ASEAN MENTAL HEALTH SYSTEMS

one vision
one identity
one community

ASEAN
MENTAL HEALTH SYSTEMS

The ASEAN Secretariat
Jakarta

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CONTENTS

Table of Contents i

Message from the Secretary-General of ASEAN ix

BRUNEI DARUSSALAM

Introduction 2

General Health System 3

Mental Health Problems in the Community 4

Mental Health System 5

Law 5

Policy 6

Facilities 6

Human Resources 7

Financing 9

Mental Health Services 9

Medicines 11

Human Rights 12

Health Information Systems 12

Integrating Mental Health into the National Health System 12

Community Empowerment 13

Priorities, Challenges and Opportunities 14

References 16

CAMBODIA

Introduction 18

General Health System 19

Mental Health Problems in the Community 24

Mental Health System 25

Mental Health Governance 25

Mental Health Facilities 27
Mental Health Human Resources 28
Financing 29
Mental Health Services **29**
Referral Hospital 29
Health Centre Level 30
Medicines 31
Human Rights 31
Health Information System 31
Integrating Mental Health into the National Health System **32**
Priorities, Challenges and Opportunities **33**
Priorities 33
Challenges 33
Opportunities 33
References **35**

INDONESIA

Introduction **38**
General Health System **39**
Mental Health Problems in the Community **41**
Mental Health System **42**
Facilities 43
Human Resources 44
Financing 47
Mental Health Services **49**
Medicines 50
Human Rights 51
Community Empowerment **51**
Health Information Systems **52**
Integrating Mental Health into the National Health System **53**
Priorities, Challenges and Opportunities **54**
References **56**

LAO PDR

Introduction **58**

Health Services Delivery System **58**

Mental Health Problems in the Community **58**

Mental Health System **59**

Mental Health Integration into Health Care System Policy and/or Regulation 59

Health Resources 59

Mental Health Financing 60

Mental Health Care Delivery **60**

Primary Care 60

Mental Health Services in General Hospitals 61

Medicines 61

Information System 61

Community Empowerment **61**

References **62**

MALAYSIA

Introduction **64**

General Health System **64**

Healthcare Facilities, 2013 65

Mental Health Problems in the Community **66**

Mental Health System **66**

Vision and Mission for Mental Health 66

The National Mental Health Policy 67

Mental Health Framework 67

Mental Health Governance 68

Mental Health Act and Legislation 68

Mental Health Resources 68

Mental Health Financing 69

Community Mental Health Program in Malaysia **70**

Mental Health Promotion 70

Healthy Mind Program in School 71

Suicide Prevention Program 71
Psychosocial Response to Disaster 72
Mental Health Services 73
Mental Health Services in Primary Care 73
Mental Health Screening and Intervention 74
Treatment and Follow-Up of the Stable Mentally Ill 75
Psychosocial Rehabilitation 76
Mental Health Services in the Hospitals 76
Community-Based Mental Health Services 77
Non-Governmental Organisations 77
Training 78
Guidelines and Modules 78
Information Systems 79

MYANMAR

Introduction 82
General Health System 84
Health System Priorities 87
An Overview of the Scope and Role of Primary Care in the General Health System 89
Mental Health Problems in the Community 90
Access to Primary Care and Specialist Mental Health Services and Barriers to Access 90
Mental Health System 92
Law 92
Policy 92
Aim of Mental Health Services 92
Strategy 93
Facilities 94
Human Resources 95
Financing 96
Services 96
Hospital-Based Mental Health Care Services 96
Community-Based Mental Health Services 97

Medicines 97
Human Rights 98
Health Information Systems 98
Integrating Mental Health into the National Health System 99
Community Empowerment 100
Priorities, Challenges and Opportunities 101
References 102

PHILIPPINES

Introduction 104
General Health System 106
Health System Governance and Organization 106
Financing 107
Human Resources 108
Health System Priorities 109
Mental Health Problems in the Community 109
Mental Health System 110
Human Resources 111
Services 112
Medications 112
Mental Health in Primary Health Care 112
Health Information Systems 113
Community Empowerment 114
References 115

SINGAPORE

Introduction 118
Healthcare Financing 118
Health Care System 119
Mental Health in Singapore 121
Mental Health Promotion 122

Mental Health Services **123**
Development of Mental Health Services – Community Empowerment 124
Mental Health Workforce 125
Mental Health Expenditure 126
Law 126
Medicines 127
Information System 127
The Future in Singapore's Mental Health Landscape **127**
References **129**

THAILAND

Introduction **132**
General Health System **133**
Health System Governance and Organisation 133
Health Services Delivery Levels 134
Health Financing 135
Health Workforce 136
Health Service Priorities 137
Access to Services 138
Mental Health Problems in Community **139**
Epidemiology 139
Community Mental Health Awareness 139
Mental Health System **140**
Governance/Administration 140
Law 140
Policy 140
Facilities 141
Human Resources 141
Mental Health Cadres 142
Mental Health Financing 144
Mental Health Services **144**
Primary Care 144
Education and Training 145
Provision of Medicines in Primary Care and in General Hospitals 145

Human Rights 146
Information Systems 146
Integrating Mental Health into the National Health System 146
Community Mental Health Empowerment 147
Priorities, Challenges and Opportunities 148
References 149

VIET NAM

Introduction 152
General Health System 153
Mental Health Problems in the Community 156
Mental Health System 158
Mental Health Governance 158
Mental Health Law and Policy 159
Mental Health Facilities 159
Mental Health Human Resources 160
Financing 161
Services 161
Medicines 162
Human Rights 163
Mental Health Information System 163
Integrating Mental Health into the National Health System 165
Community Empowerment 165
Priorities, Challenges and Opportunities 165
References 167

Message

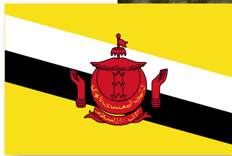
The ASEAN Socio-Cultural Community Blueprint 2025 promotes a healthy, caring, sustainable and productive community that practices healthy lifestyle resilient to health threats and has universal access to health care. Mental health is identified as one of the health priorities under the ASEAN Post 2015 Health Development Agenda for 2016-2020.

The ASEAN Mental Health Systems Report catalogues the situation of mental health in ASEAN Member States. This report provides comprehensive information on the progress made so far by AMS in integrating mental health into national health systems, increasing access to care as well as challenges faced. It also offers recommendations on how to improve the mental health system in respective ASEAN Member States.

The publication of this report was endorsed by the ASEAN Work Plan on Mental Health 2011-2015 under the purview of the ASEAN Mental Health Task Force (AMT). This report was developed by AMT with contributions from Global and Cultural Mental Health Academic, Melbourne School of Population and Global Health, University of Melbourne. The AMT pioneered in developing a joint effort to improve mental health care across the region. This joint cooperation enabled cross-sharing of mental health data, benchmarking of best practices and promotion of mutual support and accountability.

It is my hope that this Mental Health Report could become a catalyst for greater dedication towards mental health care across ASEAN. It is envisioned that this report would increase awareness of the need to improve mental health care in general and to specifically address accessibility and quality concerns related to mental health in ASEAN.

Le Luong Minh
Secretary-General of ASEAN



BRUNEI DARUSSALAM

Hilda Ho, Ministry of Health
Ramli Hassan, Raja Isteri Pengiran Anak Saleha Hospital

Introduction

Brunei Darussalam is a small sovereign state of about 2,200 square miles or 5,765 square kilometers on the north coast of the Island of Borneo. Apart from its South China Sea coastline it is completely surrounded by the state of Sarawak, Malaysia, and is separated into two parts by the Sarawak district of Limbang. The western part comprises three districts (Brunei- Muara, Tutong and Belait) while the separated rural eastern part is the district of Temburong. The largest district is Belait while the capital, Bandar Seri Begawan, is in the smallest district of Brunei-Muara.

Based on the 2011 census, Brunei's population is about 400,000, of which about 100,000 are migrant workers. 51.5% are males. About 150,000 live in the capital city. 65.7% of the population is Malay, 11% Chinese, 3.4% indigenous and smaller groups making up the remainder. The main language spoken is Brunei Malay, which is different from standard Malay but is well understood and spoken by a significant majority of the local population. Other languages spoken include Kedayan, Murut, Dusun and Iban. Brunei has a young population, with 33.5% less than 15 years old. Less than 3.5% of the population is 65 years or older. The average life expectancy is 67 years.

Brunei is a constitutional sultanate with a hereditary monarchy. The administration of the country is divided into four districts, and further sub-divided into regions and villages with village heads. Islam is the official religion of Brunei and about two-thirds of the population is Muslim. Other faiths practised include Christianity, Buddhism, Confucianism and Taoism. About 2% of the population practise indigenous religions. The sale and public consumption of alcohol is banned. However, non-Muslims are allowed to bring in a limited amount of alcohol for their own consumption. The culture of Brunei is largely Malay with a strong influence of Islam. In general, Brunei can be considered to be a conservative Muslim country.

Brunei is ranked as a high-income country, with a GDP per capita of USD 41,000 in 2012 (United Nations World Statistics Pocketbook, 2014). It has the second highest Human Development Index among South East Asian nations, behind Singapore, and is considered to be a developed country (United Nations Development Program 2014). Brunei has been able to achieve health targets set in the Millennium Development Goals (UNDP Economic and Social Commission for Asia 2012). There have been significant reductions in the under 5 mortality rate and the infant mortality rate. The maternal

mortality rate has always been low and the prevalence of HIV and AIDs has also been very low.

The main burden of disease is attributed to non-communicable diseases such as cardiovascular disease, cancers and diabetes, which accounted for approximately 80% of deaths recorded in 2014 (WHO Non-communicable Diseases Country Profile, 2014).

General Health System

The Government, through the Ministry of Health, provides free medical and healthcare to its citizens. There are four government general hospitals (RIPAS Hospital in the capital city Bandar Seri Begawan, SSB Hospital in Belait District, PIMB Hospital in rural Temburong district, and PMMPHAMB Hospital in Tutong Distric), and a large network of primary health centers and clinics (including maternal and child health clinics), while less accessible areas receive health care via a Flying Medical Service. There are also two private hospitals that cater private patients or provide some services that may not be available in the government general hospitals. Patients who need medical or surgical services not available in the country are sent overseas for further care at the Government's expense.

Brunei Darussalam has 1.1 physicians, 3.5 nurses and 1.31 midwives per 1000 population (Western Pacific Region Health Databank, 2011). Human resources are a specific challenge in a small country such as Brunei. Most health professionals gain specialist training overseas, although undergraduate nursing and pre-clinical medical training can be obtained locally. There is no training available for allied health professions such as pharmacy, psychology, occupational therapy, speech and language therapy or social work.

There is one government tertiary hospital, three government district general hospitals and two private hospitals. There are 16 primary health care centers. However, there has been some growth in primary care provision and several new primary health care centers are being planned. Primary health care centers provide basic general health care, maternity and post-natal care. Certain health centers also provide specialist care such as mental health and ophthalmology. Health care is virtually free of charge for all citizens and permanent residents. Foreign nationals can access health care in government health services with direct payment, or through health insurance providers. The general health

system priorities include meeting the Millennium Development Goal targets and tackling the increasing burden of non-communicable diseases. Achieving Universal Health Coverage is a key Ministry of Health aim.

Mental Health Problems in the Community

Hospital out-patient and in-patient data indicate that the main mental health problems that present to psychiatric services are psychotic disorders such as schizophrenia, followed by bipolar disorder and depression. There is no population-based data on the prevalence of mental disorders. The introduction in 2013 of a national electronic patient information system provides the possibility of collecting treated prevalence data in the future. There is no current plan for population epidemiological studies.

The main challenges facing people suffering from mental illness are stigma and discrimination. Beliefs regarding spirit possession and black magic dominate understanding of mental illness. Fear, ignorance and shame are major barriers to seeking help. Many people are kept at home for years and only brought to hospital to the Accident and Emergency departments in crisis situations, for example when they have become aggressive or when their carers are unable to look after them. Patients and their families may seek help from primary care clinics or hospital. Patients can be seen on the day they present to primary care services or in Accident and Emergency. Waiting list times for specialist mental health clinics are short, and rarely more than a few weeks. Expertise in the management of mental health problems varies among general practitioners working in primary care. In recent years, doctors who train in primary care locally may choose to do a 3-month attachment in psychiatry. There have also been nationwide training programs in mental health and the 2014 Mental Health Order (Laws of Brunei, 2014), which have exposed the majority of medical practitioners to the management of mental health problems. While the Ministry of Health seeks to provide mental health care of high quality the difficulties encountered include limited human resources and a considerable bureaucratic process. However, considerable progress has been made in recent years (Ho, 2014).

Mental Health System

All government health services are administered by the Ministry of Health. Within this, there are two main offices. The Department of Psychiatry is administered under the office of the Director General of Medical Services. This is due to the historical focus on hospital-based care for mental illness. Thus, despite the expansion of community services and specialist mental health clinics in primary care centers, the administration and development of these community services is regarded as an outreach activity from the hospital-based department.

Primary care services are administered under the office of the Director General of Health Services, who oversees primary care and related community services including community psychology. This separation can lead to difficulties in service cohesion, however, the Department of Psychiatry has been able to bridge the two systems relatively successfully.

Law

Brunei's new mental health legislation was implemented on 1st November 2014. This is a much needed and long overdue development which has required significant multi-agency consultation and commitment. The 2014 Mental Health Order (Laws of Brunei, 2014) signals a significant change in the approach towards mental health care. The long title is 'an Order to consolidate the laws relating to mental disorder and to provide for the admission, detention, lodging, care, treatment, rehabilitation and protection of persons who are mentally disordered and for related matters'. The guiding principles include the preservation of individual autonomy, acting in the best interests of patients, using the least restrictive alternative for treatment, reciprocity and beneficence, promoting equality and non-discrimination, and ensuring multi-agency management. It is designed to be pragmatic in its approach and straightforward to apply given the local context of services that are still in early development. The legislation emphasizes the shared responsibilities of stakeholders and the importance of carer involvement. Previously undefined terms such as 'lunacy' and 'lunatic asylum' have been replaced with modern definitions such as 'mental disorder' and 'psychiatric facility'. The legislation is accompanied by a Code of Practice (Ministry of Health, 2014) which has been published by the Ministry of Health as a guide for the use of this new legislation.

The specific components of the 2014 Mental Health Order are as follows:

I. Preliminary provisions and definitions
II. Admission and detention in and discharge from, psychiatric facilities.

III. Discharge, leave of absence and transfer of involuntary patients from psychiatric facilities.
IV. Persons admitted or confined in psychiatric facilities under Criminal Procedure Code.
V. Community psychiatric residence.
VI. Community mental health centre.
VII. Board of Visitors.
VIII. Quality of psychiatric healthcare facilities and services.
IX. Proceedings in enquiries into mental disorders.
X. General provisions.

A national training and road-show programme has been completed in order to train all medical practitioners in the implementation of the legislation, and to increase awareness amongst other key partners such as allied health professionals, the police, the prisons department, the Courts, welfare agencies and village heads. Publications regarding the change in legislation have also appeared on national media. Training and other resources have been made available online.

Policy

There is no formal national mental health policy. This is an important piece of work that requires attention. However, the integration of mental healthcare within primary care and the expansion of community mental health services is a priority.

Facilities

There has never been a dedicated psychiatric hospital in Brunei. Each district has a general hospital that also provides psychiatric services. However, full-time psychiatric services, with in-patient psychiatric facilities, are available only in two districts, Brunei-Muara and Belait. In the other two district hospitals, in Tutong and Temburong, only out-patient, day-care and community psychiatric services are provided and no in-patient beds are available. At present, there are no private psychiatric services available in Brunei, and there are no psychiatric nursing homes.

Table 1.1: Availability of mental health facilities

	Total number of facilities/ beds	Rate per 100,000 Population	Number of facilities/ beds reserved for children and adolescents only	Rate per 100,000 population
Mental health outpatient facilities	9	2.25	0	0
Day treatment facilities	3	0.75	0	0
Psychiatric beds in general hospitals	36	9.0	0	0
Community residential facilities	2	0.5	NA	NA
Beds/places in community residential facilities	20	5.0	NA	NA
Mental hospitals	0	0.0	NA	NA
Beds in mental hospitals	0	0.0	NA	NA

Human Resources

Human resources and service sustainability is a significant challenge. The majority of medical doctors are foreign nationals who are employed on a three-year contract basis. There is a medical school which offers a pre-clinical undergraduate course. Students are sent overseas to partner institutions in order to complete their clinical training. In recent years, a 2-year foundation training scheme has been set up for returning medical graduates. There is an established vocational training scheme for primary care doctors. Both schemes offer three to four month rotations through psychiatry. Promising local doctors are often sent overseas to train, funded by the government. In 2014, a higher training scheme for medical trainees in General Adult Psychiatry has been established and approved by the Post-Graduate Advisory and Training Board of the Ministry of Health. This offers an exciting opportunity to expand the specialist medical workforce.

Staff nurses are recruited into psychiatry with a basic general nursing qualification. They may apply to do a diploma in mental health nursing after working in the department. Some have the opportunity to be sent overseas or to the local university for further studies. Nurses are supplemented by mental health workers, nursing assistants and attendants. Other members of the multi-disciplinary psychiatric team – social workers, clinical psychologists and

occupational therapists – come from a central pool, although the RIPAS Mental Health Unit has allocated sessions from a social worker and occupational therapists. There are no formal training schemes for clinical psychologists, occupational therapists, or social workers. Those who wish to train in these disciplines must to seek training overseas. This severely limits the number of skilled staff available. Community welfare services exist but require much development. Nevertheless, significant efforts have been made to improve multi-disciplinary care and multi-agency cooperation with some success.

There is no formal training available for community mental health workers. Most community staff are recruited from within the nursing pool of the department of psychiatry. The department has help from a number of voluntary organizations mainly involved in providing materials, therapeutic and social activities for patients.

Table 1.2: Health professionals working in mental health, audited in 2013

Health professionals working in mental health services	Total number	Rate of health professionals per 100,000 population	Median rate of human resources per 100,000 population working in the mental health sector (Western Pacific Region Area)*	Median rate of human resources per 100,000 population working in the mental health sector (World)*	Median rate of human resources per 100,000 population working in the mental health sector (High Income Countries)*
Consultant psychiatrists / specialists	6	1.5	0.90	1.27	8.59
Other medical doctors	8	2.0	0.81	0.33	1.49
Nurses (staff nurse grade and above)	50	12.5	7.70	4.95	29.15
Occupational therapists	3	0.75	0.00	0.06	1.51
Clinical psychologists	4	1.0	0.00	0.33	3.79
Social workers	0.5	0.125	0.00	0.24	2.16

Source: Ho, 2014

*Figures taken from the Mental Health Atlas, World Health Organization, 2011

Financing

There is no separately identifiable mental health budget. Funding for mental health services comes from the central hospital budget. Individual projects are financed according to approval from the Ministry of Health. Health services are financed entirely by the government. For citizens and permanent residents, there are minimal out-of pocket fees to see a doctor (US$1) and this includes the prescription charge. Foreign nationals pay a subsidized fee (US$3.5 Brunei Dollars) to see and doctor and the cost of investigations , hospital stay and medication. However, treatment for children under 12 years is universally free-of-charge.

Mental Health Services

The Mental Health Unit, in RIPAS Hospital in the capital Bandar Seri Begawan, is an acute locked unit, mainly because 63% of admissions were involuntary admissions in 2007. It was established in 1984 as an acute 20-bed facility, providing services to a catchment area covering Brunei-Muara, Tutong and Temburong Districts, a population of 320,000. It provides inpatient services as well as an outpatient clinic. A busy community rehabilitation service and day care centre is situated in a residential area close to the hospital. There is a Community Psychiatry Service with full-time staff nursing. Patients from Tutong and Temburong needing admission are sent to RIPAS hospital inpatient psychiatric unit. The Belait hospital mental health unit is a newly refurbished centre which accommodates up to 16 inpatients, a day treatment area, outpatient clinics and a community mental health team.

Table 1.3: Admissions to RIPAS Mental Health Unit

Year	New Cases (Male)	New Cases (Female)	Admission of follow-up cases (Male)	Admission of follow-up cases (Female)	Total	Involuntary admissions	
						N	%
2012	38	27	64	46	175	91	52.0
2013	42	33	90	45	210	95	45.2
2014	34	19	90	37	180	108	60.0

*Figures from departmental statistics

Table 1.4: Admissions to RIPAS Mental Health Unit by diagnosis

ICD-10 Diagnosis	Total in 2014		Total 2013	
	N	%	N	%
Schizophrenia	74	41.1	86	41.0
Bipolar disorder	24	13.3	26	12.4
Drug-associated psychosis	20	11.1	21	10.0
Depression	14	7.8	25	11.9
Acute psychotic episode	10	5.6	16	7.6
Schizo-affective disorder	9	5.0	2	1.0
Adjustment disorder	8	4.4	8	3.8
Personality disorder	4	2.2	1	0.5
Dementia	2	1.1	2	1.0
Mental Retardation/ Related Behavioural Problems	2	1.1	3	1.4
Alcohol abuse/ dependence	0	0.0	1	0.5
Others	13	7.2	19	9.0
Total	180	1	210	

*Source: Departmental statistics

The demand for psychiatric beds has increased substantially in recent years. Bed occupancy can range from 80% to 130 %. There are no community partners providing step-down care or supported accommodation. As a result, patients with chronic illness tend to become long-term patient in acute wards. Until the establishment of psychiatric community homes for patients with chronic illness in 2012, the acute ward in RIPAS hospital had up to 40% of beds inappropriately occupied by patients with chronic illness, sometimes for many years. This problem led to a new project to establish community homes for patients in order to provide community residential rehabilitation and address the problems of institutionalization and over-crowding in acute wards. In October 2012, a supported community home was opened for female patients. A similar home was opened for male patients in January 2014. This has successfully reduced the number of patients with chronic illness occupying acute beds and created improved systems of care for patients with acute and chronic/stable illness.

The RIPAS Mental Health Unit has run a Rehabilitation Unit in a bungalow in Kiarong since 2005. This Unit, which caters for approximately 40 patients, focuses on psycho-social rehabilitation, emphasising daily living skills training, social, recreational and sporting activities, and occupational rehabilitation for suitable, selected patients.

A liaison-consultation service is provided to cater to the psychiatric needs of patients in the general medical, surgical or other non-psychiatric wards of the hospitals. Management of such patients is carried out in close collaboration and liaison with the non-psychiatric specialists, medical officers and nurses. The Child and Adolescent Psychiatry service is delivered by a team of nurses and headed by a trained Child and Adolescent Psychiatrist who also provides an outpatient service monthly in the SSB Hospital in Kuala Belait, and fortnightly at the community Child Development Centre in Brunei-Muara district. Forensic psychiatric services were started in 2011 and include in-reach clinics in the prisons and the national drug rehabilitation centre.

Medicines

Table 1.5: Expenditures for medicines for mental and behavioral disorders at country level

Type of Medicines	Expenditures at country level per year and per 100,000 population (in USD)
All the psychotherapeutic medicines	1,199,380
Medicines used for bipolar disorders	Unknown
Medicines for psychotic disorders	Unknown
Medicines used for general anxiety	Unknown
Medicines used for mood disorders	Unknown

*Figures from Mental Health Atlas, 2011.

There is a limited range of atypical antipsychotic drugs available, including olanzapine, risperidone, quetiapine and clozapine. Depot paliperidone is available on a limited "named patient basis". The only SSRI anti-depressants available are fluoxetine, fluvoxamine and sertraline. Mirtazepine and venlafaxine are not routinely available. Most psychotropic medications, such as the atypical anti-psychotics, can only be prescribed and authorized by senior medical staff working in psychiatry and are not readily available in primary health clinic pharmacies. This limits access to psychiatric care in the community.

Human Rights

Until the 2014 Mental Health Order was implemented, there were no laws specific to protecting the rights and welfare of people with mental disorders. The 1929 Lunacy Act in place until 2014 was a rudimentary piece of legislation that did not adequately address care, treatment, protection and welfare. Members of the public could apply to the Magistrate's Court for the detention of another person in hospital, without the need for any medical opinion or recommendation. Detention criteria were unspecified. Once detained, there were no review requirements or external examination process. The new Mental Health Order addresses these issues and aims to protect the rights and dignity of people with mental illness and to enable appropriate treatment. Medical practitioners, social workers, the police and Courts all have specific responsibilities. There remains much work to be done to address stigma, discrimination and ill-treatment of people with mental disorder. The main focus of the Department of Psychiatry has been public education and the improvement of overall services to make treatment more accessible and acceptable.

Health Information Systems

Since 2011, the Brunei-Health Information Management System (Bru-HIMS) has been implemented in stages in government hospitals and is a system of individual electronic patient data. It has also being rolled out to primary health centers and community health services nationwide. Demographic, diagnostic and full treatment details from the point of starting the electronic records can now be found on each registered individual receiving care in any government health service. This system will enable large-scale collection and analysis of health data in the future.

Integrating Mental Health into the National Health System

The Department of Psychiatry has been actively involved in promoting the integration of mental health in primary health care and the community. Forums on various psychiatric topics are held for primary care doctors and nurses in order to enhance their knowledge and skills in the recognition and management of mental disorders. Specialist psychiatry clinics are held weekly or fortnightly in primary health centers in order to improve collaboration with primary care

doctors. Some psychotropic drugs are now available in the primary care pharmacies as part of the effort to integrate psychiatry in primary care.

Health promotion talks are held throughout the year for target groups such as school students, teachers, community leaders and village heads in order to increase their knowledge and awareness of mental health and mental illness. The electronic and print media, and exhibitions, are used to disseminate information to the public regarding mental disorders and the services available to treat them with the hope that mental disorders will be recognized early and mentally ill patients brought for treatment early. Acceptance by the public that mental disorders are treatable medical illnesses will also help to reduce the stigma associated with mental illness with direct beneficial effects for patients and their families in their rehabilitation as well as acceptance by the community.

Community Empowerment

Table 1.6: Informal human resources (Family and User Associations)

	User associations	Family associations
Present in the country?	No	No
Number of members	NA	NA
Participation in the formulation/ implementation of policy/plan/ legislation?	No	No

*Figures from Mental Health Atlas, 2011.

Currently, there is no involvement of non-governmental organizations in the provision of mental health care in Brunei. There are organizations for children with autistic spectrum disorder, and learning disabilities, but none for other mental disorders. There are no private day-care or rehabilitation facilities, no crisis telephone counseling, no mental health user, carer or professional associations. Perhaps due to stigma, users and family members are reluctant to acknowledge the presence of mental disorders. The community rehabilitation services have been active in encouraging users and carers to meet, socialize, and support each other through psycho-education groups and other activities. It is likely that this is a process that needs time to mature in order for users and carers to take ownership over this work.

There is a variety of traditional healers in Brunei where belief in supernatural causes of illness, mental and physical, is very strong. The most dominant is the Islamic healing system which is consulted by many patients and their families before, during and after psychiatric consultation and treatment. There are also traditional Malay healers called "bomohs" who use other approaches in dealing with the supernatural causes of the illness. There is little direct communication or liaison between the different traditional healers among themselves as well as between them and the medical and mental health service. The Ministry of Health does not have a formal policy regarding the issue of traditional healers and their relationship with the medical and mental health service. There have been no studies done so far to examine the impact of these traditional healers on patients' mental illness or adherence to modern psychiatric treatment and follow-up.

Priorities, Challenges and Opportunities

The need to increase the number of psychiatric beds has long been recognized as there has been no increase in the number of psychiatric beds since 1984, although the population has increased. Plans to expand the in-patient ward in RIPAS hospital are in place, to be implemented in 2015. The National Health and RIPAS Hospital Masterplans have also detailed the required expansion of mental health beds and services for the next 20 years.

The need to increase the number of specialists in psychiatry has also long been recognized. The number of local psychiatrists especially needs to be increased because expatriate specialists and doctors who cannot communicate in Malay directly with patients and their families are at a distinct disadvantage in the assessment and psychotherapeutic management of patients. The number of local doctors who choose to take up psychiatry is small but growing. Psychiatric training for nurses and allied health professionals are all areas that require further development.

There is a limited body of local research in the area of mental health. There is some data on the prevalence of mental disorders in a population of substance abusers (Ho et al, 2014) This is an area that needs much attention and investment. Local research on the prevalence of mental disorders, and the problems specific to the country, is required to better inform service development plans. Partnerships with academic and research bodies in the region can be a helpful way of encouraging such research.

The integration of psychiatry in primary care needs to be given greater support and pursued with greater vigour. A wider range psychotropic medications should be made available at the Primary Health Centers in order to facilitate improvement in mental health care within the community. The training of primary care doctors in psychiatry has been enhanced by making a 3-month attachment in psychiatry a compulsory requirement in the local General Practitioner training scheme. This was previously an optional, although popular attachment, which has improved the psychiatric management skills of GPs. The aim is to encourage primary care doctors to manage the care of straightforward mental health problems, thus reducing the dependence on psychiatric out-patient clinics and improving the accessibility and treatment rates of mental illness.

Mental health services are being increasingly recognized as an essential component of general health in Brunei by the Ministry of Health and the Government. Services are being encouraged to expand further with the support of up-to-date legislation and development in human resources.

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CAMBODIA

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Introduction

Cambodia is situated on the Indochinese Peninsula and has land borders with Thailand to the northwest, Laos to the northeast and Vietnam to the east and the gulf of Thailand to the southwest.

Cambodia has a population of 15.1 million people and a population density of 86 persons per square kilometer.The majority of the population is ethnic Khmer with small proportions of other groups, including Vietnamese (5%), Chinese (1%), other (4%). The official language is Khmer. The majority religion is Buddhism (95%), with very small numbers of other groups, including Islam (1.6%), Christianity (0.2%) and others (3.2%).

The form of government is constitutional monarchy with a multi-party democracy. For administrative purposes Cambodia is divided into three levels of government, national/central, ProvinciaL and district. There are 24 provinces and the capital, Phnom Penh, 185 districts, 1,621 communes and 14,073 villages. Cities and towns take over some of the responsibilities of the districts and communes in the area covered by the municipality.

Economic growth in Cambodia relies mostly on the garment, tourism and agriculture industries. In 2013 and 2014 GDP growth was around 7.5%. Per capita GDP has increased from USD320 in 1995 to a current level of USD1,036. Cambodia is about to become a lower-middle income country. Extreme poverty has substantially reduced. Cambodia has achieved the 2015 target for MDG1 (Eradicate extreme poverty and hunger). [1] However, almost 20% of the population is still classified as poor (down from more than 50% in 2004), while another 8 million are near-poor, of whom 90% live in rural areas of the country. [1, 2]

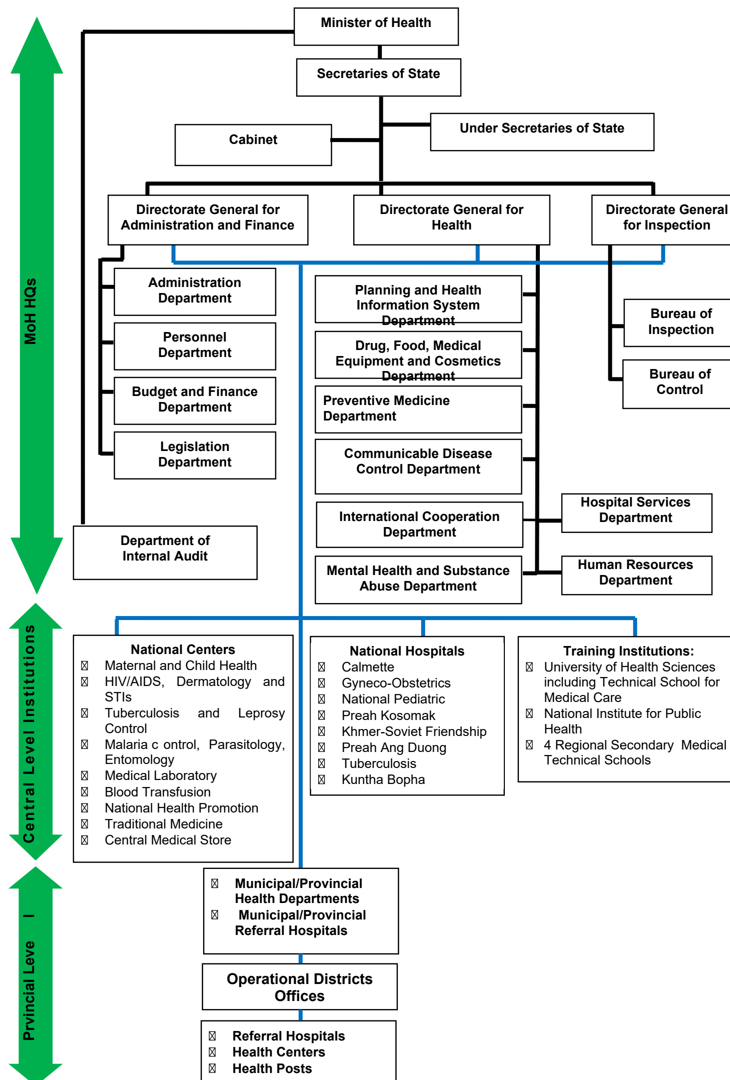
As well as rapid economic development there has been considerable health development. Life expectancy has increased to 71.4 years from 29.6 years in 1980 and 54.8 years in 1990. Infant mortality has been reduced from 85.0 per 1,000 live births in 1990 to 33.9 in 2012 and, over the same period, under-five mortality has been reduced from 116.4 per 1,000 live births to 37.7. [3]

There are many universities, both public and private, providing training for medical students and nurses. However, only the University of Health Sciences provides psychiatric residency training.

General Health System

Cambodia Health Structure has three levels, National/Central, Provincial, and District. At district level, there are two levels for health services, Referral Hospitals and Health Centers. [3]

Figure 2.1: Organisation of the Ministry of Health



- **Central Ministry**
  - Develops policies, legislation and strategic plans,
  - Responsible for resource mobilization and allocation,
  - Responsible for monitoring, evaluation, research,
  - Maintains the national Health Information System,
  - Provides training, support to provinces and districts,
  - Coordinates with other ministries and external aid.
- **Provincial level**
  - Administered by an MOH Provincial Health Department,
  - Links the central Ministry with MOH health Operational Districts,
  - Implement the Health Strategic Plan via Annual Operational Plans,
  - Responsible for the equitable distribution and effective use of available resources,
  - Supports the development of health Operational Districts
- **Operational District level**
  - Administered by an MOH Operational District Office,
  - Responsible for effective, efficient and comprehensive health service delivery,
  - Interprets, disseminates and implements national policies and provincial health strategies.

The operational district level is expected to provide services efficiently, to provide service coverage for the entire population and to ensure that services are integrated. The broad responsibilities of health centres and referral hospitals are listed below.

First level (Health Centre)

- Close contact with the population
- Encourage community participation
- Accessibility
- Delivery of high-quality basic care

Second level (Referral Hospital)

- Complement to the first level
- Care of referred patient
- Higher technical standards
- Wider diagnostic services

Based on the Health Report 2013 Cambodia has the following health workforce:

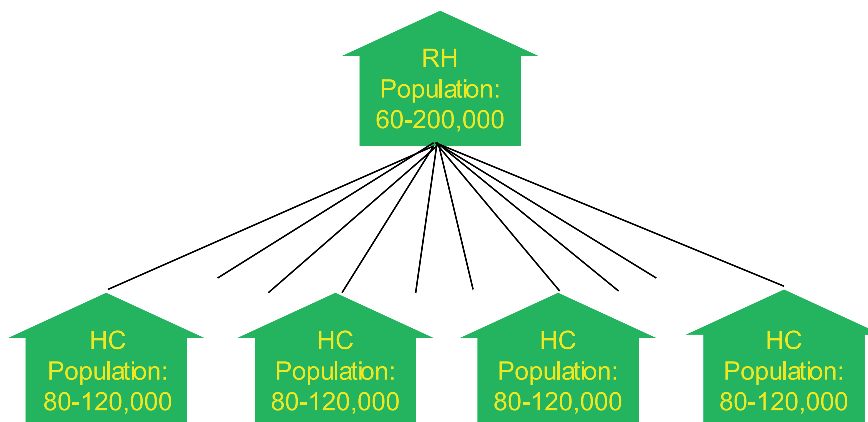
Table 2.1: Mental health workforce

Staff category	2013
Medical Doctors (including specialists)	2,021
Medical Assistant	962
Dentists	226
Pharmacists	529
Secondary Midwives	2,734
Secondary Nurses	5,534
Primary Midwives	2,332
Primary Nurses	3,387
Secondary Lab	460
Others	2,483

Health staff have been distributed 22% and 78% for central level and sub-national level respectively.

Primary Care Health Centers provide general health care at the community level. Based on the health coverage plan, each health centre is responsible for a population of 8,000-12,000. Figure 2.2 shows the optimal and actual populations sizes for which referral hospitals and health centres are responsible and the maximum distance from where people live.

Figure 2.2: The public health system in Cambodia



Criteria		
Facility	Population	Accessibility
Referral Hospital (RH)-CPA	Optimal: 100-200,000 Vary: 60-200,000	20-30 Km between 2 RHs or Max: 3 Hours by Car/Boat
Health Center (HC)-MPA	Optimal: 10,000 Vary: 8-12,000	Radius: 10 Km or Max: 2 Hours Walk

Patients requiring secondary or tertiary level care are referred to a referral hospital either at provincial or national level. All referral hospitals need to provide care and treatment based on the guidelines of Complementary Package of Activities (CPA). [4, 5]

The National Health Strategic Plan 2008-2015 [6] specifies five strategic areas in health:

1) Health Service Development
2) Human Resource Development
3) Health Care Financing
4) Health Information system
5) Health Service Governance

The Plan [6] identifies as strategic priorities two inter-related areas. These are 1) population health problems and essential services and 2) challenges in relation to functional areas of both sypply-side and demand-side elements of the health system.

Population health problems and services are divided into three priority programs (Table 2.2).

Table 2.2: Five health strategic areas across three priority program

Reduce maternal, new born and child morbidity and mortality with increase reproductive health	Reduce morbidity and mortality of HIV/AIDS, Malaria, TB, and other communicable diseases	Reduce the burden of non-communicable diseases and other health problems
To improve the nutritional status of women and children To improve access to quality reproductive health information and services To improve access to essential maternal and newborn health services and better family care practices To ensure universal access to essential child health services and better family care practices	To reduce the HIV prevalence rate To increase survival of People Living with HIV/AIDS To achieve a high Case Detection Rate and to maintain a high Cure Rate for pulmonary TB smear positive cases. To reduce malaria related mortality and morbidity rate among the general population To reduce burden of other communicable diseases	To reduce risk behaviors leading to non-communicable diseases (KAP): diabetes, cardiovascular diseases, cancer, mental health, substance abuse, accidents and injuries, eye care, oral health, etc. To improve access to treatment and rehabilitation for NCD: diabetes, cardiovascular diseases, cancer, mental health, substance abuse, accidents and injuries, eye care, oral health, etc To ensure Essential Public Health Functions: environmental health:, food safety, disaster management and preparedness

In relation to health system challenges the Strategic framework has five main characteristics:

1. Placing *Accountability, Efficiency, Quality and Equity* at the centre of the 5 cross-cutting strategies, supporting the 3 health program areas' interventions to deliver better health outcomes.
2. Translates strategy into actions, contributing to a long-term process for poverty reduction.
3. Informing and updating the health related targets of the National Strategic Development Plan on an annual basis.
4. A framework that is time-bound and takes MDGs as the milestone.
5. Reflecting the principles of the Paris Declaration (ownership, alignment, harmonization, managing for results and mutual accountability) and government's Harmonization, Alignment for Results Action Plan.

Mental Health Problems in the Community

While there are some NGOs and non-health institutions that have done prevalence studies in Cambodia, and published in international journals, there is no official MoH data on epidemiology of mental disorders.in Cambodia.

There is no study on the prevalence of mental illness among primary care attenders.

Community awareness programs have been delivered by some NGOs, however there is no official report available.

Mental health service delivery in Cambodia is based on an approach that integrates mental health into the general health system - referral hospitals and health centres. 72% of Referral Hospitals have basic mental health care services and 18% of Health Centers have primary mental health care services.

Most mental health services are provided at only the basic level of care, using the WHO mhGAP/Intervention Guide in combination with the Treatnet/UNODC guidelines.-

The priorities of the Mental Health and Substance Misuse Strategic Plan 2011-2015 {Ministry of Health, 2011 #128} are shown in Table 2.3.

Table 2.3: Strategic priorities of the Mental Health and Substance Misuse Strategic Plan 2011-2015

No	Priority Areas	Essential Services
1	Mental Health	Depression Anxiety disorders Psychotic disorders Child and Adolescent Mental Health Maternal Mental Health Epilepsy Suicide prevention Counseling services Community-based support services Psychosocial support for mentally ill Victim of trafficking and migrant mental health Post-traumatic Stress

No	Priority Areas	Essential Services
2	Substance Abuse	ATS dependence Opioid dependence Alcohol dependence Other harm drugs
3	Health System Strengthening related-mental health and substance abuse	Expand mental health and substance abuse services Develop national standards and clinical practice guidelines, and quality improvement Increase clinical skills, management and leadership Strengthen mental health information system and promote operational research Strengthen support system Strengthen coordination and multi-sector response and promote partnership
3	Health System Strengthening related-mental health and substance abuse	Expand mental health and substance abuse services Develop national standards and clinical practice guidelines, and quality improvement Increase clinical skills, management and leadership Strengthen mental health information system and promote operational research Strengthen support system Strengthen coordination and multi-sector response and promote partnership

Mental Health System

Mental Health Governance

The Royal Government of Cambodia established a Department of Mental Health and Substance Abuse (DMHSA) in July 2014, with four bureaus:

1. Bureau of Mental Health and Substance Abuse Planning and Policy
2. Bureau of Prevention, Care and Treatment Services Management
3. Bureau of Research, Education and Outreach
4. Bureau of Administrative Affairs

The Department of Mental Health and Substance Abuse has the following responsibilities:

- Develop policy, strategic plan, guidelines and other legislations related to mental health and substance abuse;
- Manage mental health and substance abuse database system;
- Supervise, monitoring and evaluation on the progress and achievement of mental health and substance abuse services,
- Conduct research on mental health and substance abuse,
- Coordinate and collaborate with other ministries, relevant institutions, development partners, national and international communities, relevant authorities, other countries in the region as well as in the world, for the development in mental health and substance abuse;
- Develop human resources of mental health and substance abuse in all levels of skills in collaboration with other relevant department and training institutions of the Ministry of Health, and other public and private agencies;
- Organize national and international events related to mental health and substance abuse.

The DMHSA of the Ministry of Health needs to be responsible for three main programs: 1) mental health, 2) substance abuse, and 3) harm reduction. In this regard, DMHSA develops its own strategic plans for the three components. The strategic plans are aligned with Cambodia health sector strategic plan of the Ministry of Health {Ministry of Health, 2008 #127} and the national strategic plan for drugs control of the national authority for combatting drugs. DMHSA collaborates with all relevant partners to ensure that its comprehensive strategic plans will be effectively implemented, and to ensure coordination imnplementation between sub-national and national levels.

There is no mental health law in Cambodia. While there is no specific mental health policy the main features of a mental health policy have been included in the Mental Health and Substance Misuse Plan 2011-2015 {Ministry of Health, 2011 #128}, which has the following Guiding Principles:

Table 2.4: Guiding principles of the Mental Health and Substance Misuse 2011-2015

Guiding Principles	Description
Universal Access	Ensure mental health and substance abuse services are geographically, financially, culturally, accessible to all Cambodians.

Quality Assurance and Evidence-based	Ensure treatment complies with evidence based standards to provide quality of care.
Integrated approach to health service delivery	Ensure provision of mental health and substance abuse services is integrated in MPA and CPA, and mainstreamed into relevant services
Client rights based approach to service provision	Ensure safe, voluntary, client-centre, and confidential services with respect to patients' rights, including informed consent.
Community-based	Ensure provision of continuation of care at community level as an alternative to institutional services, unless the patient is at risk to her/him-self of other.

Mental Health Facilities

There is no Mental Hospital in Cambodia. Most mental health services have been developed in the public health sector, in general health facilities such as Referral Hospitals and Health Centers. There are some mental health services provided by NGOs, such as Transcultural Psychosocial Organization, Center of Child and Adolescent Mental Health, and Social Services of Cambodia. However, good coordination between MoH and NGOs has not yet been achieved.

Table: Public facilities that access to basic mental health care in Cambodia

In Cambodia there are eight National Hospitals, 80 Referral Hospitals and 1,000 Health Centers.

Table 2.5: Public health facilities that provide basic mental health services

Facilities	Number of public health facilities	Number of public health facilities that provide basic mental health services
National Hospitals	8	2
Referral Hospitals	80	58
Health Centers	1,000	180

Source: Department of Mental Health and Substance Abuse Report 2013

Mental Health Human Resources

The mental health workforce in Cambodia includes psychiatrists, psychiatric nurses, psychologists, physicians, nurses and social workers. However, due to national budget constraints for health, the Ministry of Health can recruit only psychiatrists and psychiatric nurses to work in the public health sector. There is a broad range of training courses in the health sector. Examples include:

1. Psychiatric residency training: 3 year course
2. Psychiatric nurse training: 18 months course
3. Basic skills in management of mental disorders and substance dependence training for physicians: 4 week course (for referral hospital).
4. Basic skills in psychosocial interventions for mental illnesses and substance dependence training for nurses: 4 week course (for referral hospital).
5. Training in primary interventions for mental illnesses and substance dependence for physicians and nurses: 2 week course (for health centre).

There has been significant progress in human resource development for mental health, mainly through training. As a result,

- 57 psychiatrists have qualified from the locally based 3-year psychiatric postgraduate training program. Only 41 of the graduates work in the public sector, with the rest working for NGOs, have emigrated, or have retired. Those who work in the public sector are now taking part in the training program on mental health for medical students and nurses, in addition to working in health facilities.
- 45 psychiatric nurses from nine provinces and Phnom Penh city have been locally trained through 18-month courses. Most of the graduates are currently deployed at mental health clinics.
- Since 1994, about 600 nurses and primary care doctors working in referral hospitals and health centres have had exposure to basic/primary skills in management of mental disorders and substance abuse. However, about only 20% of of those who have received this training remain working in mental health services.

In addition to the provision of postgraduate training in psychiatry mental health has also been incorporated into the curriculum of the University of Health Sciences for undergraduate medical and nursing students.

NGOs staffs, social workers, and monks are considered as informal human resources in mental health as they do become involved in the process of taking

care of psychiatric patients. However, there is no study or report on these valuable resources.

Financing

Since the start of mental health program, funding for program development in Cambodia has relied almost entirely on external sources, while the government can support salary for government staff and essential psychotropic drugs. However, the budget remains low compared with the budget needed to support the program activity. Like many other developing countries, the budget for mental health in Cambodia is less than 1% of the total annual health budget. There is no reporting on budget for mental health programs provided by NGOs.

Mental Health Services

Referral Hospital

Services for Mental Health and Substance Abuse have been included in the complementary package of activities (CPA) {Ministry of Health, 2006 #124}.

Cambodia offers mental health and drug treatment services at referral hospitals. These hospitals are responsible for the care and treatment of psychiatric and drug dependent patients, including counseling, psycho-education, and psychosocial interventions.

Goals: Providing a comprehensive service for mentally ill and substance dependent patients.

Objectives: Determining roles of mental health service

a) in diagnosis making and treatment and care provision, for mentally ill and substance abuse patients
b) in providing consultation liaison with other medical services,
c) in providing psycho-education for mentally ill and substance dependent patients as well as their families,
d) in organizing an optimal services for mentally ill and substance dependent patients.
e) in collaborating with other partners to get a comprehensive treatment and care for mentally ill and substance dependent patients.

Facilities and resources

Mental health services should be integrated services for mental health and substance abuse, and should have three units.

1. Psychiatric Out-patient Unit: Provide ambulatory treatment for mild or moderate cases. The service provision at the Psychiatric Out-patient unit should focus on both medication and counseling.
2. Psychiatric In-patient Unit: Provide a short stay (maximum duration of 1 month) for treatment of emergency or severe cases or detoxification of substance dependence.
   a) Number of beds should range from 5 to 10 depending on the resources of each referral hospital.
   b) Staff for mental health service provision are the existing staff at the referral hospital, who have been trained on basic mental health treatment and care (at least 1 month training). Number of staff varies, with at least one doctor and two nurses.
   c) In case of limited resources, when hospitalization of a psychiatric patient is essential the patient can be admitted to the Intensive Care Unit or other medical service with treatment and care supervision from the psychiatric out-patient unit.
3. Day Care Unit: If possible a Day Care Unit should be established to provide Psychosocial Interventions.

Health Centre Level

Mental health services at health centres need to adhere to the following guidance in accordance with the guideline of minimum package of activities:

- Staffing: physician or nurse need to get training in basic/primary interventions for mental health and substance abuse.
- Service delivery: the health centre needs to provide:
  1. Basic/primary mental health care including substance abuse,
  2. Follow up Treatment for the patients referred from a referral hospital,
  3. Medication and counseling treatments,
  4. Collaborate with local authority or NGOs, Village Health Support Group, to detect mentally ill patients who harm themselves or others and refer them to a referral hospital.
  5. Community education and home visit,
  6. Trace and follow up patients who drop out from treatment.

Table 2.6: Access to care

Indicators	Number
Mentally ill patients treated in mental health outpatient facilities	165, 954
Admissions to psychiatric beds in general hospitals	248

Source: WHO Atlas report, 2014

Medicines

Psychotropic drugs are included in the essential drug list of the Ministry of Health. The available drugs include antidepressants (amitriptyline, fluoxetine, imipramine, nortriptiline), anxiolytics (diazepam), bipolar disorder (lithium carbonate), antipsychotics (chlorpromazine, haloperidol, olanzapine, risperidone, thioridazine, clozapine, perphenazine), anti-parkinsonian (trihexyphenidyl, benztropine), anti-epileptic (phenobarbital, phenytoin, carbamazepine, valproic acid), and methadone. The government can only support these kinds of drug through the public facilities, but those who can afford to pay can access new generation psychotropic drugs. There is no report on expenditure for mental health drugs.

Human Rights

The lack of both a mental health law and forensic psychiatric hospital in Cambodia contributes to the neglect of people with mental disorders. However, Cambodia has ratified the Convention on the Rights of Persons with Disabilities, and there is an office of High Commissioner for Human Rights in Cambodia.

Health Information System

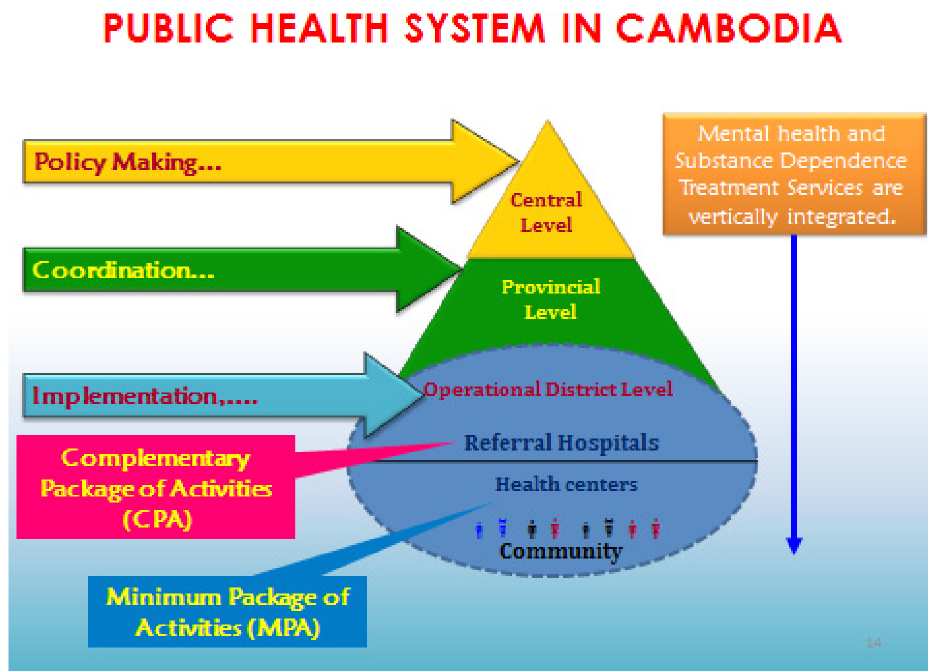
The Mental Health Information System has been incorporated in the National Health Information System (NHIS). However, there is only very limited mental health information that can be recorded through the NHIS. The NHIS focuses on collecting data from routine health service activities and health problems, reported monthly from all levels of public health facilities (referral hospitals and health centres) in the national health care system.

In order to monitor mental health service delivery at all level, the National Program for Mental Health has developed a mental health reporting system to collect mental health information in Cambodia. However, mental health report from NGOs and private sector are not able to be collected.

Integrating Mental Health into the National Health System

Mental health service development in Cambodia is based on the existing general health services, and integration of mental health into the general health care system is the main goal of continuing development (Figure 2.3). The focus on integration of mental health into the general health system is to some extent based on the severe mental health workforce shortage in Cambodia.

Figure 2.3: Integration of mental health into the public health system



Priorities, Challenges and Opportunities

Despite achievements and progress in integrating mental health into the primary care sector, there are some remaining priorities, challenges and opportunities.

Priorities

- Introducing common mental illness into primary care facilities.
- Introducing substance misuse (ATS dependence, opioid dependence, and alcohol dependence) into primary care facilities.
- Expanding mental health and substance abuse services.
- Developing national standards and clinical practice guidelines, and quality improvement.
- Increasing clinical skills, management and leadership.
- Strengthening coordination and multi-sectoral response and promoting partnerships.

Challenges

- The increased burden of mental illness will become a major burden on individuals and services, requiring long-term and costly treatment, as well as rehabilitation, and will have significant impact on investment in medical technology, clinical guidance and re-training.
- The level of population coverage by mental health services is far below the Health Coverage Plan due to resource constraints that limit expansion of services at health centres and referral hospitals. There is a great need to accelerate the expansion of services, including child mental health services.
- Improvement in quality of care in health facilities remains a critical issue of concern because of lack of clinical practice guidelines and standards and quality monitoring tools.
- Mental health and substance misuse services are under-funded.

Opportunities

- The Department of Mental Health and Substance Abuse has been created to response to the mental health needs of the population.

- The Ministry of Health of Cambodia strongly supports the integration of mental health in primary care facilities. In addition, the government also supports and allocates the budget for continous primary care training on mental health.

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INDONESIA

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Introduction

Indonesia is the world's largest archipelago, with 18,307 islands spanning more than 5,400 km from Sabang in northern Sumatera to Merauke in Papua. About 6,000 of the islands are inhabited. Remote areas include tiny islands isolated from the others and areas located deep in the middle of big islands such as Sumatera, Kalimantan (Borneo), Sulawesi (Celebes) or Irian Jaya (Papua). Located on the edges of Pacific, Eurasian and Australian tectonic plates, Indonesia is a country with at least 150 volcanoes, and experiences frequent earthquakes and volcanic eruptions.

According to the latest census in 2010 the Indonesian population was 237 million, with a population density of 123 people per square kilometer. Indonesia is the fourth most populous country in the world, with an estimated current population (2014) of 250 million. Population distribution is uneven with around 133 million (58%) living in Java island, making it the most populous island in the world. The National program on family planning and population control has not been as successful as expected. The Indonesian population is projected to reach 321 million by 2050 (United Nations, 2012). There is huge cultural diversity, with more than 300 ethnic groups and, although the country has one official language (Bahasa Indonesia), with more than 250 languages.

Indonesia has 34 provinces, subdivided into 508 districts and cities, which are further subdivided into 6,793 sub districts and 79,075 villages. Following the implementation of regional autonomy measures (decentralisation policy) in 2001, the districts and cities have become the key implementing administrative units, responsible for providing most local government services, including health services. In this political system, the role of central government in health is limited to functioning as a regulatory body and to providing budget as a stimulus for local government. As the regulatory body, the central government monitors population health status nationally and locally and provides national policies, standards and procedures. The central government has some budget to support provincial and district health offices to implement specific programs, including training to increase the capacity of local government. There are no direct interventions that can be implemented by the national government at local levels. Both the quantity and quality of health resources depend mostly on the commitment and the capacity of local governments.

Indonesia is a lower-middle-income country with a per capita income of $5200. The poverty rate is 11.66%, the human development index is 0.684 and life expectancy at birth is 71 years (Central Bureau Statistics (BPS) & Human Development Report 2012). Even though, by regulation, the national health budget should be at least 5% of the total national budget, in reality it hardly reaches 3%, resulting in difficulty in providing adequate health services. Inadequate funds have limited the development of the mental health program.

General Health System

There are two kinds of health services, primary health care, which is delivered by primary health centers, and referral health care, which is provided by hospitals. Most of the population is covered by national health insurance. The number of people covered by health insurance is increasing, from 115 million people in 2013 to 133 million people in 2014 (16% increase), mostly provided by various government bodies or social insurances. From January 1 2014, Indonesia has begun implementing the national social security system in health and will gradually increase its coverage, aiming for universal health coverage by 2019.

As with other developing countries Indonesia has placed high priority on achieving the Millennium Development Goals (MDGs). Therefore the government has been giving greater attention to health programs that are closely linked to MDGs, such as maternal and child health and infectious diseases (HIV/AIDS, TB and others).

Indonesia has had mixed results in achieving MDG targets. While poverty rate has been substantially reduced, meeting the targets on underweight children, infant and maternal mortality will not be achieved by 2015. Indonesia is on track to achieve the under-5 mortality target. While no significant progress has been made towards reducing the spread of HIV/AIDS, incidence of malaria has been significantly reduced, and the death rate from tuberculosis is less than half the 1990 rate. Indonesia received *the Champion Award for Exceptional Work in the Fight Against TB* from the WHO regional office in 2014.

Mental health has not been prioritized, except for a focus on injecting drug users due to the close links to HIV transmission. However, because of the increasing number of psychosocial problems in Indonesia, and the advocacy movement by many agencies, the government of Indonesia has realized that mental health

has become an important health problem and currently is paying more attention to mental health programs.

The distribution of doctors across the country is uneven. While the number of doctors per 100,000 population in Jakarta is 155, in West Sulawesi the figure is only 8.8. The distribution of nursing resources is also uneven, with more resources in the cities or in ‘highly developed’ provinces. The contribution of nurses in general and mental health services is significant since they are posted at the village level and are at the front line of service delivery. Sometimes they are the only health resource at village levels.

The total number of primary health centers (Puskesmas) is 9,655, one third of which have a small inpatient unit (Ministry of Health RI 2014). Each Puskesmas has small branch offices (Puskesmas Pembantu) located at village level, which are usually run by nurses. Ideally, each Puskesmas has a minimum of one doctor. Unfortunately, due to a shortage of doctors who are willing to work in rural areas, not all Puskesmas have doctors, especially in the very remote areas. Although the central government has provided incentives for doctors to spend 1-3 years in Puskesmas which are located in remote areas, there is still a shortage of available doctors.

There are 1,562 registered public hospitals in Indonesia, including 300 specialized hospitals. These hospitals are operated by the Ministry of Health, other ministries, provincial governments, district governments, the army, the police department and some nonprofit organisations. There are 666 private hospitals, run by the private sector and some public companies. The total number of beds is 230,768 in general hospitals and 27,664 in specialized hospitals. The number of hospitals is shown in Table 3.1.

Table 3.1: Number of hospitals

Public Hospitals	2011	2012	2013
Central/ local government	614	656	676
Army and Police	134	154	159
Other Ministry	3	3	3
Private Nonprofit Hospitals	655	727	724
Total Public Hospitals	1406	1540	1562
Private Hospitals			
BUMN (Government Company)	77	75	67
Private companies that own & operate hospitals	238	468	599
Total Private Hospitals	315	543	666
Total hospitals	1721	2083	2228

Source: Ministry of Health RI, 2014; Indonesian Health Profile 2013

Mental Health Problems in the Community

Mental health problems, such as depression, anxiety, somatoform disorders, alcohol and drug abuse, and some development problems in children are common. The National Health Survey done in 2013 (Indonesian Basic Health Survey 2013) estimated the prevalence of mental disorders at 6% of the adult population.

Most commonly used illicit drugs are methamphetamine, MDMA, heroin, cannabis and benzodiazepine. A national survey conducted in 2011 (National Narcotics Board, 2011) showed that 2.2% of the Indonesian population aged 15 to 64 years have a history of using illicit drugs at least once in their lifetime. From 1999 to 2008, HIV incidence was mostly driven by injecting drug users (IDU). In the last five years IDU was the second major determinant of HIV transmission after people who had transmitted HIV from heterosexual activities, which contributed around 38% of new AIDS cases.

Apart from the magnitude of illicit substance abuse problems, use of tobacco and alcohol has also been increasingly recognized as a serious health issue. Prevalence of tobacco use among people more than 10 years old was 56.7% (male) and 1.9% (female); while the number of cigarettes used per day was 12.3 (Basic Health Research, 2007). Prevalence of alcohol use in the last 12 months at national level was 4.6%, while people who actively used alcohol was 3.0%. (Balitbangkes 2007). A limited survey based on health care settings in the eastern part of Indonesia showed that 26.5% of patients who had chronic digestive diseases (e.g. dyspepsia, gastritis, hepatitis, etc.) had a history of alcohol dependence (Ministry of Health, 2013).

Symptoms of mental health problems are also common in the community. A survey from 20 PHCs at Aceh Province in 2002 showed that 25.7%% of patients who visited primary health center also had depression, 18.4% had panic disorder, 16% had substance abused disorder, 8.8% had Post Traumatic Disorders, and 7.7% had generalize anxiety disorder, which overall psychiatric co-morbidity was 51.1%, with considerable psychiatric comorbidity. (Survey of mental health comorbidity at Primary health centers in Aceh Province, 2002, unpublished). Another survey at community level showed that 15.5% of persons with chronic physical illness had depression within the last 1 year, and 10.3% within the last 2 week. (Idaiani S, Bisara D, 2009). Despite the very large number of people with mental disorder presenting to health care services, the reported number of recognized cases is limited, due to failure to recognize and diagnose mental disorder, failure to treat and failure to report. In addition to the low awareness

of mental disorders in the community, this situation is also affected by several other possible factors, including lack of mental health resources in health care facilities, low mental health knowledge in the community and among health personnel, and the high level of stigma attached to people with mental health problems.

Mental health awareness in the community is still low. Major mental disorders, such as schizophrenia, bipolar disorder and depression, are common but often ignored as health problems by the community.

On the other hand, community awareness of substance use disorders (SUD), particularly illicit substances, is relatively high. However most people do not regard SUD as a health or mental health issue. The general approach to SUD is still focused on security, although efforts to decriminalize illicit drug use and to implement harm minimisation are growing.

There are barriers for people with mental disorder to access health services. The major barrier is the stigma and misperception about mental disorders in the community. Most people think that mental health problems are psychosocial or spiritual problems and not a medical problem. The other barrier is the limited mental health services in the general health services. For example, there are no or limited mental health services at the primary health center level due to lack of facilities or skill of the staff to deal with mental health problems. Mental health specialists are rare and mainly located in the cities which are difficult to access for populations who live far from them. As a result most people with mental problems have improper or no treatment and some end up being restrained ("pasung") (Minas and Diatri 2008) or wander around and get lost in the community.

Mental Health System

The main office for mental health at national level is the Directorate of Mental Health Services, which is under the Directorate General of Health Services. The main responsibility of this directorate is to monitor and supervise mental health services in the health facilities. In addition, due to the lack of other offices for mental health, the Directorate is responsible for advocacy and other issues on mental health programs. With the number of mental health problems that should be attended to in Indonesia, the burden of this office is quite overwhelming. There is almost no provincial or district health departments with a specific mental

health office. Usually mental health is a program under the office of family or the non-communicable diseases office.

Indonesia enacted a new Mental Health Law in 2014. In 1962, Indonesia was the first Southeast Asian country to pass a specific Mental Health Law. In 1992, in the context of a national policy of integrating mental health with general health, the mental health law was repealed and several mental health articles were incorporated into the general health law, which provided an inadequate legal basis for development of mental health services and protection of human rights. The new Mental Health Law (2014) is sufficiently comprehensive to promote mental health services, with specific chapters on promotion, prevention, treatment and rehabilitation. Additional chapters deal with the mental health services system, resources, screening and mental health examination for forensic purposes. Under this new law the integration of mental health into the general health system continues to be strongly supported. To implement the new mental health law regulations are needed, and will be prepared and published by the government by the end of 2015.

In relation to SUD, Indonesia enacted Narcotics Law No. 35/2009 which obliges people who are addicted to drugs to access health service. With this obligation, national government in collaboration with provincial and local government has appointed more than 250 health facilities - including more than 100 primary care centers - to provide treatment services to SUD patients. Appointment is followed by training for health workers and technical supervision.

Facilities

There are 51 mental hospitals throughout Indonesia, 32 public/government hospitals and 19 private hospitals (Table 3.2). This number has remained unchanged for some decades, as has the total number of psychiatric beds. While there are additional beds for psychiatric care in some general hospitals, the number of beds in mental hospitals has decreased significantly, due to the fact that some mental hospitals have converted psychiatric beds for general health services such as surgery, obstetrics and gynecology, and internal medicine. Financial pressures experienced by hospitals are the main reasons for this trend, since general health services have more capacity than do mental health services to raise revenue for the hospital. While efforts are currently being made to provide psychiatric beds in general hospitals there are many obstacles to achieving this objective. Only a limited number of general hospitals, mainly in the university hospitals, have a psychiatry unit. Banyumas Hospital, in Central Java Province, has the largest general hospital psychiatric inpatient service, with 120 beds.

There are only two specialised Community Mental Health Centers, in Central Kalimantan Province and in Belitung Island. These two centers will be converted into Mental Hospitals once the necessary health regulations to enable this conversion are completed. There are currently no other specialised community mental health centers being planned.

Table 3.2: Availability of mental health facilities (Ministry of Health, 2013)

Care setting	Total number of facilities/beds/visits		
	No. of facilities	No. of beds/ places	No. of admissions / sessions / visits in last year
Mental hospitals* (including forensic units*)	48	10,012	637,659
Psychiatric units / beds in general hospitals*	144	UN	UN
Mental health community residential facilities* - Social Rehabilitation Centre	34	UN	UN
Mental health day care or treatment facilities* - Mental Health day care facility	1	1	200
- Community Social Rehabilitation	2	N/A	UN
Mental health outpatient facilities*	317	N/A	UN
Other outpatient facilities	UN	N/A	UN

Notes:
- Number of psychiatric beds in government general hospital in 2010 is 923
- Number of admission in government mental hospital in 2010 is 8755
- The data is only from the government mental/general hospital

N/A= Not applicable; UN= data are unknown

Human Resources

The current total number of psychiatrists in Indonesia is 800, a ratio of 0.3 per 100,000 population, or approximately one psychiatrist for 300,000. As is the case with general doctors, there is uneven distribution of psychiatrists, with nearly half of all psychiatrists working in Jakarta, while in some provinces there are no psychiatrists. Indonesia has ten psychiatry training programs, in the University of Indonesia, Jakarta; the Padjadjaran University, Bandung; the Gajah Mada University, Jogjakarta; the Diponegoro University, Semarang; the State University of Solo, Solo; The Brawijaya University, Malang; the Airlangga University, Surabaya; the Udayana University, Denpasar; the Hasanuddin

University, Makassar; and the University of North Sumatra, Medan. However, the number graduating each year is low, varying between10-60 total graduates per year. Compared to other medical specialties, interest in training in psychiatry remains low.

The number of nurses and midwives is 397,000, with most being diploma level graduates. Only some universities have established Nursing Schools that teach at degree level, and the number of graduates is still limited. In 1980 the only school for mental health nurses was closed due to the changes in nursing school curricula. Nurses have to complete general nurse training before they undertake specialist training. There are three post-graduate mental health nurse training program, in Jakarta and Malang (Java) and Padang (West Sumatra). The total number of graduates annually is around 100. Approximately 20% of graduates work in mental hospitals and the majority work in local nursing schools.

Following the tsunami disaster in December 2004 in Aceh Province, there was an initiative to train nurses as community mental health nurses (CMHNs) to provide services for mental health problems at primary health centre level. The CMHNs are categorized into three levels - basic, intermediate and advanced. At each level, the nurse should attend full week training on mental health and followed by at least three months of supervision. Other provinces have implemented the CMHN program, and currently the total number of CMHNs nationally is 6,500, with most at the basic level. At the community level, CMHNs work closely with mental health volunteers (cadres), who are community members who have received some training to identify mental health problems in their community. The cadres play an important role in the community mental health services provided by primary health centers. Developing capacity to train mental health volunteers is a component of the CMHN program.

Due to the limited number of ‘formal’ mental health nurses, currently the Nurses Professional Organisation considers as mental health nurses the nurses who have received specific formal education in mental health, the CMHNs, and nurses who work in a mental hospital or in the department of psychiatry in a general hospital.

There are 11,000 psychology degree holders in Indonesia. Most work in industrial, educational and other non-clinical branches of psychology, with only 451 working in mental health programs as clinical psychologists. Clinical psychologist have undertaken master level training. Schools for clinical psychology have only recently opened and the number is increasing, so the number of clinical psychologists will increase significantly in the near future. Other human resources in mental health include social workers and occupational therapists, but only a very limited number of them work in mental health programs.

Available data on mental heath workforce is shown in table 3.3, and primary care staff receiving training in mental health are shown in Table 3.4.

Table 3.3: Mental health workforce – number of mental health professionals, by care setting (Ministry of Health, 2013)

CARE SETTING	Psychiatrists working in mental health	Other medical doctors working in mental health	Nurses working in mental health	Psychologists working in mental health	*Social workers working in mental health**	*Occupational therapists working in mental health**	*Other paid workers working in mental health**
INPATIENT AND DAY CARE SERVICES							
*Mental hospitals**	174 (government mental hospitals)	487	4,728	42	54	UN	UN
*Psychiatric ward in a general hospitals**	417	UN	UN	154		UN	UN
*Mental health community residential facilities**	UN	UN	UN	UN	UN	UN	UN
*Mental health day treatment facilities**	UN	UN	UN	UN	UN	UN	UN
OUTPATIENT CARE SERVICES							
Mental health outpatient facilities - *Social Rehabilitation Centre*	UN	UN	UN	UN	28	UN	UN
- *Drop in centre at Tebet South Jakarta*	UN	UN	UN	UN	23	UN	UN
- *Community Social Rehabilitation at Sukabumi District*	UN	UN	UN	UN	14	UN	UN
OTHER OUTPATIENT HEALTH FACILITY OR SERVICE *(e.g. outreach, private practice)*	137	UN	1,700 (Community)	255	UN	UN	UN
TOTAL	728	UN	6500	451	119	UN	UN

Note:
- Psychiatric Wards in general hospitals include private, teaching, and military hospitals.
- Other Medical doctors - data are available on GPs working in Government mental hospitals
- Data on Occupational Therapists working in mental health are not available, but the total number working in health care facilities is 700.
- Total number of Social Workers in Indonesia: (1,150 + 37)

a. *Social workers at Social Rehabilitation Centre for Mental Illness = 28*
b. *Socian workers at Social Rehabilitation Centre Non Mental Illness = 350*
c. *Social workers at Educational and Research Centre = 14*
d. *Social workers for Social Protection Program (Ditjen Linjamsos) = 10*
e. *Social workers for Social Empowerment Program (Ditjen Dayasos) = 6*
f. *Social workers at mentals hospitals (6 Hospitals) = 54*
g. *Social workers at general hospitals (6 hospitals) = 19*
h. *Social workers at Province Social Institution (Dinas Sosial Provinsi) = 669*
i. *Social workers at community social rehabilitation for mental illness (Tebet and Sukabumi) =37*

[UN=unknown]

Table 3.4: primary care staff trained in mental health for at least two days in the last two years

Staff category	Number of staff working in primary care	Number of primary care staff trained in mental health at least two days in the last two years	
		New / initial in-service training	*Refresher / specific in-service training*
Physicians / Doctors	17,767	429*	UN
Nurses	115,747	2,049*	UN
Midwives	102,176	91*	UN
Community health workers	UN	110*	UN
Other health care workers	UN	UN	UN

*The data are very likely under-estimates

Financing

Calculating the total national budget for mental health is challenging since mental health programs are run at various levels of government by various government agencies. The Directorate of Mental Health of the Ministry of Health is responsible for developing regulations, undertaking supervision and mental health promotion. The total budget for the Directorate of Mental Health is under 0.5% of the total health budget. Other offices in the Ministry of Health which contribute to mental health programs include: Health Promotion and Center for Education, Center for Health Research and Development, Directorate General for Pharmacy and Center for Human Resources Development. The total budget for mental health in the ministry of health office is estimated 2.89% of the Ministry of Health's budget, but more than 90% of this budget goes to mental hospitals. Other Ministries also have some offices or programs for mental health, such as the Ministry of Education and Culture, Ministry of Social Affairs, Ministry of Human Resources, the Narcotic National Body, and some others.

The budget for mental hospitals comes from various sources. Most of the hospitals in Indonesia have financial autonomy, meaning that the hospitals can receive money for their services and manage their own budgets for operating purposes or for developing services. The public mental hospitals' revenue comes mainly from social insurance schemes which are managed by central or local governments. Some additional funds can be provided by central or local government, usually for specific purposes, such as infrastructure development or particular high-priority programs. People who are not covered by one or another of the health insurance schemes currently operating are required to pay out-of-

pocket for mental health services, including hospitalisation, professional fees and medicines. The amount of out-of-pocket expenditure varies significantly. In private services it could reach USD 300 per month only for medications, while it may be as little as USD 10 in government hospitals, which is still a problem for poor families.

The Centre for Health Promotion and Education is responsible for all health promotion and education programs, including mental health. But the funds for mental health promotion are limited to one or two small programs. The Directorate of Mental Health runs an annual World Mental Health Day program as part of its mental health promotion activities.

Available data on mental health expenditure is shown in Table 3.5.

Table 3.5: Total annual government mental health expenditure (Ministry of Health, 2013)

Care setting	Total government spending in the last year (local currency units)
Inpatient and day care services	
*Mental hospital**	560,977,189,610 (Data available is from the government mental hospitals)
*Psychiatric wards in general hospitals**	UN
*Mental health community residential facilities**	UN
*Mental health day treatment facilities**	UN
*Other residential facilities**	UN
Outpatient and primary health care services	UN
*Mental health outpatient facilities**	UN
*Primary care facilities / clinics**	UN
Other outpatient health facilities or services (e.g. outreach, private practices)	UN
Social care services	UN
Community care or rehabilitation facilities	UN
Other programmatic costs not included above *(e.g. programme management, training, media)*	30,496,389,000
TOTAL	591,977,189,610

Mental Health Services

Although mental health is not in the priority list of the primary health center program some mental health service activities are conducted in some primary health centers. Examples of such service activities include: treatment of mental health problems such as non-complicated psychoses, simple insomnia, mild depression and anxiety, the community mental health nurse program, mental health volunteers, basic counseling program by clinical psychologists and geriatric services (in Jogjakarta Province), a small mental health inpatient unit, a comprehensive mental health service by involving residents in psychiatry and methadone maintenance treatment for opiate dependence in a high-IDU prevalence area (available in 17 provinces). To support mental health services in primary health centers the Ministry of Health provides guidelines both for basic mental health services and for community mental health programs. To support SUD services in primary health centers and other health facilities, the Ministry of Health provides national guidelines on the methadone maintenance program, drug treatment and rehabilitation and various SUD-related training modules.

The number of primary health centers which provide mental health services is increasing, from 13.7% in 2011 to 20% in 2012. To increase the mental health services in primary health centers some training in mental health for doctors and nurses working in primary health has been conducted, supported by the Ministry of Health, local district health office, WHO Indonesia office, and local and international Non-Government Organisations. Data in 2011 showed that 46.5% of primary health center staff had received training in mental health, but not all have implemented mental health services. The problems include the rotation of staff, with trained staff moving to another location or moving to other positions that have no connection with mental health services. Official procedures exist for referring persons from primary health care to secondary/tertiary health care as well as back-referral from tertiary/secondary services to primary care.

Mental health services are also provided by general hospitals. In addition to university hospitals, some other general hospitals provide services even though not all of them have a psychiatrist. The total number of general hospitals with mental health services is 151 of 445 general hospitals (34%). Services in general hospitals may include outpatients clinics, inpatient units, and mental health promotion and family intervention.

The only national data available for people receiving mental health services are for services provided by mental hospitals (Table 3.6)

Table 3.6: number of persons with mental disorder who received mental health care in the last year (Ministry of Health, 2013)

CARE SETTING	All mental disorders (common and severe)	Severe mental disorders		
		Non-affective psychosis	*Bipolar disorder*	*Moderate-severe depression*
Inpatient and day care services				
*Mental hospital**	UN	182,018	20,390	29,708
*Psychiatric ward in a general hospital**	UN	UN	UN	UN
*Mental health community residential facility**	UN	UN	UN	UN
*Mental health day treatment facility**	UN	UN	UN	UN
*Other residential facility**	UN	UN	UN	UN
Outpatient and primary health care services	UN	UN	UN	UN
*Mental health outpatient facility**		UN	UN	UN
Social rehabilitation centre (34 units)	4,013	UN	UN	UN
*Primary care facility / clinic**	UN	UN	UN	UN
Other outpatient health facility or service (e.g. outreach service)	UN	UN	UN	UN
Social care services	UN	UN	UN	UN
Community care or rehabilitation facility (e.g. day care centres)	UN	UN	UN	UN
Community Social Rehabilitation	177	UN	UN	UN
TOTAL	UN	UN	UN	UN

UN: Unknown

Medicines

Medications for mental health are available at most primary health centers, but are limited to antianxiety (diazepam), antipsychotic (haloperidol and chlorpromazine), and antiparkinsonian (trihexyphenidyl) medicines. Antidepressants are rarely available. When they are there is only amitriptyline. Other newer antipsychotics and antidepressants are available in some primary health centers, especially primary health centers located in the cities. Distribution and prescription of benzodiazepines is strictly regulated under the Narcotics Law and the Psychotropic Law. Prescription regulations authorize only primary care doctors to prescribe and/or to continue the prescription of psychotropic medicines. Nurses are not authorized to do so. Psychotropic medicines are

available in mental hospitals and private practices located in the cities, and virtually all newer drugs area available if they can be afforded.

Methadone replacement therapy for opiate dependence was adopted as a national program in 2003. It is now available in 89 clinics in 17 provinces in Indonesia. Provision of methadone is funded by the national government, while operational treatment costs depend on the policy of particular local governments. In some areas patients can access methadone free of charge, while in other areas they are required to pay a minimal amount. Other than methadone, medicines for SUD patients are not free. Total government expenditure on psychotropic drugs is not known.

Human Rights

The most inhumane treatment experienced by people with mental illness is ‘pasung’, where patients are restrained. The classic restraint is placing one or both legs in wooden stocks. Other forms of restraint include locking patients in a small room or compartment similar to a ‘cage’, securing the patient’s leg with a metal chain, or simply keeping the patient in an empty small room. Data from the Basic Health Survey 2013 showed that 15.6 % of patients with serious mental illness were being restrained in the community (Balitbangkes, 2013). There are other violations of the human rights of people with mental illness, which includes prolonged involuntary hospitalisation. Human rights violations occur in the community or and in the health services and social institutions. Interestingly, human right law, regulations and infrastructure in Indonesia has improved greatly in comparison with previous decades. Despite this the violation of human rights of people continues (Irmansyah et al 2009). The active involvement of other government bodies, particularly the National Human Rights Commission and the Ministry of Law and Human Rights, together with other law enforcement agencies, is needed to ensure the protection of the human rights of people with mental disorders

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Community Empowerment

Community empowerment is one of the very important requirements for improvement of the mental health situation in Indonesia. Currently there is an active schizophrenia patient and family association (*Komunitas Peduli Skizofrenia Indonesia*), and several other organisations, like *Perhimpunan Jiwa Sehat*, and a local NGO in Cianjur and others, that focus on advocacy.

Government, through local provincial health offices and through mental hospitals, supports these activities. There is a program at primary health centers to establish mental health cadres at community level. The number of cadres is still small but the program is promising and could become a priority in the development of community mental health services.

Although a small number of user and carer organisations do exist there is not comprehensive data on number of members or on the activities of such organisations.

Health Information Systems

Recently the Ministry of Health has undertaken the development of a mental health information system. There is an office for health information system in the Ministry of Health and a discussion on this issue is already on the table. To provide a strong and useful mental health information system collaboration between central and local governments, supported by the Center for Health Research and Development, is needed. It is estimated that the implementation of a mental health information system will need some years to come to fruition.

Current national data on people with mental health problems treated at primary health centers, general hospitals and mental hospitals is not available. Efforts have been made to collect data manually on inpatients units, and for interventions (psychopharmacological and psychosocial) delivered in primary health care for people with mental disorders, but the data are not comprehensive or reliable. The situation in relation to information on SUD patients is different. Due to the drug law, the Ministry of Health is now piloting an SUD Information System (SINAPZA). The system is linked to the existing national health information system, with the intention of having comprehensive paperless data collection and entry and de-identified online reports to maintain confidentiality.

Table 3.7 demonstrates that the national mental health information system is quite inadequate.

Table 3.7: Health information systems (World Health Organization, 2011 #604)

	Data on number of people/ activities collected, reported	Data on age and gender collected, reported	Data on patient's diagnosis collected, reported
Persons with mental disorders treated in primary health care	Yes	Yes	Yes
Interventions (psychopharmacological and psychosocial) delivered in primary health care for people with mental disorders	No	No	No
Persons treated in mental health out patient facilities	No	No	No
Contacts in mental health out patient facilities	No	No	No
Persons treated in mental health day treatment facilities	No	No	No
Admissions in general hospitals with psychiatric beds	No	No	No
Admissions in mental hospitals	No	No	No
Days spent in mental hospitals	No	No	No
Admissions in community residential facilities	No	No	No

Integrating Mental Health into the National Health System

There is a long pathway for people with mental illness to get appropriate mental health treatment and care. Many members of the community consider mental symptoms to be spiritual or religious issues, and often seek help from traditional healers or religious leaders before coming to health services. Cases of mistreatment and abuse of people with mental health problems are common.

Many people with mental illness are restrained (pasung). Many others are found homeless or lost.

It is clear that low community awareness and stigma attached to mental illness are serious problems in Indonesia. To address this issue various resources should work together. The roles of consumers and families are crucial in this movement. Currently, several family and consumer organisations have initiated strong advocacy and awareness programs.

Unfortunately, some health professionals also stigmatize mental illness, hampering the integration of mental health services into general health services. The stigma can be observed by the attitude of some doctors in primary health centers who refuse patients with mental illness and directly refer the patient without assessment or intervention.

Traditional healers are playing an important role in dealing with mental health problems. However, some religious and traditional organisations who residential services for people with mental illness give unsafe and sometimes dangerous interventions. A new regulation is needed to protect people with mental illness from harmful interventions and to promote mental health services in the community, including integrating mental health services into national health services.

Priorities, Challenges and Opportunities

The Mental Health Law (2014) which has recently been enacted is a critically important resource for developing national and local mental health policy and programs. Integration of mental health programs into the general health system, especially at primary health centers, is clearly stated in this new law and has become a priority of the national mental health program. Currently the necessary regulations for implementation are being drafted. Specific guidelines to increase mental health services at the primary health centers are also being prepared. Projects for mental health training of the primary health service staff have been done, although only for a small number. Due to our country's health priorities, which still focus on common general health problems that are part of the MDGs and common non-communicable diseases, resistance from within health offices is a serious challenge, together with stigma in the community. But the growing evidence and the advocacy movement from various sources on the need for mental health services will be important in overcoming the

continuing challenges. A coordinating role of the central government through the Directorate of Mental Health will be important to speed up the process of development and delivery of mental health services for all community members.

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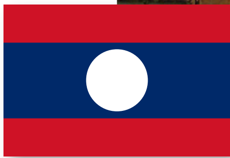

LAO PDR

Bouavanh Southivong, Ministry of Health

Introduction

In 2015, Lao People's Democratic Republic (Lao PDR) has an estimated population of 6.8 million (United Nations, 2015), with 37.3% under 15 years of age and 3.7% above 65 years. Lao PDR is landlocked country with an estimated 66.8% of the population dispersed and living in rural areas in 2010. Many places are difficult to access due to the mountainous landscape and up to 21% of the population lives in area with no road.

Health Services Delivery System

The Law on Health Care (2005) provides for administration of the health sector, national health financing and social health insurance, including the establishment of a social security fund (or health equity fund) in article 50. It also gives administrative authority to provincial and district health authorities, including the right for public facilities to implement user fees and exemption and nominate legitimate service charges. The Prime Ministerial Decree No 52 in 1995 authorized the collection of official user fees at facilities and also provides for fee- exemption for the poor. The Prime Ministerial Decree No 381 in 2006 on Technical Revenue was intended to regulate user fee collection across the public service generally

The government has made all issues related to maternal and child health a priority area in policy and strategy development. This is due to lack of health care services reaching all communities especially women and children in remote area. The National Commission for mothers and children has an advisory, monitoring, and advocacy role for MNCH strategy.

Mental Health Problems in the Community

- Limited mental health program at country.
- Employs a "community mental health" model (train village workers, provide outreach clinic) with support with development partners.

- Commenced in May 2007 with pilot community mental health projects in communities within the Vientiane Capital Province and 2010 in Borikhamxay province. Current expansion to a pilot project in Vientiane Province.

Mental Health System

Mental health policy was made available in 2007 as well on the strategy on Mental Health 2013, but there were not implemented widely due to limitations in human and finance resources

Mental Health Integration into Health Care System Policy and/or Regulation

There is no mental health integration into health care system policy and/or regulation

Health Resources

There are about 19.000 public sector health workers.

Based on the National Health Statistics Report in 2011 the numbers of health professional staff is 2.4 per 10,000 population for medical doctors and 7.5 per 10,000 population for nurses.

The number of facilities of public sector services under the Ministry of Health in 2013 is as follows:

- Central level:
  There are four central Hospitals and three special treatment centers providing tertiary curative care as well as dermatology, optalmology, and rehabilitation
- Provincial and district level:
  Health centers: 892 with 2113 beds
  District Hospital: 130 with 1944 beds
  Provincial hospital: 16 with 1589 beds

As of 2013 Lao PDR has limited a number of mental health providers:

- 2 psychiatrists
- 2 Neurologists
- One Mental Health Nurse practitioner
- 11 general physicians who were practical trained at the Mental Health Units in the country and neighboring countries (Thailand)
- 16 nurses and technical staff.
- 10 community mental health workers.

There are no Psychologist or social workers in public sector services
There are 35 mental health beds in general hospital (0.06 beds per 10,000 population)
There is no mental health hospital in the country, however, mental health units are available at the provincial level in 7 out of 16 provinces. There are no mental health units at district level

Mental Health Financing

Funding resources are limited to provide mental health care service for People with Mental Illness and Epilepsy (PWMIE).
There is limited government budget to allocate for mental health care services. As budgets for the mental health care services in hospitals are integrated within the overall hospital budgets, the mental health budget can not be calculated separately.

Mental Health Care Delivery

Primary Care

Only 1% of the training of medical doctors and nurses is devoted to mental health.

- No national mental health treatment protocol exists in primary care.
- No standard mental health referral system exists in the country
- Only medical doctors and physician assistants are allowed to prescribe psychotropic medicines
- Physician assistants and nurses are allowed to prescribe medicines in remote areas where a medical doctor is not available.
- Inadequate supervision by central team to ensure qualified and appropriate care

Mental Health Services in General Hospitals

There are only two mental health departments namely Mahosot and Military hospitals which are located in Vientiane capital and where mentally ill patients can access services. These 2 mental health departments serve inpatients and out patients. The number of inpatients and out patients as follows:

Inpatient services in general hospitals:

- There were 40% of admitted to the two inpatients units (Mahosot and Military hospitals). The admission diagnosis for these inpatient were as follows:
    - Mood/ affective disorder 38%
    - Schizophrenia and related disorder 18%
    - Substance use disorder 16%

Outpatient services in general hospitals:

- There were 2751 users treated at the two outpatient facilities.
- Primary diagnoses were neurotic, stress related, somatoform, schizophrenia.

Medicines

Limited psychotropic medications are available at general hospitals and primary care treatment centers.

Information System

National Assessment Survey shows mental health services are limited.
No National data available

Community Empowerment

There is a limited mental health care facilities at community level except those provided by Basic Need Programme. Community Awareness on mental health is limited. There is no anti-stigma program for the community and health professionals. Strong cultural belief that superstitions and stigma associated with mental illness as well as misunderstanding that mental disorders are untreatable. Traditional healers play important role for mentally ill people, with strong community belief that traditional healers can treat them.

References

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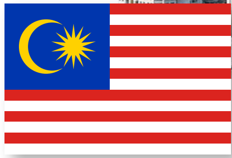


MALAYSIA

Nurashikin bt. Ibrahim, Ministry of Health

Introduction

Malaysia is a constitutional monarchy and a parliamentary democracy. With a land area of 330,289 km^2, it had has a population of 29.71 million as of 2013 (based on the Population and Housing Census 2010), 5.72 million in East Malaysia and 22.5 million in Peninsular Malaysia. There is an annual population growth of 1.3%. By year 2020, the population of Malaysia is expected to be 33.4 million.

Youths (below 20 years) comprises about 35.9% of the population, those aged 15-64 68.3%, with 8.3% aged 60 years and above. Children (below 15 years) and the aged (above 64 years) constitute 31.7% of the population.

Over the last two decades Malaysia has undergone rapid industrialisation. Slightly more of the population lives in urban areas than in rural areas. The family structure has moved towards nuclear households. Annual per capita income is RM34,126.

Health care is provided by public and private sectors, with the Ministry of Health as the lead agency. Provision of public health services is complemented by non-governmental agencies and traditional and complementary medicine.

General Health System

Estimated life expectancy at birth increased from 70.8 years for males and 75.3 years for females in 2002 to 72.56 years for male and 77.16 years for females in 2013.

Mortality rates have been decreasing over the past 40 years. Maternal mortality rate (MMR) has decreased from 1.0 per 100 live births in 1972 to 0.3 in 2011, and Infant Mortality Rate (IMR) per 1000 live births has decreased from 36.1 in 1972 to 6.6 in 2011.

Table 5.1: Financial Allocation, 2014

Total MOH Allocation	RM22,160,380,300
-Operating	RM20,498,060,000
-Development	RM 1,662,320,300
Per Capita Income	RM34,125
Percentage of Total MOH Allocation from National Budget	8.39%

Sources: Estimated Federal Budget 2014, Ministry of Finance, and Economic Report 2013,2014, Ministry of Finance

Healthcare Facilities, 2013

Table 5.2: Number of government hospitals and health clinics providing health services

Ministry of Health	No	Official Beds
Hospitals	**141**	**39,728**
• Hospitals	132	34,576
• Special Medical Institutions	9	5,152
Health Clinics		
• Health Clinics	1039	
• Community Clinics (Klinik Desa)	1,821	

Table 5.3: Health Human Resources 2013

Health Professionals	MOH	Non-MOH	Private	Total	Profession; Population
Doctors	28,949	6,270	11,697	46,916	1: 633
Nurses	56,503	6,011	26,653	89,167	1:333
Assistant Medical Officers	10,641	448	1,428	12,517	1:2,374
Occupational Therapists	858	N/A	N/A	858	
Physitherapists	1,178	N/A	N/A	1,178	
Community Nurses	23,971	181	267	24,419	
Traditional and Complementary Medicine Practitioner				12,532	

Source: Health Facts 2014

Mental Health Problems in the Community

The Disease Burden Study 2004 showed that mental disorders were responsible for 8.6% of the total Diability Adjusted Life Years (DALYS) and ranked fourth among the leading causes of burden of disease. Unipolar major depression accounts for 45% of total burden attributable to mental disorders. In the National Health and Morbidity Survey conducted in 2006, the prevalence of psychiatric morbidity among adults was 11.2% compared to 10.6% in 1996. In children and adolescents, the prevalence of psychiatric morbidity increased from 13.0% in 1996 to 19.3% in 2006 , and increased further to 20.0% in 2011.

In 2011, the National Health and Morbidity Survey yielded a prevalence of depression among adults of 1.8% and prevalence of anxiety of 1.7%. The same study also showed that prevalence of suicidal ideation, suicide plan and suicide attempt are 1.7%, 0.9% and 0.5% respectively.

Mental Health System

Vision and Mission for Mental Health

The development of mental health services in Malaysia is guided by the vision and mission of the Ministry of Health, the vision for mental health and the National Mental Health Policy, and the National Framework of Mental Health.

In line with the health vision of the country, the mental health vision aspires for Malaysia to be a nation of happy, resilient, and productive people with social, emotional and spiritual well-being within supportive family and community environments.

Mission:

- To promote mental health and well-being in society
- To reduce the impact of stigma associated with mental health problems and illness
- To prevent mental health problems and mental illness
- To ensure mental health services are holistic, equitable, community-focused, evidence-based and accessible to all.

- To optimise recovery from mental health problems and mental illness resulting in early re-integration into the community
- To assure the rights of individuals with mental health problems and mental illness

The National Mental Health Policy

The National Mental Health Policy was formulated in 1998 and was revised in 2012. The objective of the policy is to provide a basis in developing strategies and direction to all involved in health and mental health planning and implementation towards improving the mental health and well being of the entire population. The policy is based on thirteen basic principles:

- Good governance
- Social acceptance
- Comprehensiveness
- Accessibility and equity
- Continuity and integration
- Multisectoral collaboration
- Community participation
- Legislation
- Protection of vulnerable individuals
- Competency – human resource and training
- Continuous evaluation and monitoring
- Evidence based practices
- Monitoring and review

The policy requires that mental health services be made available at the primary health care level; and that mental health programs and activities will be integrated into the existing primary health care program.

Mental Health Framework

The Mental Health Framework was developed in 2001 and is a reference as the blueprint for planning, implementation and evaluation of mental health services in Malaysia. The Framework is based upon a spectrum of care across target groups, children and adolescents, adults, elderly and persons with special needs. The spectrum of care comprises of:

- Mental health promotion and prevention of mental illness
- Easy accesibility to primary health care services
- Early detection at the primary care level

- Management of people with severe mental illness at the secondary and tertiary level
- Rehabilitation

Mental Health Governance

The National Mental Health Promotion Advisory Council, established in 2011, is chaired by the Minister of Health. Members of the council include mental health experts, representatives from governmental and non-governmental agencies and mental health advocates. The council advises the Minister of Health on mental health issues, discussing and addressing mental health concerns of the country.

Mental Health Act and Legislation

Mental Health Laws in Malaysia are governed by the Mental Health Act 2001 (Act 615) and Mental Health Legislation 2010. The Mental Health Act and the Mental Health Legislation (2010) replaced the Mental Disorder Ordinance, 1952. One of the main components in the Act and Legislation is the provision on the development of community mental health centres and psychiatric nursing homes.

Mental Health Resources

There are four psychiatric mental hospitals providing mental health and psychiatric services throughout the country with 3,772 beds. In addition there are 45 general hospitals with psychiatric services with a total of 935 beds. There are 319 psychiatrists in the public and private sectors, (1 per 100,000 population). Of these, 163 are in the Ministry of Health, 77 in the Universities, four in the Ministry of Defence and 75 in private practice. There are more than 100 clinical psychologists, with only 12 in the Ministry of Health, and 188 psychology officers (counsellors) in the Ministry of Health.

At primary health care level, a total of 919 government health clinics (89% of all primary health clinics) provide mental health services, with more than 232 Family Medicine Specialists serving at the health clinics. 12 Community Mental Health Centres have been set up since 2012 through out the country.

Table 5.4: Distribution of Psychiatrists providing Psychiatric Services

Facilities	Number of Psychiatrists
Ministry of Health	163
Universities	77
Private unit	19
Ministry of Defence	4
Private Sector	56
TOTAL	**319**

Table 5.5: Human Resources providing mental health care in Ministry of Health facilities

Human Resources	Total
Psychiatrists	163
Medical Officers	314
Clinical Psychologists	12
Staff Nurses	1220
Assistant Medical Officers (Medical Assistant)	697
Counsellors	188
Occupational Therapists	146
Social Workers	40

Mental Health Financing

Total expenditure on health (public and private) in 2013 was RM35.4 (in million), 4.5% of GDP. There is no specific budget allocated for the community mental health program. Most of the budget is absorbed into the existing programs of disease control. In 2013, the budget allocated for hospitals, including mental hospitals, was RM61,250,000. No specific budget is allocated for community-based care activities. For mental health promotion activities approximately RM200,000 was allocated. The mental health budget accounts for approximately 0.28% to 0.39% of the total health budget

Community Mental Health Program in Malaysia

The Community Mental Health Program of the Ministry of Health (MOH) was developed in 1997 under the Seventh (7th) Malaysia Plan. It was originally identified as part of the main program activities under the expanded scope of the Family Health and Development Division of the Ministry of Health. Mental health promotion is one of the main strategies of this program, and also one of the strategies in the National Mental Health Policy and the National Framework of Mental Health. Mental health promotion activities are undertaken in various settings, including schools, workplaces and public places, and with specific target population, including children, adolescents, women, working adults and the elderly.

Mental Health Promotion

Prior to year 2000, localized small scale mental health promotion activities were conducted by Departments of Psychiatry at the general hospitals and psychiatric institutions. These activities were mainly aimed at creating awareness on mental health and mental illness

Beginning 2000, activities in mental health promotion were conducted at a national level through Healthy Lifestyle Campaigns and World Mental Health Day. In 2000, mental health was identified as key elements of the Healthy Life Style Campaign of the Ministry of Health.

In 2001, promotion of mental health of the family was launched through the Promotion of Healthy Family Campaign. From 2003 'Handling Stress Effectively' has been incorporated into the Healthy Life Style Campaign of the Ministry of Health with the theme "Be Healthy for Life". Several activities, including health education, interpersonal communication, multisectoral collaboration and networking as well as training, were carried out at the national, state and district levels.

Another important aspect of mental health promotion which has been emphasized is increasing public awareness on mental health, and especially reducing stigma against mental illness. In 2001 the Mental Health 'Stop Exclusion: Dare to Care' campaign was launched and carried out throughout the country to create awareness on treatment and integration and acceptance in the community of persons with mental illness. 2002 and 2003 saw the extension of mental health promotion activities for children's and adolescents' mental health, to create awareness and enhance positive emotional and behavioural development of children and adolescents.

From 2005 “Enhance Healthy Mind” has been part of the Healthy Lifestyle Campaign to promote positive mental well-being by practising effective stress management and good coping skills. Also in 2005 the Healthy Mind Package was introduced to strengthen promotion of mental health activities. The Healthy Mind Package comprises of screening for stress, anxiety and depression as well as intervention for stress, which include coping skills interventions and relaxation techniques. This package was integrated into the Healthy Lifestyle Campaign 2005.

Mental health promotion activities are also continuously conducted each year through World Mental Health Day, focusing each year on the theme determined by the World Federation for Mental Health.

In all the above activities, there has been a concerted involvement of specialists, hospitals and health personnel, universities and NGOs in the planning and implementing of the program.

Healthy Mind Program in School

The Healthy Mind Program in school was initiated as a pilot project in 2011, involving six secondary schools in Malaysia. It was expanded to 151 schools in 2012 and expanded further to 200 schools in 2013. In 2014, a total of 2,343 schools were implementing the Healthy Mind Program, with a total of 247,949 students screened for stress, anxiety and depression (Table 5.6). A total of 2,343 counsellors were trained using the Healthy Mind Module

Table 5.6: Number of students screened

Screening	Male	Female	TOTAL
Screening 1	75 335	82 832	158 167
Screening 2 (post intervention)	43 400	46 382	89 782
Total	**118 735**	**129 214**	**247 949**

Suicide Prevention Program

Suicide prevention initiatives in Malaysia had started in the year 2004 when Malaysia first observed World Suicide Prevention Day in conjunction with the announcement of the World Suicide Prevention Day in 2003, a collaboration between the International Association of Suicide Prevention and the World Health Organization. Several activities were conducted to address suicide prevention

among which were talks in the media, exhibitions and seminars. A workshop to develop guidelines for media reporting of suicide was conducted in 2004 and the guidelines launched in 2005. In 2005 and 2006 training on management of suicidal persons was carried out for school teachers and counsellors. This was hosted by Ministry of Health in collaboration with an NGO, The Befrienders, which does activities in relation to suicide prevention. A National Strategic and Action Plan for Suicide Prevention 2012 – 2016 has been formulated by a Technical Working group within the Ministry of Health with the support of World Health Organization that outlines strategies and activities on suicide prevention.

Psychosocial Response to Disaster

In Directive 20 of the National Security Council the Ministry of Health has the role of providing psychosocial trauma services to victims and disaster response workers. The activities are carried out through the Mental Health and Psychosocial Response Committee at the national, state and district level. The terms of reference of this committee are to:

a. Assess psychosocial needs and plan the response in disaster situations;
b. Coordinate the management of Mental Health and Psychosocial Response;
c. Coordinate and liase with other agencies;
d. Provide technical advise to Director General / Minister of Health;
e. Provide training and support for the response personnel; and
f. Establish and maintain a database of resources

In response to a disaster:

i) The Mental health and Psychosocial Response Team (MHPRT) will be activated in response to the situation;
ii) Teams will be mobilized depending on requirements;
iii) Each MHPRT can consists of a psychiatrist, family medicine specialists, medical officer, an assistant medical officer and a psychology officer; and
iv) All activities are reported to the National Crisis Preparedness Centre of the Ministry of Health

Mental Health Services

Mental health services in Malaysia have traditionally been provided in large psychiatric hospital settings, as early as 1827, and were delivered through the four mental hospitals, two in Peninsular Malaysia and one each in Sabah and Sarawak. They are:

- Central Mental Hospital in Tanjung Rambutan Perak, established in 1911, the first mental hospital in then Malaya
- Second mental hospital in Tampoi, Johore in 1935
- Sarawak Mental Hospital in Kuching
- Hospital Sakit Jiwa, Bukit Padang, Sabah

The services given were mainly confined to providing mental health care within these institutions. In the late 1950s and early 1960s mental health care was then further provided in general hospital settings. The first general hospital psychiatric department was set up in Penang General Hospital in a move to provide psychiatric care mainstreamed in general hospitals. In 1974, the policy of decentralisation and regionalisation of the services was developed. This continued to be the trend of service provision till 1996 when mental health care was further extended to primary health care.

Mental health care covers three major aspects, (i) mental health services in primary health care, (ii) mental health services in the hospital, and (iii) community-based mental health services.

Mental Health Services in Primary Care

Primary health care plays an important role in providing mental health care services to patients who suffer from mental disorders. This is to provide accessibility to mental health services closer to homes and community and to reduce stigma of mental illness. Among the services provided at the primary health care level delivered through the health clinics are:

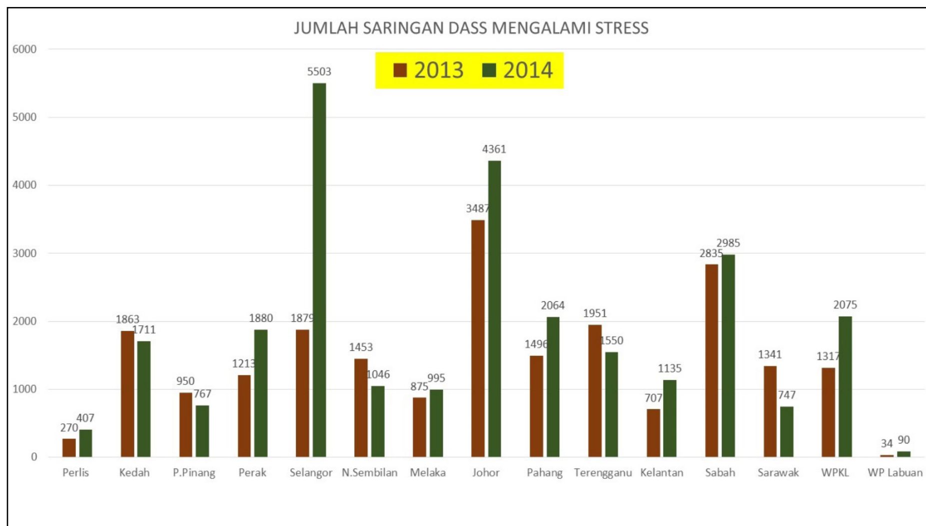
- Promotion of mental health
- Screening and stress management intervention
- Treatment of the mentally ill
- Follow-up of stable mentally ill patients
- Defaulter tracing
- Psychosocial rehabilitation services

In the primary health care clinics of the Ministry of Health approaches were introduced to enable follow-up of the stable mentally ill, and psychosocial rehabilitation began in 1997. In 2007 there were initiatives to provide Healthy Mind Service focusing on handling stress. Identification of those with stress, anxiety and depression was conducted through screening at primary health care level.

Mental Health Screening and Intervention

The Healthy Mind Service was introduced at the health clinics in 2007 with the aim to increase knowledge and awareness of the community on healthy mind, to encourage community to screen for their mental health status and risk factors (stress, anxiety and depression) and to increase skills in handling stress. This service was initially piloted in nine primary health clinics and expanded to all health clinics by 2012, using the Guidelines and Standard Operating Procedure of Healthy Mind Services. As of December 2014, of total 243,025 individuals have been screened, and 27,316 were found to have stress symptoms (Figure 5.1). There is considerable variation across locations in the number of people screened.

Figure 5.1: Number of individuals screened with stress symtoms



Treatment and Follow-Up of the Stable Mentally Ill

Care and treatment of mental disorders at primary health care level are being provided by the primary health clinics, and follow-up treatment for the stable mentally ill has been integrated into the primary health care system since 1998. Those who are mentally ill and are stable can be treated as outpatients with follow-up services at the primary health care clinics. The objective of this follow-up is to enable patients to receive optimal treatment and care in order to prevent relapse, to help them in their rehabilitation and to encourage integration into the community. The patients who are followed up were inclusive of referrals from the hospitals, psychiatric specialists' clinics and also health clinics. Assessment of mental health status was made during follow-up at the clinics. Monitoring and evaluation of the program was done through data collection and documentation from the health clinics sent to the district level. The data was then compiled and sent to the state and finally sent for analysis to the Ministry of Health.

Till December 2014, a total of 1,307 new cases were detected to have mental disorders at primary health care clinics (Figure 5.2). Figure 5.3 shows the number of new cases by diagnosis for 2013 and 2014.

Figure 5.2: Number of newly detected cases of mental disorder at health clinics in 2013 and 2014

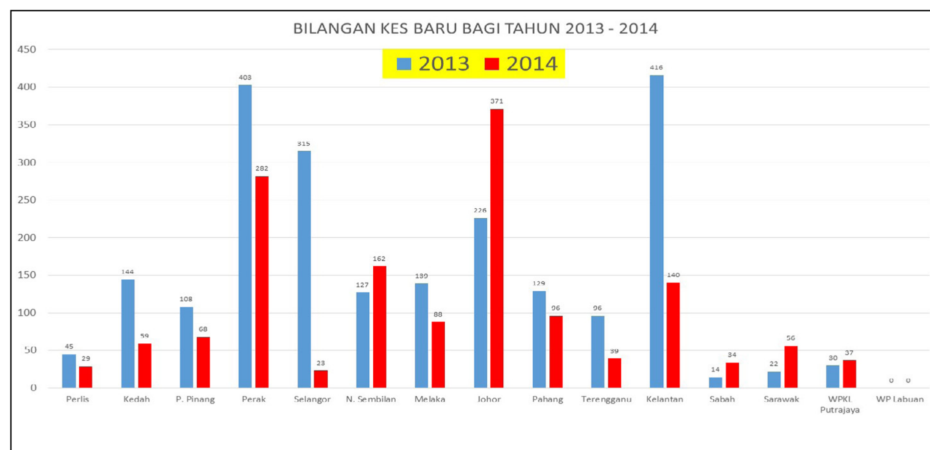
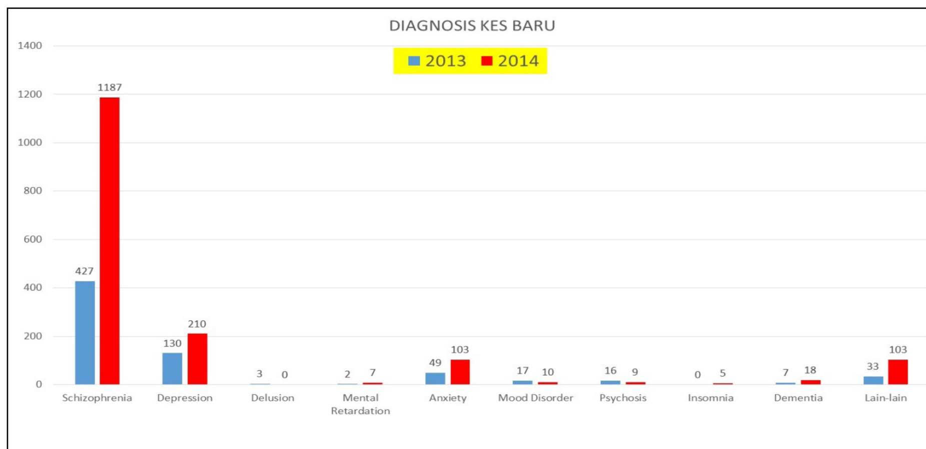


Table 7: Numbers of new cases according to types of mental disorders

Kes	Schizophrenia	Depression	Delusion	Mental Retardation	Anxiety	Mood Disorder	Psychosis	Insomnia	Dementia	Lain-lain
2013	427	130	3	2	49	17	16	0	7	33
2014	1187	210	0	7	103	10	9	5	18	103

Figure 5.3: Number of new cases of mental disorders by diagnosis in 2013 and 2014



Psychosocial Rehabilitation

Psychosocial rehabilitation services for the mentally ill were introduced into primary health care in 1997. The main objective of psychosocial rehabilitation was to enable the mentally ill to understand and control their illness, achieve optimal level of functioning and integrate into the community. Up till December 2014, 27 health clinics are carrying out psychosocial rehabilitation (PSR) activities. The PSR services follow a standardized process using the Threshold Assessment Grid (TAG) to assess patients' level of disability and the Camberwell Assessment of Needs Short Version (CANSAS) to assess mental health service and other needs.

Mental Health Services in the Hospitals

Psychiatric and mental health services are provided through the four mental hospitals and also 45 general hospitals within the MOH system. The services provided include inpatient and outpatient services. The inpatient services are high dependency care, acute care, convalescent care and rehabilitation. Outpatient mental health services include: acute treatment; follow-up treatment; psychoeducation ; family support groups; psychological interventions; cognitive behaviour therapy; assessment for autism, learning disabilities, etc; and counselling services (individual, group, marital, anger management, and medication counselling by pharmacists).

Community-Based Mental Health Services

The Mental Health Act, passed in 2001, clearly spelled out the role of Community Mental Health Centres in the mental health care delivery system. There are 12 Community Mental Health Centres throughout Malaysia providing services including: early assessment and treatment; day hospital treatment; job placement; supported employment; social skills training; and a family link program.

Community-based mental health services are also provided either through acute home care or assertive care (ACT) as part of hospital-based psychiatric services. These services have the aim to provide a comprehensive continuum of care for patients with mental illness as an alternative to hospitalisation by assisting them in the community. The community-based services are meant to complement the existing inpatient services that cater for acute admissions. Acute Home Care Services are provided with a range of comprehensive assessment and treatment to people with severe mental illness who are experiencing exacerbation of symptoms, are in crisis or have a behavioural problem that needs intervention at home. Assertive care or assertive community treatment (ACT) was designed to provide care to those who are mentally ill who need continuous care and support (medication, addressing housing needs, work, skills training) and frequent assessment (of current problems, services required and needs). A multidisciplinary team that consists of doctors, nurses/medical assistants, social workers and occupational therapists assess the patients regularly and review their progress. These services however are provided by health workers from psychiatric hospitals and general hospitals with psychiatric departments. In places which are out of coverage by the hospitals, this service can be delivered by the health centres provided there enough resources in terms of manpower.

Non-Governmental Organisations

Non-governmental organisations (NGO's) play an important part in delivering community mental health services. In Malaysia there are at least 30 NGOs involved in providing community mental health services among which are included the professional bodies, volunteers and organisations led by volunteers. One of the professional bodies is the Malaysian Psychiatric Association. Another important NGO is the Malaysian Mental Health Association in which most of the members are either volunteers or carers. This association runs a day care service and activities such as regular mental health awareness talks and public

forums. Most NGOs are linked with general hospital psychiatry departments and are affiliated to the Malaysian Mental Health Council, the umbrella body that coordinates activities on mental health. Among the other non-governmental organisations are the Malaysian Mental Health Foundation, MINDA Sejahtera, Family Support Groups and other NGOs called the Psychiatric Welfare Body (Badan Kebajikan). The Psychiatric Welfare Body was established to help the welfare of patients and to increase awareness of mental illness. Most of the activities held by the above NGOs are related to promoting mental health and creating awareness on mental illness, by providing training for families and carers, mental health promotion activities such as public forums, exhibitions, and counselling as well as psychosocial rehabilitation services.

Training

Continuous training on mental health has been conducted since 2000 with the aim to increase knowledge and skills on mental health among health care workers. The training covers identification of mental disorders at primary health care, psychosocial rehabilitation, management of children with mental and behavioural problems and psychosocial response to disaster. The training has been delivered to various categories of health care providers including Family Medicine Specialists, Medical Doctors, nurses, medical assistants, occupational therapists and counselors. Examples of training programs that are delivered are the following: Masters in Psychiatry; Sub-specialty trainjing (7 sub-specialities); Community Mental Health in Primary Care; Child Adolescent Mental Health; Healthy Mind (Healthy Mind Module); Psychosocial Response in Disaster; CPG (Depression, Schizophrenia, ADHD).

Guidelines and Modules

Since 2003 several guidelines and modules have been produced to support training and the implementation of mental health services for the country's health care providers as below:

- Guidelines on Treatment of Mental Disorders in primary health care
- Guidelines and Standard Operating Procedure on Healthy Mind Services
- Guidelines on Healthy Mind Program in School
- Module on Stress Management at Workplace (Draft)

- Guidelines on Psychosocial Rehabilitation Services in Primary Health Care
- Training Module Child and Adolescent Mental Health for Specialist
- Guidelines for Mental Health and Psychosocial Response to Disaster
- Manual on Psychosocial Response to Disaster in Community
- Guidelines on Suicide Management in Hospitals
- Training on Suicide Prevention
- Module on Mental Health Promotion Life Skills
    - Child, Adolescent, Parents, Working Adult, Elderly
- CPG on Depression, Schizophrenia, ADHD and Bipolar

Information Systems

National data on mental health problems / psychiatric morbidity are available through the National Health and Morbidity Survey conducted by the Ministry of Health every five years. In terms of monitoring, there is a data collection system in mental health. Data on mental disorders are mainly collected via the Health Informatics Information System of the Ministry of Health. These include data on Mental and Behavioural Disorders according to ICD 10 and also Deliberate Self Harm (hospital based). In addition, at the primary health care level, data are also collected routinely on the number of new cases of mental disorder at primary care and the number of mental cases treated at primary care. Several registries, such as the Schizophrenia Registry and the Suicide Registry, have also been established.

MYANMAR

Win Aung Myint, Mental Health Hospital, Yangon
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Introduction

The Republic of the Union of Myanmar is the westernmost country in South-East Asia, located on the Bay of Bengal and Andaman Sea. It is bordered on the east and north-east by the Lao People's Democratic Republic and the Kingdom of Thailand, on the north and north-east by People's Republic of China, on the north-west by the Republic of India and on the west by the People's Republic of Bangladesh. Myanmar covers an area of (676,578) square kilometres of Indo-China peninsular. It lies between 09°32' N and 28°31'N latitudes and 92°10' E and 101°11' E longitudes. It stretches 2200 kilometres from north to south and 925 kilometres from east-west at its widest point.

The population of Myanmar is estimated in 2015 as 53.9 million, with an annual growth rate of 1.01%. About 70% of the population resides in the rural areas, the remainder are urban dwellers. The population density for the whole country is 89 per square kilometres. The Republic of the Union of Myanmar is made up of 135 ethnic groups speaking more than 100 languages and dialects. The major ethic groups are Kachin, Kayah, Kayin, Chin, Bamar, Mon, Rakhine, and Shan. Based on 1983 population census, 89.4% are Buddhists, 4.9% are Christians, 3.9% are Muslims, 0.5% are Hindus and 1.2% are Animists.

The country is divided administratively, into Nay Pyi Taw Union Territory and 14 States and Regions. It consists of 70 Districts, 330 Townships, 84 Sub-townships, 398 Towns, 3,063 Wards, 13,618 Village tracts and 64,134 Villages. Myanmar falls into three well marked geographic divisions, the western hills, the central belt and the Shan plateau on the east, with a continuation of this highland in the Tanintharyi. Three parallel mountain ranges from north to south divide the country into three river systems, the Ayeyarwady, Sittaung and Thanlwin.

Life expectancy at birth is 60-64 years, while the average life expectancy for urban males and females are 65.8 years and 70.8 years respectively, and the average life expectancy for rural males and females are 64.3 years and 67.8 years respectively (Ministry of Health, Myanmar, 2013). According to UN Statistics (2008) as cited in WHO (2011), the literacy rate is 96% for men and 95% for women.

With abundant natural resources, a strategic location in Southeast Asia and a large and young population, Myanmar has a unique opportunity to lay the foundation for a brighter, more prosperous future. The country is opening up to trade, encouraging foreign investment, and deepening its financial sector. Following the move from a centralized to a market-oriented economy the

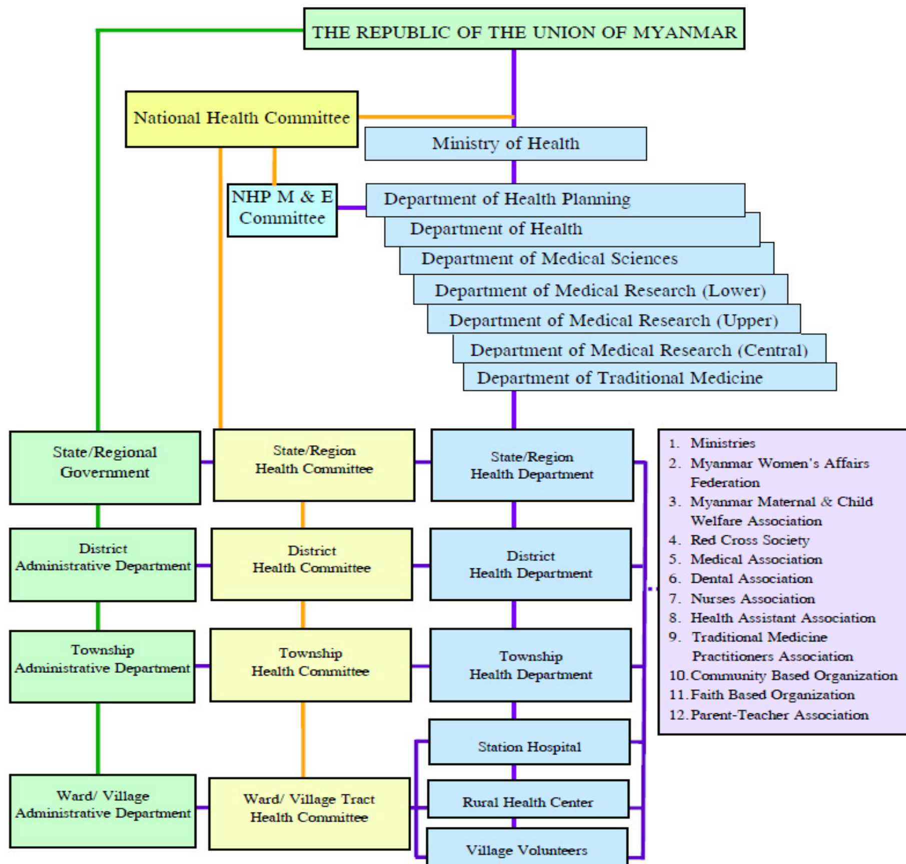
government has carried out liberal economic reforms to ensure participation of the private sector in every sphere of economic activity. The is moving into a new era, building a modern and developed democratic nation.

Mental Health Hospital Yangon

General Health System

Figure 6.1 shows the structure of the national health system.

Figure 6.1:



Substantial progress has been made in improving the general health of the population. Table 6.1 shows Myanmar's progress in relation to the health-related Millennium Development Goals (MDGs).

Table 6.1: Achievements in health-related MDGs

Goals and Targets	Indicators		First Year		Latest Year		Percentage Change
			Value	Year	Value	Year	
Reduce mortality of under-five-year-old by two thirds	Under-five morality rate (deaths of children per 1,000 births)		108.6	1990	50.5	2013	-53
Reduce maternal mortality by three quarters	Maternal mortality ratio (maternal deaths per 100,000 live births)		580	1990	200	2013	-66
Access to universal reproductive health	Contraceptive prevalence rate (percentage of women aged 15-49, married or in union, using contraception)		16.8	1991	46.0	2010	174
	Unmet need for family planning (percentage of women aged 15-49, married or in union, with unmet need for family planning		20.6	1991	19.1	2001	-7
Halt and begin to reverse the spread of HIV/AIDS	HIV incidence rate (number of new HIV infections per year per 100 people aged 15-49)		0.09	2001	0.02	2012	-78
Halt and reverse spread of tuberculosis	Incidence rate and death rate associated with tuberculosis	Number of new cases per 100,000 population	393	1990	377	2012	-4
		Number of deaths per 100,000 population	115.0	1990	48.0	2012	-58

(Adapted from United Nations site for the MDG Indicators, 2014)

Major Depressive disorder is one of the top five leading causes of Years Lived with Disability (YLDs) in Myanmar (Institute of Health Metrics and Evaluation, 2013)

The National Health Policy was developed with the initiation and guidance of the National Health Committee in 1993. The National Health Policy has placed the

Health For All goal as a prime objective using Primary Health Care approach. The objectives of the National Health Policy are to:

1. Raise the level of health of the country and promote the physical and mental well-being of the people with the objective of achieving *health for all* goal, using primary health care approach;
2. Follow the guidelines of the population policy formulated in the country;
3. Produce sufficient as well as efficient human resources for health locally in the context of broad framework of the long-term health development plan;
4. Strictly abide by the rules and regulations mentioned in the drug laws and by-laws which are promulgated in the country;
5. Augment the role of co-operatives, joint ventures, te private sector and non-governmental organisations in delivering of health care in view of the changing economic system;
6. Explore and develop alternative health care financing options;
7. Implement health activities in close collaboration and also in an integrated manner with related ministries;
8. Promulgate new rules and regulations in accord with the prevailing health and health-related conditions as and when necessary;
9. Intensify and expand environmental health activities, including prevention and control of air and water pollution;
10. Promote national physical fitness through the expansion of sports and physical education activities by encouraging community participation, supporting outstanding athletes and reviving traditional sports;
11. Encourage conduct of medical research activities not only on prevailing health problems but also giving due attention in conducting health system research;
12. Expand the health service activities not only to rural but also to border areas so as to meet the overall health needs of the country;
13. Foresee any emerging health problem that poses a threat to the health and well-being of the people of Myanmar, so that preventive and curative measures can be initiated;
14. Reinforce the service and research activities of indigenous medicine to international level and to involve it in community health care activities; and
15. Strengthen collaboration with other countries for national health development.

Health System Priorities

With the ultimate aim of ensuring health and longevity for the citizens the health sector and health programs objectives are to:

- Ensure quality health services are accessible equitably to all citizens;
- Enable the people to be aware and follow behaviours conducive to health;
- Prevent and alleviate public health problems through measures encompassing preparedness and control activities;
- Ensure quality health care for citizens by improving quality of curative services as a priority measure and strengthening measures for disability prevention and rehabilitation;
- Provide valid and complete health information to end users using modern information and communication technologies;
- Plan and train human resources for health as required according to types of health care services, in such a way to ensure balance and harmony between production and utilisation;
- Intensify measures for development of Traditional Medicine;
- Make quality basic/essential medicines, vaccines and traditional medicine available adequately;
- Take supervisory and control measures to ensure public can consume and use food, water and drink, medicines, cosmetics and household material safely;
- Promote in balance and harmoniously, basic research, applied research and health policy and health system research and to ensure utilisation as a priority measures; and
- Continuously review, assess and provide advice with a view to see existing health laws are practical, to making them relevant to changing situations and to developing new laws as required

To achieve these objectives the current National Health Plan (2011-2016) was developed around the following 11 program areas, taking into account prevailing health problems in the country, the need to realize the health-related goals articulated in the UN Millennium Declaration, the significance of strengthening the health systems and the growing importance of social, economic and environmental determinants of health. For each program area, objective and priority actions to be undertaken have been identified.

Program Areas:

1. Controlling communicable diseases
2. Preventing, controlling and care of non-communicable diseases and conditions
3. Improving health for mothers, neonates, children, adolescent and elderly as a life cycle approach
4. Improving hospital care
5. Traditional medicine
6. Human resources for health
7. Promoting health research
8. Determinants of health
9. Nutrition promotion
10. Strengthening the health system
11. Expanding health care coverage in rural, peri-urban and border areas

In relation to the human resources for health program area Table 6.2 shows the numbers of health professionals working in Myanmar;s general health system.

Table 6.2: Health workforce (2012-13)

Health Manpower	Public	Private	Total
Doctors	12800	17032	29832
Dental Surgeon	802	2209	3011
Nurses			28254
Dental Nurses			344
Health Assistants			2013
Lady Health Visitors			3397
Midwives			20617
Health Supervisor (1)			677
Health Supervisor (2)			1850
Traditional Medicine Practitioners	875	5979	6854

Source: Ministry of Health, 2014; pp. 135

An Overview of the Scope and Role of Primary Care in the General Health System

The National Health Policy aims to raise the level of health of the country and promote the physical and mental well-being of the people with the objective of achieving the *health for all* goal, using a primary health care approach. Based on a primary health care approach the Ministry of Health had formulated four-yearly People's Health Plans from 1978 to 1990, followed by the National Health Plans from 1991-1992 to 2006-2011. With the ultimate aim of ensuring health and longevity for the citizens, the basic health staff (BHS) down to the grassroots level are providing promotive, preventive, curative and rehabilitative services through primary health care approach. Infrastructure for service delivery is based upon sub-rural health centres and rural health centres where midwives, Lady Health Visitors and Health Assistants are assigned to provide primary health care services to rural communities. Those who need specialised care are referred to a Station Hospital, Township Hospital, District Hospital or to a Specialist Hospital as required. (Ministry of Health, 2014)

National Workshop on Alcohol Policy

Mental Health Problems in the Community

In 1976, a community survey done at Hle-gu (urban area), Bago division revealed total mental disorders was 8.6% (Pu T.N, 1976). In 1982, a community survey done at Sein Panmyaning ward, Mayangone township (sub-urban area), Yangon division showed all mental disorders was 5.6%, psychoses was 0.55%, neurotic and personality disorders were 1.9%, epilepsy was 0.4% and mental retardation was 0.4% (Win, Pe, Aung and Htay, 1982). In 2004, a community survey done at Daw Pone township (peri-urban area), Yangon division revealed point prevalence of all mental disorders was 8.6%, psychoses was 0.6%, anxiety disorders were 4.1%, depressive disorder was 0.6%, epilepsy was 0.4%, mental retardation (moderate and severe) was 0.5.%, alcohol dependence (Abuse was excluded) was 2.3% (7% of male over 18), and dementia (moderate and severe) was 0.2 % (2.5% of age over 65) (Myint, Lwin & Oo, 2004). In 2004, a community survey done at Pardagyi village (rural area), Kyauktan township, Yangon region revealed point prevalence of all mental disorders was 7.7%, psychoses was 0.6%, anxiety disorders were 3.8%, depressive disorder was 0.5%, epilepsy was 0.2, mental retardation (moderate and severe) was 0.1%, alcohol dependence (Abuse was excluded) was 2.3% (7.1% of male over 18), and dementia (moderate and severe) was 0.2 (3.5% of age over 65) (Myint, Lwin & Oo, 2004).

Calculation of treatment gap based on facility-based treatment of psychoses was 95.8% in 2012. Myanmar's suicide rate in 2011 was 1.96 per 100,000 population.

Access to Primary Care and Specialist Mental Health Services and Barriers to Access

Regarding access to mental health services at the primary care level, personnel of the basic health staff, such as basic doctors, nurses and health assistants, as a part of their learning curriculum, have been trained on the management of common mental health problems which are to be reported through the health management information system. Specialist mental health services are generally delivered at the district level hospitals where psychiatrists are posted. People can also obtain specialist care through satellite programs although they are not yet very widespread.

Common barriers to mental health service access are stigma, lack of knowledge about mental problems by potential service users, shortage of trained personnel

in mental health, lack of family support for some patients, difficulties in commuting and financial problems.

Service providers working at primary care level are trained in management skills for common mental disorders but the capacity of mental health services in primary health care needs to be strengthened. The catchment areas for such services need to be more widespread regarding the mental health services. Some district level hospitals still lack mental health specialists.

Training of MOs

Mental Health System

There is no designated Department of Mental Health in the government health structure. Administratively, provision of mental health services is under the Director, Medical Care of the Department of Health. There is a focal person for mental health services in the Ministry of Health. The focal person is appointed by MoH and usually the person is posted as Professor and Head of Department of Mental Health, University of Medicine(1), Yangon.

Law

A draft of the new Mental Health Law has been completed and is under processing according to the regulations to become a law.

Policy

Myanmar has a mental health policy which is incorporated in the general health policy document. Mental health is included in the National Health Plan which is revised and implemented every five years. The last version of the mental health plan was revised in 2011.

Aim of Mental Health Services

Mental health care is provided with the aim of promotion of mental health, prevention of mental disorders and strengthening of access to mental health services for the people of Myanmar. The objectives are to:

1. Implement strategies for promotion and prevention in mental health;
2. Reduce the treatment and service gap for mental disorders by 20% (by the year 2020);
3. Develop a Mental Health Law appropriate to current situations of Myanmar and international human right issues to replace an old Lunacy Act, 1912;
4. Provide evidence-based best practices for better care for mental health services by collaborating with stakeholders, international medical communities, NGOs and INGOs;
5. Ensure preparedness for mental health and psychosocial aspect of disasters;

6. Promote resource development in mental health and upgrade the hospital-based services;
7. Strengthen health information system related to mental health issues;and
8. Do research for mental health.

Strategy

The mental health reform plan in Myanmar is upgrading the quality of care in hospital-based mental health services simultaneously with developing community-based mental health services and increasing utilisation of the services by the community.

The reform plan is focusing on the following activities:

a) Strengthening and promoting access to mental health services in rural areas by integration of mental health services into the existing primary health care delivery system;
b) Building the capacity of medical officers in mental health promotion, prevention and services;
c) Providing comprehensive, integrated and collaborateive services aiming to have best practices in mental health services;
d) Developing school mental health services aiming for promotion and prevention in mental health as well as coverage of services of mental health problems of children and adolescents; and
e) Launching campaigns to reduce implementation barriers and to increase the utilisation of mental health services at community level, including mental health literacy and ant-stigma campaigns.

Reduction of treatment and services gap of mental disorders by 20% by the year 2020

As indicated above, the treatment gap based on facility-based treatment of psychoses was 95.8% in 2012. The aim is to reduce the treatment gap to 75% by the year 2020.

Facilities

The facilities providing mental health services are shown in Table 6.3.

Table 6.3: Mental Health Facilities in 2013

Facilities	Total Nunber
Mental Health Hospital	2
General Hospital with mental health services	32
Beds in Mental Health Hospitals	1400
Beds for psychiatric cases in general hospitals	220

Source: Mental Health Project, 2013

Mental Health Hospital Mandalay

Human Resources

Psychiatrists and psychiatric nurses are posted in all states and regional levels of the country and some are posted in district levels. Clinical psychologists, psychiatric social workers, occupational therapists are posted only at the two Mental Health Hospitals, in Yangon and Mandalay. The total mental health workforce is shown in Table 6.4.

Table 6.4: Mental Health Workforce in 2013

Category of Workforce	Number	Per Million Population
Psychiatrists	140	2.3
Public	90	
Private	50	
Postgraduate trainees of doctors for Mental Health	50	-
Psychiatric Nurses	156	2.6
Clinical Psychologists	3	0.05
Psychiatric Social Worker	5	0.08
Occupational Therapist trained for mental health	2	0.03
Specialists for Psychosocial Rehabilitation	-	-

Source: Mental Health Project, 2013

The Universities of Medicine (1), (2) and Mandalay offer a Master of Mental Health (M.Med. Sc - Mental Health)), a three-year degree. 20 to 30 psychiatrists graduate annually. The Universities of Nursing, Yangon and Mandalay offer a Diploma in Mental Health Nursing, a 9 months course, and a Master of Mental Health for Nursing (M.N.Sc - Mental Health) degree. There are no training programs for clinical psychologists, psychiatric social workers and occupational therapist for mental health.

There are community health workers and health volunteers, but they are not exclusively for mental health services.

Financing

Table 6.5: Mental health expenditure (Kyat, in million)

Expenditure	2010-11	2011-12
Mental Health Hospitals	13,807 (USD equivalents)	15,036 (USD equivalents)
National Health Expenditure	765,167 (USD equivalents)	810,318 (USD equivalents)

Source: Department of Health Planning, 2013

User fees for health services (out-of-pocket expenses) amount to 35 % in public hospitals.

Services

Provision of mental health care started in Myanmar in 1948, when Myanmar regained independence. In the early days, the mental health care system began in a hospital setting in Yangon and then extended to Mandalay. In 1990, mental health care was included in National Health Plan and attempts have been made to shift mental health care from hospital settings to community settings to ensure effective care. Provision of Mental health care services are delivered in mental hospitals and general hospitals, and in the community.

Hospital-Based Mental Health Care Services

There are mental health services in Mental Health Hospitals and in General Hospitals. There are two mental health hospitals, one is located in Yangon and the other in Mandalay. Mental Health Hospital, Yangon, is a 1,200 bed Tertiary Care Teaching Hospital, with an outpatient department, general psychiatry units, mood disorder units, schizophrenia units, alcohol de-addiction and research unit, drug dependency treatment and research unit, forensic unit, long-stay and rehabilitation unit, and community mental health unit. 18,922 patients attended at the outpatient department and 11,289 patients were admitted in 2013. Mental Health Hospital, Mandalay, is 200 bed Tertiary Care Teaching Hospital, composed of a 100 bed general psychiatry unit and 100 bed drug dependency treatment unit. 6,959 patients attended at the outpatient Department and 2,379 patients were admitted in 2013.

Mental health services are also delivered in General Hospitals. There are 22 Psychiatric Units attached to all 300 bed General Hospitals of all States and Regional levels in the country. Mental health services are delivered with both in

and outpatient facilities led by consultant psychiatrists. There are eight General Hospitals in which mental health services are delivered with outpatient facilities.

Community-Based Mental Health Services

Community-based mental health services are delivered at Primary Care by launching the activities of the Mental Health Project, developing model townships for community-based mental health care services, and planning to provide mental health care services by satellite continuous care programs at secondary and primary care level.

The main aim of the Mental Health project is to integrate mental health services into existing Primary Health Care delivery system. The project was launched in 1990 under the guidance of the Ministry of Health and financially supported by WHO. The main service of the project is aimed to provide care and support of mentally ill patients by trained Basic Health Staff and psychological and social support by families and the community. Mental health education is being provided through local NGOs and trained Basic Health Staff, and community health workers. 700 medical officers and 1,400 basic health workers working at secondary and primary care level have been trained to deliver mental health services. 40% of primary care centres use manuals for treatment of common mental disorders and have at least one basic health worker trained for mental health services.

Development of the Model Township program has been implemented since 2012 as a pilot project. A satellite continuous care program to provide mental health services at secondary and primary care setting was launched in 2014.

Medicines

Medicines are provided by the Ministry of Health for patients attending at Mental Health Hospitals since 2012-13. Small amounts of drugs were provided for primary care periodically by support of WHO. Drugs used in Model Township programs are provided by the financial support of well-wishers and donors. Administrative procedures for import and distribution of drugs are controlled and regulated by Department of Food and Drug Administration, Ministry of Health. Antipsychotics (risperidone and olanzapine), anti-depressants (amitriptyline, and ssri) and sedatives & hypnotics (diazepam, lorazepam, clonazepam and aprazolam) are included in National Essential Drugs List.

Human Rights

The new Mental Health Law will be enacted in the very near future. Human rights for mentally ill persons will be protected by the law which will be in line with international and regional human right standards.

Health Information Systems

A Health Management Information System has been established in the country. Data is collected on six common mental disorders (psychosis, anxiety, depression, epilepsy, mental retardation and alcohol dependence) by trained basic health staff working in rural health centres.

Table 5: Persons with mental disorders receiving treatment (from Jan to September 2013)

Persons treated in primary health care	
Report status	83%*
Number of persons suffering from psychosis	2,024
Number of persons suffering from Anxiety disorders	1,472
Number of persons suffering from depressive disorder	1,175
Number of persons suffering from alcohol dependence	14,860
Number of persons suffering from epilepsy	9,61
Number of persons suffering from mental retardation	1,505
Total numbers of persons	21,997
Persons treated in mental health outpatient facilities	
Number of persons treated in outpatient facilities of Mental Health Hospitals	25,881
Number of persons treated in outpatient facilities of General Hospitals	32,245
Total numbers of persons	58,126
Persons treated in mental health inpatient facilities	
Number of persons admitted in Mental Health Hospital	13,686
Number of persons admitted in General Hospitals with psychiatric beds	1,067
Total numbers of persons	14,173

Source: Mental Health Project, 2013 *83% of Reporting Centres

Integrating Mental Health into the National Health System

Integration of mental health services into the existing health care system is the main strategy to implement activities to achieve the objectives of mental health care provision for the people of Myanmar. Integration is implemented by the following activities;

1. Integration of mental health services into the existing primary health care delivery system to increase mental health care coverage for the whole country. The mental health project, launched in 1990 was initially sponsored by WHO and is currently operating under the guidance of Ministry of Health.
2. Integrated mental health services are operating with other medical specialties in hospital-based services of all general hospitals at State and Regional Levels.
3. Developing model townships for community-based mental health services aiming to provide mental health services by integrating the services into the primary health care level, including rural health centres, local general practitioners (GPs) and the local community. The program also aims to explore and evaluate gaps, challenges and needs and to construct a model which will be feasible, realistic, measurable and applicable for provision of mental health care services in Myanmar. A model township in Yangon region has been developed and the model township program will be expanded to two other areas in the future.
4. Integration of mental health services at secondary care level via the satellite continuous care program. A satellite continuous care program will be launched in Yangon region as a pilot project by mobile mental health teams from Mental Health Hospital, Yangon. Four secondary care centres of Yangon region have been selected and the program was implemented in 2014.

Community Empowerment

In Myanmar, many people still believe that mental illnesses are caused by evil spirits, witchcraft or by not paying respect to the 37 *Nats* or supernatural spirits. If someone becomes mentally ill or starts behaving strangely, he/she is sent to the local healers or *Payawgasayas*. Many people still do not accept that mental illnesses are treatable. Many patients still remain untreated because of stigma and discrimination, misconceptions about mental health and illness and negative attitudes towards mental disorders.

Myanmar society is cohesive. Children, parents and elders are well looked after and valued. Patience, tolerance, goodwill, kindness and voluntarism are the elementary principles of Myanmar culture. Myanmar women are emotionally secure and have equal rights. Abuse is very uncommon in the society. 90% of the population is Buddhist and every village has at least one monastery. Monasteries and monks could play a substantial role in promotion of mental health. Meditation has become popular even among the younger generation. These positive aspects of culture naturally fulfill the basic requirements of social support for people suffering from mental disorders.

Training of HAs

Priorities, Challenges and Opportunities

The most important priorities are to establish a community mental health system which covers most areas of the country, and the mental health law to be enacted as soon as possible.

The treatment gap based on treatment of psychoses (facility-based) is 95.8%. Limitation and scarcity of human resources, technical expertise, and funding are some obstacles to be overcome. In addition, stigmatisation, discrimination, lack of knowledge regarding mental health, and poverty are additional impediments to access to mental health services.

Previously, the mental health sector was a low-priority in the health system. Along with the changes in political system, there is some progress in mental health care delivery system along with other sectors of the health system. Now, mental health sector is in the medium-priority of the health system. These progresses allow better opportunity for the development of human resources, collaboration with international medical communities, and more financial allotment for the mental health sector. In addition, changes in in-patient care settings of Yangon Mental Health Hospital as aforementioned, commencement of hospital-outreached programme and community-based mental health care services will serve as a better access to mental health service. The inherent social cohesiveness, voluntarism and other positive aspects of Myanmar culture are the advantages for the basic requirements of social supports for the patients with mental disorders.

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PHILIPPINES

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Introduction

The Philippines is an archipelago located in the South East Asian Region. It is composed of 7,107 islands and two largest of which are Luzon in the north and Mindanao in the south. There are islands collectively called the Visayas in between them. It has a total land area of 343,282 square kilometers and its coastline stretched to 36.289 kilometers. It has a tropical and maritime climate. It is located in the typhoon belt of the western pacific and experiences an average of 20 typhoons each year. It is also along the "Pacific Rim of Fire" and experiences a number of earthquakes and volcanic eruptions, which makes the country one of the most disaster prone area in the world.

The estimated population in 2015 (United Nations, 2015) is 100.7 Million. The Philippines has a population growth rate of 2.4% annually (Table 1.1) and is the 12th most populated country in the world. The population is unevenly distributed, .with the largest and most concentrated population in Metropolitan Manila in the National Capital Region (NCR) located on the island of Luzon.

Table 7.1: Population/Economic indicators 2006- 2009

Indicators	
Population 2007	88.57 million
Population Growth Rate 2007	2.0%
Population Density 2007	260 persons per km^2
GDP 2009	Php 7,669,144
GDP per capita 2009	Php 83,155
Average Income 2009	PhP 206,000
Poverty Incidence 2006	32.90 % of population
Gini coefficient 2006	0.46

Sources: National Statistics Office, National Statistical Coordination Board, 2009

The majority of Filipinos belong to Malay race, and are Christian, mostly Roman Catholic. A Muslim minority is concentrated on the island of Mindanao. There are approximately 180 ethno-linguistic groups. Tagalog is the most widespread group. The predominant language is Filipino, however English is widely used in government, education, business and media.

The Philippines is divided into three geographic divisions - Luzon, Visayas and Mindanao - and has 17 administrative regions. (Table 7.2)

Table 7.2: Administrative Regions in the Philippines

Luzon	National Capital Region (NCR),
	Cordillerra Administrative Region (CAR),
	Region I- Ilocos Region
	Region II- Cagayan Valley
	Region III- Central Luzon
	Region IV-A- CALABARZON
	and Region IV-B- MIMAROPA
Visayas	Region VI- Western Visayas
	Region VII- Central Visayas
	Region VII-Eastern Visayas
Mindanao	Regions, IX- Zamboanga Peninsula
	Region X- Northern Mindanao
	Region XI- Davao
	Region XII SOCCSKSARGEN
	Region XIII- CARAGA
	ARMM- Autonomous Region in Muslim Mindanao

The Philippines is classified as a lower middle-income country. It has a gross domestic product (GDP) of Php 7.67 trillion (Table 7.1), coming mostly from service industries, industry and agriculture, which remains the major economic activity. A major contributor to the gross national income is remittances from overseas Filipino workers (OFWs). In 2006 32.9 percent of families were below the poverty threshold and the Gini coefficient indicates great economic inequality (Table 7.1). The NCR, Region IV-A and CAR are among the highest earning regions and ARMM is the poorest.

The Philippines has a presidential form of government with three branches, the executive branch, a bicameral legislature, and an independent judiciary under a supreme court. The executive branch exercises administrative and regulatory control over the health system as a whole through the national government agencies and local government units (LGU). The legislative branch approves the overall health budget and annual budget allocations to the national health agencies and institutions.

General Health System

Life expectancy at birth of Filipinos in 2007 was 72 years, while the health-adjusted life expectancy (HALE) was 59 years for men and 64 years for women. Women tend to live longer than men. The leading causes of death among people with non communicable diseases are heart diseases, vascular diseases and malignant neoplasms, and for communicable diseases, tuberculosis and pneumonia.

There is a slow reduction in the maternal mortality rate (MMR) from 182 per 100,000 live births in 1980 to 162 in 2005 and Under 5- mortality rate per 100,000 live births of 54 in 1990 to 40 in 2005 (NSCB 2010). Both are high considering that the Millennium Development Goals (MDG) targets for 2015 are 52 and 18 respectively. This may be attributed to poor health status of lower income population groups and less developed regions of the country such as Bicol region, Eastern Visayan province and ARMM, There is inequity in access to services that may be caused by social, economic and geographic barriers.

Health System Governance and Organization

The health delivery system in the Philippines involves a National Government Agency, the Department of Health, LGUs and the private sector composed of for-profit and non-profit health care facilities/providers.

Under the Local Government Code of 1991 (RA 7160) the health service system, once purely managed and controlled by the Department of Health (DOH), was decentralized and devolved to LGUs nationwide. While DOH retained control and supervision of most tertiary, teaching and training hospitals including highly specialized hospitals (i.e. Health Centre, Mental Hospital, Research Hospitals), the LGUs, under the provincial governor, manage the secondary general hospitals (also known as provincial hospitals) and under the city or municipal mayor, the smaller primary hospitals/health facilities (district hospitals, obstetric clinics, rural health units) through the city or municipal health officers, basic health services, including promotion and prevention, are provided to local constituents (Table 7.3).

Although LGUs are now autonomous in the way they manage and run health services, DOH continues to serve as the health governing agency providing guidance, technical services and, on some occasions, financial assistance to the LGUs through its Regional Office, the Centre for Health Development. DOH has likewise retained all licensing and regulatory powers.

Several laws have been in the health sector, for patients' rights and safety, "Medical Act" (RA 2382 of 1959), "Generic Act" (RA 6675 of 1988), "Higher Education Act" (RA 7722 of 1994) and the "National Health Insurance Act" (RA 7875 of 1994), On the other hand, for the health workers, "Magna Carta or public health workers" (RA 7305 of 1999).

Table 7.3: Health Delivery System in the Philippines

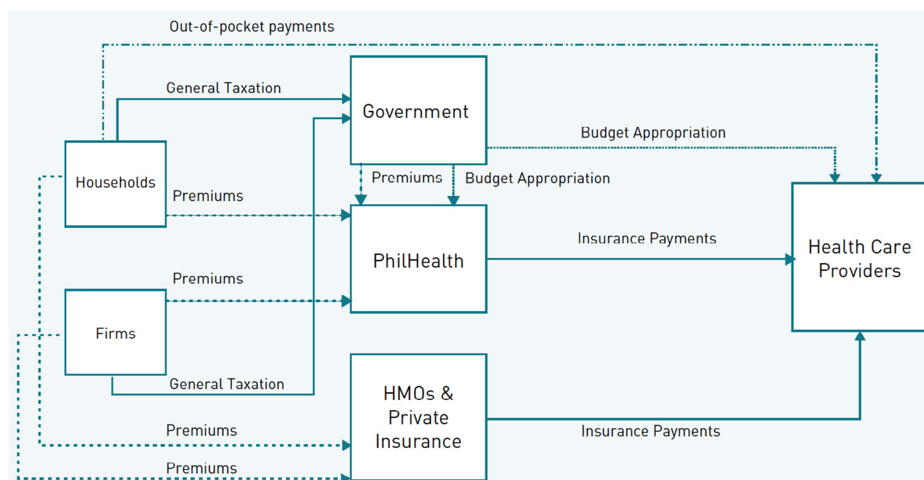
I : NATIONAL GOVERNMENT AGENCIES	
1. Department of Health	Regulatory health facilities, highly specialized hospitals, large training, teaching medical centres, nationwide programs (vaccination, etc.)
2. Non-DOH Health facilities (i.e. Military hospitals, health facilities run by academic institutions)	Special health facilities/hospitals
II: LOCAL GOVERNMENT UNITS	
1. Under the governor	Secondary or provincial hospital
2. Under the mayor	Primary hospitals, infirmaries, lying in clinics, district hospitals, rural health units, preventive and promotive health services
III: PRIVATE SECTOR	
1. For profit health facilities 2. Non profit health facilities	Hospitals and pother health facilities including drug treatment and rehabilitation units/clinics

Financing

The Philippines allotted an equivalent amount of 3.0-3.6% of its GDP for health for the years 1995 – 2005, and around 3.9% in 2007, a total health expenditure of 225 Billion 2007. The government subsidy accounted for 29-41% of all health expenditure in the period 1995-2005.

The Philippine Health Insurance accounted for 9.7% of the total spending and out-of-pocket payments accounted for 40-50% of all health expenditure. (Figure 7.1)

Figure 7.1: Philippine Health Financing Flow



Source: Romualdez, A., The Philippines Health System Review

Human Resources

The total numbers of health workers in the general health system, and the numbers per 100,000 population, are shown in Table 7.4, for the year 2011.

Table 7.4: Number of number workers by category/cadre

Health occupational category/cadre	**2011**	
	Number	Number of health workers/1000 population
Doctor	18,395	0.19921
Nurse	30,172	0.32676
Midwife	14,563	0.15771
Dentist	1723	0.01866
Nutritionist-dietician	982	0.01063
Pharmacist	3,097	0.03354
Occupational Therapist	102	0.0011
Medical technologist	5,063	0.05483
Physical therapist	492	0.00533
TOTAL	74,589	0.080778

Source: Health Human Resources Development Bureau (2011)

Health System Priorities

The Health reforms in the Philippines aim to address the poor accessibility, inequities and inefficiencies in the current health system. The priority of the reform is focused on six areas of the health care system: 1) good governance, 2) service delivery, 3) regulation, 4) health financing, 5) health information system and 6) health human Resources. DOH has also been investing heavily in health infrastructure, upgrading of health facilities and purchase of health equipment.

Mental Health Problems in the Community

According to DOH, there is increasing rate of suicide, and increase in self-inflicted injuries. Death by suicide reached 2.2 per 100,000 population in 2005, increased from 0.5 and 2 in 1980 and 1996 respectively.

There is no national system for reporting mental health cases in the country, The available data are from fragmented epidemiological studies. In 2006, a study conducted by DOH among government employees revealed that 32 percent of the respondents (n=327) have experienced a mental health problem in their lifetime. Among the most prevalent diagnoses were specific phobias (15 percent), alcohol abuse (10 percent), and depression (6 percent). Males were most likely to have substance related problem than females.

Schizophrenia and other related disorders (71%) and mood disorders (18%) are the most frequent diagnoses among patients who are treated in mental hospitals, while substance abuse and neurotic disorders are more frequent diagnoses in out-patient facilities.

Mental Health System

The provision of mental health services is governed by general health and related laws such as Magna Carta for Disabled Persons, the Penal Code, Family Code and Dangerous Drugs Act and the National Mental Health Policy (Administrative Order #8s. 2001). A proposed mental health bill is currently under the review by the Lower House of Representatives. The National Program Management Committee of the Department of Health acts as the mental health authority.

Government has allotted 5 percent of its total health budget for mental health. Most of the budget goes to operations, mental hospitals and salaries.

Mental health services are often available only in specialist mental health facilities. There are different types of mental health facilities (Table 7.5), with most located in the National Capital Region. Mental hospitals have an overall occupancy rate of 92 percent. In the past five years there has been no increase in the number of beds.

Table 7.5: Total number of mental health facilities

	Total number of facilities/ beds	Rate per 100,000 population	Number of facilities/ beds for Children and adolescents	Rate per 100,000 Population
Mentalhealth outpatient facilities	46	0.049	UN	UN
Day treatment facilities	4	0.004	UN	UN
Psychiatric beds in general hospitals	UN	UN	UN	UN
Community residential facilities	15	0.016	UN	UN
Beds/places in community residential facilities	1457	1.556	25	0.027
Mental hospitals	2	0.002	UN	UN
Beds in mental hospitals	4200	4.486	500	0.534

Source: WHO, Mental Health Atlas 2011

There are three independent mental hospitals, the government-owned National Centre for Mental Health (4,200 beds) and two privately run 60-bed mental hospitals. The majority of mental health facilities are government-owned and are attached to large medical centres or Regional Teaching Hospitals. Some teaching institutions/universities also maintain a psychiatric department with 10-20 beds and out-patient services.

The majority of patients are treated in the out-patient facilities (Table 7.6), while there are few treated in the community residential facilities.

Table 7.6: Total number of persons treated in mental health facilities

	Rates per 100,000 population	Female (%)	Underage <18 (%)
Persons treated in mental health outpatient facilities	12.25	43%	28%
Persons treated in mental health day treatment facilities	4.35	44%	7%
Admissions to psychiatric beds in general hospitals	UN	UN	UN
Persons staying in community residential facilities at the end of the year	0.60	30%	3%
Admissions to mental hospitals	5.49	38%	2%

Source: WHO, Mental Health Atlas 2011

Psychotropic medications are available in all types of facilities, but the percentage of the population that has free access is undetermined.

Human Resources

In 2010 there were 432 board certified psychiatrists registered with the Philippine Psychiatric Association, 0.38 psychiatrists per 100,000 population (Table 7.7). However most are in the larger cities. In addition about 0.13/100,000 medical doctors (not board certified) are working in the mental health sector.

Table 7.7: Number of professionals working on mental health

	Health professionals working in the mental health sector Rate per 100,000	Training of health professions in educational institutions Rate per 100,000
Psychiatrists	0.38	0.01
Medicaldoctors, not specialized in psychiatry	0.13	3.38
Nurses	0.72	48.99
Psychologists	0.22	1.87
Social workers	0.02	0.38
Occupational therapists	0.02	0.06
Other health workers	1.33	NA

Source: WHO, Mental Health Atlas 2011

Services

Mental health services have not been integrated into the primary health care system. Only a handful of municipalities, cities or provinces have the capability to provide mental health services at the primary care level. Only one out of 81 provinces has the capability of providing mental health service at the primary level. A total of 17 general hospitals have psychiatric beds and 20 general hospitals provide out-patient mental health service.

Medications

A wide range of conventional and atypical psychotropic medications are available in the country. Most commercial pharmacies carry these medications and several medical centres and general hospital carry them in their formulary. To make psychotropic medications more readily available, the government has the Medicine Access Program, which does bulk procurement of medications including psychotropic medications and distribute them to remote provinces and municipalities. National expenditure on psychotropic medications is not known.

Mental Health in Primary Health Care

Among doctors and nurses working in the primary health care (PHC) only 1 percent of doctors and 2 percent of nurses have received at least 2 days of

refresher training in mental health. The vast majority of primary health care workers have not received official in-service training on mental health within the last five years. Official manuals on management and treatment of mental disorders are not available in the PHC, although procedures for referring patients to secondary and tertiary care do exist.

In primary health care, only doctors are authorized to prescribe psychotropic medications. PHC clinics with doctors have at least one psychotropic medication of each therapeutic category (anti-psychotic, anti-depressant, mood stabilizer, anxiolytic and anti- epileptic) available.

Health Information Systems

A number of databases/information systems collect data on substance abuse, violence and injury, suicide, etc. (Table 7.8). While many health facilities, including community residential facilities, collect data on patient's profile, diagnosis, number of admissions, number of outpatients, length of stay in in-patient and residential services, etc. there is no comprehensive information system that captures mental health information at a national level.

Table 7.8: Data collected and reported

	Data on Number of people/activi ties are collected and reported	Data on age and gender are collected and reported	Data on patient's diagnosis are collected and reported
Persons with mental disorders treated in primary health care	Yes	Yes	Yes
Interventions (psychopharmacological and psychosocial) delivered in primary health care for people with mental disorders	Yes	Yes	Yes
Persons treated in mental health outpatient facilities	Yes	Yes	Yes
Contacts in mental health outpatient facilities	Yes	Yes	Yes
Persons treated in mental health day treatment facilities	Yes	Yes	Yes

	Data on Number of people/activi ties are collected and reported	Data on age and gender are collected and reported	Data on patient's diagnosis are collected and reported
Admissions in general hospitals with psychiatric beds	Yes	Yes	Yes
Admissions in mental hospitals	Yes	Yes	Yes
Days spent in mental hospitals	Yes	Yes	Yes
Admissions in community residential facilities	Yes	Yes	Yes

Source: WHO, Mental Health Atlas 2011

There is an unknown number of family and users associations (Table 7.9). Some associations have been involved in the formulation or implementation of mental health policies, plans or legislation within the past two years.

Table 7.9: Informal human resources (Family and User Associations)

	User	Family
Present in the country?	Yes	Yes
Number of members	UN	UN
Participation in the formulation/ implementation of policy/plan/legislation?	Not routinely	Not routinely

Source: WHO, Mental Health Atlas 2011

Community Empowerment

There are many interest groups that advocate for mental health awareness. Some focus on specific mental health problems, such as depressions, autism, etc. They use a variety of approaches in their advocacy work, including conducting public fora, distribution of information, education and communication materials, and use traditional and new media. The government has dedicated dates for the observance of specific mental health subjects/concerns and October 10 – World Mental Health Day - is observed annually. Several training institutions conduct post-graduate courses in mental health in different provinces and community

outreach programs in different municipalities. A number of private individuals and families (usually families with a mentally ill member/relative) have bonded together as advocacy groups.

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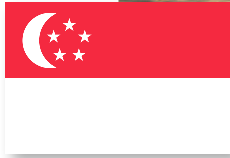

SINGAPORE

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Introduction

Singapore is located in Southeast Asia and has a population of 5.47 million (National Population and Talent Dvision, Singapore Department of statistics, Ministry of Home Affairs, Immigration & Checkpoints Authority, 2014). Based on Department of Statistics Singapore's publication of Population Trends 2014 the ethnic composition of the population is 74.3% Chinese, 13.3% Malay, 9.1% Indian and 3.3% others. The proportion of citizens over the retirement age of 65 makes up 12.4% of the population. Life expectancy has increased from 66 years in 1970 to 82.5 years in 2013, making it one of the highest in the world. Increasing life expectancy coupled with low fertility rates (resident total fertility rate of 1.19 in 2013) has resulted in an ageing population.

Singapore is in the high-income World Bank country category (World Bank, 2013) with a GDP per capita of approximately USD$50,391 in 2014 (Singapore Department of Statistics, 2015). Based on the estimates in 2010, cardiovascular diseases were found to be the main contributor to burden of disease (Ministry of Health Singapore, 2014).

Healthcare Financing

Singapore offers universal healthcare coverage to its citizens via a financing system that is based on twin philosophies of individual responsibility and affordable healthcare for all. A mixed financing system, which uses multiple tiers of protection, helps ensure that no Singaporean is denied access to basic healthcare due to affordability. The first tier of protection comes from Government subsidies. The second tier is provided by a compulsory individual medical savings account schemes. The third tier is from a low-cost catastrophic medical insurance scheme and the final tier involves a medical endowment fund set up by the government. This endowment fund acts as the ultimate safety net for needy Singaporeans who cannot afford to pay their medical bills despite the other tiers of protection. With the use of technology and market-based mechanisms to promote competition and transparency to deliver healthcare services, Singapore has managed to secure good healthcare outcomes for its population. Singapore's healthcare expenditure – total public and private - is about 4% of GDP, which is relatively low among developed countries (Ministry

of Health Singapore, 2015). However, this is expected to rise with an ageing population.

Health Care System

Singapore's healthcare system is organised broadly into primary care, hospital and Intermediate and Long Term Care (ILTC) sectors. Legislation, such as the Private Hospitals and Medical Clinics Act, is in place to ensure healthcare services are of a good standard and delivered in a safe environment. Table 1 shows the number of doctors and nurses working in the healthcare system.

Table 8.1: No. of health professionals – doctors and nurses

	2012	2013	2014
Total number of Doctors	**10,225**	**10,953**	**11,733**
>Public sector	6,131	6,661	7,330
>Private sector	3,515	3,678	3,790

	2012	2013	2014
>Not in active practice	579	614	613
Doctor to population ratio	1:520	1:490	1:470
Doctor per 1,000 population	1.9	2.0	2.1
Breakdown by:			
Number of Specialists	**3,867**	**4,124**	**4,485**
>Public sector	2,342	2,511	2,829
>Private sector	1,293	1,351	1,411
>Not in active practice	232	262	245
Number of non-Specialists	**6,358**	**6,829**	**7,248**
>Public sector	3,789	4,150	4,501
>Private sector	2,222	2,327	2,379
>Not in active practice	347	352	368
Total number of Nurses / Midwives	**34,507**	**36,075**	**37,618**
>Public sector	21,000	21,707	22,744
>Private sector	8,413	8,826	9,002
>Not in active practice	5,094	5,542	5,872
Nurse to population ratio	1:150	1:150	1:150
Nurses per 1,000 population	6.5	6.7	6.9
Breakdown by:			
Number of Registered Nurses	**25,971**	**27,556**	**28,864**
>Public sector	15,916	16,738	17,667
>Private sector	6,321	6,716	6,863
>Not in active practice	3,734	4,102	4,334
Number of Enrolled Nurses	**8,274**	**8,273**	**8,528**
>Public sector	4,995	4,890	5,006
>Private sector	2,027	2,049	2,078
>Not in active practice	1,252	1,334	1,444
Number of Registered Midwives	**262**	**246**	**226**
>Public sector	89	79	71
>Private sector	65	61	61
>Not in active practice	108	106	94

Notes:

[1] Includes doctors registered under Temporary Registration for service provision from Year 2010 onwards

(Ministry of Health Singapore, 2015)

The healthcare system is designed to ensure that everyone has access to different levels of healthcare in a timely, cost-effective and seamless manner.

Primary health care is provided through a network of publicly funded outpatient polyclinics and private medical practitioners' clinics. As of 2014, there are 18 polyclinics and approximately 1,500 private medical clinics providing primary healthcare services. Polyclinics are "one-stop" healthcare centres providing primary care treatment, preventive healthcare and health education. Patients who require more specialised treatment or hospital admissions can be referred to hospitals. Polyclinics meet 20% of the total demand for primary healthcare.

Singapore has eight public hospitals - six acute general hospitals, a women's and children's hospital (Kandang Kerbau Women's and Children's Hospital), and a psychiatric hospital (Institute of Mental Health). Each general hospital provides multi-disciplinary acute inpatient and specialist outpatient services, and a 24-hour emergency department. In addition, there are eight national specialty centres providing cancer, cardiac, eye, skin, neuroscience and dental care. Singapore also has 10 smaller private hospitals. In 2014, there was a total of approximately 11,230 hospital beds in the 26 hospitals and specialty centres (Ministry of Health Singapore, 2015). Support services to hospitals include forensic pathology, pharmaceutical services and blood transfusion service.

Singapore's Intermediate and Long Term Care (ILTC) services are typically for persons who need further care after being discharged from an acute hospital as well as community-dwelling seniors who may be frail and need supervision or assistance with activities of daily living. These ILTC services are delivered in the home, in health centres and in residential care settings. Residential ILTC facilities provide approximately 12,000 beds (Ministry of Health Singapore, 2015).

Mental Health in Singapore

Mental illness is a growing public health concern and a major social and economic issue affecting individuals and families throughout the world. Yet mental illness is often neglected due to a lack of understanding, misconceptions, discrimination and stigma. Mental disorders are one of the top five contributors of disease burden in Singapore (Epidemiology & Disease Control Division, 2010).

In 2010, a population-based mental health survey - the Singapore Mental Health Study (SMHS) - was conducted to determine the prevalence of selected mental disorders in adult Singapore residents. These included Major Depressive Disorder (MDD), Bipolar Disorder, Generalised Anxiety Disorder, Obsessive-Compulsive Disorder (OCD), Alcohol Abuse, and Alcohol Dependence. SMHS found that 12% of the adult resident population met the lifetime criteria for the common affective, anxiety, or alcohol use disorders (Chong, et al., 2012). Other key findings from the study showed that MDD, Alcohol Abuse and OCD emerged as the top three most common disorders in Singapore, and that the majority of people with mental illness were not seeking help (Institute of Mental Health, 2011).

The Singapore Burden of Disease Study conducted, in 2010, included the findings from SMHS and also used incidence estimates extrapolated from other studies or from available hospital and clinic records for other mental conditions such as alcohol use disorders, schizophrenia and bipolar disorders. (Epidemiology & Disease Control Division, 2010). Using the disability-adjusted life years (DALYs) metric it was found that mental disorders were the main cause of disability before age 40 years, and schizophrenia was the largest contributor amongst the disorders studied.

Mental Health Promotion

The Health Promotion Board (HPB) drives national mental health promotion and disease prevention programs for the population. HPB's mental health education and promotion efforts are developed with the following objectives: 1) to raise awareness and understanding of the importance of mental well- being, 2) to empower individuals to have lifestyle knowledge and skills to strengthen their personal mental well-being, 3) to improve the understanding and symptoms of mental health problems and encourage people to seek help early and 4) to reduce discrimination against people with mental health problems.

HPB's mental health programs are targeted at different segments of the population, tailored to the different psycho-emotional needs of each group. Its outreach efforts include various mental wellness promotion targeted at schools, workplaces and the general community. Examples of programs include the school-based Mind Your Mind (MYM) program, targeted at students, the Treasure Your Mind (TYM) program, aimed at raising awareness of mental health and well-being among working adults, and the Nurture Your Mind (NYM) program, which reaches out to adults in the community, to demonstrate how various aspects of life are related to mental well-being (Health Promotion Board Singapore, 2015). Public education events are organised in collaboration with partners to provide information on a wide spectrum of mental health topics including mental well-being, emotional resilience, managing stress, mental illnesses and fighting stigma.

Mental Health Services

Singapore has a wide range of mental health services and supports which promote the transition towards services based in the community (Ministry of Health Singapore, 2014). Table 2 shows the general mental health service available in the country based on 2013 data. The Institute of Mental Health (IMH) is the main psychiatric hospital in Singapore. Another four general hospitals in Singapore also offer psychological/psychiatric assessment and treatment with 78 inpatient beds in total.

Table 8.2: Mental Health Service Availability in Singapore based on 2013 data

Care Setting	Total number of facilities/beds/visits					
Mental Hospitals	*No. of facilities*	1	*No. of beds*	2,010	*No. of admissions in the last year*	7,850
Psychiatric units/beds in general hospitals	*No. of facilities*	4	*No. of beds*	78	*No. of admissions in the last year*	1,309
Mental health community residential facilities	*No. of facilities*	3	*No. of beds*	356	*No. of admissions in the last year*	495
Mental health day care or treatment facilities	*No. of facilities*	UN	*No. of places*	UN	*No. of sessions in the last year*	UN
Mental health outpatient facilities	*No. of facilities*	8	*N/A*		*No. of visits in the last year*	236,884

[UN= data is unknown]

Mental Health Atlas 2014 Questionnaire – Singapore input (Ministry of Health Singapore, 2014)

Development of Mental Health Services – Community Empowerment

Traditionally mental healthcare has been provided in hospitals. Recognising the need to develop mental healthcare capability in the community and increase integration of care between the different sectors, Singapore launched the National Mental Health Blueprint in 2007. The Blueprint introduced mental health policies and initiatives targeted at different groups (children and youth, adults and the elderly). It also guides various care agencies in providing good mental health services for the population, including mental health education, prevention, early detection and treatment for at-risk individuals, families and society. Over the years, Singapore has invested a total of approximately USD$131million in the Blueprint.

In 2012, to strengthen the Blueprint, a Community Mental Health Masterplan was developed to facilitate a network of care and supporting systems to enable integrated community living. The Masterplan comprised of three sets of initiatives 1) develop general community-based mental health services, 2) develop dementia services, and 3) develop psychiatric Intermediate & Long-Term Care (ILTC) facilities.

The Masterplan was reviewed in 2014 with feedback obtained from community partners and other key stakeholders. More focus will be given to support the following three key thrusts 1) strengthening primary care to improve access to mental health services, 2) enhancing integration and pre- and post-treatment support in the community by collaborating with social service sector and leveraging of community resources, and 3) increasing capacity to support clients and their caregivers given the expected growth in dementia with an ageing population.

The Agency for Integrated Care (AIC) is an independent corporate entity which works with various partners, including MOH and service providers, to facilitate the enhancement and integration of the long-term care sector in Singapore. As part of integrating mental healthcare, a series of multidisciplinary community mental health teams were formed and various programs developed, each catering to different demographic and target groups in Singapore. Examples of these programs include Response, Early Intervention and Assessment in Community Mental Health (REACH which targets youth); Community Mental Health Team (targeted at adults) and the Community Psychogeriatric Program (targeted at the elderly).

Mental Health Workforce

Currently, workforce data is only available for the mental hospital. It is not available for psychiatric wards in general hospitals, mental health community residential facilities or other outpatient health facilities and services (Table 3). Singapore has programs which aim to develop the mental health workforce. An example is the Graduate Diploma in Mental Health (GDMH) which was launched to train primary care physicians in mental health. The program aims to equip primary care physicians with mental health training so as to be able to detect and treat patients with mild to moderate mental health conditions in the community. In addition, the undergraduate medical curriculum at the Yong Loo Lin School of Medicine, National University of Singapore, has also undergone significant revisions, with a compulsory psychiatry rotation with opportunities for electives for clinical and research work.

Table 8.3: Mental Health Workforce in Singapore based on 2013 data

Mental Health Workforce (Number of Mental Health Professionals, by Care Setting)								
Care Setting	Total no. of profes-sionals working in mental health	Psychi-atrists working in mental health	Other medical doctors working in mental health	Nurses working in mental health	Psy-cholo-gists working in mental health	Social workers working in mental health*	Occu-pational thera-pists working in mental health*	Other paid workers working in mental health*
Mental Hospitals*	2248	54	130	978	67.6	57.3	51.7	909.4
Psychiatric ward in a general hospitals*	UN	138	UN	UN	UN	UN	UN	UN
Mental health community residential facilities*	UN	UN	UN	UN	UN	UN	UN	UN
Other outpatient health facility or service	UN	UN	UN	UN	UN	UN	UN	UN
Total	2386	192	130	378	67.6	57.3	51.7	909.4

*[UN=unknown]   *Figures given refer to the number of FTEs.*
"UN": Insufficient data and granularity of information available to fully respond to this item.
Mental Health Atlas 2014 Questionnaire – Singapore input (Ministry of Health Singapore, 2014)

Mental Health Expenditure

Based on the Singapore report for Mental Health Atlas 2011, mental health expenditure by the government health department/Ministry consumes 4.14% of the total public health budget. Mental hospital expenditures are 71.71% of the total mental health budget (World Health Organization, 2011).

Law

The Mental Health (Care and Treatment) Act in was passed in 2010, replacing the previous Mental Disorders and Treatment Act. The new legislation was to provide for admission, detention, care and treatment of mentally disordered persons in designated psychiatric institutions.

Medicines

Patients receiving care in public healthcare institutions receive drug subsidies based on their paying status and the scheme under which a particular the drug is covered. MOH maintains and regularly reviews a list of subsidised drugs which covers up to 90% of the total volume of medication prescriptions. This list includes selected psychotropic medications.

In general, prescription regulations authorize primary care physicians to prescribe and/or to continue prescription of psychotherapeutic medicines. MOH has released guidelines on prescribing psychiatric medicines potentially open to abuse such as benzodiazepines. Nurses and Pharmacists are not authorized to prescribe and/or to continue prescription of psychotherapeutic medicines.

Information System

Mental health data (public sector) is collected as part of the general health statistics collection. Singapore's Ministry of Health gathers and disseminates information about organisations and about mental and psychosocial disabilities (Ministry of Health Singapore, 2014). Some of the information can be found on the Ministry of Health's website.

The Future in Singapore's Mental Health Landscape

One of the main challenges for Singapore is to work towards community acceptance of people with mental illness. Stigmatisation of individuals with mental illness is an essential challenge to overcome. Mental illness is often neglected due to a lack of understanding and misconceptions of mental disease and discrimination against those affected. Stigmatisation of people with mental illness prevents people with mental illness from studying, working and socialising in their community (Chong, Mental Health in Singapore: A Quiet Revolution, 2007). The complexity of the situation is further amplified as Singapore is a multi-cultural and multi-faith society and stigma is deeply embedded in and related to societal, cultural and religious beliefs (Mahendran, Lim, Verma, & Kua, 2014). The Singapore Mental Health study found a large treatment gap for the majority of mental illnesses. Based on a study of help-seeking behaviours Professor Chong Siow Ann advanced three reasons for the long delay between

onset of a mental health problem and entering into treatment - “failure to identify the illness, stigma, and the lack of access to help.”

Despite ongoing efforts to address the issue in Singapore, stigmatisation of persons with mental illness is still prevalent. Over the years Singapore’s Health Promotion Board (HPB) has been raising awareness and understanding of mental health issues, encouraging people to seek help early and reduce discrimination against people with mental health problems (Health Promotion Board Singapore, 2015). An approach Singapore has adopted is to shift mental healthcare from institution-based model towards a community-based model as evident in the Community Mental Health Masterplan. The aim is for people to treat mental illness just like physical health issues while ensuring that appropriate services are in place to address the unique disabling effects associated with mental illnesses.

Singapore also faces the challenge of resource constraint. Singapore’s healthcare system is facing a lack of healthcare manpower in general, and manpower resourcing is compounded within the mental health setting as it is traditionally less attractive than other sectors. Singapore will need to build up manpower capabilities and drive innovation and productivity, so as to meet the healthcare needs of Singapore’s population adequately (Ministry of Health Singapore, 2014). The Ministry of Health will continue to enhance the healthcare capability within the community.

There is a need to ensure integration of different services across the care continuum and with the social service sector, given that people with mental illness benefit from a wider spectrum of health and social support which allows smoother transitions between services and more effective outcomes. A strong health system managed by well-trained healthcare workers coupled with a sustainable healthcare financing system will also be required to ensure affordable healthcare and efficient use of healthcare resources (Ministry of Health Singapore, 2014).

In conclusion, Singapore recognises the importance of the mental health sector. With the current developments to increase and integrate the psychiatric facilities and services, the mental health arena in Singapore will continue to grow as Singapore continues to advance as a country. Singapore will take a whole community approach to promote mental health (Ministry of Health Singapore, 2014).

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THAILAND

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Introduction

The Kingdom of Thailand has borders with Myanmar, Lao PDR, Cambodia and Malaysia. While Thailand is a constitutional monarchy the constitution recognizes that the people are the sovereign. The country has an area of 513,000 square kilometers.

Thailand has approximately 68 million people (United Nations, 2015), population density is 132 persons per square kilometer (Department of Provincial Administration, 2012). In 2012 and the population growth rate is 0.3 (World Bank, 2013). Crude birth rate per 1,000 people is 11 and crude death rate (per 1,000 people) is 7.5.

The majority - 90% - of the population is Buddhist. Thailand has inherited a strong Southeast Asian tradition of Buddhist kingship that tied the legitimacy of the state to its protection and support for Buddhist institutions. This connection has been maintained into the modern era, with Buddhist institutions and clergy being granted special benefits by the government, as well as being subject to a certain amount of government oversight. The others 10% of population consists of Muslims, Christians, Hindus, Sikhs, Jews and non-religious.

The culture of Thailand incorporates cultural beliefs and characteristics indigenous to the area of modern Thailand coupled with much influence from ancient China, Cambodia, Laos, India and the neighbouring pre-historic cultures of Southeast Asia. It is influenced primarily by animism, Hinduism, Buddhism, as well as by later migrations from China, and northern India. Thai is the national and official language. A number of other languages are also spoken in the different regions of the country.

According to the National Government Organisation Act, BE 2534 (1991), the administrative services of the executive branch are divided into three levels: central, provincial, and local. The central government consists of ministries, bureaus and departments. Provincial governments administer the 77 provinces. Each province is led by a governor and is divided into districts. In 2010, there were 7,255 municipalities in regions and 169 special districts in Bangkok, the capital city of Thailand. A city municipality is established in an area where there are at least 50,000 citizens, a town municipality where there are at least 10,000 citizens, and a subdistrict municipality in any other area.

Thailand is an upper middle-income country (World Bank, 2012). About 2% of the population lives on less than $1 (PPP int.$) per day (WHO, 2012). In 2013,

Thailand's Gross Domestic Product (GDP) per capita is USD3,437.84 with annual GDP growth of 6.5%. The GDP per capita in Thailand is equivalent to 27 percent of the world's average (World Bank, 2013).

Life expectancy at birth is 74 years (WHO, 2011). Literacy rate is 98%. Thailand's Human Development Index (HDI) in 2013 was 0.722, which is below the average of 0.735 for countries in the high human development category. Thailand's Gross National Income (GNI) per capita increased by 257 percent between 1980 and 2013 (Human Development Report, 2014).

General Health System

Health System Governance and Organisation

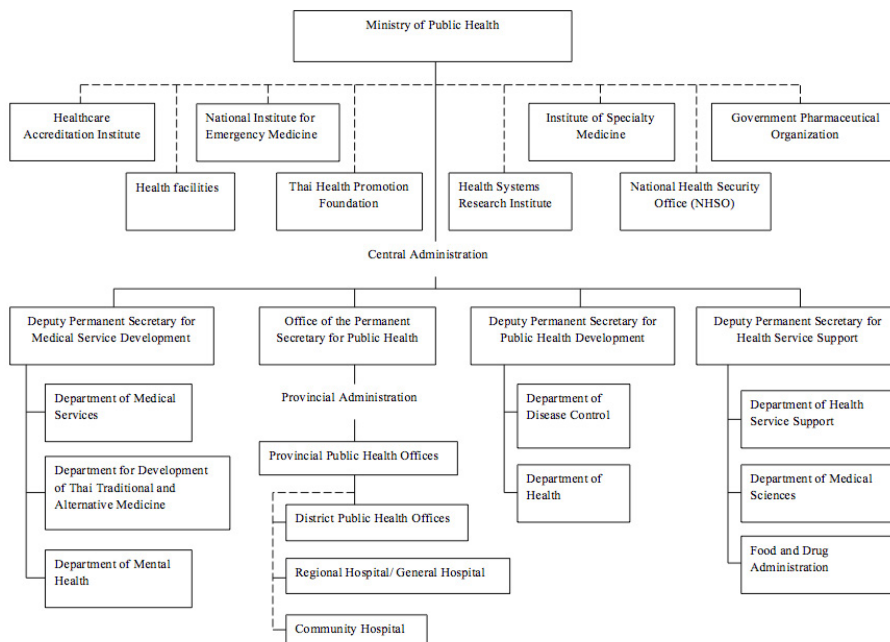
The Ministry of Public Health (MOPH) is responsible for population health and health services. It is organised into eight departments (Figure 9.1). Each of the 77 provinces has a Provincial Public Health Office (PHO) and there is a District Public Health Office in each of the 7,255 districts. At Regional level there are four medical school hospitals, 25 regional hospitals, and 38 special hospitals, including psychiatric hospitals. At Provincial level, there are 69 general hospitals, covering all provincial areas, and 56 hospitals under the Ministry of Defence. At District level there are 736 community hospitals, covering 90 percent of all districts, and 212 municipal health centres. There are 9,689 health centres covering all sub-districts. At village level, there are 67,376 rural community primary health care centres, and 1,732 urban community primary health care centres.

The Department of Mental Health, the national mental health authority, has been integrating mental health care into general health and primary health care policy. As a result community hospitals around the country have continually enhanced their capacity to provide primary and community-based mental health services, while Regional and Provincial hospitals have developed psychiatric clinics, inpatient units and psychiatric supervision.

There are eight government agencies under the supervision of MOPH, focusing on different aspects of health services management (Figure 9.1) with increasingly decentralized governance arrangements. These crucial autonomous organizations are considered an essential health system and

policy mechanism. Effective engagement with civil society occurs throughout government agencies, partnerships and Non-Government Organization (NGOs) networks.

Figure 9.1: Ministry of Public Health structure



Health Services Delivery Levels

Health services are classified into four levels.

1) Self-care: Self-care at family level includes the enhancement of people's capacity to provide self-care and make decisions about health.
2) Primary health care: Includes activities organized by the community in providing services related to health promotion and prevention.
    a) District level (Health Promoting Hospital: HPH)
    b) Sub-district level (Health centre, community health facilities)
    c) General Practitioners
3) Secondary health care level: General hospitals and Regional hospitals. Secondary health care is managed by medical and health personnel with specialization.
4) Tertiary health care: General hospital, Regional hospitals, University hospitals, large private hospitals. Tertiary care provides more specialized treatment.

Health Financing

The Bureau of Mental Health Strategy (2014) reported that the total national health budget was USD76.6 billion US dollars in 2014, approximately 4.1% of GDP. However, this budget allocated to the Ministry of Health to support public providers was USD3.26 billion, 75.5% of total health expenditure (World Bank, 2012b).

The public sector is the main health service purchaser and accounts for 75% of total national health expenditure. Thailand has attempted to develop health service schemes and benefits for all Thai citizens and to achieve *health for all*. In 2012 99.9% of Thai citizen were covered by health insurance schemes (National Health Security Office, 2012). There are currently three main health benefits schemes (Table 9.1) and additional private health insurance schemes.

Table 9.1: The main health schemes in Thailand

Categories	Government Official Benefit	Social Security Scheme (SSS)	The Universal Coverage Scheme (UCS)
Pattern	Health Welfare	Compulsory Health Insurance	Health Welfare
Home Regulator	The Comptroller General's Department	Social Security Office	National Health Security Office (NHSO)
Ministry	Ministry of Finance	Department of Labour Protection and Welfare Ministry of Labour	Ministry of Public Health (MOPH)
Source of Funds	National revenue	Payroll Tax: Employer, Employee (self-employed individuals) Tax (Government)	National revenue
Health Payments Systems	Pay Per Use	Commutation expenses	Commutation expenses
Cover (approximately)	5 million people	10 million people	48 million people
Target group	Civil servants and dependents	Employees, workers	The poor, the elderly, children, vulnerable groups

Source: Nikomborirak, 2012

The Civil Servant Medical Benefit Scheme (CSMBS) is a universal health coverage scheme launched in 2002, reducing out-of-pocket expenditure for health. It has been implemented under the Comptroller General's Department, Ministry of Finance. The Social Security Schemes (SSS), compulsory insurance under the Ministry of Labour, is funded by payroll tax paid by employers. The SSS opened up an opportunity for private hospitals to play an increasing role in the provision of care since beneficiaries are able to choose either public or private hospitals to receive health care. It was a more integrated mechanism to support public and private sectors in providing health services and to increase the level of choice of providers. The Universal Coverage Scheme (UCS) is a tax-based scheme, funded by the MOPH. It is free of charge but it has been argued that UCS beneficiaries receive services that are limited in quality.

Health Workforce

The Section of Personnel, Department of Public Health, (2011) reports that the health workforce in Thailand has been limited both in general hospitals and at the level of primary health care units (Health System Research Institute, 2012). There are particular shortages of dentists, radiographers and medical technologists (Table 9.2).

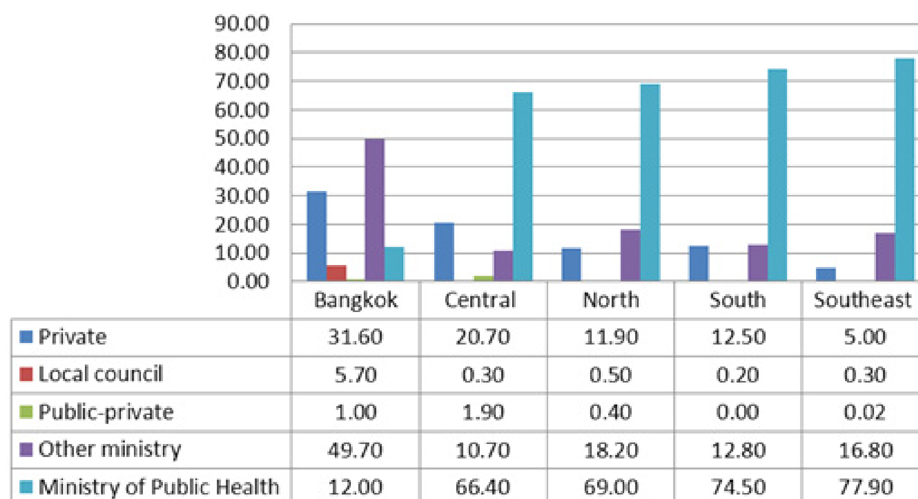
Table 9.2: Health personnel and development in hospitals managed by Office of Permanent Secretary

Health personnel (person)	General Hospital		Community Hospital	
	Need for manpower	Current	Need for manpower	Current
Doctors	6,727	6,221	7,010	2,305
Dentists	3,174	980	4,264	1,834
Pharmacists	3,194	1,959	3,848	668
Nurses	54,474	40,326	56,627	10,448
Occupational Therapists	1,280	431	2,095	1,516
Medical technologists	1,894	930	2,798	1,921
Radiographers	1,280	313	1,397	1,167

Source: Section of Personnel, Department of Public Health, 2011 cited in Health System Research Institute Forum (2012)

A workforce survey conducted in 2009 shows that doctors employed by the MOPH, are mostly outside of Bangkok (Figure 9.2). Almost half work for other ministries and approximately 31% work in the private sector.

Figure 9.2: Distribution of doctors by employer and region 2009



	Bangkok	Central	North	South	Southeast
Private	31.60	20.70	11.90	12.50	5.00
Local council	5.70	0.30	0.50	0.20	0.30
Public-private	1.00	1.90	0.40	0.00	0.02
Other ministry	49.70	10.70	18.20	12.80	16.80
Ministry of Public Health	12.00	66.40	69.00	74.50	77.90

Source: Section of Personnel, Department of Public Health cited in Thailand Health Profile 2008-2010

Health Service Priorities

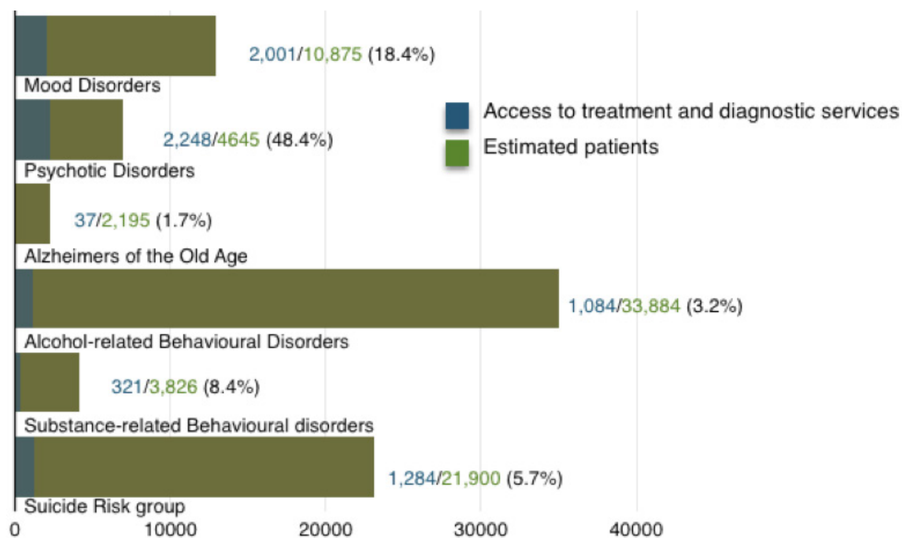
According to the Bureau of Policy and Strategy (2012) the crucial health service priorities of the 11th National Health Development Plan during 2012-2016 are:

1. Strengthening health management systems according to established standards, improving doctor/population ratio and reducing regional disparities,
2. Morbidity and mortality rates due to disasters, epidemics and health threats: (i) morbidity rates due to emerging and re-emerging infectious diseases; (ii) mortality rates due to natural disasters; and (iii) morbidity rates due to occupational and environmental diseases.
3. Controlling morbidity rates due to heart disease, cerebrovascular disease and cancer, rates of patients diabetes and hypertension.
4. Investing in health promotion and disease prevention programs for target populations with proper health behaviours (exercise, vegetable and fruit consumption, sugar/fat/salt consumption, controlling tobacco smoking and alcohol drinking).

Access to Services

As shown Figure 9.3, access to services by people with mental health and psychiatric problems is various. These 3from the Bureau of Mental Health Strategy survey (2013) reveal the different percentages of patients who can access treatment and diagnostic services, when compared with the estimated totals of people affected by mental health and psychiatric problems. Access to services is highest among patients with psychotic disorders (48.4%), followed by mood disorders (18.4%). The lowest access rate is found among the elderly with Alzheimers and alcohol-related behavioural disorders patients (1.7% and 3.2% respectively).

Figure 9.3: Access to service among people with mental disorder



Source: Thailand Mental Health Gap Survey Report (2013)

Mental Health Problems in Community

Epidemiology

The Department of Mental Health conducts a national mental health survey every five years. In 2008 the overall prevalence of mental disorders was 14.3% (7.0 million) of the population. 1.9% of the population (0.9 million) has an anxiety disorders; 2.8% (1.4 million) has an affective disorder (MMD, dysthymia, hypomanic episode and manic episode). Around 0.24 million people have a psychotic disorder. More than 10% (5.2 million) of people are alcohol dependent. The survey found that 11% of the mentally ill received treatment and 64% of mentally ill who received treatment did not continue in treatment. 21% of mentally ill people who received treatment reported that they were only slightly or not at all improved. The survey by Bureau of Mental Health Strategy (2012) reports that the suicide rate is 6.2 per 100,000 population, while the rates are 9.64 per 100,000 and 2.84 per 100,000 among and females repectively.

Community Mental Health Awareness

Mental Health problems are still stigmatised in Thai society. People are still afraid of being labeled as mentally ill and have incorrect beliefs about mental health problems. As a result, people with mental disorders in the community do not seek or fully participate in mental health care or encourage relatives and friends who have mental disorders to do so.

Activities to increase community awareness of mental health problems and the need for mental health treatment, together with promotion and prevention activities, have been implemented in the community mental health program since 1978. 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. However there are still varying superstitions in each region of the country. Some believe that all mental health problems are equal to psychosis, and some believe that psychotic disorders are symptoms of being possessed by a spirit or ghost.

Mental Health System

Governance/Administration

The Mental Health Department (MHD), the national mental health authority, provides advice to government on mental health policies and legislation, sets the standard of care and develops and transfers mental health technologies to all stakeholders. Mental health services are integrated into general health services and organized in terms of catchment/service areas. There are 13 catchment health services areas in the country, including Bangkok. After the health reform in 2012, the role of MHD now includes development of mental health policy and regulation of the mental health services system at provincial and district levels.

Law

The Department of Mental Health, as a representative of Ministry of Public Health, is responsible for implementation and administration of the Mental Health Act, B.E. 2008, and issues regulations and notifications for the execution of the Act. The National Mental Health Board is the mechanism to lay down policy and measures in relation to the protection of rights of persons with mental disorder, and to the access of mental health service as well as social inclusion. The board also has the duty to inspect and monitor the performance of mental health practice.

Policy

The vision of the Ministry of Public Health, since 2003, is health for all the people. MOPH administrators at all levels jointly create an organization that is strong in technical, administrative and service aspects, having qualified personnel with righteousness and happy working life; and all are working on the basis of community and societal participation.

The Department of Mental Health deals with mental health technical development, research and development as well as transfer of knowledge and technologies for the prevention, treatment and rehabilitation of mental health problems. It is responsible for conducting research studies; developing and transferring knowledge and technologies relating to the promotion of mental health, and prevention, treatment as well as rehabilitation of mental health problems; providing services, especially for serious or complicated cases of

mental disorders; and enhancing knowledge and skills relating to mental health and psychiatry for medical and health personnel as well other personnel in both public and private sectors.

The last revision of the mental health plan was in 2005. These plans contain the same components as the mental health services policy, but also include: human resources, involvement of users and families, advocacy and promotion, equity of access to mental health services across different groups, financing and monitoring system. The main policy mechanism to improve the quality of mental health services is working through the WHO Mental Health Gap Action Program.

Facilities

Thailand has 18 psychiatric hospitals, distributed to every part of country, and 13 mental health centres, taking the role of implementing mental health policy. Three of the 18 psychiatric hospitals are specifically for children and adolescents.

An increasing number of hospitals, including government and private hospitals, are able to provide mental health services in response to an increase of mental health service need. There are 830 government-owned mental health outpatient facilities, inpatient psychiatric units/beds in 14 general hospitals, and two mental health day care facilities. Currently government hospitals are still facing the difficulty of having insufficient beds for psychiatric patients.

Human Resources

From the survey by Bureau of Mental Health Strategy in 2013, there are 704 psychiatrists and 3,588 psychiatric nurses working full-time in hospitals. About one thousand community-based doctors (general practitioners) are trained in mental health and 7,131 community-based nurses are trained in mental health (Table 9.2).

A majority of psychiatrists (70%) work for government general hospitals and are employed by psychiatric hospitals. Approximately equal numbers of psychiatric nurses work in psychiatric hospitals and government general hospitals, 46% and 54% respectively.

For other mental health staff, official reports have not been regularly produced. However, the Bureau of Mental Health Strategy has collected some survey data, also shown in Table 9.2. There are 433 psychologists working in hospitals and 458 social workers.

Table 9.2: Mental health workforce

Mental Health workforce	Psychi-atric hospitals	%	Govern-ment hospitals	%	Private hospi-tals	%	Total	Number per 100,000 population
Psychiatrist	205	29.1	486	69.0	13	1.9	704	1.1
Nurses	1632	45.5	1926	53.7	30	0.8	3,588	5.6
Psychologist	74	17.1	339	78.3	20	4.6	433	0.7
Occupational therapist	25	41.0	32	52.5	4	6.6	61	0.1
Social worker	86	18.8	368	80.4	4	0.9	458	0.7
GP trained in mental health	12	1.2	982	98.5	3	0.3	997	1.5
Nurses trained in mental health	43	0.6	7081	99.3	7	0.1	7,131	11.1

Source: Bureau of Mental Health Strategy, survey, 2013

The last column of Table 9.2 shows the number per 100,000 population for each professional group. The majority of nurses working in mental health settings have been specifically trained in mental health.

Mental Health Cadres

There are different mental health cadres at each community level (see Figure 3).

At the *primary care units,* village health volunteers are trained on mental health problem screening skills as well as the basic skills to look after the patient, monitoring the case in their communities, and transferring the case when necessary to more specialized mental health care facilities. They also play a supportive role for patients and carers in the proper usage of psychotropic drugs and encourage the patients to regularly collect their medication. As community mental health focuses primarily on mental health promotion and prevention, village health volunteers are also play an important role in encouraging individuals to participate in mental health activities.

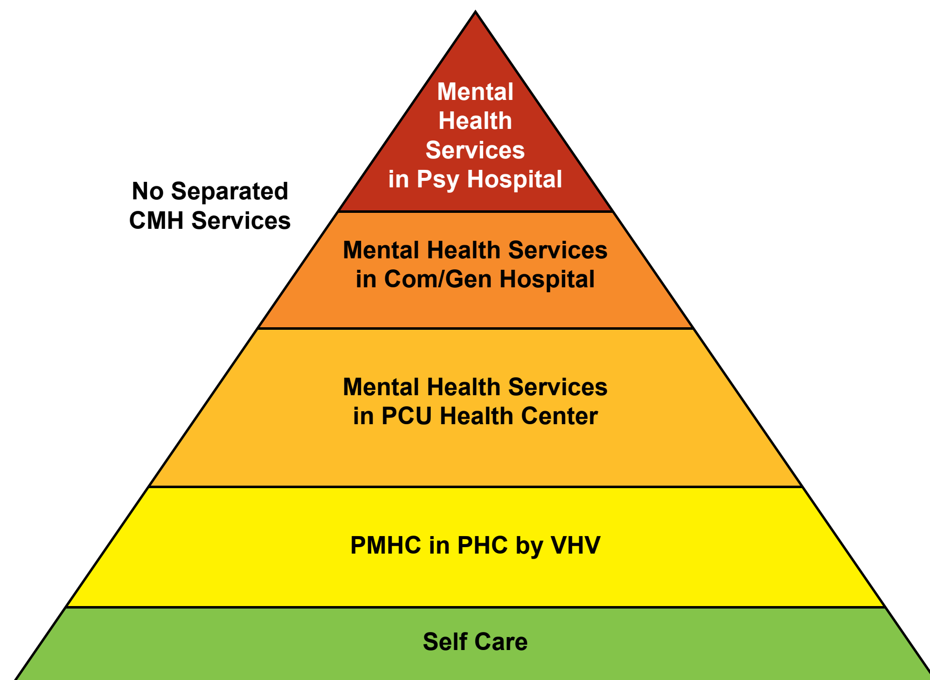
At the *community hospital level*, psychiatric nurses are trained specifically in psychiatry (a 4-month training course, or master's degree in psychiatric and mental health nursing) to assist physicians in treatment of psychiatric inpatients and outpatients. Mental health personnel at community hospital level are trained to at least be able to diagnose eight common mental disorders

- psychosis, substance use disorder, anxiety disorder, depressive disorder, mental retardation, neurosis, suicide risk, and other area-specific mental health problems. Volunteers and health personnel also collaborate to provide mental health and social support for psychiatric patients and carers both in the community and hospital, as well as supporting the implementation of support and prevention program. Pharmacists also participate in the support team to advise patients and carers about the correct usage of prescribed medication.

At *General Hospital level*, the function of the nurses is the same as at the community hospital level. However there are also multi-disciplinary teams to provide mental health and psychiatric services. At this level, psychiatrists are responsible for effective and continuing inpatient psychiatric treatment and care.

Figure 9.4 gives a summary of the levels of treatment and care in the mental health system.

Figure 9.4: Thailand Mental Health Service Delivery



Mental Health Financing

In 2014, the budget allocated to the Department of Mental Health by the Bureau of Budget was approximately USD 84.5 million, approximately 2.4% of the total health budget (Bureau of Mental Health Strategy, 2014).

USD 62.5 million (74% of the total mental health budget) is allocated to the 12 psychiatric hospitals and six psychiatric institutions. The mental health budget allocated for promotion and education is approximately 3% of the total mental health budget.

Data on mental health budget for non-governmental mental health services is not available.

Mental Health Services

Primary Care

In 2010 Suan Prung Hospital, the biggest northern psychiatric hospital managed by the Department of Mental Health, developed guidelines - *'Principles for quality enhancement in mental health service for primary health care level'* - for mental health program and service activities for regional, general, and community hospitals and for primary care units. The guidelines were developed to support achievement by the Department of Mental Health of the main strategies of re-orienting mental health service networks to the community and implementing mental health and psychiatry services equally at all levels (Suan Prung Hospital, 2010).

The guidelines aimed to achieve integrated mental health services for all hospital and PCU which are composed of the following aspects - mental health personnel, service setting, service system, patient transfer, and follow-up.

About service setting development from these guidelines, the intention is to integrate mental health clinics and services with other clinics/programs in hospitals and PCU, and in separate psychiatric inpatient wards in general hospitals.

Education and Training

There are training programs and standard curriculum for psychiatric residency for general practitioners, for psychiatric nurse residency, and for pharmacists. The Department of Mental Health has financial and other capacity to produce around 20 psychiatrists annually. The standard curriculum is regularly enhanced and approved by the Medical Council of Thailand.

For psychiatric nurse residency Thailand prioritizes the four-month training program. There is also a training program on psychotropic medicines and for pharmacists offered by the Thai Psychiatric Pharmacy Group, associated with hospitals and institutes managed by the Department of Mental Health.

Attention is paid to improving the capacity of primary health care staff in screening, diagnosis, counselling, and prescribing for the mental disorders, including psychosis, drug and alcohol addiction, depression, mental retardation, as well as implementing mental health promotion and prevention programs. In the last two years (2013-2014), about 10,500 primary care staff (38.6% of all primary care staff) were trained in mental health care for at least for at least two days .

Provision of Medicines in Primary Care and in General Hospitals

There has been a National Essential Medicines List since 2008. This is periodically updated, with the most recent revision published in the Royal Thai Government Gazette in 2013. The medicines list contains two categories of medicines: 1) a list of medicines used in hospitals and health facilities; and 2) a list of herbal medicines. The first list can be further categorized into five sub-lists according to their usage, activation, supporting research, and/or previous success when prescribed in Thailand. In each category there are indications and regulations for each prescription of each drug and recommended usage. The prescription of psychotropic medicines is regulated by the **Psychotropic Substances Act 1975** which was designed to regulate some psychotropic drugs. The Act divides psychotropic drugs into four Schedules and regulates the permission and prohibition together with punishment of each Schedule's production, sale, importing, exporting, carrying across borders or possession.

Human Rights

A Thai National Human Rights review body exists which has the authority to review involuntary admissions, discharge procedures and complaints investigation processes. This body does not oversee regular inspection in mental health facilities and has no authority to impose sanctions.

There is a gap between the legal framework and the reality of the mental ill. The incidence of abuse of people with mental illness is probably under-reported. The development of community-based mental health care, and increasing the number of people with mental disorder who are assessed and treated at primary care level, is intended to reduce the stigmatisation, raise awareness, advocate for change, improve social understanding and decrease maltreatment of people with mental illness.

Information Systems

The data that is routinely collected as part of the health information systems is shown in Table 9.3.

Table 9.3: Data collected

Data Content	Data Availability	
	Yes	No
Persons with mental disorders treated in primary health care	✓	
Interventions (psychopharmacological and psychosocial) delivered in primary health care for people with mental disorders	✓	
Persons treated in mental health outpatient facilities	✓	
Admissions in general hospitals with psychiatric beds	✓	

Integrating Mental Health into the National Health System

In 1978 Thailand added mental health to the Basic Primary Health Care component of the *Health for all by the Year 2000* Policy, resulting in a major shift in focus to mental health at the community level. Again, in early 2013, the

Department of Mental Health reformed its mental health system so that mental health services in Thailand were to be integrated into the public health system at all levels. The reform involved increasing the role of primary health care in mental health treatment, with monitoring by 13 mental health centres located in all region of Thailand. The reform also resulted in the development of excellent centres at psychiatric hospital /institute level.

Community Mental Health Empowerment

In 2006 the Department of Mental Health launched the *National Mental Health Campaign: Destigma* which aimed to reduce stigmatisation of psychiatric patients and individuals with mental health problem. The program included many many activities, including activity-based knowledge giving for patients, carer, relatives, youths, schools, police, health providers and mass media (Department of Mental Health, 2014). The activities aimed at the creation of awareness of stigmatisation and increasing acceptance and of people with mental illness via mass media, creating more positive attitudes towards people with mental health problems, and creating networks for dissemination of mental health and psychiatric knowledge and researche to the public. The program continues to operate.

National Disability Day is one of the activities resulting from the National Mental Health Campaign which was created to help reduce the stigmatisation of patients with health problems. Examples of other activities include Annual Mini Marathon activities by Srithanya Psychiatric Hospital. In collaboration among 20 countries including Thailand, *Open the Doors*, the global World Psychiatric Association anti-stigma program launched in 1999, aims to increase awareness and readjust misconceptions about patients with schizophrenia as well as to modify the attitudes of society towards people with mental disorder and their families.

Since 2003 Thailand has followed WHO guidelines to develop the Mental Health Gap Action Programme, aimed at scaling up access to mental health care by using the principles of community mental health care empowerment.

As for the traditional healers' role, monasteries and religion play a prominent role in providing mental health comfort in all communities. This is one of the major factors that could prevent mental health problems. Treatments which are based on traditional mind and soul healing such as Mindfulness meditation, Thai traditional doctors and Chinese acupuncture are also growing popularity.

Priorities, Challenges and Opportunities

In 2014-2015, Thailand has five most important policy priorities to improve the effectiveness of mental health care. They are:

1. Improve Early Intervention services for children from birth to five years to target children with delayed development, neuro-developmental disorders such as Autistic Spectrum Disorders and intellectual disability to prevent permanent disability and to improve quality of life.
2. Reduce the number of alcohol and substance abuse cases, and especially reduce the number of new cases, particularly among the young.
3. Increase the number and improve the quality of psychosocial services in general health services at all levels of care for at-risk populations such as survivors of personal violence, patients with chronic diseases, persons with HIV/AIDS, alcohol and substance abuse patients, stress and depression.
4. Accelerate the accessibility of regular mental health services for people with mental disorders, mainly focusing on depressive disorders and psychotic patients.
5. Provide training and strengthen the mental health workforce at primary care to decrease the barriers to mental health services.

Societal changes in Thailand brought about by many factors, such as the coming ASEAN Economic Community and other global movements, will have a substantial impact on Thai society. A more diverse, mobile and individualistic society is foreseen . The existing social pluralism and cultural diversity may lead to increasing mental health problems and increasing demand for mental health services. More specific services, with staff that have diverse skills, will be needed to meet the diverse and complex problems of different target populations, such as the young generation, urban populations, migrants, etc. The limitation of resources in rural areas and social stigmatisation greatly limit access to appropriate care among children and adolescents with mental health problems. Social changes such as these will be a critical challenge for the health system. Scaling up of resources and services at primary care level is a high priority.

Along with the challenges of the future there are opportunities. Realising these opportunities will be greatly supported by the increased understanding of the importance of mental health problems and the clear and strong commitment of policy makers towards mental health.

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VIET NAM

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Introduction

Viet Nam is the easternmost country of the Indochina Peninsula, covering an area of 331,210 km^2. The country has long coastline of 3,444 km and is mostly narrow from east to west. Mountains and tropical forests cover 40% and 42% respectively of the land area, and the mountainous areas are generally more remote and less developed than the Red River Delta in the north and Mekong River Delta in the south.

The population of Viet Nam in 2014 was 90 million - an increase of 4.2% from 2009 (General Statistics Office, 2014b) - and is projected to exceed 108 million by 2050. With a population density of 270 per km^2 Viet Nam is among the most densely populated countries in the world. 28.9 million people (32.3%) live in urban areas. The most densely populated regions in Viet Nam are the Red River Delta (20.4 million), and the Mekong River Delta (17.4 million) (General Statistics Office, 2014a). Viet Nam has established a population administration system, currently integrated in and managed by the health system, to take care of population administration and policy implementation.

Viet Nam's administrative system is organized into four levels -central, provincial (64 provinces), district (644 districts), and commune (11,161 communes) (General Statistics Office, 2014a). The governance model of Viet Nam has centralized and decentralized characteristics. The central government is responsible for establishing national laws, policies and plans, allocating budgets to provinces, and regulating the activities of provinces. Provincial governments have considerable autonomy in deciding the specific plans for socio-economic development and for budget allocation. In many sectors, including health, the national and subordinate governments have different clearly specified roles. For example, the central government, via the Ministry of Health, is responsible for, among other things, making national laws and regulations, issuing national health policy, establishing and disseminating standards, and supervising the operations of Provincial Departments of Health. However, the provincial governments are in charge of budget allocation and staff development in the health sector that they manage.

Since the re-unification of the country in 1975 Viet Nam has achieved substantial socio-economic development. The program of political and economic reform launched in 1986, referred to as *Doi Moi*, has lifted the country from the poorest category in the world to low-middle-income level in less than three decades. The GDP per capita in 2013 was approximately 1,800 US dollars, as compared with 580 US dollars in 2006 and less than 100 US dollars in 1986. In the last

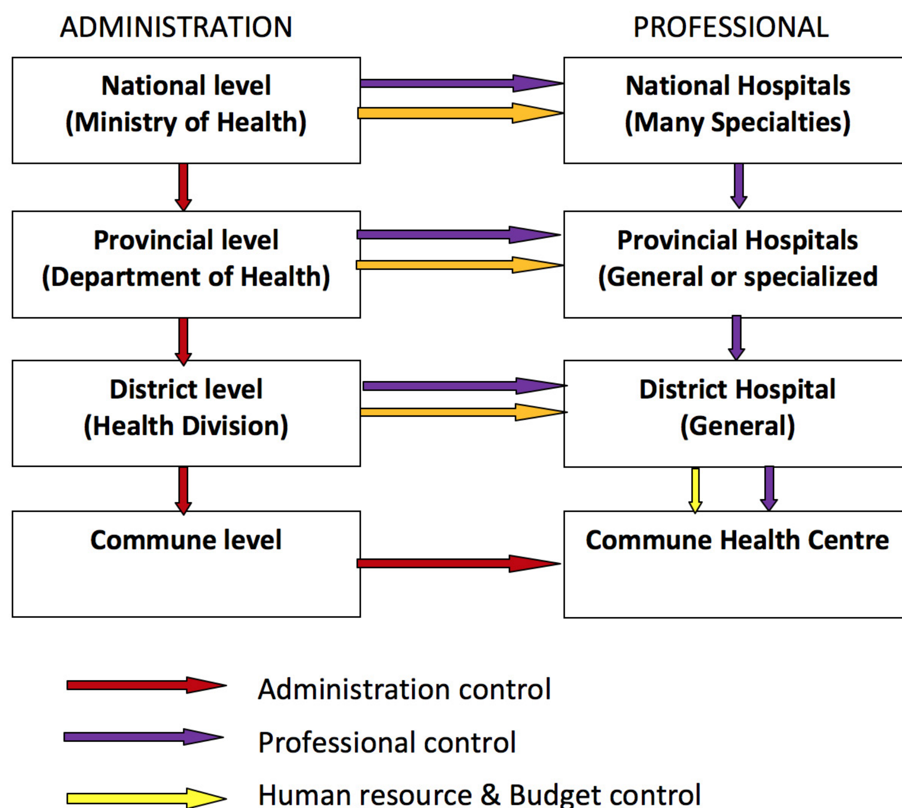
decade, the average annual economic growth has been 6.4%, yet the growth rate has recently slowed. The poverty rate was 9.8% in 2013, down from 15.5% in 2006. Viet Nam is about to move to the upper-middle income category. While six socio-economic regions (General Statistics Office, 2014a) have been designated by government, it is not clear that these regions have particular ecological, geographical, or economic criteria.

Viet Nam has achieved impressive progress in many of the Millennium Development Goals (MDGs). Targets have been achieved for MDG1 (reduction of extreme poverty and hunger eradication), MDG2 (universal primary education) and MDG3 (gender equality promotion and empowerment of women). Significant progress has also been made towards achieving the targets set for the other MDGs. There has been modest improvement of human development index, from 0.641 in 2010 to 0.665 in 2013 (Ministry of Planning and Investment, 2013).

General Health System

The state health system of Viet Nam is organized in accordance with the overall state governance structure. The health system consists of four levels - central, provincial, district, and commune. The Ministry of Health is the central administrative body, carrying out a range of state management functions related to different aspects of health and wellbeing (Viet Nam Government, 2012b). The Ministry of Health is organized into ministerial departments responsible for specific tasks. For example, the Medical Services Administration is primarily in charge of management of curative and palliative care, rehabilitation, and forensic medicine services. The Ministry of Health also organizes and manages central-level institutions covering different areas of treatment, disease prevention, research, and higher education. At the provincial level, the Departments of Health represent the provincial governments on state management of health care activities (Ministry of Health and Ministry of Internal Affairs, 2008). As noted above, Provincial Departments of Health manage the provincial health budget and human resources, under the direction and supervision of the national Ministry of Health which establishes national policy and regulations and directs technical and professional issues. Similar to the central level, there are a number of province-level organizations under the direct management of Provincial Departments of Health, including, for example, provincial general and specialized hospitals, centres for preventive medicine, and secondary schools of medicine. Figure 10.1 gives an overview of the organization of the national health system.

Figure 10.1: Health system organization



There have been considerable changes in organizational structure at district level. Before 2004, the majority of districts had only one institution, a district health centre, responsible for management of health care and implementation of curative and preventive activities in the area. Beginning in 2005, the implementation of a policy on local state management of health (Ministry of Health and Ministry of Internal Affairs, 2005) resulted in many, though not all, centres splitting into district general hospitals, focusing on medical practice, and district preventive health centres, working more extensively on preventive health. Another type of district-level health agency, the health bureau, is more involved with state management functions, including the administration of commune health stations. Recently, however, there have been initiatives to re-integrate the district health care facilities and their functions. Together with district-level institutions, commune health stations – the primary health care facilities – are responsible for primary or grassroots health care. The commune health stations are the first formal contact point of people with the public health care system and

provide basic health care services (Viet Nam Government, 2014). They also are responsible for recruiting and supervising village health workers, who assist in the provision of basic primary health care services at village level, including, for example, health communication, epidemic surveillance and reporting, pregnancy management, maternal and child health care, and first aid. The governance of health care at both district and commune levels follows a similar pattern to that at the provincial level, in which facilities work under the management of local governments and higher level health institutions.

There has been steady growth in the total number, and in the number per 10,000 population, of health staff, growing from 241,498 in 2003 to 364,876 in 2009 and 424,237 in 2013. Although growth has occurred in all categories, including medical doctors, pharmacists, nurses, and midwives, the rates of increase differ across the professions. The number of pharmacists in the state sector has remained low for the past few years and has recently declined due to low enrolment in education programs (Nguyen et al., 2014). In 2013, the numbers per 10,000 population of doctors, nurses, and midwives were 7.6, 10.9, and 3.2 respectively, with each increasing from previous years (General Statistics Office, 2014a).

Viet Nam health policy prioritizes the extension of primary health services, with efforts made to increase the supply of health workers throughout the country. However, inequitable distributions of the health care workforce remain an issue. While more advantaged places such as urban and delta regions attract more health workers than rural and mountainous areas the ratios of health workers per 10,000 population were relatively even across six socio-economic regions.

As noted, primary health care, including district and commune health care facilities, plays a vital role in the health system. The focus on development of primary care has been a long-standing commitment from the time of national independence. As in other countries, substantial efforts and resources have been invested for the improvement of grassroots health care since the 1978 Alma-Ata Declaration and the country has achieved a great deal as a result of these efforts. These achievements include development of a legal framework for preventive medicine; strengthening of the preventive medicine network at central and local levels; and expansion and development of primary health care services. Examples of the positive progress in provision of primary health care include expanded immunization, control of communicable diseases such as HIV/AIDS and avian influenza, reduction of child malnutrition, and successful implementation of accident and injury prevention strategies. Strengthening the primary health network remains a major strategy for achieving Viet Nam's health policy goal of a sustainable health care system.

The whole population has access to secondary and tertiary care as required. Secondary and tertiary facilities include both public and private sector institutions and programs and include general hospitals, specialized hospitals, rehabilitation centres, and regional polyclinics. The majority of these facilities are under the management of the health sector, i.e. Ministry of Health or Provincial Departments of Health, yet several health institutions are established and managed by other sectors, such as military, social affairs, agriculture, or post and telecommunication. In 2013, Viet Nam had 1,069 hospitals, with the Ministry of Health directly managing 43 facilities, Departments of Health 1,000, and other sectors 26. The ratio of beds per 10,000 population was 25.0, an increase from 17.7 in 2005 (Ministry of Health, 2013).

The Viet Nam health system has a large number of priorities and responsibilities, and covering all of them is beyond the scope of this overview. There are, however, a few significant examples. Health system capacity is not sufficient to fully meet the needs and expectations of 90 million people, especially among the elderly, children, and marginalized groups. The health service delivery system lacks proper coordination between levels and between preventive and curative health care services. In addition, integration and continuity of care are not well implemented. Furthermore, the health care system is not sufficiently prepared for the rapid epidemiological and demographic transitions that Viet Nam is undergoing, particularly in relation to the emerging and increasingly dominant role of non-communicable diseases and the rapid aging of the population.

Mental Health Problems in the Community

Population-based surveys are the major sources of evidence of the epidemiology of mental disorders in Viet Nam. Studies of different scale, population sub-groups, and disorders have gradually revealed diverse aspects of mental health. At the country level, there has been only one nationally representative population-based study conducted across the six national socio-economic regions, conducted by the National Psychiatric Hospital No. 1 (NPHN1) in 2002(Nguyen et al., 2014). The key results from the survey, which examined 10 common mental disorders in the community, were that these disorders combined affected 14.9% of the surveyed sample. The highest prevalence disorders were alcohol abuse (5.3%), depression (2.8%), and anxiety (2.6%). The results from the second national epidemiological survey of mental disorders, completed by NPHN1 in 2012, have not yet been published. There has as yet been no study examining the prevalence of mental disorders among primary care attenders.

Little is known, on the national scale, about community awareness of, and attitudes towards, mental health and illness, including the extent of stigma and discrimination against the mentally ill. Yet there is some evidence, though modest, at sub-national level. For example, in a mixed-method survey in three provinces of 154 people, 11.7% of the sample reported never having heard of mental illness and only 19.5% perceived that there was no stigma and discrimination in their community against the mentally ill(Ly et al., 2014). From the policy perspective, increasing investment in, and diversifying approaches to communication and mental health education activities, have been the main strategies for improving community awareness(Cuong, 2015).

Viet Nam has implemented significant efforts to expand and improve access to mental health services in primary health facilities. The overall objectives have been to manage and provide services to patients at community level to reduce re-admissions, facilitate rehabilitation, and decrease medical costs. In practice, however, the provision of services at primary health care level has been limited. In general, provincial mental hospitals refer patients and supply medicines to district and commune health facilities, which are then responsible for continuing care, distribution of medicines and management of patients. The national mental health target program, commonly referred to as the community mental health program, has only covered schizophrenia and epilepsy, with recent pilot initiatives in the provinces of Bac Ninh and Hung Yen expanding the program to include depression. By 2014, approximately 9,330 (85%) and 6,633 (61%) out of the 11,162 communes in the country had implemented the program on schizophrenia and epilepsy respectively(Cuong, 2015).

The expansion of access to mental health services in Viet Nam is likely to face, and thus will need to address, certain impediments. Most importantly, Viet Nam has not established a comprehensive legal framework for the expanded provision of services at grassroots levels. In addition, the number of specialised mental health care staff is insufficient in terms of both quantity and quality, causing difficulties in the decentralization of services, which requires training lower-level health care staff and providing continuous supervision and training. The distribution of mental health human resources is also uneven across different geographical and economic areas. Another significant barrier involves the limited awareness among the population of mental health and illness, resulting in stigmatizing and discriminating attitudes and behaviours against the mentally ill.

Mental Health System

Mental Health Governance

While mental health services in Viet Nam are provided by both the health sector and social services sector we focus here on the health sector only. The governance of mental health care in Viet Nam has been organized in accordance with the general health system,with mental health laws, regulations, policies, institutions and services implemented at central, provincial, district, and commune levels. At the central level, the Ministry of Health is responsible for state management of national mental health care. Those management tasks are carried out by the Medical Services Administration Department of the Ministry of Health and central-level institutions, including two National Psychiatric Hospitals and the National Institute of Mental Health. National Psychiatric Hospital No. 1 (Hanoi) is the Ministry's authorized institution to implement mental health policy and generally supervise the professional activities of mental health all over the country, while it shares with National Psychiatric Hospital No. 2 (Bien Hoa) the responsibility for direct management of provincial psychiatric hospitals.

The provincial level is the most active place for implementing both curative and preventive mental health care. Many provincial facilities are involved in these activities, including provincial psychiatric hospitals, mental health departments in provincial general hospitals, mental health departments in provincial centres for social disease prevention, and provincial centres for preventive medicine.

Provincial psychiatric hospitals are the key organizations in providing inpatient services for the mentally ill and are also responsible for implementation of the community mental health programs by, for example, referring patients to commune health stations for continuing care, supplying psychotropic medicines, supervising the activities of those stations, and providing training for staff involved in mental health. Mental health care capacity is very little developed at the district level, and the majority of activities have involved outpatient services, mostly via district general hospitals. The linkage role of district level institutions that exists in other areas of health has not been developed in mental health. Commune health stations detect new cases, carry out initial assessment, and refer when appropriate to provincial psychiatric hospitals, and are in charge of receiving referred patients who have been discharged from provincial psychiatric hospitals, implement follow-up care with distribution of medicines and management, and carry out communication activities.

Mental Health Law and Policy

While Viet Nam has not issued a specific mental health law many general health and related laws and regulations are very relevant to mental health governance and mental health services. There has been sustained advocacy concerning the need for mental health law and working groups have been actively engaged in drafting such a law. On the other hand, many policies that directly address mental health or that are relevant to mental health have been issued. The primary mental health policy at the national level has been the Mental Health Protection for Community and Children Project, a part of the National Target Programs on Health. First issued in 1998, this government-funded project focused on schizophrenia and epilepsy and included several objectives, including early detection, management and treatment for people with these disorders; provision of continuing treatment with a focus on relapse prevention; and rehabilitation and reduction of chronic disability. The national mental health project has implemented a range of measures to achieve these objectives, including education communication, expansion of the mental health facility network, and training of both mental health care staff and primary health care staff.

According to the policy of financial subsidy for the mentally ill people with persistent mental illness, receive a minimum of 270,000 Viet Nam Dong per month (approximately 14 USD as in 2015). In addition, people with mental illness who have been admitted to a social services facility (social protection centre) receive a monthly subsidy of 450,000 Viet Nam Dong. The provinces have also mobilized local sources to provide additional subsidy for these patients, which vary according to the financial capacity of different provinces (Nguyen et al., 2014).

Mental Health Facilities

The mental health system in Viet Nam has many types of facility across the four levels of the system. Under the management of Ministry of Health are the central-level institutions, including the two National Psychiatric Hospitals and the National Institute of Mental Health. In 2014 there were 36 provincial psychiatric hospitals, 24 departments of mental health in provincial centres for social disease protection or centres for preventive medicine, and 25 departments of mental health in provincial general hospitals. Mental health care at district and commune levels is integrated into general health care facilities, namely district general hospitals, and district health centres, and commune health stations at commune level (Cuong, 2015).

A recent survey (Cao, Tran, Ta, Dinh, & Nguyen, 2014) of capacity of mental health facilities in 49 provincial facilities of 31 provinces of northern Viet Nam showed that the total number of inpatient beds was 4,525. The average ratio of inpatient beds per 100,000 populations was 10.7, with very variable distribution across socio-economic regions. Three provinces had no inpatients beds, with patients with severe illness having to be referred to nearby provincial or central facilities. Available mental health facilities and beds are shown in Table 10.1.

Table 10.1: Availablity of mental health facilities and beds

	Total number of facilities/ beds	Rate per 100,000 population	Number of facilities/ beds reserved for children and adolescents	Rate per 100,000 Population
Mental health out patient facilities	59	0.07	UN	UN
Day treatment facilities	1	0.001	UN	UN
Psychiatric beds in general hospitals	300	0.34	UN	UN
Community residential facilities	UN	UN	UN	UN
Beds/places in community residential facilities	UN	UN	UN	UN
Mental hospitals	32	0.04	UN	UN
Beds in mental hospitals	16,000	17.97	UN	UN

UN: Unknown or unavailable
Source: World Health Organization, 2011

Mental Health Human Resources

While the health workforce, including health workers in the field of NCDs, has experienced steady growth, severe shortages exist in mental health. As reported in the survey of capacity of mental health facilities (Cao et al., 2014) there were only 530 psychiatrists in 31 surveyed provinces, 1.3 psychiatrists per 100,000 population. A matter of considerable concern is the fact that the number of psychiatrists has been declining in recent years. In the 31 northern provinces referred to above there were 650 psychiatrists in 2002 (Cao et al., 2014). The latest available national data available are from 2011 (Table 10.2).

Table 10.2: Workforce and training

Health professionals working in mental health services	Health professionals working in the mental health sector Rate per 100,000	Training of health professions in educational institutions Rate per 100,000
Psychiatrists	1.01	0.03
Medical doctors, not specialized in psychiatry	67.39	1.12
Nurses	75.34	UN
Psychologists	0.03	UN
Social workers	0.0	0.0
Occupational therapists	0.0	0.0
Other health workers	UN	NA

UN: Unknown or unavailable
Source: World Health Organization, 2011[15]

Financing

State budget, from both central and provincial sources, has played the dominant role in financing central, provincial and other hospital-based mental health care, and in curative and preventive activities in the community delivered via the national mental health project. However, this important source has been cut over the last few years and thus does not correspond with the increasing burden of mental disorders. In 2012, the total budget for the project was 75 billion Viet Nam dongs, which shrank to 74.2 billion in 2013 and sharply plummeted to 44 billion in 2014 (Cuong, 2015). This sudden reduction has brought serious challenges in maintaining the activities of the project. It was reported that the implementation of the project in 2014 was only 65-68% as compared with 2013. Health insurance is another important source of funding for mental health care. The list of drugs reimbursed by health insurance includes 38 drugs for treatment of mental illness (Ministry of Health, 2014). However, the current health insurance policy mainly focuses on reimbursing treatment services and does not generally cover preventive services, not only in mental health but also other fields.

Services

Psychiatric diagnosis, psychotropic drug prescribing, and inpatient mental health care may only be done at provincial and central levels – essentially in the central and provincial psychiatric hospitals. Primary health care is responsible

for receiving and referring patients, distributing medicines, and other relevant management tasks. The grassroots health service network does not have the capacity to provide essential mental health services. Despite the fact that there are 11,000 commune health stations and 600 district hospitals, which have made a remarkable contribution to Viet Nam's achievements in general health, these facilities have very limited capacity to respond effectively to the needs of the growing number of patients with mental illness. This may be attributed to several factors, including lack of mental health law, insufficient political commitment, insufficient skills and knowledge of health workers at district and commune levels, lack of necessary drugs and equipment at health facilities, inappropriate health insurance reimbursement policies, lack of linkages and integration between preventive and curative care, and fragmentation in health service delivery that prevents comprehensive and continuous care (Nguyen et al., 2014). In addition, the current policy and investment have not yet prioritized decentralization of mental health services, and commitments to build additional provincial psychiatric hospitals further limit the resources available for effective mental health services at the primary health care level. Access to inpatient and community care is shown in Table 10.3.

Table 10.3: Access to care

	Rates per 100,000 population	Females (%)	Under age 18 (%)
Persons treated in mental health out patient facilities	370.57	UN	UN
Persons treated in mental health day treatment facilities	1.68	UN	UN
Admissions to psychiatric beds in general hospitals	UN	UN	UN
Persons staying in community residential facilities at the end of the year	UN	UN	UN
Admissions to mental hospitals	UN	UN	UN

UN: Unknown or unavailable
Source: World Health Organization, 2011

Medicines

Viet Nam has an essential drug list and a health insurance drug formulary that includes most drugs that may be needed treatment of mental illness - the

updated formulary of essential drugs of the Ministry of Health (Ministry of Health, 2014) lists 38 medicines for mental disorders. These include six anxiolytics (e.g. diazepam), 12 antipsychotics (e.g. haloperidol) and 10 antidepressants (e.g. amitriptyline), together with other types of medicines. The National Psychiatric Hospital No. 1 is responsible for supervising the purchase of medicines by provinces. State budget from the national mental health project is disbursed to provinces for purchasing medicines, which may be done by provincial psychiatric hospitals or People's Committees. District and commune levels are not authorized to purchase medicines. Instead, they receive supplies from provincial level institutions and distribute the medicines that have been prescribed, usually and provincial psychiatric hospital level, for patients. Provinces can also use local sources of funding to supplement their stocks with new generation medicines.

Methadone replacement therapy for opiate dependence was fist piloted in 2008 and formally regulated by the government in 2012 (Viet Nam Government, 2012a). However, the major source of methadone supply comes from international donors. While it is expected that this source of funding will largely cease by 2015 steps have recently been taken to continue to provide methadone, possibly with funds from the National Target Program on HIV/AIDS Prevention, or by mobilizing social contributions.

There are no data available on national expenditure for psychotropic medicines.

Human Rights

Violation of human rights of people with mental illness can occur in many forms, of which the most severe is restraint by chaining or by locking in a confined space. Other forms of human rights violation include stigma and discrimination, prolonged involuntary hospitalization, and restriction of civil rights. However, there is little systematic evidence concerning the human rights of people with mental illness in Viet Nam. Viet Nam ratified the Convention on the Rights of Persons with Disabilities in December 2014 and protection of human rights will be a core feature of the National Mental Health Strategy that is currently being developed.

Mental Health Information System

The application of information technology has been improved in psychiatric hospitals but is still insufficient for diverse management tasks. Recently the National Psychiatric Hospital No. 1 has led a project to build an application for managing and reporting the activities of the national mental health project. This health information system initiative is expected to connect, and facilitate

collaboration across, facilities at different levels, improve the quality of data and reporting, keep track of organizational aspects of mental health facilities, and improve leadership and governance in the mental health sector (Cuong, 2015). Currently, the national mental health project requires regular reports from lower to higher levels but the information collected does not comprehensively cover all relevant clinical and organizational domains. The application that is being developed is expected to fill this gap.

The data collected through the routine national health information system are shown in Table 10.4.

Table 10.4: Data collected through the routine national health information system

	Data on number of people/ activities are collected and reported	Data on age and gender are collected and reported	Data on patient's diagnosis are collected and reported
Persons with mental disorders treated in primary health care	Yes	No	Yes
Interventions (psychopharmacological and psychosocial) delivered in primary health care for people with mental disorders	Yes	No	Yes
Persons treated in mental health out patient facilities	Yes	No	Yes
Contacts in mental health out patient facilities	No	No	No
Persons treated in mental health day treatment facilities	Yes	No	No
Admissions in general hospitals with psychiatric beds	No	No	No
Admissions in mental hospitals	Yes	No	Yes
Days spent in mental hospitals	Yes	No	Yes
Admissions in community residential facilities	No	No	No

UN: Unknown or unavailable
Source: World Health Organization, 2011

Integrating Mental Health into the National Health System

Significant efforts have been made by the Viet Nam health system, in collaboration with international collaborators, to improve the integration of mental health into the national health system. Stakeholders are in the process of identifying the best options for the treatment and care of people with mental disorders at different levels of care. Rather than adopting an existing model, the specific way in which mental health should be integrated into primary heath care in Viet Nam will be influenced by the current function, status and strengths of primary, secondary and tertiary care levels taking into account the conditions of the health system as well as the community and cultural context.

Community Empowerment

There has been modest progress in community empowerment in mental health. Development of community-based organizations, such as those established by and for people with mental illness and their families, has not been a priority and has been slow. An exception is in the area of illicit drug use, where the development of community groups has been more likely to originate from the field of HIV/AIDS prevention. Even the number of non-governmental organizations working in mental health is limited. However, health facilities have maintained practical coordination with political and social organizations in mental health care activities, such as the youth unions and women's union. These organizations can contribute to the process of care and rehabilitation for people with mental illness.

Priorities, Challenges and Opportunities

Given the current situation of mental health in Viet Nam many priorities, many of them urgent, can be identified. Developing the legislative framework, particularly adopting a specific mental health law, is among the most important priorities. It is also important to specify how mental health services are to be more closely

integrated with the national health system. Successful implementation of new legislation, integration of services, and other important initiatives will require capacity building for the mental health system (including both facilities and human resources), at all levels, to be prepared for the increasing demands and expanding provision of mental health care. Among the most important challenges in the continuing strengthening of the mental health system is the very limited state funding allocated to mental health, resulting in both limited coverage and quality of mental health services. Changing this lack of priority for mental health will require substantial efforts to build consensus among relevant stakeholders concerning the goals and methods of mental health system reform. As well as impediments, there are many opportunities for progress. Political commitment and support is without doubt growing, largely due to the increasing understanding of the importance of mental health for social and economic development, and of the very substantial economic and social costs of not attending to population mental health. As part of this it is also better appreciated that good governance and effective leadership are central to any process of reform and to building sustainability. Another opportunity involves the extensive availability and development of grassroots level health care system. Although the potential of this network has not been fully realised for mental health it is a very strong platform on which to build a community-focused mental health service delivery system.

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