CONFERENCE PROCEEDINGS

Partner's Conference on Behavioral Health

May 1-3, 2006
Kabul, Afghanistan

Introduction

On May 1-3, 2006, Afghanistan's Ministry of Public Health (MOPH) and the US Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) jointly sponsored the *Partners' Conference on Behavioral Health* at the Ministry in Kabul.

Minister of Public Health S.M. Amin Fatimie and Deputy Minister Faizullah Kakar welcomed the approximately 70 participants who attended the three-day Conference, including Administrator Charles G. Curie of SAMHSA, representatives from the MOPH and from other Ministries (including the Ministries of Foreign Affairs, Counter Narcotics, Martyrs and Disabled, and Education), doctors and other health professionals from throughout Afghanistan, partners funding health services in Afghanistan (including USAID), United Nations (UN), the World Health Organization (WHO), and non-governmental organizations (NGOs) providing mental health services, including Health Net International (HNI), Caritas Germany, International Assistance Mission (IAM) and International Medical Corps (IMC).

On the final day of the conference – after two days of presentations and discussions of core elements of mental health and substance abuse services, capacity development needs and lessons learned – participants identified human resource development and integration of behavioral health care into the Basic Package of Health Services (BPHS) as the top priority strategies in developing behavioral health services in Afghanistan. Participants also identified specific action steps for each of the nine strategies in Afghanistan's National Strategic Plan for Mental Health.

The Workgroup on Afghanistan Mental Health, led by SAMHSA and the MOPH, played a leading role in shaping the Conference agenda. The Afghan members of the Workgroup were critical to the success of the Conference, including Dr. Ruhullah Nassery, Mental Health Coordinator in the MOPH; Dr. Nahid Aziz, professor of psychology at Argosy University in Washington, DC; Ms. Awista Ayub, Health Officer with the Embassy of Afghanistan in Washington, DC; and Dr. Homaira Behsudi and Dr. Wasel Akbary of the Afghan American Medical Professionals Association. The Workgroup is currently planning specific steps to support the mental health directorate in the MOPH and to help the MOPH and its partners finalize Afghanistan's National Strategic Plan for Mental Health and implement the action steps identified at the Conference.

The following provides a summary of each of the Conference sessions, as well as a transcription of the recommendations presented by participants at the end of the Conference. The full Conference agenda is available at Addendum A. The participant list (including registered participants only) is available at Addendum B.

Monday, May 1, 2006

Welcome and Introductions

MINISTER S. M. AMIN FATIMIE (MOPH)
DEPUTY MINISTER FAIZULLAH KAKAR (MOPH)
ADMINISTRATOR CHARLES CURIE (SAMHSA)

Noting that "mental health is crucial to fostering a constructive relationship between health and development," Minister of Public Health S.M. Amin Fatimie and Deputy Minister of Public Health Faizullah Kakar opened the Conference by stating their commitment to integrating mental health into Afghanistan's Basic Package of Health Services (BPHS). Dr. Fatimie also noted that substance abuse problems in Afghanistan need international attention and concluded that it is "time for mental health to be a priority – health without mental health is incomplete."

Administrator Curie then stressed the importance of integrating mental health and substance abuse services into primary care and applauded Afghanistan for integrating behavioral health into the BPHS. He also noted that "recovery is the ultimate goal" and that we all must create systems of care around the people and families needing that care. Mr. Curie concluded by noting that Afghanistan has an unprecedented opportunity to "do things right" in implementing its National Mental Health Strategy, which will bring hope, the most important factor in recovery, to the people of Afghanistan.

Integration of Mental Health and Substance Abuse Services into Primary Care

DR. THOMAS BARRETT (WHO/GENEVA)
DR. M. SAYED AZIMI (WHO/KABUL)

Dr. Thomas Barrett of WHO reviewed findings from the WHO Assessment Instrument for Mental Health Services (AIMS Report) for Afghanistan. Stating that neuropsychiatric disorders contribute significantly to the burden of disease, Dr. Barrett noted that a third of persons with disabilities have mental illnesses, and that, although the average country expenditure on mental health is 2% of the national health budget, mental health disorders are responsible for 13% of disease burden.

Dr. Barrett explained that the AIMS Report assesses a country's mental health efforts in six domains: 1) policy, plans and legislation; 2) mental health services; 3) mental health in primary health care; 4) human resources; 5) public education and links with other sectors; and 6) monitoring and research. Afghanistan's assessment demonstrates a need to update the mental health plan, increase community services (especially in rural areas),

increase availability of medications, and increase access to services for women.

Dr. M. Sayed Azimi reported that the general hospitals and the central psychiatric hospital in Kabul have no beds for children and adolescents. Further, they have documented that 20% of patients in in-patient units have mood disorders. He concluded by noting that minorities in Afghanistan enjoy the same access to care as others.

Dr. Barrett then outlined the essential elements of a package of mental health services:

1. Formal and carefully articulated part of the overall health sector response
2. Sustainable community mental health efforts
3. Organized mental health services in primary care
4. Training in mental health for health care workers, and specialized mental health training for psychiatrists, psychologists, psychiatric nurses, and social workers
5. Materials and programs for patients and families, and for families as care providers

Specific recommendations to Afghanistan from the AIMS Report include the following:

- Update the National Strategic Plan for Mental Health
- Improve community services, including
  - Increase availability in rural areas, where users are substantially underrepresented;
  - Improve availability of medications, as most community hospitals do not have access to medications; and
  - Improve the mental hospital environment. The mental hospital currently has no electricity or running water, more than 20% of patients are restrained or secluded, and women experience barriers to access (only 18% of admissions are female).
- Increase mental health services in Marastoons
- Increase the number of mental health professionals
- Increase mental health training for primary care workers

Dr. Barrett noted that successful programs include early childhood mental health promotion, screening and treatment programs, as well as programs that empower women. He concluded by citing two success stories. Sri Lanka has divided its regions (provinces) into districts and has identified donors for each district that fund community mental health teams for their districts. He also cited Nigeria as demonstrating cost-effective provision of medications for schizophrenia, depression, and epilepsy, and conducting roadside breath tests for driving under the influence of alcohol.

In answering follow-up questions, Dr. Barrett and others made the following points:

- Although there are differences between the impact of natural versus man-made disasters, "the trends are similar" but man-made disasters have longer-term impacts.
- Untreated trauma can lead to addiction and family violence
- Although there are good examples of physical illness due to mental health disorders, the WHO doesn't have a document summarizing such examples.

Participants asked for follow-up information on the impact of mental health care and support for people living with HIV/AIDS, and they asked for further information on the use of the Disability-Adjusted Life Year (DALY) composite indicator in calculating the costs of mental disorders and mental health services.

Current Mental Health Situation of Afghanistan

DR. RUHULLAH NASSERY (MOPH)

Dr. Ruhullah Nassery, National Mental Health Coordinator for the Ministry of Public Health, began his presentation on the current mental health situation by raising three questions:

1. What can be done?
2. What has been done?
3. What should be done?

In response to the first question he reviewed the WHO's different mental health care models currently being used around the world including integrating mental health into general health care, community-based mental health care, and hospital-based mental health services. Dr. Nassery said that although each of these models is important, the best strategy for Afghanistan is integration of mental health into general health care, closely linked with community- and hospital-based care for those with serious mental illness.

Dr. Nassery reported that there are very limited efforts to establish mental health care in Afghanistan and noted that the current resources (only one 60-bed hospital for the whole country and some allocated beds in big provinces, as well as only two psychiatrists and no clinical psychologists) cannot sufficiently address the significant mental health problems afflicting the people of Afghanistan.

In response to the question of what has been done, Dr. Nassery noted that the MOPH has included mental health as one among the seven priority components mentioned in the Basic Package of Health Services (BPHS). Mental health was originally in the second tier for implementation but the new leadership of the Ministry moved it to the first tier of BPHS for implementation.

Dr. Nassery then described Afghanistan's strategy of integrating mental health into primary health care, highlighting the following achievements:

- Establishment of a mental health unit in the MOPH
- Development of a mental health strategy for integration in primary health care
- Revision of mental health requirements in the BPHS
- Revision of mental health requirements in the Essential Package of Hospital Services (EPHS)
- Development of a framework for mental health policy

- Creation of a five-year National Strategic Plan for Mental Health
- Development of standard treatment protocol

Dr. Nassery summarized the challenges facing Afghanistan as it seeks to implement mental health services:

- Severe shortage of mental health professionals
- Low service delivery
- Little attention given to the mental health of medical facility staff
- Shortage of psychotropic medication
- Lack of appropriate legislation and mental health policy
- Low support to the Central Mental Health Directorate
- Low motivation of mental health care providers
- Low mental health awareness among general population

Dr. Nassery's presentation ended by answering the question of what should be done. He asserted that the recently developed National Strategic Plan for Mental Health is the way to tackle the challenges mentioned and he stressed the need for technical and financial assistance as Afghanistan establishes a mental health system appropriate to its needs.

Experiences in Integrating Behavioral Health Services into Primary Care – The Role of the Primary Care Provider

DR. WASEL AKBARY, INTERNIST (PRIVATE PRACTICE)
DR. ANITA EVERETT, PSYCHIATRIST (SAMHSA)
DR. DAVID TARANTINO, FAMILY MEDICINE (U.S. DEPARTMENT OF DEFENSE)

Dr. Wasel Akbary stated that primary care doctors such as internists and family care doctors manage the health care needs of individuals on a regular basis in the U.S. but this trend is different in Afghanistan where most people are seen by different doctors at different times. Because of the complexity of physical symptoms of mental health issues, most patients first present to their primary care doctors for evaluation of their symptoms, thus primary care doctors play a major role in diagnosing and treating major mental health illnesses such as depression, anxiety, PTSD, learning disorders and substance abuse disorders. For example, over half of all behavioral health services in the U.S. are provided by primary care physicians. Additionally, 42% of clinical depression cases and 47% of general anxiety disorder cases were first diagnosed by primary care physicians.

Dr. Akbary cautioned that primary care physicians must differentiate between true psychiatric illnesses and those caused by medical problems such as cancer, diabetes, coronary heart disease, HIV/AIDS, Parkinson's disease and patients on hemodialysis. The primary care doctor must be aware of cultural, environmental and social conflicts that could attribute to the patient's mental health and must focus on patient education to combat the social stigma surrounding the mental health illnesses. The primary care physician works closely with other specialists such as psychiatrists, psychologists and counselors to help patients combat their mental health disease.

Dr. David Tarantino echoed Dr. Akbary's emphasis that the primary care setting is the optimal arena to address the majority of mental health issues, especially with a predominantly rural population such as in Afghanistan. However, creating the conditions whereby a country's primary care capabilities are adequate to address mental health issues requires significant investments and should follow certain essential steps:

- Establish mental health service "packages" for various levels of care, as currently being developed in Afghanistan's Basic Package of Health Services
- Develop clinical practice guidelines for the various services and conditions outlined in the mental health service packages
- Develop and empower adequate human resources to meet clinical practice guidelines in the delivery of mental health service packages through: 1) job descriptions; 2) development of multi-disciplinary teams (including ancillary mental health workers); and 3) education and training tailored to the mental health service packages
- Establishment of a primary mental health formulary (tailored to the clinical practice guidelines and mental health services packages) and assurance of adequate supply of appropriate medications
- Development of patient records and health information management systems to track symptoms, diagnosis, treatment, and referral
- Establishment of a mental health referral system with primary care as the central entry/referral point
- Development of quality assurance programs – establish metrics/indicators for mental health services in primary care

Dr. Tarantino noted that these essential steps for establishing mental health services in the primary care setting cannot be accomplished all at once across an entire country, so pilot programs may be the best way to get started.

Dr. Tarantino also stated that the specialty of family medicine is particularly well-suited to foster the establishment of mental health services in the primary care setting. Family medicine is the medical specialty which provides continuing, comprehensive health care for the individual and family. It is a specialty in breadth that integrates the biological, clinical, and behavioral sciences. The scope of family medicine encompasses all ages, both sexes, each organ system and every disease entity. Family medicine is particularly well-suited to Afghanistan's rural populace and to the cultural centrality of the family in Afghan life. Dr. Tarantino provided the following resources for additional information concerning family medicine:

- American Academy of Family Physicians: www.aafp.org
  - "American Family Physician" journal available free online
  - International Family Medicine programs
- American Board of Family Medicine: www.theabfm.org
  - "Journal of the American Board of Family Medicine" available free online: www.jabfm.org

Dr. Anita Everett's talk addressed three goals: 1) to review the historical antecedents contributing to service delivery in specialty mental health care versus the primary care

setting; 2) to review different types of presentations of mental illness in different settings; and 3) to identify lessons learned in the US during the integration of mental health diagnosis and treatment into primary care services.

Initially in the US, persons with mental illness that resulted in risks to public safety and public nuisance were essentially confined in jails and alms houses. Persons with "quieter" presentations of mental illness were contained in family settings. As specialty knowledge developed, special places were created for individuals with mental illness that often included large institutions and were seen as the idealized specialty center of treatment for all forms of mental illness. As our knowledge develops and access to medications and other forms of treatment increases, more individuals are being treated in outpatient and community settings. Today in the US 10 to 24% of all patients presenting to a primary care center have a significant mental health or substance abuse problem. Seventy per cent of all antidepressants in the US are prescribed by primary care physicians (PCPs) and the majority (about 60%) of antipsychotic medications are prescribed by PCPs.

Primary care physicians are trained to recognize basic mental illnesses and substance abuse. There is attention to the "quieter" presentations of mental illness, such as depression and anxiety disorders, as well as the "loud" forms of mental illness, such as paranoid psychosis, schizophrenia, and mania. Yet often in the US "quieter" forms of mental illness are still not diagnosed or treated. Additionally there are long waiting lists for specialty psychiatric services so that if treatment cannot occur in the primary care setting, persons often are not treated.

According to Dr. Everett, several recent studies have focused on maximizing the capacity of the primary care service system to correctly identify and treat mental illnesses particularly so that treatable suffering and disability can be appropriately addressed. The results of several current studies indicate that most mental illnesses can be effectively diagnosed and treated in primary care settings. The US experience has been that training of primary care staff is a foundation but is not alone sufficient. Too often practitioners and doctors do not look for and treat mental illnesses, especially the "quieter" presentations. We have learned in several studies that employing a mental health and substance abuse specialist in the primary care clinic significantly improves outcomes by creating an ongoing presence for mental health and substance abuse. Furthermore, we have learned that the inclusion of a mental health and substance abuse specialist in the primary care center coupled with access to a supervising psychiatrist for the most challenging cases is the most effective combination for achieving best outcomes.

Dr. Everett concluded by expressing great enthusiasm for the current progress and commitment Afghanistan has made in prioritizing the inclusion of mental health and substance abuse services within primary care set of services. Afghanistan has the opportunity to study the lessons learned from the US and other countries, choose and adapt the components that fit within Afghan culture and implement a first-rate effective and efficient system that avoids many of the challenges faced by other countries.

Managing Behavioral Health Priorities and Services: A Public Health Approach

ADMINISTRATOR CHARLES CURIE (SAMHSA)

Administrator Curie addressed Conference participants at lunch on May 1st. He called upon participants to learn from "SAMHSA's hard-won lessons" to integrate both mental health and substance abuse services into primary care, and offered SAMHSA's Matrix of Priorities as a tool for Afghanistan to organize and track activities in support of its National Strategic Plan for Mental Health. Essentially, he noted, the Matrix provides a means to establish cross-cutting workgroups and ensure that all activities support implementation of priorities: "If it's not on the Matrix, it's not in the budget."

Mr. Curie also offered SAMHSA's National Outcome Measures, ten measures that focus on the progress and recovery of the persons being served, as a potential tool. These measures include abstinence from drug use and reduced mental illness symptomatology, as well as measures of the "work" of recovery: getting and keeping a job or enrolling and staying in school; decreased involvement with the criminal justice system; securing a safe, decent and stable place to live; and social connectedness to and support from others in the community such as family, friends, co-workers and classmates. He ended by remarking that he is inspired by the resilience and determination of the Afghan people and offered SAMHSA's help for Afghanistan's integration of behavioral health into the BPHS.

Research Proposal: The Impact of Omega-3 Fatty Acids on Depression in Post-Partum Women

DEPUTY MINISTER FAIZULLAH KAKAR (MOPH)

Deputy Minister Kakar presented his proposal to study the effect of Omega-3 fatty acids on depression in post-partum women by noting that he had originally been interest in Omega-3 to prevent heart attacks. Stating that he had noticed that there are an "enormous number of intellectuals from the area [in Afghanistan] where flaxseed oil is consumed," Dr. Kakar then described his initial review of the literature on Omega-3, including information on the long-term effects of Omega-3 deficiency. He stated that he would like to do research into various observations that have been made, including that women with post-partum depression have lowered levels of Omega-3.

Panel Discussion: Challenges and Lessons Learned in Providing Behavioral Health Services in Afghanistan

DR. HAIFIZULLAH FAIZ (HEALTH NET INTERNATIONAL)
DR. SABOUR MANSOURI (INTERNATIONAL ASSISTANCE MISSION)

DR. INGE MISSMAHL (CARITAS/GERMANY)

Representatives of three NGOs providing mental health services in Afghanistan recounted the challenges and lessons they have learned.

Health Net International (HNI): Dr. Haifizullah Faiz, Mental Health Coordinator of HNI in Afghanistan, described HNI's efforts in Nangahar to build local training capacity and train local health care workers. HNI is also providing psychosocial services via support groups, psychoeducation, and case management and they have trained village volunteers to run support groups and provide some psychoeducation. Dr. Faiz described the principles of training that HNI has learned through this experience:

- Limit the content of the training
- Focus on practical knowledge
- Provide training on the spot
- Provide training in the local language
- Ensure that the training is culturally appropriate

Dr. Faiz told participants that HNI provides a two-month training for the first referral point, and two weeks of training to primary care doctors, nurses, and midwives. Community health workers receive three to five days of training, and "FIFs" (Female Influential Figures) receive one day of awareness training. All participants receive handouts and manuals.

Dr. Faiz described the following lessons learned:

- Short-term training is not enough
- Psychiatry and psychosocial work can reinforce each other
- Materials should be culturally appropriate

He ended his talk with the following challenges:

- Finding and keeping staff
- Developing a referral system to move consumers from primary care to focused mental health screening and services
- Using paramedical staff of the health facility to address mental health
- Finding effective psychoeducational interventions, especially for men

International Assistance Mission (IAM): Dr. Sabour Mansouri described IAM's efforts in Herat, noting that Herat is the site of many of the recent self-immolations by young women. He noted that IAM has a long-term commitment to capacity building and that participants in its programs are primarily women. To date, IAM has seen 2,566 people in its outpatient clinic, which is also a training facility. At this time, six doctors and three nurses have been trained and are providing mental health care. IAM plans to train community health workers and medical professionals in the western region and to offer refresher courses and residency training for medical professionals.

Dr. Mansouri noted the following challenges and problems experienced by IAM:

- Communication and coordination with "always busy" local leaders

- Coordination between different stake holders, including national and provincial officials
- Needs exceed capacity
- Need to find an adequate training program in Iran

Caritas Germany: Dr. Inge Missmahl, director of Caritas' psychosocial counseling program in Afghanistan, stated that the objectives of Caritas Germany is to develop and train 32 psychosocial counselors and to offer psychosocial services. The training is a two-year course with provision for training of trainers (TOT). The project has gone through two phases:

- Phase I (before opening psychosocial centers): 3 ½ month intensive trainings for 33 counselors; preparation to open centers.
- Phase II (after opening centers): on-going training; running counseling centers; opening a psychiatric clinic; and on-the-job (OTJ) training.

At this time, Caritas Germany is operating 15 centers around Kabul, with at least one male and one female staff each. Its ongoing training consists of a two-week intensive training provided every six weeks, supervision groups and seminars, oversight groups, and lectures.

Dr. Missmahl described the following lessons Caritas Germany has learned:

- Existing strengths in Afghanistan include family and faith
- Women and children are the most vulnerable groups
- The whole Afghanistan population has been exposed to violence, particularly women

She concluded with the following key challenges:

- Defining quality standards for psychosocial interventions
- Developing diagnostic screens for mental health and substance abuse problems including hyperarousal and aggression

Tuesday, May 2, 2006

Substance Abuse Aspects of Integrated Behavioral Health Services

DR. ABDULLAH WARDAK, FOCAL PERSON FOR DRUG DEMAND REDUCTION (MOPH)
DR. M. ZAFAR, DIRECTOR OF DRUG DEMAND REDUCTION (MINISTRY OF COUNTER NARCOTICS)

Dr. Abdullah Wardak began the session on substance abuse by describing the substance abuse activities that the MOPH is hoping to conduct, including awareness raising and community assessments, treatment and rehabilitation, reintegration of substance users into society, training, and coordination of government and NGO efforts. He also noted the importance of integrating substance abuse services into primary care and of providing

community-based, residential and harm-reduction programs. Dr. Wardak stated that current efforts are very limited, with few services and increased social dislocation, and increased drug use in the north and central zones. He did describe recent hopeful developments, which include the establishment of drug demand capacity in the MOPH, an active partnership with UN's Office on Drug Control (UNODC) including a UNODC representative in Kabul, the establishment of Demand Reduction Action Teams (DRAT) in six zones, and substance abuse training in Pakistan and Iran.

The DRAT activities include prevention efforts and community-based programs (awareness programs, community meetings and events, pre-treatment motivation, networking, home-based treatment and rehab, and follow-up.) Residential services include diagnosis and treatment, pre-treatment motivation, detox, and post-treatment motivation. Rehabilitation services include vocational training, social reintegration, and self-help groups.

Dr. Wardak stated that MOPH's next steps are to:

- Submit a proposal for two residential treatment centers to the Counter Narcotics Trust Fund
- Conduct outreach in ten provinces
- Develop and issue standard treatment guidelines
- Upgrade staff

Key challenges include:

- Inadequate funding from UNODC to provide treatment for the approximately 1 million drug users in Afghanistan
- Security problems
- Lack of specific budget for substance abuse services
- Limited capacity to provide treatment
- No appropriate places for treatment centers and prevention activities

Dr. M. Zafar, with the Ministry of Counter Narcotics (MCN), discussed the problem of substance abuse in Afghanistan. Opium and hashish have been used there for a long time, but not to the extent used today. Over the past 30 years, new drugs have caused an increase in substance abuse, including heroin, prescription drugs, solvents and glues, and alcohol. War and conflict have destroyed critical infrastructure and these issues are compounded by the reality that many Afghans are returning refugees (40-50% of substance abusers are returning refugees). Unemployment is common and there is easy availability to these substances. The public is not aware of the dangers of drug use, and many users also have serious mental illness.

Dr. Zafar presented the current picture of drug use in Afghanistan as follows:

- 40-50% of substance abusers are returning refugees
- 12% of adult males are using drugs, 2.1% of women use drugs, and 0.7% of children use drugs
- Of the 1M drug users, it is estimated that 520K use hashish, 180K use prescription drugs, 50K use heroin, 160K use alcohol and 200K use other drugs
- Half of these users are poly-drug users

- 15% of heroin users inject the drug
- 30% of alcohol users drink locally-made brew

Dr. Zafar then listed the "eight pillars" for reducing or eliminating problem drug use:

1. Rebuild Afghanistan and its institutions
2. Address the treatment and prevention needs of drug users
3. Alter "native livelihood" through training, alternative crop use, etc.
4. Improve and strengthen law enforcement
5. Improve and strengthen the criminal justice system
6. Institute effective survey and monitoring systems
7. Increase public awareness
8. Strengthen international and regional cooperation

He noted that Afghanistan does have a National Drug Control Law, which outlines responsibilities of all entities responsible for addressing drug use; this was published recently and is currently out for comment. Dr. Zafar described other accomplishments, including:

- An interagency working group, including members from a variety of Ministries, UNODC, WHO, NGOs, and the donor community, meets monthly to coordinate drug control – with subgroups on treatment/rehabilitation, prevention/education, and harm reduction.
- Treatment and rehabilitation programs have been established in Kandahar
- Monitoring and evaluation is underway, including the issuance of treatment guidelines, standard client registration and assessment form, harm reduction strategy for HIV/IDU recently signed by the MOPH and the MCN, national drug abuse prevention and education guidelines under development, and a standard evaluation program.
- Training and service programs coordinated with Colombo Plan's Drug Advisory Program (CDAF), with study trips to Malaysia, Thailand, Sri Lanka.

He concluded by stating that "what we have done is just a drop in the ocean." Only 80 beds for substance abuse are available, in only ten residential facilities. DRAT is only underway in the North, and substance abuse efforts are not mainstreamed into appropriate governmental activities. Long-term and short-term training programs are vitally needed. Dr. Zafar concluded with the following key challenges:

- Limited substance abuse services – no budget, no infrastructure, no trained staff
- Limited public awareness of substance abuse as a health issue
- Need more "supportive partnerships" among governments and NGOs to address substance abuse

Integrating Substance Abuse-Specific Elements Into Behavioral Health And Primary Care Services In Low Resource Countries

DR. THOMAS BARRETT (WHO)
DR. TAIMOUR SHAH MOSAMIM, DIRECTOR (PSYCHIATRIC HOSPITAL, KABUL)

DR. KHALID AHMAD MUFTI (KHYBER MEDICAL COLLEGE)

Dr. Thomas Barrett described the extent and nature of drug use in Afghanistan and neighboring countries, with the regional picture as follows:

- Age of first use of drugs is decreasing
- Usage of injectable drugs is increasing
- Women are using drugs more often
- Contribution to spread of HIV/AIDS
- Majority of drug abusers are not seeking treatment

Dr. Barrett described an optimal mix of substance abuse services, including high need/low-cost services like self-care and informal community and self-help groups, coupled with low need/ high cost services like residential and community-outpatient programs, and with services provided in primary health care as mid-need, moderate cost services. He ended by describing various screening tools that can be used by primary care providers, including WHO's ASSIST tool (Alcohol, Smoking and Substance Involvement Screening Test), which assesses the following eight items:

1. Lifetime use of certain substances
2. Use in the past three months of certain substances
3. Strong urge in the past three months to use these substances
4. Health, legal, social, or financial problems caused by past-three month use of this/these drugs
5. Failure to meet normal expectations over the past three months due to this use
6. Expression of concern about your drug use by friend or relative, ever
7. Efforts to try to control drug use have failed
8. Any injection drug use

The following questions and issues were raised after Dr. Barrett's presentation:

- Have guidelines been relayed to the provinces? (Answer: Yes, treatment guidelines have; prevention guidelines are under development.)
- It is critical to train primary care providers in substance abuse since most people will go there for help.
- Afghanistan's national constitution outlaws the cultivation and trafficking of any drug, including opium.
- HNI usually sends people to Peshawar for detoxification. A large number of addicts (approximately 2500) in Nangahar need help; many are addicted through processing poppies (including women).
- The majority of addicts are not leisure addicts; need to take integrated approach to this problem involving both agriculture and health officials with vocational training for alternative work.
- UNODC representatives pointed out that many people are addicted through medications.
- Participants agreed with Dr. Zafar's point in his earlier presentation that an integrated, comprehensive approach to prevention and treatment of drug abuse is needed.

Dr. Taimour Shah Mosamim told participants that the Kabul Psychiatric Hospital has 20 beds for addiction and 40 beds for mental illness. Dr. Mosamim and his staff ensure that substance abusers see a psychologist for help with family problems and problems related to mental illness. He noted that many people have problems with co-occurring disorders, especially those who self-medicate.

Dr. Khalid Mufti then described psychiatric problems among Afghan refugees in Peshawar, including PTSD in men (women report lower rates of PTSD but higher rates of depression). Lessons he has learned in working with this population include:

- There is a significant burden of disease among caregivers
- Refugees often have co-occurring disorders, both physical and mental disorders
- Providers need to include the entire family in services
- Assessment needs to be more comprehensive than just psychiatric assessment

Luncheon Address

MS. ZOHRA RASEKH, DIRECTOR OF OFFICE OF HUMAN RIGHTS (MINISTRY OF FOREIGN AFFAIRS)

Ms. Rasekh, head of Human Rights in Afghanistan's Ministry of Foreign Affairs (MFA), talked about her research on the impact of many years of war on the Afghan people. After moving to the US in the 1970s and getting an MPH at Johns Hopkins, Ms. Rasekh travelled to Afghanistan in 1996 and then in 1998 to document the impact of Taliban policies on women and the impact of war on health:

- 97% of the women she interviewed experienced depression, 86% experienced anxiety, and 42% experienced PTSD
- In the refugee camps in Pakistan, mental health was the most significant concern
- Now that she has returned to serve in President Karzai's government, she can "still say, without any study, that at least 80% of the populace has mental health difficulties"
- Afghanistan does not have the resources to address mental health problems adequately

Ms. Rasekh noted that the MFA has enabled her to continue her focus on health, but she has not yet been able to accomplish as much as she wants to. She noted that another challenge for Afghanistan to combat is low productivity. Ms. Rasekh concluded that a coordinated effort between the government and NGOs is needed to share information and conduct a campaign to begin to address the mental health problems of the Afghan people.

In follow-up question and answers, Dr. Ventevogel stated that most Afghans do not have mental illness. Ms. Rasekh responded that she trusted her study because "most people don't lie about mental health problems." They agreed that what is needed is to change people's circumstances, helping them meet their basic needs for food, water, safety, and, per Dr. Faiz, for positive human and community networks.

Developing Capacity to Provide Behavioral Health Services: Identifying, coordinating and institutionalizing training

Plenary Presentation

DR. PETER VENTEVOGEL (HEALTH NET INTERNATIONAL)

Dr. Peter Ventevogel served as the Afghanistan Country Director for HNI from 2001 to 2005, providing mental health training to health workers in Eastern Afghanistan, the Nangarhar Province.

In his presentation, Dr. Ventevogel addressed the questions of mental health training needs and who to train. He emphasized the need to create and increase mental health awareness among the general population, improve the mental health knowledge and skills of general health workers, strengthen the mental health professional workforce, and build mental health training capacity.

Dr. Ventevogel suggested that awareness of the general population could be increased by increasing mental health literacy, improving coping mechanism, identification of possible cases, and combating stigma. This can be achieved through culturally sensitive methods and approaches rather than imposing views. Dr. Ventevogel suggested interactive, simple, and adaptive approaches that use available and culturally appropriate means, such as flipcharts, radio programs, radio drama, and narrative theatre.

The second group to be trained is general health care professionals. In order to develop mental health competencies in general health care professionals, the focus should be on incorporating skills appropriate to their role within the health care system (BPHS/EPHS). Competencies of general health care professionals should also include skills immediately useful for them in their everyday clinical practice and should be realistically available treatment options.

The third group to be trained is mental health professionals. Mental health professionals who are most important to train include psychiatrists or doctors designated for mental health, psychiatric nurses, psychosocial counselors, social workers, and clinical psychologists. These mental health professionals can be trained not only through teaching, but also through practical skills, such as on-the-job training with supervision. Furthermore, certification courses for nurses and doctors with mental health as a sub-specialization should be offered, for example for a period of three months to a year. This kind of training can be offered to psychiatric nurses and doctors who serve as focal points for mental health or work in mental hospital or mental ward of general hospital.

The fourth group to be trained is mental health trainers. This group of trainers will serve as Master Trainers, based on the "Training of Trainers" (TOT) model, and will engage in rapid build up of capacity through addressing specific contents and training skills.

Panel Discussion

Afghanistan's current capacity to deliver behavioral health services in the promotion of behavioral health, and the prevention, diagnosis, treatment and rehabilitation of mental illness and substance abuse is limited to the extreme. This situation applies to all relevant domains, including human and material resources and information systems, organization and structure of programs and mental health legislation and regulation of clinical practice. The Conference focused principally on efforts required to build human capacities in order to meet the current severe shortages at central, regional and provincial levels throughout the country.

The conferees acknowledged the valuable activities of the NGOs working in the area but also observed that more comprehensive programs are essential for meeting the needs of the country as a whole. To this end and in line with the MOPH's set of priorities, a panel of professionals, including representatives of different international NGO's (IAM, HNI, Caritas, Medica Mondial, and the Aga Khan Foundation), the Afghan MOPH, including its Director of Human Resources, along with representatives of the US Department of Health and Human Services, discussed training gaps and shortcomings currently existing in Afghanistan.

Three strategies, namely short-term, intermediate, and long-term, were suggested to increase the national human capacity for delivering behavioral health services as an integral component of general health care in the community.

Short-Term: Recommended short-term goals for capacity building include, among other approaches, training of two physicians from each province to become Master Trainers (MTs). The training would follow the 1996 WHO guide which is based on the concept of Training of the Trainers (TOTs). The participants are to be selected on the basis of specified criteria by the Steering Committee of the Mental Health Task Force. MTs will then provide behavioral health training to other physicians in their own provinces and also to nurses, midwives and paramedics and health workers.

Intermediate: As a component of intermediate goals, it was suggested that periodic continuing education be provided to the MTs and other qualified personnel. The skills enhancement can be achieved through short-term continuing education courses and seminars that may be provided either in Afghanistan by outside experts or in a neighboring country such as India, Pakistan, and Iran.

Another intermediate goal is to expand the training program to include community health workers, counselors, teachers and volunteers in different districts and to also provide psycho-educational programs at mosques.

Long-Term: Long term goals should focus on developing appropriate criteria for licensing and certification, as well as the creation of national Certification Board for various health and behavioral health disciplines. Licensure and certification systems for all relevant personnel should be based on the service provision/interventions listed in the

BPHS for four levels, namely Health Post (education, detection, referral, and support groups), Basic Health Center (BHC) (all services except inpatient treatment), Comprehensive Health Center (CHC) (all services including short-term inpatient treatment), and District Hospital (all services including inpatient treatment).

Current university programs and curricula in all fields relevant to behavioral health should be updated in line with the latest advances in clinical science and practice. This may be accomplished through a variety of mechanisms including introduction of contemporary approaches to didactic and clinical behavioral health training in medical schools, schools of nursing, clinical psychology programs, etc. Professional training in contemporary psychiatry, clinical psychology, psychiatric social work, nursing, and more thorough behavior health education for general practitioners needs to be established in Afghanistan's universities. Greater and more formal collaboration between the MOPH and the Ministry of Higher Education and these universities should be established. In addition, training of such professionals through scholarships and fellowships outside of Afghanistan seems essential for the near future. Formal partnerships could be established with academic institutions outside of Afghanistan to allow for ongoing faculty exchanges as another mechanism for the maintenance of excellence in training.

To further enhance professional competency and maintain appropriate technical, professional, and ethical standards, continuing education programs need to be developed and maintained. In addition and for purposes of program and policy planning and budgeting at the national level, the magnitude and type of psychopathology throughout the country need to be assessed. Finally, continuous research on identifying and/ or developing culturally appropriate evidence-based behavioral health services must be carried out.

Key Points, Lessons Learned, Recommendations from the First Two Days of Partners' Conference Presentations and Discussions

KEY POINTS AND LESSONS LEARNED:

- Short-term training is not enough
- Psychopharmacological and psychosocial interventions can reinforce each other
- Finding and keeping staff is a significant challenge
- Gender appropriate, culturally sensitive psychosocial interventions need to be developed, implemented and evaluated
- Coordination of mental health services is needed among national, provincial and district levels
- Critical existing strengths in Afghanistan include family and faith
- Women and children are the most vulnerable groups
- The whole population of Afghanistan (and particularly women) has been exposed to prolonged violence
- Key challenges:
  - How to define quality standards for psychosocial interventions
  - How to screen for mental health and substance abuse problems
- Limited substance abuse services, including no budget, infrastructure, or trained staff
- Limited public awareness of substance abuse as a health issue
- Need more "supportive partnerships" with governments and NGOs to address substance abuse

RECOMMENDATIONS:

- Public education critical to reduce stigma; spiritual leaders, teachers, family members need to play a key role. Media programs can be very effective.
- Develop data base on prevalence of mental disorders and substance abuse (types, severity, disability associated with conditions
- Training needs:
  - Develop multi-layer training system, based on minimum common foundation, adding levels as needed
  - Determine needed types of mental health professionals and develop appropriate curricula (see below)
  - Need for updated curriculum to train mental health professionals. This could be from neighboring and other countries, e.g. India, Bangalore, Pakistan, Iran.
  - Develop training curriculum for general health care professionals that is role-appropriate
  - Training should address short-term and long-term needs
  - Training needs to be supervised and followed up
  - Improve coursework in behavioral health and substance abuse in all medical schools
  - Share the relevant recommendations of this conference with the Ministry of Higher Education
- Strengthen positive social networks
- Provision of basic needs will reduce the risk of developing chronic psychological distress
- Provide age-appropriate prevention training for kindergarten, primary, and secondary school teachers
- Provide psychoeducation at mosques (for religious leaders only or for community).
- Develop a licensure and certification system based on the service provision/interventions listed in the BPHS for the following four levels:
  - Health Post (education, detection, referral, support groups)
  - BHC (all services except inpatient treatment)
  - CHC (all services, with referral to inpatient treatment)
  - District Hospital (all services including inpatient treatment)
- Develop certification and continuing education courses in mental health for nurses, midwives and primary care doctors.

Wednesday, May 3, 2006

Presentation of Research on PTSD, Loss, Depression, and Psychosomatic Symptoms among Post-War Afghan Women

FROZAN ESMATI, PSYCHOLOGIST (MOPH)

Frozan Esmati, a psychologist with the Ministry of Public Health, began the morning with a presentation of her research on PTSD, Loss, Depression and Psychosomatic Symptoms among Post-War Afghan Women. Key points include:

- Of the 214 women surveyed in Kabul (women hospitalized in Local Hospitals)
  - 24.8% experienced PTSD
  - 60.7% experienced anxiety
  - 68% experienced depression
  - 32% had psychosomatic disorders
  - 78.5% reported ill health without access to medical care
  - 42% had lost two to three family members during war
- The rate of exposure to trauma was high, but the PTSD rates were lower compared with other studies that had taken place prior to the present study.
- Key factors related to developing PTSD in these women included low socioeconomic status, limited skills/education, domestic violence and a sense of helplessness and guilt.
- Key protective factors preventing the development of PTSD were the collectivist nature of Afghan society (good social support and group identity) and strong religious beliefs.
- Spirituality should be included in the education and group counseling needed to address these problems (using a biopsychosocial approach).

Ms. Esmati concluded by stating that this research will soon be published in the Journal of the American Medical Association (JAMA).

Implementing the National Strategic Plan for Mental Health

The final morning of the Conference was devoted to discussion of Afghanistan's draft five-year National Strategic Plan for Mental Health, including nine of the ten strategies put forth in the draft plan.

Dr. Nassery gave a short presentation on the process of development of the National Strategic Plan for Mental Health. After the presentation, participants were asked to vote for prioritization of strategies mentioned in the strategic plan, with the following results:

Priority One: Capacity Building (development of human resources for mental

	health care)
Priority Two:	Integration of Mental Health into Primary Care (integration of mental health with general services; organization of services at different levels of health care)
Priority Three:	Psychological First Aid for Adults and Children
Priority Four:	Mental Health Directorate in the Ministry of Public Health
Priority Five:	Legislation
Priority Six:	Public Mental Health
Priority Seven:	Work with Voluntary Organizations
Priority Eight:	Education Support to families with mentally ill persons
Priority Nine:	Research to Support Services

Participants then broke into small groups to formulate recommended actions for each of the nine Strategies. The following is a transcript of the presentations made by the small groups to the full Conference.

PRIORITY ONE: **Capacity Building**

I. Short-term strategies

1. Train one or two physicians from each province as Master Trainers (MTs) in a three-month training using the WHO (1996) Training Model. (The Steering Committee of Mental Health Task Force will select participants.)
2. Training of health workers in provinces, including primary care doctors, nurses, paramedics and midwives.

II. Intermediate Strategies

1. Continuing education for MTs and health workers.
2. Upgrading and further enhancement of MTs through short-term courses in neighboring or other countries.
3. Community Training (for community health workers, teachers and volunteers).
4. Training of counselors in different districts.

III. Long term Strategies

1. Develop appropriate criteria for licensing and certification, including a board of certification.
2. Develop continuing education programs to maintain appropriate technical and professional standards and ethics.
3. Update the current university programs and curricula.
4. Assess the magnitude and severity of psychopathology in the country.
5. Conduct continuous research to establish appropriate and evidence-based behavioral health services.

PRIORITY TWO: Integration of Mental Health into Primary Health Care

I. Training

1. Training should be provided at all levels of MOPH facilities, including Health Posts (HPs), Basic Health Centers (BHCs), and Comprehensive

Health Centers (CHCs), and District and all other hospitals. Courses should last at least two weeks, with continuing education and after six to eight weeks for at least two days with supervision.
2. Referral protocols should be developed.
3. WHO documents should be used at least as reference materials at the HPs and BHCs. The community health workers should be trained to identify problems and do some psychosocial counseling.
4. Training should be extended to the private sector and a referral system should be developed that includes community and religious leaders.

II. Essential Psychiatric Medicine

1. Make sure that recommended drugs are available.
2. Emphasize the appropriate use of drugs.
3. Those who do not need drugs should be treated without medications when that is appropriate.

III. Health Education

1. Methods used by the MOPH's Information, Education, and Communication Department (IEC) in collaboration with the BBC to develop education spots for radio and television
2. Only psychosocial counseling would be used at HPs and BHCs. Medications would be provided only at the CHC level.

IV. Mental Health Education Material

1. Where There is No Psychiatrist is a good publication.
2. Outreach to schools, homes and the community.

PRIORITY THREE: Psychological First Aid for Adults

1. Define the term "psychological first aid," the resources needed to provide such services, and secure the resources.
2. Ensure that such services for children are developed and implemented.
2. Ensure that Afghan policies support the delivery of these services, and the training needed to provide them.

PRIORITY FOUR: Mental Health Directorate in MOPH

1. Establish a National Mental Health Council (elevate current Mental Health Task Force). Include other relevant Ministries (e.g. Higher Education, Education, Refugees, Foreign Affairs, and Women's Affairs) as well as spiritual leaders, families and patients.
2. Develop and introduce legislation to authorize mental health department and provide appropriation
3. Develop a National Mental Health Act
4. Establish a permanent Mental Health Directorate with authorized budget and deputy directors for the functions identified by National Mental Health Council

PRIORITY FIVE: Legislation

The current Mental Health Act needs to be revised as follows:

1. Human rights issues need to be included
2. Create a forensics section in MOPH and monitor implementation
3. Incorporate a process for patient consent to treatment
4. Solidify the commitment from the government to provide services and resources to help people achieve optimal mental health
5. Include establishment of the mental health directorate within the MOPH

PRIORITY SIX: Public Mental Health Education

Goal: To improve and increase understanding and knowledge of mental health

Objectives:

- To promote better understanding of Mental Health Issues by the community (5 years).
- To encourage advocacy and better care for the mentally ill and their caregivers.
- To encourage full participation of NGO's and communities in supporting mental health services.

Activities:

- Development of mental health education materials in local languages (using simple terms).
- Advertise and promote mental health awareness through TV clips, radio dramas, brief messages, pictures, posters, etc.
- Content must include: 1) modern understanding of human behaviors; 2) the effects of stress on health; 3) common mental disorders and their symptoms; and 4) caring for the mentally ill at home.

PRIORITY SEVEN: Work with Voluntary Organizations

I. Active Organizations and NGOs

1. **Donors**: SAMHSA, UNICEF, USAID, UNHCR, European Commission, World Bank, and others.
2. **Implementers**: HNI, Medica Mondial, Caritas/Germany, American Friends Service Committee, and others.

II. Increased Capacity Building for Volunteer Organizations

1. Current activities of the implementers
2. Training of clinical psychologist (different kinds of therapy methods and techniques)
3. Training about trauma sensitive approaches
4. Practical training about group and individual therapies
5. Training about specific topics (e.g. violence, sexual violence, domestic violence)
6. Basic counseling training for psychosocial workers, health educators, nurses and midwives
7. Long-term training about behavioral changes and trauma sensitive

approach for doctors, nurses, and midwives
8. Broadcasting of radio program about mental health awareness and disorders

III. Suggestions and Comments

1. Collect training materials from organizations and standardize content
2. Expand current activities to all provinces
3. Contact with donors to attract their attention to provide financial support by having clear goals, objectives, visions and missions.
4. Identify government support needed to connect the mentioned organizations, especially donors, and to coordinate, supervise and monitor all activities on a regular basis.

PRIORITY EIGHT: Support of Families of the Mentally Ill

1. Detection of mentally ill patients' families
2. Fund collection for mentally ill patients for financial support
3. Confidence building education
4. Create safety net to protect and provide continuous support to ill patients
5. Empowerment
6. Provide knowledge through the Information, Education and Communication Department (IEC)
7. Refer to doctor and/or hospital

PRIORITY NINE: Research to Support Services

I. Research Topics

1. Prevalence of mental health disorders (magnitude and severity among various age groups)
2. Prevalence of substance abuse (types of drugs by demographics, location, gender, age and associated diseases, such as HIV/AIDS and blood bone diseases [Hepatitis B, C])
3. Association between physical and mental health (e.g. comorbidity)

II. Research Training

1. Research Methodology
2. Clinical Training

III. Development of Research Instrument

1. Survey diagnostic screening and measurement instruments, e.g. ICD 10 and DSM IV
2. Cultural adaptation and standardization norms

Addendum A

Conference Agenda
Partners' Conference on Behavioral Health
May 1-3, 2006
Kabul, Afghanistan

8:00-9:00AM **Conference Registration**

9:00-10:00AM **WELCOME AND INTRODUCTIONS SESSION**

The Conference will open with a reading from the Holy Quran. Dr. Sayed Mohammad Amin Fatimie, Minster of Public Health will greet participants and introduce his fellow Conference hosts, including SAMHSA Administrator Charles Curie and Dr. Shukrullah Wahidi, who will welcome participants. After this, participants will briefly introduce themselves to each other.

10:00-11:00AM **INTEGRATION OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES INTO PRIMARY CARE**

Dr. Thomas Barrett of the World Health Organization (WHO) will provide an overview of the core elements of mental health and substance abuse services and how to integrate these elements into primary care, particularly in low resource settings, with the goals to:

This presentation will be followed by discussion and question/answer.

11:00-NOON **Experiences in Integrating Behavioral Health Services into Primary Care – The Role of the Primary Care Provider**

Two primary care physicians and a community psychiatrist will discuss the key role primary care/family doctors play in integrating behavioral health into primary care.

Moderator: *Dr. Wahidi*
Panelists: *Dr. Wasel Akbary, Afghan American physician*
Dr. Anita Everett, Community Psychiatrist, SAMHSA
Dr. David Tarantino, US Office of the Secretary of Defense/ Health Affairs

Luncheon **MANAGING BEHAVIORAL HEALTH PRIORITIES AND SERVICES – A PUBLIC HEALTH APPROACH**

SAMHSA Administrator Curie will provide an overview of the Conference to participants, underscoring SAMHSA's intent to provide ongoing technical assistance and support to Afghanistan on behavioral health services, with this Conference being an essential next step and call to action. In that vein, he will outline the public health approach to behavioral health, stressing the importance of integrating behavioral health at every stage of the public health approach - from assessing and monitoring needs, promoting resilience and wellbeing, to prevention, screening and assessment, treatment, and recovery. Administrator Curie will also present the SAMHSA Matrix as a way Afghanistan could organize behavioral health efforts around its Mental Health Action Plan.

1:30-2:30PM **Analysis of Mental Health Needs and Services in Afghanistan**

Deputy Minister Kakar, National Mental Health Coordinator Ruhullah Nassery, and WHO Advisor Dr. Azimi will provide an overview of current mental health needs and services in Afghanistan.

2:30-3:30PM **Presentation of Afghanistan's Mental Health Action Plan – Priorities, Current Activities, Gaps, and Needs**

Deputy Minister Kakar, Dr. Wahidi, Dr. Nassery, and others from the MoPH will present Afghanistan's Mental Health Action Plan to the participants.

3:30-5:00PM **Panel Discussion:** Challenges and Lessons Learned in Providing Behavioral Health Services in Afghanistan

In this part of the conference, representatives of the Partners funding helath care in Afghanistan and Non-Governmental Organizations (NGO) currently active in mental health care in Afghanistan will be given about 15 minutes to, after briefly summarizing current activities, describe the 2-3 lessons they have learned and their current challenges.

Moderator: *Deputy Minister Kakar*
Panelists: *Jim Griffin, Gary Cook, USAID*
EC Representative
Dr. Kayhan Natiq, World Bank (invited)
Dr. Peter Ventevogel, Health Net International
Representative, International Assistance Mission
Inge Missmahl, Caritas Germany
Representative, Aga Khan Foundation
Dr. Khalid Ahmad Mufti, Peshawar

5:00-5:30PM **Integrating Behavioral Health Services into Primary Care: Recommended Actions and Next Steps**

Speakers, panelists and participants will identify recommended actions and suggested next steps in integrating behavioral health services into Afghanistan's Basic Package of Health Services (BPHS).

Co-Moderators/Discussion Leaders: Dr. Kakar
Administrator Curie

Evening **Reception and Display Session**

At the reception, NGOs and others involved in providing behavioral health services in Afghanistan will have the opportunity to share their work and materials with conference participants through various displays and poster sessions.

DAY TWO (Tuesday, May 2, 2006)

9:00-NOON **SUBSTANCE ABUSE ASPECTS OF INTEGRATED BEHAVIORAL HEALTH SERVICES**

9:00-9:45AM Dr. Abdullah Wardak, focal person for Drug Demand Reduction from MoPH, and Dr. M. Zafar, Director of Drug Demand Reduction of the Ministry of Counter Narcotics, will together give a presentation about Afghanistan's current substance abuse prevention and treatment efforts, their achievements and challenges.

9:45-10:15AM Dr. Barrett, WHO, will provide an overview of how to integrate substance abuse-specific elements into behavioral health and primary care services in low resource countries, including:

This presentation will be followed by a brief question and answer period.

10:30-11:30AM **Panel:** Afghanistan's priorities for substance abuse prevention and treatment – presentation and reactions

A panel of Afghan officials (including representatives of the Ministry of Narcotics Control), WHO/EMRO, and donors and their NGOs currently working on substance abuse issues will address the social, economic and health issues inherent in reducing substance abuse, as well as current activities and needs in prevention and clinical intervention in Afghanistan.

Panelists: *Mohammed Naim, Representative, UN Office of Drug Control (UNODC/Afghanistan (Invited)*
Dr. Zafar, Ministry of Narcotics Control
Dr. Taimour Shah Mosamim, Director, Psychiatric Hospital Kabul
Dr. Kayhan Natiq, World Bank (invited)

11:30-NOON **Integrating Substance Abuse Elements into Behavioral Health and Primary Care: Recommended Actions and Suggested Next Steps**

Speakers, panelists and participants will identify recommended actions and suggested next steps in establishing substance abuse services in Afghanistan.

Co-Moderators/Discussion Leaders: *Dr. Wahidi*
Administrator Curie

Luncheon Zohra Rasekh of the Ministry of Foreign Affairs will address the behavioral health needs of women and children and the role of her Ministry, the Ministry of Public Health, and the NGO community in addressing those needs.

2:00-5:30PM **DEVELOPING CAPACITY TO PROVIDE BEHAVIORAL HEALTH SERVICES**: Identifying, coordinating and institutionalizing training

2:00-2:30PM **Plenary speaker/panel presentation**: Overview of workforce

Speaker: Dr. Peter Ventevogel, HNI

2:30-4:30PM **Panel Members:**
Ministry of Higher Education: (representatives invited)
Ministry of Public Health: Dr. Bashhir Noormal, D.G. Human Resource Management
President of American University in Kabul: Dr. Sharif Fayez
Aga Khan Foundation: (representative invited)
Department of Nursing: Ms Gujan

The plenary speaker will provide information on the current behavioral health

workforce, the projected needs based on the Mental Health Action Plan and outline the skills needed for implementing state of the art core components of a mental health system, (e.g., screening, diagnosis, treatment including crisis intervention, social services, and public/family education, etc).

Representatives of NGOs and universities will describe the approaches now used to train the various professional and technical levels of mental health personnel, then identify the strengths and limitations of their current training programs in addressing the behavioral health needs of the country.

4:30-5:30PM **Discussion:**

Summary of discussions and identification of next steps

Co-Moderators/Discussion Leaders: Dr. Nahid Aziz
Dr. Ventevogel

DAY THREE (Wednesday, May 3, 2006)

9:00-9:30AM **MOVING FORWARD – AN INNOVATIVE RESEARCH PROPOSAL**

Deputy Minister Kakar will announce a research proposal to study the effect of Omega 3 on mental health in Afghanistan.

9:30-NOON **A CALL TO ACTION:** Next Steps Needed to Integrate, Provide and Sustain Quality Behavioral Health Services as Part of Primary Health Care in Afghanistan

The conference will conclude with a roundtable discussion to review actions recommended during the Conference in view of Afghanistan's Mental Health Plan and identify the next steps needed in implementing the Plan and providing and sustaining appropriate and cost-effective behavioral health services in Afghanistan.

Co-Moderators/Discussion Leaders: *Dr. Kakar*
Dr. Wahidi
Administrator Curie
Dr. Nassery

Luncheon **CLOSING AWARDS LUNCHEON**

At this luncheon, Minister Fatimie and/or Deputy Minister Kakar and Administrator Curie will award certificates to participants and make closing remarks.

Addendum B

Partners' Conference on Behavioral Health
May 1-3, 2006
Kabul, Afghanistan

Participant List

Afghanistan Government	
Ministry of Public Health (Central)	Dr. Sayed Mohammad Amin Fatimie, *Minister of Public Health*
	Dr. Faizullah Kakar, *Deputy Minister for Technical Affairs*
	Dr. Shukrullah Wahidi , *D.G. Policy and Planning*
	Dr. M. Daim Kakar, *D.G. Preventive Medicine and PHC*
	Dr. Mir Azizullah Akhgar, *D.G. Human Resource Directorate*
	Dr. Bashir Noormal, *Director, Institute of Public Health*
	Dr. Hasan, *Grants and Contracts Management Unit (GCMU)*
	Dr. Abdul Wase Asha, *Director, Malaria and Leishmaniasis*
	Dr. Mohammad Tawab, *Director, IEC*
	Dr. Mohammad Daud, *Technical Advisor to Deputy Minister*
	Dr. Abdullah Wardak, *Drug Demand Reduction Unit*
	Dr. Sayed Najibullah, *Drug Demand Reduction Unit*
	Dr. Ruhullah Nassery, *National Mental Health Coordinator*
	Azizuddin Hemat, *Focal Person, Psychosocial Interventions*
	Dr. M. Ihsam Gulban, *Focal Person, Mental Health in Hospitals*
	Gul Jan Jalal, *Head, Nursing/ Midwifery*
	Dr. Razi Khan Hamdard, *Disability Advisor*
	Frozan Esmat, *Technical Consultant, Disability Unit*
	Dr. Basir Qadari, *Hospital Reform Project*
	Saifuddin, *Technology Section Staff*
	Sayed Nazir Ahmad, *TV Section*

Ministry of Public Health (Field)	Dr. Waseq, *Mental Health Department, Heraat*
	Dr. Ashraf Rawan, *Mental Health Focal Person, Mazar*
	Dr. Abadul Hai Razmal, *Kandahar*
	Dr. Kymia Azizi, *Health Director, Shabarghan*
	Prof. Dr. A.S. Jalali, *Director, Indira Gandhi Hospital*
	Dr. Taimour Shah Mosamim, *Director, Psychiatric Hospital, Kabul*
	Dr. Abdul Ahad Qureshi, *Deputy Director, Psychiatric Hospital, Kabul*
	Dr. Nader Aalemi, *Neuropsychiatric Ward, Mazar Hospital*
	Dr. Halima Azimi, *Psychiatric Hospital, Kabul*
	Dr. Mohammed Masuodosmany, *Ali Abad Hospital*
	Dr. Zurmati
	Dr. Malang Muslim Ameri, *Focal Person, Kochi Affairs*
Ministry of Higher Education	Dr. M. Shareef, *Kabul Medical University*
Ministry of Foreign Affairs	Zohra Rasekh, *Director, Office of Human Rights*
Ministry of Counter Narcotics	Dr. Mohammad Zafar , *Director, Drug Demand Reduction*
	Dr. Samaruddin
Ministry of Martyrs and Disabled	Dr. Naqeebulla, *Advisor to Minister*
National TV	Mohammad Younes Dari
	M. Ahsam
	M. Fahhim
Radio Good Morning	N. Naim
Educational TV	Roya Afzahi
	Ghuylam Sarwar

U.S. Participants

Health and Human Services/ SAMHSA	Charles G. Curie, *Administrator*
	Mark Weber, *Director of Communications*
	Winnie Mitchell, *International Officer*
	Dr. A. Hussain Tuma, *Consultant*

	Dr. Anita Everett, *Senior Medical Advisor*
	Craig Hostetler, *Consultant*
Health and Human Services/ OGHA	Dr. Jeannine Greenfield, *International Health Officer*
Department of Defense	Commander David Tarantino, *Director, Civil-Military Medical Affairs*
USAID	Gary Cook, *Senior Health Advisor*
	James L. Griffin, *Senior Health Advisor*
	Dr. Shapor Ikram, Project Management Specialist
	Dr. Faiz Mohammad
Embassy of Afghanistan	Awista Ayub, Education and Health Officer
Afghan Medical Professionals Association in America	Dr. Wasel Akbary
	Dr. Gholam S. Bakhtary
Argosy University	Dr. Nahid Aziz, Assistant Professor

Multilateral Organizations

World Health Organization	Dr. Thomas Barrett
	Dr. M. Sayed Azimi, *Mental Health Officer, WHO Kabul*
UNODC (Kabul)	Mohammad Naim
	M. Aza Stanikzai
	Dr. Friba
UNDP	Dr. Norman Gustavson, *Clinical Psychologist*
	Dr. Zia, *Technical Advisor*

Non-Governmental Organizations

MSH/ REACH	Dr. Mubarak Shah Mubarak, *Program Manager for MOPH Capacity Building*
	Dr. Dad Muhammad Shinwary, *Hospital Management Advisor*
	Dr. Rashidi
	Sheena Currie
	Rafiq Yaar
Caritas/ Germany	Inge Missmahl, *Director, Psychosocial Counseling Program*
	Dr. Wahid Salim

Health Net International	Dr. Peter Ventevogel, *Mental Health Coordinator, Burundi*
	Dr. Hafizullah Faiz, *Mental Health Coordinator, Afghanistan*
International Assistance Mission (IAM)	Dr. Sabour Mansouri, *Medical Coordinator*
International Medical Corps (IMC)	Dr. Anna Thurairatnam, *Manager of IMC at Rabia Balkhi Hospital*
	Dr. Azizullah Amir
	Dr. Naseer Ahmad Hamidi, *HMIS Technical Officer*
Aga Khan Foundation	Dr. Mirwais Rahimzai
Aga Khan Health Services	Dr. Bashar Dost
Medica Mondial	Sibelle Manneschmidt
	Humira Amery, *Coordinator, Psychosocial Program*
Ibn-e-Sina	Dr. Jamshid Omar
Art of Living Foundation	Ann Godwin, *Director*
Khyber Medical College (Pakistan)	Dr. Khalid Ahmad Mufti
Swedish Committee for Afghanistan (SCA-RAD)	Anne Hertzberg
	Dr. Ab. Wakil
BRAC	Dr. Basir Sherzad
	Sayed Shahidur Rasheed
Voice of America (VOA)	Dr. Khadija Alkoza
Voice of Freedeom	Sadie Azadi Fatah Xasar
Center for Mind Body Medicine	Dr. James Gordon
	Dan Sterenchuk
Kabul Orthopedic Organization	Fahima
Equal Access	Michele Bradford, *Country Director*