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Mental Health at the Primary Care Level

Report of a meeting of experts
Jakarta, Indonesia, 14-15 December 2007

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Annexes

1. Introduction

The Regional Office of the World Health Organization (WHO) organized a meeting of leading experts in mental health from the South-East Asia (SEA) Region to discuss mental health programmes at the primary care level and how these could be linked to the WHO Director-General (DG)'s six-point agenda. Experts from India, Indonesia, Maldives, Sri Lanka and Thailand participated. The Head of the WHO Collaborating Centre at Chulalongkorn University (Drug Dependence Research Centre) and the Chief of the National Drug Dependence Treatment Centre (NDDTC), New Delhi, India also participated.

Dr Vijay Chandra, Regional Adviser, Mental Health and Substance Abuse, pointed out the importance of mental, neurological and behavioural disorders which together impose a huge burden on Member countries of the SEA Region, accounting for 12% of total Disability-Adjusted Life Years (DALYs). It is important to note that this burden is much greater compared to some other public health problems, for example, HIV which accounts for 3% of DALYs.

As an introduction, the DG's six-point agenda and the declaration of Alma-Ata were circulated to the delegates. Participants identified the following points from the DG's speech made at the Fourth Global Meeting of Heads of WHO Country Offices in Geneva, as being specifically relevant to the proceedings of the meeting:

- "the strengthening of health systems is perhaps our most critical and urgent task, both for governments and the international community."
- "we must have better delivery systems."
- "I have called for a return to primary health care as an approach to strengthening health systems."
- "evidence from this evaluation has helped overcome one of the greatest barriers in public health and moving from pilot projects to national scale."
- "mental health services are being starved of both human and financial resources."

The proceedings of the meeting were divided into four sessions:

(1) Incorporating mental health services into primary care;

(2) Prevention of mental illness and promotion of mental well-being;

(3) Prevention of harm from alcohol use and substance abuse; and

(4) Other programmes of the SEA Region:

- Adolescent mental health promotion;
- Community-based rehabilitation;
- Legislation and policy;
- WHO Assessment Instrument for Mental Health Systems and
- Mental health aspects following a disaster.

Dr Vijay Chandra introduced each session with a brief presentation of the work being carried out at regional and country levels. This was followed by recommendations on the future directions of the regional programme, and suggestions to countries on the respective programmes.

2. Session 1: Incorporating mental health services into primary care

Dr Vijay Chandra described in brief that the focus of the SEARO Mental Health Unit since 2001 had been on strengthening the primary health care system to deliver mental health care. The programme started at an intercountry workshop (held in Bangkok from 19-22 November 2001) on "Development of Strategies for Community-based Neuropsychiatric Services". This meeting, which was attended by delegates of all ten Member countries (in 2001, there were 10 Member countries) recommended that mental health should be incorporated into the existing primary health care system of countries, but that the programme as it existed needed to be reoriented taking into account that the primary health care system could provide only basic services and could not be overburdened. At this meeting, it was also emphasized that the existing

focus on considering mental health care as a tertiary care speciality should be discouraged. Delegates also decided that only select neuropsychiatric conditions could be addressed at the primary health care level. They felt that the conditions which met the following criteria should be addressed:

- Most common;
- Most disabling;
- Easy to identify in the community;
- Cheap and efficacious medication;
- Good outcome if treated.

Applying these epidemiological principles, three conditions emerged that are common in all Member countries:

- Epilepsy affecting about 1 per cent population;
- Psychosis affecting 1.5 per cent population;
- Depression affecting about 3 per cent population.

In accordance with the recommendation of this workshop, and in collaboration with experts of Member countries and headquarters, the Regional Office has systematically developed an instrument for identification of these conditions by a trained lay health worker and treatment by a community-based GP.

The programme for identification and management of epilepsy in the community has been successfully implemented in DPR Korea, Maldives, Myanmar and in some states of India. An issue that still remains is how to scale up the model project in Myanmar and the progress achieved in states of India to cover the entire country. However, in Maldives the programme has already covered the whole country. The impact of the programme has been excellent as measured by an increase in the number of people getting bonafide treatment through PHC.

2.1 Discussion

Delegates focussed on the huge treatment gap in the community (as high as 90% for some conditions). There are many reasons for the lack in taking

treatment: which include services not available, ignorance and cost, etc. This leads to a significant morbidity in the community. With advances in medical sciences, such a high treatment gap is unacceptable, and urgent steps need to be taken to relieve the situation.

It has been noted that in some communities (e.g. the *Irvadi* tragedy in India, where many mentally ill persons were killed in a fire) that even if medical services are available, people do not use them; instead, they go to faith-healers. Such behaviour is one of the main causes of the high treatment gap. Thus the **health-seeking behaviour** of the community at the village level needs to be changed, to encourage community members to seek bonafide medical care.

Delegates were of a strong opinion that all programmes be assessed for their impact in reducing the treatment gap cost-effectively.

Delegates reviewed the Regional Office's manuals on identification of epilepsy and training of GPs and the material on stigma removal. They appreciated WHO's strategy and made a strong recommendation to rapidly complete the psychosis and depression identification instruments which were at an advanced stage of preparation.

It was felt that if PHC could be strengthened to deliver services for these three conditions, a substantial burden of neuropsychiatric conditions in the community could be reduced.

3. Session 2: Prevention and promotion of mental health

The following documents were distributed:

- Prevention of Mental Disorders – Effective Interventions and Policy Options;
- Promoting Mental Health – Concepts, Emerging Evidence, Practice;
- Mental Health Promotion – Case Studies from Countries;
- Prevention and Promotion in Mental Health;

- SEARO Manual on Adolescent Mental Health Promotion;
- SEARO Manual on Managing Learning and Behavioural Problems through Parents and Teachers; and
- Sri Lanka Manual for Training Medical Officers of Health.

Dr Chandra pointed out that promotion and prevention in mental health remained a high priority for the Regional Office. But the exact strategy, methodology and evidence- based programmes still needed to be developed.

The discussion focused on the "*health protecting and damaging behaviours*" of people, i.e. the behaviour of people which protects or damages their own health, e.g. eating too much and smoking, etc. It was brought out that knowledge and information are not enough for reducing health-damaging behaviour. A good example is smoking among physicians. All physicians are aware about the serious health consequences of smoking, yet a substantial proportion of physicians smoke.

The headquarters document clearly points out that diverse programmes in multiple sectors contribute to mental well-being. The results can be gratifying in multiple dimensions as assessed by the following:

To the individual, an increased sense of:

- Belonging;
- Self-esteem; and
- Self-determination and control.

To the organization and community:

- Accessible and responsible organizations; and
- Safe, supportive and inclusive environments.

To the society:

- Integrated and supportive public policy and programmes;
- Strong legislative platform; and
- Resource allocation.

However, to develop and introduce appropriate strategies and programmes, some of the factors to be considered are:

- Evidence of effectiveness;
- The principle of prudence;
- Cultural appropriateness and acceptability;
- Financial and personnel requirements;
- Level of technological sophistication and infrastructure requirements;
- Overall yield and benefit;
- Potential for large-scale application; and
- To facilitate partnership and collaboration.

There are some examples of successful mental health promotion programmes in Member countries e.g. the school mental health programme in India, Thailand and Sri Lanka and the building community resilience programme in Maldives and Thailand. Also, there is evidence that traditional methods such as meditation and *yoga* can be successfully used for mental health promotion. Breathing exercises (*Sudarshan kria*) is practised in India as a strategy for stress management, but developing this into a public health strategy remains to be tested. In Thailand a public health strategy for stress and anger management through slow breathing exercises is being tested and implemented.

Some strategies are available for prevention of mental disorders e.g. giving folic acid to pregnant women to prevent neural tube defects, iodine supplement to prevent iodine deficiency disorders which manifest as mental retardation, and prevention of suicide by treating depression and substance abuse.

3.1 Discussion

Delegates appreciated the importance of mental health promotion and prevention but emphasized that a clear, evidence-based and culturally appropriate programme with clear impact indicators needs to be developed.

4. Session 3: Prevention of harm from alcohol use

Dr Vijay Chandra presented the programme conducted in the Regional Office for South-East Asia (SEARO) that emphasized the office's priority of prevention of harm from alcohol use and not supply reduction that was mainly a function of the police, excise and customs departments. The priority for SEARO was to prevent harm from alcohol use specially among adolescents. There was a paradox in the competing interest of some ministries in considering the alcohol industry as a source of revenue versus the broad spectrum of harm from alcohol use. There were many unique issues in the South-East Asia Region, such as alcohol and poverty, home brew, illicit and adulterated alcohol, "pay day" drinking and family violence linked to alcohol use. There was a need to develop an evidence-based and culturally appropriate prevention of harm strategy. Delegates also discussed the role of the health sector in working with other sectors to take a comprehensive multisectoral approach to prevention of harm from alcohol use.

4.1 Discussion

Availability of data on the magnitude of alcohol use:

The nationwide survey of alcohol use in Thailand had been completed with the WHO Collaborating Centre, Drug Dependence Research Centre, serving as the coordinating agency. These data are now available. The National Health Survey and National Household Survey on alcohol and drug abuse conducted in India also had data on the extent of alcohol use in the community. In addition, data from Myanmar and Sri Lanka, based on the community assessment studies that were being conducted will be available by the middle of 2008. Questions on alcohol use have been included in Indonesia's National Household Survey. These will also soon be available. All these data will be made available to the Regional Office for South-East Asia and compiled into one document. Based on these data, intervention strategies will be planned.

4.2 Community actions for prevention of harm from alcohol

Participants were of the opinion that examples of community actions in Member countries which had already been implemented and shown to be either successful or unsuccessful should be compiled. SEARO was requested to compile all country reports into one document.

4.3 Promotion of abstinence

SEARO in consultation with Member countries had developed a "life skills" programme focusing on prevention of harm from alcohol use in schools. Discussion took place on the targets set for this programme. The conclusion was to delay the age of first consumption of alcohol, the duration between first and second consumption of alcohol and to prevent occasional users from becoming regular users.

In Thailand, prevention measures are taken in schools through the programme: 'School boy mental health care' in which there is one teacher for 40 students and if a problem is spotted by the teacher, the student is referred to the local hospital. There is another programme in which a meeting place called "friends corner" is set up, usually in shopping malls that are often visited by adolescents. This is a very friendly environment for adolescents to use and encourages them to discuss issues with their friends and peers.

4.4 Intervention for hazardous drinkers

A variety of instruments involving a variety of personnel are available for intervention with this group. Some of them have been tested and used successfully used in some Member countries. In Thailand, the treatment strategy goes down to the PHC level where GPs have been trained to identify and treat this group. Health workers follow up with patients to prevent relapse.

4.5 Brief intervention for hazardous and harmful drinking

This strategy includes:

- Alcohol and drug education;
- Simple advice (guide to low-risk drinking and information on high-risk drinking);
- Brief Counselling (feedback, information, advice and encouragement);
- People need people; and
- Manage boredom.

The NDDTC, New Delhi, India has carried out a multi-site project sponsored by WHO for harmful drinking. A manual has also been developed.

4.6 The ASSIST (Alcohol, Smoking and Substance Involvement Screening Test) Project

The translation of Assist into Hindi was done by the Department of Psychiatry/NDDTC, New Delhi, India. The document Assist Questionnaire Version 3.0 (Hindi) can be accessed at: http://www.who.int/substance_abuse/activities/assist/en/index.html

4.7 Intersectoral collaboration:

Delegates were of the opinion that prevention of harm from alcohol went well beyond the health sector. Moreover, by the time a user became a patient for the health sector, it was already late in the spectrum of harm from alcohol use. However, delegates realized that convincing other sectors particularly ministries of trade, commerce and finance to limit promoting the alcohol industry was a major challenge. Also, strategies to deglamourize the use of alcohol needed to be developed.

5. Session 4: Prevention of harm from substance use

Dr Chandra described that SEARO has focused mainly on school-based programmes for prevention of substance use. In addition, it was also active in programmes on injecting drug use.

5.1 Discussion

National data on the magnitude of substance use from India and seven countries of South-East Asia Region are available. These data have been compiled with support from United Nations Office on Drugs and Crimes and have been published. Similarly, national data from Thailand are available on the type of drug abused. Substance use is a major concern in Maldives. Local experts will try to conduct an assessment of substance use in Maldives. This information can then form the basis of programme development and planning. The delegate from Sri Lanka felt that substance abuse was not as big a problem as tobacco and alcohol use.

Community actions for prevention of harm from substance use:

The Indonesia National Narcotic Board collaborates with the Ministry of Education regarding some school-based programmes for prevention of harm from substance use in all provinces using anti-drug education. The Ministry of Education has its own "life-skills" programmes on reproductive health and healthy lifestyles that it promotes.

The Ministry of Health also runs school health programmes on primary prevention of drug use for students using the lifeskill methods, and to empower parents in drug education, but the impact of such programmes is limited because of lack of commitment of school teachers. A strong commitment from the Ministry of Health and Education is therefore needed.

In Sri Lanka, the National Dangerous Drug Control Board has established a few rehabilitation centres, but generally, even if people want help, they do not know where to go. Community support centres are being developed where people can go if they need support for any problem

including those with substance use problems (and also for reduction of harm from alcohol use).

In Thailand, Princess Kulayaeewatana patronizes a national programme for prevention of substance abuse called "To be number 1". Another strategy being developed is peer counselling. Also, if an adolescent is identified as having a problem, they are referred for care.

Delegates were of the opinion that the overall health promotion programme should address the needs of the community including its recreational needs and what it can get involved in. The local government should have activities for children, such as sports. However, an impact evaluation of the lifeskills programme for substance use is needed.

Interventions

Treatment focusing on detoxification is generally undertaken in a hospital in most countries but can easily be carried out at a PHC. Even community-based detoxification programmes can be considered. An issue of concern is relapse prevention for which community support programmes are needed.

Organizing the logistics and training of staff involved with methadone maintenance programmes and guidelines for pharmacotherapy for opiate dependence are needed for Member countries in the SEA Region. Some of these guidelines have already been developed by WHO headquarters; as such, these should be disseminated to all Member countries. Amphetamine abuse is increasing rapidly in the Region, and has become a cross-border issue. Methods of detecting its use (questionnaire, urine testing) need to be developed and tested (WHO Collaborating Centre, Thailand to take the lead).

6. Other programmes of the SEA Region

6.1 Adolescent mental health promotion

SEARO's strategy is based on development of lifeskills. A set of eight manuals have been developed that have been tested and used in many

countries. Presently, the programme is an urban school-based programme, but in future rural programmes also will be developed. There is some evidence of "benefit" e.g. improvement in school grades, lesser number of school complaints and reduced incidence of bullying and fights, but exactly how the impact of the programme should be measured, remains to be determined.

6.2 Community-based rehabilitation

SEARO is presently conducting running three programmes: rehabilitation of the intellectually impaired, rehabilitation of the mentally ill and management of learning and behavioural disorders through parents and teachers.

Community-based rehabilitation of the intellectually impaired:

SEARO strategy is based on training of parents and rehabilitation workers. The focus is on urban and nearby-rural areas. There are three Centres of excellence in the Region (Rajanokol Institute, Thailand, National Institute of Mentally Handicapped, Hyderabad, India, and a centre in Chiang Mai, Thailand). These centres work closely with SEARO and can be used as training centres for Member countries in the Region. A Regional Office manual developed by local experts is available; it has been tested and is being used in many countries. The issues relate to scaling up of the programme as it is very intense and requires one-to-one training and implementation. Soft measures of impact have been advocated e.g. parents seen "smiling" for the first time and saying they did not believe that these children could be rehabilitated. The challenge is to reach the rural and remote areas.

Community-based rehabilitation of the mentally ill

Rehabilitation of persons with mental illness is usually carried out in a hospital setting but requires intense follow-up and support of the community. Many excellent examples are available e.g. in Thailand where a programme is run by monks, and in Sri Lanka and India where an NGO rehabilitates homeless women with mental illness. Intermediate rehabilitation centres are available in most districts in Sri Lanka. However

many more programmes are needed. Member countries are requesting training. The main issue is a shortage of paramedical rehabilitation staff.

Community-based rehabilitation of children with learning and behavioural problems

The recognition of learning and behavioural problems in children is extremely limited in most Member countries of the Region. However, a lot can be done by proper training of parents and teachers. An expert from the Region has developed a manual which can be used for training parents and teachers in the recognition and management of these conditions without involving a psychiatrist. In Thailand there is a special programme for children with autism. In Sri Lanka, public health workers are trained through the use of Child Health Development Records.

6.3 Suicide prevention

Suicide is recognized as a major problem in India, Sri Lanka and Thailand. A research programme has been developed by the Mental Health Department of WHO headquarters that has determined that there are similar yet different risk factors for suicide in the SEA Region compared to the West. India and Sri Lanka are participating in the headquarters project on prevention of suicide. The practical prevention programme that is being implemented in India and Sri Lanka concerns safe storage of pesticides in rural areas. Community support centres with multisectoral involvement (proposed in Sri Lanka) can provide services for suicide prevention.

Thailand has an independent comprehensive programme on suicide prevention in which every sector and ministry is involved. It includes treatment of depression, public education, training health volunteers in prevention, regular follow-up in the community and contact of "at risk" persons with the health sector. Experts also work with the media to try not to glamourize and report suicide in a way that would encourage others to copy the act. A GIS mapping programme is used to compare communities in the number and distribution of suicides. Hospitals are rewarded for meeting the goals of suicide reduction. A lot of research is being done to explain local findings e.g. the rate of suicide is higher in northern Thailand. A programme being tested and developed deals with building resilience

(optimism, happiness, positive psychology and stress and anger management).

6.4 The WHO Assessment Instrument for Mental Health Systems (WHO AIMS)

This programme was designed by the Mental Health Department of headquarters to assist Member countries from around the world to assess their mental health systems using a structured format. Based on the findings, countries can hold national consultations to decide how to enhance their mental health systems and what should be prioritized. Ten Member countries of the SEA Region have completed the instrument, including three states in India. A regional summary will be prepared.

6.5 Mental health legislation

The current mental health legislation of some Member countries is based on the British Lunacy Act of 1912. This Act considered mentally ill persons as dangerous to the community and focused on protecting the community by locking up the patients. There was very little attention on treatment and human rights of patients. With recent advances and understanding of mental illness, there is an urgent need to update the Mental Health Legislation in countries. India has developed and notified a new Mental Health Act. Recently Sri Lanka and Thailand developed revised drafts of their respective Mental Health Acts. In Bangladesh, Indonesia and Nepal the Act concerned is being reviewed. Maldives is also interested in developing a new Act. This project is being jointly supported by SEARO and headquarters.

6.6 Aspects of mental health care following a disaster

There are two components of mental health aspects following a disaster:

- Mental health and psychosocial care after a disaster; and
- Mental health and psychosocial aspects of disaster preparedness.

The strategy for mental health and psychosocial care following a disaster is well established. The experience of India, Indonesia, Maldives, Sri Lanka and Thailand in dealing with the aftermath of the tsunami helped to further develop the strategy. It is, however, important to clearly differentiate psychosocial support from mental health care. Psychosocial support involves social support (e.g. respectful disposal of dead bodies, provision of shelter, food, treatment of injuries and obtaining aid, etc.) and psychological first aid delivered by a trained community-level worker. Mental health care involves a higher level of expertise and is delivered by counsellors, trained GPs and mental health professionals. A tertiary care, clinical psychiatry approach should be avoided.

The mental health and psychosocial aspects of disaster preparedness are crucial and should be incorporated into the overall disaster preparedness plan. All sectors should be in agreement with the plan. Technical material should be developed and tested. Periodic drills should be carried out. The coordination mechanism and responsibilities should be clearly established and accepted by all concerned. SEARO has convened a workshop to discuss these aspects in Khao Lak, Thailand in June 2006.

Technical material on mental health and psychosocial aspects of disasters has been developed by the Regional Office and can be readily adapted to suit local conditions in Member countries of the Region.

7. Conclusions and recommendations

Participants focused on recommendations that would strengthen mental health care programmes at the PHC level by reaching out to the community.

7.1 Incorporating mental health services into primary care:

- WHO should give high priority to advocacy with governments, policy-makers and the community for recognizing the treatment gap for the most common and disabling mental, neurological and behavioural disorders that can be managed at the PHC level. This would lead to the development, implementation and

acceptance of programmes to reduce the high burden from these conditions. Member countries should draw up an action plan to reduce the treatment gap in a time-bound manner.

- Member countries should be encouraged to adapt and scale up the Regional office's programme on identification and management of the most common and disabling mental, neurological and behavioural disorders that have been developed and tested in the Region.
- The identification instruments for psychosis and depression (being the two most common and disabling causes of morbidity in the community) should be completed urgently.
- Special focus and research are needed on changing the health-seeking behaviour and reduction of health damaging behaviour which are major contributors to the burden from neuropsychiatric conditions.

7.2 Prevention of mental illness and promotion of mental well-being

- A clear evidence-based and culturally appropriate programme with quantifiable impact indicators for mental health promotion and prevention needs to be developed. SEARO should give priority to developing this programme.
- Culturally relevant approaches (e.g. meditation and *yoga*) with regard to their effect on well-being and prevention of mental illness and how these can be used as a public health strategy should be developed and tested.

7.3 Prevention of harm from alcohol use

- Member countries are encouraged to adapt and implement the lifeskills-based programme on prevention of harm from alcohol use especially among adolescents developed by SEARO.
- A scientific assessment of the impact of public education (IEC) on reduction of harm from alcohol use should be conducted.

(e.g.: posters/display boards on highways and the associated reduction in accidents).

- SEARO should convene an intercountry workshop for all Member countries to discuss the available data, community action programmes, intervention strategies and inter-sectoral collaboration after data from five countries in the Region have been compiled and analysed.
- All community action programmes and interventions for hazardous drinkers already implemented (whether successful or unsuccessful) in Member countries should be compiled in a document.

7.4 Prevention of harm from substance use

- SEARO should organize a regional intercountry workshop to discuss reduction of harm from substance use including methadone maintenance programmes.
- The Drug Dependence Research Centre (WHO Collaborating Centre), Thailand be requested to develop a draft of methods of detection of amphetamine use (questionnaire, urine testing) which can be tested in Member countries.

7.5 Adolescent mental health promotion

- Programmes on adolescent mental health promotion have been developed by SEARO. There is some evidence of their positive impact. These should be scaled up as much as possible to address the well-being of this vulnerable group.

7.6 Community-based rehabilitation of the intellectually challenged

- Countries are encouraged to develop community-based rehabilitation programmes for the intellectually challenged, as not only are they more effective if implemented appropriately,

they are cheaper than hospital-based programmes and can reduce the load on mental health professionals substantially.

7.7 The WHO Assessment Instrument for Mental Health Systems

- Countries that have completed the WHO AIMS instrument should consider holding national workshops to disseminate the findings and decide how to enhance their mental health systems, focusing on community-based services. SEARO should provide technical support to these workshops.

7.8 Mental health aspects of disaster preparedness

- Countries should include mental health and psychosocial aspects of disaster preparedness in their overall disaster preparedness plans. SEARO should consider organizing a review workshop of the mental health and psychosocial aspects of disaster preparedness to determine the progress made since the previous workshop held in Khao Lak, Thailand in June 2006.

Annex 1

List of participants

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Annex 2

Programme

Day 1: Friday, 14 December 2007

0900 – 0930 Opening Session

- Opening (Vijay Chandra)
- Introduction by participants

0930 – 1000 Photo session

1000 – 1030 Introduction: Mental health: past, present and future

1030 – 1300 Session 1
Incorporating mental health services at the primary care level

1400 – 1630 Session 2
Mental health prevention and promotion

1900 – 2100 Welcome Reception

Day 2: Saturday, 15 December 2007

0900 – 1230 Session 3
Prevention of harm from alcohol and substance use

1330 – 1700 Session 4
SEARO/MHS programmes on

- Adolescent mental health
- Community based rehabilitation
- Legislation and policy
- WHO AIMS
- Disaster mental health

1700 – 1730 Closing