出國報告（出國類別：參加會議）

Public Mental Health for Human Dignity

14th Annual International Mental Health Conference

12th Annual Child Mental Health and Psychiatry conference

服務機關：衛生福利部

姓名職稱：陳快樂 心理及口腔健康司司長

派赴國家：泰國

出國期間：2015/6/14-17 日

報告日期：2015/9/4

目次

摘要

衛生福利部心理及口腔健康司(心口司)陳快樂司長應邀至泰國曼谷參加泰國公共衛生部心理健康司主辦之國際年會，公共心理衛生與尊嚴。會中報告 Suicide prevention in Taiwan。

泰國重視心理健康，成立心理健康司已 20 年，辦理國際會議已 14 年，此次會議邀請 19 國家 110 名學者與會。其中英國學者報告之 Public mental health，泰國專家報告之 Thai Happiness survey 及 Thailand national mental health survey, 是我們需要學習及努力的方向。 心口司於 102 年 7 月成立，今年(104 年)委託進行台灣幸福指數調查及兒童精神疾病流行病調查。然心口司應與衛福部國健署、統計處合作將幸福指數溶入其相關統計。並應有長期之兒童及成人精神疾病之流行病調查。另參加 Dr. Prawatte 之 Mindfulness workshop 後， 擬於今年邀請 Dr. Prawatte 來台對專業人員辦理二天之種子訓練。

目的

一、應邀參加國際會議

二、報告 Suicide Prevention in Taiwan

三、與國際學者交流.

過程:

一、本次會議申請衛生福利部 1 萬元來回機票補助。食宿由主辦機構提供。

二、本次會議主辦單位為泰國公共衛生部心理健康司 Department of Mental Health，參加人員共有 995 人，其中 101 人來自 19 個國家，包括台灣、英國、芬蘭、馬來西亞、印尼、澳洲、菲律賓、日本、香港、汶萊、星加坡、中國、Cambodia、錫蘭 、印度、越南、奧地利、Siri lanka, Bangladesh。

三、本次會議泰國心理健康司動員該司員工及所屬醫院員工。

公共衛生部部長參加開幕典禮，並頒發獎狀，予當年表現優異之衛生行政人員。

四、會議進行 2 天半，議程見附件一。

前二天會議有國際(英文)之 International special lecture, plenary lecture, symposium, workshop 及泰語之 Thai symposium, panel discussion, workshop 其中 Keynote speaker, *Prof. Jonathan Campion*, UK 報告之 Public Mental Health 值得參考 (附件二)

參加 Dr. Prawatte 之 Mindfulness workshop

最後一天 Thai Happiness Survey (附件三) 及 Thai National Mental Health Survey (附件四) 也非常值得台灣學習。

五、大會邀請台灣報告者有二名，其中一名為陳快樂司長，報告 Suicide Prevention in Taiwan，(簡報見附件五)。 另一位為嘉義長庚醫院陳錦宏教授報告 Interaction between clinic practice and research : experience of clinical based research model in central Taiwan。

心得與建議

一、 泰國政府重視心理健康，於 20 年前就於公共衛生部 Ministry of Public Health 成立心理健康司 Department of Mental Health，並負責公立精神療養院。每一家療養院有其重點發展成為 Center of Excellency。

台灣自 2013 年 7 月 23 日成立之衛生福利部，其中心理及口腔健康司(心口司)主管全國心理及口腔健康，共有六科，然全司人力只有 28 人，且經費少，與泰國之心理健康司無法比擬。台灣政府需更重視國人心理健康，給予心口司更多之人力及經費，以推展心理健康促進業務。

本部精神療養院由本部醫院及衛福管理委員會管理，心口司與衛福會合作，給予經費讓各療養院院發展其特色，成為 Center of Excellency

二、 泰國心理健康司每年辦理國際會議，至成已辦理 14 年，大會提供來自國內外與會人員之住宿及三餐，

心口司人力不足，無法自行辦理，可與相關學協會合作，辦理國際會議。讓國際人士認識台灣。

泰國辦之會議，報到處就只有幾位工作人員。但外賓之接待從下飛機開始，由心理健康司及療養院員工陪同。

國內辦理大型國際會議往往外包，豪華而浪費，委外工作人員太多，浪費不少經費。

三、 泰國公共衛生部對台灣非常友善，對來自台灣的學者，以 Taiwan(台灣)尊稱我們。不同於 WHO 及 APEC，以 Chinese Taipei 稱台灣與會人員。台灣需繼續爭取在國際會議中以 Taiwan 稱，而不是 Chinese Taipei.

四、 英國學者 Campion 報告之 Public mental health 強調初級預防，早期發現早期治療之重要。重視青少年及全民之心理健康促進，精神疾病之治療。

(一) WHO 2014 之報告精神疾病及自傷造成 Years lived with disability (YLD), 泰國是 29%，英國是 30.3%, 歐洲是 29.2%

(三)精神疾病有下列特色，

發生的早:　50%精神疾病在age 14開始。

發生率高 ：23%英國人有至少一種精神疾病

31.2%歐洲人在過去一年有至少一種精神疾病

(四) 精神疾病造成之年損失:

英國**£105 billion (CMH, 2010)。EU: £415 billion (Olesen et al, 2011)，Globally: £1,502 billion (Bloom et al, 2011)**

(五) Mental wellbeing

Four main constituents of wellbeing: pleasure, engagement, meaning and achievement

Relation between mental wellbeing and mental illness

Interdependent, wellbeing reduces risk of mental disorder, mental disorder reduces wellbeing.

Promotion of wellbeing important for recovery from mental disorder.

(六) Mental wellbeing promotion interventions

Starting well – preschool and early education programmes

Developing well – school based programmes

Living well, socially well, Working well and aging well

Public mental health，是我們該了解及重視的面向，不只是精神疾病之防治，在 mental health promotion 及 mental wellbeing promotion 上我們需要加強。心口司人力不足，對國民之心理健康促進，目前僅是訂定方向，委託衛生局及民間團体辦理。建議心口司成立工作小組，邀請專家，國健署、教育部、衛生局代表，定期密集討論，加強對各項業務深入討論，訂定方案及評估機制。尤其需發展學前及學生心理健康促進方案。

六、泰國心理健康司有負責統計及研究之部門。

(一) 泰國Happiness survey，是泰國心理健康司研發有信、效度之questionnaire作調查，且自2008年起泰國政府各部會在做不同調查時，都加入此survey，因此有每年的資料作比較，並提供給各縣市作改進參考。

(二) 泰國National mental health survey，自1998起，每五年作一次調查，此次報告2013年之調查。調查5000人，有4份questionnaires: (1)WHO CIDI (精神疾病調查), (2) European quality of life, (3) MMSE (Mini Mental state Examination), (4) Strength and difficulty questionnaire for parent.

2013年調查結果如下:

Thailand any mental disorder, life time prevalence 26.4%,

12month prevalence 8.9%

有關台灣精神疾病流病調查，台大林宗義教授等人於1946-1948年，進行第一次調查，於1961-1963進行第二次調查。葉英堃、胡海國教授等人於1982-1985年調查，李明濱教授於2002-2005年調查(衛生署委託)，這四次皆為成人精神疾病流行病調查。心口司於2014-2015，委託高淑芬教授調查兒童青少年精神疾病。

泰國心理健康司有專責統計、研究的部門，有持續之Thai Happiness Survey 及Thai National Mental Health Survey。台灣心口司沒有負責統計及研究之人員及科室。

心口司於 104 年委託辦理台灣幸福指數發展及初步調查， 發展之幸福指數，未來需與國民健康署，本部統計處合作，溶入相關統計，才能有持續之調查資料。

台灣精神疾病流行病調查之經費，來源不穩定，與泰國自1998年起每五年做一次調查，差很大。如何爭取足夠穩定之經費，持續辦理台灣之幸福指數及精神疾病流行病調查是很大的課題。

七、參加Dr. Prawatte 之Mindfulness Workshop，且邀請Dr. Prawatte今年來台辦理專業人員種子訓練 workshop。

14 th Annual International Mental Health Conference and
12th Annual Child Mental Health and Psychiatry Conference
15th- 17th June, 2015, Miracle Grand Convention Hotel, Bangkok
"Public Mental Health for Human Dignity"

Tentative Scientific Programs

June 15th 2015						
09.00-10.00	Opening ceremony by former Thailand 18th Prime Minister, Dr. Anand Panyarachun Dr. Jetsada Chokdamrongsuk, Director of Department of Mental Health					
10.00-10.45	ISL(E/C): Special Speech "Public Mental Health for Human Dignity(สุขภาพจิตสู่คุณค่าความเป็นมนุษย์)" by former Thailand 18th Prime Minister, Dr. Anand Panyarachun					
10.45-11.00	Coffee Brakes					
11.00-12.30	ISL(T/C) : Public Mental Health Concept : *Prof. Jonathan Campion*, UK.					
12.30-13	Lunch Brakes					
	International conference room 1	International Workshop room 2	ห้องส่งเสริมป้องกัน(สพส.)	ห้องระบบบริการ (สบบส.)	ห้องวิกฤต(ส.กัลยาณ์)	ห้องเด็ก(ส.ราชานุกูล)

DRAFT กำหนดการ 300315

13.30-15.00	ISP(T/C) : Research/ Evidence based in Public Mental Health - Information technology and patient-centered interventions in public mental health. *Prof. MarittaVälimäki, Finland* - Estimating the Economic Burden of Violence against Children in East Asia and the Pacific *Stephen Blight, Regional Child Protection Advisor UNICEF EAPRO* - Interaction between Clinic Practice and Research: Experience of	IWS: Psychosocial Rehabilitation: Needs and opportunities 1 Speaker : *Prof. Afzal Javed, UK.* *Prof. NalakaMendis, Sri Lanka* *Prof. GolamRabbani, Bangladehh* *Prof. Michaela Amering, Austria* *Prof. PichetUdomrat, Thailand*	TWS:กายใจเป็นสุข รุกสู่สถานประกอบการ (สพส.) - ตัวเทนจากสถานประกอบการ *นายนราศักดิ์ คำดี* *น.ส.ตะติพร ฟูไพบูลย์* *น.ส.ณัชนัญ ปัญญากาศ (บ.CPAllจ.ลำพูน)* *- ตัวแทนจากกรมควบคุมโรค* *- ตัวแทนจากกรมอนามัย*	TSP : ระบาดวิทยาสุขภาพจิตระดับประเทศ พ.ศ.2556 Thai national mental health survey 2013 ระบาด - การพัฒนางานสำรวจระบาดวิทยาสุขภาพจิตคนไทย *พญ.พันธุ์นภา กิตติรัตน ไพบูลย์* - ระเบียบวิธีวิจัยและการสำรวจระบาดวิทยาสุขภาพจิตคนไทย *คุณวรวรรณ จุฑา* - ผลการสำรวจระบาดวิทยาสุขภา	TPD: อาชญากรทางเพศ: ผู้ล่าหรือเหยื่อ(ส.กัลยาณ์) ผู้ดำเนินการอภิปราย *นพ.ทวีศิลป์ วิษณุโยธิน* วิทยากร *- พญ.ดวงตา ไกรภัสสร์พงษ์* *- อ.สุนีย์ จากมหาวิทยาลัยมหิดล* *- นักจิตวิทยาคลินิก*	TSP: ก้าวข้ามผ่านความซับซ้อนปัญหาเด็กเล็ก เด็กวัยเรียนและวัยรุ่น (ส.เด็กและวัยรุ่น) - ปัญหาและทางออก เริ่มที่ช่วงปฐมวัยจริงหรือ *รศ.พญ. นิชรา เรืองดารกานนท์, คณะแพทยศาสตร์ รามาธิบดี* - ความซับซ้อนสะท้อนปัญหาเด็กวัยเรียน *ศ.คลินิก พญ.วินัดดา ปิยะศิลป์, สถาบันเด็กมหาราชินี* -

	Clinical-Based Research Model in Central Taiwan. *Dr. Vincent Chin-Hung Chen, Taiwan* - Education on Mental Health among Health Workers: A Foundation of the National Framework of Action on Mental Health *Dr. Ruth Bordado, Philippines*			พจิตคนไทย *นพ.นพพรต้นติรังสี* - การใช้ประโยชน์จากข้อมูลระบาดวิทยาสุขภาพจิตคนไทย *พญ.สาวิตรี อัษณางกรชัย*		ความซับซ้อนของปัญหาเยาวชนชายขอบระบบบริการ *รศ.ดร. ลือชัยศรีเงินยวง, ม. มหิดล*
15.00-15.	Coffee Brakes					
15.15-16.30	ISP(T/C): Public Mental Health as a national program - Mental Health Promotion In HONG KONG: Its policy and practice. *Deborah Wan, Hong*	IWS: Psychosocial Rehabilitation: Needs and opportunities 2 Speaker : *Prof. Afzal Javed, UK.* *Prof. NalakaMendis, Sri Lanka* *Prof. GolamRabbani,*	TSP : การส่งเสริมป้องกันปัญหาสุขภาพจิตในเขตสุขภาพ (PP in district health	Depression (รพ.พระศรีมหาโพธิ์)	TPD : Social Crisis of Sexual offender in Community (ส.กัลยาณ์) ผู้ดำเนินการอภิปราย *พญ.จุฬาลักษณ์*	TPD: Service Plan in Teenage Pregnancy การตั้งครรภ์วัยรุ่นในระบบบริการสาธารณสุข (รพ.ยุวฯ) วิทยากร

	Kong - The development and implementation of Brunei Darussalam's 2014 Mental Health Order. *Dr. Hilda Ho, Brunei* - National Policy on Cyber Addiction in Japan *Tomohiro Shirasaka, M.D, Ph.D., Japan* - Service Plan and Treatment Gap Program in Thailand *Dr.Burin Suraaroonsamrit, Thailand*	*Bangladehh* *Prof. Michaela Amering, Austria* *Prof. PichetUdomrat, Thailand*	system)		*ตรีสุวรรณวัฒน์* วิทยากร *- ผอ.ศูนย์ 2, ตัวแทนสถาบัน* *- MCATTจ.นครปฐม* *- ผู้นำชุมชนที่เกี่ยวข้อง*	*- กรมควบคุมโรค* *- กรมอนามัย*

June 16th 2015

09.00-10.30	ISP (T/C): Evidence based-MH promotion/prevention program *Dr.JonathanCampion,UK* *PrawateTantipiwatanaskul MD.MPH, Thailand* *Happy KL Tan, MD.MPH, Taiwan*	IWS : Mindfulness Based Therapy and Counseling Speaker : *Dr.Yongyud Wongpiromsarn Thailand*	TPD : เครือข่ายเข้มแข็ง ผู้พิการได้ประโยชน์ (รพ.ศรีธัญญา+รพ.ยุว) ผู้ดำเนินการอภิปราย นางภัทรวรรธน์ สุขยิรัญ วิทยากร : - นายชูศักดิ์ จันทยานนท์	TPL : The Neuroscience of Meditations(ส.สมเด็จฯ) วิทยากร : *รศ.ดร.นัยพินิจ คชภักดี*	TPD : "ช่วยหนูด้วย" เสียงเพรียก...จากเด็กปลายด้ามขวาน "Help me" Cry... From Southern's child (ศูนย์ฯ 12) ผู้ดำเนินการอภิปราย *น.ส.ศุภวรรณ สัจจพงศ์* - นางนุชจารี สว่า	TWS : School readiness วิทยากร : *พญ.อัมพร เบญจพลพิทักษ์และคณะ* วิ
10.30-10.45	Coffee Brakes					

格式化: 醒目提示

10.45-12.15	ISP(T/C): Mental HealthIntervention and Evaluation *PRC ,China* *Hong Kong* *Prof.Chee Ng,* *Australia* *Dr.Wirunphat Kittitharaphan,* *Thailand*	IWS : Mindfulness Based Therapy and Counseling Speaker : *Dr.YongyudWongpiromsarn,* *Thailand*	TPD: การรักษาความสงบทางใจในผู้ป่วยสูงอายุระยะสุดท้าย (สพส.+รพ.สวนสราญรมย์)	TWS: การบำบัดฟื้นฟูการรู้คิดในผู้มีปัญหาสุขภาพจิตจากแอลกอฮอล์ (รพ.สวนปรุง/รพจ.นครพนม) *รศ.ดร.เมธิศา พงษ์ศักดิ์ศรี* *ดร. กุลวดี ทองไพบูลย์*	TPD : รักแท้ไม่มีวันตาย (รพจ.ขอนแก่น) ผู้ดำเนินการอภิปราย *นางอรพิน ยอดกลาง* วิทยากร *นพ.ประภาส*	TSP :สุขภาพจิตสังคมออนไลน์สังคมใหม่ใกล้ตัว(ส.พัฒนาการเด็กดฉ.) - Social network and its effect across lifespan ประธาน : *พญ.ดุษฎี จี*
12.15–13.30	Lunch Brakes					
13.30-16.30	Oral presentation	Oral presentation	Oral presentation	Oral presentation	Oral presentation	Oral presentation

June 17th 2015						
09.00-10.30	ISP(T/C): Early Psychosis prevention program(ส.สมเด็จ) *Hongkong* *Singapore* *Taiwan* *Dr.BurinSuraaroonsamrit, Thailand*	IWS : Happiness Speaker : *PrawateTantipiwatanaskul MD.MPH, Thailand*	TWS: การให้การปรึกษาเพื่อปรับเปลี่ยนพฤติกรรมสุขภาพในผู้ป่วย NCD (MI for NCD) วิทยากร : *นพ.เทอดศักดิ์ เดชคง* *กลุ่มที่ปรึกษา*	TWS: เครื่องมือในการทำงานสุขภาพจิตชุมชน (รพจ.นครราชสีมา+เลย+นครสวรรค์) *รศ.ดร.มานพ คณะโตและคณะ*	TPD :การใช้พรบ.สุขภาพจิตสู่สังคมที่ปลอดภัย(Mental health legislation to social security)สยส. ผู้ดำเนินการอภิปราย *ดร.พญ.เบ็ญจมาส*	TWS: พัฒนาการสมวัยเพื่อคนไทยในอนาคต (ส.พัฒนาการเด็กฯ) วิทยากร : นพ.สมัย ศิริทองถาวร
10.30-10.45	Coffee Brakes					
10.45-	TSP: Report Thai NMHS /Happiness (ผอ.สบบส./กลุ่มที่ปรึกษา)					
11.45-	Summary Report of the Conference					

South London and Maudsley NHS
NHS Foundation Trust

What is public mental health?

South London and Maudsley NHS
NHS Foundation Trust

1) Assessment of population needs for:
   - Prevention of mental disorder (primary, secondary, tertiary)
   - Promotion of mental wellbeing (primary, secondary, tertiary)

2) Use of assessment information to:
   - Inform strategic development, commissioning and inter-agency coordination
   - Improve population coverage and outcomes of public mental health interventions in short, medium and longer term

3) Implementation of evidence based interventions at population level which:
   - Prevent mental disorder (primary, secondary, tertiary)
   - Promote mental wellbeing (primary, secondary, tertiary)

4) Evaluation of coverage and impacts of interventions

South London and Maudsley NHS
NHS Foundation Trust

Public mental health: An overview of principles and application

Dr Jonathan Campion

Director of Public Mental Health and Consultant Psychiatrist, South London and Maudsley NHS Foundation Trust

Visiting Professor of Population Mental Health, UCL

Annual Conference of Thailand's Department of Mental Health

Bangkok, 15th June 2015

Outline

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Impact of mental disorder

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- Proportion of total burden of disease due to mental disorder and self-harm (Years Lived with Disability) (YLD) (WHO, 2014)
  - 28.0% in Thailand
  - 30.3% in UK
  - 29.2% in Europe
  - Underestimate since omits several mental disorders
- Results in very large economic costs
- Size of impact due to mental disorder
  a) Arising early in the life course
  b) High prevalence
  c) Broad range of impacts/ outcomes

Types of public mental health intervention

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- Promotion and prevention can be described at primary, secondary and tertiary levels
- Prevention of mental disorder (primary prevention)
- Treatment of mental disorder and associated impacts (secondary and tertiary prevention)
- Promotion of mental wellbeing
  - Primary promotion focusing on whole population
  - Secondary and tertiary promotion targeting groups with low wellbeing including those with mental disorder

YLDs in Thailand across the life course

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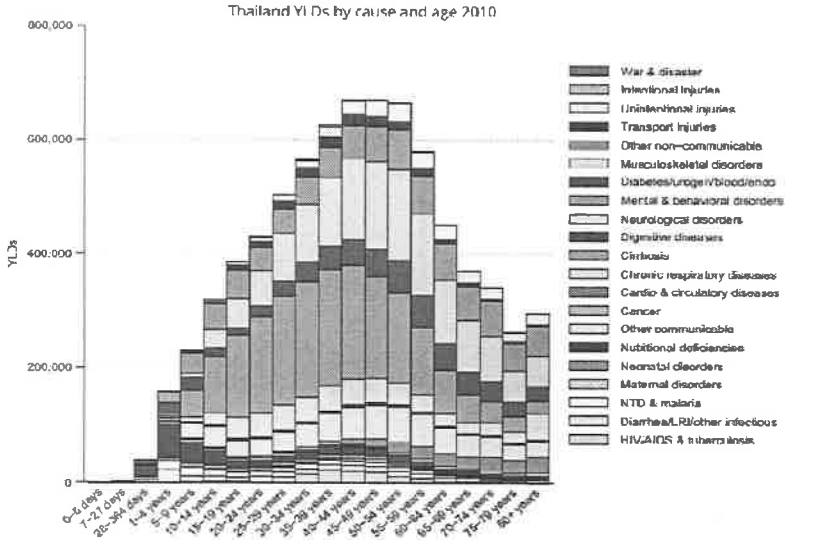

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Why is public mental health important?

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C. Broad range of impacts of mental disorder

a) Early onset of mental disorder

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- 50% of lifetime mental illness (excluding dementia) starts by age 14
- 75% by mid twenties
- Several decades before physical illness
- Implications for age of delivery of public mental health interventions

Source: Kim-Cohen et al, 2003; Kessler et al, 2005; Kessler et al, 2007

Impacts during childhood and adolescence

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Health related impacts
- Health
- Self-harm and suicide
- Health risk behaviour - smoking, alcohol and drug misuse, sexual risk, nutrition, physical activity

Broader impacts
- Educational outcomes
- School exclusion
- Antisocial behaviour and offending
- Social skills
- Teenage parenthood

Source: Campion et al, 2012; Sawyer et al, 2012; Whear et al, 2013

b) Mental disorder is common

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- UK: 23% of the population experiences at least one mental disorder
- EU: 31.2% of adult population experienced at least one mental disorder in in previous year
- Even larger proportion of the population experiences sub-threshold mental disorders
- Levels of different mental disorder and self harm vary by locality
  - Depend on levels of risk/protective factors/ higher risk groups
  - Several fold variation according to levels of deprivation

Source: McManus et al, 2009; Wittchen et al, 2011

Impacts of mental disorder in adulthood

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- Health related impacts
  - Physical illness
  - Reduced life expectancy by 10-20 years
  - Suicide and self harm – majority by people with mental disorder
  - Range of health risk behaviour including alcohol, drug misuse and smoking
  - Increased use of health and social care
- Broader impacts
  - Work related (presentee-ism, absentee-ism, unemployment)
  - Homelessness
  - Stigma and discrimination
  - Crime
  - Reduced quality of life and wellbeing

Source: Campion et al, 2012; Naylor et al, 2012; Cattrell et al, 2011; OECD, 2014

Impacts of emotional and conduct disorder in adolescents in UK

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	Emotional disorder (4%)	Conduct disorder (6%)	No disorder
Smoke Regularly (age 11- 16)	19%	30%	5%
Drink at least twice a week (age 11- 16)	5%	12%	3%
Ever Used Hard Drugs (age 11- 16	6%	12%	1%
Have ever self harmed (self report)	21%	19%	4%
Have no friends	6%	8%	1%
Have ever been excluded from school	12%	34%	4%

Source: Green et al, 2005

Mental disorder underlies large proportion of overall health risk behaviour

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Smoking as an example – single largest cause of preventable death

- 42% of adult tobacco consumption in England by people with mental disorder (McManus et al, 2010)
  31% of adult tobacco consumption in England is by those with common mental disorder (McManus et al, 2010)
- 43% of under 17 year old smokers in UK have either emotional or conduct disorder (Green et al, 2005)
- Note impact of cessation on mental health at least as great as antidepressants (Taylor et al, 2014)

Relevance to public health and other health risk behaviour

- Alcohol and drug misuse
- Sexual risk behaviour
- Eating behaviour
- Physical activity

Impacts of child and adolescent mental disorder during adulthood

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Mental disorder during childhood and adolescence leads to a broad range of poor adult health outcomes

- 3 fold higher rates of adult mental disorder
- Health risk behaviour including smoking
- Physical illness
- Unemployment and lower earnings
- Crime and violence

Source: Fergusson et al, 2005; Colman et al, 2009; Odgers et al, 2007; NICE, 2009; NICE, 2013; Copeland et al, 2013

Wellbeing

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- Different definitions – important to clarify and agree
- Four main constituents of mental wellbeing
  - Pleasure
  - Engagement
  - Meaning
  - Achievement
- Pleasure (hedonic well-being) important but limited in several ways
- Engagement and meaning also termed as eudaimonic well-being - aspects of mental wellbeing that are more than just pleasure

Source: Seligman, 2002; Jayawickreme et al, 2008

Economic impact - annual cost of mental disorder

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- England economy: £105 billion (CMH, 2010)
- EU: £415 billion (Olesen et al, 2011)
- Globally: £1,502 billion = THB 75,000 billion (Bloom et al, 2011)
- National/ international figures can lack local traction - possible to estimate locality costs for different and total mental disorder

Engagement and meaning

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- Engagement - absorption in a task e.g. work, intimate relationships, leisure, exercise, mindfulness/meditation
- Meaning – link to wisdom and for some in spiritual/ religious traditions
- Maximum mental wellbeing occurs with pursuits involving pleasure, engagement and meaning
- However, meaning and engagement have the largest impact
- Relevance to measurement and intervention focus

Source: Peterson et al, 2005; Vella-Bordrick et al, 2009

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Mental health/ wellbeing

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Risk factors for mental disorder, protective factors for mental wellbeing and higher risk groups

Impacts of mental wellbeing

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Health benefits - reductions and prevention of:

- Mental disorder in children and adolescents including persistence
- Mental disorder and suicide in adults
- Physical illness
- Associated health care utilisation
- Mortality

Broader impacts

- Improved educational outcomes
- Increased productivity at work, fewer missed days off work, higher income
- Social relationships/ contentedness
- Reduced anti-social behaviour, crime and violence
- Reduced health risk behaviour such as smoking/ alcohol/ drug misuse
- Improved resilience/ ability to manage adversity

Source: Campion et al, 2012; Vidal-Ribas et al, 2015

Risk and protective factors

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- Public health approach recognises wider determinants and lifelong impact of mental health
- As for action on cardiovascular disease, addressing determinants important to prevent mental disorder and promote mental wellbeing
- In order to address at population level, important to assess
  - Impact of different factors
  - Proportion affected by such factors
  - Levels and outcomes of intervention
- However, since mental disorder arises so early in life course, both prevention and early treatment prevent a whole range of associated impacts across the life course

Relationship between mental wellbeing and mental disorder

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- Interdependent
- Wellbeing reduces risk of mental disorder
- Mental disorder reduces wellbeing
- Single largest group with poor wellbeing are those with mental disorder
- Promotion of wellbeing important for recovery from mental disorder

Risk factors for childhood mental disorder

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Household factors

- Children from lowest 20% household income - 3 fold increased risk of mental disorder
- Poor quality of nurturing environment

Child adversity - accounts for 30% of adult mental disorder

Other child factors

- Age: increased rates as reach adolescence
- Sex: boys > girls
- Screen time – main waking activity children

Source: Green et al, 2005; Kessler et al, 2010; Sigman, 2014

Inequality - a key underlying risk factor

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- Several fold difference in rates of mental disorder between lowest household and highest 20% household income
- Inequality underlies many risk factors – important to address to prevent mental disorder but requires political will
- Mental disorder then further increases inequality which can also be prevented

Source: Campion et al, 2013

Risk factors in adulthood

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- Childhood mental disorder (3 fold increase)
- Demographic: Gender - most mental disorder more common in men (except common mental disorder and eating disorder)
- Socioeconomic
  - Socioeconomic inequality
  - Debt (3 fold increase in CMD)
  - Unemployment (2.7 fold increase in CMD)
  - Inadequate housing/ homelessness
- Work related: Stressful employment and effort/reward imbalance
- Violence and abuse
- Stressful life events
- Social isolation

Source: Kessler et al, 2005; Copeland et al, 2013; Campion et al, 2012

Risk factors for childhood mental disorder

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Pregnancy factors

- Maternal use of drugs, alcohol, tobacco
- Maternal stress/ mental disorder during pregnancy
- Prematurity
- Low birth weight

Child parental relationship – poor attachment

Parental factors

- Parental mental disorder 4–5 fold increased rate in mental disorder - particularly important during perinatal period
- Parental unemployment 2–3 fold increased risk in onset of emotional/conduct disorder in childhood

Source: O'Connor et al, 2003; Murray et al, 2011; Nosarti et al, 2012; Colman et al, 2007; Meltzer et al, 2003; Green et al, 2005

Higher risk groups

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- **Looked after children (by the state) - 5 fold increased risk of mental disorder (Meltzer et al, 2003)**
- **Children with learning disability - 6.5 fold increased risk of mental illness (Emerson and Hatton, 2007)**
- **Black Minority Ethnic groups (BME) (7.9% of UK population) - 5.6** times higher rates of schizophrenia in black Caribbeans (Kirkbride et al, 2012)
- **Long term physical conditions**
  - **2–3** times increased risk of depression (NICE, 2009),
  - **7** times increased risk of depression in people with two or more chronic physical conditions
  - Note opportunity for psychosocial intervention to prevent depression
- **Learning disability – 3** fold increased risk of schizophrenia

Protective factors for wellbeing

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- **Genetic background, maternal (ante-natal and post-natal) care, early upbringing and early experiences**
- **Socio-economic factors**
- **Education/ employment**
- **Physical activity and physical health**
- **Community factors such as trust and participation**
- **Meaning/purpose/spirituality/wisdom**
- **Values**
- **Culture**
- **Resilience/ emotional and social literacy**

Source: Campion et al, 2012

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Public mental health interventions

Certain groups at much higher risk of mental disorder/ low wellbeing

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- **Increased risk mediated by social disadvantage**
- **Benefit proportionately more from intervention to treat mental disorder, prevent mental disorder and promote wellbeing**
- **Balancing with larger groups at less elevated risk which also benefit**
- **'Proportionate universalism'**
- **Possible to estimate local numbers from higher risk groups and proportion with mental disorder**

Source: Campion & Fitch, 2012

Treatment of mental disorder

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- Evidence based interventions/ guidelines exist for each mental disorder
- Early intervention associated with better outcomes
- Broad impacts of treatment including:
  - Prevention of chronicity/ adult mental disorder
  - Suicide prevention
  - Dignity
- Access to treatment is facilitated by better recognition of mental disorder through improved:
  - Detection and treatment by health professionals
  - Mental health literacy among population to facilitate prompt help seeking

Public mental health interventions

South London and Maudsley NHS
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- Range of effective public mental health interventions across life course with massive cross-sector potential impact if delivered to those would benefit
  - Treatment of mental disorder/ prevention of mental disorder/ promotion of mental wellbeing
  - Prevention of mental disorder (primary, secondary, tertiary)
  - Promotion of mental wellbeing (primary, secondary, tertiary)
- Note than treatment alone not enough to sustainably reduce burden of mental disorder
- JCPMH guidance (Campion & Fitch, 2013) includes eight page summary of effective public mental health interventions

Source: HMG, 2010; RCPsych, ZD10; Campion & Fitch, 2013

Prevention interventions

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Prevention of

- Mental disorder by addressing risk factors such as
  - Socioeconomic inequalities
  - Factors during pregnancy (such as smoking and prematurity)
  - Parental mental disorder
  - Poor child/parent attachment
  - Adversity and abuse particularly during childhood
  - Debt
  - Work and unemployment
  - Social isolation
- Mental disorder by a range of interventions which can be provided to particular groups or in particular settings such as
  - Parenting programmes/ home visiting programmes
  - Preschool (school readiness), school and work based programmes

Source: Campion & Fitch, 2013

Interventions from a range of service providers including from outside the health sector

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Highlights importance of local cross-sector coordination including in assessment of need:

- Primary and secondary care
- Public health service providers
- Local government
- Social care service providers
- Third sector providers
- Education providers
- Employers
- Criminal justice services
- Traditional healers

Use of internet and digital resource

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- Public health campaigns or social/digital marketing of resources can improve mental health literacy of population to facilitate early recognition/ treatment of mental disorder as well as prevention and promotion

- Apps
  - Commercial
  - Targeted at general public but often without clinician/ patient input
  - Issue of quality control and regulation
  - Guidance on regulatory requirements for mHealth apps published by MHRA last year

- Outlining intervention to promote wellbeing
  - '10 Actions for Happiness'
  - '5 ways to wellbeing'
  - Note lack of evidence about efficacy

Source: Craven et al, 2013

Prevention interventions

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Prevention of

- Suicide including from improved coverage of treatment of mental disorder since majority who die from suicide have mental disorder (but receive no treatment)
- Health risk behaviours including smoking, alcohol and drug misuse particularly targeting those with mental disorder (impact of smoking cessation on mental health at least as great as antidepressants)
- Dementia through physical activity, control of hypertension, smoking cessation, social engagement
- Discrimination and stigma

Prevention of physical illness and premature death in people with mental disorder

- Early promotion of physical health and intervention for associated health risk behaviour – particularly smoking

Source: Campion & Fitch, 2013; Taylor et al, 2014

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Economic savings of public mental health interventions

Mental wellbeing promotion interventions

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- Starting well - preschool and early education programmes
- Developing well – school based programmes
- Living well
  - Adequate housing
  - Physical activity
  - Debt/ financial capability interventions
  - Learning, active leisure, volunteering, arts
  - Meditation/ mindfulness
- Socially well
  - Many of above activities if done in groups
  - Community interventions
  - Timebanks
- Working well
- Ageing well

Source: Campion & Fitch, 2013

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Public mental health implementation gap

Economic impact of public mental health interventions

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- Evidence based public mental health interventions prevent suffering and promote wellbeing – they are the right thing to do!
- Many evidence based public mental health interventions also result in economic savings even in the short term
- Economic cost of not providing interventions
- Overall savings related to level of population coverage
- Appropriate coverage of public mental health interventions therefore a key part of sustainable economic development

Source: Knapp et al, 2011

Public mental health implementation gap

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- Despite cost effective, evidence based interventions, only 10% of people with mental disorder in EU receive notionally adequate treatment – less in many lower and middle income countries
- People with mental disorder also lack access to physical health care or interventions for health risk behaviour
- Even greater lack of access to interventions to prevent mental disorder and promote mental wellbeing
- Contrasts with greater proportion of people with physical illness who receive treatment and action to address associated risk factors
- Breach of the 'right to health' which requires action

Source: Wittchen et al, 2011; Campion et al, 2013; Bhugra et al, 2015

Mental health promotion and mental disorder prevention: economic savings

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Treatment - net savings per £ invested

- Treatment of conduct disorder with parenting interventions £8
- Early detection and treatment of depression at work £5
- Early intervention for the stage which precedes psychosis (CHRS) £10
- EIP services for first episode psychosis £18
- Screening and brief interventions in primary care for alcohol misuse £12

Prevention - net savings per £ invested

- School based bullying prevention £14
- Prevention of conduct disorder through school SEL programmes £84
- Suicide prevention £44

Promotion - net savings per £ invested

- Work based mental health promotion programmes £10

Source: Knapp et al, 2011

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Recent work to assess PMH intervention gap to support implementation

Impact of public mental health implementation gap

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- Human suffering and loss of dignity
- Broad range of other impacts
- Lost potential
- Economic costs even in the short term

- Since majority of life time mental disorder arises by mid 20's, these impacts continue over a large part of life course

Source: Campion & Fitch, 2013

Needs assessments and mental health

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- Needs assessments inform actions which local areas, health and other partners need to take to improve the health and wellbeing of their population
- In UK, brought together by local public health teams
- However mental health poorly covered in needs assessments (PHE, 2015)
- Assessment of size, impact and cost of unmet need can reduce the public mental health intervention gap

Causes of the gap – important part of solution

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- Lack of knowledge/ training about:
  - Symptoms of mental disorder
  - Numbers affected
  - Associated impacts and costs
  - Evidence based interventions and their coverage
- Lack of implementation of evidence based interventions
- Lack of investment
- Lack of policy
  - Lack of mental health policy in 40% of countries (WHO 2011)
  - Lack of implementation of mental health policy where exists
- Systematic discriminatory attitudes towards mental health

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Summary

JCPMH public mental health commissioning guidance

South London and Maudsley NHS
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- Endorsed by ADPH, RSPH and LGA (Campion & Fitch, 2012, updated in August 2013 and further update in process)

- Systematically brings together different local PMH intelligence
  - Levels of mental disorder and well-being
  - Level of risk and protective factors
  - Numbers from higher risk groups
  - Coverage (numbers/ proportion) receiving effective PMH interventions
  - Outcomes of PMH interventions
  - Economics
    - Cost of mental disorder
    - Expenditure on PMH interventions
    - Economic savings of PMH interventions

- Informs need assessments, strategic development and commissioning

Summary

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- Compelling evidence for how public mental health interventions can:
  - Reduce burden of mental disorder
  - Result in economic savings even in the short term
  - Reduce inequalities
  - Improve physical health, resilience, life expectancy, healthy lifestyles, economic productivity, social functioning and quality of life

- However, only a minority of people with mental disorder receive any treatment, far fewer receive interventions to address risk factors to prevent mental disorder, even fewer mental wellbeing promotion

- Implementation gap
  - Results in untold suffering, loss of potential and dignity
  - Results in economic costs even in the short term
  - Represents a breach of the right to health

Mental health needs assessment

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- Over past two years, further development of JCPMH guidance
  - Includes all nationally available mental health relevant datasets in England
  - Local PMH intelligence not available from such datasets
  - Benchmarking against other areas, regionally, nationally and deprivation
  - Analysis and interpretation
  - Size, impact and cost of public mental health intervention unmet need
  - Working with local partners to translate into strategy and implementation

- Incorporation into four types of needs assessment relevant to different sectors
  - Mental disorder treatment needs assessment
  - Secondary mental health care assessment
  - Mental disorder prevention needs assessment
  - Mental wellbeing promotion needs assessment

- Supported/ing different local authorities covering more than 5 million people across England

Summary

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- Mental health needs assessments are key mechanism to:
  - Outline size, impact and cost of public mental health unmet need
  - Inform strategic development, priority setting and commissioning
  - Facilitate coordination between different service providers
  - Facilitate investment, implementation and coverage of public mental health interventions
  - Evaluate outcomes on population mental health

- Appropriate implementation of evidence based interventions:
  - Improves treatment coverage, prevents significant proportion of mental disorder and promotes population wellbeing
  - Results in improvement of range of outcomes within and outside health
  - Result in significant personal, social and economic savings even in the short term

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National mental Health survey 2008

Thai people age 15-59; N =17 140

Using MINI (Mini International Neuropsych[illegible]c Interview)

For 10 disorders/1 problem
Major depressive episode, Dysthymia,
(Hypo)manic Episode, Suicidality
Panic Disorder, Agoraphobia,
PTSD, GAD, Psychotic Disorders,
Alcohol Abuse & Dependence,

Thai national Mental Health Survey 2013

Phunnapa Kittirattanapaiboon, M.D.
Director, Bureau of Mental Health Service Administration,
Department of Mental Health, Ministry of Public Health
THAILAND

14th Annual International Mental Health Conference
TPL2 (E/C): National Survey Report, Miracle Grand Hall
June 17th, 2015, 10.45-11.45 AM
Miracle Grand Hotel, Bangkok

National Mental Health Survey 2008

Any current mental disorders (14.3%; 7.0 M)

- Anxiety Disorders (1.9%; 0.9 M)
  - Panic Disorder (0.3%; 0.15 M)
  - Agoraphobia (0.6%; 0.27 M)
  - PTSD (0.3%; 0.15 M)
  - GAD (0.9%; 0.45 M)
- Affective disorders (2.8%; 1.4 M)
  - MDD (2.2%; 1.1 M)
  - Dysthymia (0.3%; 0.15 M)
  - Hypomanic Episode (0.3%; 0.13 M)
  - Manic Episode (0.1%; 0.06 M)
- AUD (10.9%; 5.3 M)
  - Alcohol Abuse (4.2%; 2.0 M)
  - Alcohol Dependence (6.6%; 3.2 M)
- Psychotic Disorders (0.5%; 0,24 M)
  (Lifetime; 0.4 M)

Thai National Mental Health Survey (TNMHS)

- 1st NMHS in 1998
- 2nd NMHS in 2003
- 3rd NMHS in 2008
- 4th NMHS in 2013

The World Mental Health Surveys: WMHS

- 28 Countries join in the WMHS
- PAHO: Brazil, Columbia, Costa Rica, Mexico, Peru, USA
- AFRO: Nigeria, South Africa
- EMRO: Lebanon, Iraq
- EURO: Belgium, Bulgaria, France, Germany, Israel, Italy, Netherland, Portugal, Romania, Span, Turkey, Ukraine
- SEARO: India
- WPRO: Australia, China (Beijing/Shanghai), Japan, New Zealand

World Mental Health Survey

Year	Authors	Country	Tools	Dx Criteria	Age gr	N
1999	Hahm BJ., et al (2005)	Korea	CIDI	ICD 10	18-64	1,059
2000	Andrew G., et al (2001)	Autralia	CIDI	ICD 10	18+	10,641
2001-2002	Medina-Mora ME. et al. (2007)	Maxico	CIDI	DSM IV	18-65	5,826
2001-2002	Hasin DS., et al (2007)	USA	AUDA-DIS-IV	DSM-IV	18+	43,093
2001-2003	Gureje O., et al. (2006)	N geria	WMH CIDI	DSM IV	18-60+	4,984
2001-2003	Kessler RC., et al. (2005)	USA	WMH-CIDI	DSM IV	18-60+	9,282
2003-2004	Herman AA., et al. (2009)	South Africa	CIDI	DSM IV	18+	4,351

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World Mental Health Survey

WHO WMH-CIDI

The World Health Organization
World Mental Health
Composite International Diagnostic Interview

2012	1. Training the CIDI by 2 trainers from Michigan University 2. Translation the CIDI to Thai version
2013	1. Validate the CIDI/ pre-test : cognitive test and pilot test 2. Train the field interviewer and supervisors 3. Data collection from 16 provinces/ 4 districts (BKK)
2014	1. Data quality control: 10% recheck 2. Data Cleaning 3. Data entry
2015	1. Data analysis 2. Report/Manuscript/Publication/Academic Presentation 3. Policy brief

Thai National Mental Health Surveys: TNMHS 2013

Inclusion and exclusion criteria

Inclusion criteria

- Population aged ≥ 18 years & lived in household at least 3 months
- Thai nationality
- Being able to communicate and willing to participate

Exclusion criteria

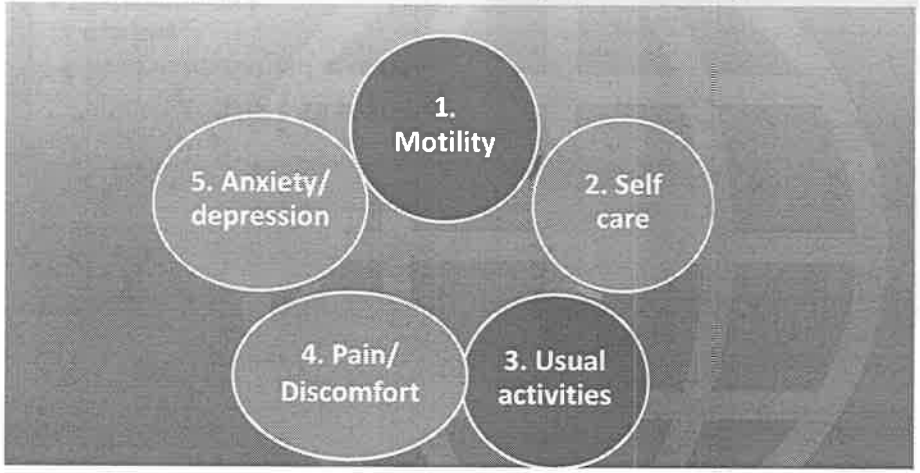
Living in dormitory, military camp or boarding school

Thailand National Mental Health Survey 2013

Administrator	Psychiatric Epidemiology unit and the committee from Department of mental health
Objective	To estimate the prevalence and associated factor of mental health problems in Thai populations
Data collection	Between July 2013 – August 2013
Sample size	5000 samples from Bangkok, Central, Northern, Northeast and southern regions

2. European Quality of Life-5 Dimensions-5 Levels: EQ-5D-5L
: Health Intervention and Technology Assessment Program: HITAP)

- 126 language version, Visual analog scale, 5 dimensions
- Each dimension has 3 levels: no problems, some problems, extreme problems



Measurements

1	2	3	4
WMH CIDI 3.0 Paper and Pencil Instrument (PAPI) 18 section (All samples)	EQ – 5D– 5L Quality of Life (All samples)	MMSE Cognitive impairment (All samples aged ≥ 60 years)	SDQ Strengths and Difficulties Questionnaire Parent version (all sample who had children aged 4-16 years in household)

3. MMSE Mini – Mental State Examination

- to screen cognitive impairment for the age group more than 60
- The education level is part of the cutting point

11 items

1. Orientation for time
2. Orientation for place
3. Registration
4. Attention/Calculation
5. Recall
6. Naming
7. Repetition
8. Verbal command
9. Written command
10. Writing
11. Visuoconstruction

CIDI-NMHS2013: 18 sections

Section 1: Screening	Section 9 Intermittent Explosive Disorder (IED)
Section 2: Depression (D)	Section 14 Tobacco (TB)
Section 3: Mania (M)	Section 20 Gambling (GM)
Section 4: Panic Disorder (PD)	Section 23 Services (SR)
Section 7: Agoraphobia (AG)	Section 24 Chronic Conditions (CC)
Section 8: Generalized Anxiety Disorder (G)	Section 40 Demographics Short (DM)
Section 10: Suicidality (SD)	Section 42 Interviewer's Observation (IO)
Section 11: Alcohol Use (AU)	
Section 12: Illegal Substance Use (IU)	
Section 19: Psychosis (PS)	
Section 21: Post-Traumatic Stress Disorder (PT)	

Demographic data (n = 4727)

Characteristics	Unweighted % (SE)	Weighted % (SE)
Gender		
Male	36.3 (0.7)	48.3 (1.1)
Female	63.7 (0.7)	51.7 (1.1)
Age group (year)		
18-24	5.2 (0.3)	13.1 (0.9)
25-34	11.6 (0.5)	19.2 (0.9)
35-44	20.0 (0.6)	21.2 (0.9)
45-54	23.8 (0.6)	20.0 (0.7)
55-59	10.5 (0.4)	7.9 (0.4)
≥ 60	28.9 (0.7)	18.6 (0.6)

4. Strengths and Difficulties Questionnaire: SDQ

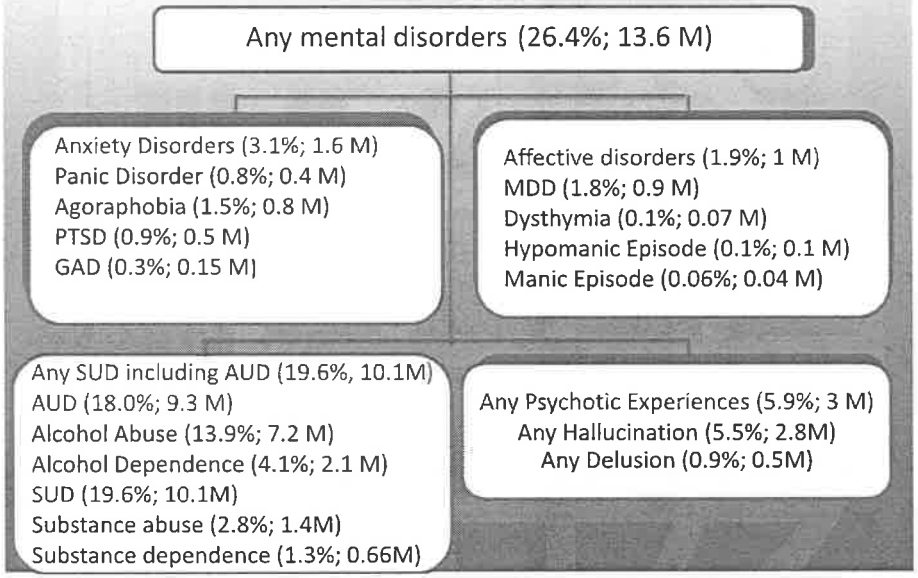
- Parent version for age 4-16 Years old
- Assess Kid's behavior in the past 6 months

25 items

1. Strength: Prosocial behavior

2. Difficulties (Behavior and Emotion) : Conduct Problems, Hyperactive, Emotional Problems, Peer problems

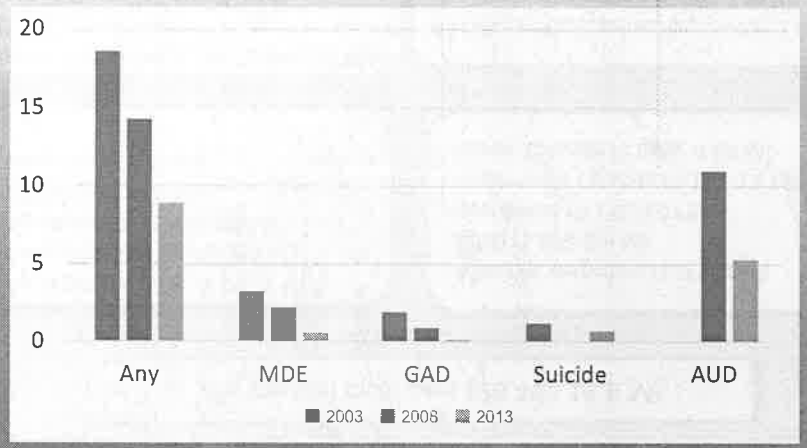
NMHS 2013: Lifetime prevalence



Participants

	Questionnaire			
	CIDI n (%)	EQ-5D-5L n (%)	MMSE n (%)	SDQ n (%)
Not found	1,482 (23.3)	-	-	-
Refused	112 (1.8)	-	-	-
Incomplete	39 (0.6)	-	8 (0.6)	15 (0.8)
Complete	4,727 (74.3)	4,727 (100)	1,356 (99.4)	1,938 (99.2)
Total	6,360 (100)	4,727 (100)	1,364 (100)	1,953 (100)

Compared with NMHS 2003 and 2008



2003 and 2008 = point prevalence, 2013 = 1 year prevalence

Any lifetime mental disorder

Prevalence of affective disorders

Disorders	Estimate prevalence; N(%)	
	12 months	lifetime
Major depressive episode	0.3 M (0.6%)	0.9 M (1.8%)
Dysthymia	0.05 M (0.1%)	0.07 M (0.1%)
Any depressive disorders	0.34 M (0.7%)	0.9 M (1.8%)
Mania	0.01 M (0.02%)	0.04 M (0.06%)
Hypomania	0 M (0%)	0.1 M (0.1%)
Any affective disorders	0.3 M (0.7%)	1 M (1.9%)

NMHS 2013: 12 months prevalence

Any mental disorders (8.9%;4.6 M)

Anxiety Disorders (1.6%; 0.8 M)
Panic Disorder (0.4%; 0.19 M)
Agoraphobia (1.0%; 0.49 M)
PTSD (0.3%; 0.17 M)
GAD (0.1%; 0.05 M)

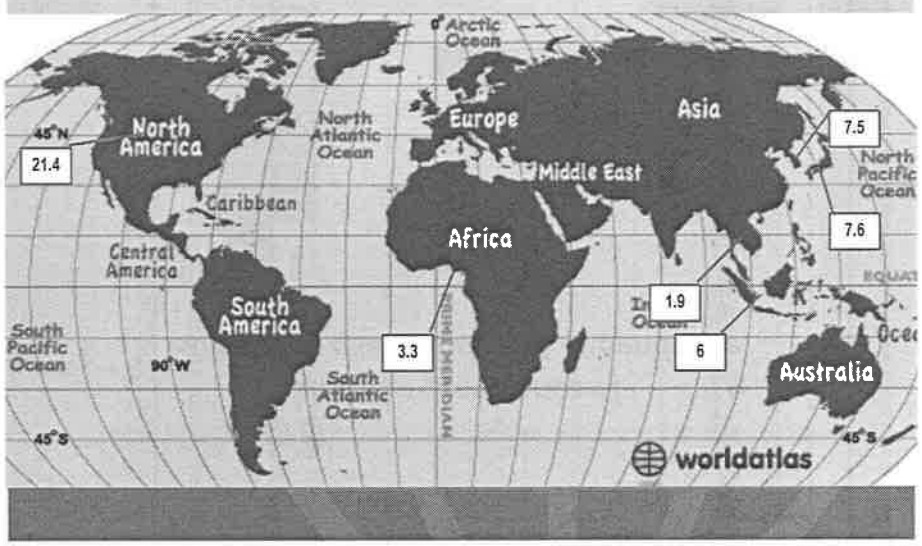
Affective disorders (0.7%; 0.3 M)
MDD (0.6%; 0.3 M)
Dysthymia (0.1%; 0.05 M)
Hypomanic Episode (0%; 0 M)
Manic Episode (0.02%; 0.01 M)

Any SUD including AUD (5.8%, 3.0M)
AUD (5.3%; 2.7 M)
Alcohol Abuse (3.5%; 1.8 M)
Alcohol Dependence (1.8%; 0.9 M)
SUD (0.6%; 0.3M)
Substance abuse (0.3%; 0.15M)
Substance dependence (0.3%; 0.15M)

Any Psychotic Experiences (1.4%; 0.7M)
Any Hallucination (1.3%; 0.7M)
Any Delusion (0.2%; 0.1M)

Any lifetime anxiety disorders

Any lifetime affective disorders

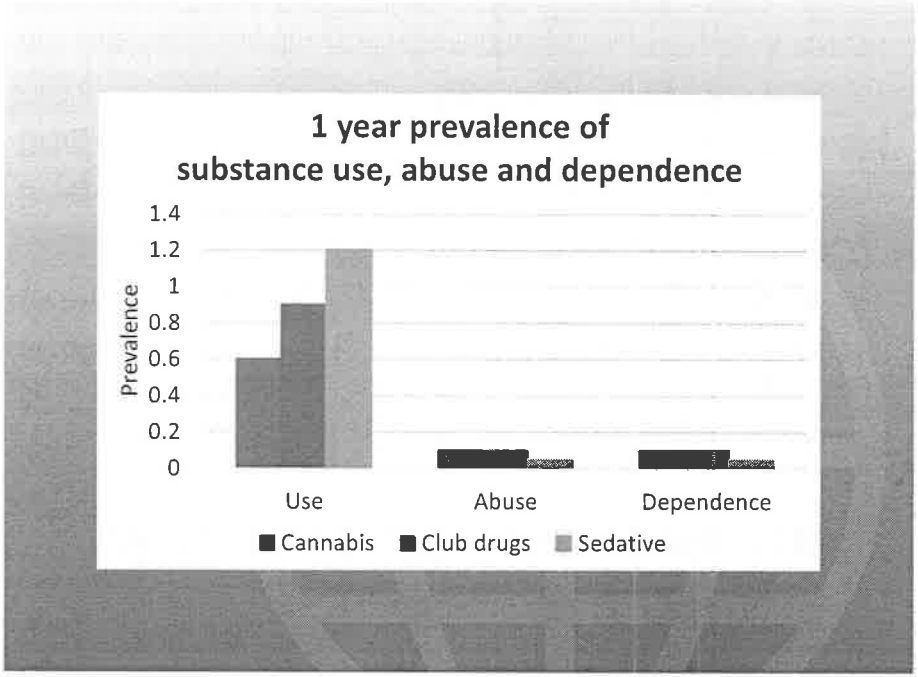


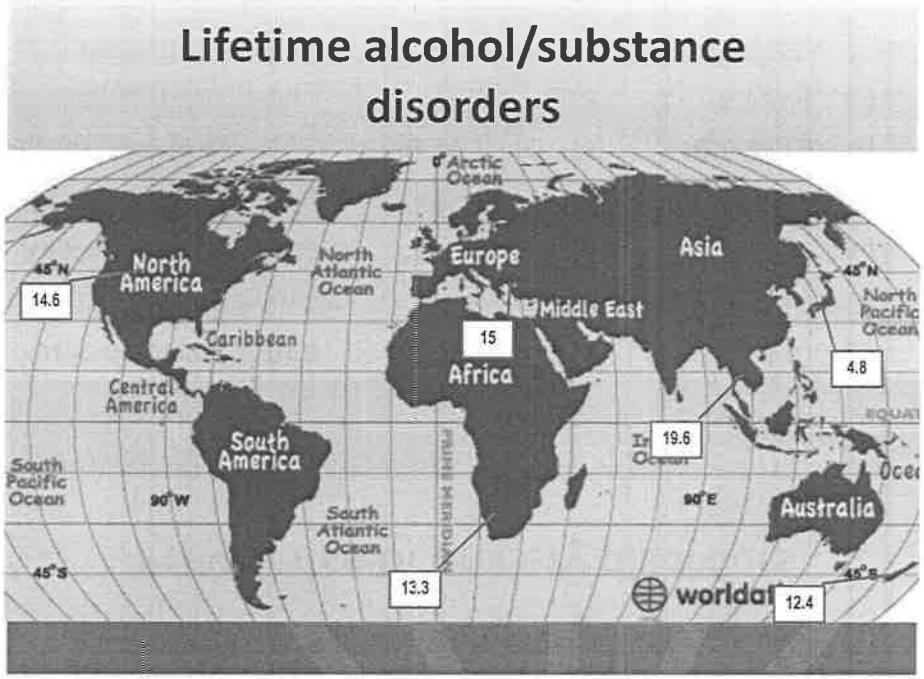
Prevalence of Alcohol and substance use disorders

Disorders	Estimate prevalence ; N(%)	
	12 months	lifetime
Alcohol abuse	1.8 M (3.5%)	7.2 M (13.9%)
Alcohol dependence	0.9 M (1.8%)	2.1 M (4.1%)
Alcohol use disorders	2.7 M (5.3%)	9.3 M (18.0%)
Drug abuse	0.15 M (0.3%)	1.4 M (2.8%)
Drug dependence	0.15 M (0.3%)	0.66 M (1.3%)
Drug use disorders	0.3 M (0.6%)	2.1 M (4.1%)
Any substance use disorders	3.0 M (5.8%)	10.1 M (19.6%)

Prevalence of anxiety disorders

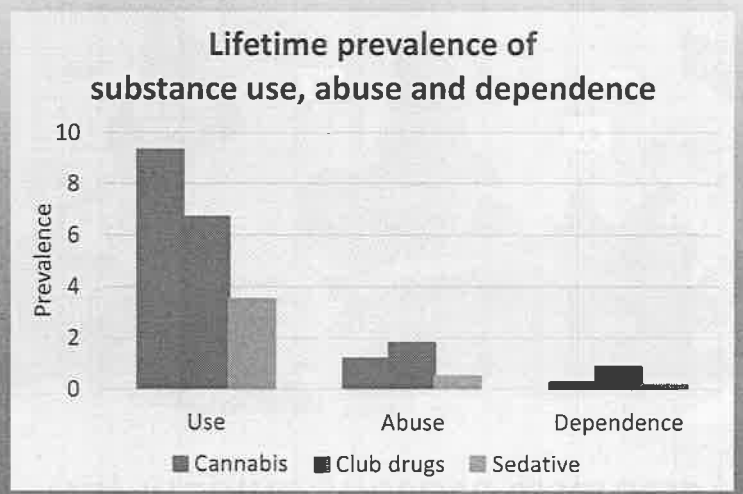
Disorders	Estimate prevalence (N (%)	
	12 months	lifetime
Panic disorder w Ago	0.09 M (0.2%)	0.1 M (0.2%)
Panic disorder w/o Ago	0.1 M (0.2%)	0.3 M (0.6%)
Agoraphobia w/o Panic	0.4 M (0.8%)	0.7 M (1.3%)
GAD	0.05 M (0.1%)	0.15 M (0.3%)
PTSD	0.17 M (0.3%)	0.5 M (0.9%)
Any anxiety disorder	0.8 M (1.6%)	1.6 M (3.1%)



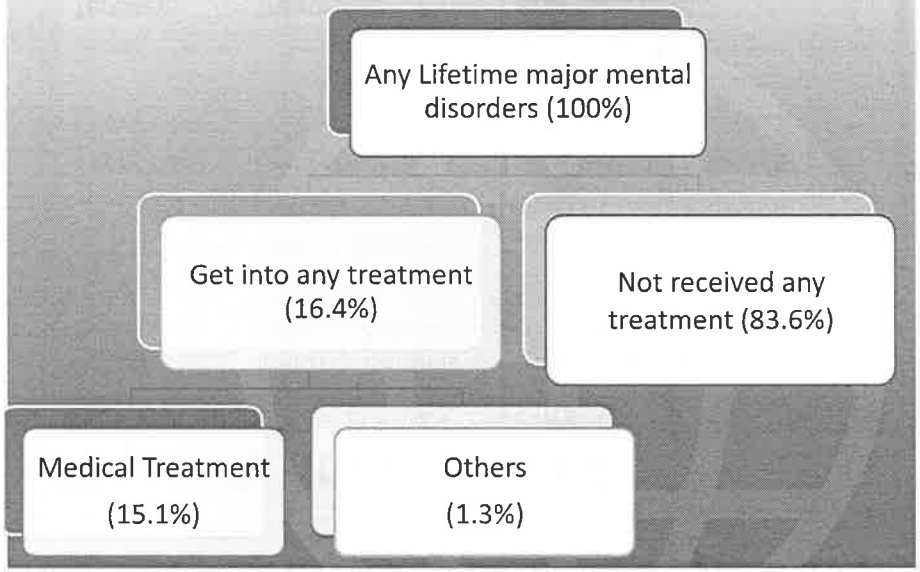


Prevalence of psychotic disorders

Disorder	Estimate prevalence; N (%)	
	12 months	lifetime
≥ 1 hallucination	0.7 M (1.3%)	2.8 M (5.5%)
≥ 1 delusion	0.1 M (0.2%)	0.5 M (0.9%)
≥ 1 hallucination and ≥ 1 delusion	0.04 M (0.08%)	0.25 M (0.5%)
Any psychotic experience	0.7 M (1.4%)	3 M (5.9%)



Accessibility to care



Prevalence of suicidality

Disorder	Estimate prevalence; N (%)	
	12 months	lifetime
Suicidal idea	0.3 M (0.6%)	1.8 M (3.5%)
Suicidal plan	0.08 M (0.2%)	0.46 M (0.9%)
Suicidal attempt	0.04 M (0.08%)	0.56 M (1.1%)
Suicidality	0.3 M (0.7%)	1.8 M (3.5%)

QOL: EQ-5D-5L (N=4,727)

Disorder (1 year)	Overall QOL (0-100)	
	Unweighted Mean (SD)	Weighted Mean (SE)
Any affective disorders	72.1 (18.2)	76.6 (3.1)
Any anxiety disorders	76.2 (17.6)	79.6 (1.9)
Any substance use disorders	81.2 (15.4)	81.4 (1.5)
Suicidality	78.3 (16.7)	78.6 (2.7)
Psychosis	76 (18.6)	77 (2.5)
No mental disorders	83.5 (14.2)	84.1 (0.3)

Prevalence of others mental disorders

Disorder	Estimate prevalence; N (%)	
	12 months	lifetime
Nicotine dependence	3.2 M (6.2%)	7.7 M (14.9%)
Intermittent explosive disorder	0.6 M (1.1%)	1.4 M (2.8%)
Pathological gambling	0.14 M (0.3%)	0.46 M (0.9%)

Implications

Researcher	Publication/Training Materials
Policy maker/ Executive manager	Understand the real situation Important data for policy decision Financial and resource allocation
Health personnel	Understand the real situation in local area analyze the gap of service Develop the intervention/project according to the problems

SDQ (4-16 years) N=1,938

Demographic	Level			
	Normal ; n (%)	Borderline; n (%)	Abnormal; n (%)	Total ; n (%)
Gender				
Boy	952 (96.4)	22 (2.2)	14 (1.4)	988 (51)
Girl	914 (96.2)	23 (2.4)	13 (1.4)	950 (49)
Region				
Bangkok	197 (100)	0 (0)	0 (0)	197 (10.2)
Central	389 (100)	0 (0)	0 (0)	389 (20.1)
North	423 (98.4)	7 (1.6)	0 (0)	430 (22.2)
NE	446 (93.9)	18 (3.8)	11 (2.3)	475 (24.5)
South	411 (91.9)	20 (4.5)	16 (3.6)	447 (23.0)
Total n (%)	1866 (96.2)	45 (2.4)	27 (1.4)	1938 (100)

Implications

Intervention	Goal	Survey Results
Primary Prevention	Reduce risk factors Support protective factors	Risk/protective factors Population at risk
	Mental Health Literacy	Awareness Accept the treatment
Secondary Prevention	Early detection	Obstacle of the accessibility to care Age of onset Duration of untreated period
Tertiary Prevention	Treatment Rehabilitation Prevent recurrent	Duration of MD Health service system or other care Community care

Limitations

- Long hours interview time
- Precaution for comparative data with previous TNMHS due to difference age group and tools
- Precaution for comparative data with other countries due to the number of module selected were varies
- MMSE and SDQ result might not be a good national representation due to the limitation of sampling technique

THANK YOU

Preventing Suicide in Taiwan

Happy Tan, MD, MPH, MHS
Director-General,
Department of Mental and Oral Health,
Ministry of Health and Welfare
June 16, 2015

Outline

- General information of Taiwan
- Improve access to psychiatric care
- National suicide prevention strategies
- Decrease of Suicide Rate

General information of Taiwan

- Area: 36,000 km2
- Population 23,386,883
- Age : 0-14 14.16%
  15-64 74.1%
  >65 11.74%
- Life expectancy
  average 79.84
  male 76.72, female 83.2
- Birth rate 1.11

Improve access to psychiatric care

National Health Insurance in Taiwan

National Health Insurance started from 1995

It cover emergency, outpatient, inpatient and community services (home care, day care, rehabilitation center and half way house) for psychiatric patients.

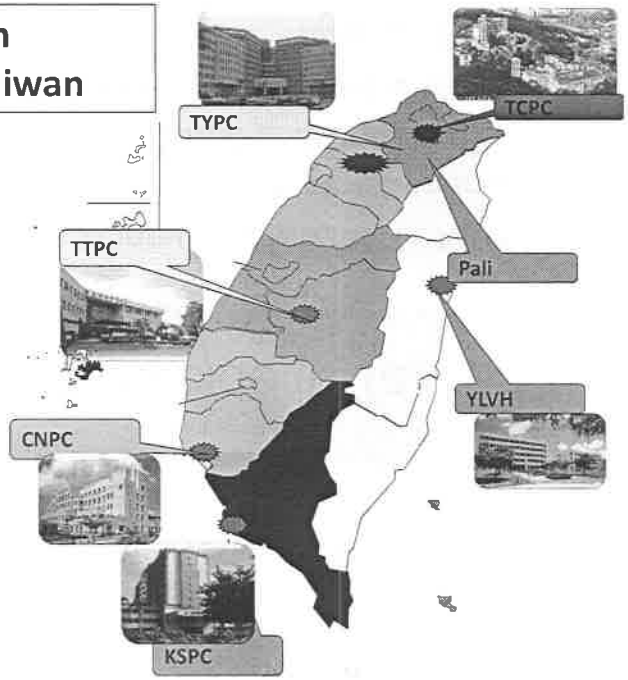
For major psychotic patients, it is free in treatment

Provide accessible Psychiatric care

- Develop and strengthen psychiatric care facilities and manpower
- Case management of psychotic patients in the communities

Mental Health Network in Taiwan

- Since 1995
- 7 areas
- Each area has a core hospital for collaboration , coordination
- providing education and execution of public mental health policy



Psychiatric care improved in quality and quantity since 1975


Bali Psychiatric Center


Tsaotun Psychiatric Center


Taoyuan Psychiatric Center

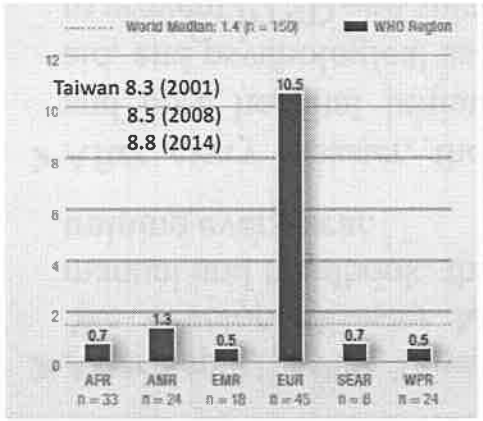

Juanan Psychiatric Center

Psychiatric Care Facilities

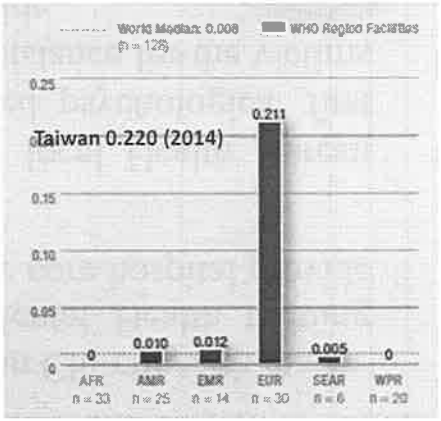
year	Acute beds	Chronic beds	Day care	Rehabilitation centers	Half way houses	Nursing home
1985	1,265	9,801	179			
1990	1,820	11,935	676			
1995	2,606	10,695	3,399	60	79	
2000	5,011	9,749	3,774	576	1,583	
2005	6,012	12,544	6,317	1,906	2,625	917
2008	6,595	13,661	6,584	3,423	3,747	1,493
2010	6,932	13,978	6,712	3,654	3,772	2,252
2012	7,188	13,895	6,534	3,531	4,736	2,477
2014	7,400	13,855	6,494	3,458	4,961	3,054

- From 1985, Hospital accreditation,
- From 1986, Psychiatric network, subsidize for acute wards in public and private hosp
- From 1995, National Health Insurance, covered OPD, admission and rehabilitation.
- From 2004, encourage setting up of rehabilitation centers and half way houses

Mental health resources



Median rate of psychiatric acute beds per 100,000 population by WHO region



Median rate of community residential facilities per 100,000 population

WHO: Atlas 2011

Psychiatric Manpower in 2012

	numbers	Per 100,000
Psychiatrists	**1,410**	**6.05**
Psychiatric nurses	**4,791**	**20.55**
Clinical psychologist	**525**	**2.25**
Occupational therapist	**635**	**2.72**
Social workers	**488**	**2.09**

Population in 2012 is 23,315,822 。

National Psychotic patients registration system and case management

The Ministry of Health and Welfare funds 22 Health Bureaus to hire case managers.
They work with public health nurses, to provide case management (home visit or call) to the psychotic patients in the communities.

	2011	2012	2113	2014(1-8)
Public health nurses	2,775	2,778	2,777	2,777
Case managers	102	96	96	96
Case numbers	127,441	130,802	134,317	**140,313**
Home visit/call numbers	490,550	524,241	664,527	**442,014**

Drug and alcohol abuse treatment

- Strengthen service facilities and manpower
- Methadone maintenance therapy
- Non-opiate treatment
- Develop rehabilitation programs for drug abusers
- Fund alcohol treatment

Domestic violence and sexual assault offenders and victims treatment

- Strengthen the psychosocial treatment for both the offenders and victims on domestic violence and sexual assault
- Integrate the treatment resources and systems
- Develop offenders' treatment
- **Strengthen the services for the victims of child abuse.** (Establish **6 demonstration centers** to provide integrated services for the victims of child abuse, at emergency service and follow up

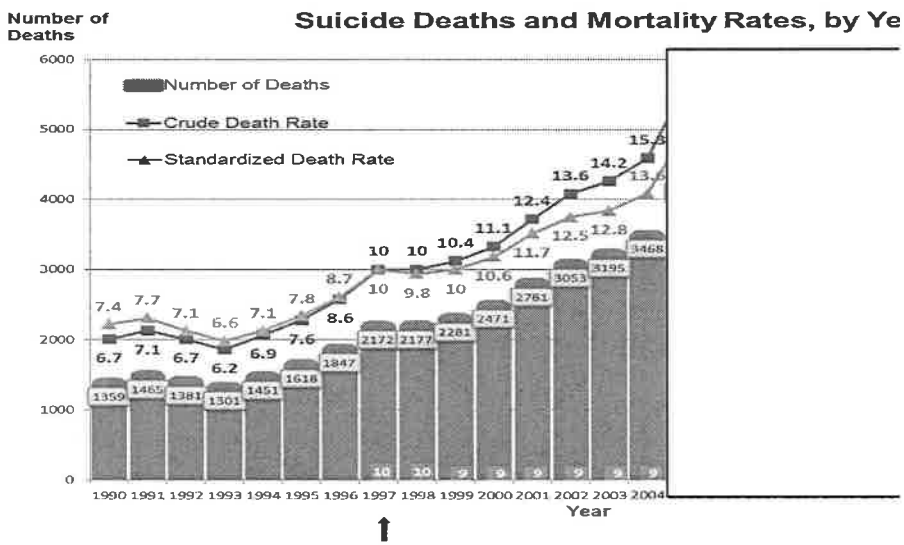
Provide integrated services for the victims of child abuse

- Publish the guideline of "child abuse and neglect" , update the teaching DVD of "Standard procedures on forensic inspection and evaluation" in 2014
- Organize continuing training programs and develop teaching materials during 2014-2015 。
- Establish **6 demonstration centers** to provide integrated services for the victims of child abuse, at emergency service and follow up.

Disaster Mental Health Services

- After Sep 21, 1999 Taiwan Chi-chi earth quake We develop Disaster Mental Health training manual and handbook, the core hospital provide training every year.
- After every disaster, the local Health Bureau and core hospital initiated psychological first aid, and psychological assistance for the victims to prevent PTSD and suicide.

National Suicide Prevention Strategies



Suicide rate increased yearly and became the 10th leading cause of death since 1997.

National suicide prevention strategies

Ministry of Health develops and implements National Suicide Prevention Strategies from **2005**

- May 2005-2008 (1st plan)
  - Set up National Suicide Prevention Center
  - Set up 24 hours hotline
  - **Set up suicide attempters report and case management system**
  - gatekeeper training
  - suicide prevention pilot program in 11 county/city

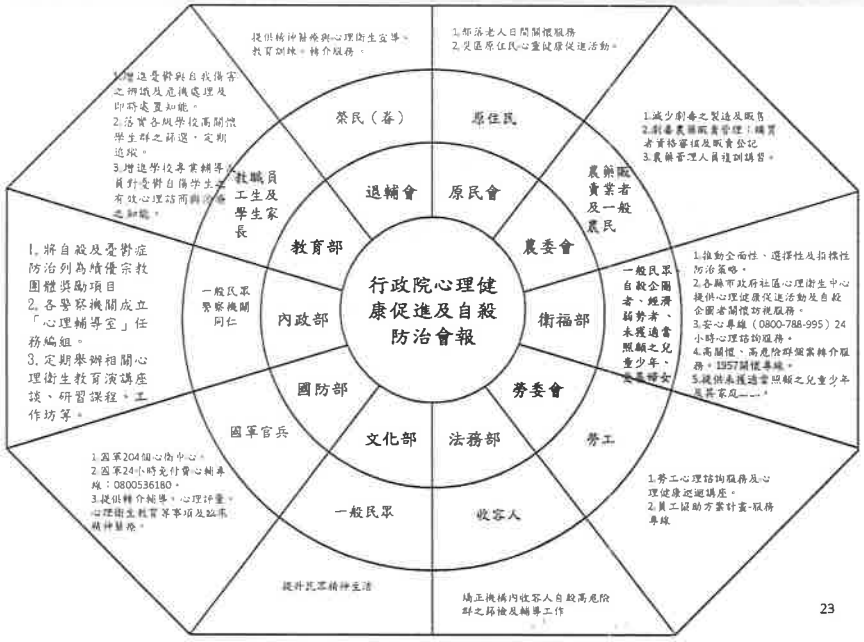
Gatekeepers training

- Teachers
- Physicians
- nurses
- Social workers
- Workers at the correction department
- Workers at the nursing homes
- volunteers

National suicide prevention strategies

- 2009-2013 (2nd plan)
  Multi sector Committee in mental health promotion and suicide prevention
  Suicide prevention program by each county/city's Health Bureau
  Reduce access to mean : charcoal
  Media guidelines
- 2014-
  Mental Health promotion
  Mental health promotion network by each county/city health bureau
  reduce stigma, public education

Committee on Mental Health Promotion and suicide prevention



Committee on Mental Health Prevention and Suicide Prevention

- Ministry of Health and Welfare
- Ministry of Education
- Ministry of Labor
- Ministry of Agriculture
- Ministry of Justice
- Ministry of Culture
- Ministry of Defense
- Ministry of Interior
- Veterans Affairs Council
- Council of aboriginal people

National Suicide Prevention Center

Goal

to promote local suicide prevention plans,

to increase public knowledge and involvement regarding suicide prevention,

to the implementation of related policies

to reduce suicide

National Suicide Prevention Center

Universal approach

- The universal approach is designed to improve the mental health of the general population.
- The related interventions included cooperation with the media, promoting the suicide prevention helpline, monitoring suicide related news, and planning of various educational activities and materials.

Suicide Prevention books

- 28 suicide prevention books published by Suicide Prevention Centers

National Suicide Prevention Center

Selective approach

Targets high risk groups.

The related interventions included the Gatekeeper Training, the promotion of Brief Symptom Rating Scale (BSRS), the implementation of local policies through the cooperation between the government, non-government organizations, and the volunteers

National Suicide Prevention Center

Indicative approach

- The indicative approach is designed to target the high-risk individuals, such as the family members and suicide attempters.
- The related interventions included the National Suicide Surveillance System (NSSS) and the training of aftercare personnel.

24 hours hot line

0800-788-995, 24 hour, free call

refer to policemen for immediate rescue

The phone number is shown on TV during suicide news, or on newspaper besides suicide news.

	2011	2012	2013	2014
number	68,303	73,986	73,750	73,341
Suicide idea	11,875 (17.4)	13,416 (18.1)	13,432 (18.2)	12,877 (17.6)
Immediate rescue	475	573	591	530

The National Suicide Surveillance System (Suicide attempt report and follow up system)

The risk of repeated suicide is high in the attempters.

So, the care and follow up of suicide attempters can prevent suicide.

The suicide attempt report and follow up system started from 2005.

In each county/city there are case managers. (Fund from the Ministry of Health)

Suicide attempt reporting system and follow up system

	2111	2012	2013	2014
Case managers	131	131	131	126
Suicide attempt no	26,183	28,475	28,091	29,047
Follow up no	129,334	149,114	183,345	208,802

Suicide attempts & deaths

	Attempts	Suicide Deaths	Attempts /Deaths
2009	25,813	4063	6.4
2010	26,870	3889	6.9
2011	26,183	3507	7.5
2012	28,475	3766	7.6
2013	28,091	3565	8.0
2014	29,047	3445	8.4

WHO(2000) for every commit suicide there are 10-20 suicide attempters

Reduce access to mean : Charcoal burning

- 1st case in Hong Kong in 1998 by Charcoal burning. Mass media reported in detail.
- Suicide with charcoal burning increase since 2001 in Taiwan
- From 2010, after discussion with the charcoal seller, charcoal is locked in stores, a tag "love your live with hotline number" is put on the charcoal.

Work with Media : Reduce stigma and Mental Health Promotion

Mental Health Promotion

- Develop mental health promotion strategies and programs for all age and at all setting
- Develop mental health promotion network in each county/city

The best tool for stigma prevention campaigns is media advocacy.

Mental health advocate: renaming of Schizophrenia

Taiwan Alliance for the mentally ill invited Dr. Fisher from USA for a renaming advocating in Taipei

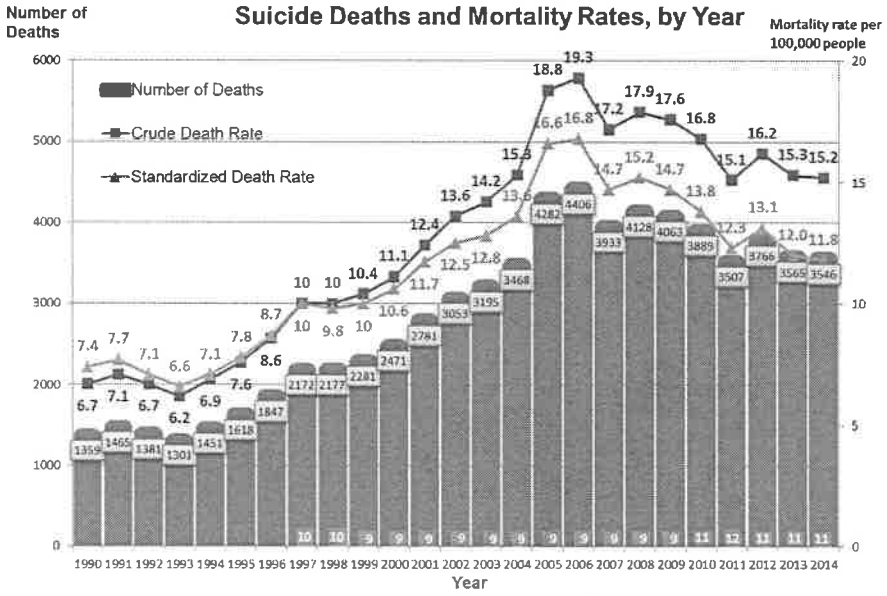
Living with Schizophrenia

Change official name to reduce stigma

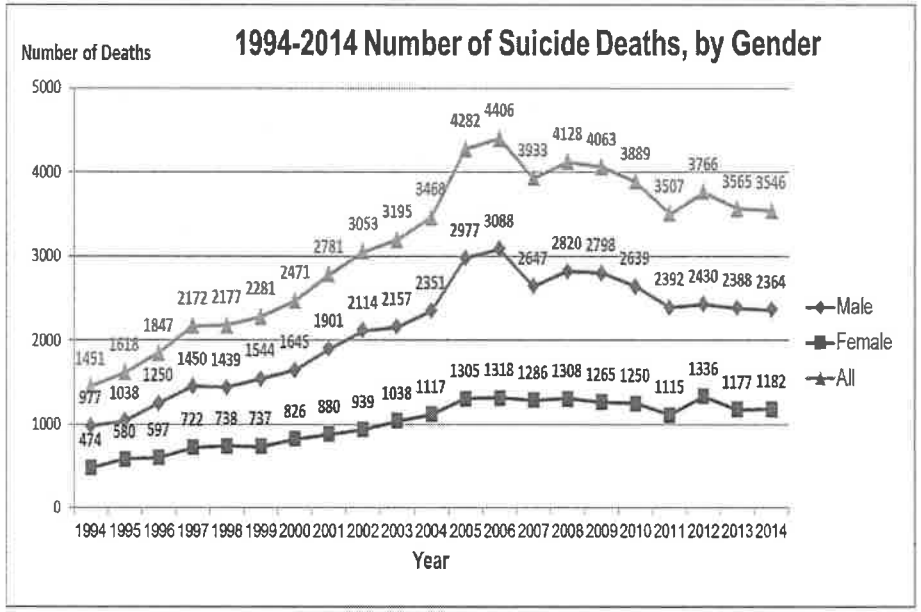
Mental Health promotion : Happiness

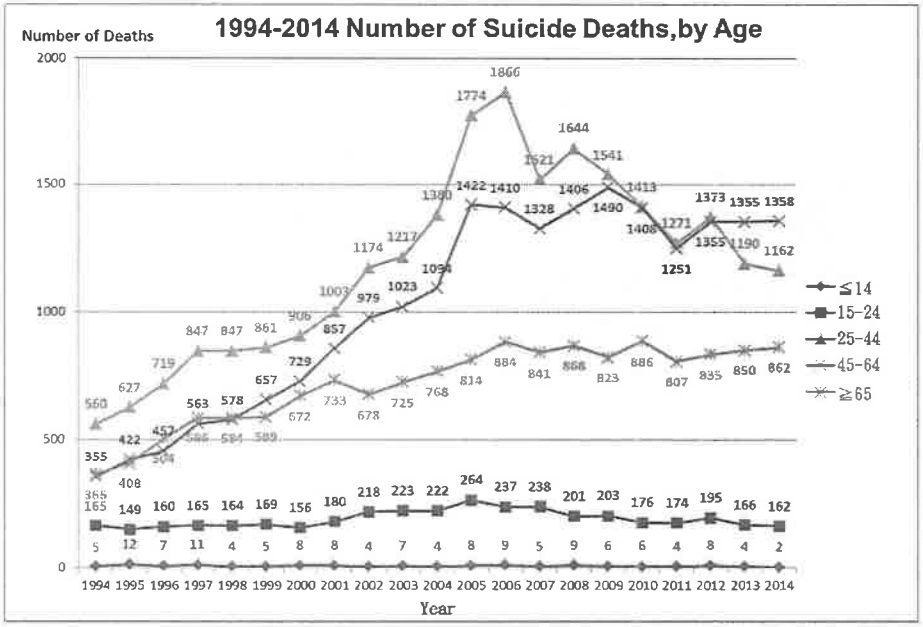
Alcoholism prevention and treatment

Child abuse treatment



Suicide rate





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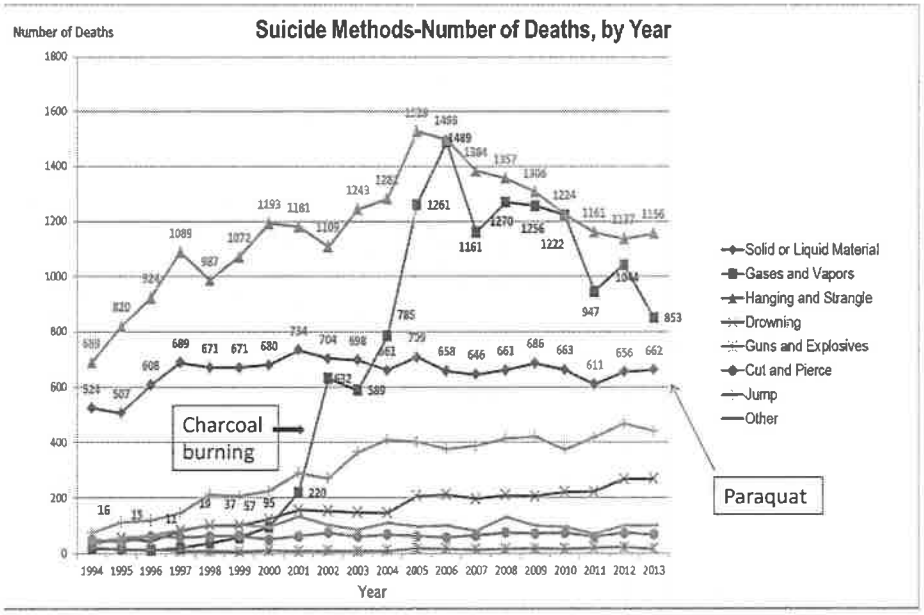

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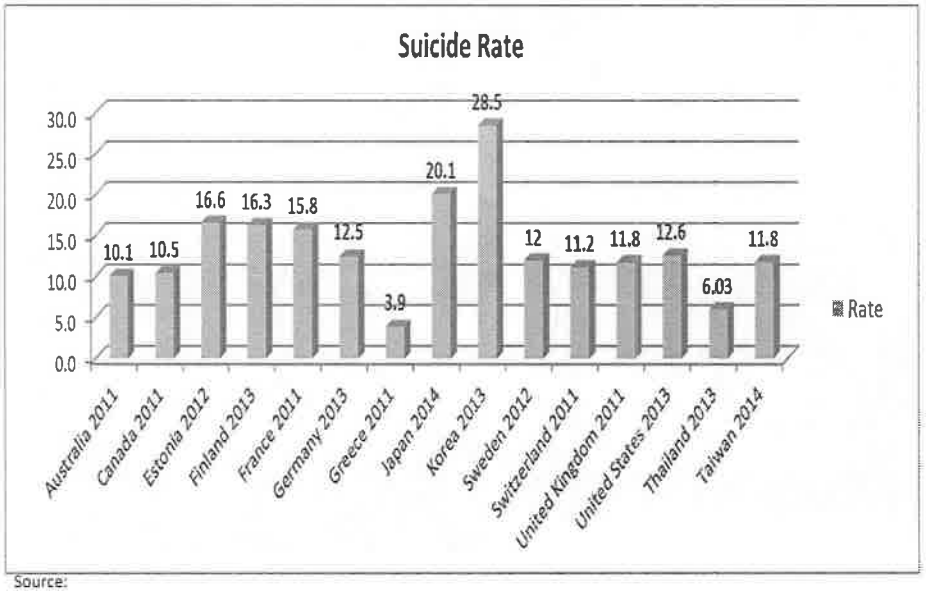

Source:
OECD Health Data: Health status: OECD Health Statistics (database).
List of countries by suicide rate "http://en.wikipedia.org/wiki/List_of_countries_by_suicide_rate"

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- Compare Taiwan suicide rate with Thailand

11.8 vs. 6.3

Taiwan have to learn from Thailand

Further tasks to be enhanced

✓Mental health promotion :
positive mental wellbeing in schools, workplaces, and elderly

✓Corporation with Ministry of Education :
programs in schools : increase self esteem control of emotion, improve interpersonal relationship

Find and implement effective

- Programs for elderly suicide prevention
- Programs for adolescent suicide prevention

to reduce suicide

Further tasks to be enhanced

✓Corporation with Ministry of Agriculture
restriction of pesticide, **paraquet**

✓Continue control of **charcoal**

✓Media cooperation

✓Anti stigma against suicide, depression and schizophrenia

Thank you for your attention

Staffs of Department of Mental and Oral Health, Ministry of Health and Welfare