

Mongolia's Country Report

Asia-Pacific Community Mental Health Development Project

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Definitions of key terms:

1. **Community:** Includes individuals, families, friends, neighbours, colleagues, volunteers, non-government and government organisations, that is all people who are living in the community
2. **Community mental health services:** Mental health services delivered outside the inpatient setting, particularly those taking place in the community which are provided by primary care and community agencies
3. **Key workers:** People who are the main workers and specialists in the mental health setting.
4. **NGOs:** Not- for- profit, community- managed organisations that provide community support
5. **Carers:** A person whose life is affected by virtue of family or close relationship and caring role with a consumer.
6. **Psychosocial rehabilitation:** Set of measures directed to improve the quality of life of people with mental disorders, in particular to improve skills, communication, work and mental ability lost due to mental illness.
7. **Mental Health Promotion:** A comprehensive set of medical, social, psychological and economic measures, aimed at maintaining mental health through organising provision of mental care and services for the population.

Country background and mental health system

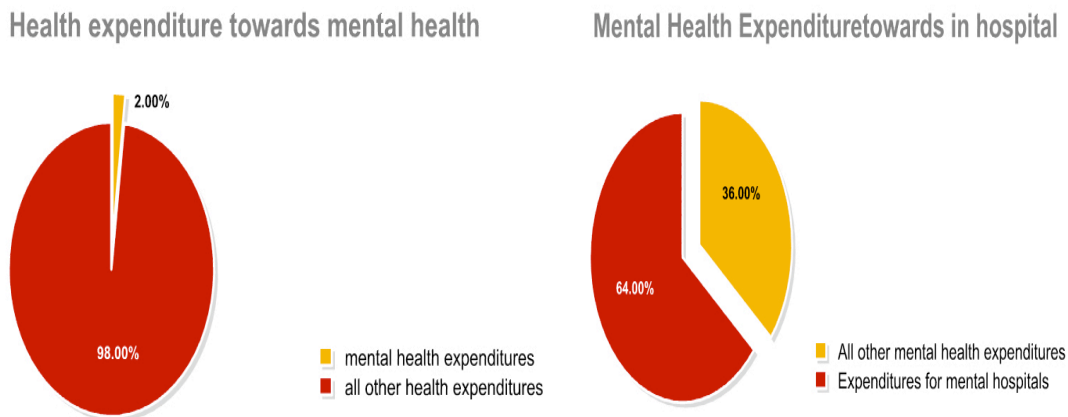
Mongolia is located in the northern part of Central Asia, between Russia to the north and China to the south. A relatively small number of people (2.53 million) live in a large geographical territory of 1567 thousand square kilometres (1). The largest ethnic group is Khalkh. 35.9% of population is under the age of 15. The official language is Mongolian. 48% of population live in rural areas and about 20 % live a nomadic life. About 80% of the land area is suitable for agriculture, mostly for animal husbandry (2). The country is a low-income group country (based on World Bank 2000 criteria). Life expectancy at birth is 60.1 years for males and 65.9 years for females.

The Mongolian Mental Health Law adopted in 2000, emphasises mental health promotion, community mental health care, accessibility to care, inter-sectoral collaboration, rights of the mentally ill person and their legal representatives, and covers forced hospitalisation, and provision of security and social welfare assistance for mentally ill people (3).

The National Mental Health Program was formulated in 2002 and aimed to reduce the prevalence of mental and behavioural disorders and to solve pressing mental health issues through reorienting mental health care in accord with new trends in mental health care. In its implementation from 2002 to 2007, components included Developing Community Mental Health Services, Developing a mental Health Component in Primary Health Care, Human resources, Advocacy and Promotion, Human Rights Protection of Mentally ill persons, Funding, Quality improvement and Monitoring systems. The program was evaluated in 2007 (3).

The country spends 2% of the total health budget on mental health. At present, mental health funding is mainly directed towards mental hospital care which consumes 64% of all mental health expenditure (Figure 1 and 2). 90% of the total budget allocated from the State for the treatment, rehabilitation, and social care of people with mental disorders is spent on hospital care, including inpatient and outpatient mental health care. The primary sources of mental health funding are government and social insurance. 77.6% of the population is covered by health insurance (1, 2).

Figures 1 & 2. Budget Allocation for Mental Health in Mongolia



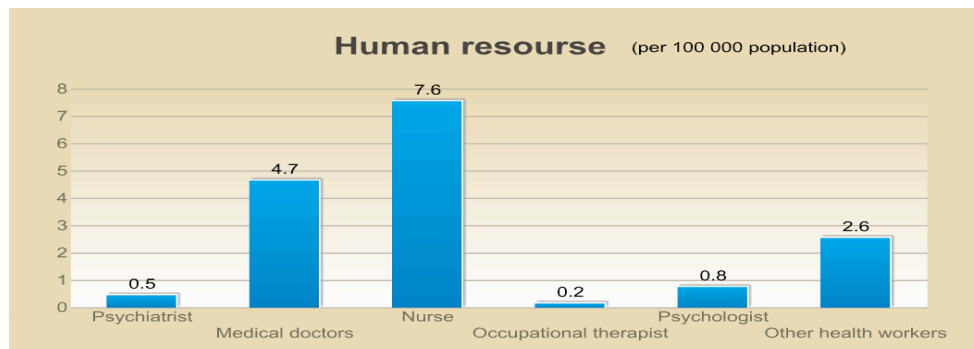
Government facilities provide primary mental health care, community-based mental health, mental hospital care (National Centre of Mental Health), residential and psychosocial rehabilitation. The Mongolian psychiatric health care delivery system operates on three levels.

There is only one mental hospital with 450 beds for the whole country. The mental hospital treats 17.7 patients per 100,000 populations and has an occupancy rate above 80%. The majority of beds in the country are provided by the mental hospitals, followed by community-based psychiatric inpatient units. There are now also 35 outpatient facilities, 7 day care centres and about 12 residential (tent-based) programs that provide occupational rehabilitation and residential services with 60 beds for chronic patients. Access to mental health facilities is uneven across the country, favouring those living in or near the capital city.

Work force

There are only 17 mental health professionals per 100,000 population. Rates are particularly low for psychiatrists, psychologists, and occupational therapists and there are no social workers (Figure 3). Psychologists and social workers are trained by state pedagogical institutes and work in social welfare organisations. There is still a disproportionate distribution of human resources with more mental health professionals working in or near the main city than the average for the entire country.

Figure 3. Mental Health Human Resources in Mongolia



There is a paucity of epidemiological data on mental illnesses in Mongolia. Professor Dorjjadamba (1970) reported that historical cultural background, geographical environment and customs of ethnic groups closely interacted with mental health status, including the rates, type and presentation of mental disorders.

According to the results of epidemiological surveys conducted from 1976 to 1984, the prevalence of mental disorder per 1000 people was 13.1 in the Khangai and Khentii mountainous areas, 18.3 in the Dornod-steppe region, 9.8 in the Altai mountainous region, 23.5 in the Gobi region, 24 in the capital city of Ulaanbaatar. Epidemiological research on prevalence of suicide and schizophrenia was conducted in 2002-2003. According to this research study, the number of suicide cases was 17.6 per 100,000 population. The prevalence of schizophrenia in Ulaanbaatar was 0.97 cases per 1000 population.

Monitoring

The country has a health information system which includes mental health details from the Health Statistics Office of the Directorate of Medical Services under the Ministry of Health and Statistics Unit of the Mental Health and Narcology (Substance Abuse) Centre. A Mental Health database has been established with the support of WHO.

The Government Health Department collates data on the number of clients who received services in mental health facilities and their diagnoses, suicide cases from mental hospitals, all the community-based psychiatric inpatient units, all mental health outpatient facilities and primary health care units. Based on the data, a report is published but no recommendations are made.

Training

1. Medical and nursing students

The Health Sciences University of Mongolia and the Nursing College recently updated its curriculum and programs in accord with modern standards and community mental health care, with assistance from WHO.

2. Psychiatrists

Postgraduate psychiatric training includes residential training (1-2 years), Masters degree course (2 years), Refresher training course (2-3 month), Ph.D. course (3 years) and scientific degree - Dr. Sc. Med. A General psychiatrist is a general practitioner who has received residential psychiatric training for 1-2 years in a hospital internship, with a curriculum which includes community mental health practice. After this training, the general practitioner can be certified as a general psychiatrist.

3. Training programs for primary health care doctors

Regular mental health care training of primary health care professionals is provided. Over the past five years, about 67% of all primary health care professionals attended training in Primary Mental Health Care. Training programs for primary care doctors in treating mental disorders are available.

Accreditation system

The Health Law of 1999 includes provisions related to the licensing of medical practitioners and the accreditation of health institutions. The Accreditation Committee controls service and quality standards which have been developed by the Ministry of Health for all health services and Accreditation Certificates are awarded to health services that have good standards. The Certificates can be renewed after 5 years.

Mental health strategy and principles

From 1929 to 1989, Mongolian Mental Health Services focussed on the development of the mental hospital, centralised in the city of Ulaanbaatar city. Patients had to travel long distances for treatment and spent much time and money in accessing mental health care. From 1975 to 1988, psychiatric outpatient and inpatient units were established in provinces and districts. Many mental health professionals were provided to work in the provinces. Psychosocial rehabilitation and occupational therapy developed in the city and rural areas.

Socio-economic changes in the 1990s have created additional challenges for medical services and created new psychosocial problems. Although the development of mental health care has faced many problems, mental health policy has focussed on provision of community mental health services in the primary health care setting, according to the WHO recommendation. We have started to decentralise mental health care over this period. Psychosocial rehabilitation was introduced and basic care was incorporated into Primary Mental health care. Both general medical and specialised training has been reoriented to meet the new requirements. We are trying to increase public awareness about mental health care and to increase the participation of all stakeholders.

The main strategy of the Mental Health Program is to incorporate mental health care into primary health care services, to train general practitioners and specialists in mental health care, to increase state and public awareness, to improve inter-sectoral collaboration through advocacy of mental health issues to the policy and decision makers, to develop and implement an integrated strategy of the mental health Information Education and Communication (IEC), to improve knowledge and skills in the population about how to protect their mental health, and to mobilise public and community participation in mental health promotion activities.

The key principles of the State Policy on Mental Health are as follows:

- Implementation of primary, secondary and tertiary prevention measures directed

- to prevent social and environmental factors that negatively affect mental health
- Protection and promotion of mental health based on the principles of humanity and compassion, scientific knowledge and achievements, and use of contemporary and traditional medicine
- Mental health policy and measures shall be implemented by the joint efforts of state administrative and local government bodies, health and other organisations, business entities, communities, families and individuals

The Province, City and District Governors and Citizens' Representative Meeting was developed, and implemented mental health sub-programs based on local needs in compliance with the policy and guidelines of the national program. They also organised implementation and monitoring of the program at the local level.

In addition to legislative and financial support, there is formal collaboration between the government departments responsible for mental health and primary and community health care, HIV/AIDS, child and adolescent health, substance abuse, child protection, education, employment, housing, welfare, the elderly and criminal justice. Of those people who receive social welfare benefits, 15% do so for a mental disability.

Community Mental Health Analysis According to the World Health Organisation (WHO) Recommendation

Long-stay Hospital (National Centre for Mental Health)

Although since 1997, Mongolia has been developing community mental health care as recommended by WHO, most mental health care is still based in the hospital which utilises 64% of all mental health expenditure. There is only one mental hospital which has 450 beds. There has been a 25% increase in the number of beds in the hospital since 1999. This situation has been aggravated by the closing of the 'Residential Occupational Therapy Facility' in 2003. Currently long-term patients are still being cared for in the mental hospital. The average length of stay is 28.2 days. However from 2006 long-term chronic patients are gradually being transferred to a long-stay residential service with 104 beds that has been built as part of the National Centre for Mental Health. Today the mental hospital still provides acute care and rehabilitation, and also receives referrals from the general hospital and primary health care facilities which do not have adequate acute hospital beds and when patients need longer periods of care. Despite the move of chronic patients to the residential service, there are still a high number of mental hospital beds, operating at a high cost.

Psychiatric Services in General hospitals

There are 21 community psychiatric inpatient units with between 5 and 15 beds within general health centres, providing a total of 198 beds. There is also an outpatient unit in each province. There is no psychiatric inpatient unit in the District General Hospital, so the National Centre for Mental Health provides secondary psychiatric inpatient services in the catchment area of Ulaanbaatar city. Now every province and district General Health Centre has an average of one psychiatrist providing mental health care.

Primary Health Care

Primary Health care is provided by Soum hospital and family general practitioners. A 'Soum' hospital is a primary general hospital of the provincial government administration

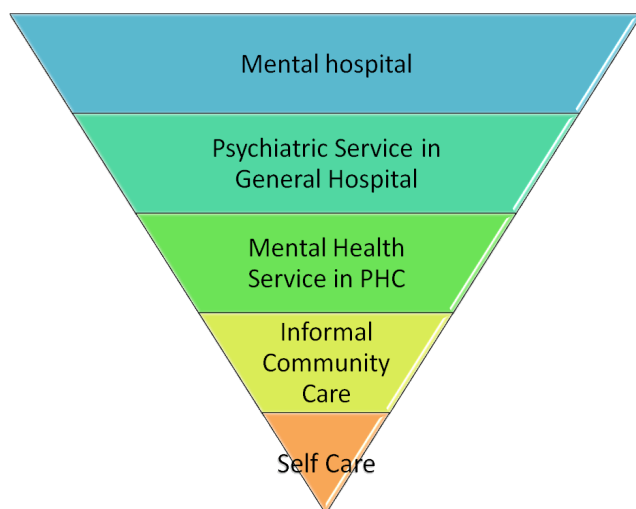
unit called 'Soum'. There are 515 of Primary Health Care units in the country. Approximately 70% of these units provide primary mental health care, including assessment, treatment and diagnosis of common disorders (according to the WHO's recommendation), prevention, promotion, and referral of severely ill patients to appropriate secondary and tertiary levels of care when required.

Non-Government Organisations

They are mainly involved in advocacy, promotion and rehabilitation. The WHO initiated the formation of the Mongolian Mental Health Association (with psychiatrists, volunteers and representatives from other NGOs as members), which is active in promoting mental health public education, community care and rehabilitation. The U.S.A, Belgian and Dutch NGOs, Asian Development Bank, ADRA and SOROS Foundation have assisted with equipment, funds and training of primary health care professionals. In recent years, NGOs and international organisations have provided community psychosocial rehabilitation services to people with mental illness but these services are still underdeveloped across the whole country.

There are two consumer associations – 'Mongolian Mental Health Association' and 'the Association against alcohol and substance abuse'. There are no family associations. Consumer associations have not been involved in the formulation or implementation of mental health policies, plans, or legislation. Mental health facilities interact with a few consumer associations. There are six other NGO's in the country involved in individual assistance activities such as counselling, housing, and support groups.

Figure 4: Optimal mix of mental health service components



Best Practice Models of Care

Best practice model 1: Primary Mental Health Care

Twenty years ago, it was our understanding that only psychiatrists would see patients with mental illness and problems. Since 1990, according to the WHO recommendation, the Mongolian mental health care system has incorporated mental health into primary health care to develop community mental health services. It was recognised that patients could receive mental health care in the family environment at the community level, which

reduced stigma and discrimination about patients with mental illness and increased understanding, knowledge and attitude among health care professionals and workers.

Since 1997, a project “Nations for Mental Health” has been implemented in collaboration with WHO to train general practitioners in primary mental health care. In addition, with the assistance of the Asian Development Bank, refresher training for general practitioners and health workers in primary mental health care has been conducted. In 2002, the National Mental Health Program incorporated mental health care into primary health care service delivery provided by ‘Soum’ hospitals and family general practitioners, to improve mental health care and accessibility.

The aim of Primary Mental Health Care is to enable patients to access mental health service close to home and receive continuous medical and psychosocial care in the community.

Service delivery

Mongolia is a large territory with a small population: as many people in rural areas are nomadic, mental health care can be accessed more easily when delivered by primary health care units. Regular mental health training of primary care professionals (social workers, nurses, midwives, trainers and volunteers) is carried out with the support of WHO. Many books and handouts on mental health care have been translated and developed, such as ‘Where there are no psychiatrist’ and ‘Community based mental health care’, and distributed at primary, secondary and tertiary care levels throughout the provinces. Educational programs on the rights and protection of people with mental illness have been conducted for all health workers.

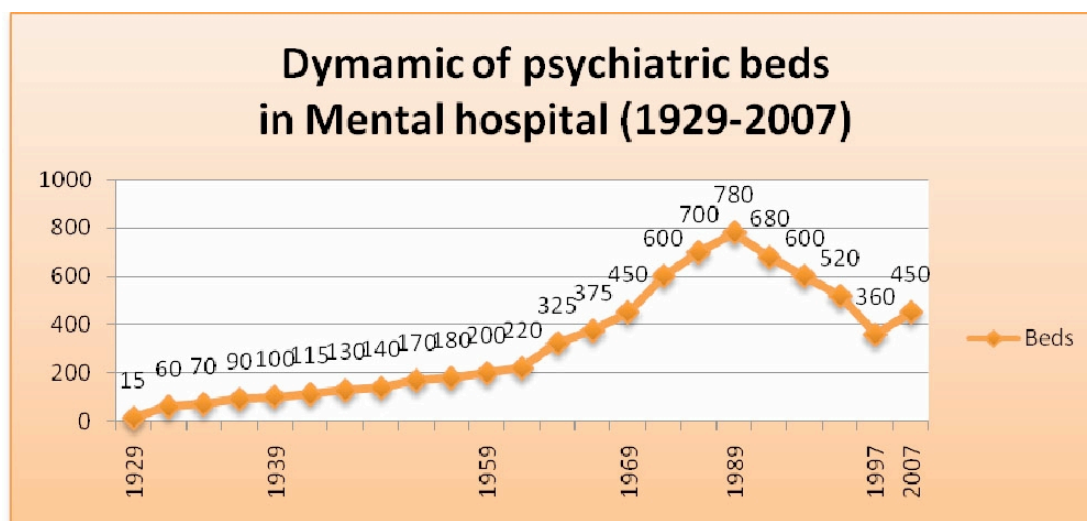
Progress

Firstly, primary mental health care has been integrated with basic health care delivery, standards have been developed and services monitored. Secondly, training in primary mental health care has been conducted for medical staff of ‘soum’ and the family general practitioners. Thirdly, ‘soum’ hospitals and family general practitioners have been trained in early detection, diagnosis, and treatment and counselling in relation to mental disorders. Fourthly, curriculum and programmes for training general and specialized psychiatric staff has been reoriented to a primary mental health focus at the Health Science University and Nursing College. Fifthly, WHO has assisted with the publication of books on mental health in primary health care?

Results and Outcomes:

Over the past 5 years, about 67% of all primary health care professionals have attended training in Primary Mental Health Care. Training programs for primary care doctors in treating mental disorders are available. 70% of medical staff of soum hospitals and Family General Practitioners have enrolled in primary mental health care training.

Figure 5: Dynamic of Psychiatric Beds in Mental Hospital



Success and Difficulties

Success: Mental health care has become more accessible, and there has been improvement in general practitioners' knowledge, attitude and skills in early detection, diagnosis, treatment and prevention of mental health problems. The incorporation of mental health care in primary health service delivery increases the possibility of primary prevention of mental and behavioural disorders in the population. The number of patients admitted to hospital and psychiatric beds has reduced.

Limitation: Although it is understood that community mental health services can be provided through primary mental health care, the results are unsatisfactory, as only 0.7% of the population received primary mental health care. This is due to the high mobility of trained doctors as they continue their specialist training, and the lack of knowledge and skills of general practitioners in mental health diagnosis, treatment and counselling. People who have mental problems are reluctant to go to general practitioners and instead directly refer to the mental hospital and outpatient units at the secondary or tertiary care level.

Inspirations and Lessons Learnt

For those people living in rural areas or who are particularly vulnerable, who had difficulty accessing mental health assessment, treatment and diagnosis, there has been improvement in access to mental health care, including improved education and information provided to the community. In future we aim to improve primary mental health care capacity, especially to children and the elderly, to improve early detection, diagnosis and treatment of mental health problems at the 'bag' and 'soum' level. Mongolia is divided administratively into 21 'aimags' and the capital city, 'Aimags' are subdivided into 'soums', 'soums' into 'bags', and the capital city into districts, and districts into 'khoroo's'.

Plan of action

- To conduct primary mental health training regularly for general practitioners and medical staff
- To provide educational materials such as books and handbooks on primary mental health care

- To provide pamphlets, posters and handbooks for consumers, families and the community
- To reorient referral system for mental health care
- To review diagnostic standards in primary mental health care
- To improve prescription of psychotropic medication by general practitioners in the primary mental health care setting
- To improve monitoring and evaluation of primary mental health care

Best practice model 2. ‘Ger’ Project

The ‘Ger’ project is a community-based psychosocial rehabilitation program which utilises tented and portable round houses called ‘gers’ in local areas of Mongolia. The ‘Ger’ project commenced in 2000 in the grounds of two district health care centres, and then expanded to other regional health centres in Erdenet, Hovd, and Uvurkhangaï and Orkhon provinces. Four Psychosocial Rehabilitation Treatment programs (‘Ger’ projects) have been established in Regional Health Centres with funding from WHO and the Soros Foundation, and other NGOs have contributed financially towards various activities.

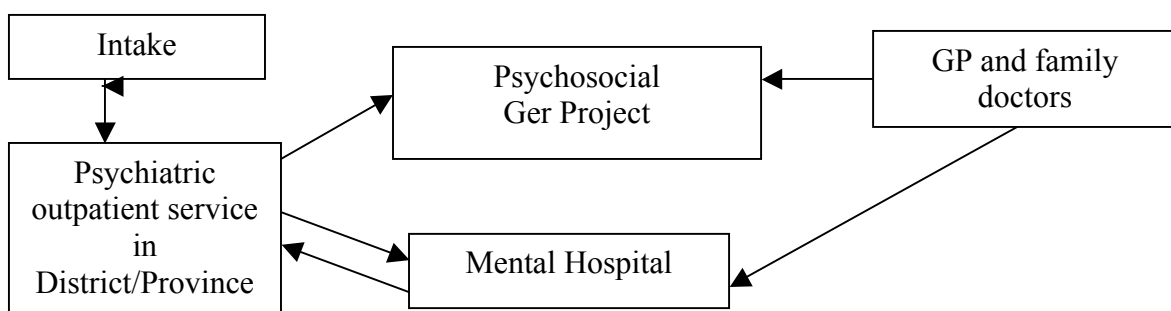
The aim of the ‘Ger’ project is to give people with chronic mental illness an opportunity to improve social and living skills through psychosocial rehabilitation activities, such as life skills, self-care, cooking, budgeting skills, hand-craft, vegetable growing, and other vocational training. The ‘Ger Projects’ have many advantages – they are close to the person’s home, they operated at a low cost (approximately 1000 USD) and they are portable.

‘Ger’ project Methodology

The ‘Ger’ project is located in the community near the sub-district where people are living in ‘gers’ and built the ‘ger’. Fifteen to twenty people with mental illness per month are involved in the program. The ‘Ger’ Project is staffed by a nurse, occupational therapist and psychiatrist, funded by the government. The Program starts at 9.00AM and finishes at 15.00PM every day.

Referral process: Outpatient service psychiatrists and general practitioners assess the patients, and if they agree to attend, they are referred to the psychosocial rehabilitation program ‘Ger Projects’. When patients are discharged from the mental hospital and referred to outpatient services, the outpatients psychiatrist discusses referral to the psychosocial rehabilitation program with the patients.

Figure 6. Referral process



Activities: When people commence at the 'Ger' Program, the psychiatrist and trained occupational therapist, social worker and nurse assess their life skills, self-care, and social life to determine what activities will benefit the patients. The occupational therapist and nurse who have been attended psychosocial rehabilitation training for one to three months, are responsible for training patients in physical and relaxation exercises, life skills, self-care, and other skills such as hand-craft, gardening, carpentry, embroidery and other vocational training.

In addition the 'Ger' project provides psycho-education, counselling, continuing psychiatric treatment and family support for patients and their families. The psycho-educational program provides patients and their families with information about mental illness, coping skills that will help them deal with psychiatric disorders such as depression, psychotic disorder, alcohol and tobacco abuse and how to cope with stress. The 'Ger' project not only collaborates with medical services, but also with employment, social welfare and transport services. Vocational training is provided in cooking, bakery and art, with the aim of finding jobs which are suitable jobs for patients.

Results and Outcomes: From 2002 to 2007, five hundred clients have attended the Psychosocial Programs in Secondary Mental Health Care, and relapse of mental disorder has been reduced by 95%.

The roles of families, NGOs and Community Agencies

Family involvement is important for the Psychosocial Rehabilitation Program, and includes improving knowledge about mental illness, understanding the rights of patients, and how to apply training in daily activities learnt at the 'Ger' project in the home environment. The Mongolian Mental Health Association represents NGOs. Their main activities are psychosocial rehabilitation programs carried out in two districts in Ulaanbaatar. We need more NGOs to implement this program in all 'aimags' (the 21 provinces of Mongolia) and districts, and we also need improved collaboration between health care providers and NGOs.

Success and Difficulties

Relapse of mental illness, rates of hospitalisation and costs of care have been reduced, and effectiveness of treatment has increased. In addition, some patients who attended the program have gained employment and they and their families have increased their quality of life.

The 'Ger' project has been limited by the lack of ongoing support for the Psychosocial Rehabilitation Programs from international organisations and agencies, as the recovery and rehabilitation process for disabled patients takes a long time. There is a lack of training opportunities, education materials and technical support in mental health service delivery due to lack of funds and support.

Inspirations and Lessons Learnt

The 'Ger' project successfully delivers psychosocial programs close to the patient's home at the district level. The advantages of the project include the low cost, its mobility, its encouragement of input from the community, and the satisfaction of families as a result

of reducing stigma and discrimination. However advocacy at Government level is important for the sustainability of the Project.

Plan of action

- To reduce misunderstanding and misconceptions about mental illness at all levels - grassroots, policy and decision-makers, health professionals and the public.
- To expand the numbers of Psychosocial Rehabilitation Centres ('Ger' projects)
- To link up with Primary and Secondary Health Care services
- To enhance psychiatric stability and functioning in patients by providing comprehensive rehabilitation services near to their home based on individual needs
- To allocate government budget for Psychosocial Rehabilitation Programs
- To increase the involvement of consumers and families
- To collaborate with international organisations and other NGOs
- To provide training in Psychosocial Rehabilitation for medical non-medical staff

Best practice model 3: Mental Health Promotion

Mental Health Promotion is defined as measures directed to promote a healthy lifestyle that gives an opportunity to control and improve mental health on an individual basis and jointly with others.

Strategies to create an environment for improved mental health:

- To increase state and public awareness, improve and mobilise inter-sectoral collaboration through the advocacy of mental health issues to policy and decision-makers.
- To develop and implement the integrated strategy of mental health Information Education and Communication (IEC), to improve knowledge and skill of the population on how to protect their mental health
- To mobilise public and community participation in order to reduce stigma and discrimination through mental health promotion activities

Objective:

- To improve knowledge and attitudes about mental health among the policy decision-makers and to increase inter-sectoral collaboration
- To increase community participation in mental health promotion activities
- To develop an integrated Information, Education and Communication (IEC) strategy on mental health, improve knowledge, attitudes and skills of the population in regard to mental health

Activities:

1. Health promotion programs and projects in workplaces have been developed and expanded, with professional advice, support and collaboration from Government, NGO and economic entities which provide mental health care.
2. The integrated strategy for mental health IEC (Information Education and Communication) for the population has been developed and implemented since 2002.
3. The Ministry of Education, Culture and Science in collaboration with Institute of Educational Development has reviewed standards of primary and secondary curriculum and programs, and developed and enforced school mental health

curriculum which has included health curriculum and program since 2003.

Since 1999 the Mongolian Mental Health Association, MOH, and WHO have conducted extensive promotion activities before and during the World Mental Health Day (1st of October). For instance, over the past three years (2005, 2006 and 2007) we have organised a press-conference and eight kilometre walkathon to raise awareness of mental health issues, and to raise funds for psychosocial rehabilitation programs. Many domestic and international NGOs and more than 300 people including businesses, participated, and around 1.5 million 'tugrugs' (about 2000 USD) was raised in 2006. We also advertised in the media (TV and national newspapers providing information to the public on different mental health topics, such as the prevention of stress, mental disorders, fighting tobacco, alcohol and drug abuse, and tolerance towards people with mental problems. Promotional films on stress, depression and alcohol abuse were created and distributed to all provinces. Lectures were organised in schools, colleges and universities, and pamphlets were distributed in places of public congregation such as markets and cinemas). Every quarter, a Healthy Mind newsletter has been published and distributed to the public.

Results

There are 208 schools with a mental health program, which is incorporated into the health curriculum and program, and integrated into the curriculum for students of high schools. There are 599 economic entities and organisations with more than 50 employees which implement mental health sub-programs and projects in their health promotion projects and programs framework.

The roles of families, NGOs and Community Agencies

The role of families, NGOs and Community Agencies is important in promotion of mental health. Governors and Citizen's representative meetings in the provinces and districts promoted organisations and communities advocating mental health by providing them with support and incentives. Social agencies and community partners who identify persons with mental illness and problems refer these individuals to the psychiatric outpatient services. Currently, the National Centre of Mental Health is trying to increase liaison with other associations and the community.

Success and Difficulties

Individuals and the community have increased knowledge and skills in relation to mental health issues such as how to protect their own and others' mental health, how to acquire a healthy life style and behaviour and how to access mental health services.

Major challenges are the lack of resources and budget for mental health promotion activities and the limits of community involvement due to the need for more advocacy at the grassroots and policy-making levels. There is a lack of commitment and knowledge from policy-makers in relation to support for psychosocial rehabilitation programs and community mental health projects.

Inspirations and Lessons learnt

Mental Health Promotion activities help raise public awareness and reduce stigma and discrimination, however there is a need for more resources and commitment from policy-makers and need to increase the involvement of NGOs, business etc. in Mental Health Promotion activities.

Plan of action:

- To educate policy and decision-makers to raise awareness of mental health issues
- To increase budget allocation for mental health promotion
- To establish and increase contact with consumer and family associations
- To disseminate information and advertisement in the media, including TV programs, newspaper, radio and internet websites
- To expand education and awareness campaigns and to improve collaboration with NGOs
- To develop awareness of mental health issues with other professional groups
- To continue to improve the school mental health curriculum, and to consider training of teachers to identify students with mental health problems
- To train volunteers in Mental Health Promotion

Best Practice Model 4. 'Rainbow Centre' for mentally handicapped children

From the school year of 1997- 1998, the ICM organisation (under the Catholic Church Mission Mongolia) cooperated with Kindergarten □ 8 of Ulaanbaatar, to integrate some mentally handicapped children. By inviting specialists from abroad, they provided training for parents and teachers of the kindergarten who had no special preparation for this kind of work. These sessions opened their eyes to the possibilities for their children and gave them hope for the future. Since then they have organised several training seminars and have invited teachers from other schools and institutions (like nurses and doctors from the mental hospital and teachers and caretakers of the Verbist Care Centre).

In 2000 we were alerted to situation of the mentally handicapped children in the mental hospital of Ulaanbaatar. A visit to these children made it clear that there was a need to do something for them too. These children were often kept in the hospital because they had no other place to go. The parents don't know what to do with them and leave the children to the care of the hospital. The whole environment doesn't offer a 'home' to these children.

They then implemented daily special sessions with children in the kindergarten □ 8, in the mental hospital (children's section) and in the Verbist Care Centre for street children (where there are several children with learning problems and others with a mental handicap).

In 2003, they established a day care centre called the Rainbow Centre, where the mentally handicapped children and slow-learners come for classes and activities. Children attending include those with autism, Down's syndrome, alcohol syndrome and brain damage. Daily classes are from 9 o'clock in the morning until 4 o'clock in the afternoon. Five teachers and one cook provide the activities. Two teachers continue the outreach program to the Mental Hospital children, and one social worker coordinates home and Centre activities.

At present the Centre offers assistance to 31 children (11 in the Rainbow Centre and 20 in the Mental Hospital) and their families.

The teachers at the Rainbow Centre and in the mental hospital are kindergarten teachers or assistant teachers. They have been trained by foreign volunteers in working with these special children.

The daily activities of the Rainbow Centre are:

1. Holistic education of children who cannot be admitted to existing special schools, which are not equipped to handle mentally heavily challenged children, who would otherwise remain hidden in homes and marginalised in society. These include:
 - psycho-pedagogical activities, in order to facilitate children's socialisation and school education;
 - ergo-therapeutic activities for disabled children, accompanied by games to strengthen their muscles;
 - speech therapy, to correct speech faults in order to enhance linguistic articulation;
 - Play-room and game activities for fostering children's socialisation.
 - individualised educational programs to promote self-help skills, social skills, speech and communication development, cognitive and fine/gross motor skills;
 - Outings and activities to help the integration of the children into Mongolian society.
 - Summer camp
2. Continuing education of their parents, caretakers and teachers, who need to continue to stimulate their children's development to their utmost capacity and – whenever possible – to share their experiences with others in their communities;
3. Regular support group meetings, training sessions and communications with parents (self-help groups).

Success and Difficulties

- Several children have 'graduated' from our Centre, which means that they have acquired skills according to their abilities, but the question about the future of these children remains. Where can they go after the Centre? There is no sheltered workshop in Mongolia where these people can work; there is no place to take them once their parents are no longer there.
- Awareness-raising with the parents is an ongoing task. Parents always hope that they can make their children 'normal'. They have a hard time accepting the children as they are. Most of the parents go out to work and have no time to spend with their special children and to follow up what happened in the school.
- There is a lack of ongoing training available for teachers in a country where this kind of training is not being offered.
- Mental handicap still remains a taboo in the Mongolian society and much is still to be done on raising awareness.
- It is still difficult to have the children diagnosed correctly, and to differentiate psychiatric patients and mentally handicapped people.
- The Mental Hospital is not the correct environment for mentally handicapped children. They are looking for another alternative.

Plan of action

A training program could be set up both in the medical-rehabilitative sector and in social and health care management, providing::

- Diagnosis and rehabilitation of disabilities: clinic activities for evaluation of autism, mental retardation, neuro-motoric and speech handicaps;

- Methods of rehabilitation: (ateliers, laboratories);
- Methods of physiotherapeutic rehabilitation;
- Strategies, techniques and fund-raising tools at the local and international level, including planning, organisation and networking of area services (home assistance, consulting, information, training);
- Recruitment and training of the operators, families and volunteers.

It would be interesting to develop home assistance services for disabled children, in order to support parents and to avoid abandonment of their children. Home assistance appears to be a positive opportunity to:

- Enhance and stimulate direct parental participation and responsibility in the process of rehabilitation of their child, and at the same time guaranteeing parents constant tutoring and qualified support;
- Attempt to increase the opportunity for disabled children to access services, given the limited space available at present in the Centre;
- Make access easier for those families for whom reaching the Centre is extremely difficult for logistic and economic reasons.
- Create small living units for mentally handicapped people, different from the Mental Hospital, where they can experience a home

Extending the current capacity of community care and the future

Community care is based on the principle that the majority of the people with mental problems can be effectively treated in community settings, with more autonomy and better quality of life. The Mental Health Service System must provide services which will ensure that clients are treated, supported and rehabilitated in or near their usual place of residence and, as much as possible, in a community based or home based setting. Service should target minimal hospitalization and maximise the ability of community-based services to respond quickly and effectively.

In the further development of policy and planning for community mental health services, we should include downsizing of psychiatric beds, involvement of consumers and families, and the reform of mental hospitals to provide more comprehensive care and equity of access to mental health services across different groups.

Our main strategy is to strengthen the current primary health care system, to develop general hospital based community teams from existing psychiatric services with psychiatrists in all provinces and districts and to improve close linkages between community care teams in general hospitals and primary health care with NGOs and informal services.

In order to strengthen mental health care, the next steps are to:

1. Develop and implement the integrated strategy of the mental health IEC (Information, Education and Communication), to improve knowledge and skill of the population about how to protect their mental health and to acquire new attitudes and skills
2. Conduct surveys to assess knowledge, attitudes and skills of population in relation to mental health
3. Improve mental health education materials, particularly on consumer rights and

protection

4. Review and update school mental health curriculum and conduct refresher training for teachers
5. Strengthen the current primary mental health care system
6. Conduct regular training in primary mental health care, including training for medical staff and general practitioners on problems such as depression, anxiety, sleep disturbance, chronic tiredness, alcohol use disorder, and psychosomatic disorders of unknown origin
7. Provide guidelines on early detection, diagnosis, treatment and counselling of mental disorders
8. Provide training materials and pamphlets, posters and handbooks for carers, consumers and families
9. Improve the capacity for prescription of psychotropic medicine in primary health care
10. Improve the referral process in the mental health care system
11. Develop general hospital-based community teams from existing psychiatrists in all provinces and districts
12. Meet with health management policy and decision-makers in districts and provinces to advocate for the provision of community mental health teams and a systematic review of the current situation
13. Study increasing the number of workplaces for psychologists, occupational therapists, nurses and social workers in general hospitals
14. Develop guidelines and standards for overall operation of the community mental health team as a multidisciplinary team
15. Access Continuing Care Treatment, Mobile support treatment and Crisis Assessment and Treatment program models for community mental health teams
16. Improve links between the community care teams in general hospital and primary health care.
17. Provide regular visits to primary health units from a mobile mental health team
18. Increase the capacity and training of the mental health workforce
 - To study and review undergraduate programs for psychiatrists nurses, psychologists, social workers and occupational therapists
 - To develop the postgraduate curriculum and programs for psychiatric nurses, psychologists, social workers and occupational therapists
 - To conduct training for psychologists, social workers and occupational therapists in community teams in general hospitals
 - To provide mental health training material for nurses, psychologists, social workers and occupational therapists
 - To train and upgrade specialised mental health professionals such as child psychiatrists, aged psychiatrists, clinical psychologists, forensic psychologists, and psychiatric nurses
19. Develop strategies for working with families, community and multi-sectorial

agencies to enhance the community care plan.

- To establish family psycho-education groups and family support groups both by institutions and NGOs and to increase their understanding of mental disorders and to garner their support in the long-term community care of patients.
 - To develop and support establishment of family and consumer associations.
 - To improve partnerships and collaboration with government, non-government and international organisations and agencies at various levels in order to further develop the capacity of community mental health care.
 - To evaluate activities of educational, social welfare, employment, legislation, private hospitals and universities, governors in the district and provinces and NGOs (counselling centres, rehabilitation and treatment for mental illness patients, primary mental health prevention, psycho-education, consumer and families associations) and international organisations in relation to mental health
 - To develop and implement a plan of action for collaboration and enhance coordination of activities between concerned organisations
20. Improve the data collection system and planning, monitoring, and evaluation of community mental health services
- Update and expand mental health indicators registration and information system
 - Expand research work such as Prevalence of mental disorders, Prevalence of Suicide and risk factors that negatively influence human mental health status
21. Develop strategy for funding and resource building

Summary

Mongolia has a Mental Health Law and a National Mental Health Program. Components addressed in the policy and plan include Developing Community Mental Health Services, Developing a mental health component in Primary Health Care, Human resources, Advocacy and Promotion, Protection of the Human Rights of Mentally ill persons, Finance, Quality improvement and Monitoring system.

At present, mental health funding is mainly directed to mental hospitals, which accounts for 64% of all mental health expenditure. All severe and some mild mental disorders are covered by social insurance schemes. No-one has free access to psychotropic medication. There are only 17 mental health professionals per 100,000 population. Rates are particularly low for psychiatrists, psychologists, and occupational therapists and there are no social workers. Human resources are disproportionately distributed, with more mental health professionals working in or near the main city than the average for the entire country.

The mental health system is still largely hospital-based. Mental hospitals treat 17.7 patients per 100,000 population and have occupancy rate above 80%. The majority of beds in the country are provided by mental hospitals, followed by community based psychiatric inpatient units.

However, there are now 35 outpatient facilities, seven day care centres and about twelve residential (tent-based) programmes that provide occupational rehabilitation. Residential services provide 60 beds for patients with chronic mental illness. Mongolian mental health care is delivered on three levels - primary, secondary and tertiary. Access to mental health facilities is uneven across the country, favouring those living in or near the capital city.

The results of an epidemiological survey in the capital city of Ulaanbaatar indicated that the prevalence of mental disorder per 1,000 people was 24, the prevalence of schizophrenia was 0.97 cases per 1,000 population and the number of suicide cases was 17 per 100,000 population.

Since 1997, we have started to decentralise mental health services, and although efforts have been made in collaboration with WHO to implement community-based mental health care, coverage and results are not yet satisfactory. Psychosocial rehabilitation has been introduced, and mental health care has been incorporated into primary mental health care. Both general medical and specialised training has been reoriented to meet the new requirements. More attempts have been made to increase public awareness about mental health care and to increase the participation of all stakeholders.

Postgraduate psychiatric education includes residential training (1-2 years), Masters degree course (2 years), Refresher training course (2-3 months), Ph.D. (3 years) and scientific degree - Dr. Sc. Med. Primary care professionals have received regular training in mental health, and in the last five years, about 67% of all primary health professionals attended training in Primary Mental Health Care. Training programs for primary care doctors in treating mental disorders are available and prescription of psychotropic medication is available.

Our best practice example is the 'Ger' Project, which provides Community-Based Day centres based in Mongolian tented and portable round houses called 'gers'. This initiative started in 2000 in the grounds of two district health care centres and four regional health centres. The aim of the 'Ger' project is to give people with chronic mental illness an opportunity to increase their social and living skills through activities focusing on psychosocial rehabilitation: life skills, self-care, cooking, and leisure skills, including hand-craft, vegetable growing, and other vocational training.

There is a lack of mental health promotion activity and a need to increase liaison with NGOs and community groups. We also need to improve inter-agency collaboration and cooperation, and to further support people with mental illness in the community. We need to increase the participation of families, consumers and NGOs in Community-based Psychosocial Rehabilitation Programs, and to allocate governmental budget for the 'Ger' program and to collaborate with NGOs who provide similar activities to enable expansion of the program at all levels.

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

Conclusion

A main aim of the National Mental Health Program was to reduce the prevalence of mental and behavioural disorders and to solve pressing problems in relation to mental health through reorientation to the new trend to deliver more services in the community. There has been considerable progress in developing mental health services: there is now a database on mental health, which indicates that there has been an improvement in the percentage of patients who have received primary mental health care, and a slight increase in the number of primary health care units that provide mental health care, however the targeted goal was not met. In addition, mental health programs and projects have been introduced in schools, and in economic entities and organisations with more than 50 employees.

However the suicide rate has increased in prevalence to become one of the highest in comparison with other countries - 17.6 per 100,000 population, and the average length of stay in mental health care has increased.

We learned from our best practices in community mental health, that it is possible for patients with mental illness to recover in the community, that relapses can be reduced, and that the individual can be protected from mental illness and learn to cope with stress. We have also improved our knowledge and skills in promoting mental health in the media. Finally, we understand that we cannot develop community mental health services alone: we need to collaborate with and involve consumers, families, NGOs and international organisations and the community for successful development.

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