WHO-AIMS REPORT ON
MENTAL HEALTH SYSTEM
IN LAO PEOPLE’S
DEMOCRATIC REPUBLIC

World Health Organization

MINISTRY OF HEALTH, LAO PDR
WHO-AIMS REPORT ON MENTAL HEALTH SYSTEM
IN LAO PEOPLE'S DEMOCRATIC REPUBLIC (LAO PDR)

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

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The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system of Lao People's Democratic Republic (Lao PDR).

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Data was collected in 2011 and based on the year 2010.

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The WHO-AIMS project is coordinated by Dr. Shekhar Saxena.
Executive Summary

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Lao PDR. The information collected is used to improve the mental health system and to provide a baseline for monitoring the change. This will enable Lao PDR to develop information-based mental health plans and targets using adequate baseline information. It will also be useful to monitor progress in implementing reform policies and strategies, delivering community services, and involving users, families and other stakeholders in mental health promotion, prevention, treatment and rehabilitation. Data for this study was collected in 2011 and based on the year 2010.

Lao PDR's first mental health policy was implemented in 2007 and include the following components; (1) developing a mental health component in primary health care, (2) involvement of users and families, (3) advocacy and promotion, (4) human right protection of users, and (5) equity of access to mental health services across different groups. However, the policy provides limited guidance and direction for community mental health services implementation, human resource development, and mental health services financing, research, quality improvement, and monitoring.

Lao PDR does not have a specific mental health law and hence mental health is governed by the general public health law. There is no existing independent human rights review body, and no data on training in human rights provided for general practitioners or mental health workers. There is no data on how many percent of health care expenditure were allocated for mental health. It is estimated that less than 1% from the total health care budget is allocated for mental health care. Although there are government and commercial insurance schemes, coverage is generally very limited and negligible for psychotropic medications.

A national mental health strategy and action plan is in the process of development by the mental health strategy development committees assigned by the Ministry of Health. It is expected to be completed and approved by the Ministry of Health in 2012.

There is no separate mental health authority body in the country and the Ministry of Health Department of Healthcare, Division of Rehabilitation and Treatment for Substance Abuse and Mental Health is overseeing health care service includes mental health activities.

There are only 2 inpatient and 3 outpatient mental health treatment facilities in the country including a NGO-run outpatient service which provides outreach community based treatment and training to local people and staff at district hospitals. At three outpatient facilities, there were only two out patients provided data for this study. The two outpatient facilities reported 3,381 users were treated in 2010. The only available inpatient mental health services in the country are the 15-bed psychiatric unit in Mahosot hospital and the 20-bed at103 Military hospital in Vientiane Capital (less than 1 bed per
100,000 populations). This is an increase from 15 beds in 2007. The inpatient units had 988 admissions in 2010. The patients admitted to the in-patient facilities had a diagnosis of mood disorders (38%), schizophrenia and related disorders (18%), substance use disorders (16%) etc. There are no stand-alone mental hospital and day treatment facility in the country.

There are no forensic beds or prison mental health facilities. Involuntary admissions and the use of restraints or seclusion are conducted in the in-patient units. However, restraint and seclusion are utilized only for those patients who are at risk of harming oneself and others during a psychotic episode. Primary health care staff has limited training in mental health and interaction with mental health services.

Only 42 personnel are working in mental health facilities in the country, providing mental health services to the 6 million populations; 2 psychiatrists, 1 neurologist, 10 general practitioners, 18 nurses, and 11 others health workers. There are no psychiatric nurses, clinical psychologists, social workers, or occupational therapists working in the country. One psychiatrist works for government administered facility and the other work for NGO.

Access to mental health facilities is uneven across the country. Only people who live in or near the capital city have access to mental health services. For those who live in the rural areas they would need to travel to mental health services at Mahosot or Military 103 Hospital in Vientiane Capital city to access care. It is estimated that 75% of the Laotian people live in rural areas where no mental health services of any kind are available.

Public education and awareness campaigns are very limited. There are links with other relevant sectors such as the Ministry of Labor and Social Welfare, but there is no legislative or financial support for people with mental disorders. There are no consumers and family associations in the country. Data are collected and compiled annually to varying extent by the mental health facilities. No national report has been produced by the government based on these data and no research on national study of mental health prevalence in the country has been done. In addition, both epidemiological and clinical assessments of mental disorders and services have never been conducted in the past.

In Lao PDR, the mental health system has not been well established. It needs immediate attention from the government and private sectors to strengthen and develop the system. There is an urgent need to create mental health resources and information and to increase mental health manpower. Despite the beds increase in the last years (from 5 to 15 at Mahosot mental health unit and 5 to 20 at Military hospital) at present mental health units are working beyond their capacity. Mental health facilities are also needed for children and adolescents. Training for primary health care staff in mental health needs strengthening as well as interaction between the primary health care and mental health system. Few psychotropic medications are available, but only a small fraction of the population has free access to it.

Lao PDR has a mental health policy which was established comparatively recently. However, the mental health plan and strategy is not available yet. Community care for
patients, as seen in many low and lower middle income countries, remains limited. Unlike the majority of countries in the world and the region there is no mental health law in Lao PDR. The country spends less than 1% of the health budget in mental health. The poor involvement of primary health care services in mental health is also a feature shared with many low and lower middle income countries. The number of inpatients, outpatients and community mental health facilities is scarce. The number of psychiatrists per 100,000 population is among the lowest in Asia (Mental Health Atlas WHO, 2005).

In the last 30 years, the number of outpatient and inpatient facilities has not grown significantly throughout the country. Efforts have been made to improve the quality of life and treatment of patients in general hospitals and some aspects of life in hospital have improved. Unfortunately, the lack of human and financial resources in mental health continues to be significant barriers to progress of the development of the services. As a result, little progress has been made in provision of affordable treatment and management in the community.
Map of Lao PDR
Introduction

Lao PDR is classified as a middle lower income country by the Word Bank. The country is landlocked and has an approximate geographical area of 236,800 square kilometres and a population of about 6 million people (WHO, 2007). The country shares border with China, Vietnam, Cambodia, Myanmar, and Thailand. Population density is 24 people per square kilometre. The average family size in 2005 was 4.5 children per family.

There are 49 officially recognized ethnic groups, each with different cultures, traditions and livelihood systems. Many of the minority ethnic groups live in remote, rural, and highland areas of the country and constitute around 32% of the population. The official languages use in the country is Lao. Buddhism is the major religion practice in the country but Islam, Catholicism, Christianity, and others are also practiced.

Administratively, the country is divided into 17 provinces and 140 districts of which 47 are considered the poorest. The majority of the poor are ethnic minorities, whom traditionally live in remote mountainous areas. Thirty-nine percent of the population is under the age of 15 and 3.8% of the population are over the age of 65. Life expectancy at birth for males is 62 and for females is 64 years, infant mortality is 42 and under-five mortality 59 per 1,000 live births while maternal mortality stands at 405 per 100,000 live births (WHO, 2010). The health status however remains one of the lowest in the WHO Western Pacific Region.

Per capita gross domestic product (GDP) as of 2008 was US$ 740 with gross national income per capita (PPP international $) 2,050. According to the WHO report (2008) from 2003-07 the average economic growth rate was 7.30%. As of 2006, 75% of the population lived in rural areas and almost 35% of the population is living below the poverty line or less than $1 per day (WHO, 2008). The average monthly per capita expenditure is US$13.4 and the average household size is 5.9 people (WHO 2009).

According to census 2007, there are a total 22 main general hospitals, 3 specialized hospitals, 127 district hospitals, and 746 health centres with a total of 6,739 hospital and health centre beds in the country. There are .067 hospital beds per 100,000 population and 1,672 general practitioners which include medical doctors, medical assistants, dentists, pharmacists, and laboratory staff. There is no private hospital in the country. However, there are 254 private outpatient clinics throughout the country as of 2009 (WHO 2009).

Only 4.1% of government expenditure in 2009 was spent on health care. It is estimated that out of pocket paid by patients account for approximately 52% of total health expenditure, donors 30%, the government 15% and the remainder by various social health protection schemes (Lao National Health Account 2006-7). Current government investment to address the future burden of non-communicable diseases such as injuries and mental health is still minimal.
Despite the market-oriented growth that takes place in the country since 1986, the Ministry of Health remains virtually the only public provider and administrator of health. However, a range of international non-governmental organizations (INGOs) also play an increasingly important role in the health sector.

The health care system and delivery including mental health service in Lao PDR is centralized. The health sector is governed by several policies and four laws including the Law on Health Care of 2005. In 1995, with the Prime Ministerial Decree No. 52, the government authorized the collection of official user fees at health facilities. Although the Decree provided exemption of fees for the poor, the law enforcement and the implementation of the exemption policy have not been uniform across various settings.

The relatively poor health infrastructure and difficult terrain in the poorest parts of the country pose challenges to effective health services delivery. Utilization of many rural health facilities remains low. The shortage and unequal workforce distribution as well as the lack of qualification and motivation for many health staff remain critical issues; the shortage of qualified health workers in rural areas is of particular concern.

For the last 30 years effort have been made to improve mental health training and services but with limited success. To date mental health system, human resources, and services are remain scarce.
Policy and Legislative Framework

Policy, plans, and legislation

1. Lao PDR's first mental health policy was implemented in 2007 and included the following components:
   (1) developing a mental health component in primary health care,
   (2) involvement of users and families,
   (3) advocacy and promotion,
   (4) human right protection of users, and
   (5) equity of access to mental health services across different groups.
   The current policy provides limited guidance and direction for community mental health services implementation, human resource development, and mental health services financing, research, quality improvement, and monitoring. Emergency/disaster preparedness plan for mental health are also not available.

   The mental health policy extends over 4 years and will expire at the end of 2012. The new or revised version has not yet been considered by the Ministry of Health. Effort has been made to revise the first mental health policy before it expires but this requires more attention by the responsible authority.

   There is currently no mental health legislation in Lao. Mental health legislation was mentioned in the policy but little information has been given to describe the content of the legislation. It is not clear whether legislation mentioned in the policy has been considered by the relevant parties. Based on the policy as it is written, it is unlikely to result in specific mental health legislation because it did not provide any sufficient information and guidance for future mental health implementation.

   The first Lao PDR National Mental Health Strategy and Plan has been drafted under support from WHO country office, Ministry of Health, and international NGO BasicNeeds in collaboration with the working group for mental health plan and strategy designated by Ministry of Health. The mental health strategy and plan will be published in 2012 after it is endorsed by the Ministry of Health. Mental health strategy and plan has targeted several important tasks that need to be achieved within five years time frame in order to accomplish sustainable mental health capacity building. The Lao PDR National Mental Health Strategy and Plan has prioritized the following tasks: 1) increase mental health training for general and alliance health care practitioners; 2) development of research capacity building in collaboration with domestic and international organizations; 3) enhance service delivery, evaluation, and monitoring from the national to the local level; and 4) increase mental health promotion and advocacy as well as policy and legislation. All of these efforts aim to improve mental health capacity building, reduce the gap in mental health treatment and enhance services availability, and increase knowledge and skills in mental health treatment, research and training as well as developing human resources within the country. The National Mental Health Strategy
and Plan also provides specific strategy and guidance to achieve each target including financial support for future mental health research, service, training, and delivery.

There is an essential medications list presently in the country. The current psychiatric and antiepileptic medicines available in the country are Haloperidol, Olanzapine, Chlorpromazine, Amitriptyline, Fluoxetine, Valproate Acid, Carbamazepine, Phenobarbital, Valium, and Deanxit. However, these medications are not always available or accessible at the local or district hospitals.

**Financing of mental health services**

The Lao National Assembly approved 9% of GDP (GDP for 2010 was about 6.3 billion US dollars) to Ministry of Health for healthcare expenditure for 2010-2011. However, according to the Ministry of Planning and Investment reported (unpublished paper), there was only 2% of GDP was allocated for 2010-2011 healthcare expenditure. No specific information is given for percentage of mental health expenditure from the general health budget or the annual governmental spending on mental health services. It is estimated less than 1% of total health budget is directed towards mental health service and treatment. According to the new health care service reform system, all service users will have to pay for medications and services fee. For those who have medical insurance, medication and services fee are covered but very limited. For none-insurers medications and services fee are paid out of pocket. The health care service fee is still considered low compared to many low income countries. In terms of out-of-pocket costs, the cost of antipsychotic medication is 1,600 kips or 20 cents (US dollar) per day, and the cost of antidepressant medication is 1,000 kips or 12 cents per day. Despite such low cost, 34% of the population who live under $1 per day will not be able to pay for such medications or hospital bed fee.

Health care sector is governed by several policies and four laws including the Law on Health Care of 2005. In 1995, with the Prime Ministerial Decree No. 52, the Government authorized the collection of official user fees at health facilities. Although the Decree provided exemption of fees for the poor, the law enforcement and the implementation of the exemption policy have not been uniform across the settings. For poor patients who can not afford to buy medications because of financial hardship he/she is required to get certified letter of their poverty from local authority. The letter will be attached to the prescription to show the hospital’s administrative staff for approval to get free medications. However, this policy is limited to Mahoshot hospital where majority of psychiatric medications are available in the hospital. For other hospitals included provincial and district hospitals where there are no mental health unit attaches to the hospital, very few psychiatric medications are available in those hospital. In most cases, patients will have to buy medications from drug store outside hospital by their own expense and is not reimbursable from hospitals or government.
**Human rights policies**

There is no separate national human rights review body which has the authority to oversee inspections in mental health facilities and impose sanctions on those facilities that persistently violate patients' rights. There is also no human rights review system generally in the country. There is no data or information on whether human rights protection training has been offered to mental health and general medical providers working in inpatient or outpatient settings in the past or previous years. However, protection of rights of patients and the access to medical and mental health services is mentioned in the mental health policy. The Ministry of Health and other relevant ministry such as Ministry of Security and Interior, Ministry of Labour and Social Welfare, and Lao Women Union are key organizations that have a role in overseeing human right protection and could conducting inspection if there is suspicion of any violation of patient’s rights.

**Mental Health Services**

**Organization of mental health services**

The Division of Rehabilitation and Treatment for Substance Abuse and Mental Health at the Ministry of Health and the provincial public health departments are responsible for the national and regional mental health administration. This Division have worked together with WHO Lao PDR and NGOs to provide advice to the government on mental health policies and legislation. Mental health services are still very limited in the country. Mental health services are not organized in terms of geographical catchment or service areas. People can access basic mental health service and treatment from some general practitioners at district levels and from central hospitals. However, treatment remains very limited due to limited skills among general practitioners and lack of mental health service delivery, and treatment including psychotropic medications.

Mental health service planning, evaluation and monitoring and quality assessment of mental health services are limited due to lack of mental health expertise, manpower and skills as well as financial support to conduct these activities.

**Mental health outpatient facilities**

There are three adult outpatient mental health facilities available in the country, but no separate facilities for children and adolescents due to lack of financial support and expertise to treat child /adolescent. However, children and adolescents can access treatment at these three adult outpatient mental health facilities.

In the past year, there were 3,381 outpatient contacts from these three facilities. One facility provided only data on outpatient contacts (630 contacts) and was excluded from further analysis due to lack of information on gender and disorders treated at the facility.
Of the 2,751 users treated at the two mental health outpatient facilities, 39% users are female but no children or adolescents were officially recorded even though verbal reports from the directors of these facilities indicated that children and adolescent were seen in the past year. As there is no computerised health information recording system, daily data collections at the facilities are hand written into the statistic books which may be inaccurate.

The users treated in the outpatient facilities are primarily diagnosed with neurotic, stress related, or somatoform disorder (23%), and schizophrenia, schizotypal and delusional disorders (8%). The average number of contacts per user is 1.23. There was no information collected regarding follow-up care in the community. After discharge from inpatient unit, patients usually return to the mental health outpatient services only for medications refill. No community-based or mobile after care services is available in the country.

In terms of available interventions, few (less than 20%) of users have received psychosocial interventions in the past year. All mental health outpatient facilities had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility or a nearby pharmacy all year round.

Mental health outpatient services are attached to the inpatient units at the teaching hospital and military hospital in the capital city. The third outpatient facility is run by the NGO, BasicNeed, in collaboration with district hospitals around Vientiane Capital and one central province in the country. There are difference kinds of services that BasicNeed has provided ranging from diagnostic assessment, basic individual and group counseling, monthly case management and home visit, life skill training, and vocational training and reintegrating to workplace.

Patients can also access basic mental health outpatient services at some provincial hospitals through general outpatient clinic. However, the outpatient mental health services are limited to only prescribing psychiatric medications and traditional psychoeducation. There is no system of scheduling appointment for follow up. Patients are responsible for attending to refill medications within a certain period of time. No psychotherapy, clinical social service, and occupational therapy are provided at the outpatient. DSM and ICD are not strictly used to diagnosis mental disorders by the providers. The methods of diagnoses are based on local and cultural appropriate knowledge with certain criteria adapted from previous DSM version and ICD. There are no detail patient’s information files available for review. Mental health treatment and service at provincial and district hospitals were not available for this study. The majority who use services at these facilities are living in the capital city or nearby cities. Few people can afford treatment at few private mental health clinics or neighbouring countries such as Vietnam and Thailand.

Data from private mental health clinics are not available for this study, and also due to poor data collection system, it is likely that the number of mental health outpatient user is
under-reported and the actual number might be higher if there is an established data collection system available.

**Day treatment facilities**

There is no day treatment facility available in the country. Those with mental illness usually receive informal care from their family members or neighbours.

**Community-based psychiatric inpatient units (psychiatric beds in general hospital)**

There are two general hospital psychiatric inpatient units with total of 35 beds available in the country (less than one bed per 100,000 populations). About 40% of admitted to these inpatient units are female and the recorded number of children and adolescents admitted to these beds is not known.

The admission diagnosis for these inpatient units were mood affective disorders (38 %), schizophrenia and related disorder (18 %), substance use disorders (16%) etc. There is no data collected on the average number of days spent in the inpatient units. However, verbal estimates by the directors of the inpatients units that the average number of days spent in inpatient is around 3 to 30 days. Only a few (less than 20%) users have received psychosocial interventions in the past year while all general hospital psychiatric inpatient units had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) available in the facility.

**Mental hospitals**

There is no stand-alone mental hospital in the country. There are only two general hospital psychiatric inpatient units and one NGO community mental health service that are available in the country.

**Community residential facilities**

There is no community residential facility available in the country for children, adolescent, adults, or geriatric patients. The mental health policy endorsed in 2007 did not mention or recommended any community residential treatment facilities. Community residential treatment for mental health and general health services have never existed in the country. However, the community mental health residential treatment for children and adults are recommended in the national strategy and plan. The lack of community residential treatment is due to the lack of infrastructure, funding, and service providers who can monitor and run the facility.
Forensic and other residential facilities

Apart from beds in the psychiatric facilities mentioned above, there are no forensic or other residential facilities such as homes for persons with mental retardation, detoxification inpatient facilities, homes for the destitute, etc. No forensic inpatient unit exists in both military and civilian hospitals.

There is no information on how persons with mental illness will be treated in institutions or prisons. In addition, there is no shelter for homeless mentally ill people available in the country. According to the current system, mental health units are the only facilities that provide treatment for forensic patients in the country. There is no bed reserve for forensic patients at the mental health facilities. The forensic patients who are not violent would share room with other general psychiatric patients. For severe and violent cases, there are seclusion room to lock them up at the mental health units.

Human rights and equity

There is no data on involuntary patient admission to these units available for this study. Involuntary hospitalization by the mental health care providers rarely occurs. However, there might be involuntary admitted persons with mental illness by the family member but such data is not available.

There is no data on how many patients were restrained or secluded at least once within the last year in general hospital psychiatric inpatient units. All the psychiatric beds in the country are located in the capital city. Those living in the rural areas of the country can access mental health services at the capital city only if they can afford travel to the capital city. Inequity of access to mental health services for other minority users (e.g., linguistic, ethnic, religious minorities) is a major issue in the country.

In addition, mental health facilities and treatment are not available at the provincial level for the majority of ethnic minorities living in rural areas. Although persons with mental illness might be able to access treatment at the general provincial hospital, very few provincial hospitals are able to provide mental health services due to lack of mental health specialists. In the past, there were few general practitioners from provincial hospitals who received short-term training at the mental health unit and then returned to work at the provincial hospitals. Lack of mental health providers in the country, mental health education and campaign and mental health budget is likely to contribute to unequal access to mental health services among ethnic minority groups.

Mental health education and campaign via mass media is very limited and almost non-existent in the country. Perception of mental illness and mental health treatment among ethnic minority are likely to be different. In addition, pattern of help seeking behaviour, cultural belief and attitude towards mental illness and treatment among each group is not well understood. Similar to other country, there is still stigma attached to mental illness and mental health treatment. Therefore, majority of those with mental illness would seek help from other providers such as traditional healers, Buddhist temples or monks, and
spiritual healers rather than mental health specialists. Accepting treatment from mental health facilities is usually seen as the last resort.

**Summary Charts**

*Psychiatric beds in the country are provided by general hospital psychiatric units, and no beds in residential units or other mental hospital exist in the country.*

*The majority of the users are treated in outpatient facilities while the rate of users treated in inpatient units is lower. There is no residential, forensic unit and mental hospital that exist in the country.*
Female users make up 40% of all users of mental health facilities in the country. The proportion of the female users in inpatient unit is a little slightly higher than female users in outpatient units. There is no residential, day treatment, and mental hospital that exist in the country.

Data on children and/or adolescents was not available. Verbal reports from directors of mental health facilities indicates that there were children/adolescents treated in both inpatient and outpatient facilities but such data is not available.
The distribution of diagnoses varies across facilities: in outpatients facilities neurotic and other disorders are most prevalent followed by schizophrenia and related disorders; within in-patient unit mood disorder and others affective disorders are most common followed by schizophrenia and substance abuse disorders.

The longest length of stay for users in community residential facilities is between 3 to 30 days. There is no residential and mental hospital that exists in the country.
Mental Health in Primary Health Care

Training in mental health care for primary care staff

Only 1% of the training for medical doctors and nurses is devoted to mental health. There is no data available on mental health training given for other primary health care workers.

In terms of refresher training, 1% of primary health care doctors and nurses have received at least two days of refresher training in mental health. There is no information whether other primary health care workers have received refresher training in mental health.

Some mental health training at the district and provincial hospitals or community level has been provided by NGOs. However, the training by NGO was limited to the districts closest to the capital city due to capability and project sites chosen agreement by the NGO and MOH. Most of the information regard to training at the district level come from personal communication with staff at the provincial and residents who attended the trainings.

Mental health in primary health care

Both physician staffed primary health care (PHC) and non-physician staffed PHC clinics are present in the country. There may not be any mental health treatment protocol available in the country. Most treatment strategies are based on physician’s experience and judgement. The majority of physician-staffed primary health care clinics (between 1%-20%) make on average at least one referral to a mental health professional. Most of these clinics, however, might make more than one referral per month if the clinics are located near the capital city where mental health services are available. Verbal reports from the general practitioners suggest that non-physician staffed primary health care clinics make a referral to a higher level of care at least one referral per month (e.g., mental health professional or physician-staffed primary health clinic). No system of referral exists in the country. Usually, physician and non-physician verbally refer patient to specialist instead of formal written referral. For this reason, it is difficult to gather data on number of patients referred to mental health specialist by physician and non-physician.

In terms of professional interaction between primary health care staff and other care providers, a few (less than 20%) of primary care doctors have interacted with a mental health professional at least once in the last year. It is also assumed that only a few of physician-staffed primary health care clinics (less than 20%) have had interaction with a complimentary/alternative/traditional practitioner, in comparison to all or almost all of the non-physician staffed clinics. There is no information available regarding physician-staffed PHC clinics that have interaction with a complimentary/alternative/traditional practitioner, in comparison to 0% of non-physician-based PHC clinics, and 0% of mental health facilities.
**Prescription in primary health care**

Non-doctor/non-nurse primary health care workers are not allowed to prescribe psychotropic medications by health care law. However, physician assistants are allowed to prescribe in emergencies and remote areas where there are no physicians available. Most of the primary health care clinics located in remote or rural areas of the country have primary health care nurses, certified nursing assistance, and physician assistants. In the major hospitals, physician assistants will be allowed to prescribe medication under supervision of physicians. In contrast, primary health care doctors are allowed to prescribe without restriction. As for availability of psychotropic medicines, a few physician-staffed PHC clinics (less than 20%) have at least one psychotropic medicine of each therapeutic category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) available in the facility or at a nearby pharmacy all year long, in comparison to none in the non-physician staffed primary health care.

Although the healthcare law has prohibited non-physician to write prescription, the law is not strictly enforced. Majority of drug stores sell medications to people without prescription from the doctors. Patients usually obtain medications from drug stores without getting prescription or advice by physician. In many parts of the country, non-physician and nurses often write prescription for patients illegally in the community. Hospital patients need to obtain prescription from doctors in order to obtain medications from hospitals’ drug stores.

**Human Resources**

**Number of human resources in mental health care**

Of the 42 personnel working in mental health facilities in the country, there are 2 psychiatrists, 1 neurologist, 10 general practitioners, 18 nurses, and 11 others health workers including auxiliary staff, non-doctor/non-physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counselors who are currently providing mental health services. There are no psychiatric nurses, clinical psychologists, social workers, or occupational therapists working in the country. One psychiatrist works for government administered facility and the other work for NGO. All of the nurses work in government administered mental health facilities, and none work for NGO or for both the sectors.

The distribution of human resources between urban and rural areas is disproportionate. The density of psychiatrists in or around the largest city is 0.67 times greater than the density of psychiatrists in the entire country. The density of nurses is 6 times greater in the largest city than the entire country.
GRAPH 4 - HUMAN RESOURCES IN MENTAL HEALTH
(rate per 100,000 population)
Regarding the workplace, 1.5 psychiatrists work in outpatient facilities, 0.5 in general hospital psychiatric inpatient units. Six other medical doctors who are not specialized in mental health work in outpatient facilities, and 5 in general hospital psychiatric inpatient units. As for nurses, 9 work in outpatient facilities, 9 in general hospital psychiatric inpatient units. There is no psychosocial staff including psychologists, social workers or occupational therapists who works in the country. As regards to other health or mental health workers 7.5 work in outpatient facilities and 3.5 in general hospital psychiatric inpatient units. In terms of staffing in mental health facilities, there are 0.01 psychiatrists per bed in general hospital psychiatric inpatient units. As for nurses, there are 0.26 nurses per bed in general hospital psychiatric inpatient units. Finally, for other mental health care staff (e.g., psychologists, social workers, occupational therapists, other health or mental health workers), there are 0.11 per bed for general hospital psychiatric inpatient units.
Training professionals in mental health

The number of professionals who graduated last year in academic and educational institutions per 100,000 is as follows: 202 medical doctors who are not specialized in psychiatry; 150 nurses who are not specialized in psychiatry; no psychiatrists, psychologists, nurses, or occupational therapists with at least 1 year training in mental health care. No psychiatrist emigrated to other countries within five years of the completion of their training. None of the mental health care staff have received at least two days of refresher training in the rational use of drugs, psychosocial interventions, and child/adolescent mental health issues within last two years.

In fact, there have been mental health workshop and training for general practitioners within last two years. However the training and workshop were focused on general mental health issues but not specific to rational drug use. For example, there was mental health training workshop (5 days) provided for general primary care physicians and nurses from provincial hospitals by the ministry of health department of substance abuse and mental health in collaboration with BasicNeeds (an community mental health NGO in Lao PDR) under funding support from WHO country office. The training was focused on mental health disorder in adults.

The Mahosot mental health unit has provided mental health training to general practitioners at the provincial hospitals as well as in house training for staff from provincial hospitals within last 5 years. BasicNeeds organization has also provided mental health training to medical doctors, nurses, village volunteers at district hospitals within nine districts around Vientiane province. BasicNeeds has extended its program to
the central part of the country where staff from three district hospitals and provincial hospital will receive training on providing mental health treatment and outreach at community level. BasicNeeds also provides supervision, evaluation, and monitoring to district hospitals staff over time.

Mental health lecture series was also provided to internal medicine and pediatric residency training program this year through joint sponsorship between WHO and Health Frontiers, an NGO volunteer organization.

GRAPH 6 - PROFESSIONALS GRADUATED IN MENTAL HEALTH

Consumer and family associations

There are no consumer and family associations in the country. However, family involvement is a crucial part of mental health treatment and recovery. Mental health facilities usually involve family in develop treatment plan and assist patient during or after leaving hospital. Family members usually stay at the hospital to assist patient for daily activities during hospitalization. Family are also involved in the support group and psychosocial support with other families during hospitalization. However, the involvement of family in the patient care plan and interaction of consumer and family with mental health facilities remains limited. Consumers and families are not involved in the formulation or implementation of mental health policies, plans, or legislation. However, other NGOs in the country, for example, BasicNeeds has involved families in activities such as counselling, housing, support groups, vocational training, and advocacy for schooling or work.
Public education and links with other sectors

Public education and awareness campaigns on mental health

Mental health awareness and campaign is very limited in the country. There may be a few mental health promotion, public education, and awareness campaigns in the last five years by an NGO or international organizations in collaboration with ministry of health and mental health unit as well as government on the World Mental Health Day. However, there is no coordinating body that oversee public education and awareness campaigns on mental health and mental disorder.

Legislative and financial provisions for persons with mental disorders

There are no legislative and financial provisions that provide support for persons who are mentally ill or disabled. However, public health and labour laws state the right of equal opportunity and non-discrimination for disabled persons to obtain employment and receive benefit from employers. However, these laws were not strictly enforced and many people who are disabled and have mental disorders still face difficulty obtaining jobs and education. This may not only be due to discrimination but may also be related to family protective factor and the lack of social and job skills of mentally ill person themselves. In Lao PDR, financial support for mental illness is dependent on family members. Disabled people have very limited financial support from the government. People who are injured at work would have financial compensation and support from work place and ministry of labour and social welfare. However, the support is very minimal compared to other countries. There is no social security and disability system in the country. There is no provision concerning priority in state housing or in subsidized housing schemes for people with severe mental disorders.

Links with other sectors

There are no data on any formal collaboration between the government department responsible for mental health and the departments/agencies responsible for child and adolescent health, education, welfare, or criminal justice. In terms of support for child and adolescent health, no primary and secondary schools have either a part-time or full-time mental health professional, and many schools do not have school-based activities to promote mental health and prevent mental disorders. Regarding mental health activities in the criminal justice system, there is no data on mental retardation or prisoners who have treatment from mental health professional. There is no written information and data for training for police officers, judges, and lawyers from mental health units or from either two psychiatrists or organizations that have provide or participated in mental health education in the last five years. In terms of financial support for users, none of mental health facilities have access to programs outside the mental health facility that provide
employment for users with severe mental disorders. Finally, few people who receive social welfare benefits do so due to a mental disability.

**Monitoring and Research**

A formally defined list of individual data items that ought to be collected by all mental health facilities does not exist. This list includes the number of beds, admissions, involuntary admissions, length of stay, and patient diagnoses. The government health department receives minimal data of general hospital psychiatric inpatient/outpatient units, and majority of mental health outpatient information was reported by BasicNeeds facilities. Based on this data, a report focusing on mental health situation analysis, community outreach and service was published. In terms of research, few health publications in the country have been on mental health.
Next Steps in Planning Mental Health Action

From the findings of the study on Assessment of Mental Health Systems in Lao PDR using WHO-AIMS, next steps in planning mental health action are suggested as below;

- Development of mental health strategy and plan.
- Revision of the mental health policy needs to be considered by the government and relevant parties.
- Development of a data collection system on mental health. Skills training on data collection, monitoring and evaluation should be given to staff who responsible for data collection and recording at provincial to MOH level.
- Strengthening of mental health related infrastructure and manpower. Delivering training to existing primary healthcare staff is needed.
- Mental health and behavioral health teaching need to be integrated into primary care training curriculum and primary care treatment systems.
- Development/adaptation of standard treatment guidelines/protocol and a referral system to streamline community based care and institutional interventions.
- Mental health campaign in collaboration with government and NGOs using local concept with mass media advertisement, publication and distribution to the local and remote areas in the country. These strategies can help reduce stigmatization and increase access to mental health information among people who live in the remote areas.
- Reducing mental health gap and improve access to mental health services and delivery at provincial and district hospitals in the remote areas.
- Increasing mental health funding support from the government, bilateral sectors, and NGOs.
References

The following documents and websites served as resources for this assignment:

2. BasicNeeds Organization, Lao PDR.
7. Mahosot hospital, Vientiane Lao PDR.
8. Military hospital psychiatric unit, Vientiane Lao PDR.
9. Ministry of Health of Lao PDR.
13. University of Health Sciences, Vientiane Lao PDR.
16. World Health Organization http://www.who.int/mental_health
WHO-AIMS report for Lao PDR provides a broad understanding of current mental health systems in Lao PDR and gives an introduction of the country. Lao PDR is a lower middle income country with a population of 6 million. 75% of the populations live in rural areas and 23% live under 1 dollar per day. Health care system is under developed and poor road connectivity in the rural areas in addition to lack of health care infrastructure and mental health manpower contributes to problems of accessing to health care services includes mental health treatment.

The report highlights the limited availability of mental health services in Lao PDR. The first ever mental health policy was endorsed in 1997. There are no mental health strategy and plan as well as legislation. However, the draft of mental health strategy and plan will be available soon. There are no mental hospital and day treatment program. However, there are 2 outpatient services attached to inpatient mental health units locate in the general hospitals in the capital Vientiane. There is one community based mental health treatment run by a NGO. The two inpatient unit has 35 beds for acute psychiatric patients. There are only 2 psychiatrists, 1 neurologist, 10 general practitioners, 18 nurses, and 11 others health workers who are currently providing mental health services to the 6 million. There is no clinical psychologist, psychiatric nurse and clinical social worker in the country.

Action is needed to strengthen the mental health system in Lao PDR. This could include undertaking training of existing primary healthcare providers to address the lack of human resources in mental health and improving supply in requiring psychiatric drugs. There is also a need for developing national standard treatment guideline and protocol. Moreover, a referral system to streamline community based care and institutional or hospital interventions should be established.