INTERNATIONAL MENTAL HEALTH DEVELOPMENT GROUP

MEETING REPORT

Meeting on Public Health and Mental Health in Asia: Review of Opportunities for Collaborative Research and Public Health Action

Convened by:

International Mental Health Development Group with endorsement of the World Psychiatric Association

2 August 2022

In-Person Meeting

Bangkok, Thailand

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NOTE

The views expressed in this report are those of the attendees of the Meeting on Public Health and Mental Health in Asia: Review of Opportunities for Collaborative Research and Public Health Action. They do not necessarily reflect the views of the International Mental Health Development Group or the World Psychiatric Association.

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Keywords:

BACKGROUND AND SUMMARY

In countries in the south and east of Asia, there is substantial unmet need for mental health disorders. The World Health Organization (WHO) Southeast Asia region accounts for 27% of all cases of depression and 23% of all cases of anxiety globally. The treatment gap approaches 90% in some of the lowest-resource settings. There is both a lack of availability of evidence-based treatments and limited local research capacity. Many countries have national mental health policies, but funding remains disproportionately low relative to the burden of illness.

In many Asian nations, the number of psychiatrists is less than the OECD average of 15.3 per 100 000 people. In addition, the distribution of psychiatrists is heavily skewed towards major urban centres. Access to other mental health clinicians is also limited throughout Asia. In low and middle-income countries, such as Bangladesh, India, Nepal, Myanmar and Cambodia, there is less than one mental health nurse per 100 000 people. The COVID-19 pandemic further highlighted the level of need across the region, as many suffered mental ill-health in response to the impact of the virus on their communities and services struggled to meet the demand for care. In addition, international collaborations on mental health reduced substantially during the peak of the pandemic.

In response, the International Mental Health Development Group (IMHDG) convened an in-person meeting in August 2022 to reignite international collaborations amongst mental health leaders from countries in the south and east of Asia. The meeting was informed by the World Psychiatric Association (WPA) Action Plan for the 2020-2023 triennium. The Action Plan includes 6 areas of focus:

- Public mental health
- Child, adolescent, and youth mental health
- Addressing co-morbidity in mental health
- Partnership with other professional organisations and non-Government organisations
- Capacity building
- Continuation and completion of previous action plans work

Prior to the meeting, attendees were given opportunities to submit proposals for international collaborations. The IMHDG Steering Committee selected proposals for discussion. Topics covered included perinatal and children's mental health, youth mental health and substance use, the mental health of carers, mental health associated with physical trauma, mental health training and telepsychiatry. The meeting involved discussion of how leaders could lead collaborations on these issues across the region.

Following the meeting, organisers circulated summaries of proposals and discussions. Attendees selected the highest priority areas to commence collaborations. Academic publications are forthcoming about this process and early outcomes of initial collaborations. Organisers welcome additional interested individuals and organisations who wish to contribute to this work.

INTRODUCTION

The Constitution of the World Health Organization defines health as a "state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity". The extensive effects of the COVID-19 pandemic across all parts of the world highlighted some of the strengths and shortcomings of health systems in responding to the complete health of individuals and communities. In particular, the pandemic drew attention to opportunities for growth in the care of people and families affected by mental disorders. Many of these opportunities are in countries in the south and east of Asia and have become a focus for WPA.

The WPA 22nd World Congress of Psychiatry (WCP 2022) was held in Bangkok, Thailand from 3-6 August 2022. This meeting was held in-person during the prelude to WCP 2022. The primary aim of the meeting was to initiate and formalise connections between leaders in mental health from across the south and east of Asia and generate collaborations on issues of highest need.

Meeting Organisation

The meeting was organised virtually ahead of WCP 2022. The Steering Committee consisted of WPA leaders and experts in mental health research from across the world. Prior to the meeting, Steering Committee members contacted leaders in psychiatry from across the region to attend and propose projects about cross-cultural areas of need. Attendees came from Australia, India, Indonesia, Sweden, United States of America, Mongolia, Philippines, Nepal, Pakistan, and Thailand. Attendees included psychiatrists, internal medicine physicians, and researchers with diverse expertise in subspeciality areas of psychiatry. A list of all invited attendees is provided in Annex 2.

The meeting occurred over a 3-hour period at the Sheraton Grande Sukhumvit in Bangkok, Thailand on the day prior to the opening ceremony of WCP 2022. Following the meeting, summaries of discussions were circulated, and projects were selected to formalise collaboration arrangements. Follow-up meetings were arranged to coincide with other major international meetings.

Meeting Objectives

The objectives of this meeting were about improving outcomes in the countries in the south and east of Asia. These included:

- Developing a formal network of leaders from countries in the south and east of Asia to champion cross-cultural collaboration projects on mental health care, aligned with the WPA Action Plan 2020-2023
- Determining research priorities and an evidence-base to support local mental health policy and,
- Establishing the foundations for producing publications about leadership directions for mental health innovation and development of local research capacity across the region

SUMMARY OF PROCEEDINGS

Opening Remarks

Professor Afzal Javed   Pakistan

World Psychiatric Association President

Professor Javed opened the meeting by highlighting how public mental health, especially across Asia is central to the mission of WPA. Professor Javed indicated a major goal of WPA is continuation – ensuring the ongoing growth of public mental health as a special focus amongst people working in mental health. The six areas of focus associated with the current WPA Action plan 2020-2023 were identified and explained as the frame for the meeting and its output.

Professor Javed emphasised that the role of WPA is to be a facilitator for psychiatrists and mental health clinicians to work together on common challenges. WPA is affiliated with associations across Asia and more than 250 000 psychiatrists across the world. This allows meetings such as these to lead to diverse pathways for collaboration.

The Steering Committee echoed the vision of Professor Javed and outlined the agenda for the meeting.

Proposals for Collaboration – Initial Proposals and Meeting Discussion Notes

Mapping the Status of Perinatal Mental Health Services in Southeast Asia

Proposal lead: Professor Prabha Chandra

                        India

Background. Depression and anxiety are among the most common of health conditions in the perinatal period, with over 25% of mothers in low- and middle-income countries (LMICs) having perinatal mental health (PMH) problems. In many countries suicide is one of the most important causes of maternal mortality. Important risk factors for PMH disorders include poor social support and family violence. It is therefore important to describe how mental health or maternal health services address protective and preventive factors for PMH in various countries. Maternal mental health has several social determinants and there is enough evidence for its importance not just for the mother but the infant and father as well. It also has implications for the health of future generations based on data from the Developmental Origins of Health and Disease research groups.

Despite prioritisation of maternal and child health, a comprehensive public health programme for PMH in most of Asia is lacking. We describe an initial review of published literature on PMH services in Asia. This can work as a template for further exploring and describing the status of PMH services in the region delivered either through non-Governmental organizations or Public Health Systems in order to create an action plan for the region.

Hospital based services. The first 8 bedded Mother Baby Unit (MBU) in South Asia was established in 2004 in Colombo, Sri Lanka. Later, the National Institute of Mental Health and Neurosciences (NIMHANS), Bengaluru started an MBU which offers mother-baby dyad joint care for all psychiatric disorders. In Sri Lanka, inpatient perinatal care is also provided by a few smaller MBUs established in urban areas, and the provinces. In most South Asian countries, due to lack of specialised MBUs, inpatient perinatal mental health care is offered through general hospital psychiatric units which may not be the most appropriate place for dyadic care and often leads to separation of the mother and infant.

Outpatient services. In India, the only specialized weekly Perinatal Psychiatry Clinic at NIMHANS in Bangalore and offers treatment, liaison, preconception counselling and a support group for families. A few other countries such as Hong Kong, Singapore, Malaysia and Taiwan have specialised out-patient perinatal psychiatry services integrated into different levels of public health systems. In Indonesia and Malaysia, perinatal psychiatry care is offered through consultation liaison psychiatrists both in public and private sector. In Kuala Lumpur, Women and Children hospital, Tunki Azizah runs a combined perinatal mental health clinic with liaison between obstetrics and psychiatry. In Doha, Qatar, Sidra Medical and Research Centre established the first and the only specialised perinatal psychiatric outpatient services, "Women's Wellbeing Clinic" in 2017. In Indonesia, MotherHope Indonesia (MHI) a non-profit organization provides psychological support to mothers with psychiatric illness.

Integration of mental health into maternal health services. Upskilling primary care workers and establishing access pathways may play a key role in providing perinatal psychiatry care. In Sri Lanka, the medical officers in primary health care services running the Maternal and Child Health (MCH) program screen for depression and provide care and referrals. Similarly, routine screening for perinatal mental illness is conducted in one secondary maternity hospital and one tertiary hospital in Shanghai, China.

Kerala state, India, has developed a maternal mental health screening programme – *Amma manasu* (mother's mind) where mothers mental health is assessed during their antenatal and postnatal visits by trained nurses with referral pathways to primary care doctors and the District Mental Health Programme are established.

Pakistan has a well-structured Community Healthy Worker (CHW) programme called "Lady Health Workers" program. However, due to shortage of CHWs, several women do not receive the help they need. WHO's "Thinking Healthy Programme" (THP) has been a successful trial conducted for the past five years in Pakistan. However, it is still not integrated within the health care system.

Singapore has a postnatal depression screening and intervention programme funded by health ministry and developed by a public hospital which handles around 12 000 deliveries every year.

In Japan, public health nurses conduct home visits for all mother and infants within four months of delivery and screen women for depression and psychosocial risk. Japan also has two national home visit programs ("newborn home visit program" and the Home Visit Project for All Infants").

In Shanghai, China, women with postpartum depression receive online services which include online therapy, access to chat groups, videos and reading material on mental health, mother-infant bonding and breastfeeding. The number of community health centres offering PMH services is gradually expanding in other provinces of China.

Involvement of midwives, nurses, community health workers and training initiatives. Despite the importance of perinatal mental health, there are few formal training programs in Asia. The perinatal psychiatry service at NIMHANS in Bengaluru, India, offers an on-site one-year post-doctoral fellowship program for psychiatrists. NIMHANS is also involved in training district psychiatrists in PMH through distance education program and has also started a three-month certificate course for health professionals in perinatal mental health. The Royal College of Obstetricians and Gynecologists, India has an online course on PMH for obstetricians.

The Japan Association of Obstetricians and Gynecologists conducts workshops to train midwives and nurses in screening mothers for PMH. In Thailand, the "Surveillance and care system for depressive disorders" program supported by the Department of Mental Health and Ministry of Public Health carries out screening of all high-risk groups, including women visiting antenatal clinics.

The above is a snapshot derived from the scant published literature on PMH. Many countries in Asia have similarities – strong family structures, focus on spirituality, gender disparity, low resources (with the exception of countries like Japan and Singapore) and well-developed maternal and child health services, providing a good framework for mutual learning. In addition, countries in this region also face other challenges like natural disasters (floods, earthquakes, and cyclones), as well as regional conflict. All these issues have high relevance for the mental health of mothers and young infants.

Mapping of PMH services and describing successful examples of PMH Services in each country within the public health framework will provide a good foundation for planning services in the region.

Meeting Discussion Notes

Professor Chandra highlighted how depression and anxiety are among the most common of health conditions in the perinatal period, with over 25% of mothers in LMICs having perinatal mental health problems. In many countries suicide is one of the most important causes of maternal mortality. Poor social support, exposure to family violence and limited resourcing for perinatal mental health play a key role in the development of these disorders. The literature reveals isolated examples of perinatal mental health services across Asian nations. However, many offer limited support, there is not always integration into primary care and obstetric services and training for non-specialists in PMH is scarce. A comprehensive public health program uniting approaches to perinatal mental health across Asia would serve to help nations work together on addressing this area of immense need.

Several attendees agreed that PMH is not a specialty area in many Asian countries. Services often rely on the advice of general psychiatrists, obstetricians, and gynecologists. There was also consensus that PMH services should extend up to the child turning 5-years-old to support the symbiotic early development of both child and family. Attendees agreed a core focus of this work should be sustaining the connection of family units as much as possible.

Potential Action Items:

- State-of-affairs position paper mapping the availability and quality of perinatal mental health services across Asia

Potential Funding Sources:

- Indonesian Ministry of Health
- Mother Hope Foundation
- Federation of Women's Mental Health

Mothers, Babies and Families at First Birth – A Cross Sectional Study

Proposal lead: Professor Prabha Chandra

                        India

This collaborative, prospective study will examine the life and health of women and families and the impact of a first birth in four countries differing in dominant cultures, traditions, and religions. We will recruit and follow 1000 pregnant women and their immediate family for one year from 12-16 weeks' gestation and measure determinants of health, their mental health, quality of life and welfare of the baby, mother, father and family. Discussions at each site with families, and health workers will facilitate the development of 1) transculturally valid and reliable instruments for assessing cultural practices related to child-birth and child-rearing and their local meaning and 2) an array of family interventions tested for feasibility and acceptability. At the conclusion of Year 3, we will have four diverse and collaborative sites with enhanced research capacity in this neglected area of study, valid measurement instruments and data about the life of women and their families, a set of potential family interventions, and a well characterized family cohort. We will also have plans and capacity to extend the project to other countries invited to join the discussions during Year 3.

This cross-cultural longitudinal study will begin with the development or adaptation of measures of mental and physical health, quality of life and functioning of mothers, babies and families. Interventions will then be developed to provide culturally appropriate supports for nurturing, safety, respect and kindness within families. In this study, families will be recruited through women receiving antenatal services in four countries (e.g., India, Guyana, Bangladesh, and Mongolia). We will work with in-country teams to develop and adapt the measures mentioned above and design the interventions. Feasibility and acceptability of these interventions will be tested in the four sites.

Phase 1, Year 1 — *Understanding and assessing traditions, beliefs and practices related to the experience of first childbirth, and consequences for the life, health, and functioning of mothers, fathers and families.*

Phase 2, Year 2 – *Focus groups, interviews and workshops with families, health providers, and other community leaders.*

Phase 3, Year 3 – *Pilot test the community-based interventions among the cohort of families in each country, analyze, report and disseminate the findings from all phases, and prepare for further study.*

Meeting Discussion Notes

Professor Chandra provided background on how the impact of first births on mental health outcomes remains largely unexplored across Asia. Professor Chandra then outlined a proposal for a 3-year cross-cultural collaborative prospective study on examining the impact of a first birth in four countries (e.g., India, Guyana, Bangladesh, and Mongolia) with different dominant cultures, traditions, and religions. The study will follow 1000 pregnant women and their immediate family for one year from 12-16 weeks' gestation and measure determinants of health, their mental health, quality of life and welfare of the baby, mother, father, and family.

Professor Chandra highlighted a major challenge in this area was the lack of culturally sensitive measurement tools with most currently available options being Anglo-centric. This was echoed by Professor Sartorius and Dr Supanya. It was recognised that the impact of a first-born child differs across Asia and often according to gender. Professor Chandra emphasised the impact of patrilocality on new mothers, especially in countries such as India, Pakistan, Nepal and Kazakhstan.

Professor Chandra indicated the study aimed to lead to the development of transculturally valid and reliable instruments for assessing cultural practices related to childbirth and child-rearing and their local meaning. The study also hopes to generate an array of family interventions tested for feasibility and acceptability.

Potential Action Items

- Publication on cultural aspects of a first birth (e.g., gender of children, attitudes of new generations, patrilocality) and the requirements of cross-cultural measurement tools

Potential Funding Sources

- UNICEF

Caring for Carers

Proposal lead: Professor Norman Sartorius

                           Switzerland

The health of people who provide care for unwell family members is a neglected part of health care. People who look after a severely-ill person in their family have significantly higher rates of physical illness than the rest of the population with similar demographic characteristics. They also have higher rates of common mental disorders, such as depression and anxiety. In many instances carers suffer a burnout state and eventually may abandon the care which they took on to provide.

It is proposed to assess and document the burden that carers who provide care to people with mental disorders and those who provide care to people with physical and those with mental disorders carry in 6 Asian countries differing in their culture, religion, history, economic condition and health care systems. Reports of this work will be used to highlight the problem and point to specific interventions which might taken.

The study will start by a series of ethnographic interviews to obtain information about the way in which the local community views different types of impairment and care for people with this type of impairment. Subsequent to this the local health service will help to identify 24 families, composed of 4 groups of 6 which have which have one of their members diagnosed as having one of four main types of impairment: moderate mental retardation, dementia, schizophrenia or hemiplegia.

A standardized assessment of the ways in which families are coping with the tasks related to caring for the persons with impairment will be carried out by local investigators trained in the use of the instruments with the usual tests of inter-rater and intra-rater reliability. The results of the ethnographic interviews will be used to assess the interventions which will be described by the carers.

The findings of this part of the study will be published and brought to the attention of the authorities dealing with health and disability.

In a second phase of the project it might be possible to introduce interventions aiming to diminish the burden of caring and its negative consequences and measure the effects of such interventions.

Meeting Discussion Notes

Professor Sartorius opened this proposal by emphasising how families and carers are the core of community mental health. Countries vary widely on defining the role of carers, and the supports provided to them. In some nations, such as China and Bangladesh, caring for elderly relatives is a cultural norm. Laws exist to punish those who do not care for their parents. In others, much less attention is given to carers. Their role varies widely, and may include looking after people with neurodegenerative disorders, such as dementia, but also people suffering other disorders like autism, schizophrenia and bipolar disorder.

Professor Sartorius highlighted the health of carers is greatly neglected. The limited available evidence suggests high rates of common mental disorders, such as depression and anxiety as well as burnout and eventual refusal to continue their caring role. However, the data is limited. Professor Sartorius proposed a study aiming to assess and characterise the burden of carers in people caring for others with mental and physical illness across 6 Asian nations with differing religions, cultures, history, economic conditions, and health care systems. This study seeks to form the basis of developing interventions to support the mental health and wellbeing of carers across Asia.

Attendees universally agreed the health of carers for people with chronic illness is greatly neglected across the world. Dr Diatri explained that in Indonesia support services are only available for patients but not their families. Dr Saha suggested there is a role for telepsychiatry in this area as a tool for provided assessments and support for carers. Professor Chandra emphasised the particular difficulty faced by young people and the impact on their own trajectories when caring for their parents who have severe mental illness and neurodegenerative disorders.

In some nations, carers receive some financial support. For example, Dr Supanya explained in Thailand, people can acquire semi-volunteer positions with a small stipend to go into rural areas to support families and communities looking after people with chronic illness. This can

include delivering health news (e.g., COVID-19 vaccination updates) and providing psychoeducation on how to care for people with severe mental illness. Professor Sartorius highlighted how such initiatives raise the question of the minimum competence for people to become carers.

Attendees emphasised the importance of data collection and providing recognition to carers. Associate Professor Bonomo described the National Disability Insurance Scheme in Australia where the support services for families are formalised and their impact measured with both positive and negative consequences. Professor Chandra, Dr Saha and Professor Hoven all emphasised the importance of schemes being designed to relieve carers from working 7 days per week to support relatives with chronic illnesses. Professor Sartorius suggested the proposal could assess the scope of such schemes and their impact across the region.

Potential Action Items

- Publication exploring the scope and impact of this topic across Asia. This paper may cover issues such as examining the minimum competence of carers before discharging patients into their care, mechanisms for relief of carers and types of supports offered by governments to carers

Trauma and Injury Prevention Training

Proposal lead: Professor Christina Hoven

                               United States of America

The prevalence of trauma and injury, including interpersonal violence, motor vehicle and industrial accidents, self-harm, suicide, etc., constitute a preventable public health crisis. While countries often possess public health institutions, university programs, policies, and the will to apply community-based approaches to address such problems, they generally do not have adequately developed research capacity to effectively access them and design evidenced-based interventions. A country-specific program would help to fill that gap by developing a Trauma and Injury Research Training Program, a potential collaboration between Columbia University in the US, and various public health institutions (e.g., local universities, ministries of health, etc.). Such a program would help train local scientists and health-care providers to independently conduct rigorous trauma/injury research and to develop, implement, and evaluate evidence-based prevention interventions that are specific to local needs. It would necessarily include didactics, mentoring and experiential learning. Didactics would include in-person and virtual classroom training in research methodologies, such as epidemiology, biostatistics, prevention and implementation science, and participation in an on-going research seminar series. Research mentoring would focus on hands-on project design; implementation of such projects with expert supervision would provide experiential learning.

We propose three training pathways, each uniquely designed to enhance the level of expertise of persons with varying levels of education, research exposure, professional roles and responsibilities:

(1) Health Care Professionals: These trainees (with advanced degrees: PhD, MD, or other equivalent training or experience) will participate in prescribed virtual course work, mentoring, and in-depth collaborative research opportunities appropriate to initiating or expanding a career as a clinician-researcher in trauma and injury prevention.

(2) Students: Open to those in training for a health profession such as nursing, social work, psychology, physical therapy, and education, as well as related fields, including engineering, health policy, computer science, economics, etc. In addition to didactics, these trainees will

direct their required practicum or research project towards a trauma/injury prevention research agenda that relates to their specific discipline. Trainees in pathway (1) and (2) will choose a one-year or two-year program.

(3) Leadership: The cohort of trainees for this program will be drawn from pathways (1) and (2), selected on the basis of interest and potential for assuming a leadership position in the areas of trauma and injury prevention. The Leadership Pathway, with a focus on integration-of-knowledge and leadership skills, is designed as a three-year program, but attendees will potentially develop close mentoring relationships that will extend far into the future, as trainees assume leadership positions and seek guidance.

All trainees will emerge with the requisite skills to carryout evidence-based research on trauma and injury prevention in their various workplaces, and to disseminate their research findings in presentations, scientific literature and in policy settings.

This training program will be a collaboration with faculty from leading international institutions, such as Columbia University, including the Center for Injury Science and Prevention, and as such will receive intellectual support contributing to sustainability of the Trauma and Injury Training Program's investment in human capital.

It is anticipated that such trauma and injury training programs would likely receive notice from national policy makers, facilitating the research findings being disseminated and implemented.

It is anticipated that all trainees who successfully complete pathway (1) or pathway (2) will receive a Certificate in Trauma and Injury Prevention awarded by Columbia University Department of Epidemiology. It is anticipated that a Leadership Certificate will also be awarded from an appropriate entity.

Meeting Discussion Notes

Professor Hoven indicated that in many parts of the world, mental health care does not feature prominently in emergency departments. Yet the prevalence of trauma and injury (including interpersonal violence, motor vehicle accidents, self-harm, suicide and others) constitute a preventable public health crisis. While many countries have public health institutions,

university programs, policies, and the will to apply community-based interventions to address these problems, there is a lack of research capacity to evaluate them and utilise evidence-based interventions.

Professor Hoven proposed the introduction of country-specific programs to develop Trauma and Injury Research Training Programs, supported by Columbia University in the United States of America and local public health institutions across countries in the south and east of Asia. These programs would include training for local scientists and health care providers to develop skills in developing, implementing, and evaluating evidence-based trauma prevention interventions tailored to local needs.

Professor Hoven proposed 3 training pathways: the first for health care professionals, the second for students training in the health care professions and the last for emerging leaders in trauma and injury prevention. Completion of the first two training pathways would lead to a Certificate in Trauma and Injury Prevention awarded by Columbia University Department of Epidemiology, while the last would lead to a Leadership Certificate from an appropriate entity.

Associate Professor Bonomo highlighted how this training would be valuable to many nations in the region, though sources of trauma may vary. Several attendees recognised the need for health care workers to screen for the contribution of mental disorders and problematic substance use in physical trauma presentations to emergency departments. Professor Chandra highlighted that the Indian Government has invested heavily into disaster management with some universities developing departments of psychosocial trauma. Similarly, Dr Supanya indicated there may be interest in this kind of project in Thailand, where some work is focusing on examining the links between physical trauma and the development of psychotic experiences.

Potential Action Items

- Compile a reading list on the topic of screening for mental disorders and psychosocial trauma in emergency presentations to health services
- Determine how this training could be delivered in countries with interested attendees

Potential Funding Sources

- National Institute of Disaster Management, India
- Nepal Institute of Mental Health
- Fogarty International Centre, United States of America

Safe Spaces for Youth Mental Health in Settings of Adversity

Proposal lead: Professor Helen Herrman
                        Australia

Young women and men in high-income countries with good access to health care rarely seek help for mental health problems. Nor is there good understanding of the opportunities to improve mental health for young people in health, education, social welfare or other settings.

In scarce resource countries and settings of adversity there is (paradoxically) less opportunity to seek access to help and support, and less demand for care through health or other settings.

In several high-income settings there is an evolving service model to deal with this problem. The model uses the concept of enhanced primary health care. The services are based in community hubs such as shop fronts and remodelled factories. Mental health and addiction specialists (including psychiatrists), primary care physicians, nurses, social workers, housing, welfare and youth workers, are co-located in these centres. Young people can attend without feeling ashamed and without being labelled as mentally ill. They can walk in to ask for information or help without referral or appointment. Their families and friends can also refer them to the centres, as can a health care professional. These centres have various names in Australia ('headspace'), Ireland ('headstrong'), and parts of North America and Europe.

A version of such a service, pared down to its essentials, is envisaged in the informal settlements in Nairobi, beginning near Mathare Hospital. Here the care settings can be created in safe spaces such as youth cultural or welfare settings (e.g., where young women and men come for help with housing, education, or social problems, or with sexual and reproductive health needs). A well-developed example of such a service is the Wellness Centre developed at NIMHANS in Bangalore, India by Professor Prabha Chandra. Young women and men, including teenage parents can talk with their peers and/or a nurse, psychologist or Anganwadi worker. The workers are empowered to assist in a number of ways, including help with social connections, sporting and arts-based activities; and can refer a young person for help from a mental health specialist as needed, as well as themselves obtain regular contact with and supervision from the specialist.

The concept for the safe spaces project is that the existing youth, housing, health (including maternal and child health) or welfare workers in these settings can become attuned to mental health needs and simple solutions such as active listening and can also refer young people to receive further help. The workers can be linked with psychiatrists or other mental health specialists for accessible training (face-to-face and/or online) and receive supervision and refresher training though the same modalities. The mental health specialists in turn can be trained and supported through the WPA-citiesRISE collaborative program. This collaborative program includes the development of online training, and manuals and resource library as needed, through partnership with digital service providers working with citiesRISE.

Meeting Discussion Notes:

Young people all over the world rarely attend health services, especially for mental health support. This occurs even in high-income countries where there is good access to health services. Professor Herrman explained that in several high-income settings there is an evolving service model to deal with this problem. The model uses the concept of enhanced primary health care. The services are based in community hubs such as shop fronts and remodelled factories. Mental health and addiction specialists (including psychiatrists), primary care physicians, nurses, social workers, housing, welfare and youth workers, are co-located in these centres. Young people can attend without feeling ashamed and without being labelled as mentally ill. They can walk in to ask for information or help without referral or appointment. Their families and friends can also refer them to the centres, as can a health care professional. These centres have various names in Australia ('headspace'), Ireland ('headstrong'), and parts of North America and Europe.

Professor Herrman outlined how similar models are emerging in other parts of the world, such as Nairobi and India where workers are empowered to assist young people with a range of problems, such as social connections, sporting, arts-based activities as well as referral to mental health specialists, as needed. Supervision is provided to workers from specialists.

Professor Herrman proposed expanding this model of 'safe spaces' for young people to other parts of the region. This may include training people who work with young people to enable access to housing, health, and welfare services. Mental health specialists can provide training

and supervision through the WPA-citiesRISE collaborative program, which includes online training, manuals, and resource libraries.

Professor Hoven outlined other similar interventions. One example was in Taipei where community groups turned a train station into an access point for basic living supplies as well as health services for people affected by homelessness. Dr Saha also gave an example of a similar initiative he ran in Calcutta where he provided meals for homeless people at a railway station using tools from his own kitchen. Dr Saha emphasised many non-Government organisations have an interest in this model of care across India. Several attendees recognised the value of health services that seek to deliver services where those in need are living, rather than requiring them to come to the health service.

Potential Action Items

- Survey across Asian nations about models of care for young people and examples of community-based care

Tackling Harmful Substance Use in Young People

Proposal lead: Associate Professor Yvonne Bonomo
                       Australia

Substance use is common among young people, and it is well documented that early onset of substance use is associated with impairments in psychosocial development, cognitive function and health and well-being. This proposal aims to co-design a curriculum and training in the approach to substance use in young people for health professionals, including general practitioners, psychiatrists, psychologists, nurses and others. The context in which these health professionals work can be primary care, schools, mental health services, community services or other contexts relevant to young people. Co-design of the program may occur in different ways, depending on the context in which it is developed, but would likely include co-work between colleagues locally and globally, as well as young people with lived experience.

The objectives of the curriculum on substance use in young people include:

- Establish the skills needed to make a comprehensive age-appropriate assessment of a young person that enables the health professional to understand the substance use in the overall context of the young person's health and well-being and psychosocial circumstances
- Evaluate a) confidence and b) competence that health professionals have in addressing substance use in young people before and after the training
- Grow a local network/Community of Practice (CoP) through which health professionals can identify common presentations or issues that occur in their community and work together to develop a management plan
- Promote the value of a holistic approach to young people which thereby improves their overall health and well-being as they grow into young adulthood
- Inform both local and broader policy that facilitates best practice for promoting health and welfare of young people in the population

Primary prevention of addiction, mental disorders and psychosocial deterioration requires best practice assessment of young people and their health needs. The key to this is being comfortable with making a holistic assessment of the individual, through which rapport with

the young person is established, and goals for improving health and well-being can be jointly determined and planned. Young people frequently do not see the substance use as 'the problem' but are more concerned about other issues such as their peer group, their identity etc. A health professional competent and confident in working with young people who use substances can assist the adolescent to work through their concerns and understand the impact of substance use on their health. Furthermore, the health professional can recognise significant psychosocial stressors and work with relevant services to address these, thereby promoting the health and well-being, not only of the young person but also the community in which they live.

The competencies which would be addressed and built into the curriculum would include the following:

- The psychosocial assessment – using the HEADSSSS acronym; how to apply it in different contexts
- Differentiating between substance use and substance use disorder and management.
- Supporting self-management in young people:
  - Communication skills
  - Information seeking
  - Problem solving
  - Behaviour change
- Optimising mental health including understanding emotional health.
- Optimising physical health including chronic diseases (where present)
- Involving families or caregivers when working with young people
- Challenging consultations with young people and how to manage these situations.
- Strategies for the health professional's own well-being when working with challenging circumstances

Note: This curriculum development could be a standalone initiative, or it could be added to some of the other proposals for the Mental Health in Asia proposals (e.g., Training for mental health practitioners' work in communities, early intervention for young people with mental illnesses etc.).

Meeting Discussion Notes

Associate Professor Bonomo highlighted that substance use is a major issue for young people throughout countries in the south and east of Asia. A straw poll involving meeting attendees indicated variation in the types of misused substances most commonly encountered in clinical practice across the region. Early substance use has lasting impacts on psychosocial development, cognitive function and health and wellbeing throughout the lifespan. Young people frequently do not see substance as problematic, but are concerned about other issues, such as their peer group and identity.

Many health professionals are uncomfortable talking to young people about substance use. Yet competent and confident health professionals working with young people using substances can make a significant impact on the full scope of their health and wellbeing. Associate Professor Bonomo proposed developing a co-designed curriculum for training health professionals, including general practitioners, psychiatrists, psychologists, nurses, and others in working with young people who use substances. The objectives of this curriculum include:

- Establish the skills needed to make a comprehensive age-appropriate assessment of a young person that enables the health professional to understand the substance use in the overall context of the young person's health and well-being and psychosocial circumstances
- Evaluate a) confidence and b) competence that health professionals have in addressing substance use in young people before and after the training
- Grow a local network/Community of Practice (CoP) through which health professionals can identify common presentations or issues that occur in their community and work together to develop a management plan
- Promote the value of a holistic approach to young people which thereby improves their overall health and well-being as they grow into young adulthood
- Inform both local and broader policy that facilitates best practice for promoting health and welfare of young people in the population

Professor Sartorius indicated there is likely some training in countries throughout the south and east of Asia, but there would be value in collating and assessing resources. Professor Chandra

suggested collating projects proposed by Professor Herrman and Associate Professor Bonomo to develop international mentorship programs for young people, highlighting that many nations have recognised the importance of youth mental health, but have not formally implemented strategies. Dr Diatri indicated primary care workers in Indonesia would benefit from this kind of training due to insurance companies offering limited support for hospital-based care of people misusing substances. It may be useful to expand the scope of training to include other forms of addiction, such as gaming.

Associate Professor Bonomo also suggesting attaching a substance use component to other proposals discussed at the meeting.

Potential Action Items

- Survey to determine most common addictions across Asia
- Development of a multi-national education and mentorship program for health workers involved with young people

Enabling Safe and Healthy Schools, Engaging Communities to Solve Problems

Proposal leads: Professor Helen Herrman

                          Australia

                          Professor Christina Hoven

                          United States of America

Given the importance of early intervention to promote mental health and prevent mental ill-health, as well as the connection between school dropout, absenteeism and mental health, school-based programs are a logical part of community-orientated mental health programs. Premature departure from education at primary and lower secondary school levels is the root cause of many social, economic and health problems which can be prevented, as shown in an earlier WPA program. Even before youth permanently discontinue schooling, absenteeism can contribute to significant problems for them and others (families, school staff, communities). There are also effective methods of responding to other significant mental health needs in schools including the prevention of bullying and abuse of students, and the provision of support for those who are bullied. Support for the mental health of teachers, given the high prevalence of disabling illness and burnout in teachers is another area that needs urgent attention.

In the Nairobi and Chennai healthy city programs initiated by citiesRISE, the World Psychiatric Association will participate in the development of a school mental health program. One part of those programs may be focused on persistent school absenteeism and the prevention of 'school dropout'. The initiative may also include support for the safety of students and for the mental health of teachers and will use a whole school approach designed in collaboration with local stakeholders and targeting needs of teachers, students and parents. It is expected that the program will be multi-modular and pragmatic using experience from the host countries and programs elsewhere (e.g., the USA "response to intervention (RTI)" programs)

It is expected that the program will be defined and executed by a School Health and Safety Team (SHST) including students, parents, teachers and a mental health professional. The SHST will be able to contact students who are persistent absentees and their parents and build a shared strategy with them, relying also on contact with social and health services in the community. A web-based portal will offer information, materials and the possibility to chat with a

professional who can provide further and specific information about mental health problems which will aid teachers to respond to behavioural problems (such as bullying).

The program should be built respecting several principles:

- The program should focus on problems identified by the schools participating in the program
- The interventions offered to schools shall be of proven effectiveness and vary in harmony with the socio-economic conditions of the country/city/town in which the school is located
- The description of interventions with sufficient detail to be applied will be easily and freely available. They may include interventions that will primarily depend on persons without medical education
- The WPA will establish a network of experts who could be invited to assist the implementation of programs

Meeting Discussion Notes

Professor Herrman began this proposal by highlighting how prior WPA work has demonstrated that premature departure from education systems has been recognised as the root cause of many social, economic and health problems, including the development of mental disorders. Several factors have been linked to an increased risk of dropping out of school. These include neurodevelopmental and sensory difficulties can impact the likelihood of dropping out of school. Adverse social experiences, including bullying and fracturing of relationships also play a role.

Professor Herrman and Professor Hoven highlighted there is a need to support teachers and school staff in responding to mental distress, bullying and learning difficulties. Mental health professionals can support school staff in developing skills in these areas. There is also a need to support the mental health of teachers given the high prevalence of disabling illness and burnout. WPA is active in this area, having supported the citiesRISE program in Nairobi and Chennai, which aims to develop school mental health programs. These programs may seek to address several areas, including school absenteeism, student safety and teacher mental health.

It is anticipated the programs will be defined and executed by a School Health and Safety Team including students, parents, teachers, and mental health professionals. The programs will be informed by several principles:

- The program should focus on problems identified by the schools participating in the program
- The interventions offered to schools shall be of proven effectiveness and vary in harmony with the socio-economic conditions of the country/city/town in which the school is located
- The description of interventions with sufficient detail to be applied will be easily and freely available. They may include interventions that will primarily depend on persons without medical education
- The WPA will establish a network of experts who could be invited to assist the implementation of programs

Professor Sartorius indicated there has been a continuous decline in the number of teachers across many countries. There is data on school dropout rates in other parts of the world, such as Latin America, but there is limited evidence on this outcome across the region. The starting point for this proposal may be simply collection of data on school dropout rates. Dr Diatri recommended adding assessing the impact of COVID-19 and the adoption of online learning approaches.

Potential Action Items

- Study on rates and characteristics of school dropouts across Asia, as well as exploration on approaches to preventing young people from dropping out and subsequent development of mental disorders.

Discussion of the following proposals titled, 'Early Intervention Programs for Young People with Mental Illnesses (Including Young People with Intellectual Disabilities)' and 'Development of Curricula for Training Mental Health Professionals in Ways of Practice that will Orient and Facilitate Their Work in Local Settings' were not discussed during the in-person meeting due to time constraints. However, details of these proposals were circulated prior to the meeting and remain areas of interest for the group.

Development of Early Intervention Programs for Young People with Mental Illnesses (Including Young People with Intellectual Disabilities)

Proposal lead   Professor Helen Herrman

                                 Australia

Young people with mental illnesses in low-and middle-income countries have very limited access to treatment and support. They are subject to difficulties and disadvantages that are compounded over time and relate to avoidable loss of education, work, and family and peer relationships. Taken together with the experience of mental ill-health itself, this means that young people without support or access to care early in the course of mental disorders such as depression or schizophrenia face the prospect of preventable disabilities and complications such as substance abuse, unemployment, homelessness or death by suicide or other causes.

Early intervention programs for young people with emerging mental disorders have been introduced in several high-income countries over the past 20 years. There is good evidence of health and social benefits for the young people themselves and their families, and social and economic benefits for the societies are described.

Young people with intellectual disabilities are often left in the care of families with few resources or help. Intellectual disability in a young person in any society or setting increases the likelihood of developing a mental disorder such as anxiety, depression or psychosis. In this situation the need for early intervention is heightened. Yet little work has been dedicated to developing and evaluating such programs in high-, middle- or low-income countries.

We envisage a cooperative program of workshops and consultations to consider how to extend modern thinking and techniques in care and support to these young people and their families. The World Psychiatric Association has convened expert groups that aim to initiate work in low- and middle-income countries in Europe, and we can learn from the experience of this work.

We anticipate:

- Convening an expert group to include advisers with experience of implementing these programs internationally and advisers from low- and middle-income countries in Asia to consider how early intervention programs can be introduced and evaluated in a local setting

- Engage with young people with lived experience

- Engage with families who have experience of supporting young people in this situation

- Consult with a local group determined to initiate an early intervention program for young women and young men with emerging mental disorders, with or without intellectual disability. The local group might connect with a local university and professional associations

The expert group can assist with implementation and evaluation as well as advocacy and fundraising and eventually consider opportunities for dissemination to other countries in Asia.

Development of Curricula for Training Mental Health Professionals in Ways of Practice that will Orient and Facilitate their Work in Local Settings

Proposal lead: Professor Helen Herrman
                         Australia

WPA has initiated this line of work by producing an outline of a curriculum to govern the training of trainers of personnel working in schools and gathering spaces in specific cities and local settings. The curriculum should help to transform mental health services, introduce activities for the primary prevention of mental disorders and ensure increased awareness of the role of psychosocial factors in the promotion of health in general.
Prof N. Sartorius is in charge of this program.

The transformation of the function of mental health services must ensure that:

- Care is provided in the community with an active involvement of the community members
- Mental health workers spend a significant amount of their time in the community searching for opportunities to inform community members about mental illness and its care and to facilitate access to care
- People who have experienced mental illness and their carers are invited to participate in the definition and evaluation of the work of mental health services
- The promotion of the value of mental health and enhancing health literacy are added to health service efforts aiming to promote health, e.g., during perinatal care
- Mental health activities are included in other programs promoting health and welfare of the population

Most of the activities leading to the primary prevention of mental disorders require the engagement of health services other than psychiatry (e.g., paediatric care) and of services outside the health sector (e.g., the educational authorities). Similarly, the recognition of the importance of psychosocial factors in the promotion of health and in general development will have to be promoted in various fora ranging from curricular committees in medical schools and

the media to contacts between mental health specialists with political and administrative authorities.

To perform effectively in these roles the psychiatrists and other mental health practitioners need a number of competencies which are currently not given emphasis in the course of their professional development. These include at least the competency to:

- Listen and communicate effectively
- Work effectively in teams
- Understand the range of actions including advocacy and collaborative activities that contribute to the improvement of mental health of young men and women in adversity.
- Understand the principles of working in collaboration with other actors in community settings
- Engage and collaborate with decision makers
- Have mastery of public health strategy and technology necessary for program development
- Have skills and knowledge to design and participate in the training and support of health workers and community workers engaged in the provision of care.
- Design and evaluate care pathways and referral chains
- Design and evaluate interventions aiming to deal with psychosocial aspects of health care
- Critically appraise scientific literature and existing models of care.
- Design programs of primary prevention of mental disorders and engage all involved in their implementation
- Design ways and describe mechanisms that will make it possible to carry out formative evaluation of activities undertaken in the framework of community- oriented psychiatry

Each competency will be described in detail along with existing and needed resources to develop a training curriculum. An online library and links to major libraries will be established. WPA has identified experts who will compose the faculty defining and implementing the curriculum leading to the acquisition of the competencies mentioned above. The faculty will meet to finalize the text of the curriculum involving also psychiatrists and other mental health workers who will participate in the courses.

Once the curriculum is fully developed (WPA) will select the attendees in the training program and bring them together for the first of two sessions in which they will participate. After a first session lasting 12 working days the attendees will return to their places of work to implement the program. The second session of the faculty with the students will take place 12 months after the course. This session will serve to receive feedback on the usefulness of the training and to amend it for publication and utilization in all the sites of the joint citiesRISE and WPA program.

Telepsychiatry: Tools for Connection and Collaboration in Areas of Need Across Asia

Proposal lead: Dr Christopher Lemon

                               Australia

Personal mobile technologies are now ubiquitous in many parts of the world. In 2013, United Nations University reported more people in India had access to a cell phone than a working toilet. Telehealth takes advantage of this infrastructure to allow unprecedented opportunities for accessing health care and psychosocial support almost anywhere in the world. This is especially valuable in areas where rates of mobile device ownership and internet access is high, but the availability or uptake of face-to-face services is low. Perhaps most importantly, telehealth can enable connection, collaboration and supervision for people working with and suffering from mental illness, which would otherwise be limited by distance and context.

The COVID-19 pandemic has led to a rapid increase in the development of telepsychiatry. Telepsychiatry offers evidence-based, innovative approaches for delivering best-practice interventions (e.g., virtual reality systems for exposure therapy), adjuncts to face-to-face care (e.g., online cognitive behaviour therapy) and entirely new approaches to treatment (e.g., online chatbots, wearables and mental health smartphone apps). Telepsychiatry can also be a valuable tool for training and supporting people working with those suffering mental illness in resource-limited settings. One example is the World Health Organization's (WHO) e-mhGAP smartphone app for supporting assessment and management of mental illness in isolated regions (e.g., rural India and Solomon Islands). Another is the online 'Step-by-Step' program, a digital intervention for depression that has been used alongside non-specialist care amongst Syrian refugees in Lebanon.

There is still much untapped potential in telepsychiatry. Technology and the Internet are embedded in many Asian societies. Members from the WPA across Asia are well-placed to investigate and lead in realizing the full potential of international collaborations in this area. Indeed, evidence already supports the use of telepsychiatry for several of the issues discussed at this meeting, including reducing problematic substance use, prevention and treatment of common mental disorders in perinatal populations and enhancing engagement amongst vulnerable young people.

This meeting provides an opportunity to establish a formal collaboration and mentoring network for the implementation of telepsychiatry systems across Asia, especially in low- and middle-income settings. This does not require advanced technologies, but instead working to capitalise on already available infrastructure that can help bridge fragmented services. Some potential functions of this network include:

- Establishing clear data on capacity and interest in telepsychiatry as well as technology literacy amongst consumers and carers (particularly those who are marginalised, such as the homeless) as well as health providers in regions where personal device ownership is likely to be high but health service access is low. This could involve a WPA survey assessing types of technologies used, Internet access and quality (e.g., reliability, modality and network speeds), typical uses of technology (e.g., most commonly used functions, apps and services) as well as questions on barriers, feasibility and acceptability of telepsychiatry. This data can then be analysed for alignment with the recently released WPA Global Guidelines for Telepsychiatry, and form the basis of advocacy, applications for funding and engagement of industry (e.g., telecommunications providers).

- Once data on capacity is established, the network could advocate for the introduction of simple services for providing supervision and support for those working with people suffering mental illness in isolated regions where specialist services are limited. This may involve developing co-designed telephone, SMS or videoconferencing consultation services with specific dates and times for primary care workers to access urban-based specialist advice. This kind of service can involve specialists delivering education and training for managing psychiatric issues and introduction of other telepsychiatry services (such as WHO's 'Step by Step' online program). It can also act as a platform for primary care workers to jointly access multidisciplinary teams (e.g., psychiatrists, specialist physicians, allied health and cultural health workers) and help translate and adapt care plans for individuals with both mental and physical comorbidities into local languages and cultural norms.

- Develop a research and innovation agenda led by lived-experience community members in low- and middle-income countries. This can involve assessing the feasibility and effectiveness of applying digital interventions developed in high-income countries (e.g., online cognitive behaviour therapy services) in low-income areas.

However, it may also involve empowering local community members to develop their own entrepreneurial digital interventions to improve health care delivery. The function of the network in this setting would be to facilitate access to education, training, and international mentorship in developing and running local telepsychiatry services.

This telepsychiatry collaboration and mentoring network can exist to solely focus on telepsychiatry across Asia. However, it's potential aims and areas of work can also be adapted to form part of other projects already discussed at this meeting.

Meeting Discussion Notes

Dr Lemon pointed out that personal mobile technologies are ubiquitous in many parts of the world. In 2013, United Nations University reported more people in India had access to a mobile phone than a working toilet. Telepsychiatry takes advantage of this infrastructure to allow unprecedented access to health care and psychosocial support almost anywhere in the world. The COVID-19 pandemic led to a rapid uptake of telepsychiatry systems due to the impact of the virus on face-to-face services. Several initiatives (e.g., the 'Step-by-Step' program and e-mhGAP by the World Health Organization) have demonstrated telepsychiatry can improve outcomes, particularly in areas where resources are low. Yet there is still much untapped potential, including in multiple areas discussed at this meeting.

Dr Lemon proposed the developed a formal collaboration and networking program to support broader implementation and integration of telepsychiatry systems across countries in the south and east of Asia. Potential functions of this program would include surveying current uses of technology in mental health programs, levels of telepsychiatry literacy in communities and use of existing guidelines, such as the WPA Global Guidelines for Telepsychiatry. The program could also seek to establish formal mentoring programs to connect urban and rural communities in parts of Asia through telepsychiatry systems. Mentoring programs could expand to involve conducting research on the use of telepsychiatry interventions in remote areas and the development of bespoke systems suited to local cultural norms.

Dr Saha indicated communities in India perceived the rapid adoption of telepsychiatry as an unexpected benefit of the COVID-19 pandemic. This has led to the development of 23 'Centres

of Excellence' in telepsychiatry across India. Dr Saha also emphasised the importance of communities having access to useful guidelines to support implementation and best practice.

Several attendees highlighted challenging aspects of using technology in relation to mental health. Professor Sartorius raised the question of who should use telepsychiatry services. Some populations may have limited access to necessary technologies to participate, such as the elderly and the poor. Dr Diatri mentioned how many young people use social media to access information about mental health. This can be through celebrities and influencers promoting the importance of mental health care, but also spreading misinformation about mental illnesses. Dr Lemon referred to recent publications on young people using social media platforms to learn about diagnoses such as attention deficit hyperactivity disorder, and the impact of this on presentations for care.

Potential Action Items:

- Publication summarising current approaches to regulating and defining the scope of telepsychiatry services across Asia

CONCLUSIONS AND RECOMMENDATIONS

This meeting represents the first step towards establishing a collaborative working group of mental health leaders focused on the development of mental health research capacity and local innovation in countries in the south and east of Asia. The proposals presented highlight the scale of unmet need as well as broad scope of opportunities for improving systems and outcomes for people affected by mental disorders across the region.

The meeting concluded with a recognition of the sociocultural similarities between represented countries and common themes amongst the issues discussed. There was agreement about the need to refine the focus of the group to around 2-3 priority areas in the initial period of work. Response to any of the proposals discussed is likely to lead to benefits spanning several related issues. In addition, it was recommended that work on these issues be locally led with support from leaders in other nations to ensure the focus remains on building regional capacity for research and innovation.

The immediate next tasks for this group are to formalise action plans for priority areas. This includes defining the scope of the work and securing sources of funding and implementation strategies. Academic publications detailing the process undertaken prior, during and immediately after this meeting are needed to formalise the call to action for collaborators across the region. These publications are also an opportunity to highlight major gaps in the literature on mental health in the south and east of Asia. A schedule for subsequent meetings virtually and in-person is being developed.

A focus of the WPA Action Plan for the 2020-2023 triennium is the role of psychiatry amongst other professions in promoting and improving public mental health. This meeting represents implementation of the WPA Action Plan for countries in the south and east of Asia. There is much to be done. However, this meeting demonstrated there is optimism and commitment to responding in ways that will meaningfully impact the lives of people affected by mental disorders throughout countries in the region.

The IMHDG welcome correspondence from any parties interested in contributing to this work.

ANNEXES

ANNEX 1:   Meeting agenda and programme of activities

Tuesday 2 August 2022

1:30 – 2:30 pm

1. Opening
2. Greeting from WPA President, Professor Afzal Javed
3. Introductions including brief country reports
   3.1 India
   3.2 Indonesia

   3.3 Mongolia

   3.4 Nepal

   3.5 Philippines

   3.6 Thailand

2:30 – 3:30 pm

4. Identifying topics suitable for multicentric collaboration in research

   4.1 Brief presentation and discussion on 10 topics

3:30 – 3:45 pm

1. Break

3:45 – 4:45 pm

2. Identification of topics for first action

4:45 – 5:30 pm

3. Timetable of action

4. Conclusions and closure

ANNEX 2:   List of invited attendees

Yvonne Bonomo	Australia
Prabha Chandra	India
Constantine Della*	Philippines
Saraswati Dhungana	Nepal, Norway
Hervita Diatri	Indonesia
Helen Herrman	Australia
Christina W. Hoven	United States of America
Afzal Javed	Pakistan
Christopher Lemon	Australia
Batuvshin Lkhagvasuren*	Mongolia
Gautam Saha	India
Norman Sartorius	Switzerland
C. P. Sedhai	Nepal
Napat Sittanomai	Thailand
Suttha Supanya	Thailand
Connie Svob	United States of America
Imran Haider*	Pakistan
Danuta Wasserman	Sweden

*Unable to attend in-person

ANNEX 3:   International Mental Helath Development Group Steering Committee

Norman Sartorius	Switzerland
Helen Herrman	Australia
Christina Hoven	United States of America
Prabha Chandra	India

ANNEX 4:   IMHDG Rapporteurs

Christopher Lemon   Australia

Connie Svob   United States of America

ANNEX 5:   Notes about research needs and interests in Asia submitted by attendees
prior to the meeting

Bangladesh

Submission author   Waziul Alam Chowdhury

Mental health is across cutting public health issue in Bangladesh since people friendly health services started after liberation. Currently Bangladesh has 18.6% adult and 12.6% children have any mental health condition and treatment gap is huge (92%), so the public health concerns came forward and it is getting more attention to the policy makers. On this context Bangladesh enacted Mental health act 2018 and we have stand-alone mental health policy which has approved by highest authority of Bangladesh government on 2022. The National Mental Health Strategic Plan 2020-2030 has been developed and costed.

The 7th Five Year Plan and Vision 2021 recognizes that health also includes mental health and social wellbeing. The National Adolescent Health Strategy 2017-2030 has adolescent mental health has one of four major thematic areas. Bangladesh has also enacted Rehabilitation Council and Disability Law of 2018 and developed the National Strategic Plan for Neurodevelopmental Disorders 2016-2021. Once the National Mental Health Strategy is approved, A National Multisectoral Mental Health Coordination Committee for implementation and monitoring of National Mental Health Strategic Plan 2020-2030 and a Mental Health Secretariat will be set up.

Mental Health Review and Monitoring Committee (MHRMC) which will be a part of Multisectoral Noncommunicable Disease Control Committees that will be established in all districts. There are prevention and promotion programmes on mental health being carried out by the NIMH, Ministry of Social Services and national level NGOs. Specific information related to these programmes need to be collected through consultations.

Now Bangladesh is approaching to integration mental health care at primary health care set up.

Mental health services integration with primary health care is not only the most desirable approach but also a feasible cost-effective achievable approach for low and middle-income countries like Bangladesh.

Improving mental health, ensuring inclusion of persons with mental health conditions in society, and protecting the human rights of those with mental health conditions will enable social and economic development as reflected in several other SDGs, including SDGs 8 and 10, and their respective targets. In May 2013, the Sixty sixth World Health Assembly formally accepted the first ever Mental Health Action Plan of the WHO. The Plan has recognized the essential role of mental health in achieving health for all. The four major objectives defined in the WHO Mental Health Action Plan 2013–2020 includes:

- Strengthening effective leadership and governance for mental health;
- Providing comprehensive, integrated and responsive mental health and social care
- services in community-based settings;
- Implementing strategies for promotion and prevention in mental health; and
- Strengthening information systems, evidence and research for mental health.

Mental health disorders, despite causing enormous social burden, continue to be neglected due to stigma, prejudice, fear of disclosing an affliction because of anxiety of losing a job and/or social standing; or because health and social support services at the community level are not available or are out of reach for individuals and their families.

Indonesia

Submission author   Hervita Diatri

Hervita Diatri, psychiatrist and academic staff at the Department of Psychiatry, Faculty of Medicine, Universitas Indonesia (FMUI), majoring especially in community psychiatry, which mainly focuses on making mental health services more accessible, improving the quality of services, and protecting the rights of people with mental disorders as humans by collaborating with various stakeholders.

I was working as:
- Head of the Division of Community Psychiatry, Psychosocial Rehabilitation, and Trauma,
- Department of Psychiatry, FMUI - 2013 - present
- Head of Community Psychiatry Section, Indonesian Psychiatric Association, 2014 – present
- Head of the Quality and Patient Safety Committee, Cipto Mangunkusumo Hospital, 2014 –present
- Based on my knowledge and experience, I am interested in conducting research that will then be developed into evidence-based policy. Research that have been and continues to be developed are related to:
- Human rights violation cases – the practice of placing patients on shackles, stigma, social exclusion, discrimination (including marginalized groups such as the LGBTi)
- Community case management – mental health care needs for patients with mental disorders and associated cardiometabolic risk, and COVID-19
- Integration of mental health services into physical health services – cardiometabolic, perinatal and maternal, geriatric risk management
- Continuity of services: inpatient to outpatient, hospital to community, vice versa - especially for re-admission cases, psychiatric emergency cases (due to self-harm and suicide)
- Quality of mental health services – primarily related to frequent re-admission, chronic care model development, implementation of patient experience principles, restraint in

health facilities and community services, suicide risks, voluntary/involuntary admission, and violence cases

- Natural disasters and other psychosocial trauma – domestic violence, natural disasters, the pandemic and its impacts (including changes in cultural values, loneliness, resilience)

- Patient and family participation – development of a safety discharge plan

- Mental health in the workplace (including healthcare facilities) – burn out, peer support development

- Psychosocial rehabilitation – mainly the approach to recovery

- The impact of capacity building among health workers in primary care – based on MH-Gaps (especially for psychotic disorders, depression, anxiety, and psychiatric emergency management in the community)

- The role of the media for mental health – self-harm/suicide cases, stigma, and discrimination

- The role of consumer groups and families in preventing mental disorders, reducing stigma and discrimination programs, and improving access to services

- Mental health cost effectiveness – related to medication procurement, referral system

- Regulation and policy impact evaluation – especially related to the government's 5-year strategic plan, decentralization policies, and national formulary

Mongolia

Submission author   Batuvhsin Lkhagvasuren

I am the current director of the Brain Science Institute at the Mongolian National University of Medical Sciences (MNUMS). I obtained my M.D. from MNUMS and completed a residency in psychiatry at the National Centre of Mental Health (NCMH) in Mongolia. After my Ph.D. course at Kyushu University in Japan, I studied behavioural thermoregulation during my postdoc at Arizona State University and Rutgers University in the US. My current research interest includes the epidemiology of psychiatric and neurological disorders, chronic fatigue syndrome, and thermoregulation.

Currently, the Brain Science Institute at MNUMS is conducting a nationwide multicentre, interdisciplinary, prospective, population-based cohort study to investigate brain-related disorders in the general population of Mongolia since 2020. We started a cohort of 48 sampling centres, including 24 primary health centres in 8 districts in Ulaanbaatar and 24 primary health centres in 4 rural regions. The cohort team comprises five research teams specialized in psychiatry, neurology, endocrinology, gynaecology, dentistry, and family medicine. Of note, no population-based study since 1989 assessed the epidemiology of mental disorders in the general population of Mongolia. The political transition from communism to democracy, rapid urbanization, air pollution, change of lifestyle, the shift in disease burden, and economic turbulence over the past three decades should have primarily impacted the mental health of Mongolian people. However, before establishing the epidemiology of psychiatric disorders, we had to determine the psychometric properties of the Mongolian versions of screening tools, including the Hospital Anxiety and Depression Scale, WHO Quality of Life-Bref, and Pittsburgh Sleep Quality Index in the beginning phase. Accordingly, the first results mainly were validation studies, and 6 papers were published recently in J Int Neurosci, Nagoya J Med Sci, Nutrient, and Neurosci Res Not.

Currently, we collaborate closely with the NCMH, which serves the entire population with specialized health care in psychiatry through prevention, early detection, registry, diagnosis, and treatment. Moreover, we just established a national research centre for neuroscience and psychology, Brain and Mind Research Institute, at the Mongolian Academy of Sciences. It enables us to build a collaborative research team at the national level strengthening human

resources and funding opportunities. However, since we do not have experience conducting large-scale population-based longitudinal studies on epidemiology, diagnostics, and treatment of mental disorders, we have been facing many difficulties and challenges in logistics, data repository, and so on.

Therefore, we continually seek collaborations with international research teams for joint studies and advisory experts who can become our honoured professors to advise on our ongoing and future studies. Since the 30-year gap in population-based epidemiological studies in Mongolia was not only limited to psychiatry but also public health and all medical specialties, we do not have any updated data on the most common mental or neurological disorders in the general population of Mongolia. Therefore, joining any international cross-cultural or multi-centre studies will significantly contribute to the development of psychiatry and mental health promotion in Mongolia.

Nepal

Submission author   Saraswati Dhugana

My name is Saraswati Dhungana, lecturer at the department of Psychiatry and Mental Health at the Institute of Medicine, Tribhuvan University, Kathmandu, Nepal. I graduated in 2013 from the same institute and since then, I have been employed as a faculty at the same institute.

As a lecturer, my responsibilities are mainly twofold, teaching and guiding undergraduate and postgraduate students, including supervising their thesis work. I am also responsible for providing care and treatment to patients, so I have my outpatient days and take rounds in wards.

Being a research enthusiast at heart, in 2019, when I got the opportunity to do PhD at the University of Oslo, I immediately said yes. This is a sandwiched program between University of Oslo and Tribhuvan University, a result of long term collaboration. So, currently, I am also pursuing my PhD which is about trauma patients visiting psychiatry outpatient at the same hospital I have been working, Tribhuvan University Teaching Hospital.

My objectives are examining quality of life, and resilience in trauma patients and with common psychiatric diagnoses, namely post- traumatic stress disorder, depression and anxiety. The PhD journey till date has been a great learning experience for me.

My interests are: Adult and adolescent mental health, women mental health (including perinatal), stigma, quality of life and resilience in general. My specific interests in relation to public health matters in my country are: Social determinants of mental health such as poverty, education; global burden of disease contributed by major psychiatric illnesses; suicide and deliberate self- harm; affordability and accessibility of mental health care in underserved regions with high burden; and promotive approaches such as inclusion of age appropriate basic mental health and gender health curricula in schools; national level integrated data on mental health scenario and problems with epidemiological studies.

Submission author   C. P. Sedhai

Nepal: at a glance

- Situated between China and India, on the southern slop of Himalaya
- Area- 147,181 Sq. Kms.
- Length- 885 Kms (East-West)
- Width- mean 193 Kms (North-South)
- Population- 29,675,000 (census-2021)
- GDP per capita 1,071.10 USD
- Literacy 67.9%
- Life expectancy 71.7 years
- Infant mortality 32 deaths per 1,000 live births
- Maternal mortality 239 deaths per 100,000 live births
- Leading causes of death COPD (16%), Ischemic heart disease (12%)
- Health Expenditure Total 2.4% of GDP (Rai,Yugesh et al ,2021)
- The Federal Democratic Republic of Nepal is a landlocked country in South Asia, between China and India.
- Nepal has diverse geography that includes the Tarai or flat river plain in the south, central hill regions, and mountainous Himalayas in the north.
- The country has a federal parliamentary republic and is made up of 7 provinces (Pradesh) with the nation's capital located in Kathmandu.
- The population of Nepal is divided between a concentration in the southern-most plains of the Tarai region and the central hilly region.
- Major economic activities include tourism, carpets, and textiles. Most of the labor force in the country is in agriculture (69%), followed by services (19%) and industry (12%) (National mental health survey ,2018)
- Financial support from family members employed overseas is a major source of income for almost 56% of Nepali.
- Remittances from foreign work equate to nearly a quarter of Nepal's income.
- The majority of migrant workers travel to Malaysia and gulf countries, such as Qatar, Saudi Arabia, UAE and Kuwait.

- Despite the enormous contribution they make to their households and home country, migrant workers are vulnerable to poor mental health due to labor exploitation, poor working conditions. (Upadaya K,2017)

- History of mental health services in Nepal

- History of mental health services in Nepal is not long. Mental health services in Nepal remained unknown till 1961 AD.

- First psychiatric OPD services were started in 1961 in Bir hospital, Kathmandu.

- In 1972, a 10 bedded Nero psychiatric unit was established in the a Royal Army Hospital was separated, which was then shifted into the Lagankhel, Patan and it has got 50 beds at present.

- T.U. Teaching hospital was established in Maharajgunj, Kathmandu in 1983 where psychiatric OPD services started in February 1986. It was followed by addition of 12-bedded psychiatric patient units in December 1987.

- In the 1997 April, their full-time residential MD psychiatry training program was started in the Department of Psychiatry, TU Teaching Hospital, Institute of Medicine, Kathmandu. Mental health services are provided by the psychiatry units of medical colleges, provincial government hospitals and a few private hospitals.

- The total number of in-patient psychiatric facil ities is 25 and the number of beds is 500.

- Clinics have been initiated in different subspecialties, such as child, memory, headache and addiction. The Child and Adolescent Psychiatry Unit a Kanti Children's Hospital is the only full-time outpatient clinic for children in Nepal.

- There is no dedicated in-patient unit for children. Non-governmental organisations (NGOs) have played a vital role in the delivery of mental health services.

- Community mental health services were initiated in the 1980s by the United Mission to Nepal (UMN).3 In the 1990s and early 2000s, NGOs such as the Centre for Victims of Torture, Nepal (CVICT), the Centre for Mental Health and Counselling – Nepal (CMCNepal)

- Three-year postgraduate training in psychiatry (MD Psychiatry) started in 1997 and is now available in 16 institutions. There are five different post-graduate training programmes, but the training curriculum and evaluation process is not uniform. There are currently about 45 residents in psychiatry training. The undergraduate syllabus in

psychiatry is not nationally standardized and each university has its own. (Upadhaya.K, 2017; Rai,Yugesh et al, 2021)

Epidemiology of mental disorders

- The first epidemiological field survey conducted in the Kathmandu Valley in 1984 estimated the prevalence of mental illness to be around 14%.
- A recent pilot study of the National Mental Health Survey reported the prevalence of mental disorders to be 12.9%.3 Suicide (16%) was the leading cause of death among women of reproductive age, with 21% of suicide occurring below the age of 18 years.
- In comparison with other countries, suicide among women (20 per 100 000) is higher than among men in Nepal (3rd highest cause of death among women versus 17th highest among men). (The National Mental Health Survey is being conducted by the National Health Research Council in collaboration with the MoHP and World Health Organization (WHO) and is expected to be completed by January 2021)

Stigma and cultural perception of mental illness

- The mind and the body are considered distinct entities in Nepalese culture, thus mental illness is viewed as being separate from physical illness.
- Mental illness is perceived as a 'spiritual dysfunction' or 'weak mind' and attributed to spirit possession, black magic, divine wrath and misdeeds committed in previous lives (karmako phal). There is a strong belief in traditional healing and the first point of contact for most people is the traditional, religious or faith healers (e.g. dhimmis, jhankris, baidangis and bijuwas).

Mental health policy

- A comprehensive National Mental Health Policy was first formulated in 1996 and incorporated in the Ninth Five Year National Plan by the Government of Nepal. However, the implementation of the policy was ineffective, and the Mental Health Act never came into existence. Several attempts were made to revise the policy and ensure effective implementation. The EDCD prepared a draft in 2018, which has undergone

rigorous consultations with federal, provincial and local government representatives in mental health and is planned to be endorsed through the MoHP. The five key strategies are:

- o To ensure the availability and accessibility of optimal mental health services for all the population of Nepal
- o To ensure management of essential human and other resources to deliver mental health and psychosocial services
- o To raise awareness of mental health to demystify mental illness and reduce associated stigma and promote mental health
- o To protect the fundamental rights of people with psychosocial disability and mental illness
- o To promote and manage health information systems and research in mental health programmes. (Koirala. N.R,2014)

- The National Mental Health Strategy and Action Plan (2020) provides a more comprehensive description of Nepal's plans for mental health care. This strategic Action Plan describes the provision of free primary care mental health services for all parts of the country. Described below are key components incorporated within the National Mental Health Strategy and Action Plan 2020.

Psychiatrist's association

- The Psychiatrists' Association of Nepal (PAN) is non-profit professional organisation of Nepalese psychiatrists established in 1990. It regularly organises annual meetings and educational events. It publishes a biannual peer-reviewed journal (Journal of Psychiatrists' Association of Nepal). Recently, PAN has been active in the national mental health programme, policy reforms and advocacy

Challenges of mental health in Nepal

Despite these improvements, the following challenges need to be addressed urgently:
- The budget allotted for mental health is still low, and there is a need to increase the budget to ensure effective scaling up of community-based mental health programmed throughout the country.

- Lack of awareness on mental health and prevailing stigma have been key barriers to accessing mental healthcare. This demands the formulation and implementation of awareness-raising and anti-stigma campaigns in communities.

- There is a need to fill existing vacancies; increase recruitment of psychiatrists; and create positions for clinical psychologists, psychiatric nurses, psychosocial counsellors and community-based psychosocial workers in the government healthcare system.

- The need for subspecialties in psychiatry is emerging over time. The government, universities and medical colleges should envision initiating various subspecialty programmes in child and adolescent, geriatric, addiction and forensic psychiatry.

- The suicide rate has been a grave concern but there is no national suicide registry or suicide-prevention strategy in Nepal. A mechanism for suicide reporting and surveillance and interventions to reduce suicide need to be developed and implemented at a national level.

- Scientific research and the generation of evidence on mental health and illness in Nepal is predominantly reliant on NGOs. The government should prioritise mental health research via academic universities and teaching hospitals.

- Although community mental health programmes have been scaled up, there is lack of clinical supervision of trained nonspecialist service providers and no regular supply of psychotropic medications.12 These need to be ensured for effective implementation of mental health services in primary care setting. (Rai, Yugesh et al., 2021)

The weakness of mental health system of Nepal are:

- Financial constraints
- Only one Mental Hospital
- Mental health services are not easily available
- Stigma around mental health
- Poor infrastructure
- Limited number of human resources
- No mental health legislation
- Poor mental health information system
- No separate division for mental health under the ministry of health

- No developed community mental health services
- No facility for rehabilitation of chronic mentally ill people

Strengths of the mental health system in Nepal are:

- Country has national mental health policy
- Good network within the general mental health can be integrated
- General increase in awareness of mental health in general population
- Increasing number of people seeking treatment in the mental health institution
- Available of psychotropic medicines
- Private medical college and NGOs are providing psychiatric services.
- Good family system, which takes responsibility to their sick family member at home

Thailand

Submission author   Napat Sittanomai

I am a pediatrician and child and adolescent psychiatrist at Division of Child and Adolescent Psychiatry, Department of Pediatrics, Faculty of Medicine Siriraj Hospital, Bangkok, Thailand. After I had finished my pediatrics and child& adolescent psychiatry training in Thailand, I went to pursue further training as a fellow in infant psychiatry at University of Toronto and Parent-Infant Mental Health Postgraduate Certificate Program, University of Massachusetts Boston. I also got a certificate of training as a clinical fellow in Neurodevelopmental Psychiatry from Surrey Place Centre, University of Toronto. Currently, my work focuses on four areas, consultation-liaison psychiatry, neurodevelopmental psychiatry, child protection and infant (0-5 years) mental health.

In term of consultation-liaison psychiatry, I focus on children who has difficulty adjusting to chronic illnesses, children with somatic symptoms, children with autism who admit for clinical procedures, etc. Our team has been developing a program to help teens with chronic illnesses cope with their illnesses and promote good adherence to their treatment. In the area of neurodevelopmental psychiatry, I am a member of the Department of Pediatrics autism spectrum disorder (ASD) care team committee and developing my department ASD care map to guide pediatricians provide comprehensive care for this population. My ASD multidisciplinary team and I developed social skill intervention for preschool and school age children with ASD as well.

In term of child protection, I work with multidisciplinary team, including social workers, psychologists, child protective officers, to assess abused children and their families, activate the child protective system and develop both acute and long-term plan for them. For infant and young children mental health, I do attachment-based assessment for young children and their families and utilize DC: 0-5 diagnostic formulation to establish a treatment plan. Our team, with nutritional team, also offers treatment for infants with feeding problems.

In Thailand, mental health service for mothers during perinatal period, infants and young children is scarce. Therefore, I am interested in developing mental health service model for this vulnerable population in my country.

Submission author   Suttha Supanya

I have been a Thai public mental health service psychiatrist for twelve years. Currently, I am a consultant psychiatrist at Somdet Chaopraya Institute of Psychiatry, the main psychiatric hospital for Bangkok and a major psychiatric training center for psychiatrists and allied mental health professionals. I also work for the Department of Mental Health on academic-related activities, such as national mental surveys, mental health monitoring post-covid-19, and the effects of cannabis legalization. The experience of being a part of these teams and the privilege of receiving the Thai government scholarship to read psychiatric epidemiology broadened my perspective on public mental health. Since this year's beginning, I have also been on the Regional Expert Group on Mental Health (REG) of the WHO SEARO.

My main area of interest is psychosis and schizophrenia, which I believe have received less interest than other common conditions even though they can have more severe consequences.

Using the data from the last national mental health survey, I studied the prevalence of psychotic experiences in Thailand and how they are related to traumatic events and other common mental disorders (for example, please see: Kilian C, Supanya S, Probst C, Morgan C, Bärnighausen T, Kittirattanapaiboon P, et al. Traumatic events and psychotic experiences: a nationally representative study in Thailand. Epidemiology and Psychiatric Sciences. 2021;30).

I am also interested in early interventions, especially for psychosis. Presently, Thailand has no early recognition and treatment system for at-risk mental states or first-episode psychosis. I am working towards establishing an EI service at Somdet Chaopraya and ultimately implementing a workable early detection and intervention system.

Currently, the public mental health issues that I think are relevant to Thailand are post-covid, plus the war and inflation/recession's economic impact on mental health, suicide, and the government's devious method of legalizing cannabis fallout on mental in the future. Since cannabis is a known risk factor for psychosis, this will probably be an issue that I will have to try to tackle quite soon.