

The Asia-Pacific Community Mental Health Development (APCMHD) Project

Introduction

The Asia-Pacific Community Mental Health Development (APCMHD) project has been established in 2005 to explore diverse leading models or approaches to community mental health service delivery in the Asia-Pacific region. The objective is to illustrate and promote best practice in mental health care in the community through use of information exchange, current evidence and practical experience in the region.

The project is based on the work of an emerging network of mental health leaders from 14 countries or regions in the Asia-Pacific, working to build culturally appropriate mental health policy frameworks and workforce in the implementation of community mental health services. Initiated in collaboration with the WHO Western Pacific Regional Office, the APCMHD project is led by Asia-Australia Mental Health, a consortium of the University of Melbourne (Department of Psychiatry and Asialink), and St. Vincent's Health.

The project, which brought many key mental health bodies to work collaboratively, is consistent with the WHO Global Action Programme for Mental Health. A key outcome is the documentation of the current status, strengths and needs of community mental health services in the region, in the hope to translate current understanding into practical changes in the future. The result is a collection of exemplary community mental health models and key guiding principles for development of services in the region.

A best practice example from each participating country/region is provided in this section to illustrate the diversity of community mental health approaches. The Summary Report of the APCMHD Project and the Full Country Report can be found on the website www.aamh.edu.au.

Commentary from WPA President Professor Mario Maj

Although the steps, the obstacles to remove and the mistakes to avoid in the implementation of community mental health care are to some extent similar worldwide, there are certainly some differences from one region to another, which limit the transferability of models and experiences. Being knowledgeable of successful experiences implemented in other regions and of guidelines produced by international organizations such as the WHO, while at the same time being aware of the specific challenges posed by local realities and of the strategies which have already proved to be effective locally, is probably the best which can be done to foster the development of community mental health care at the regional level.

This lively and interesting collection of exemplary experiences can be extremely useful to psychiatrists, other mental health professionals and policy makers of the Asia-Pacific region as well as of other areas of the world, representing a source of inspiration and encouragement.

The World Psychiatric Association will be pleased to support the further development of this initiative, and to provide its help and advice to other regions wishing to follow this example.

Australia

Editor: Rosemary Calder, First Assistant Secretary, Mental Health and Workforce Division, Australian Government Department of Health and Ageing.

Sub-Editors: Nathan Smyth, Colleen Krestensen, Lana Racic; *Contributors:* Aaron Groves, Ruth Vine, David McGrath, Jake Matthews, Simon Wells.

Australia's Mental Health System

The Commonwealth Government priorities for mental health include working in partnership with States and Territories on an integrated national approach to service delivery; developing an open, transparent system of evaluation and accountability of existing mental health services; and ensuring that mental health services are well integrated with other primary care and specialist services. The Commonwealth Government recognises the vital need for initiatives to prevent or delay the onset of mental illness, to intervene early, and to ensure access to and continuity of appropriate treatment and care for people with mental health problems.

State and Territory governments have primary responsibility for direct delivery of public mental health services. Hospital and community mental health services include accommodation, outreach support for people in their own homes, residential rehabilitation, recreational programs, carer respite and self-help.

Total spending on mental health services in 2004–05 was \$3.9 billion, representing 7.3% of government health spending. Subsidy of psychiatric medicines contributed 17% of total mental health funding.

A Best Practice Example

Housing and Accommodation Support Initiative (HASI), New South Wales (NSW)

HASI was established in 2003, with key objectives to:

- Improve housing stability for participants;
- Reduce demand on psychiatric inpatient services;
- Reduce calls to emergency services;
- Demonstrate an independent living, community-based model of psychosocial rehabilitation, support and case management;
- Improve quality of life through social, vocational, educational, life-skills development and family connections.

HASI is a three-way partnership between:

- Specialist mental health non-government organisations funded by NSW Health providing support and psychosocial rehabilitation;

- Specialist local mental health services (part of Area Health Services) providing clinical mental health care and rehabilitation;
- Public and community housing, funded by NSW Housing, providing long-term, secure, affordable housing, and property and tenancy management.

The purpose of the HASI partnership is to:

- Co-ordinate care;
- Enhance the interface between specialist mental health services, General Practitioners and non government organizations;
- Provide stable housing outcomes;
- Facilitate consumer, family and carer participation.

HASI is targeted to individual needs, with a staged support continuum ranging from very high support of 8 hours per day, 7 days per week to lower support of up to 5 hours per week.

Accommodation options include:

- Individual self-contained accommodation;
- One or two bedroom places;
- ‘Salt and pepper’ approach: HASI properties are sprinkled through the community;
- Small clusters (up to four HASI places in one site) are acceptable when deemed to be clinically viable. Virtual clusters are the preferred options, e.g. several HASI places within a few streets.

HASI does not support “asylums in the community” or congregate care. In conjunction with the local Area Mental Health Service, HASI support services:

- Provide comprehensive, client-centred, strengths-based assessment, care planning and intervention which target self-maintenance, productivity levels including education and employment and leisure needs;
- Are based on the principle of consumer recovery through fostering hope, supporting consumer empowerment and supporting self-determination;
- Ensure intervention strategies utilise mainstream community service networks and resources to encourage community inclusion.

Eligibility criteria for HASI:

- 16 years of age or more until age-related frailty inhibits ongoing involvement in the program;
- Diagnosis with a mental illness or functional impairment due to psychological disturbance identified by a mental health professional;
- Eligibility for social (public) housing;
- High levels of psychiatric disability and low level of functioning;
- Capacity to benefit from accommodation support services; and
- Informed consent to participate in the program.

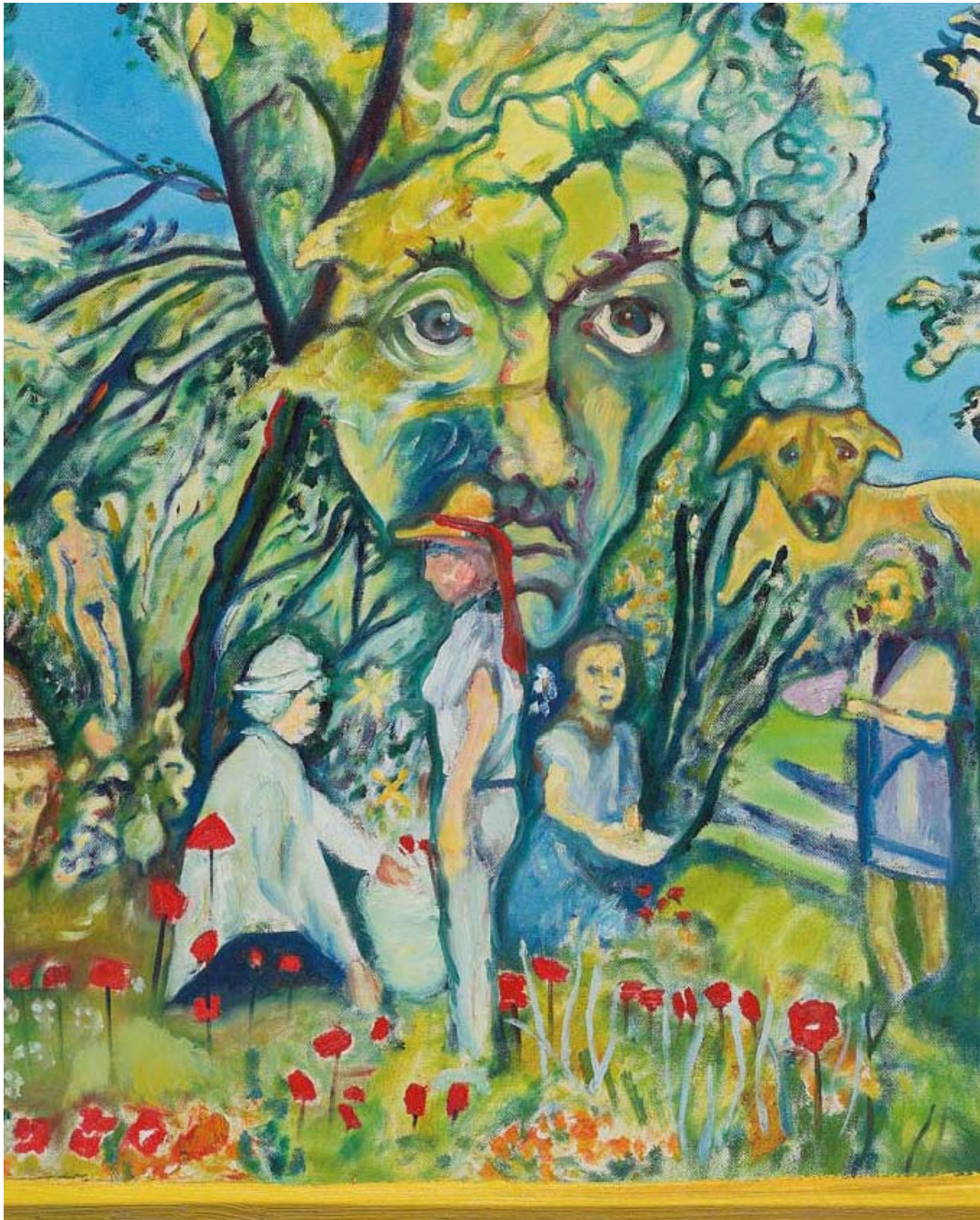
Achievements and outcomes:

The Social Policy Research Centre (University of NSW) undertook a two-year longitudinal evaluation of the initial stage (100 high support places) of the Housing and Accommodation Support Initiative. The final report has now been published on www.health.nsw.gov.au/pubs/2007/hasi_evaluation.

Findings show:

- HASI has provided secure, affordable housing with 85% of participants remaining with the same housing provider;
- 94% of people had established friendships at completion of evaluation;
- 73% of participants were participating in social and community activities;
- 43% of participants were working and/or studying at the end of the evaluation;
- Hospitalisation rates of admission and length of stay were reduced for 84% of participants;
- Time spent in hospital and emergency departments decreased by 81%.

From 2008, the HASI in the Home stage will increase to over 1,000 places across NSW.



Graeme Doyle (Australia), No title, 1990, oil on masonite, 50.5 x 40.5 cm Artwork supplied courtesy of the Cunningham Dax Collection Graeme Doyle states openly that he suffers from schizophrenia. He believes that his art should be shown to help others understand the experience of mental illness in order not to be afraid of it. The artist wants audiences to appreciate that people with mental illness can still be very creative.

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Cambodia

Editor: Sophal Chhit, Deputy Director, National Mental Health Program Cambodia.

Sub-Editor: Lo Veasna Kiry; *Contributors:* Staff of the National Mental Health Program Cambodia.

Cambodia's Mental Health System

The National Programme for Mental Health aims to improve the quality of life for people with mental illness through education and promotion of mental health care and substance abuse services, with a special emphasis on equity, quality and efficiency.

Funding for Mental Health has recently been heavily supported by international bodies, most notably WHO and Norway, with other organisations running independent projects. Many private hospitals also exist in Cambodia; however there is no formal information as to how many of these provide mental health services.

Cambodia's turbulent past has caused not only great trauma and loss for its people, but also destroyed any pre-existing mental health resources and prohibited the development of a new mental health system. The Pol Pot regime of 1975–1979 was responsible for mass genocide and the complete degradation of Cambodia's infrastructure. Of the 1,000 doctors trained prior to 1975, less than 50 survived, none of whom were mental health professionals. Cambodia's only mental health hospital, and the only access point for mental health care, was also destroyed by the Pol Pot regime.

The mental health workforce deficit caused by Cambodia's turbulent past has resulted in most mental health care being provided by physicians who can often offer only basic care. Traditional healers are often a point of contact for people with mental illness in the community; however it should be noted that these healers do not have explicit mental health training and may therefore cause harm. NGOs have worked to forge links between primary care and traditional workers; however a mechanism for an effective, sustainable system of communication has not been found.

To address these deficits, the Mental Health Policy and Strategic Plan includes the Mental Health Care Service Package, which is a vertically integrated system with services both within the general health care system and the community-based health care centres. Developed for use within referral hospitals, the Complementary Package of Activities (CPA) provides specialised mental health care services which are distinct and complementary to general health care. The CPA allows management of complex health problems, provides follow-up and continuing care, and supports the health care system with mental health clinical training and supervision. Additionally, the Minimum Package of Activities (MPA) was developed for community health care centres and aims to provide integrated, high-quality mental health care which is both efficient and affordable.

A Best Practice Example

A New Model for Mental Health in Cambodia

Due to limited human and financial resources, the delivery of mental health care in Cambodia has previously focused on primary mental health care. The new Mental Health Care model aims to extend this care to an integrated community service through the use of several guiding principles:

- Integrated approach to service delivery – including community health centres and systems such as education and social services.
- Universal access to care – equitable, affordable and high-quality care that is geographically accessible, culturally relevant and culturally competent.
- Upholding a right to confidentiality – ensuring that all information gathered about a person including identity shall be kept confidential by the mental health provider.
- Informed consent – including the right to make decisions regarding treatment.
- Quality assurance – mental health issues such as diagnosis and choice of treatment shall be assessed in accordance with nationally accepted principles and standards.
- Community-based care – emphasis on care in the least restrictive environment possible and use of restrictive environments only when necessary for the safety of the client and public, and only for as long as that situation exists.
- Efficiency and accountability – resource allocation and their use will be examined in a transparent manner according to agreed principles.

The new Mental Health Care model highlights the importance of strong leadership to allow effective patient advocacy and lobbying. The model also highlights the importance of integrating mental health issues into all levels of medical training to increase the mental health knowledge and skill base of general health practitioners.

By strengthening community links, the model aims to encourage the role of families, NGOs and community agencies in mental health care. Further, the model aims to coordinate interaction between mental health care and local resources such as primary care and traditional healers to avoid fragmentation of care. It is anticipated that these measures will also result in a decrease in stigma and discrimination for both patients and service providers.

China

Editor: Jin Liu, Chief of Executive Office, National Center for Mental Health, China- CDC (Peking University Institute of Mental Health), China.

Sub-Editors: Hong Ma, Xin Yu, Mingyuan Zhang, Yanling He, Bin Xie, Yifeng Xu, Lianyuan Cao, Wei Hao, Min Li.

China's Mental Health System

In China, where primary mental health care or community mental health is not well developed, development of community based mental health services has been led through the psychiatric hospitals, supported by general hospitals and the Centre for Disease Control. A national centrally driven program is a very rapid way to implement a new service model throughout a large and diverse country.

The sheer numbers of people who experience mental illness indicate the pressing need for improved mental health services. It is estimated that 16 million people suffer from psychotic illness, with 0.3 million new cases per year, of which between 50 – 70% have been untreated (source: National Institute of Mental Health, Peking University).

In April 2002, the first Mental Health Plan (2002–2010) was signed by the Ministries of Health, Security and Civil Affairs and the China Disabled Persons' Federation. In 2004, there were 565 psychiatric hospitals, 499 psychiatric departments in general hospitals, 57 mental health stations and 19 mental health clinics. There were also 16,103 psychiatrists and 24,793 psychiatric nurses, however the professional competence of many of them is limited.

A Best Practice Example

The 686 Project

After SARS, the Chinese Government rebuilt the public health system. In 2004, the China–Centre for Disease Control (CDC) and Peking University visited community mental health services in Melbourne, and decided to use the Victorian Model for reference. In September 2004, after competing with over fifty proposals, the Mental Health Service Model Reform Program was the only non-communicable disease program included in the national public health program.

In December 2004, the Mental Health Reform Program was formally supported by the Ministry of Finance, and named the “686 Program” because of its funding of 6.86 million RMB. The National Centre for Mental Health and China-CDC took charge of the program and established a national working group as well as a foreign consultant group with experts mainly from the University of Melbourne.

In 2005, 60 demonstration sites were established in 30 provinces in China: one urban and one rural site in each province, covering a population of 43 million. 602 training courses were held and nearly 30,000 people were trained, including psychiatrists, community physicians, case managers, community

workers, public security staff and family members of the patients. A national computerised case database was established.

In 2006, this program received increased funding of 10 million RMB, enabling improved monitoring and intervention for psychoses, as well as the establishment of a local comprehensive prevention and treatment team in each demonstration area. Staff including 15% psychiatrists and psychiatric nurses from over 12,000 facilities were trained. Nurses were recruited from psychiatric hospitals or departments, community and village health centres, and neighbourhood or village committees.

By December 2006, more than 65,000 patients were registered, nearly 22,000 patients with violent tendencies received regular follow-up, over 9,000 poor patients with violent tendencies received free medication, over 2,600 people exhibiting violent behaviours received free crisis management and more than 1,000 poor patients with violent behaviours accessed free hospitalisation. For patients who received follow-up, the level of violent incidents decreased.

In 2007, the budget was increased to 15 million RMB for continued service provision across the 60 sites. Case-management training for the demonstration areas was provided jointly by The University of Melbourne and the Chinese University of Hong Kong (CUHK). The budget for 2008 is 27.35 million RMB, enabling more patients to receive free medication and hospitalisation, and the establishment of a new demonstration area in Xinjiang Province.

It is projected that new demonstration areas will gradually be set up across China. Future directions may also include the National Mental Health Reform Program Office delegating its management role to each province to oversee its own demonstration area, thereby delegating the rapidly increasing workload as the program expands. More officials will be encouraged to provide local resources to enable mental health to become core business and to adapt the reform model to their local context. As the Program develops, staff training and project management will become more challenging, and local experts will need to take responsibility for supervision and monitoring. The Ministry of Health has already established standard evaluation forms and all provinces will use these forms to report their progress.

As a result of this program, more local officials pay attention to mental health issues and psychiatric hospitals now consider integrated prevention and comprehensive treatment. A community-based network has been established, led by the psychiatric hospitals, and supported by general hospitals and the CDC. Further, the program has benefited patients, particularly those of low-socioeconomic status, and has promoted social harmony.



686 Annual Meeting in November 2006.

Hong Kong

Editor: Se-fong Hung, Chief Executive, Kwai Chung Hospital, and President, Hong Kong College of Psychiatrists, Hong Kong.

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Hong Kong's Mental Health System

In Hong Kong, mental health care is largely provided in the public sector through the Hospital Authority (HA), a statutory body established in 1991 to manage all the public hospitals and institutions in Hong Kong. Through its network of 74 general out-patient clinics and seven hospital clusters, people with mental illness can seek help at the primary care level and if necessary be referred to specialist clinics. Inpatient, ambulatory and community psychiatric services are also provided in all seven clusters to ensure continuity of care.

The Government spends about HK\$3 billion (0.24% of GDP) on mental health care per annum, which is allocated to the Hospital Authority and eleven Non-Government Organisations (NGOs) for medical treatment, residential support and rehabilitation for patients with mental illness.

In accord with Government policy to strengthen both community care and primary care in mental health, a strategic plan was formulated to downsize the two largest stand-alone psychiatric hospitals in Hong Kong. Following completion of the plan in 2006, Hong Kong now has approximately 4,600 psychiatric beds (6.4 per 10,000 population), consisting of a mix of large mental hospitals and psychiatric units in general hospitals. The target is now to shorten the length of stay of acute inpatients. Increasing the community psychiatric team workforce is crucial for providing more intensive care to patients following discharge as well as for urgent psychiatric referrals. Having a range of well-differentiated community treatment options will enable more patients to be cared for in the community.

A Best Practice Example

Extended-care patients Intensive Treatment, Early diversion and Rehabilitation Stepping Stone (EXITERS) Project

Despite advances in pharmacological and community psychiatric treatments, a large proportion of psychiatric inpatients remained long-term in mental hospitals in Hong Kong. In a survey in June 2000 by the Hospital Authority on the length of stay of psychiatric in-patients, it was revealed that 1138 (23.1%) had an average length of stay greater than four years. Commencing in 2000 in three phases, EXITERS is a pilot project aimed at early integration of long-stay inpatients back to the community.

A Multidisciplinary Team including two medical doctors, seven nurses, two medical social workers, one occupational therapist, and a team of twelve supporting staff for each hospital unit were recruited to address the patients' complex needs.

In Phase I, vacant hospital quarters at three major mental hospitals in Hong Kong were converted to create supported group homes with home-like settings to facilitate intensive rehabilitation. In Phase II,

appropriate patients with a hospital length of stay over 6 months were recruited and each was assigned a case manager. These patients were often not suitable for half-way-houses, or had frequent admissions and discharges from half-way houses. Those with illicit drug addiction, moderate or severe mental handicap and dementia were not included. Intensive rehabilitation was provided to improve social and vocational functioning, and various community options were explored to bridge the gaps in residential services that were available. In Phase III, active community support and follow-up were offered for discharged patients. Several evaluation tools for assessing symptoms, needs, function and quality of life were administered quarterly to evaluate outcomes.

During the first three years, 387 patients were discharged from the three hospitals. The discharge destinations included living at home, either singly or with relatives, resettling in a private housing unit, re-housing in a public housing unit or staying in a private hostel. Analysis of the first 190 patients discharged from hospital in one year showed significant improvement in the patients' psychiatric symptoms, behavioural problems, functioning levels and quality of life. However these patients remained quite functionally disabled on discharge, with a large number remaining unemployed and requiring financial support from social welfare.

The project identified a group of patients with complex disabilities that required flexible matching of resources in the community. It utilised the case management model in the reintegration of patients to the community. The EXITERS hostels situated in the neighbourhood of the hospital provided a home-like environment for disabled patients to adapt slowly to community living, and with adequate resources it demonstrated that difficult-to-place patients could be successfully reintegrated back to the community. Despite having some persistent disability, the discharged patients have an improved quality of life outside mental hospitals.



Ching Wai (Hong Kong) b. 1972
Breakthrough the darkness, head into the sunlight
145 x 190 mm
sign pen

Notes accompanying the artwork:

Emerging from the darkness comes a bright broad avenue. Life contains bitterness and joy, sadness and happiness. Be determined and brave, only through an unyielding spirit can you head into brightness. Bitterness is inevitable, but as long as you have the strength to somehow recognise it for what it is, one can endure, turning negative to positive. At the low tide of your life wipe the tear, it will be soon sweet. After stepping over your difficulties you will see the sunlight... life is more brilliant. Life is a blessing no matter if it contains bitterness or joy!

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India

Editor: R.N. Salhan, Additional Director, General of Health Services, Directorate General of Health Service, Ministry of Health and Family Welfare, India.

Sub-Editors: S.K. Sinha, Jagdish Kaur.

India's Mental Health System

The prevalence of mental disorders in the population is in the range of six to seven percent, which represents a huge number of people. Before 1960, mental health services were mostly provided by mental hospitals. With the advent of psychotropic drugs, General Hospital Psychiatry Units were established in many hospitals in the sixties and following decades. Community-based mental health services began in the seventies on a small scale by incorporating mental health in primary health care through short-term training of general health personnel.

In 1987, a modern Mental Health Act was enacted. Its implementation is being monitored by the Central Mental Health Authority. Disability benefits for persons with mental disorders are covered under the 'Persons with Disability Act' (1995).

A comprehensive community-based mental health service, the District Mental Health Programme (DMHP) was started in 1996. The DMHP was expanded to 27 districts across 22 States and Union Territories in the Ninth Five-Year Plan period from 1997–2002.

A Best Practice Example

The District Mental Health Programme

The District Mental Health Programme (DMHP) was launched in 1996 under the National Mental Health Programme. Its objectives are:

- To provide sustainable basic mental health services to the community and to integrate these services with other health services.
- Early detection and treatment of patients within the community itself.
- To avoid patients and their relatives having to travel long distances to hospitals or nursing homes in the cities.
- To reduce pressure on the mental hospitals.
- To reduce the stigma attached towards mental illness through change of attitudes and public education.
- To treat and rehabilitate mental patients discharged from mental hospitals within the community.

The DMHP is run by a core team of mental health professionals including a psychiatrist, a clinical psychologist, a psychiatric social worker, a psychiatric nurse, a nursing orderly and a record keeper. The Programme's catchment area is the district and adjoining areas.

The components of the Programme are:

- Community Mental Health Services - these include a psychiatric Outpatient Department at the district hospital as well as outreach services in Primary Health Centres on designated days that provide follow-up care of patients, dispensing of psychotropic medication, record keeping and referral to an appropriate level of care as needed.
- Training of general physicians, paramedical workers and non-medical workers in mental health care.
- Information, communication and education services.
- Technical and managerial support from the district medical college/ psychiatric institution.

The State Government monitors the programme through the nodal institution, and the Central Government monitors the program through WHO Consultants in the Ministry of Health.

Basic mental health services are also provided by the extensive network of trained health staff in the general health care system. The DMHP model has demonstrated that, by training primary care physicians, basic mental health care delivery can be provided in primary care settings. Provision of supervision and support from the mental health program officer and/or the psychiatrist, empowers staff in the public health care system to respond to the mental health needs of the population.

Several reviews and consultations have identified barriers to implementation of the DMHP as well as identifying the need for mental health promotion. This has led to modification of the DMHP in the Eleventh Plan.

In the Eleventh Plan, the DMHP team is able to hire trained medical officers if a psychiatrist is not available for the programme. Other members of the team will include a psychologist, a social worker, a nurse and an office assistant, who will receive brief skill-based training with a uniform curriculum at identified centres. According to demand, new mental health promotion services will be added, and credible organisations and private practitioners will actively participate in providing services and implementing the DMHP. In order to address the shortage of trained mental health practitioners, government doctors will be trained as sub-specialists in Psychiatry through the introduction of one year in-service certificate courses in Psychiatry. In addition, Institutes of Mental Health and Neurosciences will be established to develop the mental health workforce. Upgrading of psychiatry facilities of medical colleges and general hospitals and modernisation of mental hospitals will continue. A strategy with strong emphasis on information, education and communication is needed to improve awareness of mental health issues and to reduce stigma.



Banner at an Awareness and Diagnostic Camp organized through the District Mental Health Programme in Delhi.

Indonesia

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Indonesia's Mental Health System

The number of mental health beds in Indonesia is insufficient to meet the needs of the population, such that many people with mental illness live in the community without proper treatment. Further, the poorly developed primary health care system is insufficient to support the integration of primary mental health care. Building the capacity of the health workforce to deliver mental health services has become a major focus. Training programs for primary care physicians in treating mental disorders have been established, with some primary care professionals now receiving regular training in mental health. In the last two years approximately 500 personnel received training, especially in Aceh, South Sulawesi and West Sumatra.

A Best Practice Example

Community Mental Health Nursing in Aceh, Indonesia, following the tsunami and earthquake

The earthquake and tsunami disaster in Nanggroe, Aceh, Darussalam, and Nias has had lasting effects on the mental health of the Indonesian community. This is compounded by an absence of effective and adequate community mental health services even prior to the disaster. Prior to 2004, Aceh, the Indonesian province most affected by the tsunami, had only one mental hospital for a population of 4,220,000. In keeping with international good practice and recommendations from WHO, it was regarded as important to take the opportunity of external funding coming into Aceh to develop an integrated system of services for the first time. Three months after the tsunami, a programme was developed to train community mental health nurses (CMHN) based at the Puskesmas (Public Health Centre) to deliver a range of mental health services. The curriculum is divided into three phases: Basic Course Community Mental Health Nursing (BC-CMHN), Intermediate Course Community Mental Health Nursing (IC-CMHN), and Advanced Course Community Mental Health Nursing (AC-CMHN). The CMHN project has also been kindly supported by HSPF USAID, WHO and ADB-ETESP.

Community Mental Health Nursing (CMHN) training is divided into 3 steps:

- Basic: focuses on caring for the patient and family.
- Intermediate: management of psychosocial problems, training of community leaders to form a cadre of mental health providers, develop village awareness of mental health issues via the Desa Siaga Sehat Jiwa ('Village of Mental Health Alertness') project. To date the community mental health nurses have identified 8016 patients with severe mental health problems, and awareness has been raised in 343 villages.

- Advanced: leadership, advocacy, research, mental health promotion, and case management training.

The successes of the Community Mental Health Nurse Training Program include:

- Increase in resources to provide mental health services in the community.
- Improvement in community services:
 - Many patients received treatment and support for the first time.
 - Families had an opportunity to discuss problems in coping with their family members and to receive support.
 - Enhanced community awareness.
 - Improvement in community members' ability to take care of and refer patients.
 - Improved community cooperation with CMH nurses.
 - Enhanced CMH nurse motivation and satisfaction.
 - A greater percentage of patients received regular medication and supervision in some areas.
 - Prevention of admission to mental hospitals for many patients visited by a CMH nurse.
- Improved resources through collaboration with other stakeholder organisations:
 - Provision of motorbikes for CMH Nurses by NGOs (CBM) to improve access to patients in more remote areas.
 - Funding in some districts for CMHN training at the intermediate level and advanced level covered by USAID.
 - Funding of training for nurses in psychiatric intensive care for the acute units in district hospitals covered by USAID.

The challenges faced in implementation include:

- An inadequate referral system largely due to limited pre-existing services and poor secondary services.
- Problems in access to the Public Health Centre owing to geographical conditions and transportation limitations.
- Limited range of medications.
- Inadequate recording-reporting/monitoring-evaluation in some districts.
- Inadequate allocation of funds for mental health as it is not a mandatory programme.
- An irregular supply of medication in some areas because of inadequate logistical planning.

Future directions include:

- Creating networks of care with local NGOs.
- Involvement of religious and female leaders.
- Maintaining advocacy to ensure that future budgets allow for allocation of finances to community mental health nursing activities.
- Working towards CMHN becoming a compulsory program at the primary care level.

Japan

Editor: Tadashi Takeshima, Director, Department of Mental Health Administration Studies, National Institute of Mental Health, National Centre of Neurology and Psychiatry, Japan.

Sub-Editor: Yutaro Setoya.

Japan's Mental Health System

The Japanese government has recently released, in rapid succession, policies, laws and regulations relevant to mental health. This process began in 2002, stemming from a Ministry of Health, Labour and Welfare report called Future Direction of Mental Health and Welfare Policy, which aims to shift from hospital-based medical treatment to community centred health care and welfare.

Japan has one of the highest number of psychiatric beds per capita in the world. 1,379 (83%) of hospitals are privately owned, and 1,086 are stand-alone psychiatric hospitals. Though community mental health services are increasing rapidly, they remain inadequate.

Future directions for expansion of community mental health are:

- Support for consumers to build consumer-centred services;
- Development of more community services especially housing support, vocational rehabilitation and outreach services;
- Dissemination of good quality care management and building close community networks;
- Quality improvement such as staff training, consumer and carer involvement and outcome measurement.

A Best Practice Example

Mitaka, Tokyo — Sudachi-kai

This program is chosen as an example of best practice because community mental health services provided by NGOs in the urban setting is a key issue. However, other practice examples in Japan are no less important.

Based in Mitaka city of Tokyo, Sudachi-kai (Japanese for 'Flight from the Nestgroup') is a social welfare corporation which actively promotes discharge from hospital. Over its 15 years of history, more than 130 long stay inpatients have been discharged. Its housing and vocational facilities are located in Mitaka city (population: 178,000; area: 16.5 km²) and Chofu city (population: 21,600; area: 21.5 km²). Both cities are located in the centre of Tokyo Metropolis.

Sudachi-kai started in 1992, when there was strong stigma against people with mental disorders who faced much difficulty in housing rental. The first group home was started with cooperation between the landlord, hospital staff and families. With their support, many patients were discharged to group homes and other neighbouring rooms.

Importantly, a sheltered workshop was opened in response to a need for vocational activities during the day. From these facilities, the basic concept of Sudachi-kai as a place for consumers to live, work, and find support from both staff and peers was formed. Their activities were gradually expanded and they currently have eight housing facilities (capacity 61) and three vocational facilities (capacity 90), with about 20 full-time and 20 part-time staff.

From their experience, Sudachi-kai has developed the following model pathway for discharge from hospital:

- First, the staff and peer supporters (past inpatients) of Sudachi-kai deliver talks to inpatients in hospital. The stories the peer consumers tell about their lives outside the hospital convey strong messages to the inpatients, thus motivating them towards discharge from hospital.
- Next they consult with the candidate and their family to make a support plan with them.
- When candidates are motivated, discharge training is provided and they begin attending the vocational facility in the community during the day.
- Next, Sudachi-kai helps the candidate find suitable housing which could be a group home or other rooms. Overnight training using a short stay facility also begins.
- Preparation for discharge takes place, such as a patient managing own medications, money.
- After discharge from hospital, staff (24 hour coverage) and peers support them to live in the community.

Data of 126 patients discharged from hospital with the support of Sudachi-kai is as follows: the average length of hospital stay was 11.5 years and the longest was 42.2 years; 59 patients were in their fifties (46%) when the support started, 39 patients (31%) were in their forties and 17 patients (13%) were in their sixties. 65% were men, and the majority had schizophrenia (88%). Of the 126 patients, 61 (48%) were discharged to group homes, 48 (38%) to affiliated rooms rented by Sudachi-kai, 10 (8%) to private rooms and 7 (6%) went to other residential facilities. Of the discharged patients, 85 (68 %) utilised Sudachi-kai's services, 12 (13%) terminated their use of services due to moving to other rooms or facilities, 10 (8%) had a hospital admission, 11 (9%) were deceased and 3 (2%) discontinued use of the services. The Sudachi-kai program has shown that many inpatients can be discharged and successfully live in the community if there is continuous support and a place to stay available on a 24 hour basis.



Y. A. (Japan), b. 1969, No title, oil on masonite, 45 x 38 cm.

Notes accompanying the artwork: The artist learned to paint from another artist during group work for patients with mental illness at a public health centre. He doesn't like to leave indoors, so his work is mainly of people and landscapes as seen through windows.

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Korea

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Korea's Mental Health System

Strategic collaboration between the public and private sectors has involved public sector funding and professional human resources and community mental health programs from the private sector. Since 1995, 151 community mental health centres, 170 rehabilitation centres and 56 long-term residential facilities have been established. Community Mental Health Centres provide counselling, home visits, case management, psycho-education, vocational rehabilitation and mental health promotion activities. Rehabilitation services are also provided by the private or nongovernment sector. Funding for community care is increasing and community care is planned to increase tenfold over the next decade. Vocational rehabilitation programs including sheltered workshops and supported employment are also increasing, with support from the Korea Employment Promotion Agency for the Disabled.

Despite the growth in community-based mental health services in Korea, large-scale deinstitutionalisation is not yet in sight. Under the present circumstances, private mental hospitals and asylums are unlikely to discharge patients into community-based services, to shorten the average length of patients' stay or voluntarily decrease the number of beds. It is very important that the government declare its intentions to support the development of community-based mental health programs by presenting a long-term plan for deinstitutionalisation.

A Best Practice Example

Seoul Metropolitan Mental Health Centre from Gangnam Community Mental Health Centre

The first community mental health centre was established in the southern area of Seoul in 1995. Through a contract between the Seoul Department of Health and Seoul Municipal Mental Hospital in Yongin Mental Hospital, the Seoul city government provided funding to establish the Gangnam Community Mental Health Centre (CMHC) and Yongin mental hospital sent trained staff, including a psychiatrist, nurses and a social worker. The Centre was located in an area where the City of Seoul had constructed apartment complexes for rental to poor citizens. The mental health problems of this population were great compared to other parts of the city. The Centre assessed the mental health needs of chronically mentally-ill people and their families and started psychosocial rehabilitation services and home-visiting programs for alcohol-dependent patients isolated from the community.

Seoul City also increased funding for other CMHCs and, by 1998, there were seven CMHCs with each area providing 'semi-metropolitan' mental health services. Located in the Public Health Centre, these CMHCs provided primary mental health services, established psychosocial rehabilitation services for the chronically mentally-ill population, mental health promotion for the general population and gradually increased services for children, adolescents and old people. These CMHCs were funded by the local districts and Seoul City and operated autonomously in each local district. As a result, there

was a need to develop a system to coordinate and integrate the operation of these CMHCs. The mental health planning committee and city government officials discussed the metropolitan mental health service system in order to expand the community mental health services to other districts of the city.

Seoul City commissioned the Gangnam CMHC to develop a centralised data gathering and management system, and evaluation was conducted through the Mental Health Information System (MHIS) to examine mental health outcomes separately from general services to the local community.

In response to the increasing demands on the metropolitan mental health centre, which was responsible for supporting and coordinating all the CMHCs and the development of new mental health policies and programs, Seoul City established the Seoul Metropolitan Mental Health Centre (SMMHC) in the downtown area in 2004. Staff from the Gangnam CMHC moved to this metropolitan mental health centre and commenced service provision.

In 2004, a Taskforce Team established the Seoul Mental Health 2020 Project, so that the City of Seoul could develop mental health services to meet future needs. The goals of the Seoul Mental Health 2020 Project are to:

- Analyse the present state of Seoul Mental Health Services and predict demand for future resources and infrastructure;
- Establish the Metropolitan Mental Health Centre to facilitate deinstitutionalisation and crisis management systems;
- Establish an organisation to support the development of policy and research.

The model for organising the SMMHC has been adapted from St. Vincent's Mental Health in Melbourne, Australia, through a contract between Seoul and Melbourne. The SMMHC now has four teams: the Community Assessment and Linkage System (CALS), the Crisis Intervention Team (CIT), the Mental Health Promotion Team (MHPT) and the Homeless Mobile team (HM).



Promotion of SMMHC Mental health brand, “Blutouch”, October 2007.

Malaysia

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Malaysia's Mental Health System

Funding for mental health services in Malaysia is provided largely by the Government. Malaysia spends 5% of its GDP on healthcare, of which about 3% is spent on mental health care. Most insurance agencies do not cover treatment for mental illness.

The government facilities providing psychiatric care include four mental institutions and twenty-six government hospitals. Of 5428 psychiatric beds in Ministry of Health facilities, 4640 (85.5%) are in mental institutions and 748 (14.5%) are in general and district hospitals. In addition, the three University Hospitals have about 130 acute care beds. Psychiatric care covers acute episodes, follow-up and long-term care, and includes outpatient, community and home-care services. These services were strengthened in the 1990s and are currently available in almost all hospitals with resident psychiatrists.

The Ministry of Health is in the process of integrating psychiatric care with mainstream general hospital and primary health care services. In 2005, a total of 763 Health Clinics (88.9%) provided mental health services in the community, including mental health promotion, follow-up of stable cases and tracing of non-compliant patients. In addition, twenty-five of these clinics also provided psychosocial rehabilitation services for patients with severe mental illnesses. NGOs also provide residential care, day-care services and psychosocial rehabilitation services in the community. There are concerted efforts towards promotion of mental health in both the psychiatric units and primary health care settings.

A Best Practice Example

Hospital-based community psychiatric services in a psychiatric institution – Hospital Bahagia Ulu Kinta, Perak

Hospital Bahagia Ulu Kinta (HBUK) demonstrates how a large psychiatric hospital can reorganise its services to incorporate comprehensive community outreach services for a large population. In 1970s, the Community Psychiatric Unit (CPU) was established to provide domiciliary services. Evening psychiatric clinics were operated by staff of HBUK after regular office hours in public places such as a church, community hall or temple. Peripheral psychiatric clinics operating during regular office hours at distances more than 30 kilometres from HBUK were established to provide psychiatric follow-up care services nearer to patients' homes. In 1997, follow-up of stable psychiatric patients commenced in primary health care centres in Perak, including assessment and review of patients, provision of medication, psychoeducation and support, and defaulter tracing to ensure that patients were compliant with prescribed medication.

In March 2001, HBUK started home-care services which aimed to provide continuous and comprehensive services at home, catering for the needs of the patients and carers.

The specific objectives are to:

- Provide treatment and rehabilitation to psychiatric patients.
- Enlist family members in the management of patients at home, improving communication and problem-solving skills.
- Reduce relapses and re-hospitalisation to less than 30%.
- Promote adherence to medication and illness self-management for which the compliance rate should be more than 60%.
- Provide supported employment (job search, job match and job coach) for at least 10% of the patients.

Home-care services in HBUK are provided through clearly delineated geographical zones, serving a population of about 800,000 in the Kinta district. There are seven zones based on geographical locality. Each zone is headed by a psychiatrist, working together with two to four medical officers, two full-time medical assistants, two fulltime staff nurses and two full-time attendants. There are two nursing supervisors for the nursing staff. The home-care team operates during office hours and the case-load for each nursing staff is 1: 15–20 patients.

The home-care services in HBUK consist of five components: Acute home care, Early discharge program (EDP), Assertive community treatment (ACT), Family intervention programme (FIP), and Follow-up services for stable cases with complex needs.

The HBUK home-care service has successfully reduced patients' relapses and readmission rates within 6 months after discharge, from about 25% before services were started, to 0.56% in 2005 and 0.5% in 2006.

This service model is in line with plans to down-size the mental institution. Our strategies include: reduction of acute admissions by setting up small acute units with home-care services (e.g. resident psychiatrists at district hospitals); development of alternative appropriate residential facilities with varying levels of care (high-level support, low-level support, respite care and group homes); supported education and employment; and strengthening inter-sectoral collaboration between related agencies (such as social welfare, education, labour department), carers, and NGOs.



Community mental health education in Malaysia.

Mongolia

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Mongolia's Mental Health System

Currently, Mongolia spends 2% of its total health budget on mental health. Within the mental health budget, funding is mainly directed towards mental hospitals, accounting for 64% of all mental health expenditure. All severe and some mild mental disorders are covered by social insurance schemes.

The mental health system in Mongolia is still largely hospital-based. Mental hospitals treat 17.7 patients per 100,000 population and have an occupancy rate of above 80%. The majority of beds are provided by stand-alone mental hospitals, followed by community-based psychiatric inpatient units.

A number of good results have been achieved in the development of community mental health services, such as the establishment of a mental health database and the introduction of psychosocial rehabilitation services. Deinstitutionalisation has been gradually implemented but is not currently comprehensive. The percentage of patients who receive primary mental health care and the number of primary health care units that provide mental health care have slightly increased but have not reached the targeted goals. In addition, mental health programs in schools have been developed and now economic entities and organisations with more than 50 employees implement mental health sub-programs and projects according to the Government mental health framework.

A Best Practice Example

Ger Project

Community-based day centres in Mongolian tented and portable round houses called gers were started in 2000 in the grounds of two district health care centres and four regional health centres. The Ger Project is staffed by general health care staff (nurses and occupational therapists) and a psychiatrist, and funded by WHO and the SOROS Foundation. The aim of the Ger project is to give people with chronic mental illness an opportunity to increase their social and living skills through psychosocial rehabilitation activities focusing on life skills, such as self-care, cooking and leisure skills (handicraft, vegetable growing and other vocational training).

Ger day programs are placed in the community especially near the sub-districts where people are living in gers. 15 to 20 people with mental illness per month are involved in the program. The Ger Project is staffed by a psychiatrist, nurse and an occupational therapist who are paid by the government. The program runs from 9.00 am to 3.00 pm each day.

With the patient's consent, psychiatrists in outpatient settings and general practitioners can refer patients to the Ger project.

On their first day at the Ger project, the psychiatrist, nurse and occupational therapist assess the patient's life skills, self care and social life to determine what activities will benefit them. The occupational therapist and nurse, who have attended psychosocial rehabilitation training for one to three months, are responsible for teaching and monitoring the patient's physical exercise and relaxation, life skills, self care and vocational skills, such as handicraft, vegetable-growing, gardening, carpentry and embroidery.

The Ger project also provides psycho-education, counselling, continuing psychiatric treatment and family support for patients and their families. The psycho-educational program provides patients and their families with information about mental illness, coping skills and how to manage stress.

The Ger project not only includes medical services, but also employment services, social welfare and transportation services.

A total of 500 clients have attended the Ger project and relapse of mental disorders has been reduced by 95% from 2002 to 2007.

Through these psychosocial programs, the principal lesson learnt is that there are reduced rates of relapse for patients with mental illness, when they are cared for in community settings. Also people with mental illness can be supported in the community and through inter agency collaboration and cooperation. We need to increase the participation of families, consumers and NGOs in community based psychosocial rehabilitation programs. Government funding should be provided for the Ger program.

The Ger project successfully delivers psychosocial programs close to the patient's home at the district level. Key advantages include the low cost of the ger, its mobility and the reduction of stigma and discrimination through the involvement of the community and families. Advocacy at the government level is important for the sustainability of the project.



Tented and portable round houses (Gers) used in the Ger Project.

Singapore

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Singapore's Mental Health System

Singapore has reached a somewhat balanced psychiatric care model, where the Institute for Mental Health (IMH), a large psychiatric hospital with a daily census of around 1600 patients is responsible for the care and management of 33,000 outpatients in the community. In all, IMH is responsible for close to 80% of public mental health care, with the remaining 20% provided by the psychiatric departments of the general hospitals.

The National Mental Health Blueprint for 2007–2011 is helping to galvanise the development of community-based programmes with the establishment of community mental health teams for patients of all ages. For children and adolescents, multidisciplinary teams work closely with school counsellors to detect and manage early problems in schools. For adults with established serious mental disorders such as schizophrenia, multidisciplinary community mental health teams provide support in the community with case management, home visits, psychosocial rehabilitation and crisis management in their homes. For the elderly, community psychogeriatric teams work with social agencies and primary care physicians to detect and manage the elderly with mental disorders, either in their own homes or at clinics in the community. For those with addiction disorders, the Community Addiction Management Programme (CAMP) manages the patients in the community with a multidisciplinary team.

A Best Practice Example

Early Psychosis Intervention Programme (EPIP)

The Ministry of Health awarded Singapore's Institute of Mental Health a special 5-year fund in 2001 to run the EPIP, a programme to provide early intervention for young adults and tertiary students with emerging mental illnesses within the community. EPIP offers three key activities: provision of clinical services to persons with early psychosis, training to frontline staff in schools and social agencies to allow them to identify young people with mental health problems, and training of primary care physicians to conduct initial screening and to manage stable persons with mental health problems.

The frontline staff are trained to identify and refer young people with suspected mental health problems to primary care physicians. They include counsellors from various educational institutions, officers from the Police Force and Ministry of Defence, counsellors from Family Service Centres, Community Development Councils and other grass root organisations. Training includes major mental illnesses (mood disorders, anxiety and psychosis), and refresher courses are also conducted for new staff. Joint case conferences with referring agencies are also organised to ensure continuity of care for the client.

Although historically Singapore's primary care physicians had not been involved in the management of mental disorders, EPIP managed to engage their participation through training in diagnosing psychoses and referral to EPIP for timely intervention. Patients identified with other mental health problems are

either managed by the primary care physicians, or are referred to public hospitals. They are also trained to manage stable patients from EPIP for continued treatment. A support system of telephone/email consultations for EPIP's community partners has been established.

EPIP ensures that patients with early psychosis are given community-based treatment, including a case manager to enhance appropriate follow-up and compliance with therapy and to reduce defaults. Through early detection and early intervention in psychosis, the outcome is improved along with a reduction in the duration of untreated psychosis. Case management ensures integrated and individualised care for first-episode psychosis patients, as well as continuity of care through the different phases of the illness. Evidence-based treatment is provided by a multi-disciplinary team.

The focus is on promoting recovery and integrating patients back to the community. EPIP is widely acclaimed as a successful community-based programme, recognised internationally by WHO and awarded the inaugural State of Kuwait Prize for Research in Health Promotion in 2006. It has shown a significant reduction in patient default rates, with improved functioning and increased employment of patients. Based on this success, EPIP has continued beyond the initial five years, to enable expansion of the programme nation-wide. It blazed the trail in Singapore's mental health services for training and deploying case managers and primary care physicians in its programme.

Current challenges faced by the programme include the engagement of non-traditional healthcare providers (folk and religious healers), who are seeing a number of individuals when they first present with mental disturbances, and persuasion of employers and educational institutions in Singapore to accept individuals who have received or are receiving psychiatric treatment.

Taiwan

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Taiwan's Mental Health System

As of March 2007, Taiwan had 37 psychiatric hospitals with 19,127 psychiatric beds (6,130 acute beds and 13,132 chronic beds, 2.6 and 5.5 beds per 10,000 population), of which 55.9 % are located in public hospitals. Psychiatric day care centres are available in all psychiatric hospitals, regional hospitals and some district hospitals. In addition, 61 community rehabilitation centres and 81 half-way houses operated by psychiatric institutions or non-professional groups provide community care for people with severe mental illnesses. The existing mental health network has been extended to meet the varied community mental health needs of a rapidly changing society.

Two major noteworthy events made such developments possible: the Mental Act enacted in 1990 and the National Health Insurance (NHI) launched in 1995. The Mental Act represents a significant advance, as it ensures the protection of human rights and calls for ethical practice of all mental health professionals. The NHI reimburses a wide range of medical expenditure related to the treatment of mental illnesses, including the fees for psychiatric rehabilitation. People with severe mental illnesses such as schizophrenia and bipolar affective disorder do not need to provide the co-payment, which usually constitutes 10% of the total medical expenses.

A Best Practice Example

The Taipei City Psychiatric Center (TCPC)

The Taipei City Psychiatric Center (TCPC), founded in 1969, has been dedicated to provide psychiatric services to 2.6 million residents in Taipei City. Professor E.K. Yeh, the first superintendent of this municipal hospital, established the innovative and widely known 'Taipei Model' for community care of psychiatric patients in 1970s.

The key element of the 'Taipei Model' is the development of a network between the hospital and the public health sector, and facilitation of follow-up visits by public health workers from twelve district health institutes to patients with severe mental illness discharged from the TCPC. Mentally ill patients are continuously tracked, evaluated and treated in a hierarchical style of management. Utilisation of other social resources is made as individual needs change. Health information and resources related to disease, drugs, family planning and occupational rehabilitation are provided to individuals and family members.

The psychiatrists from TCPC, as well as core hospitals in the city, provide a range of supervision in a fixed-term period. The involvement of public health nurses in the assessment, planning, implementation and evaluation of the community psychiatric services has been a key element for the success of the 'Taipei Model'.

To provide optimal treatment for people with common mental disorders, TCPC initiated the Taipei City Depression Collaborative Care System under the endorsement of the health authorities of the city government in 2003. Primary care physicians, mostly internists and family medicine specialists, were invited to participate in the training workshop to form an inter-divisional and inter-professional network. In 2005, all the municipal hospitals and 177 primary care clinics joined the collaborative care network while TCPC continued its role of providing educational courses. In addition, the executive board continued to facilitate referral between mental health services and primary care, and to negotiate with National Health Insurance for a study project looking at incentives and outcomes of the program.

In July 2005, the TCPC commenced 'individual psychological consultation services' at the twelve district health institutes, which made psychological consultation available, affordable and easily accessible for the community.

The 'Research and Development Center for Suicide Prevention' was established to work with social workers in the district social welfare centres to follow up persons who attempted suicide and presented to the emergency rooms at the hospitals in the city.

The harm-reduction anti-drug policy (methadone maintenance program) was introduced to the community in 2006, when the number of HIV-infected patients (mostly needle-sharing heroin users) sharply increased. Since 1993, TCPC has built a rehabilitation model which includes physical detoxification, psychological rehabilitation and follow-up counselling. At the same time, an information system was established to monitor drug abuse trends.



Taipei City Psychiatric Center.

Thailand

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Thailand's Mental Health System

Community mental health services in Thailand have been integrated into the public health service system throughout the Ministry of Public Health administrative infrastructure, from village to regional levels.

Primary mental health care at the village level is provided by village health volunteers, who are the main community mental health care personnel and who encourage community participation in mental health activities. At the sub-district level, primary care units and health centres staffed by health personnel provide primary medical services, including mental health screening and monitoring to ensure psychiatric continuity of care.

Community hospitals at the district level and general hospitals at the provincial level provide outpatient services for common psychiatric disorders, continuity of care for chronic patients and mental health care to general hospital patients. Specialised comprehensive psychiatric care is provided by regional hospitals, university hospitals and psychiatric hospitals or institutes. Total psychiatric beds number 8,700 (13.8 beds per 100,000 population), with 9% of beds reserved for children and adolescents.

A Best Practice Example

Crisis mental health intervention following the Tsunami

On 26 December 2004, the Tsunami severely affected the south-western area of Thailand: 5,395 individuals died, 2,991 were unaccounted for, and 8,457 were injured. People living in the disaster area were psychologically affected to varying degrees. A crisis mental health intervention plan was established by the Department of Mental Health (DMH).

The objectives were:

- To provide mental health support for survivors of the Tsunami.
- To establish a mental health care delivery system in collaboration with other organisations and community networks.

The phases of intervention were the following:

1. Emergency Phase

During this phase, the aim was to provide emotional support. Mobile mental health teams were sent out to evaluate the situation, gather information, work closely with local health personnel and provide psychological first-aid, triage and acute mental health care.

The 'Mental Health for Thai Tsunami Centre' was established in the Department of Mental Health, and a front-line centre was established in the South to facilitate daily teleconferences for developing work plans and reporting data for policy and decision-making.

2. Post-Impact Phase (two weeks to three months after the Tsunami)

The aim in this phase was to provide mental health assessment and early intervention. Outreach services focused on 'at risk' groups. The most severe cases were referred to psychiatric centres. The Ministry of Public Health established a 'Surveillance Centre' in the South to coordinate service activities and develop health monitoring information systems including general health, disease control, physical and mental health care and identification of dead bodies.

3. Recovery Phase (three months after the Tsunami)

The aim in the Recovery phase was to reduce psychological morbidity and improve quality of life. The 'Mental Health Recovery Centre' was established in the most seriously affected area, to collaborate with other organisations involved with mental health rehabilitation.

Collaborative research between the DMH and the US Centre for Disease Control and Prevention Collaboration, to assess the mental health problems among adults in affected area, found an elevated rate of post-traumatic stress disorder (PTSD), anxiety and depression two months after the Tsunami.

At follow-up after nine months, the rates of these symptoms decreased. The DMH developed a 'National Guideline for Mental Health Intervention in Natural Disasters' based on the lessons learnt from the response to the Tsunami.

Key success factors were the following:

- A well-established chain of command.
- A well-developed existing health and mental health care delivery system with the village health volunteer network working in the community.
- A comprehensive data and information-gathering system.
- Participation of partners, such as teachers and monks.
- One commander-in-charge to minimise staff confusion.
- A lead coordinator who is identified to work with the different organisations involved in order to prevent secondary trauma from repeated interviews.
- Appropriate mental health interventions for each phase or time period.

- Health personnel are sensitive and aware of the beliefs, religion and culture of the local people.
- The Centre reports all urgent physical needs other than mental health to the organisations responsible for meeting these needs.
- The mobile team is rotated every week and works less than twelve hours a day to prevent burnout.
- The Village Health Volunteers are the main personnel to deliver psychosocial relief efforts to the community.



Mental Health Recovery Center, Thailand.

Vietnam

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Vietnam's Mental Health System

Currently there are thirty psychiatric hospitals, including three major on-call duty centres run by the National Psychiatric Hospital No. 1, National Psychiatric Hospital No. 2 and the Bach Mai Mental Health Institute. Twenty-seven provinces in Vietnam have hospitals with psychiatric services, of which twenty-six are also involved in prevention of public health-related illnesses. There are a total of 5000 psychiatric beds and 2500 beds for serious mental illness nation-wide (for chronic mental illness). There are also 850 doctors with varying levels of specialty training; a ratio of one mental health doctor for every 100,000 people.

A Best Practice Example

Community-based mental health care project (CMHCP)

In 1998, Prime Minister Phan Van Khai approved this national community-based project.

Although from 2001 to 2005 the expenditure only met 38.6% of the project design cost, there was extra financial support from every province. The CMHCP received enthusiastic support from the provinces, districts and villages. Family members of people with mental illness were particularly interested because they were mostly from underprivileged backgrounds and could not afford medications for long-term treatment. Therefore, the CMHCP achieved good results from 2001 to 2005 despite a low budget and short duration.

Results of an epidemiological study of 10 common psychiatric illnesses from 2001 to 2003 were as follows: Schizophrenia 0.47%; Epilepsy 0.33%; Head Trauma/Postconcussion syndrome 0.51%; Mental Retardation 0.63%; Dementia 0.88%; Major Depressive Disorders 2.8%; Anxiety Disorders 2.6%; Conduct Disorders in Adolescents 0.9%; Alcohol Abuse 5.3%; Opioid abuse 0.3%.

The factors that facilitated the progress of the project were:

- The Party, Government, and Ministry of Health have provided support towards mental health from the beginning of the project.
- Strong support given by various public organisations.
- Despite being low in numbers and capacity, the specialist teams were enthusiastic and highly responsible in carrying out the project.
- Although still inadequate, the mental health care network in the whole country has gradually been established and spread from the central to the regional areas.

The obstacles and challenges encountered were:

- The system of mental health networks remains insufficient. Several regional areas remain unsupported and lacking in local treatment centres.
- Mass public education and communication are still limited, especially in mountainous and rural areas.
- Specialist doctors and the mental health workforce are still inadequate.
- Public awareness of mental illnesses is limited, leading to prejudices towards patients with psychiatric illnesses. Further, a large proportion of psychiatric patients in the community are still not being treated.
- Resources for travelling for administration, and examination and supervision of patients are non-existent.

The Project is a driving force for the development of networks and services for mental health in the community, covering the whole country (64 provinces). The priority is to increase public awareness of mental illness, early detection and access to treatment centres, so there are better opportunities for patients to be re-integrated in the community without neglect or abuse.

The Project has also enabled psychiatric patients from remote areas to benefit from community-based mental health care. Serious mental health illnesses like schizophrenia, epilepsy and depression were diagnosed and treated without cost to families.

The achievements have been possible due to the attention to mental health given by The Party, Congress, Government and Ministry of Health, as well as the hard work and dedication of the mental health staff.

The next stage of the project aims to increase the quality of services for people with mental health problems. Although the emphasis during the period 2006–2010 is still on schizophrenia, there are plans to include other non-transmissible illnesses, such as epilepsy and depression, within the CMHCP.

From the end of the 20th century, in line with WHO recommendations, many countries stopped building large scale psychiatric hospitals and increased the management of psychiatric illnesses in the community. This is consistent with the aim of the CMHCP.

Other future strategies of the project include: establishing mental health counselling centres or telephone help lines, increasing mental health service research to improve quality of care, increasing community mental health care, advocating for the development of mental health legislation, increasing international collaboration, and from 2008 to expand mental health care for children and older people. As there is currently only a small capacity to train mental health workers and social workers, there is a great need to build up the workforce to meet the needs of people with mental health problems.



National Psychiatric Hospital No. 1, Vietnam.