



National Mental Health Strategy 2011-2015

for a

mentally healthy Timor-Leste

Ministry of Health
Timor-Leste
Department of Mental Health

Appreciation

The Ministry of Health through the directorate of community health services, extends appreciation to mental health Department, World Health Organization, International adviser and local NGO's who supported and contributed to develop and identifying an appropriate strategies for mental health service based on the strategies principles and mental health interventions to meet the need and skill within local community to live in a healthy lives.

Apart from other health issues, mental health service also consider as national priority and needs special attention in the directorate of community health services.

Special thanks also to the policy Department of the Ministry of Health who provided support and ideas to produce a good mental health strategy. We expected that this strategy will be used by all health workers who are working at all health facilities in this country. This strategy as the main key to guide the health workers to deliver mental health services in Timor-Leste.

28th December, 2010

(Jose dos Reis Magno, Lic. SP)
Director National of Community Service

PREFACE

First of all I would like to say thank you for all of you who attended the workshop of Disseminations of National Mental Health Strategy for 2011 – 2015. This mental health strategy is like a guideline for national mental health program in Timor Leste.

On behalf of the IV Government Constitutional Republic Democratic of Timor Leste, Ministry of Health would like to congratulate those who worked very hard to finalize this strategy. Congratulations also go to the Directorate National Community Health Service, The Department of Mental Health, ICS, WHO and those who participated in the policy consultation process.

Therefore, I would like to invite all the health workers who are working in Health post, clinic health center, hospitals in Timor Leste to implement this strategy as guidance when you deliver mental health program for the community.

Mental health program is considered as one of the priority areas of Health service in Ministry of Health, because mental illnesses and physical illnesses are related. These two factors cannot separate.

According to the WHO estimated that between 1-2% of population in any country required mental health care or treatment. So, I requested to all of us, all members of government, national and international organization to work together to solved the mental health problems in Timor Leste. Mental illness is very complicated because many factors are contributing such as; Biological, Social, Psychological, Cultural and Spiritual.

Once again, I would like to encourage all citizens of Timor Leste to work together and support the government especially MoH and NGO's who are working very hard to bring the mental health services to the communities.

Together we will make a change and promote every citizen to live mentally healthy. Remember, **family is the clinic and hospital is the community.**

28th December, 2010

(Dr. Nelson Martins, MD, MHM, PhD)
Minister of Health, Timor-Leste

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ABBREVIATIONS

AusAID	Australian Agency for International Development
DHM	District Health Manager
ETNMHP	East Timor National Mental Health Project
GHW	General health worker
MoH	Ministry of Health
MOU	Memorandum of Understanding
NCD	Non-Communicable Diseases
NCDET	National Centre for Health Education and Training
NGO	Non-government organisation
NMHS	National Mental Health Strategy
PRADET	Psychosocial Recovery and Development in East Timor
SAMES	Autonomous Medical And Equipment Supply Stores
SMHW	Specialist Mental Health Worker
UN	United Nations
WHO	World Health Organisation

VISAUN
Giving good health
through good mental health

MISAUN

To provide holistic, safe, effective, high quality mental health care for all Timorese to meet their health needs, following international standards of care

I. EXECUTIVE SUMMARY

This document was developed by the Ministry of Health, Timor-Leste, in collaboration with other key stakeholders to establish a strategy for mental health in Timor-Leste together with some operational guidelines.

This document provides policy directions for financing of mental health, the scope and model of the service, service delivery, service structure, staff development and training, management, coordination, mental health promotion and pharmaceuticals. In each of these areas a policy statement is indicated where possible, together with rationale and operational guidelines or recommendations.

Following the main policy framework is a section highlighting issues for future consideration. These issues include the need to develop legislation to support mental health policy, the provision of forensic psychiatry, research to support future service planning, the need for development of a review and evaluation process for the policy (once endorsed) and future workforce planning.

Key policies, guidelines and recommendations in this document are as follows:

1. Mental health needs in Timor-Leste will continue to be met by a community-based service that is integrated into the mainstream health program, and is accessible, responsive and at no cost to the population.
2. The mental health service will give priority to the management of severe mental illness, and will provide support and training to other agencies in the management of less severe conditions and general behaviour disturbance.
3. The MoH will be responsible for coordination and regulation of all mental health services in East Timor, including by non-government service providers.
4. The mental health service should be appropriately staffed with permanently employed, adequately trained personnel. Training should be ongoing and include general health workers and doctors of Timor-Leste.
5. The mental health service should be based on a comprehensive approach to therapeutic interventions (i.e. not restricted to drug therapy), with a strong focus on counselling and family involvement that is consistent with indigenous models of care.
6. To facilitate the short-term management of disturbed patients who have no immediate accommodation or family support a crisis response plan will be implemented that will involve close collaboration between mental health services, police and the mental health NGO network.
7. The psychotropics drug list on the National Essential Drugs List should be maintained and consideration be given to an annual review of this list.
8. Ongoing training, supervision and peer support for mental health services should be provided and planned for on an annual basis.

2. RATIONALE FOR A MENTAL HEALTH STRATEGY

Mental health is an essential component of a comprehensive program of public health. If left untreated, mental disorders have serious social, psychological and physical health consequences, leading to widespread disability and cost to the government of Timor-Leste.

2.1 Burden of Mental Illness

Mental disorders are estimated to contribute 12% of the global disease burden, with the figure expecting to reach 15% in 2020. Mental disorders account for five of the ten leading causes of disability worldwide¹. These highly disabling disorders are: depression, psychoses such as schizophrenia and bipolar disorder, alcohol use and some forms of anxiety². Depression was the fourth largest contributor to the global disease burden in 1990, and it is predicted that by 2020 it will rank second of all diseases.

Population-based studies in many countries have shown that one in five of the population suffer from a mental disorder over a 12-month period. By far the most common disorders are depression, anxiety and stress disorders. Many sufferers do not seek professional care even when it is available. Some of the less common disorders, such as the psychoses (life time prevalence of 1-2%) are the most disabling and most sufferers need extensive professional assistance. Overall, WHO estimates that between 1-2% of the population in any country requires mental health care at any one time. (See annex 2 for further details on local mental health research results.)

Mental illness creates both direct and indirect economic costs for individuals and society. Direct costs include the demand for health care and social services. If mental health services are not provided, the costs to other health services greatly increase because patients often complain of physical problems (e.g. headache, weakness, stomach ailments) that may reflect untreated emotional problems such as depression. Indirect costs are created by suicide, violence, loss of income, reduced productivity, social incapacity, bizarre behaviour, poor parenting and functioning in families, dependency on others, and social disruption caused by persons with severe behavioural disturbances.

Mental health also interacts with physical illness: persons with chronic physical health problems, especially chronic diseases such as malaria or TB, are much more likely to develop mental disorders such as depression. Mental illness also increases the risk of adverse physical outcomes such as self-harm, risk-taking, poor diet, increased drug, alcohol and tobacco use, poor compliance with treatment for health problems, higher risk of elevated blood pressure and heart disease, and lowered immunity^{3 4}.

¹ Rachel Jenkins, Andrew McCulloch, and Camilla Parker (1998) , Nations for Mental Health, Supporting governments and policy makers, Division of Mental Health and Prevention of Substance Abuse, WHO, Geneva

² WHO Western Pacific Region, Regional Strategy for Mental Health (2002)

³ Mental Health Policy Project, Policy and Service Guidance Package - Executive Summary, WHO, 2001

⁴ Prince M, Patel V, Saxena S et al, No health without mental health. *Lancet* 2007; published online Sept 4. DOI:10.1016/S0140-6736(07)61238-0.

2.2 Major Mental Illnesses

- **The psychoses** (disturbances in perceptions, beliefs, thought processes): these disorders, affect 1-2 percent of the population over their lifetime. Sufferers are out of touch with reality (seeing things, hearing voices, having false beliefs, disturbed thinking and strange behaviour). Treatment is effective in relieving symptoms in most sufferers but some illnesses are chronic or relapsing and sufferers and their families may need long-term assistance.
- **Mood disorders**, most commonly depression (very low mood, hopelessness, helplessness, withdrawal, suicidality). These are common conditions affecting between 5-8% of the population over one year. They are more frequent in women. Some of these disorders are severe and prolonged, for example major depressive disorder and bipolar disorder. Suicide, loss of earning capacity and deterioration in family relationships are some of the serious effects. A combination of drug therapy and counselling is effective, especially when undertaken with the support of patients' families and community agencies.
- **Stress, anxiety and trauma:** These disorders are as common as mood disorders. Traumatic stress disorder (nightmares, poor sleep, poor concentration and memory, irritability, tension) is also present in Timor-Leste because of the history of violence, and displacement. Community treatment is effective for most cases.
- **Substance abuse (drugs) and alcoholism:** These are common disorders, particularly in men, but the prevalence is unknown in East Timor. Mental health services can assist in treating some of the complications of these social problems.
- **Neuropsychiatric disorders** occur where damage or illness affects the brain. The disorder that most commonly presents to mental health services is epilepsy. Simple treatments are effective. In Timor-Leste epilepsy is now managed by the general health system. Some patients with both epilepsy and mental disorder will need ongoing support from the mental health service.
- **Socially disruptive behaviours and personality disorders.** These occur where a person repeatedly behaves in ways that are disruptive to families and communities. Mental health services are not generally effective in dealing with these problems except by offering crisis interventions and treatment for complications such as depression.

2.3 Models of Mental Health Service

The belief that the mentally ill were possessed by spirits or cursed has persisted throughout history and across cultures, and many people affected by mental illness have been marginalised from society or even killed as a result. Throughout much of the 19th and 20th centuries, management of mental illness sufferers was based on (frequently involuntary) institutionalisation. Mentally ill people were often placed in isolated institutions for the rest of their lives, where they were kept as prisoners, vulnerable to extreme human rights abuses and had no protection or ability to seek justice. Although this system still exists in many countries, it is both costly and ineffective, and has been comprehensively discredited.

WHO's current recommendation for mental health services is that almost all mental disorders are most effectively treated in the community. Robust models for comprehensive, cost- effective treatment are now established and proven. Mental health services within Timor-Leste aim to follow these models, key components of which include:

- The provision of free community-based, accessible and equitable services that offer timely assessment and intervention.
- Integration of mental health services into the mainstream health system as part of a basic component of health care.
- Provisions for emergency care of persons who are suicidal, dangerous to others or not able to care for themselves, either by short-term admission in humane environments or other methods of providing a safe environment.
- Early diagnosis, psychosocial assessment and effective case management processes.
- Detection, treatment and referral of underlying physical disorders, and co-morbidity conditions.
- A comprehensive consideration of biological, social, psychological, cultural and spiritual elements.
- Involvement of the family and local networks in providing care and ongoing management of mental disorders.
- Reducing stigma, discrimination and neglect of the mentally ill.
- Normalisation of mental distress by raising awareness, promoting positive mental health concepts and maintaining the person in the community.
- Involvement of key stakeholders in mental health policy review and service delivery.
- Promoting the dignity and human rights of the mentally ill through humane mental health legislation that applies the “least restrictive alternative” to treatment while ensuring the safety of the sufferer and others.

3. SITUATION ANALYSIS

3.1 The Timor-Leste Context

From the 16th century until 1975, Timor-Leste was a Portuguese colony. In December 1975, after a brief period of independence, Indonesia invaded and occupied East Timor. Nearly one quarter of the population is believed to have died during the occupation as a consequence of conflict, forced migration, malnutrition and unattended public health needs. In August 1999, after a referendum that endorsed progress to independence, widespread violence led by the militia resulted in the mass destruction of infrastructure and displacement of a large portion of the population. On 20 May 2002, Timor-Leste became an independent nation.

3.2 Health Sector Overview

During the occupation, health services were provided by government-run hospitals and the church. Clinics and health posts were staffed by 160 doctors and 2000 nurses and midwives⁵. This system was insufficient to meet the physical health needs of the population, and did not provide any mental health services.

With the upheaval that followed the referendum came a total collapse of the health system. Following the referendum at least 130 of 160 doctors departed Timor-Leste. The Transitional Administration put in place following the referendum did much to facilitate the restoration and improvement of health services.

In 2009 there were 67 Community Health Centres, 172 Health Posts, and 556 SISCa posts, as well as 5 district referral hospitals (in Baucau, Maubisse, Covalima, Bobonaro, and Oecussi) and 1 National Hospital, located in the capital, Dili.

3.3 Socio-demographic Overview

The population of East Timor is around 1 million⁶, of which 49% are female⁶. Population growth is estimated at 3.18% per year and life expectancy at birth (both sexes) is 59.5 years. 95% of the population are East Timorese; the remainder are Chinese or Indonesian.

Currently 52% of the population is under the age of 15, with 59.8% under 20 and 21.3 under 5 years of age, making the age pyramid one of the 'youngest in the world'. Marriage patterns vary across the country however recent surveys indicate that marriages below 20 years of age are not common with over 60% of women being married between the ages of 20-24⁷. The estimated infant mortality rate is thought to be extremely high (88/1000), as is maternal mortality (660/100,000)^{8 9}. There is a high prevalence of malnutrition, iodine and Vitamin A deficiency in babies and children.

⁵ East Timor Policy Challenges for a New Nation, The World Bank East Asia and Pacific Region, December 2001

⁶ The 2001 Survey of Sucos - Initial Analysis and Implications for Poverty Reduction, A Partnership of the East Timor Transitional Administration, ADB, World Bank and UNDP, October 2001

⁷ Multiple Indicator Cluster Survey 2002 (MICS 2002) Republic of Timor Leste, UNICEF, January 2003.

⁸ United Nations Development Programme (2009) The Millennium Development Goals, Timor-Leste. See www.tl.undp.org/undp/MDGs_in_TL.html

Timor-Leste is divided into 13 districts, each with 4-6 sub-districts. The Oecussi District (pop. 58,521) is an enclave located inside West Timor and accessible primarily by sea or air. Dili district is divided into four regions - Eastern, Central, Western and the island of Arturo. Over 54% of the population reside in the Central region (Alieu, Ainaro, Dili, Emera, Liquica, Manufahi and Manatuto). Just over 21% of the population are located in the Western region, (Bobonaro, Covalima and Oecussi) and just under 25% are in the Eastern region (Baucau, Lautem, Viqueque). The two largest urban centres, Dili and Baucau are home to 29% of the population. 25% of households are urban¹⁰.

The economy of Timor-Leste remains underdeveloped. The primary economic activity is subsistence agriculture and the main commercial crops are rice and coffee. Rural populations live in small, scattered villages often isolated by mountainous terrain and poor roads. Public transport is limited; bus systems operate between larger towns, but in more remote districts travel is restricted to walking or use of small ponies. During the wet season, some communities are isolated by landslide or lack of functional bridges. There has been a large exodus of people to urban areas brought on by the difficulties of rural living. Timor-Leste has an unacceptably low literacy rate however within the younger population as many as 60% of young people (15-19) have some secondary education. Education levels are markedly lower for females because of drop-out rates of older girls; 66.7% of the female population aged between 35-40 have less than a primary education¹¹. This figure increases sharply with each cohort group after this. Illiteracy rates in rural central and rural west are the highest in the country. Average class sizes at primary and secondary level are approximately 50.

3.4 Risk Factors for Mental Disorders in East Timor

- **Mental health resources**

Prior to independence, no mental health services were available to the population. There were no trained specialist mental health personnel such as psychiatrists, or multidisciplinary teams. Occasionally individuals were sent to Indonesia for treatment but often they did not return. Incarceration was often used as a substitute for treatment. Those who were violent or uncontrollable were often restrained in their homes. Disability associated with mental health problems is likely to have been compounded by lack of treatment in the past.

- **Post-conflict issues**

Many of the peoples of Timor-Leste have experienced violence, torture and persecution, the death or disappearance of family members and friends as well as the loss of home and property. Post-conflict related mental health disorders will continue to influence mental health needs. For most people, the restoration of peace and security and the capacity to engage in work and other meaningful activities will lead to natural resolution of grief, stress and other reactions caused by conflict. However, in a minority, stress reactions will continue and in some cases can become disabling.

⁹ Tabela Statistica Saude, Gabinete Sistema informasaun Saude e Vigilancia Epidemiologia, Ministerio da Saude, 2009

¹⁰ Multiple Indicator Cluster Survey 2002 (MICS 2002) Republic of Timor Leste, UNICEF, January 2003.

¹¹ Multiple Indicator Cluster Survey 2002 (MICS 2002) Republic of Timor Leste, UNICEF, January 2003.

A population-wide survey undertaken in 2000 in Timor-Leste found a prevalence rate of 34% for post-traumatic stress disorder (PTSD)¹².

- **Poverty and unemployment**

50% of the population live below the national poverty line of US\$0.88 per day¹³. Rural poverty is more severe than in urban areas across a range of indicators. Poverty and unemployment directly increase risk of stress reactions and mental disorders such as depression. They also lead to malnutrition and physical illness, which, in turn, increase the risk of mental disorder. Indirectly, poverty may lead to other psychosocial difficulties such as family conflict, poor parenting and supervision of children, idleness, violence, crime, drug abuse and risk taking behaviour.

70% of the population are unemployed, a problem accentuated by the age structure of the population. 15-20,000 young people enter the working age population each year – far more than can be accommodated by existing job opportunities¹⁴. Unemployment can have a negative effect on mental health by reducing self-esteem and precipitating depression, anxiety and substance abuse.

- **Age structure**

From a mental health perspective, the age structure of the population is of substantial importance. The major mental disorders commonly have their onset in late adolescence and young adulthood and in many societies, the suicide rate is growing in this age group, particularly amongst young men. 45% of the population of Timor-Leste is under 15 years. Children are at risk of developmental delay, neuropsychiatric disorders such as epilepsy, learning difficulties, behavioural and emotional disorders. Young adults have the greatest vulnerability and need for services for psychosis, childbirth-related depression, anxiety, drug and alcohol abuse and personality disorders¹⁵. These disorders are more likely to be complicated by aggression and violence in late adolescence and young men. At the other end of the spectrum, as the population ages, it is likely that disorders of older age, such as dementia, will become more evident.

- **Malnutrition**

3-4% of children in Timor-Leste aged six months to five years are acutely malnourished, while one in five is chronically malnourished. 48.6% of all children under the age of 5 are underweight¹³. Pregnant and lactating mothers are also affected by malnutrition. Malnutrition during pregnancy can result in congenital abnormalities in infants. Malnutrition is also the cause of cognitive impairment, delayed childhood development, stress and demoralisation of parents.

¹² Modvig J, Pagaduan-Lopez J, Rodenburg J, Salud C, Cabigon R, Panelo C. Torture and trauma in post-conflict East Timor. *Lancet*. 2000;356(9243):1763

¹³ United Nations Development Programme (2009) The Millennium Development Goals, Timor-Leste. See www.tl.undp.org/undp/MDGs_in_TL.html

¹⁴ East Timor Policy Challenges for a New Nation, The World Bank East Asia and Pacific Region, December 2001

¹⁵ Rachel Jenkins, Andrew McCulloch, and Camilla Parker (1998) , Nations for Mental Health, Supporting governments and policy makers, Division of Mental Health and Prevention of Substance Abuse, WHO, Geneva

3.5 Mental Health Services in Timor-Leste after Independence

3.5.1 PRADET

From 2000-2002, a program of psychosocial recovery and development in Timor-Leste (PRADET) was initiated by AusAID and a coalition of Australian services led by the Psychiatry Research and Teaching Unit, University of New South Wales. The project established a National Psychosocial Resource Centre in Dili, initiated training of community mental health workers, and developed community clinics in and around Dili. Visiting psychiatrists and other mental health professionals from Australia provided ongoing consultancy, training and supervision. A mobile outreach service provided crisis management and support to the more distant districts. The service treated over 400 cases, most of whom were in a state of extreme social crisis because of severe mental illness or other psychosocial difficulties. A special liaison service was established with the prison system, since a substantial number of persons in prison were found to be suffering from mental disorders. The PRADET project paved the way for the development of the East Timor National Mental Health Project that commenced in November 2002. The key lessons learned from the PRADET project were:

- It is possible to establish a low cost community mental health project allowing almost all cases to be treated at home.
- It is important to define priorities clearly, particularly in relation to urgency of need.
- Referral agencies, patients and their families welcome the service and generally comply with treatments.
- Simple but comprehensive treatments are effective in the majority of cases.
- Training of community mental health workers requires intensive supervision over a prolonged period of time in order to consolidate skills and competencies.
- Transfer of skills and responsibilities to primary care health services needs to be graduated and implemented at a pace that is consistent with the absorption capacity of the services.
- The sustainability of mental health services depends on continuity of effort, security of resources and development of policy that acknowledges mental health as part of the basic package of health services.

The PRADET project also assisted in defining community assets that could be drawn on and promoted to assist in providing a comprehensive network of mental health care. These are:

- Families and indigenous community structures
- The Church
- The police and justice system
- Other NGOs with specialist trauma or psychosocial skills and an ongoing commitment to Timor-Leste
- Emerging Government Departments other than Health, including Education and Social Services.

3.5.2 The East Timor National Mental Health Project

In November 2002, a bilateral development program was initiated by the Timor-Leste and Australian governments. The AusAID funded ETNMH Project, managed by Aus Health International, is based at Lahane, Dili and operates directly under the MoH. An Australian Team Leader, Staff Development and Training Advisor and Health Promotion Adviser worked with Timor-Leste counterparts in developing and delivering mental health services

to the populace. The first phase of this project was completed in May 2004, and the second phase finished in June 2005.

The ETNMHP treated approximately 2,000 persons, most with severe psychiatric disorders, particularly psychosis.

3.5.3 The Department of Mental Health

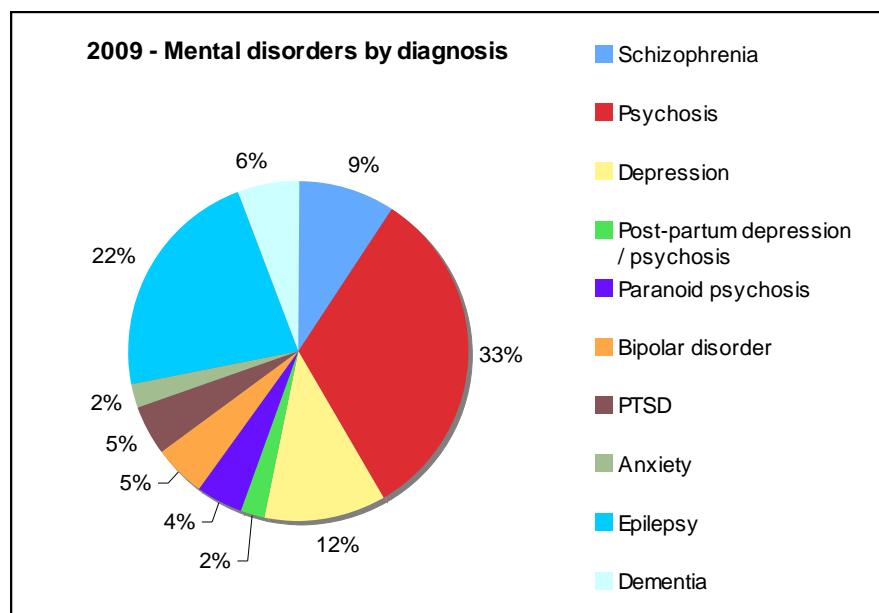
Following completion of the ETNMHP, services were handed over to the Ministry of Health. The mental health unit moved into new premises in Lahane, Dili, in 2008 and in February 2009 the unit became the Department of Mental Health, within the National Directorate of Community Health in the Ministry of Health.

The table below shows 2004-2007 data for mental illness diagnoses in Timor-Leste.

Diagnosis	Number of clients
Schizophrenia	281
Psychosis	658
Depression	332
Post-partum depression / psychosis	42
Paranoid psychosis	49
Bipolar disorder	110
PTSD	58
Anxiety	80
Epilepsy	499
Total	2109

In 2008 the total caseload for the Department of Mental Health was 2855 (Male 1345, Female 1510), of which 1026 had a diagnosis of epilepsy.

2009 data shows the following breakdown of mental illness diagnoses:



3.6 Constraints for Mental Health Services in Timor-Leste

Several constraints to the development and delivery of a mental health service in Timor-Leste need to be considered in drafting a mental health strategy. Constraints affecting the whole health system (and therefore mental health) include:

- Financial constraints: short versus long-term priorities in the health care system;
- Competing priorities in a context of poor health indicators across the country;
- Previously low level of infrastructure and embryonic infrastructure and institutional framework for health care developed since independence;
- Low skills base, literacy and work force capacity;
- Expected high rates of mental disorder (see Section 4.3: Risk factors for mental illness in Timor-Leste);
- Poor access of patients to health facilities due to transport and communication difficulties, especially for remote locations or areas affected by adverse climate conditions;
- Security issues in border districts.
- Management accountability in a decentralised district structure;
- Maintenance of effective information systems to enable service monitoring and evaluation¹⁶.

In addition to these, some constraints specific to mental health service delivery include:

- The absence of a tradition of providing any mental health services;
- Operating within the still emergent public health care services where demands for all aspects of health care are substantial;
- Consolidating commitment to mental health at all levels in society and MOH and translating this commitment into durable operational procedures;
- Addressing the additional vulnerabilities and special needs of a population exposed to mass conflict, disruption and poverty.

Although the constraints are significant, the opportunity exists for the mental health service to become a model for sustainable community-based service delivery.

¹⁶ Ministry of Health, East Timor's Health Policy Framework, June 2002

4. MENTAL HEALTH MODEL FOR TIMOR-LESTE

4.1 Underlying Principles

This document concurs with the WHO concept of mental health as:

- a positive sense of well-being
- a belief in the individual's own worth and the dignity and worth of others
- the ability to deal with the inner world of thinking, feeling, managing life and taking risks
- the ability to initiate, develop and sustain mutually satisfying personal relationships
- the ability of the mind to heal itself after shock or stress¹⁷

A Timor-Leste populace possessing the characteristics listed above would constitute a 'Mentally Healthy Timor-Leste', which falls under the broader vision of the Ministry of Health of 'Healthy Timor-Leste people in a healthy Timor-Leste'.

The mission of the Ministry of Health is to strive to ensure the availability, accessibility and affordability of health services to all people of Timor-Leste, to regulate the health sector and to promote community and stakeholder participation and ownership (including other sectors).

Mental health services specifically aim to improve the mental health of the population by prevention, treatment, rehabilitation and improved understanding of mental illness and its treatment through education and promotion. The aim is to reduce the stigma and discrimination often experienced by the mentally ill and restore both dignity and quality of life to sufferers in the community.

The National Mental Health Strategy follows the principles within the United Nations 'Principles for the protection of persons with mental illness and the improvement of mental health care', adopted by the General Assembly resolution 46/119 of 17 December 1991. Future policy created to deliver mental health services to the population of East Timor should conform to these Principles.

4.2 National Mental Health Strategy Purpose

The purpose of the National Mental Health Strategy (NMHS) is to provide strategic direction through a practical working document outlining the key objectives for development, operational guidelines for service structures, functions and accountabilities, and directions for possible future developments aimed at creating durable and sustainable mental health services in Timor-Leste.

4.3 National Mental Health Strategy Objectives

The Ministry of Health of Timor-Leste places a high value on the provision of mental health services, as demonstrated by the inclusion of mental health in the basic health care package and the permanent employment of specialist mental health workers in each district. This mental health strategy will:

¹⁷ Rachel Jenkins, Andrew McCulloch, and Camilla Parker (1998), Nations for Mental Health, Supporting governments and policy makers, Division of Mental Health and Prevention of Substance Abuse, WHO, Geneva

- define responsibilities for financing and service provision
- establish organisational arrangements to meet Mental Health objectives
- set the agenda for capacity building and organisational development
- provide guidelines for the prioritisation of expenditure

This strategy will:

- be viewed along with other national health strategies and be capable of stand alone application
- be capable of implementation within the resources of the country
- be informed by equity principles
- be integrated into primary care services
- develop in a manner and at a pace that builds on established foundations
- include systems of governance, operational policies and procedures, and accountability to ensure a viable organisational structure
- apply least restrictive approaches to management
- promote safety, dignity and participation in mental health planning and service delivery for patients, families and communities, and seek to reduce stigma and marginalisation
- be appropriate to the culture and context of Timor-Leste
- draw on the strengths of all sectors of the community, including NGOs, churches, and police.
- be accessible and acceptable to local communities
- promote a culture of learning, skills enhancement, research and evaluation
- provide opportunities for peer support and professional development
- be amenable to periodic evaluation and review and promote the development of a full national mental health strategy.

5. NATIONAL MENTAL HEALTH STRATEGY

The format of this strategy is as follows:

- Existing and proposed policies are stated in italics.
- Following this is background information and/or the rationale for the policy, where appropriate.
- Where available, this is followed operational guidelines or recommendations.

5.1 Public Provision of Mental Health Services

Policy statement:

Mental health is a component of the basic health care package adopted by the government of Timor-Leste. Consistent with principles of integration of public health services, access and equity, core mental health services will be provided, funded and managed by the Ministry of Health. Basic care services including mental health will be provided free of charge to consumers.

Rationale: High levels of unemployment, social disadvantage and poverty mean that in the short term, most of the population will not be able to afford fee for service mental health services. The mentally ill and their families commonly are particularly disadvantaged in terms of employability and financial viability.

Operational guidelines:

- Deliver mental health services through district health services, which are responsible for general health service delivery.
- Undertake planning for mental health services at the district level by District Health Management Teams, as a component of general health service planning.
- Allocate appropriate funding to the delivery of mental health services as part of general health planning.

5.2 Financing of Mental Health Services

Policy statement:

The financing of the health sector will be sufficient to ensure that mental health services continue to be funded as part of the basic primary health care package including the funding of appropriate management and coordination structures, staffing for service delivery, continuous staff development, training, drug supply and transport/logistics. Mental health will continue to be provided at no cost to the consumer.

Background: The government is heavily dependent on donor funding for the provision of service across all sectors. The per capita government expenditure on health has seen a small increase in each of the past 2 years, particularly in the areas of training and staff recruitment.

From November 2004 the government will finance 16 permanent positions in mental health - 15 specialist mental health workers (SMHW) and a Mental Health Unit Officer ('Head of the Department of Mental Health' since 2009).

Operational guidelines:

- Develop mental health budget projections, within the Basic Package of Services,

consistent with the planned policy and operational guidelines, as a priority. These projections must include consideration of funding for:

- o Ongoing staff development and training at all levels
- o An increase in the workforce in the future (as demands increase)
- o Provision for advanced training for those involved in coordination and management
- o Continuous supply of essential drugs (as per essential drugs list)
- o Supply and maintenance of transport to enable effect service delivery
- Facilitate and coordinate involvement of NGOs, churches and police in providing complementary services for people in crisis or with psychosocial problems. This is in line with government strategy and will reduce the demand on government for both funds and personnel (See Section 6.7: Non-Government Mental Health Service Provision).

5.3 Service Delivery Model

Policy statement:

Mental health services in Timor-Leste will be provided under a comprehensive primary care approach, which is community-based, multi-sectorial, integrated into the mainstream health system, equitable, accessible, affordable and responsive to the diverse needs of the population.

Operational guidelines:

- Provide services in district primary care health facilities by specialist and general health workers.
- Hospital and clinic doctors are also responsible for seeing people with mental illness and epilepsy, including assessment, diagnosis and treatment. They should at all times work closely with the SMHW and general nurses.
- Work closely with other relevant government, non-government and community organisations to promote the mental health and psychosocial well-being of the community as a whole
- Develop a model of care that is integrated with local customs of care
- Facilitate active participation by consumers, carers and the community in the mental health service
- Facilitate gender equity, access by the most vulnerable groups, and the dignity, safety and human rights of patients and their families
- Provide the least restrictive treatment, even for the most severely disturbed
- Review treatment guidelines and practice guidelines to ensure they meet the needs of the service and comply with the UN Guidelines for the Treatment of the Mentally Ill.
- Develop and document appropriate referral pathways via Serbisu Hamutuk forum to incorporate and coordinate the role of general health workers, SMHWs and non-government providers.
- Provide training in practice guidelines, treatment protocols and referral mechanisms to specialist and general health workers.

5.3.1 Principles of Service

Policy statement:

Mental health services will be visible, comprehensive, accessible and responsive. Continuous improvement in service delivery will be strived for.

Operational guidelines:

- Provide access to mental health services in all districts of Timor-Leste.
- Treat clients in the least restrictive and intrusive manner
- Ensure each client has a case manager responsible for:
 - the formulation/implementation of an individualised treatment program with the client
 - continuity of care for the client through the mental health, NGO and community structure.
 - achieving, through this relationship, informed choices and decisions made by the client and their families and carers
- Work proactively with families and other carers
- Regularly monitor, review and evaluate service provision and outcomes
- Be responsive to opportunities to provide mental health consultation services for other service providers (in health and other sectors).
- Establish clear communication and coordination mechanisms with other agencies, departments and organisations
- Operate within clear clinical and administrative lines of responsibility

5.3.2 Therapeutic Models

Policy statement:

A comprehensive approach to provision of therapy will be undertaken which will take into account the needs of the patient and the availability of treatment. This may include (but is not restricted to) drug therapy, and counselling interventions. At all times treatment will be provided with regard to local conditions and culture.

Rationale: Any mental health service must offer a range of treatment options that maximise the patient's maintenance and recovery, hence the need to incorporate both drug and non-drug treatments into the service. In a resource-constrained environment such as Timor-Leste, it is important to maximise the participation of family and community as carers. This is appropriate to the Timor-Leste context where the social structure relies heavily on communication, decision-making and belief systems within a family context, and mentally disordered people in Timor-Leste are not isolated from their families because of their illness.

Operational guidelines:

- Develop a range of therapeutic models appropriate to the Timor-Leste context and incorporate these into the treatment protocols and practice guidelines.
- Provide training to general and specialist workers and non-government providers in following these protocols and guidelines.
- Facilitate community and family participation to support service delivery and include participation in service planning, delivery, monitoring and evaluation.

5.3.3 Accountability

Policy statement:

Mental health workers are responsible to the District Health Managers for line management issues and will be supported by the Head of the Department of Mental Health and Psychiatrist for clinical supervision and case management issues.

5.3.4 Referral

Policy statement:

A shared care model will be adopted in which generalist health workers assess, diagnose and treat routine cases, and refer more complex patients to SMHWs. The generalist health worker will remain responsible for the primary care of the patient; SMHWs will provide diagnosis, treatment, case management and retain prescribing rights in conjunction with doctors.

Referral will be through hospitals, primary level health facilities, police, faith based and community organisations, and NGOs. Self-referral will be encouraged through education and promotional activities.

Rationale: Encouraging a shared care model is intended to increase the capacity of the generalist health workers and eventually reduce the need for referral.

Background: Currently the majority of referrals are self and family referrals. It is expected that primary referrals will frequently come from family members requesting home visits, due to the nature of the disorder and associated stigma. Referrals are also currently received from hospitals, health centres and health posts, police, faith based and community organisations and NGOs.

Operational guidelines:

- Continue to promote and raise awareness and understanding of the service to hospitals, primary care facilities, police, faith-based and community organisations and NGOs, to encourage appropriate referrals.
- Develop referral pathways and coordination mechanisms for the inclusion of non-government bodies in service provision.

5.3.5 Management of difficult behaviour

Policy statement:

Patients with socially disruptive and/or potentially harmful behaviour will be managed through a tiered model, which emphasises community care as far as possible and is low cost, effective, humane, and of the shortest possible duration.

Rationale: In any population group, there is a minority of patients whose behaviour is so disturbed that they are socially disruptive and may possibly harm themselves or others.

Some of these patients are potentially violent or suicidal but have not committed any major crimes. A model of care must be offered that prevents self harm or harm to others while respecting the dignity and human rights of the patient.

Background: There are currently no separate facilities in prisons for the mentally ill. Patients suffering from mental health disorders may be incarcerated after committing illegal acts, for example acts of violence. Mental health workers are required to liaise with both prison and court officials in the pursuit of justice, e.g. during criminal trials, where they may be required to perform assessments of mental status and give evidence or submit reports.

Operational guidelines:

- Develop a tiered model with two levels:

- Stage 1 – Community
- Stage 2 – Community based crisis /emergency facility
- Establish a crisis response base in Dili, for short-term management of patients who may need short term accommodation during a mental health crisis. This model may be replicated in other population centres following its successful 6months trial review. The allocation of hospital beds or hospital wing/ward in the National Hospital would be a temporary and adequate alternative to building a separate Mental health Unit
- Provide short-term crisis intervention by the SMHWs in collaboration with the police.
- Develop a standard operating procedure with the police for management, review, monitoring and evaluation of crisis referrals
- Formulate mental health legislation to address all issues concerned with implementing this policy

5.3.6 Scope of Mental Health Services

Policy statement:

The mental health service will give priority to people with severe mental disorders. Prioritisation will be based on severity, disability and social disruption posed by the mental illness to the patient and family, and the extent to which families and other services are available and capable of dealing with the problem.

For less severe disorders, the major focus of the service will be on health promotion, consultancy, advice, support and training for other agencies to manage the patients. The government service will not deal directly with problems of general behaviour disturbances not associated with major mental illness but will screen all persons referred for ongoing management.

Rationale: An important challenge in planning services is to reach a consensus on the scope and priorities for services. If the service were to focus primarily on the severely mentally ill, approximately 1 – 2% of the population (9000 -18,000 persons) would need direct, individual care. If the scope was expanded to include less severe cases of depression, traumatic stress and anxiety, this number would increase to 50,000. In reality, the referral process creates filters to care so that the community and organisations providing other care select those in most urgent need. For example, almost all patients referred to the PRADET project (2000-2002) clearly fell into a group that was not only mentally ill but who faced immediate social crises.

Developed countries have established subspecialty areas in mental health such as aged care, perinatal, child and adolescent, drug and alcohol, developmental disability, neuropsychiatry, forensic psychiatry, and specialised trauma services for survivors of torture, sexual abuse, and domestic violence. It is considered that this level of specialisation is outside of the scope of mental health service in Timor-Leste in the immediate future.

Operational guidelines:

- Develop specific guidelines for prioritisation
- Develop guidelines for establishing a model of care for co-morbid conditions
- Develop guidelines for specific conditions that frequently present to the mental health service but are better treated by the general system e.g. epilepsy
- Develop referral pathways and coordination mechanisms that include non-government service providers based on the mental health forum – ‘Servisu Hamutuk’

5.4 Ministry of Health Mental Health Services Structure

5.4.1 Management Structure

Policy statement:

The mental health portfolio will be the responsibility of the National Directorate of Community Health Services. Mental health services will be supported by a psychiatrist, who reports to the Director General, and a Head of the Department of Mental Health, who will report to the National Director of Community Health. A Mental Health Services Steering Committee that includes key figures in MOH and stakeholders will provide oversight for service planning, delivery and monitoring.

Operational recommendations:

- The Head of the Department of Mental Health: under the direction of the National Director for Community Health, will have overall responsibility for ongoing mental health services including policy review and modification, clinical guidance, research, monitoring and evaluation, as well as a key coordination, liaison and advocacy role with other stakeholders and institutions, including non-government service providers, throughout Timor-Leste.
- The psychiatrist will have ultimate responsibility for the use of psychotropic medication, clinical supervision, mentoring of SMHWs, and input to policy development.
- A Mental Health Service Steering Committee will be convened by the Mental Health Unit Officer, consist of key stakeholders and will advise the MOH on policy and strategic matters.

5.4.2 Staffing Structure

Policy statement:

The Mental Health Service workforce comprises general health workers (doctors and nurses), and 15 Specialist Mental Health Workers who receive technical and clinical support from the Head of the Department of Mental Health and psychiatrist and receive direction from the District Health Managers for MoH policy, staff development and administrative issues.

General health workers will provide clinical service for the majority of cases, referring difficult cases to the Specialist Mental Health Workers.

The SMHWs' key role will be as consultant, trainer and mentor for generalist health workers as well as Case Managers for some patients. SMHWs will refer difficult cases beyond their expertise to the psychiatrist.

See Annex I: Organisational Chart

Background:

- The ETNMHP has trained 127 general health workers and 15 Specialist Mental Health Workers.

Operational guidelines:

- Document the role of Head of the Department of Mental Health and Psychiatrist and distribute throughout the health service.
- Formalise the role of GHWs in mental health service delivery through development of minimum standards.

- Train SMHWs to provide support and clinical supervision to general health workers.
- Develop and document the process for generalist health workers and SMHWs to have input into service delivery, management and monitoring.
- Formulate policy (and supporting legislation) to address issues of accountability in treatment.

5.5 Government Mental Health Services Staff Development and Training

Policy statement:

A sufficient number of health personnel, based on identified health service delivery needs and available resources, will be recruited, trained and managed by the MOH. All training programs will be based on identified needs of the health service and should be delivered in the most cost-effective way.

Additional policy:

The Ministry of Health will ensure provision of advanced training in mental health to selected workers to ensure effective service delivery (and appropriate referral capacity), management and coordination through the National Directorate for Community Health Services.

Background: The current lack of fully trained personnel constitutes one of the major constraints to the delivery, management and coordination of comprehensive mental health services in Timor-Leste. The current cadre of Specialist Mental Health Workers are generalist nurses by background who have been trained by ETNMHP. The Project also provided basic training to generalist health workers.

By the completion of the current ETNHMP, core elements of a national service will have been established (as described in Section 6.5.2: Staffing Structure). However, capacity-building and full coverage of mental health needs was not complete. There is a need for ongoing training, supervision, mentoring and professional support of all levels of health personnel in primary services, including advanced training for selected specialist mental health workers. (See 6.5.1: Management Structure)

Operational recommendations:

- Develop a 2 year Diploma II level curriculum for students having completed secondary school, to obtain the qualification of 'Specialist Mental Health Worker'.
- Extend training for SMHWs beyond the life of the ETNMHP to include knowledge about areas including child, adolescent and elderly mental health, gender, drug and alcohol, and developmental disability as well as continuous education to build on existing knowledge in other areas.
- Develop options for advanced training of selected Specialist Mental Health Workers, for example through partnerships between NCNET and regional training institutions for undergraduate and postgraduate courses in mental health.
- Ensure the psychiatrist conducts continuing education for SMHWs with the support of NCNET.

5.6 Non-Government Mental Health Service Provision

5.6.1 Scope of NGO Service

Policy statement:

Non-government service providers will deliver services that are complementary to, but not a duplication of, government services through provision of psychosocial support, counselling and non-medical interventions.

Rationale: Although there are currently no NGOs equipped to deal with core, severe mental illness, there is potential for NGOs currently working in other areas (e.g. trauma) to assist in supporting families affected by mental illness and provide counselling and non-medical interventions for those with less disabling disorders such as traumatic stress, anxiety and the less disabling forms of depression. External involvement is especially important considering the desire of the MOH to give special attention to the health issues and problems of women, children and the vulnerable poor.

Operational guidelines:

- NGO guidelines delineating what services may be provided by non-government providers have been developed and a Mental Health NGO monthly forum has been established
- Develop and document referral pathways and coordination mechanisms
- Develop a process for disseminating the above guidelines and mechanisms and a training program for their use
- Head of the Department of Mental Health to have core responsibility for facilitating forum

5.6.2 Coordination and regulation

Policy statement:

The Head of the Department of Mental Health will coordinate, regulate and monitor the service provided by non-government service providers. All service providers will adhere to the MoH guidelines for mental health.

Rationale: Regulation and coordination is essential to safeguard the health and safety of patients, and to maximise use of scarce resources by avoiding duplication or gaps in service delivery.

Operational guidelines:

- Develop standards and regulatory mechanism, with supporting legislation where necessary, for: prescribing rights, drugs procurement rights, treatment standards, training levels
- Identify training needs of non-government service providers and provide training to enable them to meet the expected standards and comply with regulations.

5.7 Intersectoral Links

Policy statement:

Mental health services will be developed within the cross-sectoral approach of service delivery. This will require the need to create and sustain relationships with other government sectors to plan, advise and consult on the mental health aspects of their programs. The impact of external influences on mental health will be openly acknowledged (eg unemployment, poverty, gender) and

cooperative links established to create effective multi-sector collaboration on issues and initiatives for mental health. Inter-sectoral policies and programs will be developed which will improve and maintain the mental health of the community.

Rationale: All areas of public policy and all sectors have an impact on the mental health of the population. The most direct impact comes from general health, housing, welfare, work and income, education, employment, justice (including the courts and prisons), police, district and local government.

Background: Under ETMHP intersectoral links have already been established with the faith based organisations, police, human rights groups, the prison system, key NGOs and UN agencies. These will continue to be enhanced during the Project with the development of crisis response services, mental health education programs and case management systems.

Operational guidelines:

- The Head of the Department of Mental Health and Mental Health Services Steering Committee will assume responsibility for facilitating intersectoral links (see section 8.8) and within the overall National Integrated Primary Health Policy intersectoral /interagency framework (pending).

5.8 Pharmaceuticals

5.8.1 Ordering and supply

Policy statement:

Drugs supply will be timely, reliable and consistent. Psychotropic drugs listed on the National Essential Drug List will be provided free of charge to all patients accessing mental health services, when prescribed by an approved person.*

Additional policy:

Ordering of drugs from Central Pharmacy will be undertaken with the regular re-supply systems established between the District Health Services (Sub-districts) and SAMES.

*The Psychotropic Drugs List that is part of the National Essential Drugs List is attached at Annex 3.

Operational guidelines:

Within the overall framework of SAMES drug control and distribution:

- Maintain the existing range of psychotherapeutic drugs on the essential drugs list and extend the list where the need arises and if available funds permit.
- Establish a review process for the essential drugs list to consider disorders being treated, efficacy of drugs being used, availability of affordable alternatives, and requirements for monitoring alternatives (e.g. if a drug must be monitoring by blood screening). (This is dependent on an effective clinical information system being in place)
- Refine and maintain the procurement and distribution system for drugs and ensure it is specific to the needs of each district (e.g. Oecussi is hard to access and may need to order further in advance than other districts).
- Many sub districts that are geographically isolated will need special consideration to ensure that a regular drug supply is available.

- Develop and document an appropriate authorisation procedure to ensure ordering and supply complies with the policy.
- Develop a policy document to address quality control of pharmaceutical products and regulation of supply to consumers. Identify areas requiring supportive legislation.
- Refine process for monitoring drug prescription and usage.

5.8.2 Prescription and regulation

Policy statement:

Psychotropic drugs listed on the National Essential Drug List will be prescribed by an approved person. Supply, prescription and administration of drugs by non-government service providers must comply with MoH procedural guidelines and standards.*

Background: Currently, Specialist Mental Health Workers are able to dispense all psychotherapeutic medications on the essential drugs list including both oral and injectable medications. General health workers operating at levels 3, 4, and 5 facilities are able to prescribe medications under the supervision of Specialist Mental Health Workers. Drug protocols have been developed for all medications.

Operational guidelines:

- Support the development of MoH policy concerning who is allowed to prescribe, administer and monitor drugs. Policy and legislation must cover both government and non-government services.
- Develop National Mental health Treatment Guidelines relevant to existing morbidity patterns and train staff in the rational use of drugs, using the National Essential Drug List and the National Formulary (reference manual).
- Develop procedure to monitor compliance of staff with the National Treatment Guidelines.

5.9 Community Participation and Mental Health Promotion

Policy statement:

Mental health services will include mental health promotion to raise awareness of the public about mental health issues and mental illness and will facilitate community participation in mental health to improve prevention, treatment and care outcomes for individuals.

Rationale:

The absence of mental health care in Timor-Leste is not only related to the very constrained professional and financial resources, but also to the fact that a large segment of the population have little understanding of the concepts of mental illness¹⁸. The Ministry of Health has a small health promotion unit within which mental health promotion initiatives will be integrated. In the interests of cost-effectiveness, MoH focus is on prevention and promotion recognising the importance of ensuring that the community is well informed and aware of mental health issues.

¹⁸ Dr F.Kortmann, Plan for Service Delivery and Public Health Activities in the Field of Mental Health in East Timor, WHO, 2000

The aim is to a) create a more supportive and less stigmatised environment for people with an existing mental illness and b) to encourage early assistance seeking behaviour without fear of discrimination or social alienation.

Operational guidelines:

Within the general framework of the National Health Promotion Strategy:

- Develop community education and awareness raising that focuses on minimising social ignorance and stigmatisation and discrimination against the mentally ill in order to facilitate the active participation of the mentally ill and their families in society.
- Develop mental health promotion interventions that are appropriate to the cultural and social context e.g. taking into account low literacy levels and the importance of audio-visual messages rather than reliance on print media only.
- Ensure mental health promotion activities are included in district health plans.
- Draw on community forums and mechanisms identified in related MoH policy (e.g. community level health/facility health committees, district health committees, *Servisu Hamutuk*) to facilitate the involvement of communities and community organisations in being supportive of mentally ill individuals and their families through involvement in their treatment and care is to be encouraged. This is important both for positive health outcomes and for sustainability of the service.
- Provide training to families and communities in areas such as dealing with problematic behaviour and the need for treatment compliance.
- Develop mechanisms to facilitate active community involvement in service planning, monitoring and evaluation.

5.10 Logistics

5.10.1 Location of Service

Policy statement:

Mental health services will be provided through government sub-district and district health centres, health posts, and clinics outside the government service network where arranged. For those patients unable to access fixed clinics, services will be provided by a mobile outreach service.

Rationale: Information regarding the utilisation of health services indicates that many people are hesitant to attend clinics or health centres for 'physical' problems and even more so for mental disorders. Depending on the nature of the disorder and the financial resources and physical isolation of the family, (among other reasons), attendance at the district community health facilities may not be viable for a number of patients, hence the importance of a mobile outreach service.

Operational guidelines:

- Encourage patients to access services at clinics. Develop guidelines and criteria for deciding on extent and frequency of home visits – these will address prioritisation according to severity of the condition and location of the patient.
- Ensure continued commitment to the reliable and continuous funding of supply and maintenance of transport for the workers.
- Ensure implementation of a fair and equitable transport policy within the health service that enables health workers to do their jobs.

5.10.2 Hours of Service

Policy statement:

Operating hours for mental health workers are in line with MoH operating hours of the health facility and may require responsive management of patients referred after hours by partners agencies; police, etc. Regular hours may be reviewed from time to time.

5.11 Research

Policy statement:

The need for conducting mental health research to inform planning and service improvement is recognised. The Ministry of Health is committed to conducting research as part of any broader health research undertaken, e.g. through inclusion of mental health questions on general health surveys and the national census.

Rationale: Mental health research is essential to inform continuous improvement in mental health planning, costing, service delivery, promotion, monitoring and evaluation. Integrating collection of mental health data into general health surveys will ensure comprehensive coverage of the population and simplify administration and collection of data.

Background: The MoH has stated its intention to further research through national research mechanisms. Mental health will be included on the list of essential health research initiatives.

In addition, the MoH Health Management Information System (HMIS) is currently being expanded and strengthened. Once operational, the improved system will enable the collection of a more meaningful set of data and analysis opportunities. For more information regarding research issues refer to section 9.2.

Operational recommendation:

In the short term the mental health service will use the ETNMHP Intake and Assessment form as well as random auditing of case notes and medication records for data collection and analysis purposes.

5.12 Service monitoring and evaluation

Policy statement:

Mental health service delivery will be monitored and evaluated as part of the basic package of health care in the general health system

Background:

The ETNHP has developed a monitoring and evaluation framework that is focused on monitoring the outputs of the project, but will also seek to monitor some service outcomes as part of this. Data collection is being undertaken predominantly through the Intake and Assessment Form currently used for each patient service – the project developed a simple computerised data entry and analysis process during Phase I. However, this is an interim measure being undertaken to enable monitoring and evaluation until the MoH's Health

Management Information System is improved. Where possible the mental health service information collection will then be integrated with the general system.

Operational guidelines:

- Establish indicators for monitoring service delivery
- Establish data analysis methods and reporting procedures
- Establish mechanisms for utilising reports to inform service planning and improvement.
- Clarify responsibilities for monitoring and evaluation and deliver training to those responsible
- Ensure that key stakeholders are involved in monitoring and evaluation e.g. through consumer satisfaction surveys

6. POLICY AND OPERATIONAL ISSUES FOR FUTURE CONSIDERATION

6.1 Mental Health Legislation

There is no National Mental Health Legislation in Timor-Leste. Currently a mix of Indonesian law and UN regulation is in operation. Indonesian law is used as a guide in the courts but currently there is no legal means of detaining a person with mental illness or protecting their human rights.

There are a number of policy and operational issues raised in this document that are likely to require supportive legislation if the policies are to be operationalised effectively. These include:

- Regulation of service provision by non-government providers
- Regulation and standardisation of the workforce (i.e. levels of training)
- Accountability of staff providing treatment
- Regulation of supply of pharmaceuticals
- Regulation of prescription and administration of pharmaceuticals
- Forensic psychiatry including compulsory treatment of mentally ill (including maximum detention periods), assessment of prisoners for mental illness, defence of prisoners claiming mental illness, and management of mentally ill people in prisons.
- Rights of mentally ill people to the least restrictive forms of treatment

6.2 Research

As mentioned at section 5.11, the MoH has stated its intention to continue to support relevant research. Research carried out will be planned and coordinated in consultation with the relevant MoH Division of Health Services (including the Mental Health Department) and Division of Policy and Planning and will include both qualitative and quantitative studies.

Research is necessary to understand basic issues such as prevalence as well as further insight into actions necessary to develop truly Timor-Leste mental health services. Areas of research could include:

- Indigenous approaches to mental health in order to tailor psychiatric input and create knowledge.
- Family systems models
- Community care models
- Perinatal health care
- Drug and alcohol abuse
- Epilepsy
- Trauma
- Psychosis
- Diagnosis and cultural norms
- Suicide prevalence.

Ideally, targeted mental health surveys incorporating social determinants of mental health, quality of life, disability and measures of illness need to be created and administered. Mental health research will involve a collaborative approach with a wide range of stakeholders and health service agencies, including WHO and NGO health providers.

6.3 Future Workforce Planning

- An increase in the workforce: All future workforce planning will be undertaken within the framework of the MoH Human Resource Plan and within the government ceilings on public service staffing. It is inevitable though that the number of patients accessing the service will grow and therefore that the minimum number of Specialist Mental Health Workers required to provide an appropriate level of care will increase. Provision must be made to ensure also that the worker/patient ratio is tenable, to avoid burnout of staff. The MoH Human Resource Development Plan will therefore consider future needs for training of new workers. With the growth of the service, plans will be made for organisational growth and career development, which ensure that the skills of more experienced workers are not lost to the community through recruitment into purely administrative roles.
- Regulation of training: MoH recognises that it will take time to develop capacity in managing mental illness. Current health training protocols emphasise the need for a competency based approach to training that is based on a sound rationale with objectives and expected outcomes clearly stated and agreed at both central and district level. There are many donor projects providing training across the health sector and as yet no comprehensive policy on qualifications of trainers or standardized accreditation process. A government regulation on mental health qualifications will therefore need to be developed in order to ensure that a sustainable, quality service is provided to the population. These regulations should cover such areas as ability to diagnose and competency to prescribe medications. When quality information regarding incidence of particular disorders becomes available, the development of more specialised training may be appropriate. The issue of regulation of qualifications is also very important for the general standardisation of service delivery by non-government service providers (see Section 8.7.2) to ensure that any worker delivery mental health services is trained to minimum standards.

6.4 Forensic Psychiatry

It is important for any mental health services to have the capacity for provision of forensic psychiatric services in order to provide appropriate assessment and evidence for criminals with mental illness, or in cases where mental illness is used as a defence. Given the current resource constraints in Timor-Leste, the uncertainty of the feasibility of a permanent psychiatrist in Timor-Leste, and the need for supportive legislation, it is not considered realistic currently to develop a policy statement on provision of forensic psychiatry services.

This document seeks to highlight the importance of this area and to raise the issue for future consideration for development of policy, and ultimately for development of supporting legislation.

Current attention to this area includes:

- Psychiatric assessments are negotiated by legal/formal request to the visiting psychiatrist.
- Assessment of people for forensic reasons in specialised cases only by visiting psychiatrists. Assessments can only be provided on a highly selective basis. A request for assessment may not necessarily result in that outcome. (This is because the primary role of visiting psychiatrists is assessment and diagnosis of complex cases, case review, and staff development and training. There is little time available under the existing inputs to incorporate more regular forensic assessments).
- SMHWs can provide routine reports bearing in mind patient confidentiality and rights – informed consent.

- All aspects of forensic psychiatry will need to be put in place by MoH guidelines to lead to mental health policy and ultimately, legislation.

6.5 Review and Evaluation of the National Mental Health Strategy

The National Mental Health Strategy will provide the direction and form the basis of ongoing Ministry of Health operational strategy. For this to be effective on time, the following process is required:

- a timely review of the success of the policy implementation process itself; and
- an evaluation of the NMHS per se.

Key indicators will be developed to guide these processes with the review being organised and coordinated by the Mental Health Working Group drawing on appropriate expertise for the purpose.

The reviews will be undertaken after the completion of the 2nd full planning/implementation cycle of MoH, post approval of this strategy document.

6.5.1 Implementation review

Given the dynamics of the political and social situation within Timor-Leste and the developments and opportunities available to the Ministry of Health, there is a need to ensure that policies, strategies and plans continue to remain relevant to the needs of the community and within the capacity of the service to implement.

Mental health services have been developed and implemented with the support of the ETNMHP, and prior to this with PRADET, since 2001. Therefore, while this strategy was endorsed in late 2004, the interventions have already been in place for varied amounts of time. Building on the achievements of the two projects the MoH will fully integrate services, interventions and support within the provision of basic health services for ongoing sustainable service delivery. Review will be spaced to enable the MoH systems to fully take up responsibility and ownership of the strategy and be able to demonstrate achievements or problem areas in implementation.

Such a review should pick up teething problems to do with the implementation plan itself. It will sometimes also identify potential problems with the strategy per se, but it is usually wise (unless these are manifestly serious) not to act on these until the evaluation of the strategy itself has been completed.

During the implementation review, care should be taken to distinguish between problems to do with implementation and problems intrinsic to the strategy itself.

The implementation review will cover:

- the degree to which the implementation process was carried out and reasons for any incompleteness of the process;
- the degree of understanding of how to apply the strategy among those involved in implementation (including an assessment of the adequacy of initial training and further training needs).

6.5.2 Evaluation: reviewing and measuring policy outcomes

The National Mental Health Strategy will be evaluated at an appropriate length of time after acceptance and initial implementation. The evaluation will:

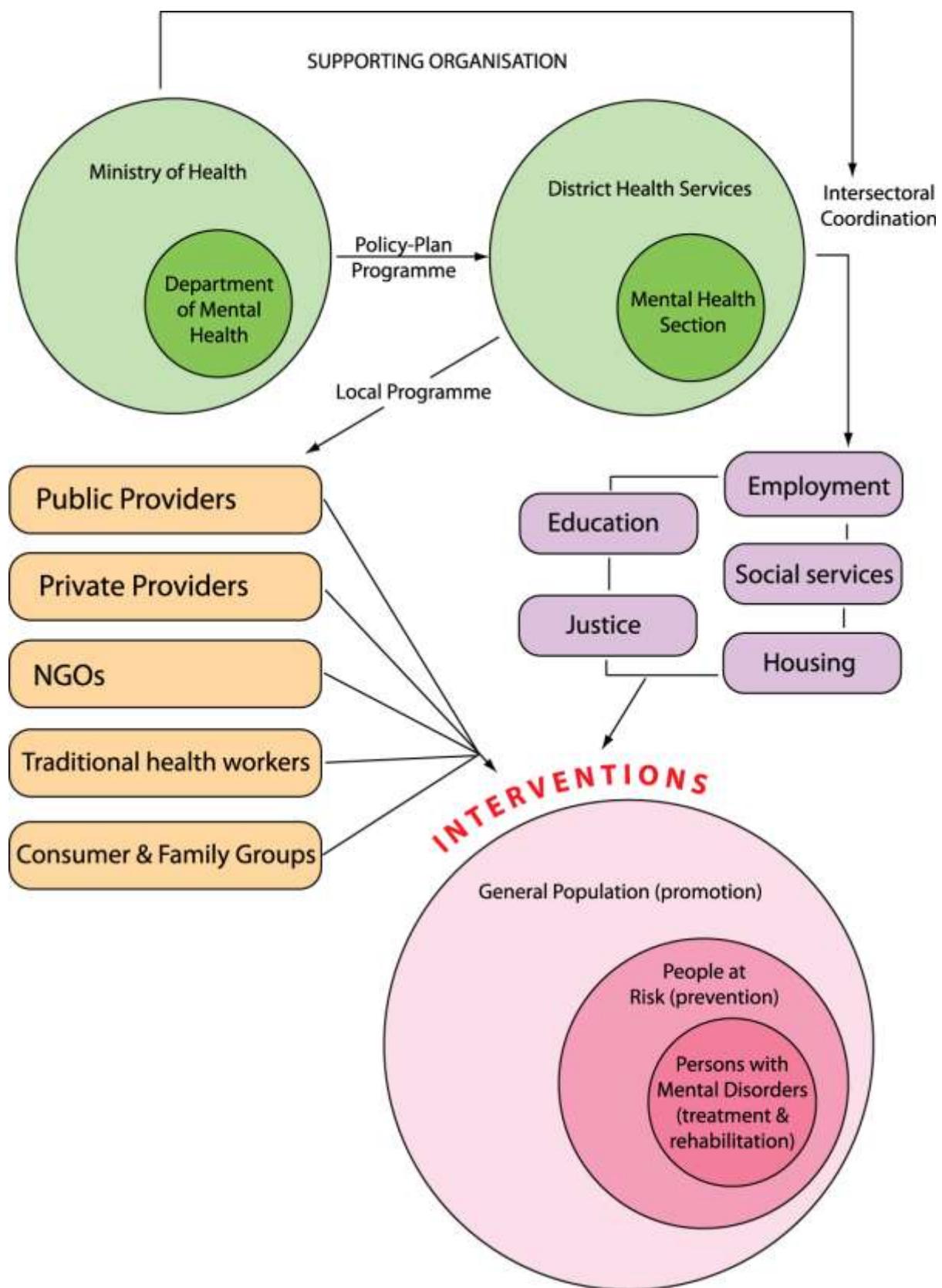
- measure the achievement of strategic outputs and program outcomes against pre-determined criteria measures;
- identify emergent issues and problems;
- provide feedback to aid improvement or corrective action.

Assessing strategic effectiveness is more complex than assessing whether strategic objectives have been achieved. It involves arriving at an informed judgment about whether the objectives included in the strategy design were the right ones, given the overall policy environment and outcomes, and whether the strategy was accepted by the stakeholders.

The following are some relevant questions for consideration when planning the evaluation of a policy document:

- Has the strategy realised its objectives? Is it still relevant?
- Does the strategy meet client and management expectations?
- Are the key performance measures appropriate?
- Has the scope changed? Why?
- What are the impacts and costs?
- Do new areas need to be addressed? Are new risks or trends emerging?
- Were the chosen performance measures and indicators appropriate?
- What was the impact of the policy on its audience?

ANNEX I: IMPLEMENTATION OF NATIONAL MENTAL HEALTH STRATEGY, PLANS AND PROGRAMMES¹⁹



¹⁹ Adapted from Figure 2, Page 71: Mental Health Policy, Plans and Programmes. World Health Organisation 2005

ANNEX 2: A COMMUNITY PROFILE FOR TIMOR-LESTE

Sources of data:

1. In 2004, the Ministry of Health approved a mental health epidemiological study to be undertaken by the Centre for Population Mental Health Research, University of New South Wales. The study was completed in late 2004 in Becora and Hera, matching the areas surveyed in the pilot census.
2. The East Timor national census, conducted at the same time as the epidemiological study, included one question enquiring into the presence of mental disorder across all households in East Timor. Preliminary data are now available.
3. An additional survey was undertaken in Atauro in which village chefes and elders were asked to identify persons with severe mental disorder across 70 of the island population.

Severe Mental Illness

a. **The Becora/Hera Study:** This was a multi-stage epidemiological study. In the first stage, all households ($n = 1500$ adults) in a census-defined area were visited and the head of the household was asked whether anyone had a mental disorder using Tetum terms for these conditions (for example, *bulak*, *hanoin barak*, *pontu*). Village chiefs and elders were also consulted.

Results: 1.9% of the adult population was identified by the community as mentally ill (community identified cases). Two psychiatrically trained doctors then interviewed as many of these persons as possible using a structured clinical interview.

Reports by family were obtained for those who could not be interviewed. Almost all cases had severe, disabling mental illness in need of urgent treatment. The most common disorders were the severe psychoses with most sufferers experiencing major disability and/or chaotic social behaviour. Interestingly, there were some cases of "culture-bound syndromes" particularly half-moon madness and rai nain possession which is similar to the amok syndrome of Indonesia and Malaysia.

b. **Census Data:** The census question yielded an average national prevalence for mental disorder of 2.8%. For the Dili area, the rate was 1.5%, a figure which is only slightly lower than the Becora/Hera study (1.9%) (the latter study used a more extensive approach in which the interviewer probed more deeply into the family). In the census data, there was notable variation in rates across districts with high rates in Liquica (4.8%) and Ermera (5.1%).

c. **Atauro study:** Using information from the chefes and elders, approximately 0.8 of the population of the island was identified with severe mental disorder. The lower rate is likely to be an underestimate compared to the census and Becora/Hera study, since the inquiry was only with the chefe not individual heads of families. The types of cases were very similar to those in Becora/Hera: people identified with severe mental illness were at great risk of sexual abuse, assault, malnutrition and physical illness.

More common problems of traumatic stress, anxiety and depression

Only the Becora/Hera study addressed this issue. In the second stage of the study, all adult members of the same households were surveyed for symptoms of more common mental problems related to anxiety, depression and posttraumatic stress.

Most people reported exposure to major trauma risk, including violence, loss of family and other human rights abuses in 1999 and before. Yet, although individual symptoms of stress were fairly common, less than 1% of the population continued to have PTSD, a figure that does not differ from countries not exposed to war or mass violence. This suggests that there has been a remarkable pattern of recovery from traumatic stress (from 34% in 2000 to less than 1% in 2004) over the 4.5 years since the violence of 1999. Clinically significant depression was slightly higher (6%) than in countries such as Australia.

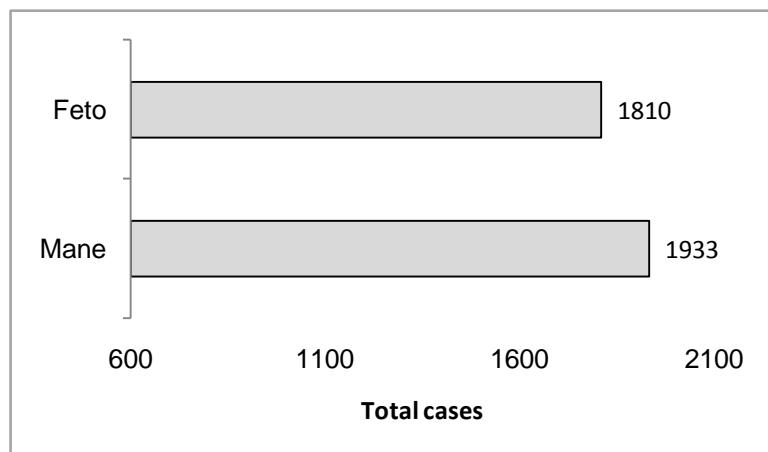
Implications

- Most post-conflict developing countries do not have reliable population-wide data on mental health needs.
- Although there are limitations to the methods used across the three studies (and there are no data on children), the information as a whole provides a helpful snapshot of the level of mental health needs in the community
- The evidence suggests that the percentage of persons with severe and disabling mental disorders needing urgent treatment may vary between 2 and 2.8 percent of the adult population. Most of these conditions are highly responsive to low-cost treatment although many require follow-up and rehabilitation and cure is not usually possible.
- The profile of persons with severe mental illnesses found in the community mirrors that of patients seen by specialist mental health workers in Saude Mental. This means that the service is accurately focusing its attention on the most disabling mental disorders as planned.
- Rates of posttraumatic stress disorder (PTSD) are much lower than they were in 2000. This suggests that there has been remarkable recovery from traumatic stress. The fact that East Timor has largely been peaceful and stable since 2000 and that people no longer live in fear is likely to be the main factor leading to this recovery.
- Levels of general community depression may be slightly higher than in some other countries and it may be that socio-economic hardship is partly responsible. This does not mean that all these persons need or want clinical interventions: some may be helped by community support, the church, NGOs, and other agencies. Further analysis of the data will be needed to assess how disabling these conditions are and to what extent additional clinical services may be needed for depression.
- The apparent wide variation (1.5 to 5.1%) across districts in mental health needs revealed in the census warrants further epidemiological research.

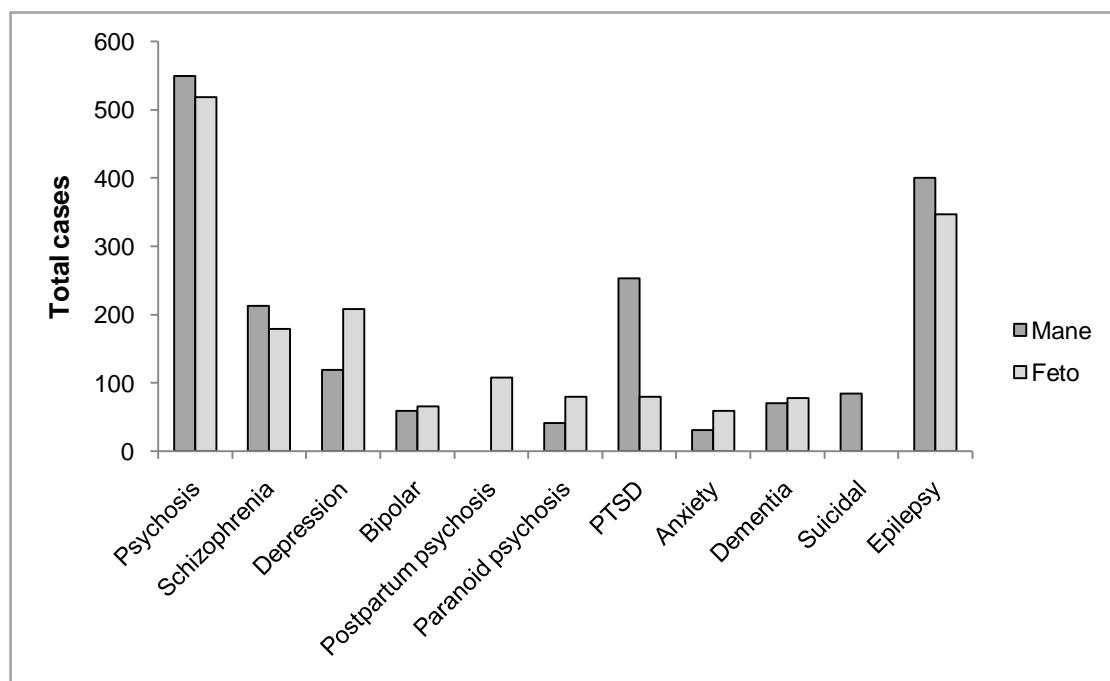
ANNEX 3: MENTAL HEALTH DATA FOR 2009

Data for this report was collected by the Specialist Mental Health Workers in each district, in collaboration with trained General Nurses in Community Health Centres. Data was collected monthly and returned to the Department of Mental Health through the Health Management Information System (HMIS) within the Ministry of Health.

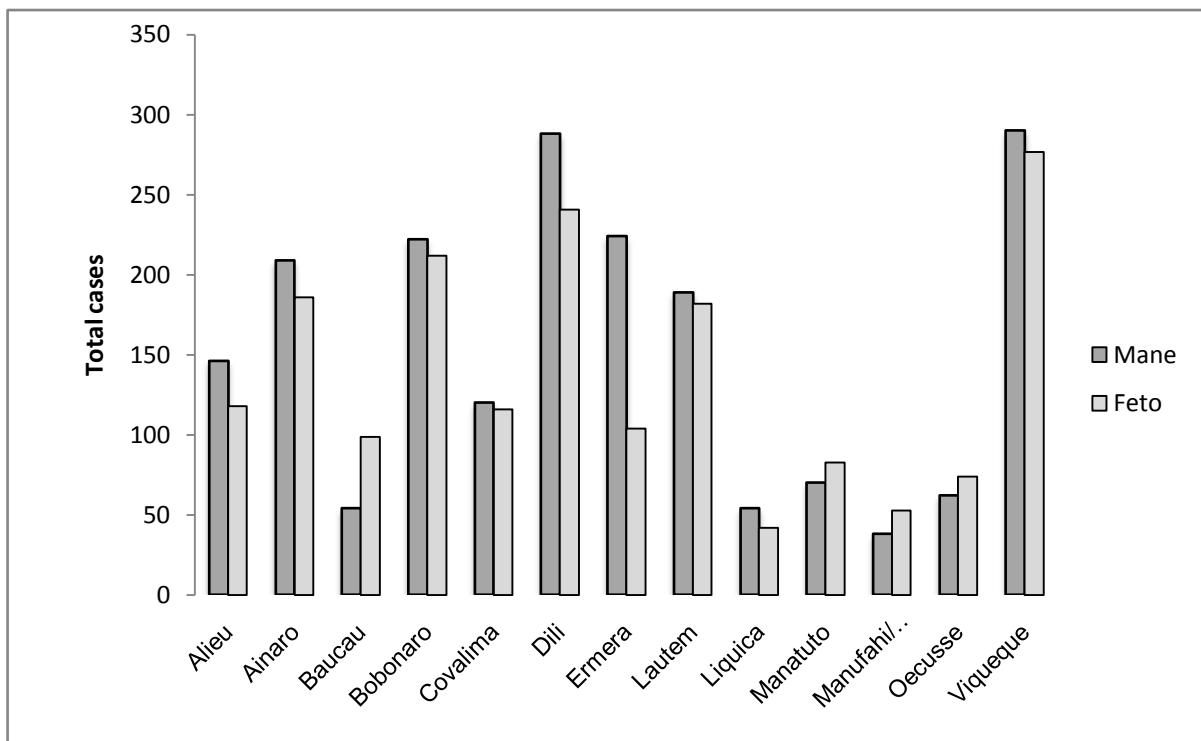
1. Total mental health caseload, 2009



2. Mental health caseload by diagnosis and gender

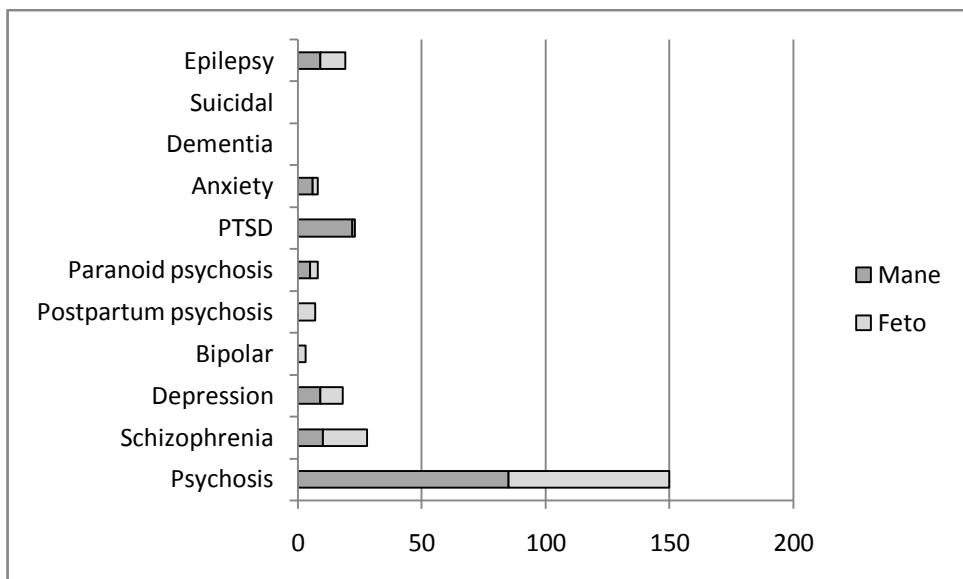


3. Mental health caseload by district and gender

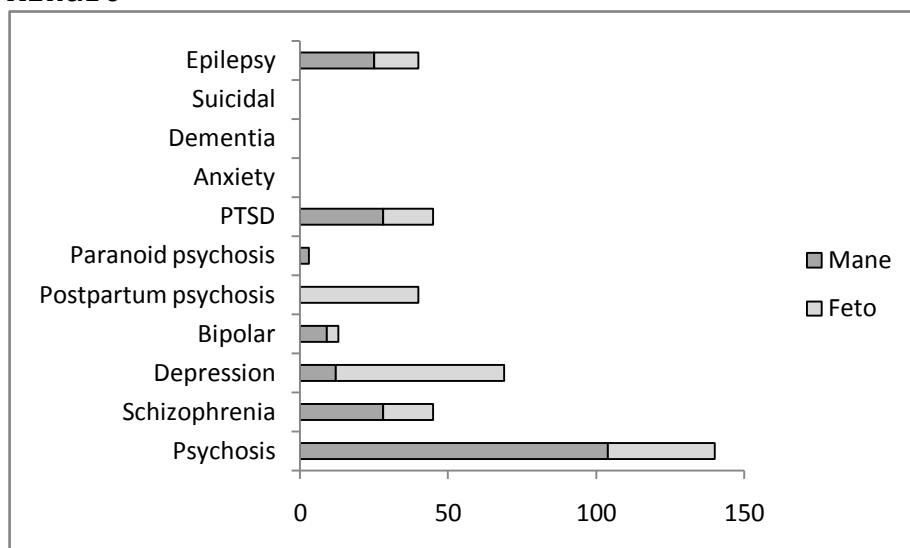


4. District caseloads by diagnosis and gender

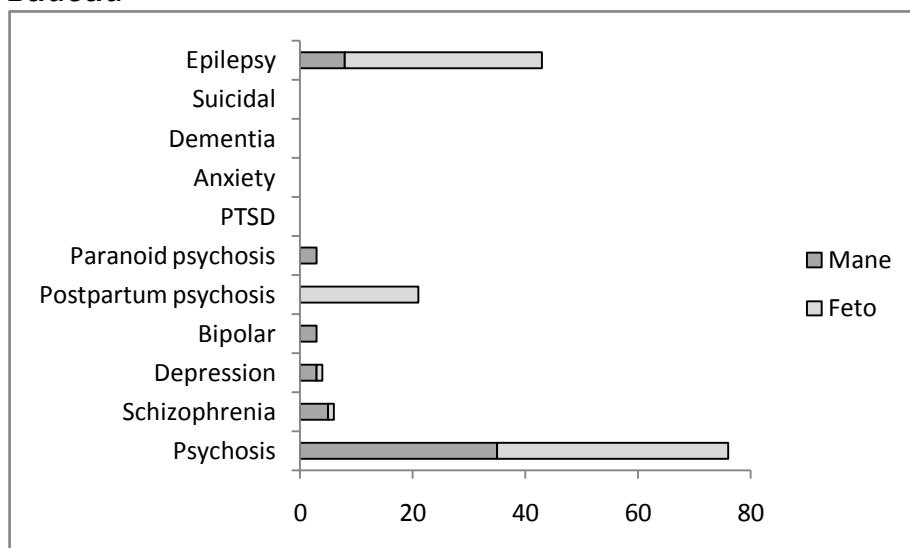
Aileu



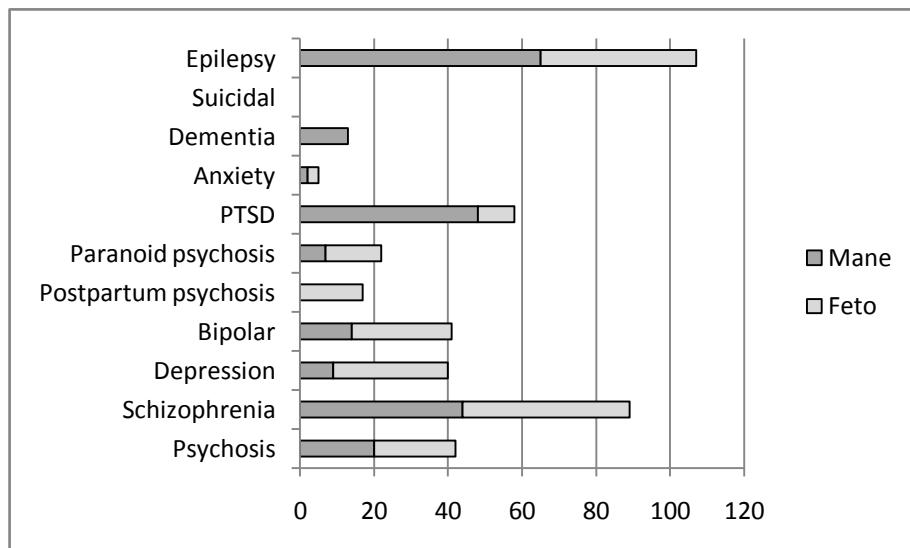
Ainaro



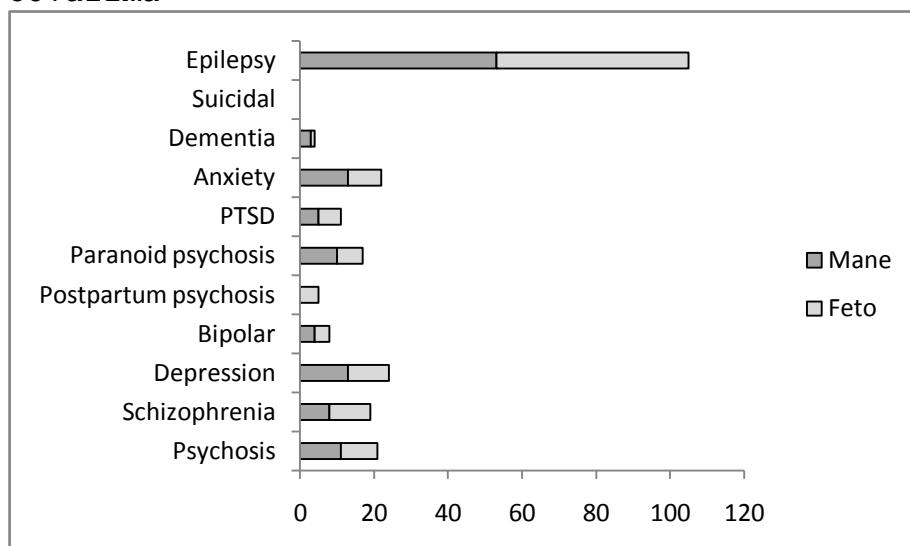
Baucau



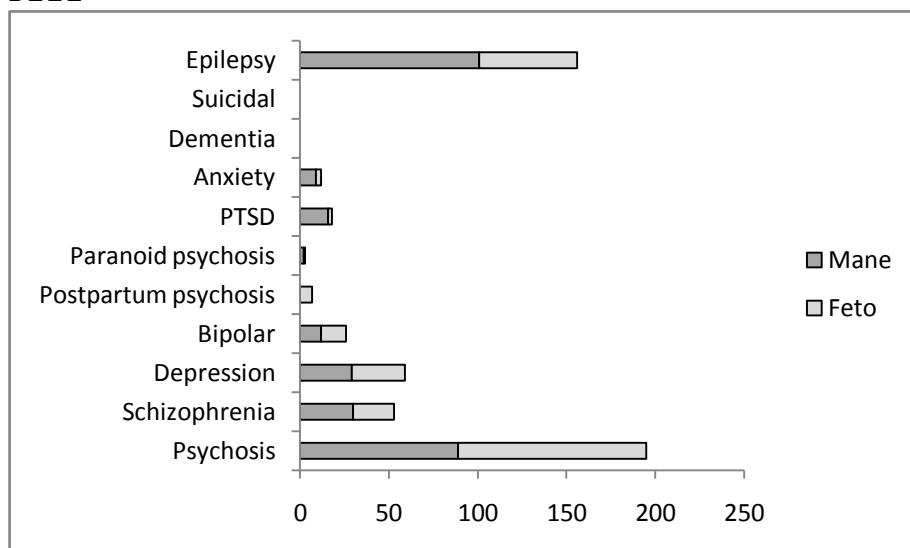
Bobonaro



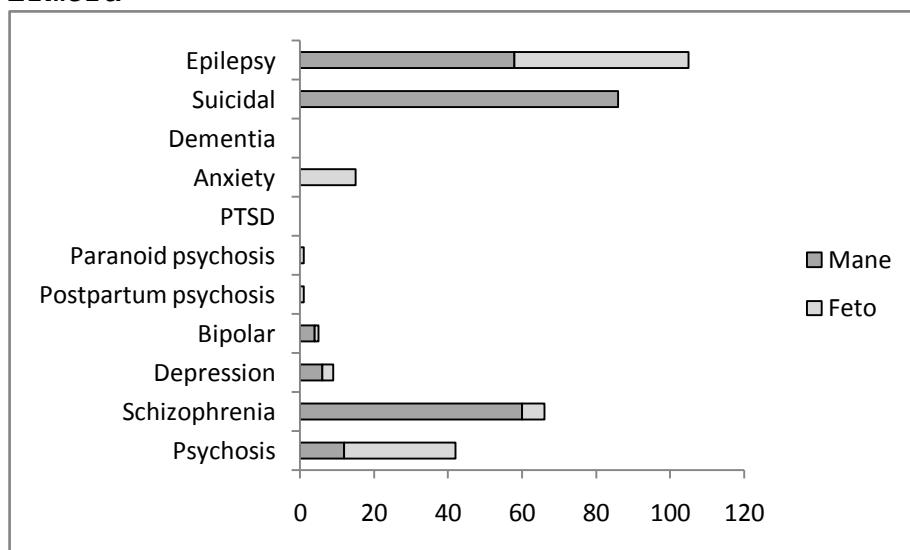
Covalima



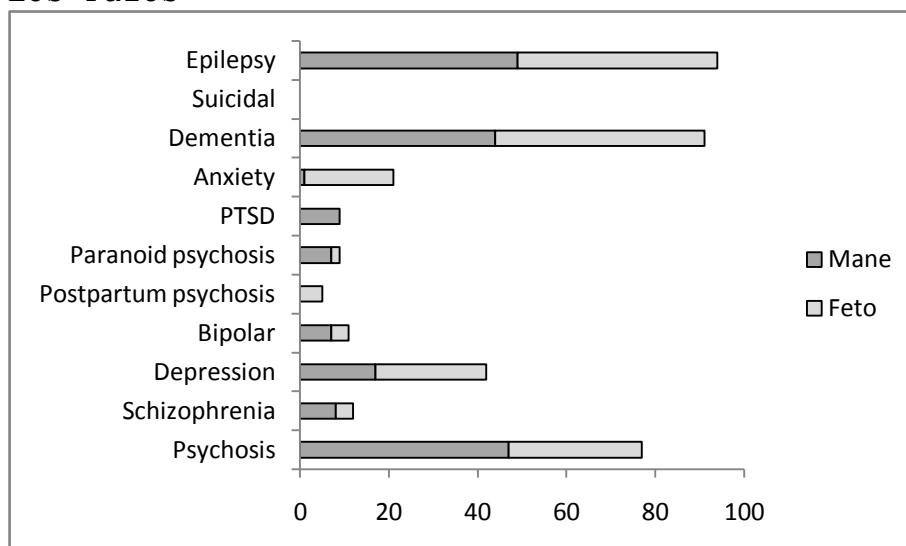
Dili



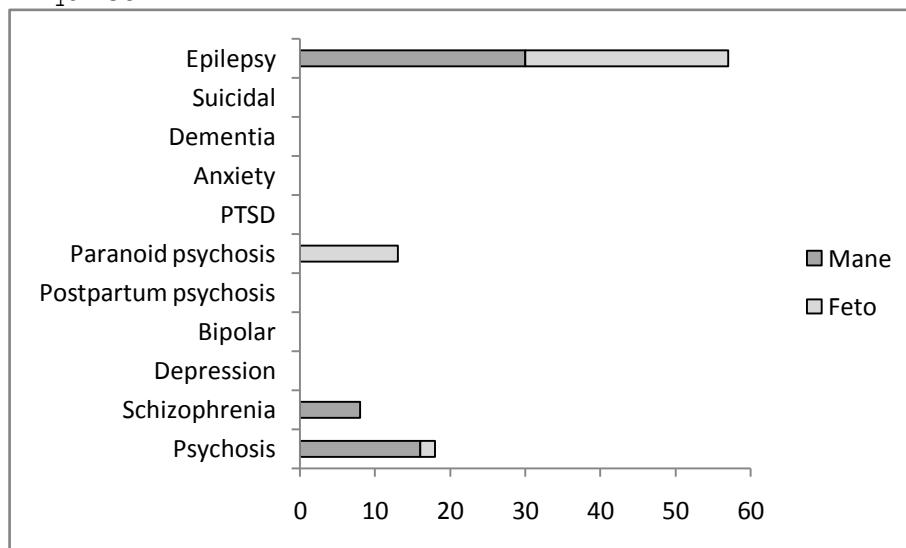
Ermera



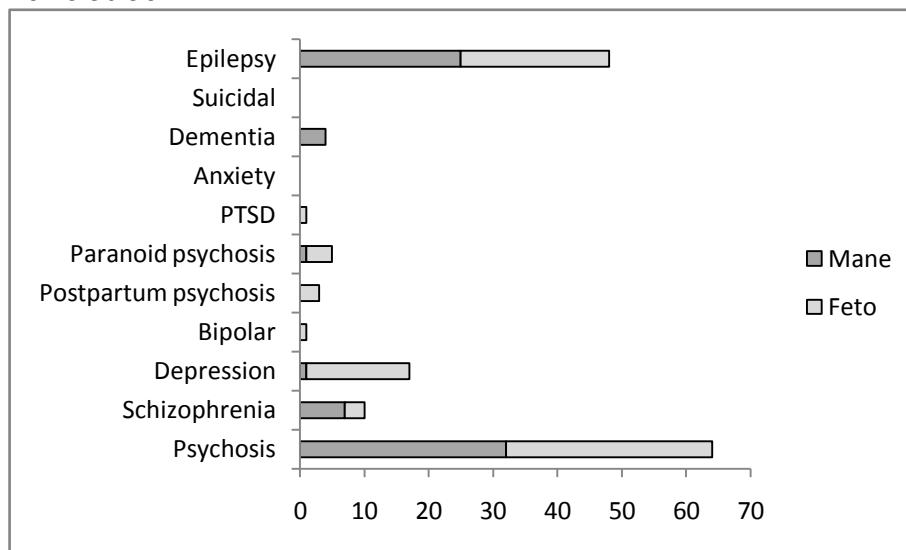
Los Palos



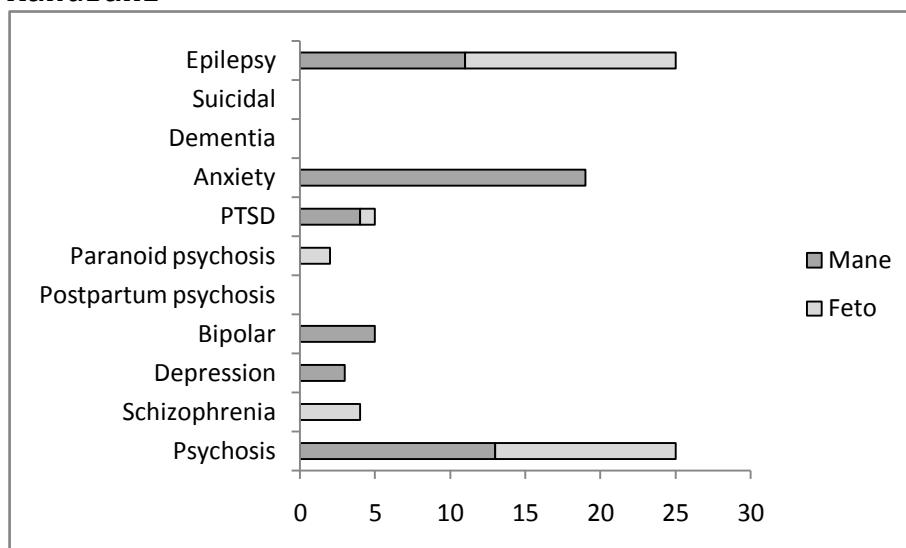
Liquica



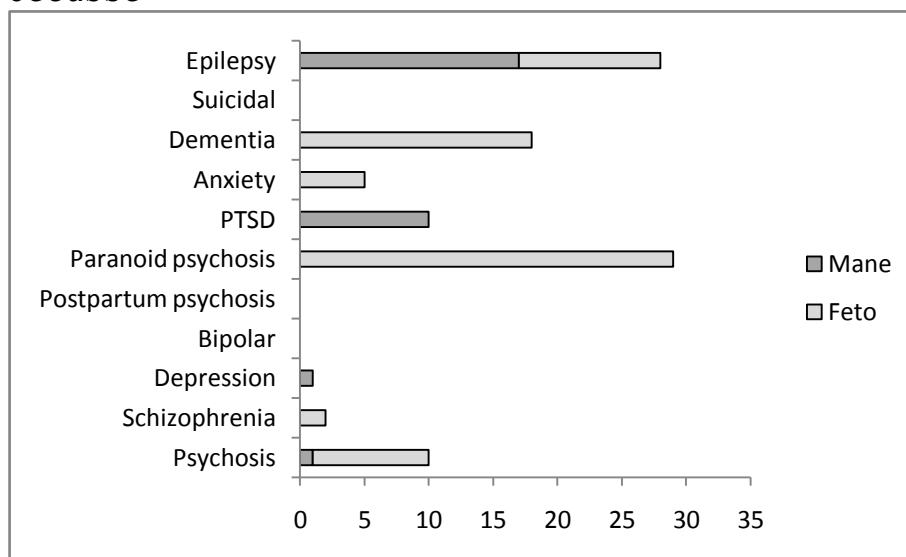
Manatuto



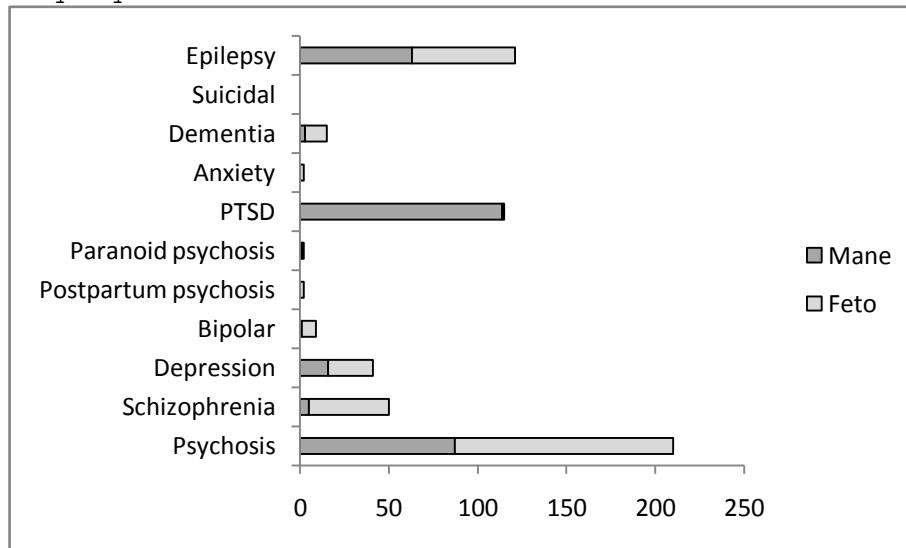
Manufahi



Oecusse



Viqueque



ANNEX 4: ESSENTIAL PSYCHOTROPIC MEDICINES LIST

LIST OF DRUGS ON ESSENTIAL LIST SUPPLIED BY CENTRAL PHARMACY CATEGORY: PSYCHOTHERAPEUTIC DRUGS

24.1 Drugs used in psychotic disorders

Chlorpromazine	10mgs; 25 mgs; 100mgs TABS 50mg in 2ml injectable
Fluphenazine decanoate injection (Modecate)	12.5mg in 0.5ml 25mg in 1 ml 1ml; 2ml syringes and correct grade needles available
Haloperidol (Serenace) TABS	0.5mg 1.5mg (1mg tabs manufactured by Harper)

24.2 Drugs used in mood disorders

Amitriptyline TABS	25mg 50mg
Sodium valproate TABS	200mg

24.3 Drugs used in generalized anxiety and sleep disorders

Diazepam TABS	2mg 5mg
---------------	------------

24.4 Drugs used in epilepsy and organic disorders

Carbemazepine (Tegretol) TABS	100mg 200mg
Sodium valproate TABS	200mg

24.5 Complementary Drugs

Benztropine (Cogentin) TABS	0.5mg 2mg
Benztropine injection	2mg in 2mls

ANNEX 5: DISTRICT REPORTING AND RECORDING FORMS



REPUBLICA DEMOCRATICA DE TIMOR-LESTE
MINISTERIO DA SAUDE

Distritu: _____

Formulario 13

Fulan: _____ Tinan: _____

Total CHC _____

Total HP _____

Total private clinic _____

Total CHC relata _____

Total HP relata _____

Total priv. clinic relata _____

DEPARTAMENTU SAUDE MENTAL
RELATORIO MENSAL SAUDE MENTAL

CODE	DIAGNOSIS	TOTAL KAZU TUIR IDADE NO SEXU																	
		0-10 anos		11-20 anos		21-30 anos		31-40 anos		41-50 anos		51-60 anos		>61 anos		TOTAL			
		Foun	Tuan	Foun	Tuan	Foun	Tuan	Foun	Tuan	Foun	Tuan	Foun	Tuan	Foun	Tuan	Foun	Tuan	Foun	Tuan
F23	Acute psychosis																		
F20#	Schizophrenia																		
F32#	Depressive disorder																		
F31	Bipolar disorder																		
F41.3	PTSD																		
F41.1	Anxiety disorder																		
F05	Delirium																		
F00#	Dementia																		
F70	Mental retardation																		
G40#	Epilepsy																		
	Diagnosis seluk																		
Fulan ne'e, total pasientes mental:		Simu tratamentu		Mate		Disk ona		Drop-out											
		F																	
		M																	
	Total																		
Fulan ne'e, total pasientes epilepsy:		Simu tratamentu		Mate		Disk ona		Drop-out											
		F																	
		M																	
	Total																		

_____ / _____ / 2010

NB. Pasientes nebe totalmente disk ona, leliku hatuna iha relatorio mensal, malibe wainhira nia monia fati, bele considera hanesian kazu foun



REPUBLICA DEMOCRATICA DE TIMOR-LESTE
MINISTERIO DA SAUDE

Distritu: _____

HP/CHC recording form

Fulan: _____ Tinan: _____

Name of HP/CHC/private clinic: _____

DEPARTAMENTU SAUDE MENTAL

RELATORIO MENSAL SAUDE MENTAL

CODE	DIAGNOSIS	TOTAL KAZU TUIR IDADE NO SEXU																	
		0-10 anos		11-20 anos		21-30 anos		31-40 anos		41-50 anos		51-60 anos		>61 anos		TOTAL			
		Foun	Tuan	Foun	Tuan	Foun	Tuan	Foun	Tuan	Foun	Tuan	Foun	Tuan	Foun	Tuan	Foun	Tuan	Foun	Tuan
F23	Acute psychosis																		
F20#	Schizophrenia																		
F32#	Depressive disorder																		
F31	Bipolar disorder																		
F41.3	PTSD																		
F41.1	Anxiety disorder																		
F05	Delirium																		
F00#	Dementia																		
F70	Mental retardation																		
G40#	Epilepsy																		
	Diagnosis seluk																		
Fulan ne'e, total pasientes mental:		Simu tratamentu		Mate		Disk ona		Drop-out											
		F																	
		M																	
	Total																		
Fulan ne'e, total pasientes epilepsy:		Simu tratamentu		Mate		Disk ona		Drop-out											
		F																	
		M																	
	Total																		

Chefe CHC/Private clinic, Distritu _____

No. ID Card _____

_____/_____/2010

Resp. Programa Saude Mental Sub-distrito

_____/_____/2010

NB. Pasientes nebe totalmente disk ona, leliku hatuna iha relatorio mensal, malibe wainhira nia monia fati, bele considera hanesian kazu foun

ANNEX 6: MONITORING AND EVALUATION FORMS



Supervisaun no Revisaun ba Enfermeiro Specialista Saúde Mental (1)

Formulario ne'e sei prenxo hosi ekipa supervisaun, nebe halo diskusaun ho enfermeiro saúde mental no halo revisaun mais ou menus dala 4 ba file kazus, inklui kazu epilepsia.

Naran (Enfermeiro
SM) _____ Distrito _____

Naran
(supervisor) _____ Data _____

	Kompetensias (Competencies)	SIM	LAE
1	Avaliasaun no diagnóstiku		
a	Enfermeiro saúde mental bele rekolha dadus kompletu hosi pasientes no familia		
b	Enfermeiro saúde mental usa informasaun nebe rekolha ona iha assemento hodi dertermina diagnostiku		
c	Enfermeiro saúde mental bele responde perguntas "tansa hau" ka "why me"? (exemplo; tansa ema ida ne'e moras? No "tansa agora?"		
d	Enfermeiro saúde mental bele identifika faktores bio-psychosocial-spiritual iha apresentasaun kazu pasien nian. The case manager can identify bio-psychosocial-cultural-spiritual factors in the patient's presentation		
e	Komentarios seluk/detalhos		

2	Plano tratamentos
a	Enfermeiros saúde mental dezenvolve plano ba kazu ida nebe iha ona negosiasaun entre pasiente, enfermeiro saúde mental, familia no parte seluk nebe involve.
b	<i>Biological</i> : medikamentus nebe fo'o ho seguru no neneik-neneik no hakerek detalho ka kompleto iha file
c	<i>Psycho-social-cultural-spiritual</i> : intervensoens Non-medikamentus usa atu ajuda pasiente hodi rekopera no hakerek iha file
d	<i>Kounseling</i> : Enfermeiro saúde mental usa konseling atu ajuda pasientes no familias hodi kompriende problema ne'e, no hodi buka hetan fali no aumenta sira nia kapasidades hodi resolve problemas ne'e
e	Komentarios seluk/detalhos
3	Follow-up
a	Enfermeiro saúde mental bele halo follow-up ba pasientes ho tempu nebe apropriadu. <i>Karik lae, razaun saida</i> :
b	Enfermeiro saúde mental bele halo re-Avaliasaun no plano kontinuasaun ka intervensaun foun <i>Fo exemplo hosi kazu ida</i> :
c	Enfermeiro saúde mental bele responde ba perguntas 'saida mak bele ajuda? Se mak bele ajuda?'
d	Enfermeiro saúde mental halo ligasaun ka koordena ho enfermeiros geral sira iha centros da saúde kona ba klientes sira Fo dethalhos inklui frekuensia no tipo diskusaun/referal pasientes

e	Enfermeiro saúde mental refere pasientes ho apropriadu ba NGO Pradet	
4	Jentaun ba kasus (Caseload management)	
a	Enfermeiro saúde mental bele determina nivel diferentes 4 ba necesidade pasientes (A-D) no fahe ka aloka sira nia tempu ho lolos ka apropriadu	
5	Promosaun saúde mental no dezenvolvimento komunidade (Mental health promotion and community development)	
a	Enfermeiro saúde mental envolve ka partisipa iha programa hasa'e kañhesimentu komunidade nian kona ba moras mental no saúde mental. Enfermeiro saúde mental usa estratéjias no intervensoens hodi promove no mantein saúde mental	
b	Iha tinan 2009, aktividades edukasaun ba komunidade hala'o dala hira ona? <i>Fo esplikasaun detalhos:</i>	
6	Jestaun ba servisu no administrasaun	
a	Relatorio mensal hala'o no entrega tuir data nebe determina ba Departemento saúde mental	

Supervizaun no Revizaun ba Enfermeiro
Saúde Mental (2):
Relatorio aktividades no Avaliasaun Servisu

Sei prenxo hosi enfermeiro saúde mental

Naran _____

Distrito _____

Data _____

Home visits

a) Ita bo'ot sira hala'o home visit dala hira?

- lor-loron
- 2 x kada semana
- 1 x kada semana
- 2 x kada fulan
- 1 x kada fulan
- < 1 x kada fulan
- nunka

b) Ita bo'ot sira simu osan insentivus ba aktividades home visit?

SIM / LAE

c) Ita bo'ot hetan assesu ba transporte hodi hala'o home visit?

SIM / LAE

Kontakto ho enfermeiros geral sira

a) Ita bo'ot hasoru malu / kontakto ho enfermeiros geral sira dala hira iha CHC hodi koalia kona ba klientes nebe ho moras mental?

- lor-loron
- 2 x kada semana
- 1 x kada semana
- 2 x kada fulan
- 1 x kada fulan
- < 1 x kada fulan
- nunka

b) Komentarios/ desafios / sujetostoen

Treinamento ba enfermeiros geral

a) Iha tinan 2009 ita bo'ot sira hala'o treinamento ba enfermeiros geral sira? SIM / LAE

b) Karik sim, hala'o dala hira? _____

c) Fo detalhos: formal ka informal, durasaun hira, topiku saida

d) Komentarios / desafios / sugestoes

Medikamentu/aimoruk

a) Ita bo'ot sente confidente kona ba aimoruk no nia dose wainhira ita bo'ot fo ba moras/ganguan nebe diferente?

- confidente tebes
- confidente oituan/naton
- laiha confidente

b) Ita bo'ot usa guidelines/guia medikamentus ba tratamento saúde mental? SIM / LAE

c) Ita bo'ot iha esperiensiia aimoruk psychotropic hotu/stock out durante tinan 2009 nia laran?

SIM/LAE

d) Karik sim, favour fo esplikasaun(iha fulan nebe, durasaun hira, aimoruk saida, etc.)

e) Komentarios / desafios / sugestoes

Total kazu (Caseload)

a) Agora dadaun ita bo'ot nia kazu hira? _____

b) Ita bo'ot bele jere ka maneija kazus hirak ne'e no didika tempu ho suficiente ba pasientes nebe presisa? SIM / LAE

c) Proporsaunka kondisaun klintes oinsa mak hetan atendimento hosi

Ita bo'ot sira

Enfermeiros geral

d) Komentarios / desafios / sujetostoen

Epilepsia

a) Ita bo'ot sira sei hare/atende klientes ho Epilepsia? SIM/LAE

b) Karik sim, iha kondisaun/proporsi saida klientes nebe hare hosi

Ita bo'ot sira

Enfermeiros geral

c) Ita bo'ot sente confidente/fiar an wainhira usa guia standarte ba tratamento epilepsia?

- confidente tebes
- confidente oituan
- laiha confidente

d) komentarios / desafios / sujetostoen

Aktividades SISCa

a) Karik ita bo'ot involve iha aktividades SISCa nebe iha relasaun ho saúdemental? SIM/ LAE

b) Karik sim, favour fo esplikasaun inklui horas, aktividades, desafios, no avaliaun ba aktividades

Loron Mundial Saúde Mental

a) Karik ita bo'ot organisa aktividades rumi hodi komemora loron mundial saúde mental iha tinan 2009? SIM / LAE

b) Karik sim, favour fo esplikasaun

Suporta hosi Senior (Senior support)

a) Karik ita bo'ot hetan suporta suficiente hosi

	Laiha suporta	Suporta oituan	Suporta nakon	Suporta diak	Suporta massimu
Director Saúde Distrito	1	2	3	4	5
Enfermeiros geral	1	2	3	4	5
Departamento Saúde Mental	1	2	3	4	5

b) Saida deit mak ita bo'ot hakarak Director hosi ita bo'ot nia distrito halo hodi suporta ka hadia ita bo'ot nia servisu?

c) Saida deit mak Departmento Saúde Mental halo hosi suporta ka hadia ita bo'ot nia servisu?

Kontinua dezenvolve profesional

(Continuing professional development)

a) Ita bo'ot hetan assesu ba materials/recursus hodi kapasita ita bo'ot nian iha area saúde mental (mental health for self-study)? SIM / LAE

b) Areas saida mak ita bo'ot hakarak aprende iha treinamento tuir mai?

Budget/orsamento ba aktividades saúde mental

a) Karik iha distrito ita bo'ot nian aloka ona orsamento ba saúde mental? SIM/LAE

b) Karik sim, fo hatene nia total karik hatene

c) Karik orsamento ne'e suficiente atu implementa ita bo'ot nia aktividades? SIM / LAE

Desafios

a) Desafios saida deit mak ita bo'ot hasoru wainhira hala'o ita bo'ot nia servisu?

Hadia Saúde Mental iha Timor-Leste

a) Ideas saida deit mak ita bo'ot iha atu hadia sistema saúde mental iha Timor-Leste?

Obrigada barak tamba prenxe ona avaliaçāun ne'e

ANNEX 7: INDICATORS



MENTAL HEALTH AND EPILEPSY INDICATORS

I.1. % Centru Saúde hala'o tratamentu ba moras mental

Definisaun Centru Saúde ne'ebe hala'o tratamentu ba moras mental, inklui assesmen, konsultasaun, no referal pasientes.

Esplikasaun Centru Saúde hanesan fatin ida integradu ba programa hotu-hotu saúde ne'ebé fo mos opurtunidade ba programa saúde mental hodi hetan tratamentu ba pasiente moras mental bele hetan fali rekoperasaun ou normaliza hikas nune'e pasiente, familia no komunidades bele hetan hikas fali kondisaun nebe saudavel iha ambiente nebe sira hela ba.

Formula
$$\frac{\text{Numeru Centru Saúde nebe hala'o tratamentu ba Moras mental iha tinan ida nia laran}}{\text{Total numeru Centru Saúde}} \times 100\%$$

Utilizasaun no Interpretasaun Utuliza indikador ne'e hanesan sasukat ida ba pesoal Centru Saúde ne'ebé fo assesu tratamentu ba saúde mental. Komunidade fasil atu hetan assesu asisténsia tratamentu ba moras mental nune'e labele sai grave ka izola an iha familia ou komunidade nia ambiente.

I.2. Ema nebe hetan tratamentu schizophrenia hanesan proposaun hosi total estimasaun predominio (prevalence) hosi schizophrenia hosi populasaun (1%)

Definisaun Pasientes ho diagnostiku schizophrenia hetan tratamentu aimoruk psikotiku, kompara ho numeru estimasaun hosi ema nebe ho schizophrenia iha nasaun/distritu ida.

Esplikasaun Indikador ne'e avalia/sukat tratamentu hotu-hotu hosi ema ho moras schizophrenia, no

bele fo indikasaun ida hosi tratamentu hotu hosi moras mental seluk.

Formula Ema nebe hetan tratamentu schizophrenia x100
Estimasaun predominio (prevalence)
schizophrenia hosi total populasaun (1%)

Utilizasaun no
Interpretasaun Utuliza indikador ne'e atu avalia) expansao (desenvolvimentu servisu no assesu pasientes mental ba servisu saúde mental

I.3 Ema nebe hetan tratamentu epilepsy hanesan proposaun hosi total estimasaun predominio (prevalence) hosi epilepsy hosi populasaun (1%)

Definisaun Pasientes ho diagnostiku epilepsy hetan tratamentu ho aimoruk anti-epileptic, kompara ho numeru estimasaun hosi ema nebe ho epilepsy iha nasaun/distritu ida
Esplikasaun Indikador ne'e avalia/sukat tratamentu hotu hotu hosi ema ho moras epilepsy, no bele fo indikasaun ida ho nivel assesu tratamento ba pasiente epilepsy

Formula Ema nebe hetan tratamentu epilepsy kada tinan-tinan x100
Estimasaun predominio
(prevalence epilepsy hosi total populasaun (1%)

Utilizasaun no
Interpretasaun Utuliza indikador ne'e atu avalia expansao (desenvolvimentu) servisu no assesu pasientes ho epilepsy ba servisu Epilepsy Project



***MINISTERIO DA SAÚDE
DIRECÇÃO NACIONAL SAÚDE
COMUNITÁRIA
DEPARTAMENTO SAÚDE MENTAL***



***LIVRO REGISTO PASIENTE
MORAS MENTAL
PROGRAMA NACIONAL SAÚDE MENTAL
TIMOR LESTE***

REGISTRO PASIENTE MORAS MENTAL

CHC :
HP :
.....

Distrito :
Sub Distrito :

Data Follow-up Pasiente Mental Kada Fulan-Fulan

ANNEX 9 : LOGFRAME PLANU STRATEGIA SAÚDE MENTAL 2030

OBJECTIVES: To provide a high-standard, comprehensive mental health service across the country and at all levels of the health system, including advocacy, education, prevention, diagnosis, treatment and follow-up services \							
STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	PRIMARY RESPONSIBILITY	Target 2015	Target 2020	Target 2025	Target 2030
1. Improving access to health facilities and treatment for all people with mental illness or epilepsy	Improve access to mental health services at all levels of health facility	% of Hospitals, CHC, and HP that provide mental health services	National, Hospital and District Level	30 %	60%	80%	100%
	Increasing identification and access to diagnosis and treatment for all people with mental illness in a community	% of mental disorders treated as a proportion of the estimated prevalence of mental disorders in that population	National, Hospital and District Level	10%	50%	80%	100%
	Increasing identification and access to diagnosis and treatment for all people with epilepsy in a community	% of epilepsy treated as a proportion of the estimated prevalence of epilepsy in that population	National, Hospital and District Level	10%	50%	80%	100%
2. Increase community awareness and understanding of mental illness and epilepsy through advocacy, education, and promotion.	Improve community awareness and understanding of mental illnesses and epilepsy, to increase case finding and decrease stigma and discrimination	% of SISCa posts which provide advocacy and education about mental illness and epilepsy every month	National, Hospital and District Level	20%	30%	50%	100%
To develop a comprehensive multi-disciplinary team consisting of psychiatrists, psychiatric nurses, psychologists, and mental health technical professionals who have professionals, who have been appropriately skilled and have reached specific standards of training	To provide Senior Specialist Psychiatrists for National and Referral Hospitals Qualifications BM BCh or equivalent (medical degree) Minimum 5 years supervised post-graduate training in an approved post in Psychiatry Member of a RoyalCollege of Psychiatry or equivalent	Number of Senior Specialist Psychiatrists	National	2	5	6	7 (2 National , 5 referral hospitals)
	To provide Junior Specialist Psychiatrists for District Hospitals Qualifications BM BCh or equivalent (medical degree) Minimum 2-4 years supervised post-graduate training in an approved post in Psychiatry	Number of Junior Specialist Psychiatrists	National	2	5	6	7 (district hospitals)

	To provide Specialised Psychiatric Nurses (Bachelor degree 3 years + 1 year specialization) for Ministry of Health, National and Referral Hospitals	Number of Specialised Psychiatric Nurses working in Acute Care Facilities		5	10	14	14 (7 in district hospital, 5 in referral hospital, 2 in National Hospital)
		Number of Specialised Psychiatric Nurses working in CHC, outreach, MoH		25	50	66	66 (1 in MoH)
	To provide General Nurses (Bachelor degree 3years) with mental health interest and on-the-job training	Number of mental health trained General Nurses working in Acute Care Facilities		30	40	59	59 (28 in districts, 25 in referral hospital, 6 in National)
		Number of mental health trained General Nurses working in CHC, outreach		25	50	65	80
	To provide Clinical Psychologists (Bachelor degree 4 years)	Number of Psychologists		10	20	29	29 (1 in MoH)
	To provide Social Workers (Bachelor degree 4 years)	Number of Social Workers		10	20	28	28
3 To provide Acute Care Facilities for the short term assessment and treatment of the most severely mentally ill, at National Hospital, Referral and District Hospitals	Establish Acute Care Facilities at the National Hospital (12 beds)	Acute Care Facility established at National Level		1			
	Establish Acute Care Facilities at the 5 Referral Hospitals (6 beds)	Acute Care Facility established at Referral Level		5			
	Establish Acute Care Facilities at the 7 District Hospitals (4 beds)	Acute Care Facility established at District Level		7			