ASIA-PACIFIC COMMUNITY MENTAL HEALTH DEVELOPMENT PROJECT

SUMMARY REPORT
Artworks by people who experienced mental illness have been included in this publication to remind us of the individuals we are trying to help. These artworks tell the story of personal experiences of mental illness in different countries. We are grateful for their contributions. Non-exclusive copyright licences to publish these images have been obtained from the artists or their family (in a situation where the artist is deceased). The name of each artist and their illness is published only when they have given their consent.
SUMMARY REPORT
ASIA-PACIFIC COMMUNITY
MENTAL HEALTH DEVELOPMENT PROJECT

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ACKNOWLEDGEMENTS

Asia-Australia Mental Health would like to acknowledge the considerable assistance of the following in the delivery of the APCMHD project summary report:

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- International Strategies Branch, Australian Government Department of Health and Ageing
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- Royal Australian and New Zealand College of Psychiatrists
- St. Vincent's Health (Melbourne)
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INTRODUCTION

Based on international guidelines to advance mental health care, many health systems, particularly in Western countries, have reformed their mental health policy and services which include the provision of patient-centred community mental health care. This has led to global trends in a reduction of large mental institutions, a shift from hospital to community care, the development of community treatment teams and closer links with community agencies and the provision of mental health care as part of primary health care services (WHO, 2001). However, the delivery of quality and appropriate community mental health care remains an ongoing challenge for all countries at different socio-economic levels.

Difficulties and obstacles in the implementation of comprehensive community service models include funding issues, availability of a trained mental health workforce, integration with primary care services and community agencies and the collaboration between public and private health systems (Saraceno et al, 2007). Modern community mental health service systems are largely dependent on sufficiently skilled mental health workers for adequate service delivery. The stark reality is that a global mental health workforce shortage continues to impede the progress of mental health reform.

In response to such increasing global trends, many countries in the Asia-Pacific region have begun to establish mental health policies and guidelines that reflect the move from institutional care to community mental health services. While these reforms are supported by recommendations from WHO governing bodies —such as the Western Pacific Regional Mental Health Strategy (WHO WPRO, 2002)— social, economic and cultural factors in Asia-Pacific countries do not often allow ready translation of current (mostly Western) community mental health models of care. Governments and service providers commonly face challenges in the development and implementation of locally appropriate community mental health care and services. Rigid recommendations or unanimous consensus for a singular community mental health care model would be unrealistic and undesirable given the diversity of nations and cultures found across the Asia-Pacific region.

For constructive change to occur in the region, innovative, culturally appropriate and economically sustainable pathways for community treatment models need to be explored, developed and shared. Community mental health service reform is gaining momentum in our region, despite the obstacles. Valuable lessons and inspiration for further development can be gained from both the successes and difficulties in reforming mental health systems and practices in the region.
PARTICIPATING COUNTRIES:
ASIA-PACIFIC COMMUNITY MENTAL HEALTH DEVELOPMENT PROJECT

- INDIA
- CHINA
- HONG KONG
- THAILAND
- CAMBODIA
- VIETNAM
- MALAYSIA
- SINGAPORE
- INDONESIA
- MONGOLIA
- KOREA
- JAPAN
- AUSTRALIA
An innovative network of representatives from governments, peak bodies and key organisations is emerging in the Asia-Pacific to build supportive relationships to facilitate the implementation of locally appropriate policy frameworks for community mental health service reform. The network is supported by the Asia-Pacific Community Mental Health Development (APCMHD) project, which involves 14 countries/regions in the Asia-Pacific region. Initiated in collaboration with the WHO Western Pacific Regional Office (WHO WPRO), the APCMHD project is led by Asia-Australia Mental Health (AAMH), a consortium of the University of Melbourne and St. Vincent’s Health, which is a part of the WHO Collaborating Centre for Mental Health (Melbourne). The WHO Department of Mental Health and Substance Abuse has conveyed strong support for this project as it is in line with the WHO Global Action Programme for Mental Health.

In the first 3 years, this unique Asia-Pacific network of mental health leaders has collaborated closely in the APCMHD project to produce a landmark document. Its contents describe the status of community mental health service models across the region, its major successes as well as challenges, in the hope of inspiring and guiding practical change for the future.

This Summary Report is an abridged version of the complete report of the APCMHD project. Section 1 provides an overview of the project, the objectives of the project, and discussion of the context in which the project has developed and of principles of community mental health care in the Asia-Pacific. Summary Country Reports from each participating country/region are presented in Section 2. These reports include examples of best practice from each country/region. Section 3 presents concluding remarks and recommendations for future directions for the APCMHD Network.
PROJECT AIM, OBJECTIVES AND OUTCOMES

The aim of the APCMHD Project is to illustrate and inspire best practice in community mental health care in the Asia-Pacific region through the exchange of information, current evidence and practical experience.

THE KEY OBJECTIVES OF THE PROJECT ARE:

- to build understanding of the guiding principles for the development of culturally appropriate practices of community mental health care;
- to identify local achievements and analyse common problems to inform future policy development and implementation of community based services;
- to make available a regional resource that will facilitate:
  — sharing of experience of real-life best practices in the continuous evolution of different community mental health care models;
  — promotion of efficient utilisation of local resources for community mental health care including potential partnerships with primary health care, informal care, traditional treatments and substance abuse services;
- to develop a regional network of key representatives from Ministries of Health and key organisations working in community mental health.

THE PLANNED OUTCOMES OF THE PROJECT ARE:

- the sharing of understanding of key principles and components in developing locally appropriate community mental health care;
- the documentation and analyses of local models or approaches to community mental health service delivery in the region;
- the publication of a report of diverse experiences and learning gained to be used as a regional resource;
- a network of Asia-Pacific mental health leaders and organisations engaged in the development of appropriate quality mental health care and services in the community.
DEVELOPMENT OF THE PROJECT

The APCMHD project has developed over three years. During that time the enthusiasm and good will demonstrated by all involved has created a spirit of collaboration and support to progress the project through all its phases of development. AAMH, WHO partners and groups of network participants provided continuous technical support and reviewed the progress of the participating countries in this project. Participants valued the free exchange of ideas while focusing on the common goals.

A BRIEF HISTORY OF THE PROJECT

NOVEMBER 2005
INITIAL SCOPING MEETING, ASIA PACIFIC PHILANTHROPIC CONGRESS: PHUKET
A planning meeting was convened to explore the potential of the project. The meeting agreed on the key goals and directions for the project. To facilitate the APCMHD project coordination, implementation and administration, an action plan was drafted.

MAY 2006
INAUGURAL MEETING OF THE PROJECT GROUP,
ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS CONGRESS: PERTH
Status reports outlining policy challenges and current practice models in community mental health were presented by representatives of participating countries. The participants also reached consensus on the principles and methodology to be followed in the production of a report that would describe models of community mental health development in each country. Proceedings from the regional meeting at the 41st RANZCP Congress in Perth can be found at www.aamh.edu.au

OCTOBER 2006
FIRST INTERIM MEETING, PACIFIC RIM COLLEGE OF PSYCHIATRISTS MEETING: TAIPEI
The meeting reviewed processes of national data collection, formation of local consultative committees, literature reviews and contents and compilation of country reports. A draft report template was developed to assist each country or region to document in a consistent way its mental health resources, policies and strategies, best practice community models and future goals of reform.

APRIL 2007
SECOND INTERIM MEETING, WORLD PSYCHIATRIC ASSOCIATION REGIONAL MEETING: SEOUL
The project members shared information about progress in the development of their draft country reports. Discussion also took place on the process of collecting and presenting the information from participating countries.
PROJECT COLLABORATORS

In partnership with AAMH, WHO WPRO and the WHO Collaborating Centre in Mental Health (Melbourne), representatives from Ministries of Health, regional WHO Collaborating Centres and key mental health organisations were brought together to work collaboratively on this project. Other collaborators included the World Psychiatric Association (WPA), the Australian Government Department of Health and Ageing, the Royal Australian and New Zealand College of Psychiatrists (RANZCP), and equivalent peak professional organisations from participating countries in the region. Key representatives from international organisations such as the World Association for Psychosocial Rehabilitation, Pacific Rim College of Psychiatrists, ASEAN Federation of Psychiatry and Mental Health, Indo-Australasian Psychiatric Association, World Federation for Mental Health, World Fellowship for Schizophrenia and Allied Disorders, and other international non-government organisations such as Basic Needs and the Christoffel Blinden Mission were also involved in the project.

NOVEMBER 2007
CONSENSUS MEETING, WORLD PSYCHIATRIC ASSOCIATION INTERNATIONAL CONGRESS: MELBOURNE
The meeting finalised and presented all country reports, and discussed key guiding principles learnt from the analyses of useful and different approaches to community mental health care. Editorial and publication processes were agreed upon for the final report. The Meeting proceedings were compiled for the publication of the final project report. Country Presentations at the WPA International Congress Melbourne are currently available on the website: www.aamh.edu.au

DECEMBER 2007 – AUGUST 2008
REPORTS FINALISED
Each country/region drafted a full report and a summary report for publication. Editing of the draft reports was completed and signed off by all participating members. Both the Summary and Full project reports (incorporating all country reports) were finalised to become a resource document outlining the diverse local approaches to community mental health service delivery and practical guidelines applicable to the Asia-Pacific region.

SEPTEMBER 2008
LAUNCH OF APCMHD PROJECT REPORT, WORLD PSYCHIATRIC ASSOCIATION CONGRESS: PRAGUE
The Summary Report of the APCMHD project is published and launched globally. The Full Reports are currently available on the website: www.aamh.edu.au

NEXT STEPS FOR THE PROJECT
CIRCULATION OF THE PUBLISHED REPORT AND FUTURE PLANNING
The published report will be disseminated across the Asia-Pacific region. Further educational materials, guidelines and manuals will be planned – informed by best practice models of community care described in the Regional Report. It is also anticipated that new local models of care, inspired by the APCMHD project, will be trialled, implemented and evaluated in various countries. A three-year cycle of project reviews, evaluations and reports will be established to inform future planning and development of community mental health in the region.
PRINCIPLES OF COMMUNITY MENTAL HEALTH CARE IN THE ASIA-PACIFIC REGION

The Asia-Pacific region is characterised by great diversity of people, culture, ethnicities, languages, socioeconomic development, climate, geographical features and government systems. There is also wide variation among the countries in terms of population, gross national product, social infrastructures, health systems, education resources and employment rates. In recent times, rapid socioeconomic development, population growth, propensity for natural disasters, threat of viral epidemics, shifts in social and family structures occurring in many countries in the region have resulted in significant challenges and impact on their health systems.

THE CONTEXT OF THE ASIA-PACIFIC REGION AND COMMUNITY MENTAL HEALTH

The Asia-Pacific region has close to half of the approximately 450 million people affected by mental illness globally (WHO, 2008). Mental disorders such as schizophrenia, mood disorders, substance abuse and dementia contribute more to global disease burden than cancer or cardiovascular disease (Prince et al., 2007). WHO has projected that, by the year 2030, mental disorders will be one of the leading causes of the global disease burden. Mental disorders are associated with significant long-term disability and decreased physical and psychosocial functioning. Poor mental health significantly contributes to a cycle of poverty wherein people who experience social hardship and poverty are at an increased risk of mental illness, and conversely those with mental illness are at an increased risk of poverty.

Despite the crippling socioeconomic cost of mental illness, 40% of low-income and middle-income countries contribute less than 1% of their health expenditure to mental health. Where there is specific budget allocation available, the vast portion of mental health funding is tied up in providing institutional care for the severely mentally ill (WHO, 2005). Throughout the region, the proportion of health budget expenditure on mental health is generally low compared to Western countries. While mental health funding is provided mostly by government budgets or insurance systems, in a number of countries, the private sector, NGO’s and international aid contribute significantly to the mental health resources.

A common issue across nearly all countries has been the relative lack of resources in mental health, in terms of funding, workforce, facilities, availability of psychotropic drugs and research provisions. While most countries have mental health policies and plans, and many have mental health legislation, the standards and quality of mental health service provision vary widely between and within countries. Stigma associated with psychiatric conditions and lack of community acceptance of mental illness remains a major barrier throughout the region.
Community psychosocial rehabilitation facilities provide better and earlier care for people with mental disorders, help preserve the human rights of mental illness sufferers, and limit the stigma of mental health treatment. Globally, however, community care facilities exist only in 68.1% of countries, and in several regions including South-East Asia, such facilities are only available in about half the countries (WHO, 2005).

Where present in Asian countries, community mental health services are not equally available and are often restricted to a few well-resourced areas within urban centres in the country. Therefore, it is necessary to develop innovative approaches to scale up and expand community mental health resources, services and facilities (Lancet Global Mental Health Group, 2007).
Most recently there is evidence of new ways of thinking about community mental health in our region. Significant efforts have been made to develop locally appropriate community-based mental health services in line with the recommendations in the World Health Report (WHO, 2001) and WHO Policy and Service standards (WHO, 2003). However, the different socio-economic and cultural factors of mental health systems in Asia-Pacific countries often do not necessarily lend themselves to direct application of a standard or Western-based approach to community mental health models of care. Locally and culturally appropriate models of care are needed to implement sustainable mental health services that can be embedded in local community and health infrastructures.

The APCMHD project has been set up to explore diverse local models or approaches to community mental health service delivery in the region. The APCMHD project has found that although there is wide diversity in the models of community mental health care across and within Asia-Pacific countries and regions, consensus derived from these experiences is useful. The exchange of information about regional practices and solutions to challenges is helpful in building appropriate community-based mental health care in the future.
UNIVERSAL PRINCIPLES FOR COMMUNITY MENTAL HEALTH CARE SERVICES

Although there is wide diversity in the models of community mental health care found in the Asia-Pacific countries and regions, there are universal principles of community care that can be generically adopted from international guidelines (WHO, 2003). The following principles have been identified in the examples of local models or approaches to community mental health service delivery that are developing in the region. While the intention is not to replicate existing international benchmarks and guidelines (e.g. WHO recommendations), they represent the key elements that have been regarded as appropriate in building mental health care across the Asia-Pacific.

1: ACCESSIBILITY
Mental health services that are locally accessible enable people suffering from mental illness to maintain close links with their families and community. High costs incurred by patients and family members who are forced to travel long distances to obtain treatment can be avoided. Larger proportions of people can be treated, not only those living in urban areas but also those in provincial or remote rural areas. Local services can provide continuity of care and address many psychosocial issues by using local community support structures.

2: EQUITY
Although mental disorders are found in all social strata, the poor are likely to be affected disproportionately. Provision of mental health care based on needs rather than socioeconomic levels ensures that mentally ill people most in need of services are highly likely to receive care. The investment in providing equitable treatment for all can significantly decrease long term disability and health economic burden for the whole community.

3: PROTECTION OF HUMAN RIGHTS
Access to appropriate and safe mental health care is a basic right for all sufferers of mental illness, no less than those suffering from physical illness needing medical care. Respect for the autonomy of persons with mental disorders can empower and encourage them to make decisions about their lives and livelihoods. Treatment provided in the least restrictive setting is not only consistent with this principle but can enhance the potential for rehabilitation and recovery.

4: COMPREHENSIVENESS
As the individual needs of patients with mental illness are complex and multi-dimensional, a range of mental health services is required to meet these needs. A comprehensive menu of different services can help match the right program or intervention to the different phases of mental illness over a longitudinal course, not just providing either acute or chronic care. Services can be organised either as a system of many different service types or one service with multiple functions. The exact mix of services required depends on social, economic and cultural factors, the characteristics of disorders, and the way in which the broader health systems are organised and funded.
5 : COORDINATION AND CONTINUITY OF CARE

Continuity of care and coordinated care are essential elements to increase mental health service efficiency and outcomes. People with severe mental disorders often face difficulty in accessing a range of social, psychological and medical services. To promote better outcomes for patients, a coordinated approach can help link them to various psychosocial services including social, welfare, housing, employment, vocational and other services. To deliver an integrated mental health service requires a great degree of coordination at a system level.

6 : EFFECTIVENESS

Effective, evidence-based treatments are available for many mental disorders such as depression, schizophrenia and alcohol dependence. Community services that adopt such effective biological and psychosocial treatments are likely to enhance both clinical outcomes and quality of life for patients with mental disorders. Policy updates on the cost-effectiveness of treatments and interventions can be informed by continuous outcome evaluation and research.

7 : INTEGRATION INTO PRIMARY CARE THROUGH SHARED CARE

Due to the relative lack of resources and mental health specialists in many countries, the integration of mental health services into the primary health sector represents a viable strategy for increasing access to mental health care. Successful delivery of such services requires the training of sufficient primary care staff in the identification and treatment of mental disorders as well as the provision of ongoing clinical support. Linking specialist mental health services with primary care is however essential. The provision of mental health services locally through primary health centres is unlikely to be sustained without the specialist services giving training, supervision and support for primary care workers. Adequate referral mechanisms across specialist and primary care enable smooth transfer between the service sectors and promote continuity of care.

Left: Tae-Yeon Hwang, Director, WHO Collaborating Centre Yongin Hospital Seoul Korea and Mental Health Division, Korean Neuropsychiatric Association and Dr Kojima, President, JSPN, Japan. Right: Julia Fraser, Co-Director, AAMH, Wang Xiangdong, Mental Health Advisor, WPRO WHO and Shekhar Saxena, Coordinator, Mental Health: Evidence and Research, WHO Geneva. WPA International Congress 2007, Melbourne.
8 : INTEGRATION INTO GENERAL HEALTH SYSTEM
The integration of mental health services into existing general health and social care programmes represents another useful strategy for overcoming resource constraints and providing seamless mental health services. General hospitals and district hospitals require input from specialist mental health professionals to manage patients with mental disorders (either alone or co-existing with physical disorders). Ideally, patients can be referred to primary health systems that can provide mental health care in collaboration with specialist mental health services in the community.

9 : PLANNED PROCESS OF DE-INSTITUTIONALISATION
A gradual reform process of changing from an institutional-based mental health service to a community-based service is required, via a series of steps and different stages. Deinstitutionalisation is more likely to be successful if it occurs after, not before, the establishment of community-based mental health services. A process of preparation is required at all levels including the patients, families, staff and community, before discharge from hospital can take place. A small proportion of patients require long-stay facilities such as in small units in the community or in hospitals.

10 : MULTI-SECTORAL LINKAGES
The use of existing networks of community services and resources, especially those provided by non-governmental organisations is a key strategy to maintaining discharged patients with mental illness in the community. To optimise resources and build community support structures, key stakeholders such as local governments, community representatives, family/carer groups, housing and social services all need to be engaged.
KEY PRINCIPLES FOR BUILDING COMMUNITY MENTAL HEALTH CARE IN THE ASIA-PACIFIC

There is a pressing need to build and scale up cost-effective models of community mental health care throughout the region. In addition to guidelines derived from international principles, local experience has highlighted a number of focal approaches. These are deemed to be particularly relevant for the local environment and culture, and mental health systems in the Asia-Pacific. The following key principles are distilled from the regional exemplars of best practice in the Asia-Pacific found in the Full project report (some of these are mentioned here to illustrate each principle). Some principles represent important regional illustrations of the broader universal principles outlined previously.

1: EMPHASIS ON COMMUNITY-BASED CARE IN THE HOSPITAL SYSTEM

The concept of community mental health care takes different meanings in different cultures and varies throughout the region. Community-based care can be developed within a mental health hospital system. Many hospitals have developed community outreach teams to provide specialist mental health services in local settings, and to train primary health workers and community agencies. While adequate beds for acute care must still be provided, alternative community mental health services are needed to facilitate early discharge, optimise treatment and rehabilitation outside the hospital, and prevent relapses of illness or re-hospitalisation. Community-based care must be incorporated within a balanced mix of service components ranging from psychiatric hospital care to general hospital and primary care.

HOME-CARE SERVICES (HCS), HOSPITAL BAHAGIA ULU KINTA, PERAK, MALAYSIA

The Hospital Bahagia Ulu Kinta is a large psychiatric hospital which has developed Home Care Services offering individualised rehabilitation in the community. The large tertiary hospital is the ‘hub’ which administers and resources the ‘spokes’, which are the community mental health centres. Resources are gradually moving from the hospital’s bed-based services to the community-based services. Relapse and re-admission rates have been reduced from 25% to 0.5%.

KYONGGI PROVINCIAL MENTAL HEALTH PROGRAM, KOREA

In parallel with the existing mental hospital systems in Korea, 14 community mental health centres have been established across the Kyonggi province in 1998 providing essential services such as day care services, case management, family support, community education and linkage to various community resources. Owing to its successful implementation, the Ministry Division of Mental Health adopted Kyonggi’s model project in starting a national mental health project in 1999.
2: EQUITABLE ACCESS TO MENTAL HEALTH CARE

Access to basic mental health care usually means access to practitioners with mental health training, basic medications and family support. To support basic mental health care, access to specialist services, including acute care, and to rehabilitation and vocational programs is also needed. Access may be restricted for many reasons including geographical barriers, a shortage of trained staff and medication, social stigma, a lack of financial support and poor patient advocacy. The transition from institution-based care to community-based care has resulted in innovative approaches to address gaps in care across the region.

NATIONAL MENTAL HEALTH SERVICE MODEL REFORM PROGRAM (686 PROGRAM), CHINA

Named for its initial $6.86 million RMB funding, the program was developed by the National Centre for Mental Health to increase access to mental health care through the development of 60 demonstration areas in 30 provinces. Free clinical care and medications have been provided to thousands of disadvantaged patients. Each site covers a population of about 400,000, with a total coverage of 42.9 million. Over 600 training sessions have been conducted for psychiatrists, community doctors, allied health workers, policemen, community workers and patients’ families, resulting in more than 50,000 people being trained. Globally, this has been one of the largest mental health reforms ever seen.

COMMUNITY MENTAL HEALTH NURSING (CMHN), INDONESIA

The CMHN Project increased access to mental health care in the community and rural areas through the use of a mobile outreach service made up of nursing staff, community health workers and medical doctors with mental health training. The CMHN, based at the Public Health Centres provided a range of services in terms of education, support and treatment targeting patients, their families and the greater community. Through education given through this project the community can also support mental health care and vocational rehabilitation.

3: SUPPORT IN THE TRANSITION OF CARE FROM INSTITUTION TO COMMUNITY

The process of shifting from institution-based care to the community is particularly difficult for people with chronic and severe mental illnesses who have spent many years in institutions. This may be due to a paucity of resources, both personal and external, that may result from their disability and institutionalisation. However, the values of autonomy, self efficacy, personal strengths and good quality of life are no less important in these patients. Patients leaving institution-based care require not only strong psychiatric support, but also practical support such as housing assistance and vocational and life skills training to ensure good mental health outcomes.

THE FLIGHT FROM THE NEST GROUP: SUDACHI-KAI, JAPAN

Sudachi-kai is a social welfare corporation with an active role in both mental health staff and peer-led discharge promotion. Further, it places a strong emphasis on vocational training and providing housing support to ensure successful discharge from hospital-based care. This community-based programme run by an NGO in Japan has discharged over 126 people.
EXTENDED-CARE PATIENTS INTENSIVE TREATMENT, EARLY DIVERSION AND REHABILITATION STEPPING STONE (EXITERS), HONG KONG
The EXITERS Project achieves supported transition of care of long-stay patients using a 3-Phase System including flexible matching of resources, active community supports and follow-up structures utilising multidisciplinary staff. Intensive rehabilitation and case-management is provided to improve social and vocational rehabilitation functioning.

GER PROJECT, MONGOLIA
Fostered by the WHO and SOROS Foundation, the Ger Project utilises traditional portable round houses and tents called “gers” to deliver education and training in life and social skills to people with mental illness in the community. The Ger Project also provides psycho-education, counselling, family support and continuing psychiatric treatment, resulting in a reduction in the relapse rate from 95% for 500 participants so far.

4 : CONSUMER AND CARER ROLES
Empowering users and carers, and the inclusion of their agendas is critical to the planning and development of community mental health care. Many of the projects reviewed place a strong emphasis on patient autonomy. A patient’s involvement in decision making regarding their care is not only in accordance with their human rights, but may also contribute to better compliance and may therefore result in better health outcomes. This is just as pertinent for people with mental illness as for those with other forms of illness. The role of a patient as consumer is powerful as it can be used to guide the future of care for people with mental illness through sharing of experience and advocacy. The role of consumer also extends beyond mental health care alone, and can be used to further validate the role of people with mental illness in the greater community.

THE HOUSE OF BETHEL, JAPAN
The House of Bethel is a complex of services, self-help groups and private firms, that was established by a group of consumers. The House of Bethel places a strong emphasis on meetings and consumer studies, during which consumers discuss issues that they have faced, use problem-solving techniques to resolve these issues, and record their progress for the future benefit of other consumers.

5 : COMMUNITY PARTNERSHIPS AND NETWORKS
The formation of community networks and partnerships increases the resources available to people with mental illness who are living in the community. Community partners such as community agencies, NGOs and volunteers bring valuable experience and resources that allow the development of projects that are appropriate to the patient group and their local community. They are also key partners in developing community linkages with local agencies and stakeholders.
NEW MENTAL HEALTH CARE MODEL, CAMBODIA
This new approach highlights the importance of effective patient advocacy by strengthening community links, and the role of families, NGOs and community agencies in mental health care. By putting emphasis on integrating mental health issues into all levels of medical training the mental health knowledge and skill base of general health workers can be increased.

COMMUNITY-BASED MENTAL HEALTH (CSSKTT) PROJECT, VIETNAM
The establishment of an integrated mental health network between the provinces initiated the development of mental health services in the community. The priority is to increase public awareness of mental illness, early detection and access to treatment centres therefore benefiting patients and families from underprivileged backgrounds and remote areas. This community-based project received support from the provinces, districts and villages.

6 : INTEGRATION INTO EXISTING HEALTH CARE RESOURCES
Community mental health services should be integrated with primary care and the general health system to ensure a seamless and more cost-effective system of care. Integration will maximise holistic care of mentally ill patients who may have medical as well as psychological problems. In the context of limited resources in many countries, there is a need to maximise available resources and adapt to the socio-economic reality in developing appropriate community mental health services. Integration may be achieved by locating mental health workers in primary care settings or by training the primary care and community workers in basic mental health care.

DISTRICT MENTAL HEALTH PROGRAMME (DMHP) MODEL, INDIA
Building on the Bellary Model, the DMHP created a sustainable, decentralised mental health service through the integration of mental health into the primary health care system. In doing so, the DMHP also aims to raise community awareness and subsequently improve early detection, provide treatment and reduce the stigma of mental illness.

TAIPEI CITY PSYCHIATRIC CENTER (TCPC), TAIWAN
The key elements of the “Taipei Model” are the building of a bridging network between the hospital and the public health sectors, and the facilitation of follow-up visits by public health workers from 12 district health institutes to patients with severe mental illness discharged from the TCPC. Public health nurses are involved in the assessment, planning, implementation and evaluation of the community psychiatric services.

7. COMMUNITY AWARENESS AND MENTAL HEALTH PROMOTION
The process of shifting the locus of care from institutions to the community runs parallel with stigma reduction and mental health promotion. The very presence of mentally ill people in the community raises community awareness of mental health and illness. However, stigma is still present in many communities and acts as a barrier to accessing services. Mental health promotion can be a positive and pro-active way to promote acceptance of mental health care services, raising both the community’s awareness and understanding of mental health issues.
DISSTRICT MENTAL HEALTH PROGRAM (DMHP) – INDIA
DMHP employed a variety of techniques to improve mental health awareness including Mental Health Camps, the production and distribution of information booklets to youth clubs, volunteer organisations, teachers and government staff, screening of films on mental health in villages and the creation of cinema slides to bring awareness of mental health issues to a broad audience.

COMMUNITY-BASED MENTAL HEALTH PROGRAM (CMHP), THAILAND
Mental health promotion is an integral part of community mental health in Thailand. Established through its public health service system, the regional mental health centres coordinate mental health promotion, prevention, treatment and rehabilitation with other public health facilities in every province. The CMHP increases mental health awareness through the involvement of communities and their leaders in mental health promotion and prevention of mental illness in their own populations.

MENTAL HEALTH PROMOTION PROJECT, MONGOLIA
The primary objective of this project in Mongolia was to create an environment of mental health promotion through an integrated strategy to increase mental health awareness in the population. The use of this strategy aimed to increase community participation in mental health promotion activities, to improve the knowledge and attitude of policy makers regarding mental health and to build inter-sectoral collaborations in mental health awareness and the prevention of mental illness.

8. CRISIS INTERVENTION
A key component of community mental health care is the provision of adequate and timely crisis intervention services to respond to people with acute psychiatric conditions or psychiatric emergencies. The crisis service should be part of a strong community mental health infrastructure which can provide ongoing care and support to reduce the incidence of psychiatric emergencies. Early intervention in acute episodes of psychiatric illness may decrease the need for hospital admission or prevent the development of chronic psychiatric disorders.

SEOUL METROPOLITAN MENTAL HEALTH CENTRE (SMMHC), KOREA
The SMMHC delivers comprehensive care to people with mental illness in the metropolitan community using four distinct teams specialising in coordination of mental health centres, crisis intervention, providing care to homeless people with mental illness and mental health promotion. The crisis management system also coordinates related agencies to prevent suicide and build social safety networks.

CRISIS MENTAL HEALTH INTERVENTION (CMHI), THAILAND
Rapidly developed in response to the 2004 Tsunami, the CMHI utilised models of community care and links with community networks and other organisations to deliver care in three phases to a large population, many of whom were displaced. Through the use of mobile mental health teams, and with the participation of primary care workers, village health volunteers and community leaders such as teachers and monks, all villages received timely and appropriate mental health care.
9. EARLY INTERVENTION

The prevention of chronic illness and disability as a result of mental disorders has been shown to be possible with early intervention. This can result in improved mental health outcomes including reductions in the incidence of illness relapses, long term complications and the need for inpatient care. Early intervention is especially critical for young people. Social withdrawal and disengagement from schooling often occur early in the illness and can have a significant impact on the young person’s quality of life.

**EARLY PSYCHOsis INTERVENTION PROGRAMME (EPIp), SINGAPORE**

EPIP aims to increase early detection of mental health problems, including psychosis, through improved mental health literacy in schools. EPIP also promotes early intervention through the training of primary care physicians in screening and the ongoing management of young people with mental illness.

**EARLY ASSESSMENT SERVICE FOR YOUNG PEOPLE (EASY), HONG KONG**

EASY promotes early intervention by raising awareness through an extensive information campaign, assists early detection through the use of an open referral system and provides optimal care through the use of pharmacological and psychosocial management delivered using a case management structure.

10. ADOPTING A PATIENT-CENTRED APPROACH

10.1. FLEXIBLE SERVICES THAT ARE SENSITIVE TO INDIVIDUAL NEEDS

Patients’ needs are complex and vary from person to person, from group to group, and over time. A comprehensive and flexible mental health service that includes in-patient, community outreach, rehabilitation and home-based care is needed to cater for both acute episodes and long term care for people with mental illness. Integration of various types of service provision is required to ensure continuity of care so that patients can move between inpatient, community and home as their needs change. In meeting the variety of individual needs, services also need to be culturally sensitive and recovery oriented.

**PREVENTION AND RECOVERY CARE SERVICES (PARC), AUSTRALIA**

PARC services based in Victoria provide early intervention in the relapse process and post-acute support and interventions to promote comprehensive care, self-management, relapse prevention and rehabilitation. Such services have both clinical and rehabilitation components to close the gap between inpatient care and the community support system provided through the psychiatric disability rehabilitation and support sector. They reduce inpatient admissions by assisting those with acute mental illness (step up) and providing an early discharge alternative from inpatient units (step down).
10.2. MULTI-DISCIPLINARY APPROACH

A multi-disciplinary team approach, where clinicians of various mental health disciplines work collaboratively in the care of patients is likely to provide higher quality, integrated care in the community. The team approach enables a more comprehensive approach to care as it draws on the training and experience of all the staff involved. A multidisciplinary approach to care also promotes coordination, with all members of the treating team participating in planning a comprehensive delivery of care. Community-based programs would also work closely with primary health care practitioners, NGOs and community resources, in achieving good mental health care outcomes.

COMMUNITY PSYCHO-GERIATRIC PROGRAMME (CPGP), SINGAPORE

The CPGP is a home-based clinical service that uses a multidisciplinary team approach to increase patients’ access to services and the early detection of mental illness. The CPGP places a strong emphasis on building community networks by actively engaging NGOs and community agencies. The programme provides training and support to these agencies in areas such as screening and early diagnosis of mental illness, and the ongoing management of older people with mental illness in the community.

10.3. CASE MANAGEMENT

To ensure that each patient is able to access the services they need and when they need them, it is essential to provide mental health professionals with skills to better manage and coordinate their activities. A coordinated patient-centred service is referred to as case management, which includes assessment, planning, implementation, coordination and monitoring aspects. Case management needs to be practiced differently depending on cultural contexts, resources and system preparedness. However there are some principles that remain constant and can be implemented generically (for example, individual service plans).

NATIONAL MENTAL HEALTH SERVICE MODEL REFORM PROGRAM OR ‘686 PROGRAM’, CHINA

The priority of the national reform program is to build workforce capacity to deliver a comprehensive mental health system by skilling mental health staff and enhancing the practice of community care and case management. A comprehensive training program for groups of multi-skilled case workers for mainland China is currently underway through a tripartite training program. The program conducts training workshops in mainland China, Hong Kong and Australia. Over 500 mental health professionals have been trained in basic case management to deliver coordinated mental health care in 60 sites and given skills to train others in their communities.
PRINCIPLES THAT FACILITATE CHANGE IN MENTAL HEALTH SYSTEMS

Derived from local reform experiences, the evolution of mental health system change in the region, and the learning gained from the process of collaboration and exchange between countries in the course of this project, Asia-Australia Mental Health and the respective collaborating partners in several Asian countries have identified a number of key ingredients to facilitate constructive change in mental health systems (Ng, 2007).

1: DEVELOP UNDERSTANDING OF LOCAL AND SYSTEMIC FACTORS

Before any reform strategy or plan is developed, it is important to consider the mental health system within the broader socioeconomic and political contexts of the country or region. Local factors in terms of readiness for change, cultural compatibility and funding or resource availability will determine if planned reforms in mental health services are realistic and/or practical.

2: INFLUENCE BELIEFS AND ATTITUDES AT ALL LEVELS OF THE MENTAL HEALTH SYSTEM

Change can seldom occur at one level without needing to affect change at other levels of a mental health system. Advocating change in attitudes, priorities and approaches across sectors and at all levels of the mental health system is hence essential. The engagement of key policy makers, bureaucrats and administrators to support change is a necessary focus whether the focus is to create change from the top level down or from the bottom level up.

3: CREATE WILLINGNESS TO WORK IN TRUE PARTNERSHIP ACROSS SECTORS

Strong partnerships are required for sustainable mental health reform. All stakeholders in the reform process including the mental health specialist workforce, academics and trainers, informal carers, community partners, multi-sectoral networks and the health authorities need to develop a collaborative approach. Each partner needs to recognise how to maximise what is currently working, what are the limits of the local system, what is within their capability, what needs further inputs and who is best placed to initiate and then sustain the change.

4: ESTABLISH A LOCAL STRATEGY AND MODEL FOR CHANGE

Due to the diversity of health and social systems, each country needs to develop an appropriate and suitable model of community care delivery to meet its population needs. Internationally recognised community mental health care principles need to be adapted into individual country contexts. Furthermore, locally modified models can establish clear achievable targets that best suit local processes and conditions. Piloting of new models of care and community mental health programs may be the first step in demonstrating the value of more widespread system change.
5: MOBILISE APPROPRIATE RESOURCES
Appropriate mobilisation of resources is critical for successful delivery of any new program and this is best planned at the outset with all relevant stakeholders. The development of clear objectives, work plans, resources required and implementation of the project has to be suited to the local contexts and done collaboratively with the key partners. Support from the bureaucrats, mental health policy makers and administrators at the local level are vital for the sustainability of the program.

6: UTILISE CULTURALLY APPROPRIATE APPROACHES
Adopting a culturally sensitive approach is fundamental to all partnerships within any country or region. Training resources, materials and references which are derived from international guidelines such as WHO and WPA need to be modified according to local models and experience. All training programs and intervention programs need to be designed in a culturally sensitive way, to maximise uptake across urban, semi-urban and rural settings consistent with the cultural aspects of the population served.

7: BUILD IN FLEXIBILITY FOR DIFFERENT ENTRY AND TIME POINTS
In a reform process, a range of service developments in community mental health practice can be developed for medical, nursing, community, administrators and policy staff. These materials not only need to contain generic principles but also need applications that are specific to different stages of reform. Therefore, they can be adopted at the appropriate entry points of each country or region at various stages of reform and development. Capacity building interventions are best matched to stages of development of individual community mental health systems.

8: MAXIMISE ADMINISTRATIVE AND MANAGEMENT SKILLS
Adequate management, administration and leadership skills ensure that: mental health resources are maximised; projects are implemented in a timely fashion; evaluations are completed and translated into further improvement; and staff are motivated and empowered to accomplish goals. A useful strategy is to equip local leaders with management skills so they can oversee the reform and project plan at a local level.

8: BUILD ON THE SYSTEM STRENGTHS
Crucial to any practical reform strategy is the need to build on the strengths and successes of the existing service system in each respective country. By acknowledging current achievements and expanding policies and practices that are working well, practical development steps can be identified and collaboratively undertaken by various stakeholders. Broad promotion of success builds staff confidence and encourages all stakeholders to widen reform.
SECTION 2 : SUMMARY REPORTS AND BEST PRACTICE EXAMPLES

This Section provides the Summary Reports on community mental health from each of the 14 participating countries/regions, in alphabetical order. Each Report provides an overview of current directions in mental health care and service systems, and the context in which these initiatives have been developed.

The reports outline the overall approach within each country to mental health service delivery, the current mix of mental health services and adaptation of international benchmarks to local models. Where applicable, the reports outline relevant policy, funding structures, facilities and services, professional workforce, training and working with related partners including non-professional (informal) care and non-governmental organisations. Future directions to build existing services and improve the community service systems within each country are also outlined.

Many examples of best practice models of community-based services or care can be found across the Asia-Pacific. The examples present local modifications of community mental health models, highlighting successes and gaps, as well as some of the strategies used to overcome challenges encountered. One best practice example has been selected from each country/region for inclusion with the Summary Reports. The examples selected have been collectively chosen to represent the range and diversity of approaches found throughout the Asia-Pacific, rather than as the leading best practice model in each country/region. Several other best practice examples are also found in each participating country/region which are not included in this report but which are of equal quality, and these are presented in the Full Report of the APCMHD project.

The Full Report of the project which contains the complete report on community mental health for each country/region will be published separately. The Full Report will include information from each country/region regarding community mental health such as the mental health system, mental health strategy and principles, several examples of best practice models of community-based services or care, building the capacity of community care and future goals.

The Full Reports are currently available on the website: www.aamh.edu.au
Notes accompanying the artwork: Bruce Doyle was an artist who did not receive recognition during his lifetime. He had several exhibitions but chose not to reveal that he suffered from schizophrenia. Perhaps he was afraid of the consequence of the problem of stigma surrounding mental illness.
AUSTRALIA

The Commonwealth Government priorities for mental health include working in partnership with States and Territories on an integrated national approach to service delivery; developing an open, transparent system of evaluation and accountability of existing mental health services; and ensuring that mental health services are well integrated with other primary care and specialist services.

ROLE OF GOVERNMENT, FUNDING AND POLICY

In area, Australia is the sixth largest country (nearly 7.7 million square kilometres), however its population is just over 20 million. In 2003, mental illnesses were among the ten leading causes of disease burden in Australia, accounting for 13% of the total burden. Responsibility for health care is a partnership between the Commonwealth and State and Territory Governments.

The Commonwealth Government is responsible for a range of initiatives delivered through the private sector, in particular the primary care sector through general practitioners and other professionals, and much of the non-government mental health sector. The Commonwealth Government also administers non-health specific mainstream programs that provide essential support for people with a mental illness, including income support, disability, employment and housing assistance programs.

State and Territory governments have primary responsibility for direct delivery of public mental health services. Hospital and community health services include accommodation, outreach support for people in their own homes, residential rehabilitation, recreational programs, carer respite and self-help. The private sector delivers a significant proportion of primary, specialist and allied health care through a multi-disciplinary workforce.

FUNDING

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

The Commonwealth Government is directly responsible for over 40 per cent of total health care spending and provides significant funds ($331 million from 2003 to 2008) to States and Territories through the Australian Health Care Agreements (AHCAs).

Recurrent government expenditure on direct mental health services has increased during the twelve-year period from 1993–2005 by 90% in real terms. In addition, the cost of non-direct support services is estimated to be over three times the outlays on specific mental health programs, equivalent to $4.3 billion in 2005 prices.
DEVELOPMENTS IN MENTAL HEALTH

Significant progress in reforming mental health services has been made throughout Australia since the inception of the Mental Health Strategy and the National Mental Health Policy in the early 1990s. Prior to 1992, mental health in Australia was traditionally considered the responsibility of the States and Territories. Each State and Territory was responsible for developing their own plans for services and the Commonwealth Government funded the private sector through national health insurance. During this period, declines were seen for bed numbers in stand alone psychiatric hospitals and this decline coincided with the development of the community mental health services sector, a process which became known as deinstitutionalisation. This process was largely uncoordinated and led to many people with mental illness living without appropriate support or accommodation.

Through the 1990s and concurrent with increasing national focus on mental health, was a growing awareness that the mental health system needed further reform. In responding to these challenges, Australian Health Ministers in April 1992 endorsed the development of the National Mental Health Strategy to guide mental health reform over the period 1992 to 1998.

The Strategy provided a framework for national reform, with the focus being the transition from an institutionally based mental health system to one that is consumer focused, with an emphasis on supporting the individual in their community. The Strategy was accompanied by a series of National five year Mental Health Plans; 1993–1998, 1998–2003, 2003–2008).

The Mental Health Statement of Rights and Responsibilities recognises the aspirations of all Australian residents to a dignified and secure way of life with equal access to health care, housing and education, and equal rights in civil, legal and industrial affairs. It aims to protect those who suffer from mental health problems from abuse and neglect. The Commonwealth Government is committed to consumer and carer involvement in its activities related to mental health. It funds the Australian Mental Health Consumers Network (AMHCN) and the Mental Health Council of Australia (MHCA) to inform the development of government policy and programs. These organisations aim to build and strengthen mental health consumers’ and carers’ capacity to represent their sectors in the development of mental health mental health policy and service design.

COMMUNITY-BASED CARE MODELS

Commonwealth Government: Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative. This initiative provides better access for people with a clinically diagnosed mental disorder to mental health care. It encourages a team-based, multi-disciplinary approach (psychiatrists, psychologists, GPs, social workers and occupational therapists), for short to medium term treatment, through Medicare, Australia’s universal health care system which provides eligible Australian residents with affordable, accessible and high-quality health care.

Victoria: Prevention and Recovery Care services (PARC). Victoria has an area-based mental health system which provides integrated community and bed-based services, and a well-developed non-government psychiatric disability rehabilitation and support (PDRSS) sector. The two sectors jointly operate the new PARC service model which provides 10 sub-acute beds in a community residential setting. ‘Prevention’ refers to intervening early in the relapse process, with the aim of averting hospital admission, while ‘recovery’ refers to maximising people’s well-being through providing post-acute support and a foundation for self-management, relapse prevention and rehabilitation.
Queensland: Mental Health Intervention Project (MHIP). This is a tri-agency partnership between Queensland Health (QH), the Queensland Police Service (QPS) and the Queensland Ambulance Service (QAS). The program is aimed at the prevention and safe resolution of mental health crisis situations. It was developed in response to deaths of people with mental illness in crisis during police interventions. In 2005, a collaborative program was established to develop an infrastructure, governance process and knowledge base across the three departments to support better outcomes for consumers and service providers.

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

A BEST PRACTICE EXAMPLE
HOUSING AND ACCOMMODATION SUPPORT INITIATIVE (HASI) NEW SOUTH WALES (NSW)

HASI WAS ESTABLISHED IN 2003, WITH KEY OBJECTIVES TO:
- Improve housing stability for participants;
- Reduce demand on psychiatric inpatient services;
- Reduce calls to emergency services;
- Demonstrate an independent living, community-based model of psychosocial rehabilitation, support and case management;
- Improve quality of life through social, vocational, educational, life-skills development and family connections.

HASI IS A THREE-WAY PARTNERSHIP BETWEEN:
- Specialist mental health non-government organisations funded by NSW Health providing support and psychosocial rehabilitation;
- Specialist local mental health services (part of Area Health Services) providing clinical mental health care and rehabilitation;
- Public and community housing, funded by NSW Housing, providing long-term, secure, affordable housing, and property and tenancy management.

THE PURPOSE OF THE HASI PARTNERSHIP IS TO:
- Co-ordinate care;
- Enhance the interface between specialist mental health services, General Practitioners and non-government organisations;
- Provide stable housing outcomes;
- Facilitate consumer, family and carer participation.
HASI is targeted to individual needs, with a staged support continuum ranging from very high support of 8 hours per day, 7 days per week to lower support of up to 5 hours per week.

**ACCOMMODATION OPTIONS INCLUDE:**
- Individual self-contained accommodation;
- One or two bedroom places;
- ‘Salt and pepper’ approach: HASI properties are sprinkled through the community;
- Small clusters (up to four HASI places in one site) are acceptable when deemed to be clinically viable. Virtual clusters are the preferred options, e.g. several HASI places within a few streets. HASI does not support “asylums in the community” or congregate care.

**IN CONJUNCTION WITH THE LOCAL AREA MENTAL HEALTH SERVICE, HASI SUPPORT SERVICES:**
- Provide comprehensive, client-centred, strengths-based assessment, care planning and intervention which target self-maintenance, productivity levels including education and employment and leisure needs;
- Are based on the principle of consumer recovery through fostering hope, supporting consumer empowerment and supporting self-determination;
- Ensure intervention strategies utilise mainstream community service networks and resources to encourage community inclusion.

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

**ACHIEVEMENTS AND OUTCOMES**
The Social Policy Research Centre (University of NSW) undertook a two-year longitudinal evaluation of the initial stage (100 high support places) of the Housing and Accommodation Support Initiative.


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

From 2008, the HASI in the Home stage will increase to over 1,000 places across NSW.
Graeme Doyle (Australia), No title, 1990, oil on masonite, 50.5 x 40.5 cm
Artwork supplied courtesy of the Cunningham Dax Collection
Graeme Doyle states openly that he suffers from schizophrenia. He believes that his art should be shown to help others understand the experience of mental illness in order not to be afraid of it. The artist wants audiences to appreciate that people with mental illness can still be very creative.
CAMBODIA

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

Standing on the peninsular of Indochina, Cambodia is a country emerging from decades of hostile regimes and civil war. Cambodia spans an area of 181,035 km², and has a population of 13.1 million people, 90% of whom are indigenous Khmer. The distribution of the population is largely rural, with only 15% of Cambodians residing in an urban environment. Cambodia has a relatively young population, with children aged 0–14 years making up 39% of the total. The average life expectancy at birth is 60 years for men, and 65 years for women. The average adult literacy rate is 74%, and is only slightly less in rural areas, currently 72%.

Cambodia is a developing nation, with a comparatively low income both within the region and worldwide. Currently, the Government expenditure on health care per capita per year is US$2.96 and the household expenditure on health care is US$24 (Ministry of Health NHSP 2008–2015, 2008). Funding for Mental Health has recently been heavily supported by international bodies, most notably WHO and Norway, with other organisations running independent projects. Many Private Hospitals also exist in Cambodia however there is no formal information as to how many of these provide mental health services.

Cambodia’s turbulent past has caused not only great trauma and loss for its people, but also destroyed any pre-existing mental health resources and prohibited the development of a new mental health system. Most notably, the Pol Pot regime of 1975–1979 was responsible for mass genocide and the complete degradation of Cambodia’s infrastructure. Of the 1,000 doctors trained prior to 1975, less than 50 survived the regime, none of whom were mental health professionals. Similarly, Cambodia’s only mental health hospital, and the only access point for mental health care, was also destroyed by the Pol Pot regime (NHSP 2003–2007, 2003). The subsequent civil war, which continued until the signing of the Paris Peace Accord in 1991, further contributed to the trauma and displacement of the Cambodian people.

Since that time, Cambodia has made mental health a high priority for development and has worked to build a new mental health care system. The Cambodian Ministry of Health has collaborated with international institutions and organisations such as the University of Oslo, the Norwegian Committee for Mental Health (NORCOMH), the Norwegian Ministry of Foreign Affairs, the International Organization for Migration, the World Health Organization (WHO), the Harvard Trauma Program in Cambodia (HTPC), the Association of Medical Doctors in Asia (AMDA), the Transcultural Psychosocial Organization (IPSER/TPO), Louvain Development (LD, Belgium), the Social Services of Cambodia (SSC), Caritas Internationalis and Supporters for Mental Health (SUMH) to develop new mental health services. The first of these services was made available to the Cambodian people in 1994 (MHCR, 2004).
The Mental Health workforce deficit caused by Cambodia’s turbulent past has resulted in most mental health care being provided by physicians who can often offer only basic care. Traditional healers are often a point of contact for people with mental illness in the community, however it is important to note that these healers do not have explicit mental health training and may therefore cause harm. NGOs have worked to forge links between primary care and traditional workers, however a mechanism for an effective, sustainable system of communication has not been found. There are few NGOs that offer mental health resources themselves, and there is often poor coordination between community agencies that focus on social development or human rights. This poor coordination both within and between sectors has resulted in a fragmented system of intervention with an increased potential for malpractice (Minutes of International Workshop, 2004). The development of a Community Mental Health service has been further restricted by inadequate financial support.

To address these issues, the Cambodian Government, with the support of the WHO, has developed a Mental Health Policy and Strategic Plan, which aims to improve the level of mental health and psychosocial well-being of the Cambodian people through education, information, early identification and treatment. The policy also incorporates services for substance abuse and will help to ensure that all Cambodian people with mental health needs will receive the highest quality services which respect their dignity, rights and culture through meaningful engagement with all stakeholders. The National Programme for Mental Health aims to improve the quality of life for people with mental illness through education and promotion of mental health care and substance abuse services, with a special emphasis on equity, quality and efficiency.

The resulting Mental Health Care Service Package is a vertically integrated system with services both within the general health care system and the community-based health care centres. Developed for use within referral hospitals, the Complementary Package of Activities (CPA) provides specialised mental health care services which are distinct and complementary to general health care. The CPA allows management of complex health problems, provides follow-up and continuing care, and supports the health care system in mental health clinical training and supervision. Additionally, the Minimum Package of Activities (MPA) was developed for use in community health care centres and aims to provide integrated, high-quality mental health care which is both efficient and affordable. The MPA encourages community participation to foster a close relationship with the population that it serves. Further, the MPA aims to overcome financial, geographical and cultural barriers to accessing mental health care in Cambodia (Guidelines of CPA and MPA).

Following the guidelines of the health coverage plan, the Mental Health Care Service Package will be coordinated at both a central and provincial level. The central body of the proposed health system will assist in the development of policies, legislation and strategic planning, and will aid resource allocation and mobilisation, monitoring, evaluation, research, health information system management and training. The central body will also assist in multi-sectoral coordination and external aid. As well as providing some of the above functions, the health system will also work at the provincial level to implement health policies and link and support the development of out-patient departments (Guidelines of HCP, 1997).
The Cambodian Mental Health Workforce is currently staffed by Psychiatrists, Basic Mental Health Care Physicians, Psychiatric Nurses and Basic Mental Health Care Nurses. Psychologists and Social Workers are also working within the NGO sector, but are not yet included in the public health sector. Mental Health training has been integrated into the general medical curriculum, with medical students receiving 120 hours of training, and nursing students receiving 99 hours. Post-graduate training ranges from 3 months for Basic Mental Health Care Nurses and Physicians, to 18 months for Psychiatric Nurses and 3 years for a Psychiatric Residency for doctors (MHT Curriculum, 2004).

A BEST PRACTICE EXAMPLE

A NEW MODEL FOR MENTAL HEALTH IN CAMBODIA (NSPMH)

Due to limited human and financial resources, the delivery of Mental Health Care in Cambodia has previously focused on primary mental health care.

The new Mental Health Care model aims to extend this care to an integrated community service through the use of several guiding principles:

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

The new Mental Health Care model highlights the importance of strong leadership to allow effective patient advocacy and lobbying. The model also highlights the importance of integrating mental health issues into all levels of medical training to increase the mental health knowledge and skill base of general health practitioners. By strengthening community links, the model aims to encourage the role of families, NGOs and community agencies in Mental Health Care. Further, the model aims to coordinate interaction between mental health care and local resources such as primary care and traditional healers to avoid fragmentation of care. It is anticipated that these measures will also result in a decrease in stigma and discrimination for both patients and service providers.
CHINA

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

COUNTRY BACKGROUND AND MENTAL HEALTH SYSTEM

China has a land area of approximately 9597 thousand km². Its population is 1295.33 million (including Hong Kong, Macau and Taiwan), equal to 21.5% of the world population. A high number of people are in the labour force, with 70.15% of the population in the age range of 15 to 64 years. About 36.06% of the population live in urban areas. The average household size is 3.65 persons in rural families and 3.1 persons in urban families. There are 56 ethnicities in China, with Han forming the majority, accounting for 91.6% of the whole population. The main language is Mandarin.

After 30 years of economic reform, China moved from a planned economy to a market economy. Based on World Bank criteria, the country is a lower middle income group country. The GDP per capita in 2006 was US$2039, which was ranked sixty-ninth in the world. China is undergoing rapid change, with an economic growth rate of approximately 10% per annum for the last five years. However, growth in wealth has not been equitably spread, resulting in an increasing gap between rich and poor. The move to an industrially-driven economy has seen a massive shift of people from rural areas to the cities, with consequent loss of social cohesion.

Monitoring Beijing area by MOH and WHO August 2007
The sheer numbers of people who experience mental illness indicate the pressing need for improved mental health services. For instance, it is estimated that 16 million people suffer from psychotic illness, with 0.3 million new cases per year, of which between 50 – 70% have been untreated (source: National Institute of Mental Health, Peking University)

In April 2002, the first Mental Health Plan (2002–2010) was signed by the Ministries of Health, Security and Civil Affairs and the China Disabled Persons’ Federation. In September 2004, the Proposal on Further Strengthening Mental Health Work was agreed by six Ministries and the China Disabled Persons’ Federation and transmitted in the name of the General Office of the State Council. The Proposal is regarded as the mental health policy of China.

The funding model for mental health is complex, with inpatient services provided by three main Ministries – Health, Civil Affairs and Security, with some other facilities administered under other Ministries. The mental health budget is less than 5% of the health budget. In 2004, there were 565 psychiatric hospitals, 499 psychiatric departments in general hospitals, 57 mental health stations and 19 mental health clinics.

The community-based health system was destroyed by the introduction of the market economy due to a lack of regulation for systematic referral and service provision and the pressure to make a profit, and as such, mental health services are mainly hospital-based outpatient and inpatient services in which patients may access tertiary psychiatric hospitals directly.

The mental health professional workforce in China consists mainly of psychiatrists and psychiatric nurses. In 2004, there were 16,103 psychiatrists and 24,793 psychiatric nurses, however the professional competence of many of them is limited. China now has a specialist training system and Continuous Medical Education (CME) regulations. Psychiatrists and licensed psychiatric nurses
are approved by the Ministry of Health (MOH), psychological counsellors by the Ministry of Labour and Social Security, and psychotherapists by the Ministry of Personnel and MOH. In recent years, the National Centre for Mental Health, China–CDC has conducted national training in standardised diagnosis and treatment of schizophrenia, depression and bipolar disorder for psychiatrists in local psychiatric hospitals, and in identification and routine treatment of depression for physicians in general hospitals. Private hospitals mainly provide nursing home services and also provide long-term hospitalisation for chronic patients for a relatively low service fee compared with large state hospitals.

**COUNTRY MENTAL HEALTH STRATEGY AND PRINCIPLES**

“Government-led, society-attended, prevention-dominated, treatment-combined, focally intervened, comprehensively covered and legally administrated” are the principles for mental health service delivery in China. Compared with the recommended mix of services by WHO, specialist services still play the most important role in China. Mental health services provided by primary health centres, community mental health services and psychiatric services in general hospitals are still limited. Long-stay facilities often provide housing and cheap medication for chronic patients for a relatively low fee.

In accord with the terms of the WHO principles of mental health services, patients in the national mental health reform program called the '686 Program' are followed up in their homes, and some receive medication at home or in a clinic quite near their houses. Services are consumer-oriented and comprehensive, and family members and patients receive basic education about psychoses, and training in domestic living skills. Many patients treated in locked wards are now in open wards.

However, because this program is replicated in each geographical area, individual patients do not have a choice between a range of complementary models. Due to a lack of resources, the mental health needs of patients with special requirements due to physical disabilities, intellectual disability, mental retardation, homelessness or imprisonment are not met. Limitations of the mental health reform program are due to the high needs and large number of people requiring services and the limited funding available. The service network is not fully developed and systems are not optimal. Mental health staff are still underpaid for highly demanding work, and there are insufficient support resources which limit the capacity of staff to deliver services.

Service reform should be jointly implemented and supported by different departments and organisations within the country. Community care should be the basis of mental health service provision, covering the entire population, and should be easily accessible, continuous, seamless, and comprehensive, and meet the needs of different groups of patients. Community mental health services should include public education, prevention, treatment, and rehabilitation. Restoration and protection of patients’ functioning should be the final goal of services.

Developing countries can learn from mental health service models in developed countries and modify them to make them suitable for the current situation in their own countries. In China, where primary mental health care or community mental health is not well developed, development of community-based mental health services has been led through the psychiatric hospitals, supported by general hospitals and the Centre for Disease Control. A national centrally-driven program is a very rapid way to implement a new service model throughout a large and diverse country.
A BEST PRACTICE EXAMPLE

THE 686 PROJECT

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

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

In 2005, 60 demonstration sites were established in 30 provinces in China: one urban and one rural site in each province, covering a population of 43 million. 602 training courses were held and nearly 30,000 people were trained, including psychiatrists, community physicians, case managers, community workers, public security staff and family members of the patients. A national computerised case database was established.

In 2006, this program received increased funding of 10 million RMB, enabling improved monitoring and intervention for psychoses, as well as the establishment of a local comprehensive prevention and treatment team in each demonstration area. Staff including 15% psychiatrists and psychiatric nurses from over 12,000 facilities were trained. Nurses were recruited from psychiatric hospitals or departments, community and village health centres, and neighbourhood or village committees.
By December 2006, more than 65,000 patients were registered, nearly 22,000 patients with violent tendencies received regular follow-up, over 9,000 poor patients with violent tendencies received free medication, over 2,600 people exhibiting violent behaviours received free crisis management and more than 1,000 poor patients with violent behaviours accessed free hospitalisation. For patients who received follow-up, the level of violent incidents decreased.

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

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

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

Prof. Yu Xin, Peking University Institute of Mental Health hosted Ms. Therese Rein, wife of the Australian Prime Minister, at a 686 project site on Wednesday 9 April 2008. Ms Rein’s visit was organised by AusAID Australia’s overseas aid programme. AusAID recently announced support of the 686 project. Photo: Cai Linna, AusAID.
HONG KONG

Through its network of 74 general out-patient clinics and seven hospital clusters, people with mental illness can seek help at the primary care level and if necessary be referred to specialist clinics. Inpatient, ambulatory and community psychiatric services are also provided in all the seven clusters to ensure continuity of care.

Hong Kong is a special administrative region (SAR) of the People’s Republic of China which covers an area of 1104 km\(^2\) and has a population of around 7.23 million. The proportion of Hong Kong’s health budget to GDP is around 5.5%, and the public expenditure on health is around 14.5% of total spending. The health care policy stipulates that no citizen should be denied health care because of lack of means and as such, health care is easily accessible to all through both the private and public sectors.

The Government spends around HK$3 billion (0.24% of GDP) on mental health care per annum, which is allocated to the Hospital Authority and eleven Non-Governmental Organisations (NGOs) for the provision of medical treatment, residential support and rehabilitation services for patients with mental illness. For the time being, medical insurance is voluntary, and most of the current insurance schemes do not cover mental illness. The government is actively exploring different models of universal medical insurance arrangements.

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

Based on 2007 data, there are around 256 doctors (115 are specialist psychiatrists, and the remainder are trainees and service medical officers), 2,000 nurses and 300 allied health professionals (including social workers, occupational therapists and clinical psychologists) working in the psychiatric field under the HA. There are also 50 private psychiatrists providing fee-for-service to those who can afford to pay. Other private providers include a small number of general practitioners trained to treat milder forms of mental illness. Although the number of psychologists, counsellors, therapists, and hypnotherapists in the private sector is growing, no official regulation and data is available.

Hong Kong supports the recommended mix of mental health service components by WHO, and the Government’s direction is to strengthen both community care and primary care in mental health. Therefore, a strategic plan was formulated to downsize the two largest stand alone psychiatric hospitals in Hong Kong. The plan was completed in 2006 such that Hong Kong now has approximately 4,600 psychiatric beds (6.4 per 10,000 population). There is a mix of large mental hospitals and psychiatric units in general hospitals. The recent target has been to shorten the length of stay of acute inpatients. Increasing the workforce of the community psychiatric teams is crucial in order to
provide more intensive care to patients after discharge as well as for urgent psychiatric referrals in crisis situations. Having a range of well-differentiated community treatment options will enable more patients to be cared for in the community.

One of the most important goals for the Hong Kong mental health system is the formulation of a consistent and long-term mental health policy, involving stakeholders and ensuring collaboration amongst all key players. In order to achieve this, Hong Kong needs to plan for future manpower requirements. Recently, the Food and Health Bureau of the Hong Kong SAR Government formed a working group to examine this issue. Furthermore, the funding model for primary care systems needs to be revised to address the balance of priorities given to the severely mentally ill, as well as the issue of payment or co-payment of fees for the less impaired patient groups (such as those suffering from depression and anxiety).
To some extent, the HA has been trying to adopt the recommended approaches from the international community on the organisation and delivery of mental health services. As the health care system has conventionally been oriented towards secondary and tertiary care, the role of primary care providers in mental health has not been strong. Closer and better collaboration between the HA mental health professionals and the NGOs need to be strengthened so as to avoid service overlap, and continue the campaign for public education and de-stigmatisation of mental illness. Enhancing the involvement of carers and consumers in the care process is also important. As part of the exercise to review Hong Kong’s mental health services, the Hospital Authority sent a delegation to Australia in 2007 to study the service model of Victoria and subsequently a mental health consultant from Victoria visited Hong Kong to evaluate the mental health services to make recommendations for further changes.

Hong Kong has to strike an appropriate balance between hospital versus community care. Local experience has demonstrated that with limited resources in an overcrowded city, a hybrid model of community care could be developed together with adequate inpatient beds in purpose-built facilities, where patients are cared for with dignity, respect and adequate space. A bed ratio such as 6 per 10,000 population could be necessary, a figure higher than some developed countries where there are adequate community support services. There are a number of early intervention programs, targeting early detection and intervention of depression and psychoses. Programs are also in place for the discharge of long stay patients back to be cared for in the community. Although the overall financial implication will be more cost-effective, such a hybrid model still requires a major financial input from public spending. There is a need for commitment in terms of policy as well as allocation of resources in order to implement a better community care model.

A BEST PRACTICE EXAMPLE
EXTENDED-CARE PATIENTS INTENSIVE TREATMENT, EARLY DIVERSION AND REHABILITATION STEPPING STONE (EXITERS) PROJECT

Despite advances in pharmacological and community psychiatric treatments, a large proportion of psychiatric inpatients remained long term in mental hospitals in Hong Kong. In a survey in June 2000 by the Hospital Authority on the distribution of length of stay of psychiatric in-patients, it was revealed that 1138 (23.1%) had an average length of stay greater than 4 years. Commencing in 2000 in three phases, EXITERS is a pilot project aimed at early integration of long stay inpatients back to the community. A Multidisciplinary Team including 2 medical doctors, 7 nurses, 2 medical social workers, 1 occupational therapist, and a team of 12 supporting staff for each hospital unit were recruited to address the patients’ complex needs.

In phase I, vacant hospital quarters at three major mental hospitals in Hong Kong were converted to create supported group homes, with home-like settings to facilitate the intensive rehabilitation. In phase II, appropriate patients with a hospital length of stay over 6 months were recruited and each was assigned a case manager. These patients were often not suitable for half-way-houses, or had frequent admissions and discharges from half-way houses. Those with illicit drug addiction, moderate or severe mental handicap and dementia were not included. Intensive rehabilitation was provided to improve social and vocational functioning, and various community options were explored to bridge the gaps in residential services that were available. In phase III, active community support and follow-up were offered for the discharged patients. Several evaluation tools for assessing symptoms, needs, function and quality of life were administered quarterly to evaluate the outcome.
Kin (Hong Kong), b. 1961, Sichuan earthquake. The dead and injured are miserably heavy. 145 x 190 mm, sign pen.
Notes accompanying the artwork: This work bemoans the destruction caused by the earthquake in Sichuan China. The disaster not only broke peoples' hearts but also injured the whole of nature. Trees fall; rock, stones and mud slides block roads making rescue work difficult; happy butterflies wings are damaged; the sun shrinks back to a corner of the painting; and the moon is dim and deformed. A broken up house [tenement] symbolises the disaster itself. People in the painting represent the victims, a death toll of over 60,000 people. Many children were orphaned and many schools collapsed with a lot of students buried in the rubble. Death and injury are miserably heavy, continuously crying shedding bitter tears. The yellow “F” in the painting stands for FLOODING, FIRE, and FUTURE. The fragmented pattern represents the fracturing of small villages, and injured mother nature.
During the first three years, 387 patients were discharged from the three hospitals. The discharge destinations included living at home, either singly or with relatives, resettling in a private housing unit, re-housing in a public housing unit or staying in a private hostel. Analysis of the first 190 patients discharged from hospital in one year showed significant improvement in the patients’ psychiatric symptoms, behavioural problems, functioning levels and quality of life. However, these patients remained quite functionally disabled on discharge, with a large number remaining unemployed and requiring financial support from social welfare.

The project identified a group of patients with complex disabilities that required flexible matching of resources in the community. It utilised the case management model in the reintegration of patients to the community. The EXITERS hostels situated in the neighbourhood of the hospital provided a home-like environment for disabled patients to adapt slowly to community living, and with adequate resources it demonstrated that difficult-to-place patients could be successfully reintegrated back to the community. Despite having some persistent disability, the discharged patients have improved quality of life outside mental hospitals.
Mental health in India was comprehensively addressed in 2002 when a new National Health Policy was framed. The Policy endorsed the District Mental Health Programme (DMHP) by envisaging a network of decentralised mental health services for providing care for common psychiatric disorders by trained general duty medical staff. The Policy also endorsed upgrading mental health infrastructure, mental health institutions, and general hospital psychiatry units for inpatient treatment and further endorsed generating a larger skilled mental health workforce.

India is one of the oldest civilisations in the world with a kaleidoscopic variety and rich cultural heritage. There is a great variation on social parameters such as income and education, and the geographical diversity of India includes all the climatic conditions and terrains in the world. Spread over an area of 3,287,263 km², India occupies 2.4% of the world’s land area and houses 1.136 billion people constituting over 17.5% of the world’s population. India is a union of twenty-nine states and six union territories. Life expectancy is 63.9 years for males and 66.9 years for females. The prevalence of mental disorders in the population is in the range of six to seven percent which constitutes a huge number in absolute terms.

Before 1960, mental health services were mostly provided by Mental Hospitals. With the advent and availability of psychotropic drugs, General Hospital Psychiatry Units were established in many hospitals in the sixties and the following decades. Community-based mental health services began in the seventies on a small scale by incorporating mental health in primary health care through short-term training of general health personnel.

The National Mental Health Programme (NMHP) was launched in 1982 with the objective to ensure availability and accessibility of minimum mental health care for all in the near foreseeable future, particularly to the most vulnerable sections of the population, and to encourage mental health knowledge and skills in general health care and social development. NMHP also aimed to promote community participation in mental health service development and to stimulate self-help in the community. A model for delivery of community-based mental health care at the district level was developed and trialled in the Bellary district of Karnataka in the mid-eighties. The trial demonstrated that mental health services could be delivered in primary care settings by providing a limited number of drugs and short-term training for primary care physicians and other health personnel.

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

A comprehensive community-based mental health service, the District Mental Health Programme (DMHP) based on the ‘Bellary model’ was started under the NMHP in 1996. DMHP was expanded to 27 districts across 22 States and Union Territories in the Ninth five-year plan period from 1997–2002.
Spurred on by the inclusion of a comprehensive approach to Mental Health in National Health Policy as well as an in-depth assessment up to the Ninth Plan, the National Mental Health Programme was re-strategised in 2003 for implementation during the Tenth Five Year Plan (2002–2007). The re-strategised NMHP forms the basis for public health initiatives in the field of mental health and aims to provide a balanced mix of closely networked services, with dedicated budgetary support for modernisation of the Government mental hospitals, up-grading of the psychiatry wings in General Hospitals and Medical Colleges, implementation of the DMHP in 100 districts across the country, focused IEC strategies, training and research.

National consultations and reviews over the past few years have revealed that the Programme is facing difficulty due to an acute shortage of skilled mental health personnel, as well as administrative barriers. These problems are being addressed in the current Eleventh Five Year Plan. Additionally, important additions such as suicide prevention, workplace stress management, adolescent mental health and college counselling services have been made. The Plan includes the active participation of credible community based organisations and private practitioners in providing services and implementing the DMHP. Further, a strong IEC strategy for awareness creation and stigma reduction is being incorporated. A dedicated monitoring and coordinating system would be established at the central, state and district level to facilitate the implementation of the DMHP. The aim is to extend the DMHP to all the districts by the year 2012. Financial allocation for NMHP during the proposed Eleventh Plan is over five times that of the Tenth Plan.

There is currently a shortage of skilled mental health personnel in India. Psychiatry is taught as a subject in the MBBS curriculum in 271 medical colleges and as a specialisation in the form of three year MD/DNB–Psychiatry and 2 year DPM courses and is regulated by the Medical Council of India. Clinical Psychology and Psychiatric Social Work are taught as two year M.Phil. courses and 3 year Ph.D courses in psychiatric institutions regulated by the Rehabilitation Council of India. Psychiatric Nursing is available as a two year M.Sc. Psychiatric Nursing and a one year Diploma in Psychiatric Nursing under the regulation of the Nursing Council of India.

Non-government organisations (NGOs) are involved with mental health in some parts of the country. Family members of mentally-ill persons have recently started coming together to form self-help groups. Private hospitals and private psychiatrists are also important contributors to mental health care.

The long-term goal in community care is to overcome the shortage of mental health professionals by increasing training places in the various disciplines. The infrastructure in rural areas needs to be improved to attract more mental health professionals, and thereby reduce the disparity in distribution of trained personnel between urban and rural areas. A well-developed IEC strategy would increase awareness and decrease stigma. Long-term care, residential facilities, sheltered workshops, half-way houses, day-care programmes and community-based rehabilitation services need to be created and integrated with the DMHP for a comprehensive mental health system.

The nation strives to deliver mental health services to its entire population and promote well-being through consistent and sincere efforts in line with modern scientific thinking. At the global level, India is certain that its community mental health model and experiences would benefit countries with scarce mental health resources. Standing true to its tradition of exemplary international cooperation, India would be happy to provide technical support to any country and to host a collaborative centre for further action and cooperation in this important field.
The District Mental Health Programme (DMHP) was launched in 1996 under the National Mental Health Programme.

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

**BRIEF DESCRIPTION**
The DMHP is run by a core team of mental health professionals including a Psychiatrist, a Clinical Psychologist, a Psychiatric Social worker, a Psychiatric Nurse, a Nursing Orderly and a Record keeper. The Programme’s catchment area is the district and adjoining areas.
COMPONENTS OF THE PROGRAMME

- Community Mental Health Services. This includes a psychiatric Out Patient Department at the district hospital as well as outreach services in Primary Health Centres on designated days that provide follow-up care of patients, dispensing of psychotropic medication, record keeping and referral to an appropriate level of care as needed.
- Information, communication and education services.
- Technical and managerial support from the district medical college/ psychiatric institution.

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

Basic mental health services are also provided by the extensive network of trained health staff in the general health care system. The DMHP model has demonstrated that by training primary care physicians, basic mental health care delivery can be provided in primary care settings. Provision of supervision and support from the mental health program officer and/or the psychiatrist, empowers staff in the public health care system to respond to the mental health needs of the population. Several reviews and consultations have identified barriers to implementation of the DMHP as well as identifying the need for mental health promotion. This has led to modification of the DMHP in the Eleventh plan.

In the Eleventh plan, the DMHP team has the provision of hiring trained medical officers if a Psychiatrist is not available for the programme. Other members of the team will include a psychologist, a social worker, a nurse and an office assistant, who will receive brief skill-based training with a uniform curriculum at identified centres.

According to demand, new mental health promotion services will be added, and credible organisations and private practitioners will actively participate in providing services and implementing the DMHP. In order to address the shortage of trained mental health practitioners, government doctors will be trained as sub-specialists in Psychiatry through the introduction of one year in-service certificate courses in Psychiatry. In addition, Institutes of Mental Health & Neurosciences will be established to develop the mental health workforce. Upgrading of psychiatry facilities of medical colleges and general hospitals and modernisation of mental hospitals will continue.

A strategy with a strong emphasis on information, education and communication is needed to improve awareness of mental health issues and to reduce stigma.
INDONESIA

Building the capacity of the health workforce to deliver mental health services has become a major focus in Indonesia. A number of training programs for primary care physicians in treating mental disorders have been established, with some primary care professionals now receiving regular training in mental health. In the last two years approximately 500 personnel received training, especially in Aceh, South Sulawesi and West Sumatra.

Indonesia is a large archipelago in Southeast Asia with the fourth largest population in the world (222,611 million), nearly 60% of whom are still rural based. In March 2006, 3,905 million people (17.75% of the total population) were recorded as living on or below the poverty line. As with many developing countries, mental health has historically been a low priority in country development programmes. This is contributed to by insufficiencies in mental health policy and laws, poor infrastructure and a lack of human and financial resources. Previously, less than 1% of the total health budget was allocated to mental health, of which 97% was allocated to mental hospitals, leaving a very limited budget for community mental health. There are limited epidemiological studies of mental health in Indonesia, with the last survey completed in 1995.

The total number of mental health beds in Indonesia is insufficient to meet the needs of the population, such that many people with mental illness live in the community without proper treatment. Further, the poorly developed primary health care system is insufficient to support the integration of primary mental health care. Traditional healers and nurses from Government mental hospitals make occasional outreach visits to patients in the community. Stigma remains high in the community due to socio-cultural factors such as religion, and is worsened by poor understanding and a lack of integrated care within both the broader health care community and other sectors, particularly in rural and remote areas. Serious workforce shortages exist in all mental health professional groups, including public health workers, village leaders, community workers, mental health nurses, mental health medical officers, clinical psychologists and psychiatrists.

For many years, Indonesian people with mental illness were removed from their communities and kept in psychiatric hospitals or institutions, leading to further stigmatisation of patients. There was little choice for patients and carers, who experienced difficulties gaining access to and remaining in contact with services. In Indonesia, Community Mental Health is understood as the provision of mental health services to people in the community with the participation of local people. Community-based mental health services were first addressed in 1976–1987, when a psychiatrist from a state mental hospital provided mental health care to people in primary health care settings and general hospitals, however this model was sub-optimal due to the inability of mental hospital staff to reach many primary health centres and district hospitals. In 1987–2000, empowered doctors and nurses in primary health centres and district general hospitals began to screen and manage patients with mental disorders such as psychosis, depression and anxiety. Unfortunately, obstacles such as a high turnover rate of trained doctors as they undertook further specialised study, and high demands for other primary health care programs resulted in weak outcomes such as poor availability of psychotropic drugs, inadequate supervision from the district health office and a low priority for
mental health overall. In 2000, a decentralisation policy of health care provision was implemented under which most psychiatric hospitals now came under local government administration. At that time, province and district health offices did not see mental health services as a priority, and therefore did not allocate funding for the provision of mental health care services in primary health care centres.

Awareness of mental health issues in Indonesia greatly increased in 2004 following the Indian Ocean tsunami. The influx of many international non-government organisations (NGOs), who provided large amounts of funding, led to improved mental health services. This was a turning point for community mental health in Indonesia, with international agencies such as WHO, ADB, IOM, CBM, focusing specifically on community service delivery, especially in Aceh Provinces. The Indonesian mental health care community, in concert with NGOs, has worked to deliver mental health advocacy, promotion, prevention, treatment and rehabilitation services, particularly in disaster-affected areas such as Jakarta, Aceh, Jogjakarta, West Sumatra and Bengkulu. Further, Indonesia now has specific mental health programs for refugees, disaster-affected populations, the elderly and children. Specific services are also available for drug users, HIV/AIDS patients, prisoners and workers.

Building the capacity of the health workforce to deliver mental health services has also become a major focus. A limited number of training programs for primary care physicians in treating mental disorders have been established, with some primary care professionals now receiving regular training in mental health. In the last two years approximately 500 personnel received training, especially in Aceh, South Sulawesi and West Sumatra. In order to deliver a high standard of mental health treatment and care, the Ministry of Health has advocated the adoption of an integrated system of service delivery to comprehensively address the full range of psychosocial needs of people with mental disorders. Specific policy directions include an increase in the mental health workforce in order to improve its ability to meet patient needs across Indonesia, particularly in rural and remote areas, and to support the non-government and private sectors to provide quality services for people with mental disorders.

According to WHO guidelines, mental health service delivery in Indonesia includes the following components:

- Self and family care through empowering consumers through mental health promotion, education campaigns such as life skills development for adolescents and parenting skills to assist parents to prevent drug abuse in their children.
- Primary health care that is delivered at the sub-district level by public health personnel such as doctors, nurses, midwives and public health officers, who can provide basic mental health assessment and treatment, prevention measures and promotion.
- Community Mental Health Teams comprising multidisciplinary teams who provide services via mobile outreach and through the primary health care system. These teams do not exist in most districts and external technical and financial support is needed to develop them.
- Secondary medical care which is provided by district general hospitals, of which there were 976 in 2005. The services include outpatient services, crisis intervention, counselling clinics and medical treatment for patients with psychiatric problems.
- Tertiary Care Services (Mental Hospital and Specialist Services) provided by 51 mental hospitals and 27 general hospitals with specialist psychiatric services, specialist medical care, and public health care, including both provincial and university hospitals. They provide a full range of mental health care including assessment, treatment, rehabilitation in the crisis, acute and follow up phases in hospital and in the community.
A BEST PRACTICE EXAMPLE
COMMUNITY MENTAL HEALTH NURSING IN ACEH, INDONESIA,
FOLLOWING THE TSUNAMI AND EARTHQUAKE

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

TRAINING OF NURSES FOR COMMUNITY MENTAL HEALTH SERVICES
Community Mental Health Nursing (CMHN) training is divided into 3 steps:

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

SUCCESSES OF THE COMMUNITY MENTAL HEALTH NURSE TRAINING PROGRAM

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

**CHALLENGES FACED IN IMPLEMENTATION**

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

**FUTURE DIRECTIONS**

- Creating networks of care with local NGOs.
- Involvement of religious and female leaders.
- Maintaining advocacy to ensure that future budgets allow for allocation of finances to community mental health nursing activities.
- Working towards CMHN becoming a compulsory program at the primary care level.
Japan (population: 127.7 million; area: 377,915 km²), an island country in East Asia, has one of the highest number of psychiatric beds per capita in the world and a mental health system which relies heavily on in-patient treatment. In 2004, Japan had 1,671 hospitals with psychiatric units, 354,923 psychiatric beds, and a bed:population ratio of 2.8 beds per 1,000 population. Out of these hospitals, 1,379 (83%) are privately owned, and 1,086 are stand alone psychiatric hospitals. These figures are inflated by the number of patients with dementia who are treated in psychiatric units. Though community mental health services are increasing rapidly, they remain inadequate especially in terms of housing support, vocational rehabilitation and outreach services.

The Japanese government has recently released in rapid succession, policies, laws and regulations relevant to mental health. This process began in 2002, stemming from a Ministry of Health, Labour and Welfare report called *Future Direction of Mental Health and Welfare Policy*. The policy fundamentally addressed the shift from hospital-based medical treatment to community centred health care and welfare.
Y. A. (Japan), b. 1969, No title, oil on masonite, 45 x 38 cm.
Notes accompanying the artwork: The artist learned to paint from another artist during group work for patients with mental illness at a public health centre. He doesn’t like to leave indoors, so his work is mainly of people and landscapes as seen through windows.
In December 2002, the Headquarters for Mental Health and Welfare were established. Headed by the Minister of Health, the Headquarters submitted a mental health policy paper in 2004 called The Reform Vision for Mental Health and Welfare Services or Reform Vision. The overall aim of the policy is to realise the transition “from institution-based medical treatment to community-based care”.

The Reform Vision addresses three main themes:

- educating the public to achieve better understanding of mental health disorders and people with mental illness;
- reforming the mental healthcare system by enhancing the specialisation of psychiatric units and promoting early discharge;
- strengthening community support systems to secure community environments for people with mental illness.

To achieve the objectives of the Reform Vision, definitive goals for the next 10 years have been set for public education and reform of the mental healthcare system. By achieving these goals, the Reform Vision aims to reduce the number of hospital beds by 70,000 within the next 10 years.

In 2005, the new “Act on Support for Persons with Disabilities” was established which contains the key elements of the above reports and has five main aims:

- to streamline three disabilities (i.e. physical, intellectual, and mental) to provide the same types of services;
- to put greater emphasis on user-oriented services;
- to enhance support for employment;
- to clarify the benefit supply process;
- to secure financial resources.

Other examples of the reform are revision of the Mental Health and Welfare Law, revision of the Law on Promoting Employment of the Disabled and revision of the National Medical Fee Schedule oriented towards more community services.

This reform process has had a large impact on community mental health. However, many community and hospital service providers are struggling to cope with this major change. Although many complaints against the new law have arisen, and probably more problems are expected during this process, the reform has been a major step towards a community-centred mental health system.

Four best practices in community mental health services in Japan have been chosen from different viewpoints: a consumer-centred service; a practice initiated by a hospital; a practice initiated by welfare; and a practice with a balance of medical and welfare services. Many other candidates should be included as best practices, but by exchanging opinions with MHLW, only one practice from each category was selected. These are: the unique consumer-run activity at the House of Bethel; the development of services in the community by Sawa Hospital; the discharge promotion program run by the social welfare cooperation Sudachi-kai; and the Obihiro-Tokachi area comprehensive community care network system.

The four examples of best practices in community mental health provided invaluable lessons. It is now understood that it is possible to support severe mental illnesses in the community and that the strengths of the consumer should be recognised. Further, the importance of building a community network and the need for around-the-clock housing and vocational support was also highlighted.
Future directions to expand the current capacity of community mental health in Japan are:
- support for consumers to build consumer-centred services;
- development of more community services especially housing support, vocational rehabilitation and outreach services;
- dissemination of good quality care management and building close networks in the community;
- quality improvements such as staff training, consumer and carer involvement and outcome measurement.

Using these lessons, Japan aims to decrease the number of beds by 70,000. However, it is important to note that even if this is accomplished, the number of beds in Japan will still be around 280,000, or 2.2 per 1,000 population, which is more than double that of other countries. Whether this is the right balance for Japan or not still needs to be reviewed. Service system reform cannot be done in a single stage but rather, should be a continuing process to make a better system. Lessons learned from local practices in Japan and in other countries are valuable to keep the reform going.

A BEST PRACTICE EXAMPLE

MITAKA, TOKYO — SUDACHI-KAI

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

Based in Mitaka city of Tokyo, Sudachi-kai (Japanese for ‘Flight from the Nest-group’) is a social welfare corporation which actively promotes discharge from hospital. Over its 15 years of history, more than 130 long stay inpatients have been discharged.

Its housing and vocational facilities are located in Mitaka city (population: 178,000; area: 16.5 km²) and Chofu city (population: 21,600; area: 21.5 km²). Both cities are located in the centre of Tokyo Metropolis.

Sudachi-kai started in 1992, when there was strong stigma against people with mental disorders who faced much difficulty in housing rental. The first group home was started with cooperation between the landlord, hospital staff and families. Through their support, many patients have been discharged to the group homes and to other neighbouring rooms. Importantly, a sheltered workshop was opened in response to a need for vocational activities during the day. From these facilities, the basic concept of Sudachi-kai as a place for consumers to live, work, and find support by both staff and peers, was formed. They gradually expanded their activities and currently have 8 housing facilities (capacity 61) and 3 vocational facilities (capacity 90), with about 20 fulltime and 20 part time staff.

From their experience, Sudachi-kai has made the following model pathway for discharge from hospital:
- First, the staff and peer supporters (past inpatients) of Sudachi-kai deliver talks to inpatients in hospital. The stories the peer consumers tell about their lives outside the hospital convey strong messages to the inpatients, thus motivating them towards discharge from hospital.
- Next they consult with the candidate and their family to make a support plan with them.
T. N. (Japan)
b. 1953
No title
gouache on paper
110 x 60 cm
Notes accompanying the artwork:
The artist began to paint while in hospital. At first his paintings were mainly abstract, but as his confidence grew, he also began to diversify his style basing some of his work on photographs. Discharged from hospital, he now paints at home, but seems less able to afford time for his creative activities.
When candidates are motivated, discharge training is provided and they begin attending the vocational facility in the community during the day.

Next, Sudachi-kai helps the candidate find suitable housing which could be a group home or other rooms. Overnight training using a short stay facility also begins.

Preparation for discharge takes place, such as a patient managing own medications, money, etc.

After discharge from hospital, staff (24 hour coverage) and peers support them to live in the community.

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

A Mental Health Act established in 1995 defined Mental Health Services to include psychiatric inpatient facilities, mental asylums for those who need long-term residential care and social rehabilitation facilities including community mental health centres, ambulatory psychosocial rehabilitation services and group homes in the community. These changes formed the starting point for the development of a new paradigm of community mental health care in Korea.

The development of community mental health services in Korea is based on a model of public-private collaboration between Public Health Centres and the University, or Mental Hospital. There are few mental health professionals in public health centres, however the University Hospital or Mental Hospital has trained mental health professionals for over ten years to enable them to support public health centres. Strategic collaboration between the public and private sectors has involved public sector funding and professional human resources and community mental health programs from the private sector.

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

The Korean Government has supported a variety of training programs for mental health professionals. Since the implementation of these training programs in 1995, there has been a considerable increase in the number of trained mental health professionals working in community mental health settings. In 2006, there were 2,089 Psychiatrists, 1,782 Psychiatric Nurses, 778 Psychiatric Social Workers and 295 Clinical Psychologists in Psychiatry working in mental health. These trained mental health professionals will form the mental health workforce in the expansion of community mental health. Alcohol-related mental disorders and suicide are some of the most serious social problems in Korea. As such, there has been an increased effort to promote intervention and prevention for mental health issues that have arisen as a consequence of the rapid social changes in Korean society. Even though Korea has a sufficient number of professional mental health experts, few mental health services are integrated with the primary health care system. This relative lack of integration continues to separate mental health from the general health care system in Korea, and consequently contributes to the current social stigma against mental illness.

In 2006, there were a total of 1,432 mental hospitals and psychiatric clinics, of which 86 were mental hospitals with 31,689 psychiatric beds, and 1,038 were tertiary university hospitals, secondary general hospitals and local private psychiatric clinics with 32,071 psychiatric beds. Despite the growth in community-based mental health services in Korea, large-scale deinstitutionalisation is
not yet in sight. Under the present circumstances, private mental hospitals and asylums are unlikely to discharge patients into community-based services, to shorten the average length of patients' stay or voluntarily decrease the number of beds. It is very important that the government declare its intentions to support the development of community-based mental health programs by presenting a long-term plan for deinstitutionalisation. In 2007, in accord with its commitment to mental health, the Government plans to establish ‘the Ten-Year Plan’ for mental health. This Ten-Year Plan aims to increase the number and improve the quality of community mental health centres, reduce social stigma and the rate of suicide, control the increase of psychiatric beds and encourage the policy of deinstitutionalisation.

In terms of the limitations of mental health reform, Korea does not yet have a public community mental health system in every catchment area and the average length of stay in mental hospitals is still too long. Even though there are sufficient mental health professionals in Korea, primary care staff do not receive an adequate mental health education, which results in the separation of the mental health system from the general health care system. This separation in provision of mental health services from the mainstream health care system may contribute to the current social stigma against mental illness. Lastly, consumer and family associations are not organised systematically yet. Even though a common mental health system does not exist across the country, Korea is rapidly developing a comprehensive mental health service system in each catchment area. In addition, the Korean government has invested in a community-based, public mental health system rather than in an institution-based system. However at this time, the community-based system of mental health care is insufficient, especially compared to the system and provision of services in mental hospitals.
The next steps in further developing the mental health system in the Republic of Korea will be to strengthen and improve community-based, public mental health services, as well as monitoring systems for each catchment area and province. Linkages with the primary health care system, the education system and the judicial system should be strengthened through training and distribution of information about mental health. This effort will contribute to making the country’s mental health system more efficient and will hopefully decrease social stigma. In order to restructure a mental health system with limited resources, the Korean government should develop and establish a monitoring and information system of good quality and efficiency. Finally, there should be a program of long-term ongoing research that examines the effectiveness of the country’s mental health services. In this way, the Republic of Korea can identify and maximise those services which produce positive outcomes for people with mental disorders.

The rapid development of community mental health in Korea has been made possible through the enthusiasm of young psychiatrists and mental health professionals from the private sector with the support of Government mental health policies. In the future this private-public collaboration will involve consumers, families and NGOs in the development of mental health care in Korea.

A BEST PRACTICE EXAMPLE
SEUL METROPOLITAN MENTAL HEALTH CENTRE FROM GANGNAM COMMUNITY MENTAL HEALTH CENTRE

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

Seoul City also increased funding for other CMHCs and in 1998, there were seven CMHCs with each area providing ‘semi-metropolitan’ mental health services. Located in the Public Health Centre, these CMHCs provided primary mental health services, established psychosocial rehabilitation services for the chronically mentally-ill population, mental health promotion for the general population and gradually increased services for children, adolescents and old people. These CMHCs were funded by the local districts and Seoul City and operated autonomously in each local district. Consequently there was a need to develop a system to coordinate and integrate the operation of these CMHCs. The mental health planning committee and city government officials discussed the metropolitan mental health service system in order to expand the community mental health services to other districts of the city. Seoul City commissioned the Gangnam CMHC to develop a centralised data gathering and management system and evaluation was conducted through the Mental Health Information System (MHIS) to examine mental health outcomes separately from general services to the local community.
As a result of the increasing demands on the metropolitan mental health centre, which was responsible for supporting and coordinating all the CMHCs and the development of new mental health policies and programs, Seoul City established the Seoul Metropolitan Mental Health Centre (SMMHC) in the downtown area in 2004. Staff from the Gangnam CMHC moved to this metropolitan mental health centre and commenced service provision.

In 2004, a Taskforce Team established the Seoul Mental Health 2020 Project so that the City of Seoul could develop mental health services to meet future needs. The goals of the Seoul Mental Health 2020 Project are to:
- Analyse the present state of Seoul Mental Health Services and predict demand for future resources and infrastructure;
- Establish the Metropolitan Mental Health Centre to facilitate deinstitutionalisation and crisis management systems;
- Establish an organisation to support the development of policy and research.

The model for organising the SMMHC has been adapted from St. Vincent’s Mental Health in Melbourne, Australia, through a contract between Seoul and Melbourne. The SMMHC now has four teams: the Community Assessment and Linkage System (CALS), the Crisis Intervention Team (CIT), the Mental Health Promotion Team (MHPT) and the Homeless Mobile team (HM).
The vision for mental health services in Malaysia is to create a psychologically healthy and balanced society with an emphasis on promotion of mental health and prevention of psychological problems, and to provide adequate and appropriate treatment and rehabilitation for those with chronic disabilities by ensuring their optimal potential is realised and protected by their families, communities and the nation.

This is strengthened by the development of the National Mental Health Policy (1998) and the National Mental Health Framework (2001), with a legislative provision examining the mental health service. Funding for mental health services in Malaysia is provided largely by the Government. Malaysia spends 5% of its GDP on healthcare, of which about 3% is spent on mental health care. Most insurance agencies do not cover treatment for mental illness.

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

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

As of April 2007, there are 176 psychiatrists in Malaysia; its psychiatrist to population ratio is 0.68 per 100,000. Of these, 87 Psychiatrists are in the Ministry of Health, 2 in the Ministry of Defence, 54 in the Universities and 35 in private practice. Of these, 25% have sub-specialty psychiatry training in Child, Forensic, Community, Liaison, Neuropsychiatry, Psycho-geriatric, Clinical Epidemiology and Addiction. There are accredited structured programmes developed in this country for post-graduate training in psychiatry, subspecialty training and post-basic training for paramedical staff.

The present laws limit involvement of the private sector in the provision of inpatient treatment services. Private psychiatrists may provide out-patient care or consultation for patients in private hospitals.

Our strategy is to strengthen the current primary health care system, develop hospital-based community teams from existing psychiatric services in all hospitals with psychiatrists, and form close linkages between the hospital and primary health care. At the same time, the two systems need to
work together with the local community and other relevant agencies and departments, coordinating a system of care for patients and their families. In this system, both primary care and psychiatric units or departments, have an important and complementary role. People with mental disorders, their families and communities are equal partners in planning mental health services, and it is important that all of these various stakeholders should actively communicate and collaborate with each other.

These strategies are operationalised as follows:
- Hospital-based outreach services provide for short hospital stays and early discharge, crisis intervention, family intervention and active defaulter tracing. The case-management model is adopted where a key worker looks after a patient and coordinates services based on the patient’s needs.
- Funding is provided to support community care development and to sustain the program.
- Training of human resources involved in providing community psychiatry services, in both hospital and primary care settings. The skills and knowledge of staff involved in community psychiatry service should be up-dated on a regular scheduled basis.
- Provision of mental health services in primary care settings or health clinics for follow-up of stable psychiatric patients nearer to their homes. Close monitoring and defaulter tracing remain important to ensure patients are compliant with follow-up and treatment.
- Psychosocial rehabilitation centres are based in health clinics, to enhance psychiatric stability and functioning in patients by providing comprehensive rehabilitation services nearer to their homes, based on individual needs.
- The current model used by the Ministry of Health will be evaluated to ensure quality of care and assess long term cost effectiveness. There are numerous models of community-based rehabilitation and each has its strengths and weaknesses. There is a need to look for a consistent approach that will fit into our socio-cultural context.
The decision to admit to hospital will be based on a comprehensive assessment and formulation of a management plan, which should consider various treatment options, including treatment in the community.

Inpatient admission in district hospitals must be seen as a valid treatment option.

The four psychiatric institutions will be gradually downscaled, in parallel with the development of community services. Some of the strategies that would be introduced are:

- Provision of alternative residential facilities matching care with the needs of institutionalised patients. In the four institutions there are about 2,000 inpatients who could be managed in alternative residential care in the community rather than the hospital. These ‘long stay’ patients could be classified into different levels of need: high level support; low level support; respite care; group home.

- Reduced referrals from the mainstream psychiatric units and departments. Setting up small acute units in district hospitals (10 to 20 beds) to provide comprehensive services, with acute beds, outpatient care, rehabilitation and outreach programmes. By having smaller psychiatric departments in hospitals and using these as a base to incorporate ‘hospital-based community psychiatry services’ referrals or admission to the psychiatric institution should be prevented and could provide management nearer to home, with easy accessibility and gradually minimising associated stigma.

- In future, psychiatric institutions in the country would provide “forensic psychiatry” services and care for those individuals with serious illnesses and significant co-existing conditions in whom community treatment has failed.

- There is a need to increase the budget allocation for the purchase of newer generation psychiatric drugs that have a better safety profile and are better tolerated by patients.

- Community psychiatry services need to participate in research especially in the area of service delivery, to look into the effectiveness of the different service delivery models in Malaysia.

A BEST PRACTICE EXAMPLE

HOSPITAL-BASED COMMUNITY PSYCHIATRIC SERVICES IN A PSYCHIATRIC INSTITUTION – HOSPITAL BAHAGIA ULU KINTA, PERAK

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

HOME-CARE SERVICES

In March 2001, HBUK started home-care services, which aimed to provide continuous and comprehensive services at home, catering for the needs of the patients and carers. The specific objectives are to:
- Provide treatment and rehabilitation to psychiatric patients.
- Enlist family members in the management of patients at home, improving communication and problem-solving skills.
- Reduce relapses and re-hospitalisation to less than 30%.
- Promote adherence to medication and illness self-management for which the compliance rate should be more than 60%.
- Provide supported employment (job search, job match and job coach) for at least 10% of the patients.

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

The home-care services in HBUK consist of 5 components: (a) Acute home care; (b) Early discharge program (EDP); (c) Assertive community treatment (ACT); (d) Family intervention programme (FIP); and (e) Follow-up services for stable cases with complex needs.

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

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

Community Awareness & Carers Support
MONGOLIA

The Law of Mongolia on Mental Health was adopted in 2000. It emphasised mental health promotion, community mental health care, accessibility to care, rights of the mentally ill person and their legal representatives, forced hospitalisation, provision of security and social welfare assistance for mentally ill people and inter-sectoral collaboration (Mongolian Government, 2003).

In 2002, the National Mental Health Program was formulated. This program, implemented between 2002 and 2007, emphasised reorientation of mental health care in accordance with WHO recommendations. It aimed to reduce the prevalence of mental and behavioural disorders and address the needs of people currently living with mental illness. Components addressed in the policy and plan include: developing community mental health services; developing a mental health component in primary health care; human resources; advocacy and promotion; human rights protection of mentally ill people; financing; quality improvement and monitoring systems.

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

However, the suicide rate has increased to a high prevalence level compared to other countries (17.6 per 100,000 population), and the number of mental and behavioural disorders and average length of stay in psychiatric inpatient care has increased.

Currently, Mongolia spends 2% of its total health budget on mental health. Within the mental health budget, funding is mainly directed towards mental hospitals, accounting for 64% of all mental health expenditure. All severe and some mild mental disorders are covered by social insurance schemes. Nearly 60% of registered patients with severe and some mild mental disorders are eligible for essential psychotropic medicines. However, provision of essential psychotropic medicines is very difficult in provinces. When general practitioners prescribe psychotropic medicines for mentally ill patients, pharmacies discount 10% of the retail price. Patients who attend private clinics have to pay the full price.

86% of all psychiatric units within general hospitals have at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic and antiepileptic medicines) available in the facility. Primary health care nurses are not allowed to prescribe psychotropic medications. Primary health care doctors are allowed to prescribe with some
restrictions, such as only 10 daily doses at a time. A few (1–20%) physician based Primary Health Centres have at least one psychotropic medicine of each therapeutic category available in the clinic or at a nearby pharmacy.

The mental health system in Mongolia is still largely hospital-based. Mental hospitals treat 17.7 patients per 100,000 population and have an occupancy rate of above 80%. The majority of beds are provided by stand-alone mental hospitals, followed by community-based psychiatric inpatient units. The density of psychiatric beds in or around the largest city is 1.6 times greater than the density of beds in the entire country. This distribution of beds limits access to mental health services for rural users. Inequity of access to mental health services for other linguistic, ethnic or religious minority users such as the Kazak, Burjat, Tsaatan, or Durdung people, is of moderate concern in the country. However, the equity of access to mental health services is an important problem for many groups in Mongolia (WHO 2006).

There are now 35 outpatient facilities, seven day care centres and about twelve residential (tent-based) programmes which provide occupational rehabilitation and residential services, with sixty beds for patients with chronic mental illness. Mongolian mental health care is delivered on three levels – primary, secondary and tertiary. Access to mental health facilities is uneven across the country, favouring those living in or near the capital city of Ulaanbaatar.

There are only seventeen mental health professionals per 100,000 population. There are very few psychiatrists, psychologists and occupational therapists and no social workers. There is a disproportionate distribution of human resources, with more mental health professionals working in or near the main city than in the rest of the entire country. Post-graduate psychiatric education includes residential training (one to two years), Masters degree courses (two years), Refresher training courses (two to three months), Ph.D. (three years) and scientific degrees – Dr. Sc. Med.

Regular training of primary care professionals in mental health takes place. Over the last five years, about 67% of all primary health professionals attended training in Primary Mental Health Care. Training programs for primary care doctors in treating mental disorders are available as well as prescription of psychotropic medication.

There are two consumer associations, the ‘AA’ group and the Association against Alcohol and Substance Abuse, however there are no family associations. In addition to legislative and financial support, there is formal collaboration between the government departments responsible for mental health and primary health care/community health, HIV/AIDS, child and adolescent health, substance abuse, child protection, education, employment, housing, welfare, the elderly and criminal justice.

It is necessary to develop community mental health services and to implement best practice in the Mongolian Mental Health System. The best practice in community mental health has shown that it is possible for patients with mental illness to recover in the community, that relapses can be reduced, that the individual can be protected from mental illness and assisted to cope with stress, and that the media can promote increased knowledge and skills about mental health. In addition, it is recognised that mental health services should not work alone to develop community services but should involve and collaborate with consumers, families, the community, NGOs and international organisations to achieve mental health service development.
**A Best Practice Example**

**Ger Project**

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

**Method of the Ger Project**

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

**Referral Process**

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

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![Referral Process for the Ger Project, Mongolia](image)
ACTIVITIES
On their first day at the Ger project, the psychiatrist, nurse and occupational therapist assess the patient’s life skills, self care and social life to determine what activities will benefit them. The occupational therapist and nurse, who have attended psychosocial rehabilitation training for one to three months, are responsible for teaching and monitoring the patient’s physical exercise and relaxation, life skills, self care and vocational skills (eg. handy-craft, vegetable-growing, other vocational training, gardening, carpentry and embroidery).

The Ger project also provides psycho-education, counselling, continuing psychiatric treatment and family support for patients and their families. The psycho-educational program provides patients and their families with information about mental illness, coping skills and how to manage stress. The Ger project not only includes medical services, but also employment services, social welfare and transportation services.

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

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

INSPIRATIONS AND LESSONS LEARNT
The Ger project successfully delivers psychosocial programs close to the patient’s home at the district level. Key advantages include the low cost of Ger, its mobility and the reduction of stigma and discrimination through the involvement of the community and families. But advocacy at the government level is important for the sustainability of the project.
SINGAPORE

Singapore’s mental health system began with the establishment of Woodbridge Hospital in 1928, a mental asylum where patients once admitted were expected to stay on indefinitely till they recovered sufficiently, with less than ideal rehabilitation offered. In the last two to three decades, the mode of service delivery evolved to an increasingly community-based delivery, beginning with the establishment of Day Centres and the Community Psychiatric Nursing programme. The pace of change accelerated from the nineties onwards, after the hospital was moved into a modern new building and new service programmes were developed.

With the move in 1993, the hospital’s name was changed to the Institute of Mental Health and Woodbridge Hospital, signifying its focus on training, mental health education and research. Expansion of mental health services also took place in the last two to three decades, with the opening of departments of psychological medicine in five general hospitals. Such a development augurs well for the mental health service as service options and accessibility improved considerably as mental health services moved closer to the community.

The Mental Health Policy, drawn up in 2005, signified a watershed milestone in Singapore, with the aims of (a) promoting mental health and where possible, preventing the development of mental health problems and disorders and (b) reducing the impact of mental disorders. The National Mental Health Blueprint for 2007 to 2011 was developed soon after, focusing on mental health education, integrated mental health care, developing mental health professionals and developing mental health research.

Funding has been committed to the Blueprint, while key performance indicators for each programme are specified. The government's support for mental health service development is inspirational and unsurpassed. Community-based mental health care is essentially subsumed under the integrated mental healthcare component.

Over the last decade, the in-patient census of IMH has reduced gradually as proactive measures are taken to discharge long-stay patients to the community where possible. Similarly, new patients are actively treated and rehabilitated in the community to prevent institutionalisation and the creation of 'new long-stay patients'. An emphasis on community psychiatric care is the logical direction to take, for psychiatric hospitals cannot and should not, continue to grow in size, to accommodate patients who should rightly live and work in the community as far as they are able to. Almost all patients prefer to live a free and unfettered life in the community, and as such, mental health professionals should assist them to achieve this aim in so far as it is safe and appropriate to do so.

There remain a significant proportion of patients who are difficult to discharge back to the community, for intrinsic reasons peculiar to Singapore, such as the prevailing cultural attitudes towards psychiatric patients, and the society’s expectations of public psychiatric services which are deeply
entrenched and different from those of other countries. Paradigm shifts and cultural change need
time to take effect. Patience is required for the public to be educated and trained, the community
support services to be gradually enhanced and the community residential facilities to increase.

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

The Blueprint is helping to galvanise the development of community-based programmes with
the establishment of community mental health teams for patients of all ages. For children and
adolescents, multidisciplinary teams work closely with school counsellors to detect and manage
early problems in schools. For adolescents and young adults with early psychosis, the EPIP (Early
Psychosis Intervention Programme) trains frontline staff of schools and social agencies, as well as
primary care physicians, to identify/detect early psychosis and refer them to EPIP for early treatment.
For adults with established serious mental disorders such as schizophrenia, multidisciplinary
community mental health teams support them in the community with case management, home
visits, psychosocial rehabilitation and crisis management in their homes. For the elderly, community
psychogeriatric teams work with social agencies and primary care physicians to detect and manage
the elderly with mental disorders, either in their own homes or at clinics in the community. For those
with addiction disorders, the Community Addiction Management Programme (CAMP) manages the
patients in the community with a multidisciplinary team.

While Singapore's psychiatrists had not, in the past, courted the participation of general practitioners
(GPs), the scenario is now changed to an emphasis on 'right siting of care' where GPs are trained to
detect and manage early psychiatric disorders, and to take on the management of stable patients on
a long-term basis. Interested GPs are being trained in a structured programme, and there are plans for
a graduate diploma in psychological medicine for family physicians.

The National Mental Health Blueprint will assist the community-based programmes to evolve and
strengthen into an indispensable feature of Singapore’s public mental health service, while the state
psychiatric hospital can enhance its role as a tertiary institution that treats treatment-resistant cases,
trains mental health professionals and embarks on meaningful research. With the current concerted
multi-disciplinary tracking of imminent new long-stay patients, it is expected that the size of the long-
stay population of the future will be contained.

A robust community mental health programme requires the requisite number of mental health
professionals to drive and deliver. The Blueprint has highlighted the lack of mental health
professionals in the country and measures are underway to improve the situation. At 2.5 psychiatrists
per 100,000 population, Singapore needs to double its existing 100 plus psychiatrists within the next
10 years.

While Singapore is aware of how the rest of the world is moving in terms of rapidly downsizing the
psychiatric hospitals and will continue to learn from them, it needs to develop at its own pace in
relation to its own needs and intrinsic differences.
A BEST PRACTICE EXAMPLE
EARLY PSYCHOSIS INTERVENTION PROGRAMME (EPIP)

The Ministry of Health awarded Singapore’s Institute of Mental Health a special 5-year fund in 2001 to run the EPIP, a programme to provide early intervention for young adults and tertiary students with emerging mental illnesses within the community. EPIP offers 3 key activities: a) provision of clinical services to persons with early psychosis; b) training to frontline staff in schools and social agencies to allow them to identify young people with mental health problems; and c) training of primary care physicians to conduct initial screening and to manage stable persons with mental health problems.

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

Although historically Singapore’s primary care physicians had not been involved in the management of mental disorders, EPIP managed to engage their participation through training in diagnosing psychoses and referral to EPIP for timely intervention. Patients identified with other mental health problems are either managed by the primary care physicians, or are referred to public hospitals. They are also trained to manage stable patients from EPIP for continued treatment. A support system of telephone/email consultations for EPIP’s community partners has been established.

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

EPIP is widely acclaimed as a successful community-based programme which was recognised internationally by WHO and awarded the inaugural State of Kuwait Prize for Research in Health Promotion in 2006. It has shown a significant reduction in patient default rates, with improved functioning and increased employment of patients. Based on the success, EPIP has been continued beyond the 5 years, to allow for expansion of the programme nation-wide. It blazed the trail in Singapore’s mental health service in training and deploying case managers and primary care physicians in its programme.

Current challenges faced by the programme include the engagement of non-traditional healthcare providers (i.e. folk and religious healers) who are seeing a number of individuals when they first present with mental disturbances, and persuasion of employers/educational institutions in Singapore to accept individuals who have received or are receiving psychiatric treatment.
The existing mental health network has been extended to meet the varied community mental health needs of a rapidly changing society such as a shared-care program for people with common mental disorders, early intervention for children, drug abuse prevention, suicide prevention and disaster mental health. Community-based mental health care can be embedded in the process to mobilise different resources and empower the community for developing various programs.

Covering a total area of nearly 36,000 km², Taiwan is a long, narrow island separated from the Chinese mainland by the 200 kilometre wide Taiwan Strait. It has a population of 22.7 million, the majority of whom are Han, however Taiwan is home to many ethnic groups including an aboriginal population which makes up 2%.

The Taiwanese Mental Health system was poorly developed until the end of the 1970s, at which time the first survey of the mental health service was conducted by Dr. Eng-Kung Yeh. Completed in 1980, the survey revealed a lack of care facilities (4.0 psychiatric beds per 10,000 population) and a shortage of professional personnel (0.1 psychiatrist per 10,000 population). At the same time, the Taiwan Psychiatric Epidemiology Project showed a very high prevalence of various mental disorders amongst the general population. In response to these findings, the Department of Health granted a 15-year project to establish a mental health care network for the provision and distribution of adequate services throughout Taiwan (1986–2000).

At the commencement of the project, the various geographical and administrative districts over Taiwan and off-shore islands were divided into seven catchment areas. A main treatment centre was established within each catchment area, aiming to develop and extend services into the community, including in-service training of health care professionals. The majority of the mental health facilities established were done so according to the specifications of the project. These facilities included community mental health services that were mostly based on Yeh’s experience of Taipei City Psychiatric Center (TCPC) as part of the comprehensive hospital care system. In the meantime, manpower from public health sectors was mobilised to overcome the shortage of community mental health personnel. Yeh’s proposal achieved remarkable success, not only in terms of building the capacity of facilities and manpower, but also transforming two Yuli mental hospitals, which previously provided custodial care in remote areas, to modern comprehensive mental health care centres.

At the time of writing (March 2007), Taiwan has 37 psychiatric hospitals with 19,127 psychiatric beds (6130 acute beds and 13132 chronic beds; 2.6 and 5.5 beds per 10000 populations), of which 55.9 % are located in public hospitals. Psychiatric day care centres are available in all psychiatric hospitals, regional hospitals and some district hospitals. In addition, 61 community rehabilitation centres and 81 half-way houses operated by psychiatric institutions or non-professional groups provide community care for people with severe mental illnesses.
Two major noteworthy events made such developments possible: the Mental Act enacted in 1990 and the National Health Insurance (NHI) launched in 1995. The former, amended in July 2007, represents a significant advance as it ensures the protection of human rights and calls for ethical practice of all mental health professionals. The NHI reimburses a wide range of medical expenditure related to the treatment of mental illnesses, including the fees of psychiatric rehabilitation. People with severe mental illnesses such as schizophrenia and bipolar affective disorder may not need to provide the co-payment, which usually constitutes 10% of the total medical expenses.

The existing mental health network has been extended to meet the varied community mental health needs of a rapidly changing society such as a shared-care program for people with common mental disorders, early intervention for children, drug abuse prevention, suicide prevention and disaster mental health. Community-based mental health care can be embedded in the process to mobilise different resources and empower the community for developing various programs.

Whilst it is true that community mental health services have been comparatively less developed so far, there are reasons to be optimistic about the future. For example, there is a new trend of social empowerment and community participation which may facilitate the development of community mental health services. Further, in a rapidly changing society like Taiwan, mental health issues which can trigger contemporaneous socio-political and institutional changes are likely to receive public attention and result in many mental health programs. Such can be seen from the experience of Taiwan’s mental health transformation in the 1980s.
THE WAY FORWARD

Undoubtedly, there is a clear need for national and global initiatives to address mental health issues. Actions required to move forward include:

- Conducting epidemiological studies to clarify the mental health needs of the population.
- Strengthening community alliances through defining and specifying key issues of interest to the broader society.
- Forming mental health policies and strategies.
- Addressing primary prevention of mental disorders and mental health promotion to change the deep-rooted negative public attitude.
- Demonstrating evidence of system changes by outcome research.

A BEST PRACTICE EXAMPLE

THE TAIPEI CITY PSYCHIATRIC CENTER (TCPC)

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

SPECIFIC LOCAL AND CULTURALLY ADAPTED COMMUNITY SERVICES

The key element of the “Taipei Model” is to build up a network between the hospital and the public health sector, and to facilitate follow-up visits by public health workers from 12 district health institutes to patients with severe mental illness discharged from the TCPC. Mentally ill patients are continuously tracked, evaluated and treated in a hierarchical style of management. Utilisation of other social resources is made as individual needs differ. Health information and resources related to disease, drugs, family planning and occupational rehabilitation are given to individuals and family members. The psychiatrists from TCPC, as well as core hospitals in the city, provide a range of supervision in a fixed-term period. The involvement of public health nurses in the assessment, planning, implementation, and evaluation of the community psychiatric services has been a key success in the “Taipei Model”.

INTERACTION WITH OTHER STAKEHOLDERS

Based on the experience and the original infrastructure for the patients with severe mental illness, TCPC extended its services to the following arenas:

1. Taipei City Depression Collaborative Care System

To provide optimal treatment for people with common mental disorders, TCPC initiated the Taipei City Depression Collaborative Care System under the endorsement of the health authorities of the city government in 2003. Primary care physicians, mostly internists and family medicine specialists, were invited to participate in the training workshop to form an inter-division and inter-professional network. In 2005, all of the municipal hospitals and 177 primary care clinics joined the collaborative care network while TCPC continued its role to provide educational courses. In addition, the executive board continued to facilitate referral between mental health services and primary care, and to negotiate with National Health Insurance for a study project looking at incentives and outcomes of the program.
2. Individual Psychological Consultation Services
In July 2005, the TCPC commenced “individual psychological consultation services” at the 12 district health institutes, which made psychological consultation available, affordable and easily accessible for the community.

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

4. Service model for drug abuse in TCPC
The harm-reduction anti-drug policy (i.e., methadone maintenance program) has been introduced to the community since 2006 when the number of HIV-infected patients (mostly needle-sharing heroin users) sharply increased.

Starting from 1993, TCPC has built a rehabilitation model which includes physical detoxification, psychological rehabilitation and follow-up counselling. At the same time, an information system has been established to monitor the trends of drug abuse.
THAILAND

Community mental health (CMH) 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.

Thailand is a low to middle-income country located in Southeast Asia with a population of 62.8 million. Of the total disease burden for Thailand, alcohol dependence or abuse ranked third for men, and depression ranked fourth for females (WHO 2004). In 2004, the suicide rate was 5.7 per 100,000 people.

The Department of Mental Health (DMH) under the Ministry of Public Health (MoPH) is mainly responsible for strategic planning and a national mental health policy which was last revised in 2007. Mental health legislation was enacted in 2008. It aims to develop positive mental health for Thai people by focusing on the following strategies:
- academic and technical development through research and knowledge management;
- empowerment through integrating mental health care into the public health system as well as strengthening the mental health network;
- building the capacity of mental health personnel; and
- reforming the health management system.

The Department of Mental Health accounts for approximately 3.8% of total Government health care expenditure. Health insurance covers 96% of the Thai population; 74.3% of the national universal coverage includes the cost of mental health care.

Mental health services in Thailand were established in 1889, when the first psychiatric hospital began operating, followed by many regional hospitals throughout the country. In 1976, the ‘Monitoring Mental Health Needs’ project (in cooperation with WHO), demonstrated the need for community mental health services. As a consequence, mental health services began to extend from psychiatric hospitals to the public health care 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.

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

Primary mental health care at the village level is provided by village health volunteers, who are the main community mental health care personnel and who encourage community participation in mental health activities. At the sub-district level, primary care units and health centres staffed by health personnel provide primary medical services, including mental health screening and monitoring to ensure psychiatric continuity of care. Community hospitals at the district level and general hospitals at the provincial level provide outpatient services for common psychiatric disorders, continuity of care for chronic patients and mental health care to general hospital patients. Specialised comprehensive psychiatric care is provided by regional hospitals, university hospitals and psychiatric hospitals or institutes. Total psychiatric beds number 8,700 (13.8 beds per 100,000 population) with 9% of beds reserved for children and adolescents.
Mental health care at each level includes not only psychiatric care and rehabilitation, but also covers mental health promotion and prevention. The principle of community mental health is that the service is provided to the community, in the community, with community participation and suited to community needs. Community mental health has been extended to networks outside the health system, including schools, temples and community authorities. Thus the community itself is part of community mental health care. The goal of community mental health care is not only providing continuity of care for psychiatric patients, but also supporting them to stay in their own community. Cooperation with the community authorities is an important factor for the success of community mental health activities.

Community mental health services are provided by a network of health personnel. As there are only 0.7 psychiatrists per 100,000 population, an emphasis on capacity building for local health personnel and the community network is crucial. Psychiatric hospitals and institutes, and the regional mental health centres under the Department of Mental Health have a key role in empowering the local community mental health network to integrate mental health into their services; and to provide training for health personnel to strengthen and sustain the effectiveness of the community mental health system.

Community mental health has been expanded to cover the population across their lifespan, and includes community mental health care for difficult patients, the school mental health program, the community-based mental health project and crisis mental health intervention following the Tsunami.

Due to the lack of specialised personnel and budget, emphasis is placed on human resource capacity building, especially the development of psychiatric nursing at the district level. Through national universal insurance coverage, the cost of mental health care is allocated to the local health facilities responsible for providing services.
In improving community mental health services, the approach in Thailand should focus on the following areas:

- Development of an optimal mix of services, particularly more community mental health services such as community-based rehabilitation services, hospital diversion programs, supervised residential services, home health and community crisis services.
- Strengthening the capacity of local community mental health networks. Although the health service system infrastructure supports integrated mental health care, comprehensive coverage and efficiency are still limited due to the prioritisation of inpatient facilities.
- Implementation of mental health service standards across all levels of care facilities, to ensure that people receive quality mental health care close to their homes.
- Regular provision of psychotropic medication in local health facilities, at least at the community hospital level. Due to the unavailability of psychotropic medication in local health facilities, medication is discontinued for many chronic patients which results in relapse. Programs emphasising continuity of care with the collaboration of local health facilities and the community should be implemented consistently.
- The non-health community network system should have a greater focus on mental health with more emphasis on reducing stigma and discrimination against mentally-ill patients and their families.
- Community mental health services should work through the local authority administration to ensure long-term sustainability and to meet community needs.

A BEST PRACTICE EXAMPLE

CRISIS MENTAL HEALTH INTERVENTION FOLLOWING THE TSUNAMI

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

OBJECTIVE
To provide mental health support for survivors of the Tsunami.

STRATEGY
To establish a mental health care delivery system in collaboration with other organisations and community networks.

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

  The ‘Mental Health for Thai Tsunami Centre’ was established in the Department of Mental Health and a front-line centre was established in the South to facilitate daily teleconferences for developing work plans and reporting data for policy and decision-making.
**Post-Impact Phase** (two weeks to three months after the Tsunami)
The aim in this phase was to provide mental health assessment and early intervention. Outreach services focused on ‘At Risk’ groups. The most severe cases were referred to psychiatric centres. The Ministry of Public Health established a ‘Surveillance Centre’ in the South to coordinate service activities and develop health monitoring information systems including general health, disease control, physical and mental health care and identification of dead bodies.

**Recovery Phase** (three months after the Tsunami)
The aim in the Recovery phase was to reduce psychological morbidity and improve quality of life. The ‘Mental Health Recovery Centre’ was established in the most seriously affected area, to collaborate with other organisations involved with mental health rehabilitation.

**IMPACTS OF THE TSUNAMI**
Collaborative research between the DMH and the US Centre for Disease Control and Prevention Collaboration to assess the mental health problems among adults in affected area, found an elevated rate of Post-traumatic Stress Disorder (PTSD), anxiety and depression two months after the Tsunami. At follow-up after nine months, the rates of these symptoms decreased. The DMH developed a 'National Guideline for Mental Health Intervention in Natural Disasters’ based on the lessons learnt from the response to the Tsunami.

**KEY SUCCESS FACTORS**
- A well-established chain of command.
- A well-developed existing health and mental health care delivery system with the village health volunteer network working in the community.
- A comprehensive data and information gathering system.
- Participation of partners – teachers, monks, etc.

**LESSONS LEARNT**
- One commander-in-charge minimises staff confusion.
- A lead coordinator should be identified to work with the different organisations involved to prevent secondary trauma from repeated interviews.
- Mental health interventions should be appropriate for each phase or time period.
- Health personnel should be sensitive and aware of the beliefs, religion and culture of the local people.
- The Centre should report all urgent physical needs other than mental health to the organisations responsible for meeting these needs.
- The mobile team should be rotated every week and work less than twelve hours a day to prevent burnout.
- The Village Health Volunteers should be the main personnel to deliver psychosocial relief efforts to the community.
Currently in Vietnam, there are thirty psychiatric hospitals, including three major on-call duty centres which are run by the National Psychiatric Hospital No 1 (NPH1), National Psychiatric Hospital No 2 (NPH2), and the Bach Mai Mental Health Institute. Twenty-seven provinces in Vietnam have hospitals with psychiatric services, of which twenty-six are also involved in prevention of public health-related illnesses. In addition there are five independent psychiatric centres.

The Ministry of Labour, War Invalids, and Social Welfare currently manages a total of 5000 psychiatric beds and 2500 beds for serious mental illness nation-wide (for chronic mental illness). There are 850 doctors with varying levels of specialty training ranging from certificates of mental health diagnosis to higher qualifications, as such there is a ratio of one mental health doctor for every 100,000 people. Within this group of doctors there are also 169 post-graduate doctors, and a cadre of twelve doctors who are trained in mental health screening. Eight courses in psychiatry are offered at eight medical universities.

Medical universities no longer train doctors with certificates of mental health diagnosis, and will only train doctors with level 1 or 2 specialty or masters degree and higher. As a result, the task of training doctors with certificates of mental health diagnosis essentially falls on the responsibility of NPH1 and NPH2, to meet the shortage of workforce in the mental health field.

In 1976, the 15/CP decree was announced by the Vietnamese Government which signalled the creation of an integrated mental health network between the provinces that would enable a united approach to mental health. In 1998, Prime Minister Phan Van Khai approved the mental health resolution for a national community-based project called the Community-based Mental Health Care Project (CMHCP). The NPH1 is the focal point for this project in terms of planning, management and reporting for the Ministry of Health. The NPH1 organises training courses and conferences for an annual review of CMHCP activities conducted by all province hospitals and other mental health centres.

Vietnam is aiming to implement a treatment model currently applicable to government/public hospitals. All patients referred to the hospital would be adequately screened and assessed before being admitted to hospital. During admission, specialist assessment, monitoring and effective treatment is commenced. The care and treatment regime/schemes like medication assistance, hospital fee assistance etc. are provided through government support. Prior to discharge, patients will receive rehabilitation in hospital, and be engaged in activities to integrate them back to the community. Post-discharge, medication, follow-up treatment, work support and guidance in the community would be provided by CMHCP.
A BEST PRACTICE EXAMPLE
COMMUNITY-BASED MENTAL HEALTH CARE PROJECT (CMHCP)

OUTCOME OF THE PROJECT IN 2001–2005
(According to resolution 190/2001/QDTTg, signed by Deputy Prime Minister Pham Gia Khiem 13/12/2001)

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

1: EPIDEMIOLOGICAL DATA
Results of the epidemiological study of 10 common psychiatric illnesses from 2001–2003, are as follows: Schizophrenia 0.47%; Epilepsy 0.33%; Head Trauma/Post-concussion syndrome 0.51%; Mental Retardation 0.63%; Dementia 0.88%; Major Depressive Disorders 2.8%; Anxiety Disorders 2.6%; Conduct Disorders in Adolescents 0.9%; Alcohol Abuse 5.3%; Opioid abuse 0.3%; and a total percentage of 14.9%.
2: GENERAL PROGRESS AND SETBACKS

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

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

General conclusion of the Project:
- The Project has created a driving force for the development of networks and services for mental health in the community, covering the whole country (64 provinces).
- The priority is to increase public awareness of mental illness, early detection and access to treatment centres. Therefore, there are better opportunities for patients to be re-integrated in the community without neglect or abuse.
- The Project has also enabled psychiatric patients from remote areas to benefit from CMHCP. Serious mental health illnesses like schizophrenia, epilepsy and depression could be diagnosed and treated without cost to families.
- The achievements have been possible due to the attention to mental health given by The Party, Congress, Government and Ministry of Health, as well as the hard work and dedication of the mental health cadres.

GENERAL TARGET OF THE PROJECT DURING THE PHASE 2006–2010

The next stage of the project aims to increase the quality of services for people with mental health problems. Although the emphasis during the period of 2006–2010 is still on schizophrenia, there are plans to include other non-transmissible illnesses (e.g., epilepsy and depression) within the CMHCP. From the end of the 20th century, in line with WHO recommendations, many countries have stopped building large scale psychiatric hospitals to increase the management of psychiatric illnesses in the community. This is consistent with the aim of CMHCP. Other future strategies of the project would include: establishing mental health counselling centres or telephone helplines; increasing mental health service research to improve quality of care; increasing community mental health care; advocating for the development of Mental Health legislation; increasing international collaboration; and from 2008 to expand mental health care for children and older people. As there is currently only a small capacity to train mental health cadres and social workers, there is a great need to build up the workforce to meet the needs of people with mental health problems.
SECTION 3: CONCLUSION AND RECOMMENDATIONS FOR FUTURE DIRECTIONS

CONCLUDING REMARKS

The Asia-Pacific Community Mental Health Development Project provides impressive evidence that throughout the Asia-Pacific region, there is increasing emphasis on system-wide reform in community mental health care rather than a series of localised and uncoordinated initiatives. Legislation, government policy and service standards are being established to support such mental health reform. Increasing resources are being directed to the provision of community-based services, including the expansion of mental health workforce training (medical practitioners, nursing and allied health workers) in community-based services, as well as training of primary health care and community workers in basic mental health care. There is increasing recognition of the human rights of mentally ill people throughout the region while steps are being taken to increase consumer and carer involvement. Emphasis is also given to strengthening inter-sectoral links such as social welfare, housing, employment and education. Overall the reports put emphasis on: significant progress made within each country/region; the commitment of the mental health leadership and staff to increase community-based services; and the shared vision between countries for continuous improvement of mental health care.

The Project has showcased the current status of community mental health systems in each participating country as well as the innovation of a number of best practice community care models for people with mental illness found in the region. Contained within the rich materials of the full reports are also the future plans and roadmaps to extend the current capacity within each country/region through building on the existing strengths of the respective community mental health models and system. As such local advances are analysed and better understood in terms of translating into future practical improvements in service delivery, there are positive implications and the potential for constructive development for the rest of the region. However, the process has in fact only just begun, and much more needs to be done. There is considerable consensus in the region on the guiding principles and ingredients for successful implementation of community mental health care and also what is necessary and essential to meet future challenges.
There is currently strong evidence and support in the Asia-Pacific region for a shift from institution-based care to community care, thereby allowing greater autonomy and achieving the best possible quality of life for people with mental illness. The consensus of the participating Asia-Pacific countries is that the region needs to continue to strengthen its commitment to developing adequate and appropriate community mental health services within their mental health systems. To this end it is critical to advocate for increased priority and sufficient resources to build and scale up cost-effective models of community mental health care throughout the region. Strong health policy, governmental commitment and political will are required to move from a predominantly hospital-based to a community-based mental health care system in the region. The learning derived from the existing local experiences and best practice models in community mental health can inform future policy and service system development within and across different countries.
RECOMMENDATIONS FOR FUTURE DIRECTIONS OF THE ASIA-PACIFIC COMMUNITY MENTAL HEALTH DEVELOPMENT NETWORK

The long term goals of the Asia-Pacific Community Mental Health Development Project are to build the capacity of mental health systems, and implement policy and services that contribute actively to the development and improvement of community mental health care for people with mental illness in Asia-Pacific region. In addition to learning from the information sharing via the project, inter-country exchanges are encouraged to promote knowledge transfer through direct experiences of best practices and different models of community mental health care. Ideally benchmarks and targets need to be developed for each country/region to track the progress made respectively. At the same time, data and outcome research on the impact of community care is highly essential to inform appropriate policy change and strengthen further service reform.

The network of key participants developed through this project can help Asia-Pacific mental health leaders and organisations to engage in positive community mental health service reform. The functions of such a network could include:

1: Promoting innovations and best practice in community mental health policy, models and service delivery to address the diverse needs of Asia-Pacific cultures and local regions.
2: Strengthening the capacity of government, non-government mental health organisations and multi-sector mental health stakeholders to carry out community mental health reform.
3: Promoting mental health services research and evaluation that will contribute to improved service design and implementation.
4: Building an ongoing database of evidence-based and practical experience in the Asia-Pacific region that will inform future policy and practice of quality mental health care in the community.

Proposed future activities of the network could include:

1: Collaboratively arranging exchange study visits to best practice sites in community mental health services or centres of excellence within and between countries in Asia-Pacific to share the learning gained from another site.
2: Setting up and organising regular conferences or meetings for a regional network of mental health leaders and representatives of key organisations around community mental health development projects in the region.
3: Contributing to the development of guidelines in community mental health promotion, best practice and treatment, service standards and evaluation methods.
4: Establishing a website that hosts an on-line database of the community mental health care projects and activities documenting strengths and challenges that can be shared across the region.
REFERENCES


Full references of the Summary country reports are found in the Full Country Reports. These are currently available on the website: www.aamh.edu.au
Artworks by people who experienced mental illness have been included in this publication to remind us of the individuals we are trying to help. These artworks tell the story of personal experiences of mental illness in different countries. We are grateful for their contributions. Non-exclusive copyright licences to publish these images have been obtained from the artists or their family (in a situation where the artist is deceased). The name of each artist and their illness is published only when they have given their consent.