trained personnel and medical resources. In the last five years there have been substantial developments in the country, including the development of community-based activities. Recently, 18 000 community clinics have been established. A draft Mental Health Act 2011 is also under consideration by the government. Bangladesh had developed a long-term plan up to 2015. This includes development of mental health services in general hospitals, rehabilitation within the community and a multidisciplinary approach to managing patients. In order to increase service utilization, a strong awareness campaign is being launched.

**Bhutan**

Mr Tandin Chogyel made a presentation on the mental health care system in Bhutan. He pointed out that health care is completely free in Bhutan. There is an excellent PHC network that tries to reach out to the community. However, difficult geographical terrain, stigma and limited skilled manpower make service delivery difficult. In recent years, efforts have been made by the government to integrate mental health care into general health services. Traditional, religious and indigenous systems of medicine popular in Bhutan are being integrated into allopathic systems of medicine. There is no mental hospital in Bhutan so all mentally ill patients are treated in general hospitals and basic health units. A national referral hospital located in Thimphu provides tertiary-care services. In recent years, training programmes for village health volunteers have been intensified. District and community leaders have also been sensitized on the need for appropriate mental health care. Bhutan has already launched the mhGAP-IG in one district as a pilot project. Another innovative programme that has been launched is a community-based programme to reduce harm from alcohol use. Results of these community programmes will be available before the end of 2011.

**Indonesia**

Dr Irmansyah, Dr Eka Viora and Dr Hervita Diatri made a joint presentation on the status of mental health care in Indonesia. They described the available mental health resources in the country based on information
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compiled for the WHO AIMS. National estimates of the prevalence of major neuropsychiatric disorders were available. Local experts had conducted a study in Leuwileang subdistrict with a population of 177,454. In this study, the treatment gap was documented as 90% for epilepsy and 95% for psychosis. They described the developments in the last five years, including: a new mental health law; development of the second national Mental Health Policy 2009-2015; development of the community mental health nurse programme; establishment of user groups; mental health to be included in PHC activities; and good political support. Strengthening the PHC system to deliver mental health care will be under renewed focus.

**Maldives**

Ms Aminatha Shareef made a presentation on mental health in Maldives. The population of Maldives is 300,000 living on 199 islands. Each island has a doctor who provides PHC services. These services are supported by secondary-level services in six regional hospitals and one tertiary-care hospital in Male. On one island there is a home for people with special needs such as mental illness and disabilities; psychotropic medications are available free. A national sample survey conducted in 2003 provides some estimates of the neuropsychiatric morbidity. The geographical distances between islands and the high cost of travel are a barrier for people to access services, both in regional hospitals and in Male. Attempts will be made to draft a new mental health policy; standardize treatment protocols; enhance training for mental health care; and launch awareness campaigns. Programmes are also being initiated for adolescent mental health promotion and establishing a national disability register that will provide information on patients getting treatment for neuropsychiatric conditions.

**Myanmar**

Dr San Dar and Dr New Ni described the mental health resources available in the country. Some national estimates of common mental health disorders are available from Myanmar with depression, psychosis, epilepsy and mental retardation being the most common. Training in mental health care is given every year to primary care doctors, nurses and basic health workers. Several nongovernmental organization (NGO) volunteers are also trained. Community-based services to reduce harm from alcohol have also been developed. There is a large treatment gap at the community level. Some of
the reasons are limited numbers of mental health workers; stigma; and people still believing in evil spirits and thus going to traditional healers. A pilot project conducted in 2004 clearly documented that with optimum training and availability of medication, the treatment gap can be substantially reduced. This model needs to be replicated in other parts of the country.

**Nepal**

Dr Surendra Sherchan pointed out the limited specialized services for mental health in Nepal. NGOs play a prominent role in mental health service delivery in the country. At present there are very limited mental health services at the PHC level. However, NGOs have implemented community mental health services in select districts. Although mental health services have been created in general hospitals, there is a serious shortage of manpower, making the services ineffective. In Kathmandu there is a 50-bed mental hospital. Private psychiatric services have also been established.

**Sri Lanka**

Dr R. Hettiarachchi, Dr Usha Gunawardhana and Dr T. Suveendran made the presentation. Sri Lanka has a very high literacy rate and a stable population. There is strong political commitment for the development of mental health care. Health services and medications are provided free. There are extensive private mental health care services in the country. A comprehensive mental health care policy 2005-2015 has been developed and adopted by the government. The national mental health programme is comprehensive and includes promotion of mental well-being; standardized protocols for patient care; development of human resources and infrastructure; improved surveillance; and alcohol and substance abuse prevention programmes. There is also focus on violence and suicide prevention. A unique model of Medical Officer-Mental Health has been developed. This is a qualified medical doctor with enhanced training in mental health. Sri Lanka also has a unique model of community support centres. The mandate of these centres is to focus on mental health promotion and identification and referral of persons with mental illness, and deal with minor mental health problems, family problems, alcohol and substance misuse, and gender-based and domestic violence. Several NGOs are also active in providing mental health services. The government, in
collaboration with technical experts, is planning to take forward mental health in the PHC programme through development of national uniform assessment/treatment protocols, clinical and referral guidelines, training of primary-care physicians, interaction with complementary and traditional practitioners, monitoring and evaluation of the activities of NGOs, and coordination of mental health promotion activities.

**Thailand**

Dr Apichai and Dr Youngyud reported that national survey data suggest that for men, alcohol abuse, depression and suicide are among the 10 leading causes of morbidity. For women, depression is the third leading cause of morbidity. Thus mental health is a high priority for the government. More than 95% of the Thai population are covered by health insurance. Approximately 75% of the population are covered by national universal coverage, popularly known as the 30 Baht scheme.

The Thai mental health programme can best be described by domains:

- **Domain 1: Policy and legislation** – The national mental health plan and policy aim to develop positive mental health for all Thai people. A new mental health law was enacted in 2008.

- **Domain 2: Mental health services** – Mental health services are delivered through an extensive network starting from psychiatric hospitals spread across the country, to regional hospitals, general hospitals, community hospitals and primary care units.

- **Domain 3: Primary health care** – The Thai model of mental health care provides substantial emphasis on self-care, services by village health volunteers and care through PHC centres. There is an extensive network of community care that puts the individual and family at the centre of the programme, supported by the local community.

- **Domain 4: Mental health resources** – Thailand has a large number of specialist mental health workers and the number is gradually increasing. Formal mental health services are supported by family and advocacy groups and carer and consumer groups.
Domain 5: Public education and links with other sectors – There is a substantial linkage with other sectors such as education, where there are programmes to develop the intelligence quotient (IQ) of school children, lifeskills programmes, prevention of drug abuse campaigns and prevention of violence campaigns, etc.

Domain 6: Monitoring and research: There is a continuous effort to monitor ongoing projects and make corrections wherever needed.

Developments in the last five years:

- Mental Health Act 2008
- Suicide prevention programme
- Intelligence quotient (IQ) / emotional quotient (EQ) programme
- School mental health project
- Community-based mental health project by local authorities
- Mental health management in disasters
- Mental health in justice system

Future developments that the government would like to include:

- Quality improvement of mental health care in community hospitals
- Strengthening primary health care systems to deliver essential mental health care
- Community-based mental health promotion and prevention

**Timor-Leste**

Mr Tilman made the presentation for Timor-Leste. Mental health services to the community are provided by 15 specialist mental health workers. One consultant psychiatrist is available in Dili. Training has been provided to specialist mental health workers for care of patients with epilepsy by visiting consultants from Australia. The current estimated treatment gap for epilepsy is approximately 75%. Some reasons for the treatment gap are inadequate
infrastructure, remote communities and lack of awareness of mental illness. In collaboration with SEARO, a proposal will be developed to enhance the existing PHC system to deliver essential mental health care.

### 2.5 Group discussions

Delegates from each country worked among themselves, with technical support from WHO participants. The topics for group work were:

1. Strengthening the mental health system to reduce the treatment gap: develop a pilot project; and

2. Strengthening the mental health system: long-term proposals.

**Bangladesh** will develop a proposal on reducing the treatment gap for childhood epilepsy in one *upazila*. The current prevalence rates for epilepsy have already been established in the survey done previously. A detailed project proposal will be developed by the National Institute of Mental Health, Dhaka, and submitted to SEARO.

Impact indicator: reduction of treatment gap by 20% each year.

**Bhutan** already has an ongoing project on reducing the treatment gap for epilepsy, promotion of mental well-being in schools, reintegration of patients with chronic psychosis and reducing harm from alcohol use. Results will be available before the end of 2011.

Impact indicators:

- Epilepsy project: reduce treatment gap by 20%
- Promotion of mental well-being: reduced bullying in schools, improvement of grades
- Reintegration of patients with chronic psychosis: reintegration into family
- Reducing harm from alcohol: drunk people cannot come to the temple or the Basic Health Unit, alcohol-free receptions by the Governor.
Indonesia plans to develop a model for reducing the treatment gap for psychosis by increasing the human resources capacity with the following objectives:

- Improve and increase community and service provider awareness in identification of psychosis.
- Improve knowledge, skills and attitudes in psychosis management among primary health workers.
- Increase case-finding of psychosis in the community.
- Improve treatment coverage of cases.
- Improve the management strategy at the PHC level.

Impact indicator: reduce the treatment gap for psychosis by 15% each year.

Maldives formulated its pilot study to assess the real versus theoretical treatment gap for epilepsy and psychosis. The following steps are planned:

- Identify community leaders in the islands in one atoll.
- Form a network of community leaders.
- The theoretical number of patients with epilepsy and psychosis will be based on presumed prevalence.
- The real number of patients with epilepsy and psychosis will be obtained using a simple questionnaire to island leaders.
- The number of people actually getting medical treatment will be determined by examining government records of medication dispensed.
- Conduct a three-way comparison to study gaps in services.

Impact indicator: reduction of treatment gap by 50%.

Myanmar proposed a project to promote mental health services in Myaung Mya township. The following activities are planned:

- Giving health education to the community (cooperation with local leaders, religious persons, schoolteachers, traditional healers)
- Training of trainers, volunteer health workers
Promotion of treatment guideline, manuals, modules for medical officers, general physicians and basic health staff.

Easy availability of medication, monitoring for long-term management

Outcome: improving resources to address mental health in the community

Nepal proposed a pilot study to strengthen the existing mental health system by reducing the treatment gap for epilepsy in Dhading district. The following activities are proposed:

- Awareness and advocacy programme
- Increase human resources and build capacity
- Development of infrastructure and facilities
- Logistical support and supplies
- Monitoring, evaluation, research
- Collaboration with other stakeholders
- Development of mental health law

Impact indicator being developed by local experts.

Sri Lanka proposed a project to evaluate ongoing mental health activities as assessed by the level of service utilization. The following activities are proposed for this project:

- Documentation/mapping of existing mental health medical services
- Socio-demographic data of the district (Regional Director of Health Services Office, Survey Department)
- Existing service utilization information
- Estimation of (theoretical) treatment gap using psychosis as an example
- Identification of barriers to service utilization, and solutions

Outcome: assessment of current level of treatment gap. A national workshop will be convened to discuss findings and solutions (October 2011)

Future plans: implementation of solutions/recommendations (2012-2013)
Thailand proposed a project to reduce the treatment gap for psychosis in one subdistrict (division), with a population of 25,000 to 50,000. The plan is to train the mental health workforce and volunteers, use them to identify untreated persons with psychosis in subdistricts, and provide treatment. The plan is to use traditional antipsychotic drugs that are affordable for the National Health Service and are easier for patients to take, thus leading to better compliance. Psychosocial intervention will also be provided to patients by the district hospital.

Impact indicator: reduction of treatment gap for psychosis by approximately 20%.

Timor-Leste will implement a project in Liqadua subdistrict, with the following activities:

- Intersectoral meeting of partners to create awareness of epilepsy (including religious leaders, village leaders and traditional healers, etc.).
- All health post staff and village-based health volunteers will be trained in the identification of epilepsy (using SEARO Manual).
- Health volunteers to be responsible for bringing patients to case workers.
- Availability of anti-epileptic medication to be ensured.
- Health volunteers to be responsible for compliance and reporting.

Impact indicator: reduction of treatment gap for epilepsy by 10% each year.

3. Recommendations

- WHO to provide technical material to Member States (SEARO Epilepsy Manual, mhGAP IG).
- SEARO to provide technical assistance in implementing the pilot projects developed in the meeting.
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- SEARO to conduct a mid-term evaluation of the ongoing projects to discuss any mid-course correction in their implementation.

- A workshop be held with all investigators who have implemented and completed pilot projects on reducing the treatment gap to discuss the findings at each site, scaling-up within countries and adaptation in other countries. This workshop could be held in November 2011 in cooperation with the Department of Mental Health, Ministry of Public Health, Government of Thailand.

4. Concluding session

The Chair, Dr Mongkol, conveyed his appreciation to the Regional Director for approving the organization of this important meeting that would help all Member States to enhance their mental health systems and in turn lead to improvements in the overall health and well-being of all persons. He felt that it had been a very useful and intensive meeting and that every participant had learned from sharing of the intraregional experiences. He said that he was committed to taking forward the steps outlined at this meeting and looked forward to SEARO’s technical support and networking in bringing together ideas and best practices in the Region. On behalf of the Department of Mental Health, he also committed to helping less-resourced countries in the Region with training and, if needed, procuring psychotropic medications. He thanked the Ministry of Health, Indonesia, for the excellent arrangements and for their warm hospitality.

The Co-chair, Dr Irmansyah, thanked SEARO for bringing into focus the issues related to mental health and how services can be enhanced by recognizing the specific needs of each country and their stage of development. He looked forward to the fruition of the plan of action developed by each country.

Dr Vijay Chandra thanked the Chair, the Co-chair and Rapporteur for their leadership in guiding and recording the discussions and in making the meeting a successful platform for the development of mental health in the SEA Region. He thanked the Ministry of Health, Indonesia, for hosting the consultation and for their excellent arrangements for its conduct. Finally he thanked all participants for their time and valuable contributions.
## Annex 1
### List of participants

<table>
<thead>
<tr>
<th>Country</th>
<th>Name</th>
<th>Position</th>
<th>Organization/Institution</th>
<th>Location</th>
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<tbody>
<tr>
<td>Bangladesh</td>
<td>Mr Abu Masud</td>
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Annex 2

Objectives

General objectives

To create awareness about development of appropriate community-based mental health interventions in Member States

Specific objectives

(1) Advocacy with policy-makers on the benefits of prioritizing mental health service delivery.

(2) Advocacy with policy-makers and technical experts on development of community-based mental health services.

(3) Exchange of information with experts on successful models to deliver essential medical health care through the primary health care system.

(4) To identify operational research issues to strengthen community-based mental health service delivery.
Annex 3

Agenda

(1) Inauguration

(2) Address of the Regional Director, WHO

(3) Introductory session:
   – Transition from traditional to contemporary mental health systems
   – New approaches to delivery of mental health care

(4) Country reports:
   – Findings of previous WHO-AIMS reports
   – Developments in mental health systems in the past decade
   – Successful models of mental health care delivery through the PHC

(5) Group work and presentations on:
   – Adaptation of successful models for strengthening mental health systems
   – Adaptation of successful models on delivery of mental health care through the PHC
   – Developing a conceptual framework for further strengthening mental health systems in Member States
   – Identifying operational research issues to bridge the gaps in mental health delivery

(6) Recommendations and way forward for countries and WHO in development of mental health systems within Member States.
Annex 4

Message from Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region (to be read by Dr Vijay Chandra)

Dear Delegates,

Welcome to the beautiful island, Bali, Indonesia. You are participating in a very important technical consultation on strengthening mental health systems. Your deliberations will be extremely important not only for WHO but also for your respective countries in formulating policies that will more appropriately address issues of concern to mental health.

Recently, the WHO Department of Mental Health developed the phrase “No health without mental health”. Although this statement cannot be considered as conveying something absolute, one must consider why WHO has made such a bold statement.

WHO initiated a step-wise process to develop the mental health programme. An early step was taken in 2001 with the publication of the World Health Report 2001, entitled “Mental Health: New Understanding, New Hope”. The report estimated that 450 million people were suffering from mental, neurological and behavioural disorders or from psycho-social problems such as those related to alcohol and drug abuse. It was also estimated that one person in every four would be affected by mental disorder at some stage of life. The report aimed at raising the professional and general awareness on the real burden of mental, neurological and behavioural disorders, including its costs in human, social and economic terms.

The next step was the publication of the Mental Health Atlas in 2005. This project aimed at collecting, compiling and disseminating information on mental health resources in the world. Information was obtained from 192 countries, including 8 Member States of the South-East Asia (SEA) Region. The reports from Member States of the SEA Region showed that mental health resources as measured by the number of trained
professionals, beds for mental health patients and primary care services, were limited. So, although the burden of mental, neurological and behavioural disorders was huge, the resources available to deal with them were limited.

In the last decade, numerous changes have occurred in the approach to health care delivery for people with mental illness. Large, custodial type mental hospitals in which patients were incarcerated and restrained have been replaced with modern hospitals where patients are free to move about, and are given rehabilitation therapy and appropriate medication. Newer medications have replaced archaic forms of treatment such as insulin shock in which patients were injected with insulin to reduce their blood sugar levels and rescued just in time from catastrophic side-effects. There is now a better understanding of the functioning of the brain and why mental illnesses occur. More recently, we have started talking about the mind that is considered the centre of our emotions and feelings. The entire concept of psychiatry has been replaced by the concept of mental health.

Despite all this progress in the field of mental health, the treatment gap (i.e. the number of people not getting appropriate care) is as high as 90% in some parts of our Region. Thus, there is a need to develop new ideas and approaches to the delivery of mental health care. There is now increasing awareness among policy-makers and mental health experts that the optimal method of delivery of mental health care to the patient is not through the tertiary care mental hospitals, but through the primary health care system.

The primary health care system can be enhanced to deliver essential mental health care to the community, in the community, thus reaching out even to remote and rural areas. This would be in line with the Regional Office’s programme on revitalizing primary health care. This programme aims at providing essential care (including mental health) to the community through the primary health care delivery system.

Support from several segments of administration is required for the development of mental health care. It is closely affected by planning and budget at the central and state government levels, roles and responsibility of tertiary care mental hospitals, availability of services in general hospitals, capacity of primary health care delivery systems to deliver essential care,
community outreach programmes and very importantly, the severe scarcity of trained manpower in the Region. We must also remember, that any public health programme should be culturally appropriate so the community can identify with the programme. Thus the entire health system needs to be reviewed and each component modified as appropriate to the country.

WHO’s role at this time is to advocate with governments to accord greater priority to mental health services in their countries, and also to advocate with governments and technical experts to review their mental health systems in totality. Governments and experts should consider the important role that community-based programmes in mental health can play when delivered through the primary health care system. The importance of reaching out and delivering services in the community should be reiterated, as such measures are less stigmatizing, facilitate reintegration of patients into the mainstream of society and are cost-effective when compared to tertiary care mental hospitals.

I look forward to your active participation in this consultation. We can exchange ideas and learn from each other for our mutual benefit.

I wish this consultation every success and look forward to receiving its recommendations.
Despite tremendous progress in the field of psychiatry, including the availability of new psychotropic medication, the treatment gap (i.e. the number of people not getting appropriate care) is as high as 90% in some Member States of the Region. Thus, there is a need to develop new ideas and approaches on the delivery of mental health care.

The optimal method of delivery of mental health care to the patient is not through the tertiary-care mental hospitals but through the primary health-care system. The primary health-care system can be enhanced to deliver essential mental health care to the community and within the community, thus reaching out even to remote and rural areas. This is inkeeping with the Regional Office’s programme on revitalizing primary health care, including mental health, to the community through the PHC delivery system.

Thus, WHO’s role at this time is to advocate with governments to accord greater priority to mental health services in their countries, and also to review their mental health systems in totality.