REPORT

REGIONAL WORKSHOP
ON FUTURE DIRECTIONS OF MENTAL HEALTH SERVICES
IN THE WESTERN PACIFIC REGION

Manila, Philippines
2-6 October 1989
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Convened by the

REGIONAL OFFICE FOR THE WESTERN PACIFIC OF THE WORLD HEALTH ORGANIZATION

Manila, Philippines, 2-6 October 1989
NOTE

The views expressed in this report are those of the participants of the Workshop on Future Directions of Mental Health Services in the Western Pacific Region and do not necessarily reflect the policies of the World Health Organization.
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1. INTRODUCTION

The Workshop on Future Directions of Mental Health Services in the Western Pacific Region was held from 2 to 6 October 1989 at the WHO Regional Office for the Western Pacific in Manila.

Dr Liu Guo-bin, Director, Programme Management, opened the meeting on behalf of Dr S.T. Han, Regional Director.

In his opening speech, the Regional Director observed that the benefits of recent scientific achievements in psychiatry, such as psychopharmacotherapy and appropriate psychological support, have not been made available to the majority of the patients in developing countries. He noted, however, that there had been several promising developments in recent years to organize humane, cost effective and socio-culturally relevant mental health services.

He stressed the importance of reviewing recent progress, exchanging views and formulating principles and courses of action in order to develop new directions for mental health services.

The opening speech of the Regional Director is attached as Annex 1.

The workshop was attended by 18 participants from 11 countries and areas and one observer. Three participants from China were unable to attend due to unforeseen circumstances.

Dr Anthony Williams, Australia; Dr Lourdes L. Ignacio, Philippines; Dr Pierre Bailly-Salin, France; and Dr Susumu Maruyama, Japan provided technical support as consultant and temporary advisers.

The list of participants, temporary advisers, consultant, observer and secretariat is attached as Annex 2.

In the opening session, the Acting Regional Director proposed the following nominations as Chairperson, Vice-Chairman and Rapporteurs, which were unanimously accepted:

Chairperson: Dr Brigida Buenaseda, Philippines
Vice-Chairman: Dr Ezekiel Nukuro, Solomon Islands
Rapporteurs: Dr Veer Indra Singh, Fiji

Dr Selvadurai Jeyarajah, Malaysia

The agenda of the meeting is attached as Annex 3.
2. OBJECTIVES OF THE WORKSHOP

The objectives of the workshop were:

(1) to review the current situation in the Region with regard to the organization and delivery of mental health services for schizophrenia and other similar mental disorders;

(2) to evaluate the effectiveness of past and ongoing activities in the development of services for schizophrenia and other similar mental disorders in countries and areas of the Region;

(3) to identify appropriate strategies to be used for improving the case management of schizophrenia and other similar disorders with special reference to pharmacotherapy, family support, community care and institutional care;

(4) to develop plans for future activities and necessary action at national levels.

In the objectives, the words "schizophrenia and other similar mental disorders" were used to designate major functional disorders which tend to be chronic and recurrent.

3. REVIEW AND EVALUATION OF CURRENT SITUATION

3.1 The Western Pacific Region

The Western Pacific Region of the World Health Organization is one of great diversity in the geography, populations, politics and socioeconomic background of the various Member States. It includes the most populous nation in the world, China, and the least populated ones, the island states of the South Pacific. Ethnically there are areas of predominantly Mongoloid, Malays, Polynesian, Melanesian and Caucasian populations, some with a long history of civilization, some with more recent histories. Some areas of the Region have been significantly affected by elective migration, and movement of refugees.
3.2 Current WHO policies on mental health programmes in the Region

In the first few decades following its inception, the efforts of WHO have mainly been directed towards the prevention and control of communicable diseases. Mental health has been given a relatively low priority; however, in more recent years there has been collaboration with Member States to initiate and promote new directions of mental health services in three areas. These areas are as follows: the promotion of psychosocial aspects of health, the prevention and control of alcohol and drug abuse, and the prevention and treatment of mental and neurological diseases. Numerous meetings have been held during the last decade, and this workshop was convened to review recent progress, exchange views, and formulate principles and courses of action for the management of schizophrenia and other similar disorders. This review would be done at both regional and national level, with specific reference to developing countries.

The mental health programmes of WHO in the Region have developed a wide scope, characterized by a public health approach directed towards development of community-based mental health services.

3.3 Review of current situation in countries involved

The traditional psychiatric disorders such as psychoses place a heavy demand on family, community and health services in all countries. It has been estimated that 13.5 million people suffer from psychotic illness in the Western Pacific Region, a significant proportion of these people having schizophrenia.

In alphabetical order, the Member States attending the workshop will be briefly reviewed in terms of a description of current services, the major constraints, major thrusts and new approaches.

3.4 Brunei

The mental health services are coordinated from the two general hospital psychiatric units, as there is no separate psychiatric hospital. The services, still in their developing stages, were reorganized and updated in 1983, and have outpatient, day and inpatient facilities. The inpatient facilities have an open door policy. Most referrals suffer from psychotic illness, and attempts are made, where appropriate, to involve family members.

Popular community attitudes of fear and stigmatization of the mentally ill are seen to be major constraints in the delivery of services. The service has developed an aggressive follow-up programme with its community wing for defaulters, and a reported decrease in relapse rate.
3.5 China

In 1985, there were 348 psychiatric hospitals with more than 60,000 beds and 6,000 psychiatrists in China, a rapid development of staff and resources since 1958. A number of pilot schemes have been set up to evaluate comprehensive programmes of community mental health care in both urban and rural settings to help develop a model for services to meet the community needs in China.

Major constraints are the vast size of the country, its large population and uneven economic development in different areas. There has been difficulty in attracting skilled professionals to the rural areas, and developing adequate rehabilitation programmes in urban areas.

In 1985, the Mental Health Counselling Commission was established and a National Mental Health Coordinating Group is in the planning stage. China is moving towards establishing a three level network of services - province (city), county (district) and primary level (village, town, street or factory).

3.6 Fiji

Since a mental hospital was built in the capital city, nearly 100 years ago, it has remained the provider of psychiatric services for the whole of the Fiji Islands. Patients are admitted under mental health legislation via committal orders, and on discharge are followed up by local health services. The hospital runs an outpatient clinic, and a clinic is conducted also at the university teaching hospital.

The service is constrained by limited and centralized resources, and the absence of community participation in the management of psychotic disorders associated with attitudes towards severe mental illness.

3.7 Guam

The Department of Mental Health and Substance Abuse in Guam has a diversified comprehensive community based mental health service, which includes an inpatient unit, outpatient facilities, day and community residential facilities. Psychiatrists rotate through the service supported by the United States Federal Government, and other mental health professionals are employed by the Department.

With the rapid economic growth and development of the territory, much of Guam's multi-cultural values and traditions are under threat, with associated emotional problems and effects of substance abuse. Homelessness is emerging as a significant problem.
3.8 Lao People's Democratic Republic

Since 1980 neuropsychiatric consultations have been held in Mahosot Hospital in the capital city, and a four-bed unit was opened there in 1987. The small number of staff are involved in service delivery to the local area, and are committed to undergraduate nursing and medical student teaching, as well as seminars to educate health personnel and community leaders from the provinces.

The service is heavily constrained by its limited resources; however it is committed to family involvement in the management of its patients.

3.9 Malaysia

In the past, mental health services were provided through two large psychiatric hospitals in Peninsular Malaysia, but since 1959 a process of decentralization has been initiated with the establishment of smaller psychiatric units in some general and district hospitals at a provincial level.

Training in psychiatry at undergraduate and postgraduate medical and nursing education has been developed, although there remains a shortage of trained mental health professionals in the public sector.

3.10 New Caledonia

Mental health services in New Caledonia are situated in the capital and consist of a psychiatric hospital and a community based mental health dispensary. There are also private psychiatric facilities. These facilities attempt to provide a comprehensive service to the capital and its suburbs, with continuity of care.

A major constraint is the servicing of the rural area of the main island and the other secondary islands, where problems of access and follow-up occur.

3.11 Papua New Guinea

Papua New Guinea's health services have been decentralized to the provincial level, and 12 of the 19 provincial hospitals have a psychiatric nurse and eight of them have small psychiatric units. There is a psychiatric unit in the National Referral Hospital in the capital, and a psychiatric rehabilitation centre near the capital.

Training in psychiatry occurs with all health personnel and recently the medical undergraduate curriculum has been significantly expanded. Postgraduate training in psychiatry for nurses has been developed.
3.12 Philippines

Over the past 30 years concepts of mental health care have changed significantly in the Philippines, moving from an institutional based model in large institutions at the central and provincial level to decentralized mental health services integrated with general health care and community care.

In 1986, a Project Team was established as an advisory body to the Ministry of Health. It has collaborated with university centres to initiate programmes to promote awareness of mental health problems in primary care providers, and there is a fellowship in social psychiatry for trainee residents in Psychiatry. Services in the regions are constrained by lack of staff and resources, but they are attempting to implement community services.

3.13 Republic of Korea

The health services in the Republic of Korea are centralized, and this has influenced the mental health services, which tend to be closed, institutionalized and underresourced. There are about 800 psychiatrists with 10 000 beds; however there are also an unknown number of patients residing in privately owned asylums.

Other major constraints in developing community based services are the high stigma attached to mental illness, and the popular belief that hospitalization is the most effective treatment for psychiatric disorder.

Recently moves have been to develop pilot community mental health services, and some hospitals have adopted open door policies.

3.14 Solomon Islands

The major psychiatric resource in the Solomon Islands is the National Psychiatric Unit, which is located in another province to the central referral general hospital in the capital city. The health services plan to provide preventive and treatment resources throughout the community, utilizing the general primary health care system and resources. A major constraint is the shortage of skilled manpower.

3.15 Viet Nam

In Viet Nam, each province has access to psychiatric beds and there are two major psychiatric hospitals. The hospitals are open, and in large cities 24-hour day care beds have been set up. At the provincial level, psychiatric clinics are being established to manage patients in the community.

The major constraint in developing these services is the paucity of resources and trained staff.
3.16 Overall review and conclusions

In the developing countries in the Western Pacific Region there is a wide diversity in the development of mental health services for their communities. Resources, although generally limited in all countries, are very limited in countries such as Lao People's Democratic Republic, Viet Nam, China, Korea and the Philippines. In Lao People's Democratic Republic and Viet Nam, the psychiatric units are open; in Korea, China and the Philippines they tend to be closed. Papua New Guinea, Malaysia, Brunei, Fiji and the Solomon Islands all have mental health legislation to detain and protect the rights of patients. China and the Philippines are formulating such legislation and there is none in Lao People's Democratic Republic or Viet Nam.

National coordinating committees on mental health have been established in a number of Member Countries, and all countries report the need to develop culturally appropriate programmes.

4. WHO’S PROGRAMMES ON COMMUNITY MENTAL HEALTH SERVICES

The mental health programmes of WHO have a wide scope which is characterized by the public health approach. At present, they cover three major activities: the promotion of the psychosocial aspects of health; the prevention and control of alcohol and drug abuse; and the prevention and treatment of mental and neurological diseases.

In the Western Pacific Region, WHO has increased its collaboration with Member States in the development of community-based mental health services since the 1980s.

At present, WHO sets only very modest objectives for the prevention and control of mental diseases. Although they are very modest, they are very challenging objectives in many countries, particularly in developing countries. They are simply to develop humane, socially and culturally relevant, cost effective mental health services.

We know that a community-based approach is indispensable to achieve these objectives in many countries.

Magnitude of the problems

According to statistical studies, about 1% of the population in the world is affected by severe mental and neurological disorders, and another 4% to 5% suffer from mild to moderate mental and neurological problems including the abuse of alcohol and drugs.

There are several variables which determine the magnitude of these mental and neurological problems. The demographic structure, the level of socioeconomic development, the cultural system and the social system, are major variables in the epidemiology of mental and neurological disorders.
**Constraints**

Generally speaking, mental health is accorded very low priority in the government, and mental health services are poorly developed. Even in countries where mental health services exist, they are concentrated in traditional psychiatric hospitals with closed doors.

In many countries, there is no national mental health policy, no mental health legislation and no mental health programme planner within the Government. Therefore, mental health services are fragmented and involuntary admissions are enforced without any legal basis.

Also, there is a lack of trained manpower in psychiatry and, in some countries, a massive exodus of educated people is worsening the situation.

**Approaches**

In view of the present situation and constraints, WHO has adopted the following approaches to establishing community-based mental health services in developing countries.

These approaches differ from country to country depending upon their specific socio-cultural conditions, but the major directions have been as follows:

To collaborate with the government and national experts:

(a) to develop or strengthen comprehensive national policies and programmes on mental health. This approach includes assistance in formulating or reviewing national mental health legislation;

(b) to promote education and training in mental health. This includes assistance in the organization of national training courses or workshops, support for short or long term fellowship programmes and the participation of national experts in international or regional workshops;

(c) to stimulate research on mental health, particularly epidemiological or operational research on mental health. This includes the involvement of collaborating centres in developing countries to international and regional collaborative research projects.

**National coordinating committee on mental health**

The community-based mental health plan requires the commitment of various sectors in the country. It is essential to establish a national multisectoral committee to have regular meetings to develop and review national mental health plans. The national coordinating committee should include representatives from various government and social sectors such as welfare, law enforcement and judicial sectors.

WHO has collaborated with several countries in the developing world to establish a national multisectoral committee as a high-level advisory body to plan national mental health policies and programmes.
Comprehensiveness and continuity in the service delivery

In many developing countries, both trained psychiatrists and psychiatric beds are very scarce. Therefore it is important to make the maximum use of scarce resources.

In terms of manpower, WHO has collaborated with Member States to provide psychiatric training for general health workers. This training includes the identification of mental and neurological diseases, use of basic psychotropic drugs, and knowledge on basic psychotherapeutic and counselling techniques.

The need for psychiatric training for general health workers is acutely felt, as 15% to 20% of the patients referred to general practice are primarily suffering from psychological and family problems.

In terms of mental health facilities, the organization of a referral system is the key to the success of community-based mental health programmes. The three-level referral system has been well developed in a few Member States. It consists of a general health clinic, psychiatric outpatient care, and residential psychiatric care. Smooth coordination between community care and residential care calls for a psychiatric team which can ensure the comprehensiveness and continuity of mental health care in the community.

Community-based mental health rehabilitation

It is reported that 90% of schizophrenia patients relapse within one year if they do not take medicine continuously. This shows the importance of follow-up of discharged schizophrenia patients by a psychiatric team. Therefore, education for the patients and family members on the nature and possibility of treating the disorder is a prerequisite for the success of community-based mental health services.

In psychiatry, our technologies are basically psychotropic medication and psychological support. Knowledge on these technologies can be provided not only to health workers but also to patients and family members.

Conclusion

In the past several years, WHO has collaborated with Member States in the development of community-based mental health services. These efforts can be summarized as four main areas. The first is to formulate a comprehensive national mental health policy through the establishment of a multisectoral coordinating committee on mental health.
The second is to provide training and education in mental health to mental health workers and general health workers.

The third is to promote research activities in the field of mental health.

The fourth is to facilitate the exchange of information between countries in the Western Pacific Region.

WHO wishes to cooperate with Member States to develop humane, socially and culturally relevant and cost-effective mental health services in the Region.

5. NEW APPROACHES

5.1 Variety of new approaches

A variety of new approaches in the development of national mental health policies and programmes for the chronically mentally ill patients was mentioned in the country profiles of the workshop participants.

These approaches vary country by country. However, they may be summarized as follows:

(1) Principles
   - decentralization and regionalization
   - community involvement
   - networking of care system
   - from hospital care to community care

(2) Mechanism
   - advisory body to the government
   - office or department in the government
   - national coordinating group
   - mental health legislation

(3) Systems
   - mental health in primary health care
   - sectorization
- diversification of psychiatric services
- structured referral system
- integration of private and public services

The above new approaches have brought new problems and new emphasis in training and research needs. Some of these were summarized as follows:

(1) New problems
- vagrant psychosis and homeless
- forensic cases

(2) New emphasis on training
- training of primary health workers and general health physicians
- reorientation of psychiatric education
- collaboration with traditional healers, religious groups, and social agents, e.g. policemen.

(3) New emphasis on research
- epidemiological surveys
- needs assessments
- operational and pilot research
- evaluation, e.g. coverage, and quality of care.

5.2 The "SECTORIZATION" of comprehensive psychiatric services

The sectorization of mental health services was introduced as an example of community based mental health services.

The sectorization of mental health services (sectorization) was started in France in 1960 and has now been adopted in a few European countries (e.g. Portugal, Spain) and French-speaking developing countries (e.g. Algeria, Morocco, and others). One mental health team is made responsible for the prevention, emergency services, treatment, care, rehabilitation and follow-up of all mental health problems of the population of a specific geographical area.
It is desirable to have several mental health workers, such as psychiatrists, psychiatric nurses, and social workers in the team. This system makes it possible to provide continuity and comprehensive mental health care in the community.

In one sector, there may exist a variety of care facilities, e.g. consultation, outpatient clinic, day care, sheltered workshop and hospital bed. The respective size of those different facilities will therefore be decided in accordance with the size of the other facilities in order to arrive at a harmonious whole.

In the sector, the mental health team remains responsible wherever and whenever the patients need or seek help.

One mental health team can be in charge of 100,000 to 200,000 population on average, which may contain 1,000 to 2,000 severe mental disorders.

This approach has succeeded in providing mental health services to patients in the community and in preventing them from becoming vagrants or homeless.

However, this approach requires careful community education to accept mentally disordered patients to be taken care of in the community. Mental health education for community agents such as policemen, school teachers, priests and community leaders is an essential factor for the success of this approach.

5.3 Mental health care in primary health care - An alternative approach to the development of a mental health delivery in developing countries

In 1981, WHO reported on the results of a study conducted in seven developing countries. 10.6% - 17.2% of adults consulting primary health care stations in these study areas showed psychiatric disorders. 48% were depression, 40% anxiety, 4.8% schizophrenia and the other psychoses, and 5.2% other disorders. 11.6% - 29.4% of children (5-15 years) had psychiatric disorders. 75% of all these disorders were not recognized by primary health workers. These findings show that the need for mental health services is as great in rural as in urban areas in developing countries. These results further support the figures presented by WHO about the magnitude of mental health problems in developing countries that has led to the belief that traditional models of mental health care cannot hope to make an impact when faced with this reality. This is especially true if one considers that stigmatization, negative community responses and low priority attention among health planners, prevail.
Decentralization and psychiatric deinstitutionalization have yet to be realized in developing countries. A continuing search for an alternative approach has led to the conduct of research to test the feasibility of integrating mental health care in primary health care.

The WHO Collaborative Study on Strategies for Mental Health Care in general health care has shown that decentralized peripheral mental health services can be provided in the community by using primary health workers. These workers can be trained to undertake care for selected mental problems which include psychiatric emergencies, chronic psychoses, mental retardation and psychological problems such as anxiety and depression. Training programmes have been designed to be appropriate, simple and relevant to the tasks in mental health care to be undertaken by these workers; the community can be mobilized to support such a case because it is part of the care they have accepted and adapted in their midst.

The Research on Psychosocial Problems in Primary Health Care presently being conducted by three Philippine teams has gone further than previous studies. The focus is the development of a psychosocial problem guide for use by the primary health worker in recording these problems among their patients. After a short, task-oriented training programme they have shown an increase in the use and recording of psychological and social problems. They have also undertaken more psychosocial interventions such as simple reassurance and advice, special discussions with the patient and his family. This empathy has improved with training.

These studies have been presented to the local health authorities and there has been a shift from their initial resistance to the development of an open minded attitude. The authorities now accept the utilization of primary health workers for selected mental health care. This increased attention from the health authorities has allowed for the planning of other aspects of mental health care at the regional level; this includes mental hospitals and clinics, and the provision of neuroleptics.

These developments have led to the recognition that there is a new change in psychiatrists' roles in developing countries. They must assume broadened roles and be socially aware of relevant community conditions, be open minded and ready to modify traditional models of care. They provide direct patient care because a small part of their tasks, are the planning and management of services as well as training. Supervision of those in the community becomes the primary concern. There are implications for this in the design of psychiatry training programme for psychiatrists in developing countries.

A national mental health care plan must include a primary health component. This alternative and complementary approach addresses the need to provide care to inaccessible peripheral areas in the country. This strategy is acceptable to health authorities. The resultant openness and acceptance form these authorities may still be the opportunity to break the barriers in the community for those with mental and psychosocial problems.
6. CASE MANAGEMENT OF PERSONS WITH LONG-TERM DISABILITY FROM MENTAL DISORDERS

6.1 Principles

6.1.1 Definitions of terms

Case management is defined as a community-based strategy which involves a multidisciplinary approach towards mental health care, with the primary health care worker as the case manager. It consists of various supportive measures such as: (1) client identification, assessment and outreach; (2) service planning; (3) linkage with requisite services and monitoring of service delivery; and (4) client advocacy and period home visits.

In this discussion, the term 'persons with long-term disability from mental disorders' refers to that sub-population of long-term mentally disordered persons that have been discharged from the mental hospitals and therefore have received previous treatment, and to those that are in the community and have never received any form of treatment.

The term 'primary health care worker' refers to a person from a professional discipline or a para-professional who, by his perceived role or function in the community, is the first person consulted by an ill person for treatment. This person, besides having admirable personal qualities such as warmth, empathy and regard for local patients, requires clinical training in case identification and treatment.

6.1.2 Case identification

The primary health care workers can be trained to identify cases of long-term mental disorders by the use of a flow chart that describes directly observable symptoms of mental disorders, gives a simplified and operationalized process of arriving at a diagnosis and of provisional disposition.
An example of such a chart is as follows:

**Observed symptoms**

- sleep disturbance
- social withdrawal
- inappropriate/inordinate mood
- bizarre behaviour
- bizarre somatic complaints
- negligence of basic personal needs

**suspect long-term mental disability**

**look for**

**history of:**
- trauma
- difficult birth
- exposure to toxic substance

**pressure of:**
- fever
- changes in sensorium
- weakness or loss of function in libido or senses
- changes in ability to read
- disorientation
- memory impairment

**Manage patient:**

- **Present**
  - talk to patient/family
  - assess strengths and deficits
  - refer to community support agencies
  - give major tranquilizers

- **Absent**
  - Refer to a psychiatrist or hospital

**Not improved in 4 weeks**

**Improved**
6.1.3 Continuity of care

Continuity of care is essential in the treatment of the long-term mentally disabled person. One measure that can ensure the patient of consistent and comprehensive care is the establishment of a mental health referral system.

The primary health care worker can do this in three steps.

Firstly, he should study the community's demographic records to gain an overview of its subcommunities, ethnic and racial groupings, age distribution, patterns of hospital utilization and currently available care givers.

Secondly, he should meet designated community leaders in various sectors, such as health and government, religion, economics, and education, to solicit the community's perceptions and needs as well as its strengths and support systems.

Finally, he should set up an alliance with a board of community citizens to set his priorities and to establish a network of support programmes for the long-term mentally disabled.

Another measure that can ensure continuity of care is to take steps to adequately motivate the primary health care worker by developing his confidence in his capability as a mental health worker. Therefore, he should get adequate training and supervision in case identification. Such training should be undertaken within his work environment and should be aimed at teaching knowledge and skills that will result in directly and immediately obtainable results. Furthermore, he should be adequately trained and supervised in the use of psychotropics. Lastly, he should be assured of continued support from the family and various community agencies, especially during periods of acute exacerbations of the illness.

6.2 Psychopharmacotherapy

The introduction of antipsychotic and antidepressant medication significantly revolutionized the management of psychiatric patients with particular reference to open door policies, deinstitutionalization and community psychiatric programmes. Pharmacies are being flooded with the introduction of new drugs by different pharmaceutical concerns. One can safely state that, by and large, the efficacy of different antipsychotics, antidepressants and anxiolytics in their respective areas are about the same. The differences lie in the nature and degree of side effects, sedative properties, risk in the case of overdosing and half life of the drugs.

The availability of psychotropic agents and the preferential use varies from one country to another. However, the following general principles are applicable when presenting psychotropic drugs:

(1) There is very little rationale in polypharmacy.
(2) There is little evidence to support the routine long-term use of antiparkinsonian drugs along with neuroleptics.

(3) Taking advantage of the long half life of the psychotropics especially the antipsychotics and antidepressants one could prescribe the medication as a single dose at night.

There would be better compliance and the need for an additional hypnotic would not arise in most of the cases.

(4) It would be helpful for the members of the team to be thorough with a few drugs in each group.

Listed below are some of the commonly used drugs in the care of the long term mentally disabled persons:

(a) **Antipsychotics**

Chlorpromazine (oral, parenteral)

Thioridazine (oral)

Trifluoperazine (oral, parenteral)

* Haloperidol (oral, parenteral)

+ Sulpiride (oral), Pimozide

Depot neuroleptics - advantage in terms of improved compliance

Fluphenazine decanoate

Flupenthixol

Haloperidol decanoate

In the long term use in particular it is essential to review the dosage at regular intervals and not to fall into the 'repeat prescription' trap.

The minimum required dose for the maximum therapeutic benefit.

* = The probability of extrapyramidal symptoms is marked

+ = Comparatively free of side effects
(b) **Antidepressants** - For depressive illness

- Amitriptyline
- Imipramine
- Mianserin Hydrochloride
- Maprotiline

particularly useful in the elderly and those with cardiac problems.

(c) **Antianxiety agents and hypnotics**

There is the obvious risk of abuse. They should be used only when strictly indicated and on a short term basis.

- Diazepam
- Chlordiazepoxide
- Nitrazepam, Temazepam, Flurazepam

(d) **Anti Parkinsonian drugs**

- Procyclidine Hydrochloride
- Benzhexol

(e) **Anti epileptic medication**

- Carbamazepine, Phenobarbitone, Phenytoin sodium,

**Lithium Carbonate** - Prophylactic medication for affective disorder, usually used on a long term. Tardive dyskinesia is the most serious long term hazard of neuroleptic medication. The primary health worker should be able to identify this and bring it to the attention of the doctor for appropriate measures.

The health worker should reassure the patient and the family in the event of appearance of other side effects which are transient and reversible. Regarding the duration of neuroleptics the worker could convey to the client the need to continue medication for 1-2 years after overt symptoms have disappeared and subject has been reviewed by his doctor.

6.3 **Psychosocial intervention**

All measures for psychosocial intervention should be directed at the family and the patient as a unit, as in the community, the family is directly affected by the consequences of the patient's illness.

The primary aim of psychosocial interventions is to hasten the patient's social reintegration. This can be achieved by providing education and support for the patient and the family. Reality orientation can take the form of teaching the patient and his family about the etiology, course and prognosis of his illness in simple, non-technical language. Likewise, he should be educated on the need for compliance to
medication. Remotivation may be achieved by educating the patient and his family on basic social skills giving advice on job choice difficulty in relationships.

6.4 Institutional care

It is important that inpatient care in the hospital be kept to a minimum required period which would help to avoid disruption of family connections and to minimize institutionalization of patients.

The open door policy should be encouraged and forms an integral part of humane mental health care. However there should be appropriate secure facilities for those forensic psychiatric cases with dangerous propensities.

It must be pointed out that some mentally subnormal patients, particularly those with superimposed psychotic disorders, may need long term institutional care.

A word of caution about deinstitutionalization; hasty discharges of chronic inpatients into the community without adequate supportive services might lead to patients returning to the institution immediately.

It would be helpful from the therapeutic, educational and supportive points of view if the key family members were actively involved in the patient care from the early stages of the management of the patient in a mental health facility.

This may be in the form of the key family member residing in the unit ("watcher concept"), or the family ward approach, or the family spending several hours in the unit per week.

Of course, the involvement would depend on several factors, such as the size and structure of the family, the distance from home and available facilities in the hospital.

6.5 Community care

In the care of the person with long-term disability from mental disorder in the community setting, the multidisciplinary team approach is essential because of the multi-faceted nature of the consequences of such an illness. With such an approach the sum of individual contributions from the psychiatrist, psychologist, nurse and social worker will ensure a holistic approach to the patient's illness. However, the key person in the team is the primary health care worker in his capacity as case manager.

Facilities from practical hospitalization in the form of day care centres, foster homes or halfway homes, are recommended as a suitable alternative to long-term hospitalization.

Community education on mental health is important as a means of lessening the stigma of mental illness. This can be done through educational campaigns, civic groups, schools, or through the various forms of mass media.
7. FUTURE DIRECTIONS OF NATIONAL MENTAL HEALTH POLICIES AND PROGRAMMES

7.1 Introduction

During the workshop it became clear that it was not possible to prepare a comprehensive, unified report on the developing countries in the Western Pacific Region. There were wide variations in styles of service, administrative structures, resources and community attitudes.

Each Member State's representative was requested to identify problems and constraints in the state's services, and within the framework of a comprehensive community based service, present future plans.

The situation in each state was discussed individually in small groups, and presented at a plenary session.

The outcome of these presentations is now presented country by country. Issues on regional collaboration are presented in the next section.

7.2 Brunei Darussalam

The main philosophy is one of a community oriented, short-stay, open door policy. With an increase in patients utilizing the services, and in order to maintain quality of care, there is a need for separate facilities for the out, day and inpatients. Small psychiatric units need to be developed in the district hospitals, and psychiatric outpatient clinics should be incorporated into the community oriented programmes. Sheltered workshops, industrial therapy units and group homes would need to be developed.

With this open, community based programme, secure facilities for dangerous (including forensic) patients will be required, as well as institutional services for the developmentally disabled with psychiatric disorders who cannot be managed in the community.

A mental health coordinating committee, chaired by the Director of Medical Services needs to be established to oversee these developments. Necessary to these developments is the updating of the existing mental health act, which relates to the previous, centralized custodial type service prior to 1983.

Training needs in three areas have been identified:

1. in service training of personnel already working in the psychiatric services;
2. training of primary health care workers in aspects of basic mental health; and
3. training of medical staff who will be working in the psychiatric units.
To help change community attitudes towards the mentally ill, public education directed at all levels in the community needs to be planned.

WHO collaboration will be sought in:

(1) support in psychiatric epidemiological surveys;

(2) sponsorship of appropriate health care workers in overseas training in identified areas of need; and

(3) facilitating exchange visits with other Member States in the South Pacific Region.

7.3 Fiji

To provide better access and services to the community, the mental health services will need to decentralize into the divisions (Western, Northern and Eastern), with the psychiatric hospital continuing to act as a referral centre and rehabilitation unit servicing the central division. Each divisional hospital would admit patients for short-stay; patients requiring longer stay would be transferred to the psychiatric hospital.

With staffing and financial constraints, such developments would need to be supported by training programmes directed towards all health personnel: medical officers; general registered nurses; and medical orderlies. With the registered nurses, psychiatric training could be incorporated into the already existing post basic courses in maternal and child health and public health.

In 1990, a new programme for training medical officers will commence, which will focus on community postings. Incorporation of appropriate community based psychiatric training into this programme would enable its graduates to assist in the decentralization process.

7.4 Guam

Since the community mental health act of 1963, deinstitutionalization has been practised in Guam's treatment of the seriously mentally ill, from hospital care to community care.

Guam's mental health services for the seriously mentally ill with family support systems is seen as adequate. However, those seriously mentally ill who do not have natural support systems or resources, and are not covered by governmental services, have become a major concern to Guam's community.

The growing number of the homeless mentally ill draws community concern as earlier mentioned. Guam is currently in the process of opening the first phase of the adult residential facility geared for the seriously mentally ill in October 1989. The second phase will open in November
1989. In May 1990 Guam's mental health facility will have its ground-breaking. Guam needs to expand its mental health services for the seriously mentally ill, especially those who are homeless. Guam needs to develop:

1. adequate occupational programmes to teach and train the seriously mentally ill in basic job skills;
2. group homes for the seriously mentally ill who can live on their own;
3. case management services to all levels of mental health care.

Guam also needs to recruit and develop its manpower resources.

It will be in Guam's best interest to be involved in activities at the national and regional levels pertaining to the role and scope of mental health care. Of particular interest are new developmental trends and methods of psychiatric treatment, workshops or conferences in relation to the Western Pacific Region.

7.5 Japan

Currently there are 1.5 million disabled people in Japan (about 1% of the total population) and 250 000 psychiatric beds, of which 70% are in the private sector. The overall bed occupancy rate is 99.1%; 80% of the inpatients have chronic schizophrenia.

In the last 10 years, the Japanese Government has focused on opening wards. This was assisted through:

1. producing guidelines on psychiatric treatment; and
2. providing financial support for reconstructing hospitals and provincial mental health centre day care activities.

There has been a significant increase (70%) in the admission rate to open wards.

The Japanese Government has now drawn up the following priorities:

1. a shorter length of stay in hospital;
2. an efficient menu system for rehabilitation;
3. a decrease in readmission rates;
4. construction of new alternative facilities;
5. promotion of small sized workshops fostered by patient's family association; and
6. construction of a special hospital for violent patients.

The psychiatric services need to survey patient requirements and develop basic data for rehabilitation, and appropriate strategies for
cooperation with other Member States.

7.6 Lao People's Democratic Republic

To meet the needs of the Laotian people, the small service based in the main hospital in the capital needs expansion. An increase in size to 25 beds, with complimentary facilities in the community following a sectorization philosophy would help ensure continuity of care. Training in basic mental health skills for primary health care workers would strengthen the community base of the service.

To help implement these developments, it will be necessary to convene a National Mental Health Coordinating Committee.

With limited manpower and resources, training of health workers at all levels is required as follows:

(1) regular seminars in psychiatry for doctors and nurses from hospitals throughout the whole country;

(2) training in psychiatry to fifth year students in the University Medical School;

(3) training in psychiatry in the Nursing and Medical Technology Schools;

(4) training of qualified nurses in psychiatry;

(5) training of medical practitioners abroad in psychiatry, both with short term placements and long term courses;

(6) development of programmes for social workers and health workers in the field;

(7) development of close cooperation and liaison with the general hospitals and primary health care services.

7.7 Malaysia

In order to provide adequate facilities for the promotion of mental health and treatment of mental disorders within the community in Malaysia, the following principles need to be followed:

(1) continue the policy of decentralization by opening new units in district and general hospitals in all states;

(2) confine acute psychiatric care to the district and general hospitals;

(3) use the reduced number of beds required at both central psychiatric hospitals for rehabilitation and forensic cases; and

(4) promote mental health care by integrating a basic mental health component into primary health care.

Implementation of these principles would be assisted by the establishment of an effective and adequately resourced Division of Mental
Health within the Ministry of Health, having access to a high level national mental health coordinating committee.

The principles can be achieved by:

(1) developing a structured referral system consisting of health centres, district hospitals, general hospitals and psychiatric hospitals in that order;

(2) introducing mental health work to the primary health care workers and ensuring continued supervision is provided by skilled mental health workers; and,

(3) providing diversified services such as partial hospitalization, day centres and sheltered workshops at district and community levels.

The increasing problem of the vagrant psychotic and homeless patient should be addressed jointly by the Health and Welfare Departments.

Training requirements can be divided into

(1) Training of existing staff:

(a) training of existing primary health care workers in basic mental health care;

(b) training of health personnel in health centres and district hospitals to enable these facilities to act as referral centres for primary health care workers.

Specialized workers in mental health should provide inservice and rotational training programmes for existing staff who are to work in new facilities.

(2) Health profession training:

(a) The curricula of public health nurses, midwives and primary health care workers should incorporate a mental health component.

(b) Training programmes for nurses and medical assistants should include community mental health care.

(c) Medical undergraduates should be trained to recognize and treat the mental health component in physical illness.

It is recommended that research in all areas of mental health be supported in Malaysia.

7.8 New Caledonia

To plan and supervise the adequate development of community based mental health service, a national coordinating committee on mental health needs to be set up.
In the capital there are adequate facilities and manpower; however, to develop community based services in the provinces and islands, it will require significant training initiatives, particularly in the nursing field.

The model of sectorization with continuity of care involving community services, day and night care, home beds and partial hospitalization as well as the psychiatric hospital, is easier in the more concentrated population areas, but will need to be adapted for the rural areas.

7.9 **Papua New Guinea**

Accelerating the devolution of decision making is a major element in promoting local participation in the economy and facilitating integral human development. The linkages between the Department of Health and provincial governments are being improved effectively to monitor the health status of the people and to direct budgetary allocations to priority areas.

Expansion of the Regional Epidemiological Units is under active planning to provide comprehensive health support and monitoring resources to the provinces but not to detract from provincial autonomy.

Each province will include in its provincial health plans the aims and objectives of its mental health programmes which should include the essential tasks of primary health workers.

Primary health workers are the health workers who come into contact with patients. These are health extension officers, nurses and community health workers, and their five essential tasks are:

1. management of persons severely disturbed by mental or neurological disease;
2. early identification of those patients developing severe mental disorders, and institute management to help prevent severe and disturbing complications;
3. recognition and understanding of the need for continued support and maintenance for long term mental and neurological disorders and the ability to implement appropriate actions;
4. recognition of a patient with signs or symptoms which are alcohol or drug related and institute initial preventive interventions.
5. recognition of frequently presenting somatic symptoms of psychosocial distress and avoidance of inappropriate investigations and medications. They should also help the person to find appropriate support.

Inservice training is to be conducted at provincial levels by provincial staff with assistance from the national mental health, resource and monitoring unit in terms of resources and expertise.
Currently clinical support for mental health is provided by base hospitals. It is anticipated there will be regional mental health officers in the near future.

The National Health Ministry (Department of Health) will continue to support the development of mental health services as follows:

(1) The Mental Health Resource and Monitoring Unit will:

(a) provide preservice training programmes for all levels of health workers in association with training institutions and the national training support unit;
(b) provide provincial support programmes; and
(c) provide health protection programmes.

(2) The National Health Ministry will continue to support the national referral hospital psychiatric unit in the capital city and the national psychiatric rehabilitation centre. These facilities will provide clinical, consultative and educational support to the provinces.

(3) A national coordinating committee on mental health will be set up to advise the Secretary for Health on mental health issues and support the Mental Health Resources and Monitoring Unit.

7.10 **Philippines**

The present national coordinating body on mental health has to be formalized as a government agency by an act of legislation. This is meant to ensure its continued existence, to strengthen its position within the government structure and to allow it to fully implement its programmes. Likewise, its implementing body, the National Center for Mental Health should be situated within the government structure for mental health care so that it is empowered to exert technical supervision over all mental health facilities in the country.

Psychiatric education should modify the present hospital based orientation to that of a community-based one. This is seen as a vital step in implementing a comprehensive community based national mental health programme.

Research in mental health, specifically on epidemiology and systems of care should likewise be re-emphasized as a basic foundation for policy-making and programme implementation.

Incorporation of mental health care in primary health, networking of the mental health care system, setting up a structured referral system and diversification of mental health services are the chosen methods of implementation of the stated policy on community involvement.

Finally, the integration of public services with private services may be the way in which to link all available resources in the community.
The Philippines may collaborate with WHO in a number of ways. The process of legislating the national coordinating body for mental health can be hastened by a strong statement of support for mental health from WHO. Logistic support for manpower development in community psychiatry will promote the reorientation in psychiatric education. Technical supervision on methods and areas of research would be appreciated. Then, having acquired new knowledge, skills and attitudes in training and research, the Philippines can collaborate with other countries in the region as a training and research centre.

7.11 Republic of Korea

It is a high priority to reduce the stigma upon the mental patient, by educating influential persons and school students. Mass media would be used to educate the public about the nature and consequences of mental illnesses and the real, not exaggerated, dangerousness of psychotics.

Illegal private institutions where patients are just detained without medical care should be disbanded.

To assist in the development of comprehensive community based mental health services, it is proposed that a mental health section be established in the Ministry of Health, and that this section secure the budget. To oversee and carry out research in Korea, a national institute for mental health should be established.

It is recommended that a pilot programme be set up in a defined rural region, attached to a mental hospital, to provide initial secondary prevention (early detection of cases and community based treatment) and later tertiary prevention (rehabilitation programmes). Such a pilot study would undergo research in terms of its effectiveness, both economic and clinical, and its effect on stigma. Results of the study could be used to establish a treatment model for Korea.

7.12 Solomon Islands

Very little progress has been made in the development of mental health services in the past years because available resources were used for other fields considered to be of priority. However the significant presence of psychiatric disorders and disabilities necessitates the need to promote and develop mental health services.

A more comprehensive and community oriented mental health service utilizing the general PHC system and resources should be established.

The objectives of the service would be:

(1) to promote community awareness of the existing mental disorders, enhance community support and participation;

(2) to limit institutional care and promote community based care;

(3) to improve case identification and management at all levels;

(4) to undertake appropriate training of all care givers.
(5) to coordinate, monitor and evaluate the programme activities and undertake periodic reviews; and

(6) to undertake appropriate research in mental health.

To achieve the above objectives, the following strategies are anticipated and should be considered:

(1) Community education about mental health care issues to be undertaken through meetings, seminars, workshops, for all levels of the communities.

(2) No increase in the number of psychiatric beds is expected. Cases should be managed at existing facilities and inpatients' homes.

(3) Case identification and management should be improved as follows:
   - Simple flow charts should be developed for PHC workers in the diagnosis and management of psychiatric disorders.
   - Simple standardized treatment required for psychiatric disorders should be developed.
   - A well defined referral system should be established.

(4) Training should be carried out:
   (a) Medical officers or nurses should be selected for specialized training.
   (b) Mental disorders should be included in the current regular (inservice training) course for all categories of health workers.

(5) Coordination, monitoring and evaluation should be carried out:
   (a) The national coordinating committee on mental health should be revived and the Undersecretary of Health should be the chairman. The Committee would have multisectoral representation.
   (b) The existing information system should be improved. Mental disorders should be included in the current disease notification form.
   (c) An annual review of activities should be undertaken by the coordinating committee utilizing the necessary external expertise. The mental health act should be reviewed utilizing the services of a consultant.

(6) There should be collaboration with appropriate agencies and institutes to undertake needed research especially in the field of epidemiology.
7.13 Viet Nam

The mental health services in Viet Nam are developing in line with WHO policies on future directions.

It is proposed to establish a national mental health coordinating committee with wide representation, together with similar bodies at a local level to oversee the development of services.

Viet Nam already has an "open door" policy with its psychiatric hospitals. In order to decentralize the mental health services to the community, and integrate mental health care into primary health care, there will have to be more training programmes for general physicians and primary health workers.

With sectorization, it is planned in the long-term to have one psychiatric team for each 100,000 population. The utilization of home beds for day and night care would support the clinical services.

7.14 Overview

There was unanimous agreement between Member States on the policy of decentralizing mental health services towards comprehensive, culturally appropriate community based services. These services would utilize where possible, all available and appropriate resources. To do this it was recognized that involvement of other health care workers, in particular in many states the primary health care worker, would be necessary.

Training requirements to support this change in level of care varied from state to state. In those member states with specialized mental health professionals, these specialists could be involved in such training; in states without these specialists outside assistance would be needed.

In some states, any such change in policy would require major changes in community attitudes in terms of discrimination against mental illness. This would necessitate extensive community education. The setting up of pilot programmes to establish an appropriate model for decentralization was seen, particularly in the more centralized states, to be an appropriate way to develop the services.

It was generally agreed that a central mental health coordinating committee with wide ranging representation should be operational in all member states, overseeing the development of services. Such committees were already in existence in some Member States, or in the planning stages, but it was recognized that in some states, for varying reasons, this might take time.
8. REGIONAL COLLABORATION

8.1 Training

Education and training in mental health in the Region should consider the supervisors and the actual care givers. This is quite crucial in fact considering the wide diversity in the development of mental health services among the countries of the Western Pacific Region.

In countries where psychiatrists and specialized mental health professionals (such as psychologists and social workers) are available to function as supervisors, a reorientation of their training programmes will need to be planned so that these professionals can be equipped to assume the broadened roles demanded in mental health care in the community. In addition to clinical knowledge and skills, they will be expected to acquire the orientation and the necessary competence to plan and evaluate mental health services as well as train and supervise direct care givers in the community.

In countries where these specialized professionals are not available, training and education in mental health will need to be directed to existing health workers in the community. They can then provide mental health care for selected psychosocial problems which have been defined as a priority concern in the community.

There are postgraduate training centres with a social and community orientation in some countries in the region. Training programmes in mental health for general physicians, nurses and primary health workers are undertaken in other countries, and training materials are available for these purposes.

Regional collaboration can be undertaken in the form of a postgraduate fellowship programme for psychiatrists and specialized mental health professionals so that they can function as leaders and supervisors in mental health activities.

Short term consultancy and exchange educational visits can be used to assist those undertaking training programmes in mental health care in general (primary) health care. These field activities can provide actual learning experiences, because task oriented training has been found to be an effective method for this kind of programme.

Exchange of information about available training materials being developed is also deemed useful.

8.2 Research at regional level

Research must be considered as a natural and important part of the work of every team "in the field", and not as the specific purpose of very specialized units.

Regional collaboration in research could occur in a number of areas:
(1) support and advice in carrying out epidemiological studies for use in planning of services;

(2) assistance and advice in evaluating pilot projects in community mental health, both within and between Member States;

(3) collaboration in projects designed to reduce the stigma of mental illness;

(4) collaboration in research into particular issues in Member States when requested; and

(5) Involvement in dissemination of information throughout the Region.

Where possible WHO should help foster interest in research and build in research components to its various activities in the Region.

9. CONCLUSIONS

(1) The current situation with regard to the organization and delivery of mental health services for schizophrenia and other similar mental disorders was reviewed for each participating country or area in the region.

The review revealed that, in many countries/areas, mental health services were hospital centered and community based mental health services were poorly developed. In some countries, the hospitals were closed and custodial, however the open door policy had begun in a number of countries.

(2) However, there have been increasing attempts made to develop new systems of culturally appropriate health care. These include the following approaches and developments:

(a) integration of mental health into primary health care;

(b) comprehensive and multisectoral mental health services in the community (sectorization);

(c) diversification of psychiatric care into such facilities as day care, night care and home beds;

(d) structured referral systems.

(3) The workshop participants were well aware of these principles of community based programmes; however in many countries and areas, efforts to implement them have met with serious obstacles. Mental health services receive low priority in government policy.
(4) In only a few countries or areas are there mental health offices or departments in the government. This has resulted in a lack of leadership in planning and developing comprehensive national mental health programmes.

(5) In the past several years, WHO has collaborated with several countries and areas to develop culturally relevant community based approaches to schizophrenia and similar mental disorders. These collaborations included facilitating the setting up of national coordinating groups on mental health, workshops and training courses in mental health, and recruitment of short-term consultants.

(6) The overall shortage of trained manpower in mental health is considered a major constraint in the development of community based mental health services. It was recognized that significant training initiatives directed towards both mental health professionals and primary health care workers are required if such services are to develop.

(7) A number of Member States have mental health legislation pertaining to patient detention and the protection of rights of patients. Most of this legislation is based on custodial concepts of care, and has only limited application to community based care. It was recognized that individual Member States will need encouragement to either prepare or update appropriate mental health legislation.

(8) In many countries, there are no clear cut guidelines on the use of psychotropic drugs in schizophrenia and similar mental disorders. This leads to unnecessary and inappropriate psychopharmacotherapy.

(9) Vagrant psychotics and homeless psychiatric patients have become social and health concerns in the countries where the decongestion of psychiatric hospitals was undertaken without the adequate development of community mental health care.

(10) Stigma attached to schizophrenia and similar mental disorders are still strong and widely prevalent in the Region; they are a major constraint in many countries and areas to patients and their families seeking treatment.

(11) In various countries and areas, a considerable number of patients continue to be taken care of by traditional healers; and at this stage there is little dialogue with or information about this group of practitioners or this form of care.

(12) Thus far, little effort has been undertaken for the education and support of patients and families suffering from schizophrenia and similar mental disorders.
10. SUGGESTIONS FOR FUTURE ACTION

During the workshop, the participants examined the future action for their individual countries and areas, the region as a whole, and the collaborative role WHO could play in this action.

(1) Individual countries

The future directions of individual national mental health policies and programmes formulated in the workshop are presented country by country in Section 7 of this report.

(2) Case management

Extensive discussion occurred about the principles of case management of persons with long term disability associated with mental disorders, both in institutional and community care. The implications for training and service needs are presented in Section 6 of this report.

(3) Intercountry cooperation

Although there are significant differences in services, resources and manpower in the different countries and areas, with the sharing of information in the workshop, five areas were identified where the issues related to all countries.

(a) Exchange of views and experiences between countries was agreed by all participants to be of benefit, especially for those working in areas where services tended to be limited and practitioners isolated.

(b) With limited resources in member countries, regular exchange of technology and advances in treatment on a formal and informal basis, utilizing consultants, exchange visits and publications would serve a major educative support.

(c) Psychiatrists should be encouraged to broaden their role from treatment issues alone to taking an active role in planning, teaching, consultation and community education in mental health.

(d) In all countries, training needs to be addressed in terms of:

   (i) support and training of mental health professionals in remote areas; and,

   (ii) support and training of primary health care workers to broaden their skills to include basic assessment and management of mental health problems.
(e) To assist in planning and delivery of services, it was seen necessary to promote research in the following areas:

(i) the mental health needs of the community; and

(ii) studies on the health seeking behaviour of people in different cultures, both in urban and rural settings.

The workshop participants felt that WHO should continue to support and be involved in all these areas.
OPENING ADDRESS BY THE REGIONAL DIRECTOR
WHO REGIONAL OFFICE FOR THE WESTERN PACIFIC
AT THE WORKSHOP ON FUTURE DIRECTIONS OF MENTAL HEALTH SERVICES
IN THE WESTERN PACIFIC REGION, MANILA, 2-6 OCTOBER 1989

Distinguished Participants, Dear Colleagues, Ladies and Gentlemen;

It gives me great pleasure to welcome you today to the WHO Regional Office and to the Workshop on Future Directions of Mental Health Services in the Western Pacific Region.

WHO has collaborated for many years with the Member States in developing community-based services for patients who are mentally ill. Severe mental illnesses such as schizophrenia, major depression, epilepsy and mental handicap place a heavy burden on the affected individuals, their families and their communities. Such diseases can often be prevented from becoming chronic or recurrent if they receive appropriate treatment and the patients are properly looked after.

It has been estimated that most of schizophrenia patients relapse within one year if not provided with medication and community support, whereas with proper treatment only about a third do.

In the developing countries and areas of the Region, most patients with mental disorders are neglected or provided only with various kinds of traditional healing of questionable validity because of the strong stigma and superstition attached to mental illness. For the lack of understanding, mental health services are fragmented and poorly organized. Even where they exist, they are usually confined to inpatient services in specialized psychiatric hospitals. There are few activities for prevention and rehabilitation in the community.

The benefits of recent scientific achievements in psychiatry, such as psychopharmacotherapy and appropriate psychological support, have not been made available to the majority of the patients in developing countries. However, there have been several promising developments in recent years to organize humane, cost-effective and socio-culturally relevant mental health services.

In the People's Republic of China and Viet Nam, the establishment of three-level mental health referral systems have made it possible to treat and follow up mental patient in their communities. In Malaysia and the Philippines, efforts have been made to integrate mental health services into general health care. Diversification of facilities for mental patients, such as home beds and day care have been introduced in several countries. Increased importance has been attached to family and community education.

It is therefore important to review recent progress, exchange views and formulate principles and co...
directions for mental health services. As you are aware, it is not an easy task to develop humane, therapeutic and culturally appropriate mental health services, particularly in the developing countries.

I hope that scientific treatment for mental patients will become more widespread, so that it is available to at least half of the mental patients in need of such treatment by the end of this century.

I would like to express my sincere thanks to Dr Anthony Williams, from Australia, Dr Lourdes Ignacio, from the Philippines, Dr Pierre Bailly-Salin, from France and Dr Susumu Maruyama, from Japan for their support to this workshop as consultants and temporary advisers.

I wish you all a useful and rewarding meeting and an enjoyable stay in Manila.
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</tr>
</tbody>
</table>

* Unable to attend.
### Annex 2

<table>
<thead>
<tr>
<th>Country</th>
<th>Name</th>
<th>Position/Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lao People's Democratic Republic</td>
<td>Dr Sisouk Vongphrachanh</td>
<td>Chief Department of Neuropsychiatry Mahosot Hospital Vientiane</td>
</tr>
<tr>
<td></td>
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<td>Assistant Chief Department of Neuropsychiatry Mahosot Hospital Vientiane</td>
</tr>
<tr>
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<td>Dr Selvadurai Jeyarajah</td>
<td>Consultant Psychiatrist and Head Department of Psychiatry General Hospital Kuala Lumpur</td>
</tr>
<tr>
<td></td>
<td>Dr Narayanasamy Raman</td>
<td>Director and Psychiatrist Hospital Permai Johor Bahru</td>
</tr>
<tr>
<td>New Caledonia</td>
<td>Dr Eric Franchette</td>
<td>c/o Direction Territoriale des Affaires Sanitaires et sociales B.P. 3278 Noumea</td>
</tr>
<tr>
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<td>Assistant Secretary (Mental Health) Department of Health Box 1239 Boroko N.C.D.</td>
</tr>
<tr>
<td></td>
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</tr>
</tbody>
</table>
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Regional Adviser in Mental Health and Drug Dependence
WHO Regional Office for the Western Pacific
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AGENDA

1. Opening ceremony
2. Adoption of the agenda
3. Introduction to the workshop
4. Country reports
5. Review and evaluation of the current situation
6. WHO's programmes on community mental health services
7. New approaches
8. Case management of chronically mentally ill
9. Development of national policies and programmes
10. Regional collaboration
11. Review and adoption of the report
12. Closing ceremony