

# **Treating Common Mental Health Disorders in Burma and the need for Comprehensive Mental Health Policies**



**Published by:**

**Assistance Association for Political Prisoners (AAPP)**

# Table of contents

List of Acronyms	4
Introduction	5
0.1 AAPP Mental Health Assistance Program	6
0.2 Aims	6
0.3 How to use this report	6
Chapter 1: Common Mental Health Disorders	7
1.1 What are Common Mental Health Disorders?	7
1.2 How do Common Mental Health Disorders Affect Society?	8
1.3 Who treats Common Mental Health Disorders?	9
Chapter 2: Challenges in Low and Middle-Income Countries	11
2.1 Factors Contributing to Ill Health	11
2.1.1 Poverty	11
2.1.2 Conflict	12
2.1.3 Lack of Political Freedom	12
2.2 Mental Health Resources	13
2.2.1 Community-Based Care and Institutionalized care	14
2.2.2 Mental Health Workforce	14
2.2.3 Distribution and Accessibility of Mental Health Services	14
2.2.4 Funding for Mental Health	15
2.2.5 Policy and Legislation for Mental Health	15
2.2.6 Research into Mental Health	16
2.2.7 Stigma of Mental Illness	16
Chapter 3: Mental Health in Burma	18

Chapter 4: How is Global Mental Health Developing?	20
4.1 World health organization: Mental Health Action Programme	20
4.2 International Solutions to Mental Healthcare Scale-Up	22
Chapter 5: CETA in Burma	25
Chapter 6: Recommendations and Conclusion	28
References	30
Recommended Readings	36

# List of Acronyms

<b>AAPP</b>	Assistance Association for Political Prisoners
<b>ASPiRE-MHS</b>	Asia Pacific Research for Mental Health Service
<b>CETA</b>	Common Elements Treatment Approach
<b>CMHD</b>	Common Mental Health Disorders
<b>GAP</b>	Generalized Anxiety Disorder
<b>CRPD</b>	Covenant on the Rights of Persons with Disabilities
<b>FPP</b>	Former Political Prisoner
<b>HIC</b>	High Income Country
<b>ICESCR</b>	International Covenant of Economic, Social and Cultural Rights
<b>IDP</b>	Internally Displaced Person
<b>INGO</b>	International Non-Governmental Organization
<b>JHU</b>	Johns Hopkin’s University
<b>LIC</b>	Lower Income Country
<b>LMIC</b>	Low and Middle Income Country
<b>MGMH</b>	Movement for Global Mental Health
<b>MHAP</b>	Mental Health Assistance Program
<b>mhGAP</b>	Mental Health Gap Action Program
<b>mhGAP-IG</b>	Mental Health Gap Action Program Intervention Guide
<b>MHIN</b>	Mental Health Innovation Network
<b>NGO</b>	Non-Governmental Organization
<b>OCD</b>	Obsessive Compulsive Disorder
<b>PTE</b>	Potentially Traumatic Event
<b>PTSD</b>	Post Traumatic Stress Disorder
<b>UDHR</b>	Universal Declaration of Human Rights
<b>WHO</b>	World Health Organization

# Introduction

In 2015, two of the ten health problems that cause most disability in Burma were mental health problems: depressive and anxiety disorders (IHME 2015). Prevalence of both of these disorders is increasing (WHO 2017a). They make up what are called Common Mental Health Disorders (CMHDs). Effective therapies are available for CMHDs, however, the majority of the world's population does not have access to these treatments. In Burma, the treatment gap for CMHDs is nearly 90% (Than Tun Sein et al. 2014). Recent political reforms in Burma create a window of opportunity for policy makers to strengthen the mental health system. The Assistance Association for Political Prisoners (AAPP) is amongst Burma's leading implementers of, and supporters for the improvement of, mental health services. This is AAPP's first advocacy report on mental health.

## 0.1 AAPP's Mental Health Assistance Program

For the last several years, AAPP has had the opportunity to work with Johns Hopkins University (JHU) Applied Mental Health Research group to implement a novel and promising mental health treatment program, named Common Elements Treatment Approach (CETA). CETA trainers began educating actors from the civil society to practice alongside them and extend the reach of the program. The Mental Health Assistance Program (MHAP) is now an integral part of AAPP's work. AAPP has witnessed the life-changing effects that mental health treatment can have on people suffering from mental health disorders. But AAPP has also experienced first-hand how fragile Burma's current mental healthcare system is. AAPP raises awareness of mental health treatment at all levels of society. AAPP collaborates with the Ministry of Health and Sports in Burma, Burmese universities, international research groups, actors of civil society, and many more. Together, AAPP works for a system where people suffering from mental illness are no longer neglected, but get the healthcare they are entitled to.

## 0.2 Aims

This report aims to:

- Explain the importance of providing evidence based mental health services for CMHDs, in particular to the Burmese population;
- Show examples of the successful implementation of CETA; and

- Outline AAPP's recommendations for strengthening the mental health system in Burma after years of experience in the field

### **0.3 How to use this report**

This report is meant for policy makers of Burmese health policy; all medical care providers and providers of mental healthcare in particular; providers of public service, such as all health workers, prison staff, police, teachers, military, and social workers; students in all these fields; national and international academics; staff from non-governmental organizations (NGOs), international NGOs (INGOs) and civil society organizations (CSOs); and any other interested parties.

Depending on their background, readers will use this report in different ways. Chapter one through four are largely informative, and will be useful to those with less experience in mental healthcare or the Burmese context. Others who have experience in mental healthcare in Burma will be able to briefly scan through these sections. Chapter five is more narrative and illustrative, and will be interesting to those not familiar with CETA. AAPP strongly recommends **all readers** to read the recommendations set out in chapter six. These recommendations can give anyone an idea of what they can do to support and contribute to mental healthcare in Burma.

A list of recommended readings is included at the end. This serves to elaborate on some of the major issues this reports argues for, but that are sometimes touched upon only briefly because of space limitation.

# Chapter 1

## Common Mental Health Disorders

The World Health Organization (WHO) defines mental health as “A state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” (WHO 2014c). By definition, for a mental state to classify as a ‘disorder’, it has to cause dysfunction. It is then called “mental disorder” or “mental illness”. CMHDs are a group of disorders that are especially prevalent globally (WHO 2017a). The term is understood to involve two groups of mental disorders: depressive and anxiety disorders (ibid). Occasionally, the definition includes substance abuse disorder as well.

This section will describe what CMHDs encompass: their relation to other mental health disorders, prevalence, clinical presentation, and treatment.

### 1.1. What are Common Mental Health Disorders?

An international standard source for an overview of mental disorder is the International Classification of Diseases (ICD) of Mental and Behavioral Disorders, released by the WHO in 1993<sup>1</sup> (WHO 1993). This document, like others of its kind, excludes neurological disorders from psychiatric disorders. Traditionally, neurological disorders have to do with the brain as an organ. Psychiatric disorders, including CMHDs, have to do with the mind. The breadth of mental disorders include dementia, schizophrenia, bipolar disorder, eating disorder, and mental retardation<sup>2</sup> (WHO 1993). Amongst these, depressive and anxiety disorders are especially common. Global prevalence rates are estimated at 4.7% for depressive disorders (Ferrari et al. 2013), 7.3% for anxiety disorders<sup>3</sup> (Baxter et al. 2013), and 17.6% for CMHDs (Steel et al. 2014). In a population affected by political violence and displacement, prevalence of depression and the anxiety disorder post-traumatic stress disorder (PTSD) have been estimated to average 30.6% and 30.8% respectively (Steel et al. 2009). Depression now ranks 13th of the 20 leading causes of disability globally (WHO 2016). For both depressive and anxiety disorder, evidence-based treatments are available. Yet most affected people, especially in low-middle-income countries (LMICs), do not receive any treatment. This is

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<sup>1</sup> A new version of the ICD is expected in 2018.

<sup>2</sup> For the full scope of mental disorders, the reader is advised to look at the ICD-10.

<sup>3</sup> Anxiety disorder and depressive disorder may also present together. This is called comorbidity, and makes prevalence of these diseases complicated to estimate (Wu and Fang 2015)

called the treatment gap, and is 86-93% in LMICs (Chisholm et al. 2016). This makes CMHDs a priority in global health, and a focal point in AAPP's work.

Depressive and anxiety disorders are both diagnosable conditions that affect feeling or mood of affected persons, distinct from feelings of sadness, stress or fear that anyone can experience from time to time in their lives (WHO 2017a). Both encompass a wider scale of disorders, which we will briefly address. Depression is the prolonged loss of interest and enjoyment of otherwise pleasurable things, on a scale ranging from mild to moderate and severe (ibid). Diagnosis depends on the prolonged presence of a combination of symptoms, commonly including depressed mood, loss of interest and enjoyment, and reduced energy leading to increased fatigability and diminished activity (WHO 1993). The disease can occur in anyone, at any age (WHO 2017a). The risk of becoming depressed is increased by poverty, unemployment, life events such as the death of a loved one or a relationship break-up, physical illness, and problems caused by alcohol and drug use (ibid). Anxiety disorders are characterized by anxiety and fear, and include the following disorders: generalized anxiety disorder (GAD), panic disorders, phobias, social anxiety disorders, obsessive-compulsive disorder (OCD) and post-traumatic stress disorder (PTSD) (ibid). Anxiety disorders can be manageable at low levels, but increased severity can lead to avoidance of even the simplest tasks, like going outside, using public transport or having social interactions. Affected people can have great difficulty maintaining their normal daily routine (ibid).

## **1.2. How do Common Mental Health Disorders Affect Society?**

The loss of mental health does not only affect the health and wellbeing of the person who suffers from mental health illness themselves and their families, but also has inevitable consequences for society at large, including employers and governments (Kessler 2012; Hoffman et al. 2008). Chisholm et al. (2016) estimated that lack of mental health facilities is currently causing the loss of 43 million healthy years worldwide, with an economic value of \$310 billion. This is a result of, amongst others, diminished productivity at work, reduced rates of labor participation, foregone tax receipts, and increased health or other welfare expenditures (Kessler 2012; Hoffman et al. 2008; Chisholm et al. 2016). Moreover, depressive and anxiety disorders might be causative of a variety of somatic diseases, including artery disease, stroke, diabetes, heart attack, certain types of cancer, and HIV/AIDS (Prince et al. 2007). Development of unhealthy behaviors during mental illness, such as smoking, substance abuse, and low compliance to treatment regimens has been linked to this association (ibid). This somatic effect has led to the well-known slogan: 'No health without mental health' (ibid). Mental health problems further affect the family. Robust evidence indicates that depression in

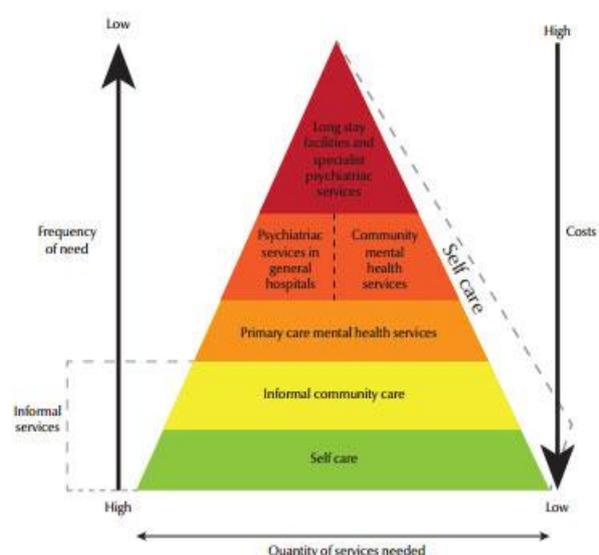
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a caregiver or parent can adversely affect infant attachment and subsequent child growth (Prince et al. 2007). Depression in teenage girls is associated with an increased chance of teenage pregnancies (Kessler 2012). Chisholm et al. (2016) calculated that investment in mental health has major returns. Benefit to cost ratios are as high as 2.3–3.0 when only economic benefits are considered (Chisholm et al. 2016). When not only the instrumental or economic value, but also the intrinsic value of being healthy is estimated, the return of investment is 3.3–5.7 (ibid).

### 1.3. Who Treats Common Mental Health Disorders?

CMHDs are treatable. As with all (mental) health disorders, treatment of CMHDs is provided through different platforms. These platforms can broadly be categorized into three groups: community-based, general health system based, and based in specialized institutions (WHO 2003). Community-based platforms are not based in hospital or clinic settings, but instead in schools, at people’s homes, through mobile health teams, or in other community settings. They can be both formal or informal. Formal healthcare refers to those services provided by certified and skilled health-staff. People without prior training in mental healthcare form the informal mental health sector. Examples of this include patients themselves, their family, community leaders, or people who have gone through similar experiences. The general health system comprises of primary and secondary healthcare. Primary care is supplied by for instance general practitioners, nurses and midwives in primary care clinics. Secondary care is the provided in general hospitals. Hospitals play a role in emergency cases or patients who require highly specialized care. For CMHDs, they are of minor importance. Specialized institutional services can be provided by specialized outpatient clinics and public or private hospital-based facilities. It includes highly specialized and high-security care in emergencies, as well as care for chronic patients. Specialized care is costly but valuable for a select group of patients (WHO 2003). Patients with CMHDs do not generally need such services (WHO 2014b).

CMHDs can be treated through a mixture of evidence-based psychosocial therapy, pharmaceutical therapy, and community support (Patel et al. 2007).



Comprehensive therapy for one patient is delivered through several treatment

Figure 1. WHO service organization (Saraceno et al. 2015)

platforms. For instance, there is a variety of drug therapies available for CMHDs, but only a select group of professionals are authorized to prescribe medication. Psychosocial therapy, or talking therapy, can be delivered by a range of specialist and non-specialist providers (Singla et al. 2017). Non-specialist providers can include primary care workers and community health workers trained in psychosocial therapy. Examples of psychosocial therapy include the widely used cognitive behavioral therapy, behavioral activation therapy, and narrative exposure therapy. Some of these will take only one session, while others have to be continued for years. Treatment for CMHDs generally takes about ten consultations (ibid). Family, peers, and others in the community, then play the main role in ensuring social support for someone suffering from mental health disease.

## **Chapter 2**

### **Challenges in Low and Middle-Income Countries**

LMICs face a great burden of CMHDs. But they have significantly fewer resources available for mental healthcare than Higher Income Countries (HICs) (WHO 2015). There exists a great treatment gap as high as 86-93% in LMICs (Chisholm et al. 2016). Inequality is great in the distribution of mental health resources, both between and within countries (Saxena et al. 2007). In all levels of society, it seems that often, those with the highest need for care have the least access (Saxena et al. 2007; WHO 2014a; Roberts and Browne 2010).

The current section will first address the factors contributing to the burden of CMHDs in LMICs, and then the main barriers to mental healthcare in LMICs. This will aid the understanding of the challenges Burma is facing in broader context.

#### **2.1 Factors Contributing to Ill Health**

The historical context of a country, its current political, social, economic, and environmental situation, and cultural and social norms operating within society, shape the conditions in which people live and maintain their mental health (WHO 2014a). To promote fair distribution of mental health services worldwide and target the most vulnerable populations, it is important to understand what the root causes of poor mental health are in a setting. This section will explore three significant causes of poor mental health that can affect LMICs: poverty, conflict, and lack of political freedom.

##### **2.1.1. Poverty**

The majority of studies find a positive association between poverty and CMHDs (Lund et al. 2010). To understand this relationship, poverty can be dissociated in its different dimensions (Lund et al. 2010; Patel and Kleinman 2003). This reveals consistencies in which factors of poverties can contribute to poor mental health. These include education, food insecurity, housing, social class, socioeconomic status, and financial stress (Lund et al. 2010; Patel and Kleinman 2003). Others such as income, employment and consumption are more equivocal (Lund et al. 2010). A positive association between poverty and mental health can mean two things: That conditions of poverty cause worse mental health, or that people living with mental illness drift into, or remain in, poverty (Lund et al. 2010). Both hypotheses are regarded valuable explanations that must be considered together (Lund et al. 2010; Lund et

al. 2011). For example, interventions targeting socioeconomic status could be an opportunity to reduce the burden of CMHDs (WHO 2014a). Lund et al. (2011) found that there is a positive effect of mental health treatment on poverty outcomes. This could mean that the upscaling of mental health services is not only a public health and human rights priority, but also a developmental priority (Lund et al. 2011).

### **2.1.2. Conflict**

Populations affected by armed conflict unsurprisingly have high rates of poor mental health (Roberts and Browne 2010). Various conditions of armed conflict have been singled out to associate to poor mental health. Displacement, especially internal displacement, is an important contributor to the development of CMHD (Roberts and Browne 2010). Further contributors to poor mental health in conflict-affected populations are exposure to traumatic events, including murder, rape, illness without medical care, torture, and being forced to accept ideas (Roberts and Browne 2010). Return of Internally Displaced Persons (IDPs) in a post-conflict setting significantly lowers their burden of mental illness (Siriwardhana et al. 2015). However, the prevalence of mental health disorders in returned IDPs is still high and warrants attention (Siriwardhana et al. 2015). Delivering mental healthcare in both conflict and post-conflict settings is challenging (e.g. Siriwardhana et al. 2016). Especially because the vast majority of conflict affected people are living in LMICs, where mental health infrastructure is generally underdeveloped (Siriwardhana et al. 2013; Roberts and Browne 2010).

### **2.1.3. Lack of Political Freedom**

Lack of political freedom and unstable policy environments can also have deleterious effects of mental well-being (WHO 2014a). However, only little research has been done on the contribution of political violence on mental health. Political violence and resulting exposure to potentially traumatic events (PTEs)<sup>4</sup>, in particular torture, is associated with depression and PTSD on a population level (Steel et al. 2009). Living in a country that scores high on the political terror scale (PTS) shows also a modest but statistically significant association with levels of PTSD (Steel et al. 2009). A different study shows high rates of PTSD, depression and anxiety are reported in former political prisoners, regardless of the political environment (Willis et al. 2015).

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<sup>4</sup>PTEs are a selection of events which can cause significant stress in people. These events may leave no traces in some people, but will usually lead to varying degrees of trauma, possibly PTSD.

LMICs, especially when there is ongoing conflict or a history of political oppression, have a great and specific need for care for CMHDs yet the mental health infrastructure in LMICs is disproportionately underdeveloped. The next section will address the mental health resources in LMICs.

## **2.2 Mental Health Resources in LMICs**

Infrastructure for mental health services is underdeveloped in LMICs (WHO 2015; Saxena et al. 2007). Not only compared to HICs, but often also relative to the development of other health infrastructure within the country (WHO 2015; Saxena et al. 2007). Certain trends are common to many LMICs. For example, there are too few platforms that provide mental health services, and access to them is low. There is a severe lack of mental health workers, and policy on mental health is often outdated or non-existent. Yet, LMICs are underrepresented in research (Razzouk et al. 2009). There is thus both a treatment gap and a knowledge gap.

The Grand Challenges in Global Mental Health study (Collins et al. 2011) ranked the top five global priorities: integration of mental health into the accessible primary healthcare, mental health component in training for all health personnel, providing community-based care, improving children's access to mental healthcare, and reduce the cost of effective medication. The subsequent international action plan for mental health care (WHO 2013) published four objectives:

- 1) Strengthen effective leadership and governance for mental health;
- 2) Provide comprehensive, integrated and responsive mental health and social care services in community-based settings;
- 3) Implement strategies for promotion and prevention in mental health; and
- 4) Strengthen information systems, evidence and research for mental health.

The more recent publication on the lessons learned from the Disease Control Priorities study (Patel et al. 2016) stressed the challenges posed by pervasive stigma, the lack of leadership in implementing evidence-based mental health programs and a persisting belief in hospital-based care services. This section will review some of these great challenges, and how they manifest in LMICs.

### **2.2.1 Community Based Care and Institutionalized Care**

There exists a consensus that the majority of mental healthcare should be provided through community-based or primary healthcare, where it is accessible to the general population (WHO 2014b). Specialized mental health institutions are important for a set of severe cases (WHO 2014b). But they are also expensive, inaccessible, and often unpleasant (WHO 2003; WHO 2014b; Drew et al. 2011). In many cases, patients live away from their families, against their will, and are subjected to degrading treatment (ibid). These institutions should not be the focus of mental health policy (WHO 2014b; WHO 2013; Collins et al. 2011). But despite decades of promoting deinstitutionalization and community-based care, mental hospitals continue to consume a large majority of the budget. They take up around 70% of the mental health budget in LMICs and 50% in HICs. Community based care, on the other hand, is often underdeveloped or nonexistent (WHO 2014b). Integration of mental healthcare further means integrating mental health services in institutions such as the judiciary, maternal care, schools, and elderly homes. These institutions have access to vulnerable populations - notably victims of crimes, detainees, recent mothers, children, and elderly - and are thus invaluable in early detection of mental disorder.

### **2.2.2 Mental Health Workforce**

There is a severe shortage of human resources in mental healthcare in LMICs (Saxena et al. 2007; Kakuma et al. 2011). This shortage is regarded as one of the greatest bottlenecks in provision of care (Kakuma et al. 2011). The estimated number of mental health workers needed in LMICs is between 22 and 27 individuals per 100.000 population, comprising of 6% psychiatrists, 54% nurses and 41% psychosocial care providers (Kakuma et al. 2011). There is currently a 0.9 workforce per 100.000 population in the lowest income countries, and 3.2 in low income countries (WHO 2015). There is an overall shortage of mental health providers at both the community and specialist level. Health workers at the community level often must rely on support from specialist levels for advice or referral, and lack of both makes the health system very weak (van Ginneken et al. 2013). The emigration of skilled mental health workers from LMICs to HICs poses a further challenge to the mental health workforce (Saxena et al. 2007).

### **2.2.3. Distribution and Accessibility of Mental Health Services**

Mental health services are not equally distributed nor accessible (Saxena et al. 2007; WHO 2014a). Often, people who most need these services are the ones that have least access to

them. The first problem is posed by geographical location. For example, health services tend to be located near urban populations (Saxena et al. 2007; WHO 2014a). The second problem is posed by social characteristics of the affected population. Certain characteristics are associated with limited accessibility to mental healthcare. These include ethnicity, poverty, age, gender and sexual orientation (Saxena et al. 2007; Semrau et al. 2015). Many of these groups are also vulnerable to mental health disorders (ibid). A third problem is posed by stigma against people with mental health issues. It is not uncommon for people with mental health disorders (not limited to CMHDs) to be kept away from society (Semrau et al. 2015). They may be locked away, or suffer social exclusion, for example through unemployment (ibid). Poor understanding of their own condition may also limit their initiative to seek treatment (ibid). All these limitations are human rights violations against people with mental health disorders under the international law of the Universal Declaration of Human Rights (UDHR), the International Covenant of Economic, Social and Cultural Rights (ICESC) and the Convention on the Rights of Persons with Disabilities (CRPD) (Drew et al. 2011). They warrant special attention in the development of mental health systems (Drew et al. 2011).

#### **2.2.4. Funding for Mental Health**

The budget allocated to mental health is disproportionately low. About 5.10% of the national health budget is spent on mental health in HICs, and a mere 0.53% and 1.90% in lower and lower-middle-income countries respectively (WHO 2011). Notably, budgets for health in general are already much lower in LMICs than they are in HICs (Saxena et al. 2007). Social insurance, voluntary health insurance, and tax-based arrangements could compensate for some of these scarcities (Dixon et al. 2006). But LMICs largely rely on the less effective and less equitable out-of-pocket payments instead (Dixon et al. 2006). Moreover, pharmaceuticals in LMICs are significantly more expensive than in HICs, relative to gross national product (Saxena et al. 2007).

#### **2.2.5. Policy and Legislation for Mental Health**

Mental health governance is often underdeveloped in LMICs. Mental health governance includes strategic policy and a legislative framework. Among LMICs, there are fewer countries that have up to date policy and legislation. Policy, referring to a statement of overall direction and values, is present in about 60% of countries, but only in 48% of Lower Income Countries (LICs) and 55% of LMICs (WHO 2011). Legislation refers to laws on various topics, including human rights protections for people with mental health disorders, involuntary admission and treatment, professional training and certification, and service structure (WHO 2015). About

60% of countries worldwide have mental health legislation, but only 38% and 47% of LICs and LMICs respectively (WHO 2011). Moreover, in 15% of countries with such legislation, it is enacted before 1970 and thus severely outdated (ibid).

### **2.2.6. Research into Mental Health**

There is a severe lack of research on mental health and related policy in LMICs. Research is pivotal in guiding policy makers (WHO 2013). It is important for policy makers to know what treatments work best, and how to implement them efficiently. Research from HICs cannot simply be adopted for use in LMICs. Pharmacological treatments need to be tested in their target groups for right dosing, psychotherapies need to be culturally adapted, and specific research needs to go into the epidemiology of mental health disease and effective implementation strategies of mental health interventions in LMICs (e.g. Docherty et al. 2017). Only once such data has been collected can policy makers decide what treatments to certify, how to rapidly implement those treatments and in what programs and locations to put their (limited) funding (Docherty et al. 2017). But routine information systems for mental health in most LMICs are rudimentary or absent, making it difficult to understand the needs of local populations and to plan accordingly (WHO 2013). LMICs account for only a small part of academic literature on mental health. 57% of the 114 LMICs were found to contribute fewer than five articles to the international mental health indexed literature between 1993–2003 (GFHR and WHO 2007). Researchers from LMICs are limited by lack of available research grants and of access to research journals (Razzouk et al. 2009). Furthermore, there exists a gap between researchers and policy makers. Policy is not always based on evidence based practice, even when it is available (GFHR and WHO 2007).

### **2.2.7. Stigma of Mental Illness**

People with mental health illness suffer from pervasive stigma, almost everywhere (Seeman et al. 2015). Stigma is the social devaluation of a person because of an attribute that is deeply discrediting and based on problems of ignorance, prejudice and discrimination (Semrau et al. 2015). Mentally ill individuals are stereotyped as dangerous, incompetent, blamed for their illness, or socially excluded (Semrau et al. 2015). They might experience stigma against themselves, called 'internalized stigma'. This can lead to a negative self-image, but also reluctance to seek treatment or social exclusion (Clement et al. 2013). For example, a report explains that when primary care workers have stigmatizing attitudes towards people with mental illness, it might make them more reluctant to take on mental health care duties, or the

community might prefer mentally ill peers use specialist psychiatric outpatient facilities, because they wish not to stand in line with the mentally ill at a primary care clinic (Mendenhall et al. 2013). The stark pervasion of stigma can also lead to the neglect of mental illness in policy (Saxena et al. 2007). Policy makers might find it unimportant to address mental illness in national health policy, allocate disproportionately low funds to mental healthcare, or even explicitly exclude mentally ill patients from programs such as social benefits (Saxena et al. 2007). Such discrimination is regarded a human rights violation under the same international law named in 2.2.3. (Drew et al. 2016). Increased exposure to people with mental illness, improved mental health literacy (i.e. knowledge about what mental illness encompasses), and classification of mental illness as 'a disease as any other' tends to lessen negative attitudes against people who suffer from mental illness (Clement et al. 2013). This can be achieved through for instance mass media campaigns (ibid).

All these challenges are integrated. For instance, stigma and low mental health literacy contribute to the low financial resources allocated to mental healthcare, leading to an underdeveloped mental health infrastructure, and the absence of mental healthcare from the public health care system reinforces stigma and low mental health literacy (Patel et al 2016). But global initiatives are breaking the cycle. Chapter 4 will discuss recent strategies implemented by the WHO, as well as a major innovation in the increase of mental health workforce. First, we will look at the status of mental healthcare in Burma.

## **Chapter 3**

### **Mental Healthcare in Burma**

Mental health disease is highly prevalent in Burma. Of the ten diseases that caused most disability, two were mental health diseases in 2015 (IHME 2015). These were depression and anxiety, which ranked fourth and tenth in 2015 (ibid). Despite the high prevalence, the treatment gap for mental health disease is nearly 90% (Than Tun Sein et al. 2014). Burma's mental health policy is incorporated in the national health plan (NHP). The latest version of this plan was enacted in 2017. In the NHP, mental health and substance abuse is a project under the non-communicable diseases program. Whether mental health is part of the Essential Package of Health Services is not clear. The Government has not published a comprehensive mental health policy, and official information on the current state of the mental health system is also not available. But in a conference on mental health in September 2016, the Government presented a country profile and nine objectives for mental healthcare. The legislation related to mental health is described in the 1912 Lunacy Act. The Government started revising this legislation a few years ago. Non-governmental actors have, to our knowledge and at the time of this publication, not been involved in this process.

This section will review available information on the mental healthcare system in Burma, and address the nine objectives the Government set to strengthen the system.

According to the latest data, Burma spent 3.6% of its total government expenditure on healthcare in 2014, which is much lower than the world average of 15.9% in 2011 (WHO 2014d). How much of this is allocated to mental healthcare is unclear. The latest report states that 0.3% of health expenditures is contributed to mental healthcare (WHO & MHUM 2006). This information is severely outdated. The Government of Burma is undertaking reforms in the fragile health system, and has made changes in its health expenditure over the recent years. For example, in 2011, the Government spent only 1.8% of its budget on health (WHO 2014d).

Mental health services are provided both through hospital based facilities and community based facilities. According to the information presented by the Government, there are 1600 beds in mental health hospitals and an additional 220 for psychiatric cases in general hospitals. Furthermore, secondary and tertiary care includes a number of addiction treatment centers. The community based care refers to three programs: The Mental Health Project, Satellite Continuous Care Program, and the Model Township Project. The Mental Health

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Project is the largest of these, and has been running since 1990. It is sponsored by the WHO under the guidance of the Ministry of Health and Sports, and aims to integrate mental health services in primary healthcare. Between 1990 and 2014, the project trained a total of 4760 people on mental health care including health staff, school teachers and local NGOs (Than Tun Sein et al. 2014). No report on the status of the Mental Health Project is available online. The other two projects are recent pilot studies. The remaining mental health workforce in Burma consists of 200 psychiatrists and 156 psychiatric nurses. There are a further three clinical psychologists, five psychiatric social workers and two occupational therapists.

The Ministry of Health and Sports developed nine objectives to guide policy-making. These were presented in 2015 and are commonly cited, but have not been officially published. The objectives of the Government are the following.

1. Develop and implement strategies for promotion and prevention in mental health;
2. Reduce the treatment and service gap for mental disorders by 20% (by the year 2020);
3. Develop a Mental Health Law appropriate to current situations of Burma and human rights issues to replace the 1912 Lunacy Act;
4. Provide evidence-based best practices for better care for mental health services by collaborating with stakeholders, international medical communities, Non-Governmental Organizations (NGOs) and International Non-Governmental Organization (INGOs);
5. Ensure preparedness for disaster mental health and provision of psychosocial facilities for disasters;
6. Promote resource development in mental health;
7. Upgrade the quality of care in hospital based services;
8. Strengthen the health information system related to mental health issues; and
9. Do and participate in research related to mental health (eg. World Mental Health Survey).

Research worldwide is contributing to our knowledge of how policy makers can effectively improve mental health systems and reduce the treatment gap in mental health. Lessons from these initiatives can aid the Ministry of Health and Sports to reach the objectives set out above. The next section will review some promising trends in global mental health.

# Chapter 4

## How is Global Mental Health Developing?

Mental health has received increasingly more attention over the last decade. The Movement for Global Mental Health (MGMH)<sup>5</sup>, the WHO Mental Health Gap Action Programme (mhGAP)<sup>6</sup> and the Mental Health Innovation Network (MHIN)<sup>7</sup> are just a few of the leading actors that are implementing groundbreaking strategies to address global mental health and reduce the mental health gap. An important resource of their combined work are the two series on mental health published by the Lancet - one in 2007 and one in 2011 - reviewing global literature on mental health in LMICs. This work and other reports from these actors show that it is possible to scale up evidence-based mental health programs with limited resources, and some degree of consensus exists on the priorities of mental health capacity building and best practice. This section will review the development of work by the WHO in mental health and some innovations of global importance that were developed by other actors to address realities on the ground.

### 4.1 World Health Organization: Mental Health Action Plan.

The year of publication of this report, 2017, is the year that the theme of the World Health Day is Depression: let's talk<sup>8</sup>. It is the first time that the World Health Day focused on mental health, highlighting the renewed efforts of the WHO to put mental health on the global agenda. Over the past few years, the WHO has taken significant measures to support countries to improve their mental health infrastructure. The following paragraphs will discuss their key document, the 2013-2020 health action plan, and their major program, mhGAP.

The 2013-2020 health action plan was adopted as the first of its kind in the history of the WHO, a testimony of the global shift in thinking about mental health (Saxena et al. 2013). It is based on four key objectives:

1. To strengthen effective leadership and governance for mental health;
2. Provide comprehensive, integrated and responsive mental health and social care services in community-based settings;
3. Implement strategies for promotion and prevention in mental health, and;

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<sup>5</sup> Available online: <http://www.globalmentalhealth.org/>

<sup>6</sup> Available online: [http://www.who.int/mental\\_health/mhGAP/en/](http://www.who.int/mental_health/mhGAP/en/)

<sup>7</sup> Available online: <http://www.mhinnovation.net/>

<sup>8</sup> This day marks the anniversary of the WHO on April 7. For more information about the campaign, visit: <http://www.who.int/campaigns/world-health-day/2017/campaign-essentials/en/>

#### 4. Strengthen information systems, evidence and research for mental health (WHO 2013).

Every section in the plan includes what is expected from governments, the UN, and from other partners, as well as measurable targets to track progress. With the issue of this report came more global consensus of what the increased coverage of mental health services should look like.

The plan highlights what is now seen as the norm in mental healthcare, and issues that used to be at the periphery are now seen as central to providing an effective response to mental healthcare (Saxena et al. 2013). It puts provision of a community-based approach on the forefront and promotes deinstitutionalization; and it focusses on patient recovery and demedicalization<sup>9</sup> of care. Actors are expected to take action in promotion and prevention strategies, and engage civil society in policy making. The Global Health Action Plan was adopted by the General Assembly, and thus reflects a commitment of all member states to implement these measures.

The WHO has supported these efforts by developing the mental health mhGAP. The mhGAP provides planners, policy-makers, and donors with a set of clear and coherent activities and programs to scale up care for mental health disorders (WHO 2008b). These are set out in the Intervention Guide (mhGAP-IG) launched in 2013 (WHO 2013). This intervention guide is part of a toolkit for the upscaling mental healthcare, while the document itself can be distributed after training of mental health professionals (WHO 2013). The program focusses on priority disorders, including depression, bipolar disorders, epilepsy, dementia, substance use disorders, and self-harm/suicide (WHO 2013). The program is designed to be used by non-specialized health settings, as part of the effort to integrate mental health into primary care (WHO 2013). The efforts of the mhGAP are accompanied by regular release of comprehensive documents on key issues by the WHO, such as the integration of mental health into primary care (WHO 2008a), deinstitutionalization (WHO 2014b), and appropriate use of medicines in mental healthcare (WHO 2017b).

Although the work of the WHO is quite comprehensive, there is a lot more going on at the international level. The next section will cover some of these further innovations.

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<sup>9</sup> Demedicalization is reducing reliance on pharmaceuticals and an increased view of mental illness as a result of the socio-historical context rather than only biology

## 4.2 International Solutions to Mental Healthcare Scale-Up

Innovation in global mental health occurs on all levels of society, addressing the challenges set out above and more. Some of the proposed solutions are truly innovative, in that they break with currently held perceptions of what mental health looks like. One such major innovation is the recruitment of non-specialist providers (NSPs) in 'task sharing' approaches, to enhance the mental health workforce (Singla et al. 2017). While mental healthcare treatments which have been developed in highly specialized academic centers are valuable, they pose problems. For example, they often rely on expensive and scarce mental health professionals. When considering LMIC and the unavailability of affordable mental health treatments and professionals, a solution must be found to rapidly upscale mental healthcare, using as few resources as possible. Task sharing is such a solution, alongside for example the increased use of technology and anti-stigma campaigns to rally support for the upscaling of mental health. These innovations happen against a backdrop of the formation of global networks like the MGMH and MHIN, that encourage and empower mental health researchers from all over the world.

In this section, we will first discuss what is meant by the trend of 'task sharing' or 'stepped care', and 'integrating mental health services in primary care', and then look at the remarkable work recently done by Singla et al. (2017), who reviewed the what, who, where and how of the role of NSPs in psychological treatment of CMHDs.

Task sharing is a heterogeneous concept, and requires tasks traditionally being carried out by specialist mental health staff to be delegated to less specialized staff under supervision of and collaboration with the specialist (Mendenhall et al. 2014). It helps to use human resources more efficiently and increase capacity and health care coverage within a constrained budget (Singla et al. 2017). These less specialized staff can include a whole range of actors: commonly, they are primary care staff, but they can also include maternal health professionals, educational professionals, social workers at community centers, peers from the same community, HIV/AIDS workers, or people without a professional role, to name a few (ibid). These new workers have varied relationships with the health system: some will be part of the primary care delivery channel, while others part of community care. What tasks they can fulfill depends on their role as well as their training, but commonly includes recognition, diagnosis and referral of patients, and basic treatment, the latter especially in the case of CMHDs (Singla et al. 2017). There are some significant advantages to integrating mental

health services into primary or community care. Firstly, it gives the caretakers a chance to treat the whole individual, which is especially important in the case of co-morbidities<sup>10</sup> in acute and chronic physical health, reproductive health, and chronic pain problems (Patel et al. 2013); and secondly, integrated programs outside of the specialized care setting are often more attractive to patients and family members who are concerned about stigma (Patel et al. 2013).

Integrating mental health services in primary care has been called the ‘most viable way of closing the treatment gap’ for mental health by the WHO (WHO 2008a). Many countries have indeed made this transition. A notable example with similarities to that of Burma is Sri Lanka, where an integrated mental health program was successfully implemented in some provinces as part of post-conflict recovery<sup>11</sup> (Siriwardhana et al. 2016). Primary care workers can be trained using guidelines such as mhGAP (Patel et al. 2013). Subsequent tasks should be negotiated, depending on the available time of the often already busy professional (WHO 2008a). Examples from the WHO 2008(a) report show that different clusters of mental diseases can be dealt with in primary care, while CMHDs are particularly suited for such treatment. In South Africa, schizophrenia, bipolar disorder and major depression are managed in primary mental health care; in Saudi Arabia, treatment of CMHDs occurs in primary care and complex cases are referred to secondary care; and in Chile, primary care initially only dealt with emotional problems, but gradually included depression, domestic violence, and child mental health (WHO 2008a). Such treatment does not only imply that the health professional is skilled in providing psychosocial interventions, but in some cases also has access to pharmaceuticals and the authority to prescribe them. Moreover, it implies that the primary care professional has access to guidance and continuous supervision from a mental health specialist, as well as the possibility to refer to a mental health professional where they cannot provide the treatment themselves - a process called ‘stepped care’ (Patel et al. 2013). A major consideration in this approach, however, is the workload of the primary healthcare professional (WHO 2008a).

Singla et al. (2017) found that the most common NSPs in research trials (thus not representative of the actual population) were community health workers or peers with no formal healthcare role, who typically belonged to the same community as the beneficiary population. In many cases, the value of peer support - people who have had the same

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<sup>10</sup> The diagnosis of more than one health disorder

<sup>11</sup> In post-conflict Sri Lanka, mental healthcare used to be delivered primarily through untrained primary care practitioners (PCPs) (Siriwardhana et al. 2016). A pilot program implemented the WHO’s mhGAP in Northern Province, and was the first to study the implementation of the program in a post-conflict, low-resource setting (ibid). The research shows that it is challenging but highly necessary to integrate mental health services in primary care in such setting.

experience - was acknowledged. Examples of this practice includes postpartum mothers trained to deliver psychosocial support to other women suffering from postpartum depression, or the same setup with individuals diagnosed as HIV positive, and with Burmese refugees (see Singla et al. 2017 for an overview of these studies). What was furthermore important was that those who received training in psychosocial support were of a sustainable population: that after the training, they were part of a platform (such as a health facility, school, NGO, or other community platform) that ensured the continuation of their work. Singla et al. (2017) found that most trainings consisted of about ten days of face-to-face training, and subsequent supervision was typically conducted weekly in person, during which individual cases were reviewed with an expert supervisor. The treatment most commonly lasted less than ten sessions, up to one hour each, delivered during two to three months. Most importantly, many of these treatments successfully improved the CMHD outcomes (ibid).

CETA is one such task-sharing program. CETA works closely with the policy-makers in Burma, and is taking the lead in countrywide coverage of evidence-based CMHDs counseling. This program received a lot of attention from global leaders in mental health, such as Vikram Patel, for its innovative approach and evidence based work. Burma is the first country where it is being implemented, and, with the right support from the government, the program could kickstart a new approach to mental health in Burma. In the next section, we will discuss this in more detail, to illustrate what can be done concretely to improve mental health coverage in Burma.

# Chapter 5

## CETA in Burma

In 2010, AAPP was approached by the Applied Mental Health Research (AMHR) group at JHU to be one of three organizations partaking in a randomized controlled trial of CETA. CETA is a psychotherapeutic intervention aimed at improving the mental health of individuals experiencing CMHDs. One of AAPP's priorities has always been the mental and physical well-being of former political prisoners (FPPs). FPPs are a segment of the population vulnerable to CMHDs (Willis et al. 2015). Moreover, AAPP had proven to be a sustainable organization. It was therefore an ideal organization for the CETA trial. AAPP was part of the development of CETA and its adaptation to the Burmese context in 2010, and the implementation phase in 2012. That study found that CETA was acceptable, accessible, and effective in improving mental health and functioning of adults (Murray et al. 2014). While the other two organizations ceased CETA activities in the years following the trial, AAPP continued the practice for two reasons. Firstly, it was apparent that AAPP's target group had pressing needs for counseling, and CETA proved effective in reducing CMHDs. Secondly, assisting in employment of FPPs is part of AAPP's core activities, and continuing CETA could create sustainable jobs for FPPs. In 2014, AAPP opened two new counseling offices, one in Rangoon and one in Mandalay. Ten new counselors were recruited and trained, and provided free counseling services to FPPs in their respective areas. In the years that followed, AAPP recruited more staff, and started providing counseling services to people of the general population. At the time of writing, AAPP employs a total of twenty counselors, four supervisors, and three trainers. In 2015, the AMHR group at JHU launched the Asia Pacific Research for Mental Health Services (ASPiRE-MHS) project. This project studies the scale-up of CETA in multiple areas in Myanmar. AAPP provides the trainers for this study.

This section will review CETA as an example, to bring the treatment of CMHDs from the abstract to the concrete and show that it is possible to bring effective treatment for CMHDs to a large population.

CETA was designed to be a cost-effective intervention suitable for delivery by lay counselors, individuals without specific background or training in counseling or mental health. CETA is a 'transdiagnostic' and 'common elements' approach, and an 'apprenticeship model' (Murray et al. 2014). Transdiagnostic means that the treatment is not specific for only one illness. Rather, it uses the core elements of various treatment protocols that are similar across different disorders. This has two major advantages. Firstly, this reduces the study-load for the

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counselor, and simplifies the training. Secondly, the intervention can treat several common disorders because of the core elements being combined with the flexibility of additional components for specific issues clients are facing. Investment in one intervention thus reduces the burden of not only depression, but also anxiety and substance abuse disorders. Moreover, depressive and anxiety disorders and substance abuse disorders often present together (ibid). Using a transdiagnostic approach means that the counselor does not have to decide which of the co-morbid problems to target first, but can effectively treat all at the same time. This transdiagnostic efficacy is achieved by using a varying set of elements common to many psychological interventions. This approach has gained popularity in HICs, but there is a global trend to apply it in LMICs as well (Singla et al. 2017).

What makes CETA special is that it can be taught to people without any prior education in health or mental health care (Murray et al. 2014). Their training starts with a two-week intensive training, followed by extensive group practice, and a supervised client (Murray et al. 2011). If they are considered sufficiently skilled, they are put under supervision of a supervisor, to assure their long-term quality. This supervisor is in turn under distance-supervision and training of a CETA trainer. The materials are carefully adapted to each training and the participants to make sure that the materials are relevant to the context and appropriate for the counselors. They minimize the use of jargon and predominantly rely on practice rather than reading, to make the training accessible even for people with a limited educational background.

The common elements that CETA counselors learn include a number of basic therapeutic elements like encouraging participation and introducing the treatment, seven therapeutic methods, plus two additional ones to address alcohol abuse and suicidal thoughts. They are then trained to plan different “flows” of these common elements for a client. Such a flow could look like this:

- 1) Encouraging participation,
- 2) CETA introduction,
- 3) Thinking in a Different Way - Part 1,
- 4) Talking about Difficult Memories, and
- 5) Thinking in a Different Way - Part 2.

The treatment takes about 8-12 sessions, in which the counselor gradually introduces new elements and continuously monitors and adapts the process. The plan for the flow is also flexible and can be adapted, if needed, based on individual client response to components and

answers on the weekly monitoring form. The counselor learns to do this in a two-week intensive training. After the training, they continue practicing in groups, with pilot cases, and then start working under close supervision. This method relies on three layers of people: Trainers, supervisors, and the counselors. The trainers, usually from outside of the intervention area, train both supervisors and counselors during the intensive 2-week period. The supervisors are local individuals, trained as counselors, but selected to handle the additional responsibilities. This structure implies that, over time, the program can become independent of technical support from CETA, making it sustainable in the long-term.

The approach has now been tested globally. Studies were conducted in Iraq (Murray et al. 2014; Weiss et al. 2015), the Thai-Burma border (Murray et al. 2014; Bolton 2014), and Colombia (Pacichana-Quinayáz et al. 2016). Results of these studies showed consistent positive results.

The counselors were able to adhere to the protocol, perform well in role-plays, and

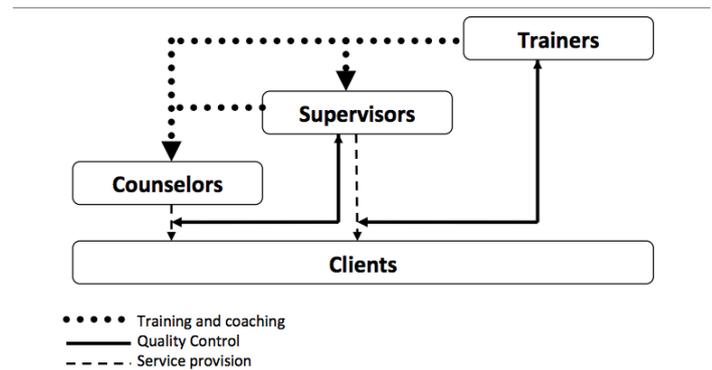


Figure 2: Apprenticeship model (Murray et al. 2011)

reduce symptoms of mental disorders in real life settings (Murray et al. 2014; Bolton et al. 2014; Pacichana-Quinayáz 2016; Weiss et al. 2015). Their supervisors were able to ‘catch’ errors in counselor practice and skillfully correct them (ibid). In the first major study by Murray et al. (2014), average weekly symptoms significantly decreased in both Iraq and on the Thai-Burma border. Bolton et al. (2014) published the quantitative results of the pilot study on the Thai-Burma setting, as compared a wait-list control (WLC) group. This study showed a 77% reduction in overall scores compared to baseline score for the CETA group, while the control group score reduced 44% (Bolton et al. 2014). The authors concluded the treatment is highly effective (Bolton et al. 2014). These findings were confirmed by Weiss et al. (2015) in another controlled study in the Iraqi context. This study showed large significant effect sizes for all outcomes, compared to only small changes in the wait-list control group (Weiss et al. 2015). Pacichana-Quinayáz et al. (2016), in the Colombian setting, studied CETA without a control group, but gave a quantitative description of the impact of the treatment. Interviewees noted early decrease in anxiety and increase in hope in their clients, which were maintained as clients became better equipped to deal with their anxieties and gained a renewed positive outlook on life (Pacichana-Quinayáz 2016). Clients were positive about the treatment, and expressed the therapy was an emotional release (Pacichana-Quinayáz et al. 2016).

# Chapter 6

## Recommendations and Conclusion

On the basis of the literature review presented in this document, experience of AAPP's MHAP team and different stakeholders in Burma, AAPP has compiled a list of recommendations for the Ministry of Health and Sports and mental health practitioners in Burma. They represent a list of measures that appear most urgent, realistic, cost-effective, and are based on evidence and on examples of best practice. These recommendations are in line with recommendations by the WHO.

AAPP strongly urges the **government** to:

1. Make the development health policy and the new health legislation a **transparent and collaborative process**, consulting the relevant stakeholders from the health sector, academic institutions, civil society, and more;
2. Focus on providing **community based care** rather than institutionalized care;
3. Participate in **networks** of mental health service providers, academic institutions, social services, and relevant public service providers; and support the formation of these networks where possible;
4. Integrate mental health services in **public institutions** including the legal system, schools, maternal care, and elderly homes, for an early detection of vulnerable individuals;
5. Create a system of **certification** for the recognition of evidence-based training of non-specialist providers, such as CETA providers;
6. Implement population-based interventions, such as a mass-media campaign on Facebook, to **target stigma** in Burma; give attention to mental health in public speech for the same reason; and be sensitive to stigma when implementing mental health interventions;
7. Enable **researchers** of mental healthcare in Burma to narrow the knowledge gap in mental healthcare in Burma;
8. Increase the share of **funding** for health that is attributed to mental health; and
9. **Realize the nine objectives** set out by the Government.

AAPP strongly urges **mental health practitioners** in Burma to:

1. **Advocate** for mental health with all relevant stakeholders, including the Government
2. Give priority to **community based** healthcare

3. Participate in **networks** of mental health service providers, academic institutions, social services, and relevant public service providers; and support the formation of these networks where possible;
4. Raise awareness for mental health in the community to target **stigma**, and be sensitive to stigma in their work; and
5. Contribute to **research** to close the knowledge gap in mental healthcare

AAPP strongly urges **all other individuals**:

1. **Advocate** for mental health with all relevant stakeholders, including the Government;
2. Support the integration of mental healthcare in **public services**, such as the legal system, schools, maternal care, and elderly homes where possible;
3. Participate in **networks** for mental healthcare where they can contribute;
4. Raise awareness for mental health in the community to target **stigma**, and be supportive of individuals with mental disorders in their environment; and
5. Contribute to **research** to close the knowledge gap in mental healthcare.

This list is by no means comprehensive of all needs of the mental health system. But AAPP is convinced that if the Government recognizes and implements these recommendations, it would resolve some of the most important bottlenecks in the provision of mental health in Burma and drastically improve access to treatment for the thousands of people suffering from CMHDs and other mental health disorders in Burma.

The mental healthcare system in Burma has suffered neglect, and levels of common mental health disorders in the country are soaring high. Especially after years of military dictatorship, the Burmese people are in dire need of mental healthcare. Building such a system will take well-directed dedication, adequate funding, and time. Due to such little infrastructure that currently exists, many hurdles will have to be faced. Education to produce mental health professionals is underdeveloped, there are too few mental health experts to guide the process, pervasive stigma is smothering demand for mental healthcare, and inadequate understanding of mental health disorders prevails in all levels of society. With sufficient research and expertise currently available, it is all possible to build a mental health system in Burma. We now know that there are many evidence-based methods to treat patients suffering from common mental health diseases, to scale up treatment, and to lift stigma. This process needs to be kickstarted as soon as possible, to provide the Burmese population with the mental healthcare they deserve.

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## Figures

Figure 1: Saraceno B, Gater R, Rahman A, Saeed K, Eaton J, Ivbijaro G, Kidd M, Dowrick C, Servili C, Funk MK, Underhill C. 2015. Reorganization of mental health services: from institutional to community-based models of care. Eastern Mediterranean Health Journal. 21(7)

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## Recommended Readings

### Reports:

#### **Global 2013-2020 Mental Health Action Plan**

World Health Organization (WHO). 2013. Mental health action plan 2013-2020. Available online from: [http://apps.who.int/iris/bitstream/10665/89966/1/9789241506021\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/89966/1/9789241506021_eng.pdf?ua=1) (last accessed May 2017)

#### **On CETA**

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#### **On Stigma**

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#### **On Mental Health Disorders in LMICs**

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#### **On Integration into Priority Care**

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### **On Integration into Primary Care**

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### **On Human Resources**

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### **Other media**

Mental Health for All by Involving All | Vikram Patel | TED Talks  
<https://www.youtube.com/watch?v=yzm4gpAKrBk>

Mental Health Innovation Network

<http://www.mhinnovation.net/>

Movement for Global Mental Health

<http://www.globalmentalhealth.org/>

## **Author Acknowledgements**

Ronja Baatz

MHAP supervisor and counselling team.

Martha Snow