

WHO-AIMS

**WHO-AIMS REPORT ON
MENTAL HEALTH SYSTEM
IN MONGOLIA**



**World Health
Organization**



**Ministry
of Health**

WHO-AIMS REPORT ON

MENTAL HEALTH SYSTEM

IN MONGOLIA

A report of the assessment of the mental health system in Mongolia using the World Health Organization - Assessment Instrument for Mental Health Systems (WHO-AIMS).

Ulaanbaatar, Mongolia

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WHO, Regional Office for the Western Pacific
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Please refer to *WHO-AIMS* (WHO, 2005) for full information on the development of WHO-AIMS at the following website.

http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html

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The WHO-AIMS project is coordinated by Shekhar Saxena.

Executive Summary

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Mongolia. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring the change. This will enable Mongolia to develop information-based mental health plans with clear baseline information and targets. It will also be useful to monitor progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care and rehabilitation.

Mongolia has a Mental Health Law and a National Mental Health Program. Components addressed in the policy and plan include: 1.Human resources 2.Developing a mental health component in primary health care 3.Developing community mental health services, 4.Advocacy and Promotion, 5.Human rights protection of mentally ill persons, 6.Financing, 7.Quality improvement and 8.Monitoring system. At present, mental health financing is mainly directed towards mental hospitals, which account for 64% of all mental health expenditures. All severe and some mild mental disorders are covered in social insurance schemes. None of the population has free access to psychotropic medication.

A national human rights review body exists but it has no specific authority on mental health e.g. to oversee regular inspections in mental health facilities, review involuntary admissions and discharge procedures, review complaints investigation processes or impose sanctions. In general, Mongolia has only few inspections of human rights protection in mental hospitals or in forensic units.

The mental health system is still largely hospital based. Nevertheless, there are now thirty- five outpatient facilities, seven day treatment facilities and twelve community residential facilities. Mental hospitals treat 17.7 patients per 100,000 population, and have an occupancy rate above 80%. The majority of beds in the country are provided by mental hospitals, followed by community based psychiatric inpatient units. Female users make up close to 50% of the population in all mental health facilities in the country. There has been a 25% increase in the number of mental hospital beds in the last 5 years in order to accommodate patients who were in the Residential Facility of Occupational Therapy in Maant that was closed in 2003. No data is available on involuntary admissions or the use of restraints or seclusion. No facilities are specifically devoted to children and adolescents. Access to mental health facilities is uneven across the country, favoring those living in or near the capital city.

The distribution of diagnoses varies significantly across facilities: in outpatients facilities disorders such as epilepsy, organic mental disorders, mental retardation or behavioural and emotional disorders are most prevalent. Mood disorders are the second most prevalent diagnosis and mental disorders due to substance the third most prevalent. Within in-inpatient units, neurotic disorders and mental disorders due to substance abuse are most common and in mental hospitals "other" diagnoses like organic mental disorders, mental retardation, etc. and schizophrenia and neurotic disorders are most frequent.

Both physician based primary health care (PHC) and non-physician based PHC clinics are present in the country. However, primary health care staff have limited training in mental health and interaction with other mental health services is rare. In terms of physician-based primary health care

clinics, the majority of physician-based primary health care clinics (80-100%) and only a few (1-20%) non-physician based clinics have assessment and treatment protocols for key mental health conditions available.

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 in mental health facilities. In addition, most mental health professionals in government administered facilities only work for 12 to 15 hours a week. There is still a disproportionate distribution of human resources with more mental health professionals working in or near the main city than in average in the entire country.

Education and awareness campaigns are overseen by coordinating governmental bodies. The links between the mental health sector and other sectors, like the school system or the criminal justice system are weak or underdeveloped. A number of legislative and financial provisions exist to protect and provide support for users, but they are not enforced sufficiently. There are mental health consumers associations but no family associations in mental health.

Mental health statistics are collected and compiled by facilities to a variable extent and no report has been produced by the government based on these data. In addition, no research on mental health has been published in indexed journals.

WHO-AIMS COUNTRY REPORT FOR MONGOLIA

Introduction

Mongolia is located in between two neighboring countries, Russia to the north and China to the south. Mongolia is a country with an approximate area of 1567 thousand sq.km.(UNO, 2001) and a population of 2.53 million (2533100). The proportion of the population under the age of 15 is 31 % (UNO, 2004), and the proportion of population above the age of 60 years is 6% (WHO, 2004). Forty-five percent of the country's population is rural. About 1 million people live in the capital city of Ulaanbaatar. The main language used in the country is Mongolian. The largest ethnic group is Mongolian (Khalkh Mongol-four-fifths of the population), and the other ethnic groups are Kazakh, Tuvin, Uzbek, Russian and Chinese. The largest religious group is Buddhist.

The life expectancy at birth is 60.1 years for males and 65.9 years for females. The healthy life expectancy at birth is 53 years for males and 58 years for females. The literacy rate is 94% for men and 91.5% for women (Mental Health Atlas, WHO, 2005). The country is a low income group country based on the World Bank 2004 criteria. The proportion of health budget to GDP is 6.4%. The per capita total expenditure on health is 122 international \$ and the per capita government expenditure on health is 88 international \$ (WHO, 2004). The per capita government expenditure on mental health is 2% of the total health expenditures by the health department. There are 79.9 hospital beds and 26.17 general practitioners per 100,000 populations in the public sector. The total number of human resources working in mental health facilities or private practice is 17 per 100000 population. In terms of primary care, there are 230 physician-based primary health care clinics and 11 non physician-based primary health care clinics. These data are only available for the public sector.

From 1997 efforts have been made in collaboration with the WHO to implement community based mental health care, but its coverage and results were unsatisfactory until now. Furthermore, the Asian development bank has assisted in the training of family practitioners in mental health as part of a larger program to improve primary care services in Mongolia. The following data were collected in the year 2005 and they are based on the year 2004.

Domain 1: Policy and Legislative Framework

Policy, plans, and legislation

A National Mental health program was enacted by the Government in 2002. Both the plan and policy include the same components including the development of community mental health services, development of a mental health component in primary health care, human resources, advocacy and promotion, human rights protection of users, financing, quality improvement and monitoring system. In addition, a budget, a timeframe and specific goals are mentioned in the last mental health program. However, the documents mentioned above do not include the downsizing of large mental hospitals, the involvement of users and families, reforming mental hospitals to provide more comprehensive care and equity of access to mental health services across different groups. Furthermore, the Mental Health program determines financing on mental health only in general, but does not define a detailed scheme.

The timeframe for the implementation of the National Mental Health Program is from 2002 to 2007. Some program objectives have already been achieved in the last year:

1. In order to develop a mental health component in primary health care, training for general practitioners has been conducted.
2. The WHO received a curriculum and teaching programs from the Health Science University of Mongolia and the Nursing College. Its contents are in compliance with modern standards.
3. Postgraduate training on mental health and refresher training for specialists in three Mongolian regions has been conducted.
4. Advocacy for people with mental health issues was done by activities such as awareness campaigns in newspapers, radio or community TV programs. Furthermore, three training movies on mental health issues have been developed.
5. As part of the community education program, mental health posters and pamphlets have been distributed in the population.
6. Diagnostic and treatment criteria for mental disorders and substance abuse have been standardized.
7. Publication of books on mental health such as "Recommendation and diagnosis of common mental disorders", "Rights of patients with mental illness" or "Families involvement in mental health care".
8. "AA" treatment became available on the Aimaglevel (=highest level of regional administration) and on the city level.
9. The National Mental Health Program was monitored and evaluated in some Aimags.

The Parliament of Mongolia adopted a mental health law in 2000. The Mental health law includes components such as access to mental health care (including access to the least restrictive care); rights of mental health service consumers, family members, and other care givers; competency, capacity and guardianship issues for people with mental illness; voluntary and involuntary treatment, law enforcement and other judicial system issues for people with mental illness; mechanisms to oversee involuntary admission and treatment practices; mechanisms to implement the provisions of mental health legislation and liability for offenders of the Law on Mental Health. However, the Mental Health law does not include the accreditation of professionals and facilities.

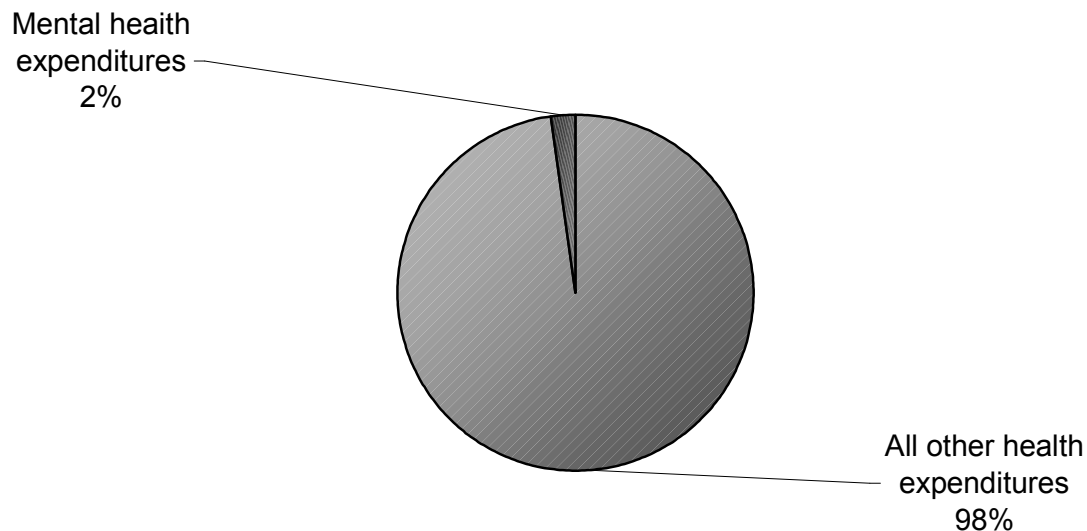
A list of essential medicines is present in the country. These medicines include antipsychotic, anxiolytic, antidepressant, mood stabilizers and antiepileptic drugs. The latest version of a disaster emergency preparedness plan for mental health was enacted in 2004.

Financing of mental health services

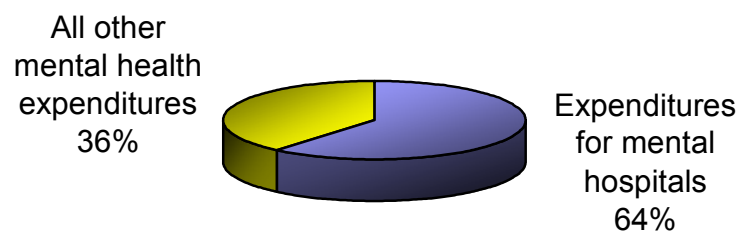
Two percent of health care expenditures by the government health department are directed towards mental health. Of all the expenditures spent on mental health, 64% are directed towards mental hospitals. In terms of affordability of mental health services, none of the population has free access to essential psychotropic medicines. For those that have to pay for their medicines out of pocket, the cost of antipsychotic medication is 10% and the cost of antidepressant medication is 7% of the minimum daily wage (approximately 0.17 US\$ per day for antipsychotic medication and 0.12 US\$

per day for antidepressant medication). All severe and some mild mental disorders are covered in social insurance schemes. When general practitioners prescribe psychotropic medicines for mentally ill patients, drug stores will discount 10% of the retail price. Private patients have to pay the full price. The provision of essential psychotropic medicines is very difficult in provinces, because only 10 tablets of psychotropic medicines can be prescribed at one time, which provides the patient with a drug supply for only 2-3 days.

Graph 1.1 Health expenditure towards mental health



Graph 1.2 Mental health expenditure towards mental hospitals



Human rights policies

A national human rights review body exists but does not have the authority to oversee regular inspections in mental health facilities, review involuntary admissions and discharge procedures, review complaints investigation processes or impose sanctions. The mental hospital had at least one review of human rights protection of patients in the year of assessment, while none of the community-based inpatient psychiatric units and community residential facilities had such a review. In general, Mongolia has only few inspections of human rights protection in mental hospitals or in forensic units.

The mental hospital staff had at least one day of training, meeting, or other type of working session on human rights protection of patients in the last two years, but no inpatient psychiatric unit and no community residential facility has had such training.

The mental health law and the annex to the 210th resolution of the Minister of Health of Mongolia (ratified on July 17th, 2000) included regulations on involuntary treatment, a review of involuntary admissions and the investigation of complaints, but they have not been implemented yet at all levels.

Domain 2: Mental Health Services

Organization of mental health services

A national mental health authority, consisting of one specialized counselor at the Mongolian Ministry of Health, exists and provides advice to the government on mental health policies and legislation. The mental health authority is also involved in service planning, service management, co-ordination and monitoring and quality assessment of mental health services. The mental health service is organized by service areas and there are no regional mental health authorities.

Mental health outpatient facilities

There are 35 mental health outpatient facilities available in the country, but there are no specialized child and adolescent services available. Only the “Mental Health and Narcology Center” has children’s doctors to see children presenting for treatment. The number of users per 100,000 general population is 841. Of all users treated in mental health outpatient facilities, 45% are female and 3% are children and adolescents. The users treated in outpatient facilities are primarily diagnosed with behavioral disorders due to alcohol and psychoactive substance use (24%) and schizophrenia and related disorders (11%)

The average number of contacts per user treated through mental health outpatient facilities is 7.6. None of the outpatient facilities provide follow up care in the community or have mental health mobile teams. In terms of available interventions, few (1-20%) users have received one or more psychosocial interventions in the last year. The “Mental Health and Narcology center” has a department for psychosocial rehabilitation.

All outpatient mental health facilities had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility or a near-by pharmacy all year round.

Day treatment facilities

There are 7 day treatment facilities available in the country. None of them are for children and adolescents only. These facilities treat 12.7 users per 100,000 general population. Of all users treated in day treatment facilities, 52% of them are female and none are children or adolescents. On average, users spend 40 days per year in day treatment facilities.

Community-Based Psychiatric Inpatient Units

There are twenty-one community-based psychiatric inpatient units available in the country for a total of 4.1 beds per 100,000 populations. There are no community-based inpatient units reserved for children and adolescents only. Fifty percent of admissions to community-based psychiatric inpatient units are female and 8% of admissions are children and adolescents. The diagnoses of admissions to community-based psychiatric inpatient units were primarily neurotic, stress-related and somatoform disorders (41%), mental and behavioural disorders due to psychoactive substance (17%) and schizophrenia and related disorders (15%). On average, patients spent 17.5 days per discharge.

Some (21-50%) of the patients in community-based psychiatric inpatient units received one or more psychosocial interventions such as psychotherapy, occupational therapy, physical therapy and cultural therapy in the last year. Eighty-six (86%) of all community-based psychiatric inpatient units had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic and antiepileptic medicines) available in the facility.

Community residential facilities

There are twelve community residential facilities available in the country for a total of 52 beds per 100,000 population. None of the beds in community residential facilities are reserved for children and adolescents only. These 12 community residential facilities are operated by 4 organizations. Seven of the facilities are located in the mental hospital, though independent of the hospital and run by the patients. Three of them are located near the "Mental Health and Narcology Center". The "Aimags" of Hovd and Orhon have one community residential facility each. 71% of users treated in community residential facilities are female and 7% are children. The number of users in community residential facilities is 2.2 per 100,000 population. The average number of days spent in community residential facilities is not known.

Mental hospitals

There is only one mental hospital (State Mental Hospital in Ulaanbaatar) available in the country for total of 17.7 beds per 100,000 populations. The mental hospital is organizationally integrated with the mental health outpatient facilities. Four percent (20 beds) of these beds in the mental hospital are reserved for children and adolescents only. There has been an increase of 25% in the number of beds in the hospital since 1999. This situation has been aggravated by the closing of the

"Residential Facility of Occupational Therapy" in 2003. This has led to an occupancy rate of over 80%. The patients admitted to the mental hospital belong primarily to the following diagnostic groups: schizophrenia and related disorders (21%) and neurotic, stress-related and somatoform disorders (20%). The number of patients treated in mental hospital was 4187 for 2004

The average number of days spent in the mental hospital is 31. 53% percent of patients spend less than one year, 25% of patients spend 1-4 years, 11% of patients spend 5-10 years, and 11% of patients spend more than 10 years in the mental hospital. The majority (51-80%) of all patients in mental hospitals received one or more psychosocial interventions such as psychotherapy, music therapy, art therapy, carpentry therapy, reading therapy, sewing therapy and psychodrama in the last year.

The mental hospital has at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility.

Forensic and other residential facilities

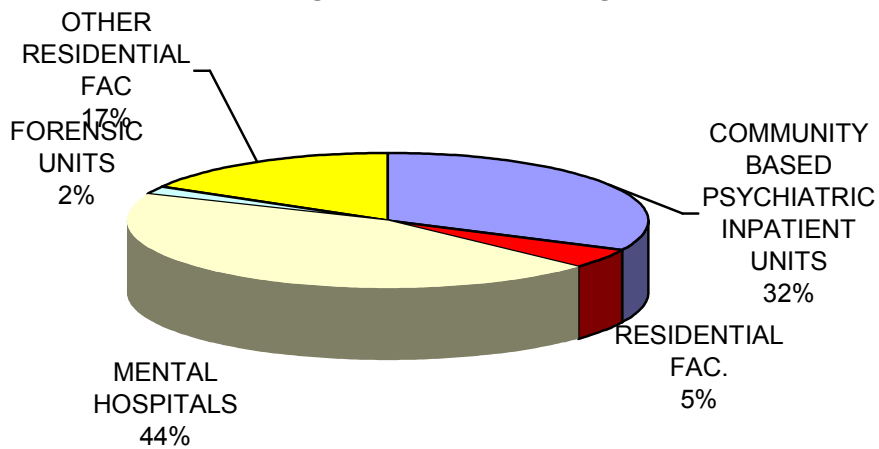
In addition to beds in mental health facilities, there are also 20 beds for persons with mental disorders in the forensic inpatient unit in the State Mental hospital, 120 beds in the involuntary residential facility of Maant, and 50 beds in the voluntary facility of Tolgoit for alcoholic patients that offer psychotherapy, detoxification, and alcohol treatment (Disulfiram). There are no separate forensic mental hospitals for mentally ill patients. In forensic inpatient units, sixty-four percent of all patients spent less than one year and 36% of all patients spent 1-4 years. None of the patients spent more the 5 years in the forensic inpatient unit.

Human rights and equity

The proportion of involuntary admissions to community-based inpatient psychiatric units and mental hospitals is unknown. The percentage of patients, who were physically restrained or secluded at least once within the last year in mental hospitals and community-based psychiatric inpatient units, is also unknown. The Mongolian Mental Health Law and the annexes of the Mental health law in the 210th resolution of the Ministry of Health in the year 2000 provide regulations on reporting involuntary treatment, physical restraint or seclusion of mentally ill patients but they are not followed on all service levels.

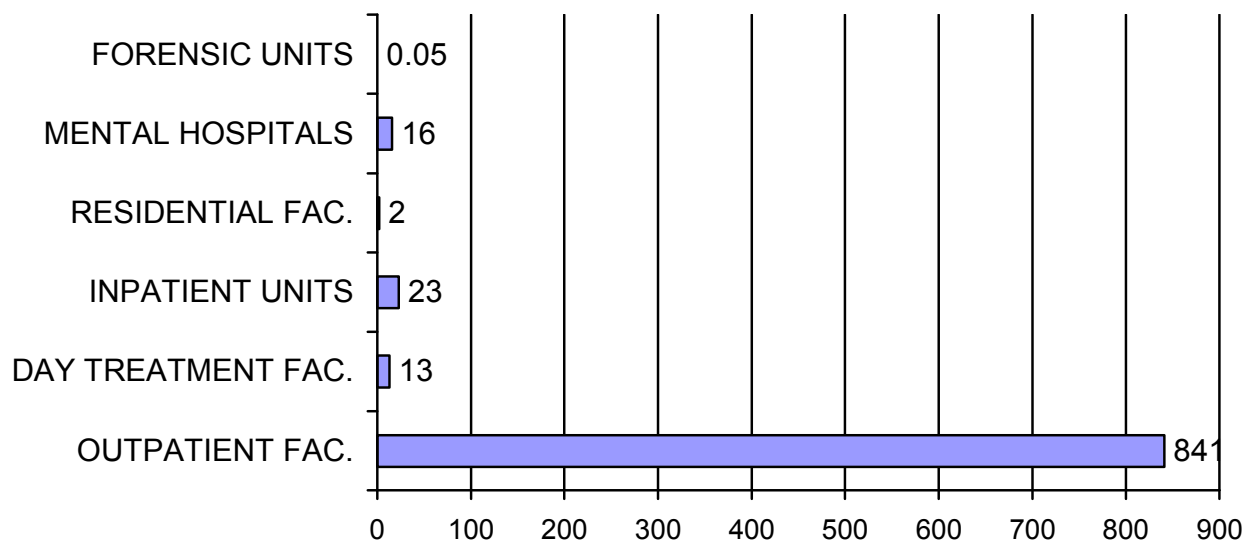
The density of psychiatric beds in or around the largest city is 1.6 times greater than the density of beds in the entire country. Such a distribution of beds limits access to mental health services for rural users. Inequity of access to mental health services for other minority users as Kazak, Buriad, Tsaatan, Durvud (e.g., linguistic, ethnic, religious minorities) is of moderate concern in the country. However, the equity of access to mental health services is an important problem for many groups in Mongolia.

GRAPH 2.1 - BEDS IN MENTAL HEALTH FACILITIES AND OTHER RESIDENTIAL FACILITIES



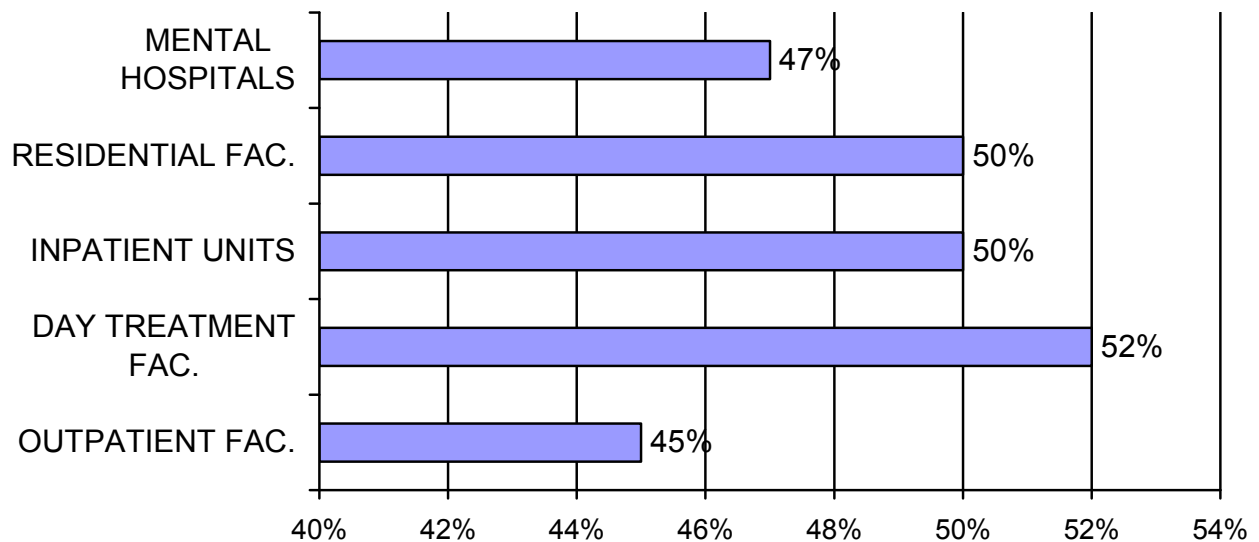
The majority of beds in the country are provided by mental hospitals, followed by community based psychiatric inpatient units.

GRAPH 2.2 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES (rate per 100.000 population)



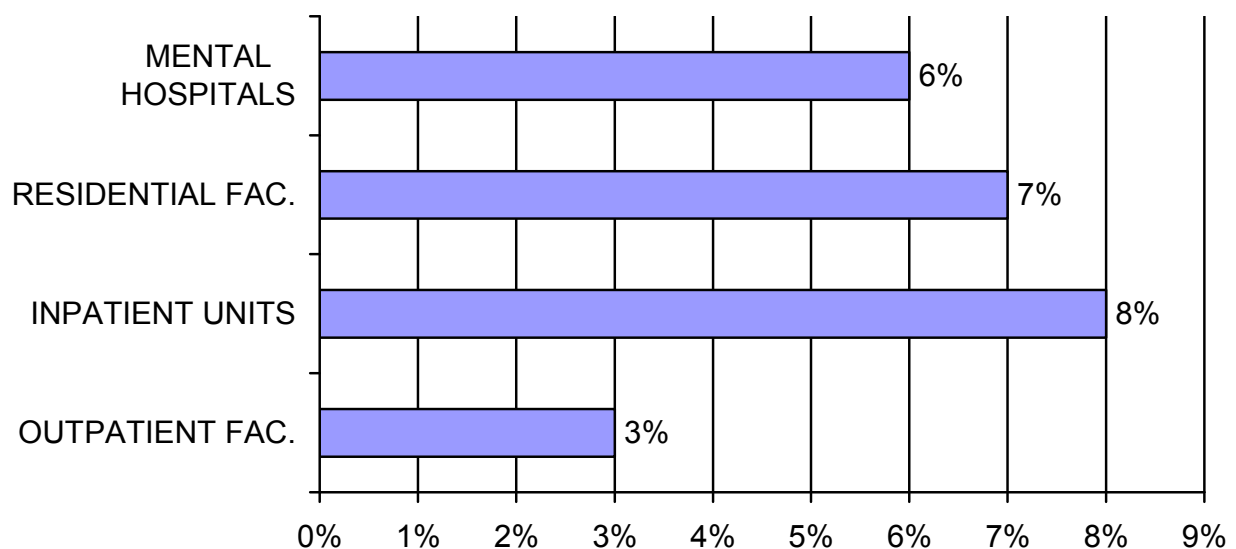
The majority of the users are treated in outpatient facilities, while the rate of users treated in psychiatric inpatient units, mental hospitals and day treatment facilities is significantly lower.

GRAPH 2.3 - PERCENTAGES OF FEMALE USERS TREATED IN MENTAL HEALTH FACILITIES



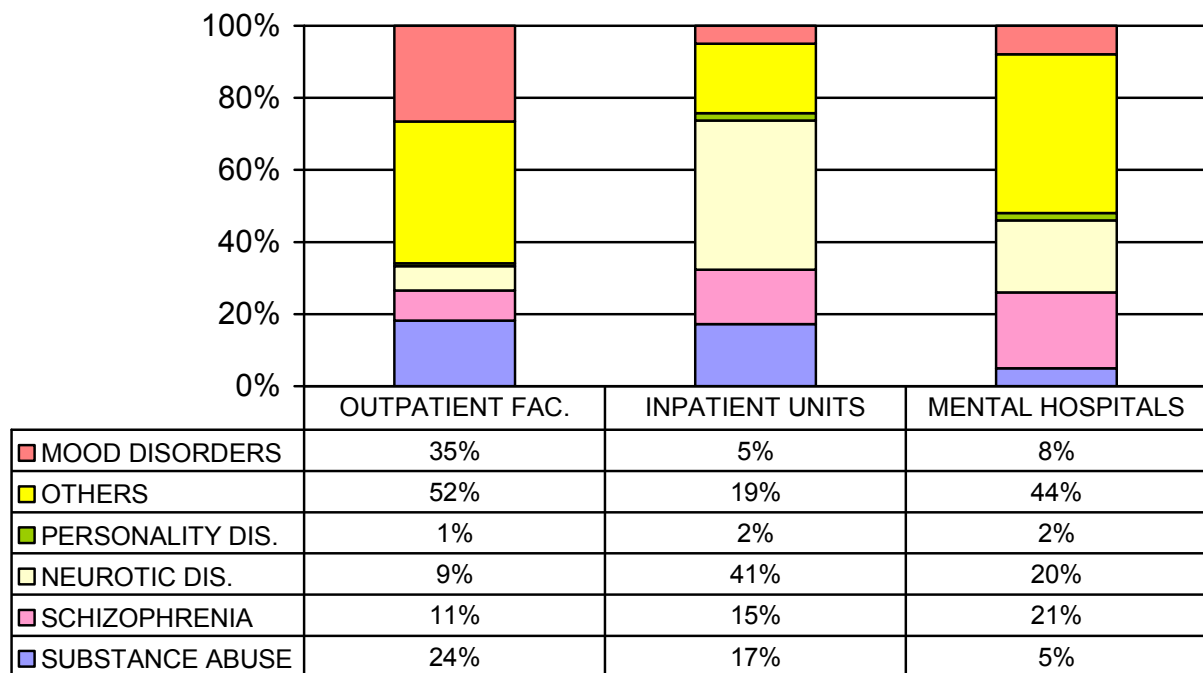
Female users make up close to 50% of the population in all mental health facilities in the country. The proportion of female users is highest in day treatment facilities and lowest in outpatient facilities.

GRAPH 2.4 - PERCENTAGE OF CHILDREN AND ADOLESCENTS TREATED IN MENTAL HEALTH FACILITIES AMONG ALL USERS



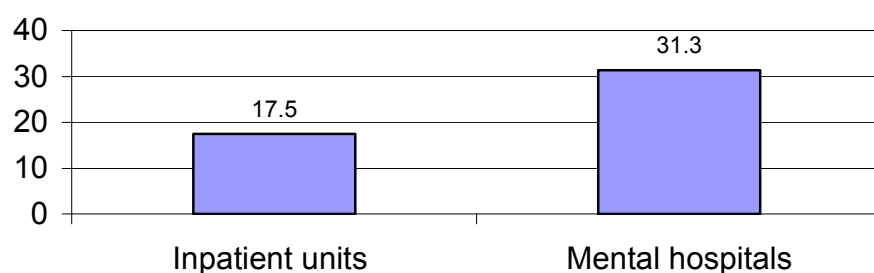
The proportion of children users is highest in psychiatric inpatient units, residential facilities and mental health outpatient facilities and lower in outpatient facilities.

GRAPH 2.5 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES BY DIAGNOSIS

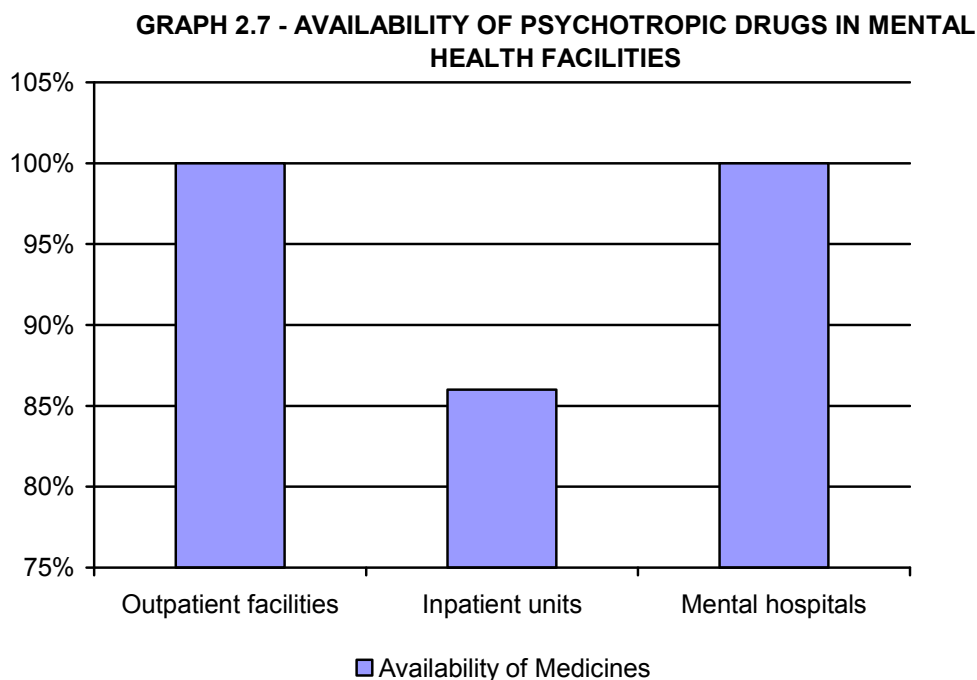


The distribution of diagnoses varies across facilities: in outpatients facilities "other" disorders like epilepsy, organic mental disorders, mental retardation or behavioural and emotional disorders are most prevalent. Mood disorders and mental disorders due to substance use follow on place two and three. Within inpatient units neurotic disorders and mental disorders due to substance abuse are most common and in mental hospitals schizophrenia and neurotic disorders are most frequent.

Graph 2.6 Length of stay in inpatient facilities (Days per year)



The longest length of stay for users is in mental hospitals followed by community-based inpatient units. There is no data available on the length of stay in community residential facilities.



Psychotropic drugs are available in all mental hospitals and outpatient facilities and in most psychiatric inpatient units.

Domain 3: Mental Health in Primary Health Care

Training in mental health care for primary care staff

The project “Nations for mental Health”, implemented in collaboration with the WHO for several years beginning 1997, was aimed to start a training initiative in primary mental health care for general practitioners. With the help of the Asian Development bank refresher training for general practitioners on primary mental health care has been conducted. Five percent of the training for medical doctors is devoted to mental health, in comparison to 1% to nurses and 1% to non-doctor/non-nurse primary health care workers. In terms of refresher training, none of the primary health care doctors and none of the nurses and non-doctor/non nurse primary health care workers have received at least two days of refresher training in mental health in the year 2004.

Mental health in primary health care

Both physician based primary health care (PHC) and non-physician based PHC clinics are present in the country.

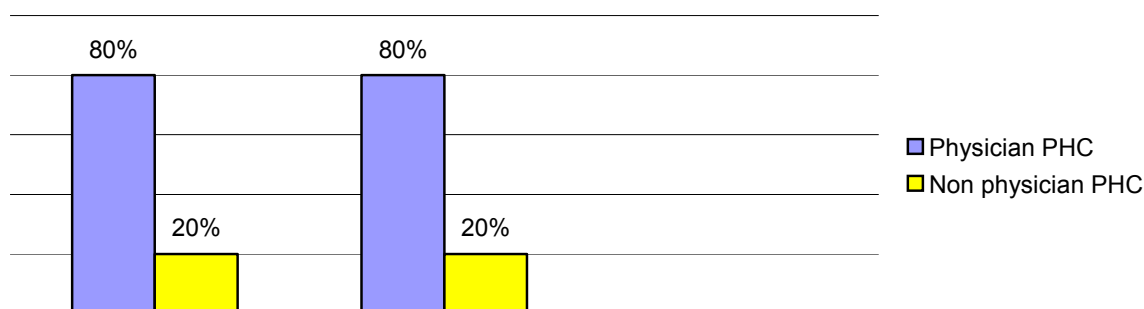
In terms of physician-based primary health care clinics, the majority of physician-based primary health care clinics (81-100%) have assessment and treatment protocols for key mental health conditions available, in comparison to a few (1-20%) for non physician-based primary health care clinics.

Last year some books on mental health for general practitioners and professionals were published such as “Community Based Mental Health Care Service”, “Where there is no psychiatrist”, “Diagnostic and Management Guidelines for Mental Disorders in Primary care” and the “Summary of ICD-10 for Primary Health Care and Mental Health Care on Disaster”.

The majority of physician-based primary health care doctors make on average at least one referral per month to a mental health professional. A few (1-20%) full-time primary care providers in non-physician-based primary health care clinics make on average at least one mental health referral to a higher level of care. As for professional interaction between primary health care staff and other care providers, some of primary health care doctors have interacted with a mental health professional at least monthly in the last year.

It is unknown how many physician-based PHC facilities, non-physician-based PHC clinics, or mental health facilities have had interaction with a complementary /alternative/ traditional practitioner.

Graph 3.2 Comparison of Physician Based Primary Health Care with Non-Physician Based Primary Health Care



Note: Tx protocols = % of PHC clinics with treatment protocols available for key mental health conditions.

Referrals = % of PHC who make at least one mental health referral per month

Prescription in primary health care

Primary health care nurses and non-doctor/non-nurse primary health care workers are not allowed to prescribe psychotropic medications in any circumstance. Primary health care doctors are allowed to prescribe but with restrictions. Primary health care doctors in provinces are only allowed to prescribe 10 daily doses at a time.

As for availability of psychotropic medicines, a few of the physician based PHC clinics (1-20%) and none of the non-physician based PHC clinics have at least one psychotropic medicine of each therapeutic category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic and antiepileptic) available in the clinic or at a nearby pharmacy.

Domain 4: Human Resources

Number of human resources in mental health care

The total number of human resources working in mental health facilities or private practice per 100,000 population is 16.4 per 100000 population. The breakdown per 100 000 population according to profession is as follows: 0.5 psychiatrist, 4.7 other medical doctors (not specialized in psychiatry), 7.6 nurses, 0.2 psychologists, 0.8 occupational therapists, 2.6 other health or mental health workers (including auxiliary staff, non-doctor/non-physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counselors). There are no social workers working for mental health facilities or private practice.

Eighty-five percent of psychiatrists work only for government administered mental health facilities, 0% work only for NGOs/for-profit mental health facilities/ private practice, while 15% work in both sectors. All psychologists, nurses, and occupational therapists work only for government administered mental health facilities. These figures are best estimates based on official registration data and data from professional associations.

Regarding the workplace, four psychiatrists (who were trained for at least 2 years in postgraduate psychiatry) work in outpatient facilities, one in community-based psychiatric inpatient units and eight in the mental hospital. As for other medical doctors (i.e. those not specialized in mental health), 58 work in outpatient facilities, 31 in mental hospitals and 19 in community-based psychiatric inpatient units. There are 54 nurses working in outpatient facilities, 72 in community-based psychiatric inpatient units and 62 in mental hospitals.

No other mental health professionals (psychologists, social workers or occupational therapists) work in outpatient facilities or community-based psychiatric inpatient units, but 22 occupational therapists work in mental hospitals. These figures do not include those who work in private practice. As regards to other health or mental health workers 6 work in outpatient facilities and 14 in mental hospitals.

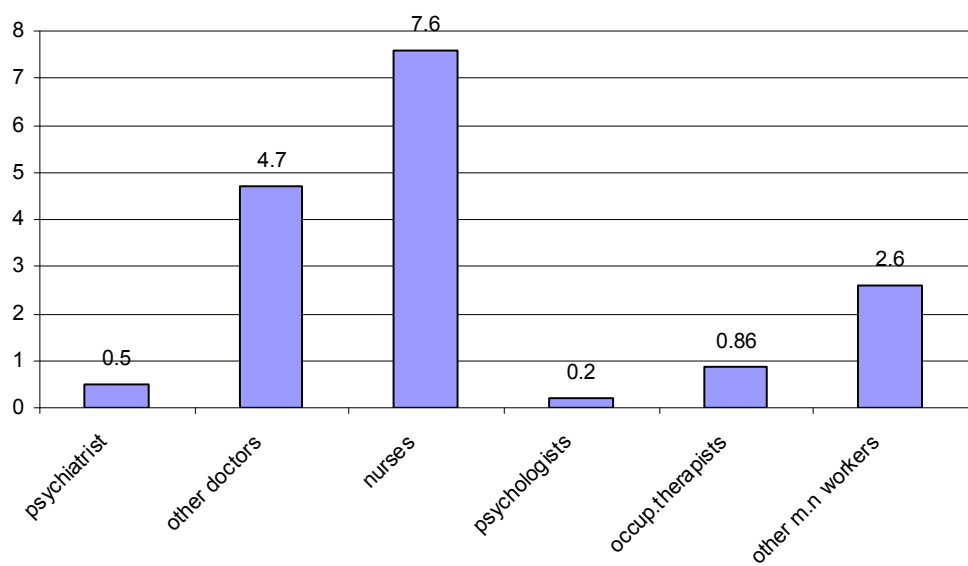
In terms of staffing in mental health facilities, there are 0.003 psychiatrists per bed in community-based psychiatric inpatient units, in comparison to 0.02 psychiatrists per bed in mental hospitals.

As for nurses, there are 0.22 nurses per bed in community-based psychiatric inpatient units, in comparison to 0.14 per bed in mental hospitals. There are no other mental health care staff (e.g., psychologists, social workers, occupational therapists, other health or mental health workers) working in any community-based psychiatric inpatient unit, and 0.05 psychosocial staff (psychologists, social workers and occupational therapists) and 0.03 other health or mental health workers per bed in working in mental hospitals.

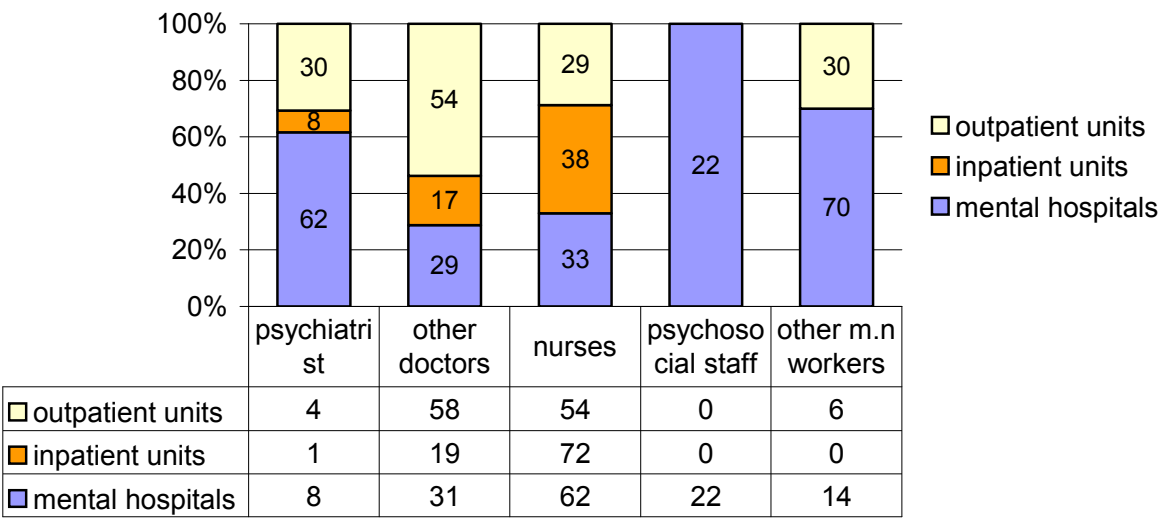
The distribution of human resources between urban and rural areas is roughly proportionate for the population. The density of psychiatrists in or around the largest city is 0.43 psychiatrist per 100000 population compared with 0.50 for the entire country. On the other hand, the figure for nurses is slightly disproportionate. In the largest city you find 10 nurses per 100000 population while there are only 7.6, nurses per 100000 population in the entire country.

It should be taken into consideration that psychiatrists, psychologists and social workers in government administered facilities only work 12 to 15 hours per week. Consequently, the number of mental health professionals may appear to overestimate the actual human resources in these facilities.

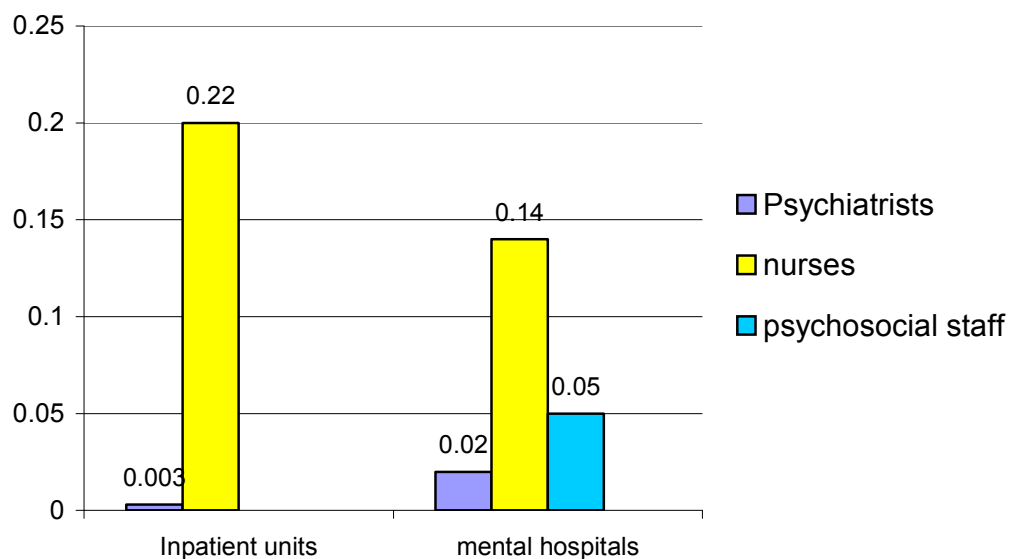
Graph 4.1 Human resources in mental health
(Rate per 100.000 population)



Graph 4.2 Staff Working In Mental Health Facilities
(Percentage in the graph, number in the table)



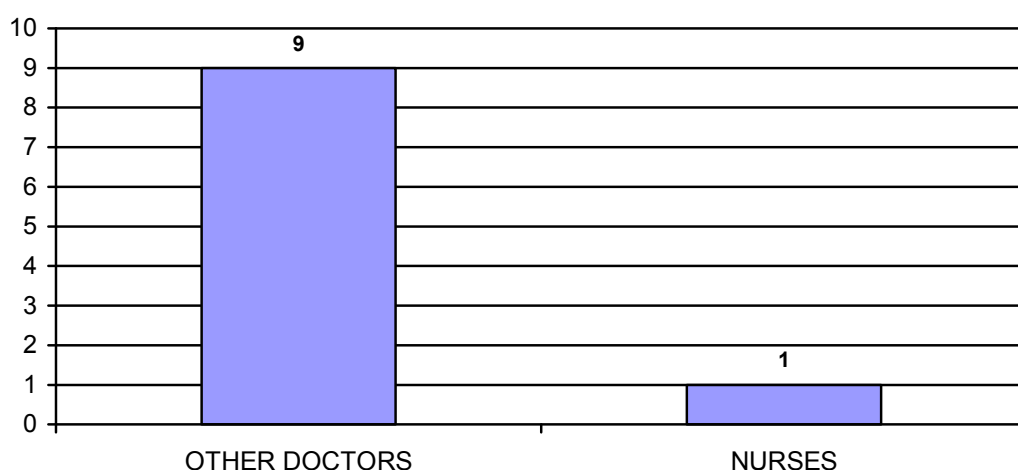
Graph 4.3 Ratio Human Resources/Beds



Training professionals in mental health

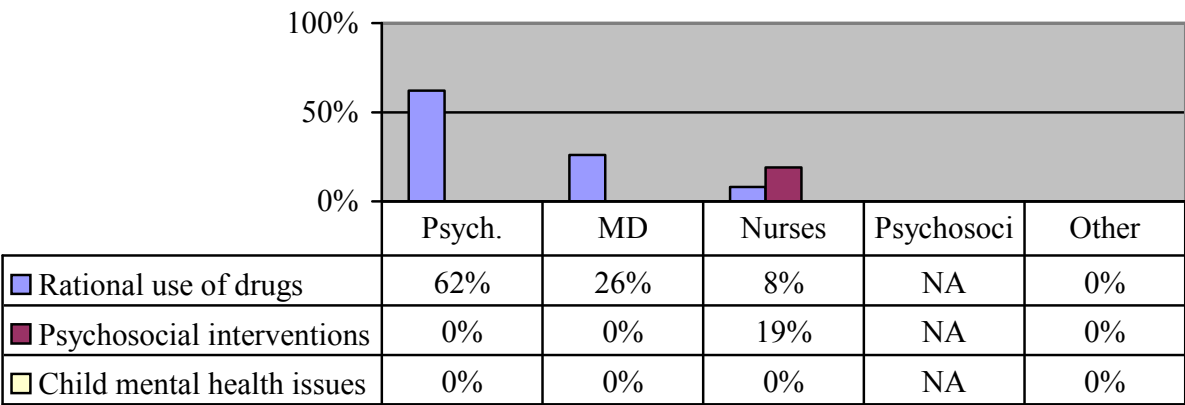
The number of professionals who graduated last year in academic and educational institutions per 100,000 is as follows: 9 medical doctors and 1 nurse. No psychiatrists or psychologists, nurses, social worker or occupational therapists with at least 1 year training in mental health care graduated last year in academic and educational institutions. No psychiatrists emigrated from the country within five years of completion of their training.

Graph 4.4: Professionals graduated in mental health (rate per 100.000 population) in the last year



Graph 4.5 shows the percentage of mental health care staff with at least two days of refresher training in the rational use of drugs, psychosocial interventions, and child/adolescent mental health issues.

GRAPH 4.5 - PERCENTAGE OF MENTAL HEALTH STAFF WITH TWO DAYS OF REFRESHER TRAINING IN THE PAST YEAR



Consumer and family associations

There are 2 consumer associations and there are no family associations. The government provides economic support for consumer associations such as the "Mental Health Association", the "AA" center and the "Association against alcohol and substance abuse", e.g. the government provided economic support in form of 6 millions tugrug to the "AA" center of mental health in 2003. Consumer associations have not been involved in the formulation or implementation of mental health policies, plans, or legislation in the past two years. Mental health facilities interact with a few consumer associations (1-20%). In addition to consumer and family associations, there are 6 other NGOs in the country involved in individual assistance activities such as counselling, housing, or support groups.

Domain 5: Public Education and links with other Sectors

Public education and awareness campaigns on mental health

Psych = psychiatrists; MD =other medical doctors not specialized in psychiatry; psychosocial staff = psychologists, social workers, and occupational therapists. Others = other health and mental health workers

mental and s in the last five years. These campaigns have targeted the following groups: the general population, children, adolescents, women, trauma survivors and other vulnerable groups. In addition, there have

been public education and awareness campaigns targeting professional groups including health care providers and lecturers at the "Health Science University of Mongolia", social services staff, leaders and politicians, and other professional groups linked to the health sector.

Legislative and financial provisions for people with mental disorders

The following legislative and financial provisions exist to protect and provide support for users, but are not enforced: legislative provisions concerning a legal obligation for employers to hire a certain percentage of employees that are disabled, provisions concerning protection from discrimination solely on account of mental disorder, provisions concerning priority in state housing and in subsidized housing schemes for people with severe mental disorders and provisions concerning protection from discrimination in housing for people with severe mental disorders.

Links with other sectors

In addition to legislative and financial support, there are formal collaborations between the government department responsible for mental health and the departments responsible for primary health care/community health, HIV/AIDS, child and adolescent health, substance abuse, child protection, education, employment, housing, welfare, the elderly, and criminal justice. In terms of support for child and adolescent health, only 2 of 710 of primary and secondary schools have a part-time or full-time mental health professional and only a few (1-20%) of primary and secondary schools have school-based activities to promote mental health and prevent mental disorders.

According to the forensic department, the percentage of prisoners with psychosis is less than 2%, while the corresponding percentage for mental retardation is likewise less than 2%. Regarding mental health activities in the criminal justice system, only a few prisons (1-20%) have at least one prisoner per month in treatment contact with a mental health professional. As for training, few police officers (1-20%) and few (1-20%) judges and lawyers have participated in educational activities on mental health in the last five years. In terms of financial support for users, few (1-20%) of mental health facilities have access to programs outside the mental health facility that provide outside employment for users with severe mental disorders. Finally, 15% of people who receive social welfare benefits do so for a mental disability.

Domain 6: Monitoring and Research

A formally defined list of individual data items that ought to be collected by all mental health facilities exists and includes the number of psychiatric beds, the number of admissions, the number of days spent in hospital and the diagnoses.

The government health department received data from the mental hospital, all the community based psychiatric inpatient units and all mental health outpatient facilities. Based on this data, a report was published on this data but did not include comments. In terms of research, 2% of all health publications in the country were on mental health. Research in Mongolia is focused on the following topics: epidemiological studies in community samples and clinical samples and non-epidemiological clinical/questionnaires assessments of mental disorders and service research.

In Mongolia, mental Health research findings are usually published in non-indexed journals such as the "Mongolian Medicine". There are no mental health research publications in indexed journals. In addition, 301 publications on health and 5 publications on mental health have been published in international journals from 2000-2003.

Graph 6.1 Percentage of mental health facilities transmitting data to Health Department

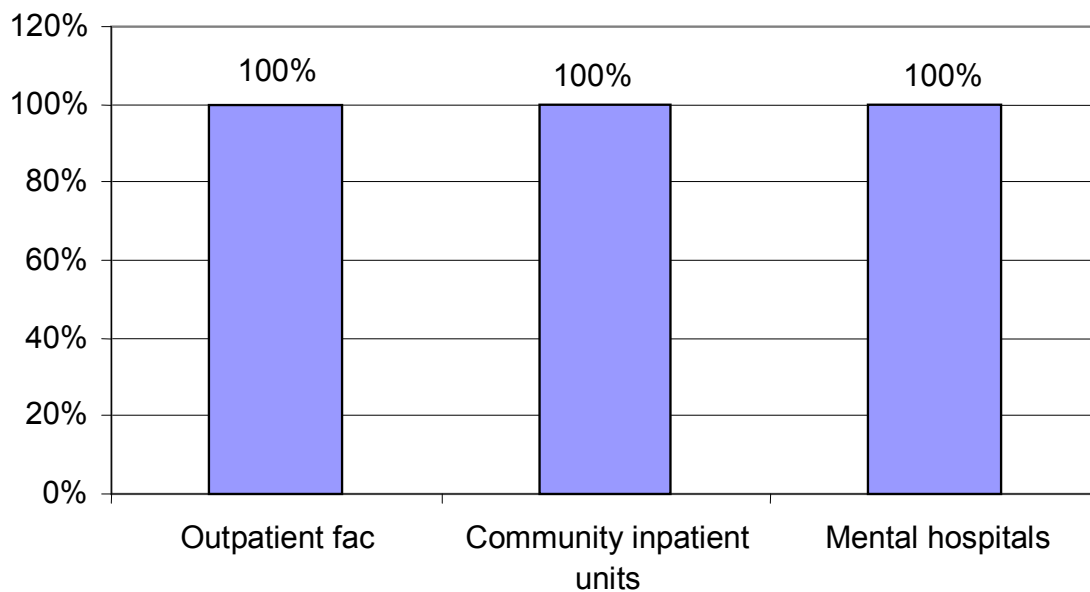


Table 6.1 Percentage of mental health facilities collecting and compiling data by type of information

Type of information compiled	Mental hospital (1)	Inpatient units (21)	Outpatient facilities (35)
Number of beds	100%	86%	NA
Number of inpatient admissions in outpatient facilities	100%	86%	100%
Number of days spent in outpatient facilities	100%	86%	100%
Number of involuntary admissions	0%	0%	NA
Number of users restrained	0%	0%	NA
Diagnoses	100%	86%	100%

Next steps in planning mental health action

The mental health system in Mongolia has the whole range of mental health facilities, however some strengthening and further development is needed. Based on the results of WHO-AIMS data we have determined the following issues to be considered in order to improve the mental health system of Mongolia:

1. Despite a mental health programme and legislation envisaging community based care, the existing mental health system is still hospital based. Psychosocial rehabilitation of people with chronic mental disorders needs to be supported by establishing day care centres and community residential homes. A move towards community care will also require a redirection of mental health financing towards community mental health facilities and mental health promotion.
2. Links between mental health practitioners and family doctors needs to be strengthened. Training family doctors in basic mental health care, referrals, and follow up is needed. In addition, the supply and accessibility of psychotropic medicine in primary care should be improved.
3. The development of training material on mental health is needed in order to provide initial and continuing training to professionals including medical students, nurses, psychologists, social workers and psychiatrists in mental health and substance abuse.
4. Special attention needs to be given to develop professional competence and services in the area of child and adolescent mental health.
5. Specific actions that need to be taken urgently include:
 - To review the human rights situation in all mental health facilities regularly and conduct training for mental health workers on human rights. It will also be important to collect data on involuntary admissions and the use of restraints or seclusion in mental health facilities.
 - To improve data collection and its use in planning, monitoring and evaluation of mental health services and to meet regularly among policy and decision makers.
 - To expand research on mental health and to publish scientific articles in indexed journals (e.g. to conduct epidemiological surveys according to WHO standardized methods and to establish a surveillance systems on mental health).
 - To support establishment of family and consumer associations for mentally ill persons.
 - To expand education and awareness campaigns and to collaborate better with NGOs.
 - To improve law enforcement and its related regulations on social welfare and protection of disabled people
 - To improve inter- sectoral collaboration in the field of social welfare, housing, law, work provision, and education for people with mental disorders.
 - To develop awareness of mental health issues under members of other professional groups.
 - To expand collaboration with WHO and its financial and technical support.

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used for collecting information about the mental health system in Mongolia. Data was collected from all of the mental health facilities in the country and from 60 other related organizations.

The assessment revealed that there are 35 outpatient facilities, 7 day treatment facilities, 12 community residential facilities, 21 community-based psychiatric inpatient units and one mental hospital in Mongolia. Although the mental health system is still largely hospital based, the majority of the users are treated in outpatient facilities. Access to mental health facilities is uneven across the country, favoring those living in or near the capital city. 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 in mental health facilities. There has been some training of primary health care staff. However, this training is limited and primary health providers have limited interaction with mental health providers.

A national human rights review body exists but it has no specific authority on mental health e.g. to oversee regular inspections in mental health facilities or review involuntary admissions. Mental health statistics are collected by facilities to a variable extent but there is no summary report for these data. In addition, little research on mental health has been published in indexed journals.

It is expected that the information reported here will form the foundation for the development of strategies to strengthen the mental health services for the people of Mongolia.