Meeting of the
Pan American Health Organization/World Health Organization
Collaborating Centers in Mental Health in the Americas
8 January 1999

at the
PAHO/WHO Collaborating Center for Training and Research
In Mental Health and in the Prevention of Substance Abuse
At
The Nathan S. Kline Institute for Psychiatric Research
Orangeburg, New York

PAN AMERICAN HEALTH ORGANIZATION
PAN AMERICAN SANITARY BUREAU, REGIONAL OFFICE OF THE WORLD HEALTH ORGANIZATION

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2 Canada: Mr. Ric Ament
3 Canada: Julio Arboleda-Florez, M.D., Ph.D.
4 Canada: Wendy Austin, Ph.D.
5 Canada: Gaston P. Harnois, M.D.
6 United States: Alexander Cohen, Ph.D.
7 United States: Eugene M. Laska, Ph.D., Marc Galanter, M.D., Kim Hopper, Ph.D. and Carole Siegel, Ph.D.
8 United States: Arthur Stone, Ph.D.
9 Mexico: Maria Elena Medina-Mora, M.D.
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at The Nathan S. Kline Institute for Psychiatric Research, Orangeburg, New York
(Notes taken by Ms. Rheta Bank)

Attendees:

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United States: Rheta Bank, Thomas Bornemann, Ed.D., John C.S. Breitner, M.D.,
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Eugene M. Laska, Ph.D., Ronald Manderscheid, Ph.D., Carole Siegel, Ph.D.,
Arthur A. Stone, Ph.D.
WHO Headquarters: Benedetto Saraceno, M.D.
PAHO/WHO: Itzhak Levav, M.D.
Consultant: Walter Gulbinat

Aim of the meeting: to address the question of how the collaborating centers can work together, creating synergy, in addressing and accomplishing PAHO/WHO and WHO mental health goals.

Welcome:
Dr. Eugene Laska welcomed the group to The Nathan S. Kline Institute for Psychiatric Research.

Dr. Itzhak Levav extended greetings from Dr. George A.O. Alleyne, Director of PAHO/WHO. Dr. Levav thanked the generous hosts of the meeting - the WHO Collaborating Center at The Nathan S. Kline Institute for Psychiatric Research -- for their efforts on behalf of PAHO/WHO and to the participants for having answered the call.

Dr. Benedetto Saraceno extended greetings from Dr. Gro Harlem Brundtland, Director-General of the World Health Organization and Dr. Yashuhiro Suzuki, Executive Director, Social Change and Mental Health, WHO.

I. Introduction

Mental Health Priorities of PAHO: Dr. Itzhak Levav
(A full presentation of Dr. Levav’s talk may be found in Appendix D.)
The opportunity exists for [the numerous experts from] the collaborating centers to make a difference. Centers are motivated to make science and technology available to all and to contribute to the achievement of equity in health, a leading principle for PAHO. With the participation of the centers, these objectives can be achieved more effectively. The expertise of the centers is needed:
• in the development and testing of inputs for public policy development and implementation, especially inputs of proven cost-efficiency;
• in research that is truly relevant to populations in adversity and in the support of local partners in the science of research and the art of grant-making;
• in the facilitation of access to knowledge, particularly for those who lead programs, services, and community laboratories, and for those professionals, such as nurses, that are often neglected by the establishment;
• in the development of data-bases that will enable more rational planning;
• in health services research that will enlighten care-givers, planners and administrators;
• in the joint design of evaluation strategies for community programs and services to lift them from the level of craft to the level of science;
• in the design, promotion and implementation of primary preventive programs and of psychosocial rehabilitation, particularly in the context of the Healthy Municipalities movement; and,
• in the continuous promotion of mental health as an integral component of all health programs and of human development, capitalizing on the authoritative position of the WHO Collaborating Centers led by recognized world figures in science and technology.

Mental Health Priorities of WHO: Dr. Benedetto Saraceno
(A fuller presentation of Dr. Saraceno’s talk may be found in Appendix E.)
Nations for Mental Health is a WHO action program at country level to improve the mental health and psychosocial well-being of underserved, disadvantaged and vulnerable populations. These populations comprise of persons in extreme poverty, children and adolescents experiencing disrupted nurturing, abused women, abandoned elderly people, persons traumatized by violence (victims of war/conflicts), migrants (including refugees and other misplaced persons), and indigenous populations.

The program aims:
• to raise awareness of the burden of mental health problems through the development and dissemination of advocacy and policy resources;
• to increase the commitment of governments to reduce this burden through educational meetings with national leadership;
• to increase the technical capacity of countries to create and implement mental health policies and legislation through technical seminars;
• to create country-level research and demonstration projects to serve as models for wider dissemination; and
• to disseminate existing best practice models. The program has established field demonstration projects in all WHO regions, has conducted awareness seminars and capacity building conferences, and has developed operational field research projects.

Dr. Saraceno suggested that the collaborating centers could play several roles in the Nations for Mental Health program. Centers could:
• participate in the awareness campaign by formalizing knowledge derived from their research;
• develop evaluation strategies to examine the success of the approaches; and
• participate in site visits.

Recommendations of the World Mental Health Report: Dr. Leon Eisenberg
Dr. Eisenberg stated that the sub-title of the report should have been the mental health of low income populations (rather than low income countries).

Predictions and findings of studies by the World Bank and WHO indicate that the burden of mental health problems is increasing, and that depression which was fourth in terms of burden in 1990 will be second in 2010. Nevertheless, while there is a great deal of talk, little money is allocated, and even well-meaning law, e.g., parity legislation in the U.S., is flawed. There is a need world-wide for funding of general health services, for giving primary care physicians and teachers mental health skills, and for providing them with mental health backup to care for serious cases. Strategies that work on low income populations in one part of the world might also work on low income populations in another part of the world where problems are remarkably similar.

Social policy affects health. The effect of the education of women on children’s health, and the effect of raising taxes on cigarettes on smoking reduction are examples. Dr. Eisenberg suggested that there be instituted mandated health consequences reviews of new legislation, e.g., such as
might have been prevented with the erection of high-rise apartment buildings which greatly affected social life.

Today, budgets are driven by cost concerns, and cost effectiveness becomes a justification for cuts. This leaves the question, if a program is costly but beneficial, should it be discarded? Some benefits, e.g., happiness, can not be valued; policy questions have double benefits, e.g., should all persons be well educated because Alzheimer’s disease seems to be more prevalent in the less educated? Willingness to pay affects what gets funded. Shifts in funding to the education budget, may produce mental health benefits.

DALYs are useful in making people aware of the costs of mental illness. DALYs may also affect policy development, e.g., information from the DALYs and the tables in the printed report helped to pass resolutions supporting mental health programs in the U.S. and in Latin America.

II. Presentations

Current Programs of the WHO Collaborating Centers
(Program descriptions are attached as Appendix H.)

Presentations on the programs of the Centers oriented to the priorities outlined in the talks by Drs. Saraceno and Levav were made by:

Argentina: Roger Montenegro, M.D. (See H1.)
Canada: Ric Ament (See H2.)
Julio Arboleda-Florez, M.D., Ph.D. (See H3.)
Wendy Austin, Ph.D. (See H4.)
Gaston P. Harnois, M.D. (See H5.)
United States: John C.S. Breitner, M.D., M.P.H. (See H6.)
Alexander Cohen, Ph.D. (See H7.)
Eugene M. Laska, Ph.D., Marc Galanter, M.D., Kim Hopper, Ph.D., and
Carole Siegel, Ph.D. (See H8.)
Arthur Stone, Ph.D. (See H9.)

In addition, written material was made available on the Center in Mexico by Dr. Maria Elena Medina-Mora (See H10.) and the Center in Texas by Dr. Wayne Holtzman (See H11.).

WHO and the Collaborating Centers: Setting Agendas and Facilitating Linkages:
Discussion Dr. Benedetto Saraceno, moderator

Dr. Saraceno talked briefly about the evolution of the WHO Mental Health Division from a center of academic excellence, through a phase of emphasis on addressing the needs of the donors/funders, to the new perspective of serving the needs of the member states. A new director will be appointed within the next month.

WHO needs the skills represented by the collaborating centers to develop simple, realistic strategies for measuring:
- the success of the awareness campaign, e.g., reduction of stigma, media coverage;
- the impact of changes in legislation and policy and in curriculum;
- the impact of assisting a country in the development of a mental health plan;
- the changes occurring with intersectorial management of mental health;
- the effect of involving family and consumers;
- the effectiveness of demonstration projects in the creation and dissemination of “best practice” models, e.g., in China;
- the effect of combining mental health and primary medical care.

Also needed is research on costs of illness, costs of treatment, primary prevention strategies and programs of training for human resources. We do not yet know what makes a difference.

Among the other points discussed were the need for:
- systematic documentation, so money can be raised to apply the results of the research;
• one center take the lead in a research area, organize the research and raise the funds;
• investigating whether what works in one country might work in another;
• methodology to translate research into actual practice, e.g., clinical trials are conducted often in artificial environments; actual practice brings in other factors;
• a structured examination of each disease, its course and treatments; and
• consideration of cultural variation, stage of life, gender and social class when developing community-based service models.

III. Discussion

Charge to the Breakout Groups:
The groups were asked to develop, in the light of the previous presentations, priority areas within their topic and to suggest possible activities by the collaborating centers that would address them.

Reports of the Breakout Groups

Technical Support/capacity building to achieve mental health goals: Dr. Ronald Manderscheid, moderator
Participants: Drs. Wendy Austin, Carole Siegel, Heather Stuart, and Arthur A. Stone

This breakout group defined the requirements and the mechanisms through which technical support could be provided to enhance the delivery of mental health services in the Americas. Requirements were defined in terms of PROCESSES that need to be carried out and the FUNCTIONS that need to be fulfilled. Mechanisms were defined in terms of a TECHNICAL RESOURCE CENTER and the formation of a WORK GROUP to bring it into existence. Conceptually, the group agreed that PROCESSES ---＞ FUNCTIONS ---＞ TECHNICAL RESOURCE CENTER ---＞ WORK GROUP is a useful approach to addressing the question. Necessary PROCESSES include the acquisition of resources, the development of a consultant data base, preparation of a manual guide for translations, and development of a list server and an electronic journal. These would improve the key FUNCTIONS of training, services delivery, information systems for decision support, management and administration, technical skills, and research and evaluation. To meet these requirements, a TECHNICAL RESOURCE CENTER should be developed that, at minimum, has responsibility for training, communication about best service practices, information system support, and case studies. Unanimously, the Group recommended that a WORK GROUP be formed to plan a proposal and to seek funds to implement it. Dr. Carole Siegel volunteered to chair this work group.

Clinical research/evidence based practice in cultural contexts: Dr. Gaston Harnois, moderator
Participants: Dr. John Breitner, Dr. Alexander Cohen (rapporteur), Dr Marc Galanter, Dr. Wilson Lit (A full presentation of Dr. Harnois’ opening talk may be found in Appendix G.)

Dr. Harnois began by summarizing some of the observations of Roy Carr-Hill about health services researchers, some of whom look at outcomes, some at evaluation and others on data. Decision makers seem to want simple answers quickly, leading to narrowing of the themes under investigation, ignoring the wider picture, and assuming that health care is static.

Dr. Harnois pointed out that, while they remain key actors, doctors are no longer the only decision makers concerning the outcome of mental health services; clients, families, HMO’s, regional boards, and the community play increasingly significant roles. According to Sederer, Dickey and Hermann, there is also a shift in the focus of patient care from clinical priorities to fiscal priorities and a basic theme of managing costs by reviewing and restricting utilization of clinical services. Consumers question the value of psychiatric services and demand that clinical practice be accountable for the outcome of care. Continuous quality improvement may result in:
• the development and adoption of treatment guidelines that can be linked to specific outcomes;
the integration of outcome assessment into clinical practice to produce data to legitimize the treatment of psychiatric and substance abuse problems in the eyes of legislators;
the viewing of outcome assessment as a marketing tool for the mental health care service system; and
the opportunity to regain public trust by linking accountability to outcomes assessment.

One other large domain which creates problems in evidence-based practice is the issue of cultural context. In most, if not all countries of the world, mental health practice is rarely evidence-based; it always involves interpersonal relationships, family context as well as a social and cultural environment. For example,

- How are we to take into account the patient’s and the family’s belief system concerning the etiology of schizophrenia in Senegal?
- How will we integrate in our practice the fact that most patients in Dominica will have seen two ministers of the faith and at least one traditional healer before coming to a mental health professional?

Dr. Harnois concluded that there is a movement away from research in classical, controlled experimental conditions to one that takes place under “naturalistic” conditions in hospital clinics and in the community. There is the impression that as we learn more about what works under naturalistic conditions, psychiatric research may shift from clinical trials to mental health services research or from efficacy to effectiveness studies.

For the most part, the discussion was a free-floating discourse that did not reach conclusions but rather raised a number of issues. Dr. Breitner pointed out that there are critical distinctions between delivery of mental health care in a "conventional" setting, where we know what to do, and the delivery of appropriate care in less developed nations and regions where the problem is case identification and enrollment. In less developed nations, treatment decisions are based more on the availability of resources than on the most recent clinical research. Dr. Breitner also felt that the greatest challenge is to extend prevention and treatment to populations in a manner that is compatible with their economic resources and culture. Also considered was that empirical findings in one setting may need to be adapted to other settings, i.e., psychotherapies are often culture-bound, and there are significant differences among ethnic groups in their responses to psychopharmacology.

**Mental Health and Social Policy Research:** Dr. Kim Hopper, moderator
Participants: Dr. Julio Arboleda-Flores, Dr. Thomas Bornemann, Dr. Leon Eisenberg, Dr. Benedetto Saraceno

Four areas of immediate priority were identified:

1. Development of minimally adequate national mental health system datasets like the standardized “report card” format to assess performance suggested earlier – though more in the nature of a “core syllabus.”
   - These would be informed by the best, most seasoned counsel WHO could assemble – not only from leading experts in epidemiology and mental health service research, but from experienced practitioners, well-versed in the structural engineering of basic service systems.
   - The essential question they would answer is: what are the elementary data needed to inform planning and decision-making at the most fundamental of mental health systems?
   - Such a protocol should be integrated and agreed-upon in advance, across all relevant WHO programs, so as to minimize both demands on national informants and problems of incompatible measures in joint planning.

2. Investigation of social systems of confinement and control – their overlap, exchange practices, and competing interests. This concerns formal mental health and correctional systems primarily – which, in parts of some developing nations (the U.S., notably), are rapidly cultivating a common (if shifting) clientele and, in some sectors, increasingly kindred working procedures. Data are needed at the level of basic descriptive epidemiology (how many, how long, with what degree of disorder); at the level of incentives and disincentives to serve (do such “clients” represent a drain, a challenge, a source of revenue, an unanticipated cost to such systems?); at the level of institutional interests at stake; and at a more macro
level that analyzes the potential for cross-system collaboration, governed by more encompassing social policy directives.

3. Development of a manual for the development of basic mental health system infrastructure. Over three-quarters of the requests Nations for Mental Health currently receives from the developing world have to do with foundation questions: the design and building of a basic mental health system. Model legislation is available. And a great deal of practical, hands-on knowledge is embodied by seasoned consultants, who have worked as system broker, facilitators, technology transfer agents, etc. But this knowledge needs to be abstracted, systematized, and put into a coherent set of directives, choice points, trade-offs and resource considerations. This "reverse engineering" approach would not only help newly emerging agents map out alternative routes of development, but would alert them to the resource, information and political considerations associated with different options.

4. Design of appropriate evaluation technology – chiefly, follow-up protocols – for the continuing measurement of the difference made, or valued added, by policy changes, inter-sectoral commitments, or international agreements. An immediate opportunity may be presented by the upcoming meeting in China, for which Dr. Arthur Kleinman has agreed to provide the follow through assessment. At the very least, a set of working lessons from this experience, and what it might imply for like-minded efforts, ought to be derived.

Methods for enhancing linkages: Walter Gulbinat, moderator
Participants: Mr. Ric Ament, Dr. Joan E. Broderick, Dr. Sheppard Kellam, Dr. Roger Montenegro, and Dr. Zebulon Taintor

The Group identified three types of linkages which were seen as prerequisites for successful collaboration within a WHO/PAHO context:

1. the linkages a collaborating center has within its own country;
2. the linkages the collaborating centers maintain among themselves and with the WHO/PAHO office(s); and
3. the linkages that need to be established and maintained in regard to particular projects.

ad 1.: One of the conditions that needs to be met before an institution is designated a collaborating center is that it is well placed within its own country. This includes that its designation is supported by the government concerned (i.e., political linkage); it is recognized as a leading national center in its field of designation, such as mental health, (i.e., academic or public health linkage); it collaborates with other national agencies, organizations and institutions involved in the field of designation, such as mental health (i.e., linkage to NGOs, patient or family groups, self help groups, various professional groups); its existence and work does not depend upon funding from WHO (i.e., linkage with private and/or public funding sources). If those conditions are met, it is to be expected that the collaborating center will be able to contribute successfully to international health (through WHO) and to benefit from the leading and catalytic role WHO plays in all matters of international health.

ad 2.: An important role of the WHO network of collaborating centers is to act as a source of expertise in health matters. Therefore, each individual collaborating center and the network as a whole should be in a position and prepared to respond quickly to requests for information in the fields of designation. Such requests may originate from a WHO office, another collaborating center, the press, young scientists or public health professionals, or other sources. If a CC cannot respond itself to a question related to its field of designation it should be in the position either to obtain the information at short notice (by having the relevant linkages already in place) or to refer to institutions or sources where the required expertise may be expected.

The individual collaborating centers should also be aware of what the other members of the network of collaborating centers are doing, who the significant collaborators are, which events are planned (such as conferences), what the research priorities are and what projects and activities are ongoing. In this context it will be helpful if, occasionally, exchanges of visits and/or meetings are organized.
It is recommended that the collaborating centers arrange for data, information, knowledge and/or reference banks to be established and maintained (or access to existing ones be facilitated).

The Group also felt that the network of collaborating centers should be encouraged not only to respond to requests for information and knowledge, but also to take the initiative in preparing position statements, papers or press releases on issues related to the designated fields of expertise, whenever a suitable opportunity arises.

The Group stressed the importance of the WHO office(s) (be it PAHO or WHO headquarters) in playing an active coordinating, stimulating and even demanding role. Collaborating centers, in the past, had the feeling that their expertise and their managerial capacities were not always used by WHO to their full potential.

Modern means of communication and information exchange should be used and collaborating centers pages on the INTERNET should be established.

ad 3.: Initiatives for collaborative projects may come from individual collaborating centers or from WHO (PAHO or Headquarters). The Group felt that the success of such initiatives, in terms of actual implementation, largely depends on the availability of appropriate funding. The Group was fully aware of the fact that WHO cannot act as a funding agency (though WHO funding or co-funding may be possible on an ad hoc basis). Therefore, individual collaborating centers and WHO offices should use their linkages (See 1. above) to facilitate fund generation for specific research or training projects. WHO should, even more actively than in the past, play a coordinating role and arrange for the collaborating centers involved in a particular project and potential funding agencies to meet or to make contact at the time when the project proposal is developed. Experience has shown that it is extremely difficult to find a funding source after the research protocol has been finalized.

The Group discussed, in general terms, the various (and well known) mechanisms for linkage at the time of project implementation (such as e-mail, list servers, INTERNET pages, computer-based access to literature, data or knowledge banks).

IV. Conclusion

The group concluded that this meeting was a good beginning toward achieving the objective, but that further meetings would be necessary to develop specific research plans and activities. Because it is the wish of the Director of PAHO to have the collaborating centers actively involved in PAHO activities, he has indicated his willingness to support such meetings and other research activities. Dr. Levav pledged his personal involvement in assisting centers develop research and activities and in helping to make them possible and rewarding.
Appendix A

Invitees

* = unable to attend

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Appendix B
Agenda

Thursday, January 7, 1999
6:00 - 7:30 pm Welcome and Reception at the Pearl River Hilton.
7:30 - Introductions and Dinner

Friday, January 8, 1999
8:00 - 8:30am Breakfast

8:30 - 8:35 Welcome: Dr. Eugene Laska, Dr. Itzhak Levav, Dr. Benedetto Saraceno

8:35 - 8:50 Mental Health Priorities from PAHO: Dr. Itzhak Levav

8:50 - 9:20 Mental Health Priorities from WHO Headquarters: Dr. Benedetto Saraceno

9:20 - 9:50 Recommendations of the World Mental Health Report: Dr. Leon Eisenberg

9:50 - 10:20 International Collaboration and Funding Possibilities: SAMHSA: Drs. Thomas Bornemann and Ronald Manderscheid

10:20 - 10:45 Coffee

10:45 - 12:45 Current Programs of WHO Collaborating Centers: Center Directors

12:45 - 1:45 Lunch

1:45 - 2:45 WHO/PAHO and the Collaborating Centers: Setting Agendas and Facilitating Linkages - Discussion: Dr. Benedetto Saraceno, Moderator

2:45 - 3:30 Break-out Groups
Technical support/capacity building to achieve mental health goals - Dr. Ronald Manderscheid
Clinical research/evidence-based practice in cultural contexts - Dr. Gaston Harnois
Mental health and social policy research - Dr. Kim Hopper
Methods for enhancing linkages - Mr. Walter Gulbinat.

3:30 - 3:45 Coffee

3:45 - 4:30 Report of Break-out groups: Drs. Manderscheid, Harnois and Hopper and Mr. Gulbinat

4:30 - 5:00 Crisis points, Priorities and Immediate Action: Summation and Action Plans - Discussion: Dr. Itzhak Levav, Moderator
Appendix C
Breakout Groups

Technical Support/capacity building to achieve mental health goals -
Dr. Ronald Manderscheid, moderator
  Dr. Arthur A. Stone  Stony Brook, NY USA
  Dr. Wendy Austin    Edmonton, Alberta Canada
  Dr. Carole Siegel   NKI
  Dr. Heather Stuart  Kingston, Ontario Canada

Clinical research/evidence-based practice in cultural contexts -
Dr. Gaston Harnois, moderator
  Dr. Alexander Cohen*  Boston, MA USA
  Dr. Marc Galanter    NKI/NYU
  Dr. John Breitner    Baltimore, MD
  Dr. Wilson Lit       Guelph, Ontario Canada

Mental health and social policy research -
Dr. Kim Hopper, moderator
  Dr. Benedetto Saraceno  WHO, Geneva
  Dr. Thomas Bornemann   SAMHSA, Washington DC USA
  Dr. Leon Eisenberg     Boston, MA USA
  Dr. Julio Arboleda-Flores  Kingston, Ontario Canada

Methods for enhancing linkages -
Walter Gulbinat, moderator
  Dr. Sheppard Kellam    Baltimore, MD USA
  Mr. Ric Ament          Guelph, Ontario Canada
  Dr. Joan E. Broderick Stony Brook, NY USA
  Dr. Rodolpho Montenegro Buenos Aires, Argentina
  Dr. Zebulon Taintor    NKI/NYU

* = rapporteur
Appendix D

Mental Health Priorities of PAHO: Address by Dr. Itzhak Levav

Conditions necessary to the improvement of mental health services and programs in the PAHO region have never been better. Military regimes in Latin America, which repudiated both mental health and human rights have given way to democracy, and civil wars have ended. Issues related to mental health as a human right have become visible. The recently adopted PAHO resolution CD 40.R19 expresses better than a thousand words the new winds blowing in the region. The Resolution urges member states to:

- formulate and implement national mental health programs as an integral component of mental health plans and within the framework of health sector reform;
- intensify support for efforts to reorient mental health services from an institutional to a community approach, in keeping with the initiative for the restructuring of psychiatric care;
- actively promote and support the inclusion of mental health services in every health insurance or payment plan and every health care services program;
- develop programs for the treatment of affective disorders, epilepsies and psychoses;
- strengthen or carry out actions for the promotion of mental health and psychosocial development of children, with special emphasis on the early years;
- support training of the managers of mental health programs in the schools of public health;
- make efforts to improve the legislation that protects the human rights of persons with mental disabilities;
- declare 10 October World Mental Health Day/Pan American Mental Health Day; and
- increase the appropriations for mental health training.

These policies require creative planning and demand the application of evidence-based practices to replace models based on tradition and on untested ideologies. Divisions of mental health are finding new partners, e.g., consumer and family organizations; PAHO supports their continuing presence at their meetings. Furthermore, PAHO and many health officials in the nations of the region, influenced by publications such as Investing in Health by the World Bank, World Mental Health by Harvard University, and the study, The Global Burden of Disease, are fully cognizant of the role mental health plays in overall health and human development.

The global burden of disease, needless to say, does not spare the Americas. Staggering numbers of persons suffer from schizophrenia and affective disorders, and projections suggest an increased percentage as the populations age.

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<td>North America</td>
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<tr>
<td>Canada</td>
<td>1.3 thousand</td>
<td>1.8</td>
<td>1.6 million</td>
<td>1.9</td>
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<tr>
<td>USA</td>
<td>2.9 million</td>
<td>3.2</td>
<td>15.4 million</td>
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<tr>
<td>Latin America and the Caribbean</td>
<td>3.3 million</td>
<td>5.3</td>
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Children do not have access to treatment by specialized personnel. Based on rates provided by Canino et al. in Puerto Rico, projections for ages 4 through 16 in Latin America and the Caribbean indicate that probably 17 million suffer from disorders that need care. Also, indigenous populations (40 million people) and people living in rural areas seldom, if ever, are cared for by mental health agents, whether directly or indirectly.

Mental health professionals are now being asked to address new problems related to the epidemiologic transition, e.g., diabetes, hypertension and cirrhosis, and the emergent disorders, e.g., abuse of women/children, violence, suicide and AIDS/STD, bringing visibility and placing mental health on the agenda of Ministries of Health.
Against this background of change and progress, many professionals trained in mental hospital environments resist modifying their loci of practice and resist searching the literature for new options. It is also true that even where the motivation for change exists, the difficulty of accessing knowledge generated in other countries often hampers efforts. Mental health activities throughout the area are centered mostly on the restitution of health, while primary prevention, rehabilitation and promotion are not yet a significant part of the repertoire of divisions of mental health, e.g., the dynamic movement Healthy Municipalities has yet to include mental health. Admittedly, knowledge that would propel professionals into action and mayors into becoming our interlocutors is missing. Furthermore, the lack of data, including cost data, turns planning by many divisions of mental health into an operation run in darkness, a contrast to other ministerial divisions.

Lastly, governments that adopted the PAHO Resolution on Mental Health are to be congratulated; however, many have yet to implement it fully. Unless PAHO intervenes through advocacy and with information, it might very well become a valueless piece of paper.

In summary, the opportunity exists for the numerous experts from the collaborating centers to make a difference. Centers are motivated to make science and technology available to all and to contribute to the achievement of equity, a leading principle for PAHO. With the participation of the centers, our objectives can be achieved more quickly.

Where is the expertise of the centers needed?
- in the development and testing of inputs for public policy development and implementation, especially inputs of proven cost-efficiency;
- in the promotion of research that is truly relevant to populations in adversity and that tackles emergent disorders whose control are just beginning, and in the support of local partners in the art of grant making and the science of research;
- in the facilitation of access to knowledge, particularly for those who lead programs, services, and community laboratories and for those professionals, such as nurses, that are often neglected by the professional establishment;
- in the development of data-bases that will enable more rational planning;
- in health services research that will enlighten care-givers, planners and administrators;
- in the joint design of evaluation strategies for community programs and;
- in the design, promotion and implementation of primary preventive programs and of psychosocial rehabilitation, particularly in the context of the Healthy Municipalities movement; and,
- in the continuous promotion of mental health as an integral component of all health programs and of human development, capitalizing on your authoritative position as recognized world figures in science.

Thank you once again for heeding our call.
Appendix E

Mental Health Priorities of WHO: Dr. Benedetto Saraceno

Dr. Saraceno began by briefly describing the reorganization of WHO into nine clusters. Social Change and Mental Health, one of the nine, was itself reorganized into four departments: Health Promotion, Disability/Injury Prevention and Rehabilitation, Prevention of Substance Abuse and Mental Health with two groups, Aging and Health and Assessment, Classification and Epidemiology, as backup support for the four departments.

In support of its mission to contribute to the reduction of the impact of mental and neurological disorders on individuals, families, communities and societies, and to provide advice on policies and interventions that could potentially positively or negatively impact on mental health, the Department of Mental Health works to give mental health a higher priority in governmental health agencies, to fight against stigma and discrimination, and to promote the human rights of mentally ill persons. The Department also provides technical advice and assistance to countries:

1) on building mental health services and on training health professionals especially with regard to depression, suicide, schizophrenia, epilepsy, Alzheimer's disease and the mental health of refugees,
2) sets norms and standards for policies, planning, service organization, prevention and care, including psychosocial rehabilitation,
3) promotes research in a public health context through WHO collaborating centers,
4) disseminates information on best practices, and
5) advises both programs within WHO and in other United Nations and international agencies on policies and interventions that could potentially impact mental health.

The Department of Mental Health develops an evaluative approach to mental health problems, responds to the needs of countries, adopts strategies that encompass all levels of the mental health system, coordinates with WHO regional advisors on mental health, develops partnerships with non-governmental organizations and develops operational research with WHO collaborating centers. By dividing into three teams, Mental Health Promotion, Policies and Service Development: Nations for Mental Health and Mental and Neurological Disorders Control, the Department advocates on behalf of mentally ill persons and for its programs, supports each country in addressing its needs and encourages the development of evidence-based knowledge.

Nations for Mental Health is a WHO action program at country level to improve the mental health and psychosocial well-being of underserved, disadvantaged and vulnerable populations such as persons in extreme poverty, children and adolescents experiencing disrupted nurturing, abused women, abandoned elderly people, persons traumatized by violence (victims of war/conflicts), migrants (including refugees and other misplaced persons), and many indigenous populations. The program aims:

1) to raise awareness of the burden of mental health problems through the development and dissemination of advocacy and policy resources,
2) to increase the commitment of governments to reduce this burden through educational meetings with national leadership,
3) to increase the technical capacity of countries to create and implement mental health policies and legislation through technical seminars,
4) to create country-level research and demonstration projects to serve as models for wider dissemination and
5) to disseminate existing but geographically-limited best practice models.

The program has established field demonstration projects in all WHO regions, has conducted awareness seminars and capacity building conferences, and has developed operational field research projects.

Dr. Saraceno suggested that the collaborating centers could play several roles in the Nations for Mental Health program. Centers could:

1) participate in the awareness campaign by formalizing knowledge derived from their research,
2) develop evaluation strategies to examine the success of the approaches and
3) participate in site visits.

Appendix F

International Collaboration and Funding Possibilities: Drs. Thomas Bornemann and Ronald Manderscheid

The Center for Mental Health Services (CMHS) in the Substance Abuse and Mental Health Services Administration (SAMSHA) of the US Department of Health and Human Services.

Its core functions are: 1) supporting mental health services in communities, e.g., by advocating for people in institutions and by transitioning people from homelessness (the PATH program), 2) stimulating findings transfer so research gets used in communities and by funding grants that put effective models in place, 3) fostering consumer and family involvement, 4) protecting consumer rights, and 5) addressing emerging mental health needs and emergency mental health issues. In carrying out these functions, the Center works with key public health partners, other federal agencies, state mental health authorities, county and local mental health authorities, service providers, family representatives and mental health consumer representatives.

In the fall 1999, the office of the US Surgeon General will issue its report on mental health. Senior editor, Dr. Howard Goldman, working with the Center and the National Institute of Mental Health (NIMH) and others, is developing a science-based document with a life cycle structure.

The Center has special interest in training professionals to work with victims of disasters, bioterrorism and torture and with refugees, e.g., in Russia. With PAHO, the Center is working on a community-based integrated system of care for children sites, and will work with Mexico in the area of organization and financing of services for mental health planning.

The CMHS will be focusing on populations, especially screening, prevention and early intervention, monitoring problems and peer support. It will look to technology to provide self-screening and to delivery interventions through the internet, to develop monitoring strategies for use in the home and to provide peer support directly through video conferencing. Further, websites that have the capacity to collect, process, analyze and report (encrypted) information will become subject to world-wide competition, so that “middle” entities that do not “add value” will be eliminated. Any organizational level will be able to operate the web site, so these levels can/will become more remote.

To its more traditional activities of building data structures and developing minimum data sets, the Center is adding the development of outcome data and report cards. A prototype person-centered performance indicator system that cover access to services, appropriateness of service, prevention strategies and clinical outcome has been developed; grant awards for further work and testing have been made to 20 states, and a new grant announcement will be forthcoming shortly. A prototype mental health policy scorecard has also been developed; it looks at such areas as accomplishment of the mission, adding value for the consumer, using resources efficiently and effectively, and developing the work force.
Appendix G

Clinical research/evidence based practice in cultural contexts: Dr. Gaston Harnois

In an editorial to Vol. 41 of Social Sciences and Medicine, Roy Carr-Hill humorously talks about a health service researcher from Mars who would be very puzzled about health services research on Earth, and more importantly, by a lot of talk about “evidence and how important it is as a basis for practice.” He would be faced basically with three different groups, one team insisting on the outcome route, a second one on the evaluation route, and a third one on the information revolution route. Each group is of course very enthusiastic about its point of view and yet must face many challenges:

Group I: Quickly realizes that “outcomes” are not easily attainable and require a lot of agreement as to what is to be considered an outcome and such agreement, in turn, requires complex negotiations between different groups of health workers.

Group II: focusing on audits and evaluation, it is quickly realized that this is easier to design than to implement; there is also the realization that different people seem to be reaching different results and that the reliability of the data depends “on the context and the way in which the audit and evaluation is implemented.”

Group III: which basically would recommend surfing the internet is likely to be confronted with more confusion than enlightenment. “As data sources multiply and are increasingly interrelated, the likelihood of error increases dramatically and the likelihood of detecting error decreases.”

Hill also makes the point about the problem with decision-makers; they always seem to want simple answers “yesterday.” He feels that this has led to a degree of pragmatism or more correctly “short-termism” which has to be developed in order to meet ridiculous deadlines. This, in turn, leads to a considerable “narrowing” of the themes under investigation with the result that managers at times cannot make any sense of the data that are given to them. People have a tendency to ignore the wider picture because there are too many confounding variables: issues such as access and equity quickly become overshadowed in the quest for even greater effectiveness and efficiency. He then mentions that all too often there is a tendency to want to produce evidence which can be summarized on one graph; he also makes the point that carrying out “systematic reviews” presumes that health care is static, whereas we all know that technology changes all the time and that the design of research should reflect this. At this point, he feels that there is now a hierarchy of evidence with the “randomized control trial” at the top of the tree and one-off studies at the bottom. He concludes by saying that “there are no simple answers to apparent simple questions: there is always a role for judgment and decision-making.”

The 90’s have brought into much sharper focus the fact that, while they remain the key actors in decisions concerning outcome of mental health services, doctors are no longer the only ones: clients, families, HMO’s, regional boards, and the community all play increasingly significant roles.

As reported by Sederer, Dickey and Hermann in their book Integrating Outcome Assessment into Clinical Practice, we have entered an era in which there is a very perceived shift in the focus of patient care from clinical priorities to fiscal priorities. Utilization review organizations have as a basic theme to manage costs by reviewing and restricting utilization of clinical services. A second factor, that of increasing consumer demands, adds an important voice to question the value of psychiatric services and demand that clinical practice be accountable for the outcome of care. One, therefore, has the impression that evaluation is moving quite a bit from structure and process to focus considerably more on outcome of care, both short-term and long-term. There is a move away from classical control experimental condition to one that takes place under “naturalistic conditions in hospital clinics and the community.” It is felt now that instruments should be developed, if they do not already exist, to measure the following:

1. Changes in symptomatology, although this takes a different perspective when the family or the community looks at it.

2. Functional capacity, is the patient’s capacity to function within a family, a community or work environment or to exist independently without undue burden on the family and the social welfare system?
3. The patient’s ability to show improvement in any concurrent medical or psychiatric disorder, for instance, alcoholism, liver or heart disease.
4. Consumer satisfaction: the patients also want to experience a subjective sense of health and well being. In the United States, some HMO’s and Managed Care organizations require patient satisfaction to be measured and the rate of satisfaction to reach at least 90%.

The authors feel that the issue of continuous quality improvement (CQI) is a very important tool to achieve all of the previously mentioned targets. It may also have a result on the following:
1. The development and adoption of treatment guidelines that can be linked to specific outcomes.
2. The integration of outcome assessment into clinical practice can produce data to legitimize the treatment of psychiatric and substance abuse problems in the eyes of legislators contemplating changes.
3. Outcome assessment can be seen as a marketing tool for the mental health care service system.
4. Accountability through outcomes assessment offers an opportunity to regain the public trust.

Cultural Context: One other large domain which creates problems in evidence-base practice is the whole issue of the cultural context. In most, if not in all countries of the world, mental health practice is rarely purely evidence-based; it always involves interpersonal relationships, family context as well a social and cultural environment.

- How are we to take into account the patient and the family’s belief system concerning the etiology of schizophrenia in Senegal?
- How will we integrate in our practice the fact that most patients in Dominica will have seen two ministers of the faith and at least one traditional healer before coming to a mental health professional?
- Etc., etc.

In summary, one has the impression that as we learn more about what works under naturalistic conditions, psychiatric research may shift from clinical trials to mental health services research or from efficacy to effectiveness studies.
ARGENTINE WHO MENTAL HEALTH COLLABORATING CENTRE

- Department of Mental Health, University Hospital, School of Medicine, University of Buenos Aires
- Latin American School of Bioethics, Mainetti Foundation
- Institute of Post Graduate and Continuing Medical Education in Psychiatry, Argentine Psychiatrists’ Association (APSA)
- ACTA Foundation, Foundation for Mental Health

It has been difficult for these institutions to work together on a single project, but their individual productions and their cooperative disposition to interact have contributed to the improvement of mental health issues in the region.

Activities undertaken by the four institutions:

Department of Mental Health, University Hospital, School of Medicine, University of Buenos Aires

Detection of depressive disorders in primary health care
Study of the health care conditions of the homeless
CME program for primary care physicians
Efficacy of short term psychotherapy on patients suffering from severe personality disorders

Latin American School of Bioethics, Mainetti Foundation

Ethics in Mental Health
Research and documentation related to Bioethics
Undergraduate and post graduate education in Bioethics
Institutional development of ethics committees in mental health institutions.

Institute of Post Graduate and Continuing Medical Education in Psychiatry, Argentine Psychiatrist's Association (APSA)

Rights of the patients and mental health legislation in Latin America
CME in psychiatry
Modular, practice-based, supervised training on: ICD 10 and DSM IV, disorders mood disorders, psychopharmacology, psychogeriatry, child and adolescent psychiatry
Research awareness in young psychiatrists through training on research methodology and development of specific projects:
- the use of anorexigens in clinical practice and in self-medication
- the assessment of quality of life in oncological patients
- anthropologic and psychosocial studies of migrating population in Buenos Aires general hospitals

Psychosocial Rehabilitation
Network for education in community mental health (Red Maristán)
Promotion of the creation of self help groups of patients and relatives and joint work with them

ACTA Foundation for Mental Health
Psychiatry and mental health data professionals in the field
Publication of a comparative study of ICD 10 and DDSM IV, in Spanish
Publication of series of psychopharmacology
Appendix H2

A Report for the WHO Collaborating Centres in the Americas
Homewood Health Centre, Guelph, Ontario, Canada

Efforts to date

1. St. Kitts/Nevis

Edgardo Pérez, M.D., CEO of Homewood, visited St. Kitts at the request of PAHO on 28 April 1998. He met with several individuals, including Dr. Honourable Earl Martin, Minister of Health and Women’s Affairs, Dr. Tissa Wickramasuriya, and Dr. Izben Williams. The discussion, at the time, revolved around formulating policies on psychiatric care for the islands, as well as exploration of the use of telepsychiatry. Proposals were submitted. In June 1998, Dr. Izben Williams visited Homewood and met with clinical staff and witnessed a videoconference demonstration.

2. Jamaica

Wilson Lit, M.D., Director of Homewood’s Community Division, visited Jamaica in April 1998, at the request of PAHO. Homewood is providing training and support to assist in the development of community and rehabilitation programs at Bellevue Psychiatric Hospital. A recommendation was made that several Bellevue nurses visit Homewood, and that several Homewood clinicians visit Bellevue, for training purposes.

3. Belize

Dr. Levav forwarded to Homewood a request from the First Lady of Belize for telepsychiatry services in that country. A proposal has been submitted.
The Calgary WHO Collaborating Centre for Research and Training in Mental Health

J Arboleda-Flórez, MD, PhD, Director & H. Stuart, MA, PhD, Associate Director

The Calgary WHO Collaborating Centre for Research and Training in Mental Health was inaugurated in 1993. Located at the Calgary General Hospital, the Centre was affiliated with the Montreal WHO Collaborating Centre for Research and Training in Mental Health and affiliated with the University of Calgary Departments of Community Health and Psychiatry. The Centre was mandated in four specialty areas:

- **Forensic Psychiatry**, defined as the area in which the law overlaps with mental illness. This often relates to the assessment of mentally ill offenders in order to determine whether they are fit to stand trial or are criminally responsible.

- **Psychiatric Epidemiology**, defined as the study of the occurrence of psychiatric disorders in clinical and non-clinical populations in order to advance the understanding of the origins and causes of mental illness, and to improve public health.

- **Occupational Therapy and Psychiatric Rehabilitation** addresses the needs of the chronically mentally ill who suffer some disability as a result of their illness.

- **Psychopharmacology** is concerned with the development and evaluation of effective drug therapies for the treatment of mental illness.

The Centre closed in 1998 after completing its five year term. During its tenure the Centre was involved in a number of activities at local, national, and international levels such as:

**International Conferences:**
- Human Rights, Mental Health and Therapy in a Radically Changing World - WPA Regional Meeting
- Communities in Crisis: Development of National Suicide Prevention Strategies – WHO/UN Sponsored

**Consultations to UN Member States**
- Columbia - Effects of Working Maximum Security Environments on Staff Stress
- Jamaican Mental Health Act
- Canada - Automatism as a Legal Defence

**Projects Initiated Through WHO/PAHO**
- Quality Assurance Guidelines for Forensic Facilities
- Survey of Mental Health Legislation and Services in 21 Latin American Countries

**Epidemiologic studies in the areas of**
- suicide
- violence
- outcomes assessment
- depression
- criminality

**Teaching/Training:**
- Forensic Fellowship
- Special Locums - Geriatric and Forensic Nurses from Trinidad
- Psychiatric Epidemiology Courses and Workshops
Faculty of Nursing, University of Alberta, Canada

The Faculty of Nursing is applying to become a WHO Collaborating Centre in *Mental Health and Nursing*. The administrative head of such a Centre would be Dean Marilyn Wood. The proposed Director of the Centre is Wendy Austin RN, Ph.D.

**The Proposed Terms of Reference for the Centre include:**

a. Support WHO endeavours to integrate mental health care into primary health care initiatives.
b. Facilitate the education of nurses internationally in mental health care practice.
c. Accept visitors, students, and scholars in pursuit of research expertise.
d. Collaborate in international interdisciplinary education and research in mental health promotion and care.
e. Encourage the development of standards of practice for psychiatric and mental health nursing.

**The Existing Educational and Research Milieu of the FON**

The University of Alberta is situated in Edmonton (population: 875,000), the capital city of the Canadian province, Alberta (population: 2.7 million). Founded in 1908, it is Canada’s fourth-largest university and a national leader in research and teaching. Internationalization is one of the University of Alberta’s major priorities. The Faculty of Nursing, one of the oldest nursing faculties in Canada, is one of five Health Sciences Faculties at the University of Alberta and is a member of the Coordinating Council of Health Sciences whose goal is the development of interdisciplinary opportunities for students and faculty. The Faculty offers three undergraduate programs leading to a BScN degree: collaborative baccalaureate (with colleges in four sites in addition to the U of A campus); post diploma; and Registered Psychiatric nurse (RPN) to BScN. At the graduate level, the Faculty offers an Advanced Nursing Practice Masters program with thesis and non-thesis routes and a Ph.D. in Nursing program (the first fully funded Canadian program). A complement of 70 full-time faculty, engaged in more than 75 funded research projects, offers approximately 70 courses to over 1050 undergraduate students, 80 masters students and 46 Ph.D. students. The Faculty of Nursing has extensive experience with distance education strategies. Newly acquired “Telehealth” telecommunication hardware (video, audio and medical data) which, when coupled with computer based communication (e-mail, Internet), facilitates trans-country distance education.

**Referred Journals based at the FON**

*Qualitative Health Research: An International, Interdisciplinary Journal*
*Western Journal of Nursing Research*
*Clinical Nursing Research*
*Partners in Psychiatric Health Care Journal*

**International Nursing Centre (INC) of FON**

Established in 1998 to create an environment where international nursing initiatives can flourish, the FON international linkages are fostered and coordinated through the INC. Dialogue regarding international dimensions of curricula are fostered, as is faculty development. Over time, a body of comparative nursing and health research will be accumulated and disseminated. The
INC has a resource centre, with print, electronic and audiovisual resources for students and faculty. A Bursary Fund is being established for international nursing students.

**Institute for Philosophical Nursing Research**

Founded by Dr. June Kikuchi and Dr. Helen Simmons in 1989, the FON’s Institute for Philosophical Nursing Research is devoted to research of philosophical nursing issues and the answering of questions fundamental to nursing’s development as a discipline. The current Director is Dr. Donna Romyn.

**Mu Sigma Chapter of Sigma Theta Tau International**

Chartered in 1992 at the University of Alberta, the Society’s mission is to improve the health of people world wide through increasing the scientific base of nursing practice. Mu Sigma cosponsors two major events each year with the Faculty of Nursing, International Day and Margaret Scott Wright Research Day.

**Interdisciplinary Centres and Institutes Associated with the FON**

**John Dossetor Health Ethics Centre**

Governed by the Coordinating Council of Health Sciences, under the co-direction of Dr. Vangie Bergum (Faculty of Nursing) and Dr. Paul Byrne (Faculty of Medicine), the Centre is comprised of an interdisciplinary professional group who, through partnership and dialogue, promote professional and public reflection, debate, and research on matters of ethical and moral concern in healthcare institutions and in the community. Graduate level courses in healthcare ethics are provided, as are community outreach information workshops and public forums. *Health Ethics Today* is published four times a year in collaboration with the [Alberta] Provincial Health Ethics Network (PHEN). The 1999 meeting of the International Association for Bioethics (funded, in part, by Health Canada) and The Canadian Bioethics Society 1999 Conference will be hosted by Centre in collaboration with St. Joseph’s College Ethics Centre and PHEN.

**International Institute for Qualitative Methodology**

This Institute was established to provide leadership to address the issues in qualitative inquiry and to facilitate the development of qualitative methods; to promote excellence in qualitative research through education and research; and to provide a forum for collaboration among international experts in the field of qualitative inquiry. The Institute sponsors one major international conference every year, alternating between Qualitative Health Research and Advancing Qualitative Methods. *Qual Institute Press*, a publishing firm for qualitative research work, is located at the Institute. Professor and Director of the Institute is Janice M. Morse Ph.D. (Nurs), Ph.D. (Anthro), FAAN. Dr. Morse is the editor of *Qualitative Health Research* - an international, multidisciplinary journal for the health sciences, which is published six times per year by *SAGE Periodicals Press*. International sites of the Institute are as follows: University of Newcastle, Australia; Ewha Women’s University, Korea; University of São Paulo, Brazil; University of Utrecht, Netherlands; Raand Africaan University, Johannesburg, South Africa. Negation is underway for sites in Israel and Mexico.

**Centre for Health Promotion Studies (CHPS)**

The Centre is committed to interdisciplinary research and graduate education to advance knowledge and theory development, practice and policy in health promotion through community and academic partnerships. Dr. Miriam Stewart is the Director.
The Montreal WHO Collaborating Centre for Research and Training in Mental Health

The Douglas Hospital Research Centre was designated as the Montreal WHO Collaborating Centre for Research and Training in Mental Health in March 1982 and redesignated in 1986, 1990 and 1995. Part of a worldwide WHO network, our Centre is the only one carrying such a designation in Canada; it has one affiliate Centre in Hamilton, Ontario.

Structure and Administration

The Montreal WHO Collaborating Centre functions as the international arm of the Douglas Hospital Research Centre, McGill University’s largest research centre in psychiatry and mental health, engaged primarily in research on the biological, psychosocial and epidemiological aspects of mental disorders and alcoholism.

Brief History of Collaboration with WHO

Collaboration with WHO began in 1966 when Dr. H.E. Lehmann, then scientific director of the Douglas Hospital, was elected chairman of a WHO scientific group on research in psychopharmacology. At present, most of the international activities of the Montreal WHO Collaborating Centre and its affiliate fall within the following categories:

1. Advisory Role

This involves the exchange of information with other collaborating centres and members of the international scientific community, as well as a number of more specific activities which fall within the scope of the WHO medium-term program on mental health such as mental health policy development, national mental health programs and quality assurance. Our Centre is intimately involved in the recent WHO program “Nations for Mental Health”, targeting underserved populations around the world. Our WHO Centre has acted as consultant to several countries in the Americas and has an ongoing program in Guatemala. We have accepted to develop the mental health section of GLADNET, the Global Applied Disability Research and Information Network for Employment and Training under the aegis of the International Labor Organization (ILO).

2. Scientific Role

The neuroscience and Clinical Research Division works on the normal aging of the human brain, depression, schizophrenia and alcoholism. The Psychosocial Research Division works on psychiatric epidemiology, chronic psychiatric problems, adapting psychiatric services to local conditions, and psychosocial aspects of aging. We are assisting WHO Headquarters in the development of various instruments on issues such as quality of life, satisfaction of users, families and staff, employability, etc. We are co-sponsors of the 5-year program between McGill University and the Universidad Peruana Cayetano Heredia (UPCH) in Lima, Peru.

3. Educational Role

The Montreal WHO Collaborating Centre is the host of scholars from around the world who come to train on issues ranging from psychopharmacology to psychosocial rehabilitation, and also child psychiatry, community development, research methodology, policy formulation, prevention, alcoholism, etc. In the last few years we offered training to candidates coming from China, India, Belize, Guatemala, Guyana, Brazil, Argentina, Indonesia, France and Dominica. Currently, we co-sponsor McGill University’s Annual Summer Program in Epidemiology and Biostatistics and in Social and Cultural Psychiatry.

Current areas of cooperation with WHO

1. Evaluative research through the development of instruments for quality assurance, quality of life.
2. Biological markers and longitudinal study of schizophrenia and affective disorders, as well as alcohol abuse and alcoholism.
3. Community-based epidemiological study of mental disorders and interpersonal violence.
4. Development of instruments to assess capacity of persons with mental illness to return to work and description of successful models (also in cooperation with the International Labour Organization).
5. Study of optimal models of service delivery.

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ACTIVITIES OF WHO COLLABORATING CENTER
AT DEPARTMENT OF SOCIAL MEDICINE, HARVARD MEDICAL SCHOOL

1) The Mental Health of Indigenous Peoples: An International Overview
   This report, the first international overview of the topic, was prepared at the request of Nations
   for Mental Health. Its purpose was to:
   1) develop a working definition of the term indigenous people;
   2) survey the general sociocultural contexts of indigenous peoples in North and
      South Americas, Oceania, Asia, Europe, and Africa;
   3) conduct a literature review to determine the state of our knowledge regarding mental
      health problems among indigenous peoples;
   4) initiate the organization of an international task force;
   5) prepare a report based on this work; and,
   6) present the findings of this research at a meeting on this topic that will be organized by
      Nations for Mental Health.

2) Primary Health Care Strategies: Their Effectiveness
   This is another report that is being prepared at the request of Nations for Mental Health.
   The report will consider the following question: Is the common assumption that primary
   mental health care yields higher public health benefits than other approaches to mental health
   care documented in the literature and, if so, how? Like the report on the mental health
   of indigenous peoples, this work will offer an international perspective and will provide
   discussions of the relevant theoretical, practical, and methodological questions.

3) Casebook of Promising Mental and Social Health Programs in Low-Income Countries
   This project is a follow-up to World Mental Health: Problems and Priorities in Low-
   Income Countries, Desjarlais, et al. 1995, Oxford University Press. One of the key activities
   during this current phase of the World Mental Health project has been to identify several
   exemplary mental and social health programs for low-income populations and to write case
   histories of each. The case histories will be collected together in a book that will, first,
   provide models others may follow, second, allow us to speculate about the elements that are
   critical to the success of programs, and, finally, provide a forum by which we can make
   suggestions about how such programs can be generalized to entire countries or regions.

4) Initiate a collaboration between Nations for Mental Health and the Department of Social
   Medicine to plan and produce a second volume of World Mental Health: Problems and
   Priorities in Low-Income Countries.
   The book produced by this collaboration will be a joint Harvard/WHO Nations for
   Mental Health publication.

5) Organization of China Mental Health Awareness Project, including review and preparation of
   documents regarding evaluation.

6) Two-day meeting at Harvard concerning mental health needs and services in China, with a
   specific focus on the problem of suicide.

7) Assist Nations for Mental Health in review of its demonstration projects in Sri Lanka, India,
   Mongolia, and China.
World Health Organization Collaborating Center for Training and Research in Mental Health and in the Prevention of Substance Abuse

Eugene M. Laska, Ph.D., Director
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AREAS OF COLLABORATION

The WHO Collaborating Center at The Nathan S. Kline Institute for Psychiatric Research conducts health services research and develops epidemiologic, statistical, economic, educational, treatment and information management methodologies and applies them to issues in mental health and substance abuse.

PROJECTS

International Study of Schizophrenia (ISoS)

The Center, in collaboration with WHO Geneva and sixteen other collaborating field research centers in thirteen (now twelve) countries, coordinated a follow-up study of patients who had been involved in previous WHO-coordinated multicenter epidemiological research into schizophrenia, the International Pilot Study of Schizophrenia (IPPS), the study on the Determinants of Outcome of Severe Mental Disorder (DOSMeD), and the study on Reduction and Assessment of Psychiatric Disability (RAPyD) and in other comparable studies. In the International Study of the Course and Outcome of Schizophrenia (ISoS), subjects were assessed in their second and for some, their third decade after onset of psychosis.

In addition to project monitoring, meetings of investigators and ongoing administration, Center activities included design of data collection instruments, development of a database, development of data analysis methodologies in conjunction with Expert Committees, statistical analysis of the data and preparation of a book, the final report on ISoS, to be published by International Universities Press/Psychosocial Press in 1999.

Development of Methods for Mental Health Planning and Program Evaluation: NKI/WHO Mental Health Information System

The WHO Center at NKI has developed the NKI/WHO Mental Health Information System, a microcomputer-based mental health information system designed to be used for planning, managing, evaluating, and delivering mental health services. The System, may be used in individual facilities as well as on regional and national levels. The current version has been translated into Chinese, Czech, Japanese, Portuguese and Spanish. The newest version of the system, to be released in February, 1999, incorporates recent advances in computer and communications technology.

Collaboration with the People's Republic of China

Since 1989, the Center has been collaborating with the People's Republic of China to develop a national mental health information system. These efforts included adapting the NKI/WHO Mental Health Information System to the needs of China, training Chinese clinical and computer scientists and providing continuous technical support. In January, 1995, the Center was notified that the System had been approved by the Ministry of Health for use nationwide.

Collaboration with PAHO (the WHO Office for the Americas, AMRO) in the transfer of information technology

Consultative visits and information/technology transfer activities with countries in the Americas are ongoing. Spanish language copies of the NKI/WHO Mental Health Information System have been distributed to: Chile, Colombia, Dominican Republic, Ecuador, Mexico and Uruguay. A Portuguese version is also available.
Cost Effectiveness Analysis

Methods of conducting cost-effectiveness analysis of treatment interventions are being adapted for application to countries with highly diverse economic profiles. Also, a method for studying the cost-effectiveness of the treatment of depression was proposed for observational/naturalistic studies that aim to estimate the prevalence of depression and to assess the rate at which primary care physicians identify depression, the adequacy of treatment, the prognoses, and the consequences of morbidity on public cost.

Development of a methodology for assessing the costs of mental illness and psychological disorders to health and social services

To assist mental health authorities in planning, the Center has developed an approach to obtaining data on the characteristics of the health, mental health and social service networks in a defined area and on the patients with mental health problems who use these services. The methodology includes a survey to be conducted over a short time period during which data are collected on patients seen in a typical week in each setting. In addition to descriptions of the providers in an area who serve persons with mental health problems and of the persons with mental health problems who seek service, the survey provides data for an annualized estimate of the number and proportion of persons in the service system that have mental health problems and for an assessment of the costs to the services of such patients.

Reevaluating the "D" in the DALY

The World Bank, that reports the burden of mental illness is as high as 11 %, bases its conclusion on estimates provided by the Disability Adjusted Life Year (DALY) methodology. A joint project with the developers of the WHO Disability Assessment Instrument (DAI) under a supplemental grant to WHO Geneva from the U.S. National Institute of Mental Health, has begun to pilot test a methodology to form an adjusted time measure based on empirical ratings from the DAI.

Mapping Treatment Approaches in Substance Abuse

The Division of Alcoholism and Drug Abuse is collaborating with the section on Treatment and Care of the WHO Programme on Substance Abuse (PSA) in a global initiative for demand reduction. Designed to disseminate medical information, treatment approaches, and educational techniques in substance abuse, this project targets senior health professionals and their teachers in countries designated by the PSA.

Organizing Medical Curricula in Substance Abuse

This project focuses on the needs of different countries relative to their principal drugs of abuse and to their respective cultures, i.e., transferring technology on new treatment modalities; establishing an organizational base for medical training in national settings; and adapting treatment procedures from one national setting to another. Assessment of treatment delivery structures in various countries and cultures are being undertaken with the WHO PSA.

Technology Transfer of Psychosocial Treatments

This project focuses on technology transfer of psychosocial treatments singly and in combination with pharmacotherapies including the adaptation of drug-free therapeutic community modalities to different subcultures and treatment contexts and the development of training approaches.
WHO Collaborating Center
for Research and Training in Mental Health Program Management
and in the Prevention of Substance Abuse

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Brief overview of the WHO-Coordinated International Study of Schizophrenia
Kim Hopper, Ph.D.

The Center at the Nathan S. Kline Institute for Psychiatric Research has spent much effort in the last two years organizing, analyzing and editing material on the recently completed WHO-Collaborative International Study of Schizophrenia (ISoS).

ISoS offers a singular opportunity to test the prospect of “slow, uphill” progress in cross-cultural cohorts of great diversity. The study encompasses a large number of treated incidence cohorts – chiefly from two earlier WHO studies, the Determinants of Outcome of Severe Mental Disorders (nine of the original 13 centers), and the Reduction and Assessment of Psychiatric Disability (three of the original seven) – assembled from diverse catchment areas, using common case finding techniques and inclusion criteria. To broaden the global representativeness of the follow-up study, these were supplemented by opportunistic cohorts from two additional centers (Madras and Hong Kong) where circumstances allowed the retrospective identification of broadly comparable incidence cases. It was possible, too, to include three (out of seven) prevalence cohorts from the original International Pilot Study of Schizophrenia, as well as an additional retrospective analysis cohort (Beijing), from which information about very long-term outcome may be gained. In all, sufficient data for analysis was collected on 1043 individuals (accounting for two-thirds of the original study participants) from eighteen study cohorts scattered across sixteen field research centers. Follow-up times ranged from 12 to 26 years.

The study aimed to examine:

1. long-term course and outcome in this diverse set of centers;
2. durability of the developing vs. developed outcome differential, documented with some consistency in the earlier WHO studies; and
3. evidence for late recovery.

Briefly: some two-thirds of the members of the treated incidence cohorts (and a slightly lower percentage of the prevalence cohorts) were judged recovered or stable with mild impairment. This compares quite favorably with the results of eight other long-term follow-up studies, ranking with the Bleuler (Swiss) and Harding (U.S., Vermont) studies.
The Center for the Study of Issues in Public Mental Health, established in 1993 through a grant from the National Institute of Mental Health, is a community of researchers, stakeholders and policy makers whose mission is to improve the outcomes of public mental health services through the integration of research, policy and practice. The Center provides a structure and staff with which to inform the scientific and public communities on ways to understand persons with severe mental disorders and to provide them services and supports. It uses its strong collaborative links with stakeholders to study persons with severe mental disorders, their problems and potential solutions and to develop the methodologies required for such research.

The Center has four integrated research cores that address problems confronting persons with severe mental disorders who now spend most of their lives in communities: Methodology, Promoting Recovery, Seeking Systems Integration and Negotiating Lives in the Community. Since the Center began, more than 80 researchers have collaborated in more than 35 projects, 14 of which are ongoing (See attached list.).

The focal location of the Center is the Nathan S. Kline Institute for Psychiatric Research in Orangeburg, New York, a research institute of the New York State Office of Mental Health. Its collaborative sites are the Central Office of the New York State Office of Mental Health, the Rockefeller College of Public Affairs at the State University of New York (Albany, NY) and the Robert F. Wagner Graduate School of Public Service and the Departments of Psychology and Psychiatry at New York University (New York, NY).
Navigating the de facto MH System: Systems Integration

i) Service improvement
Decision support service integration methodology
Decision support in psychiatric emergency rooms
Mental health community level indices*
Involuntary outpatient commitment*
Ethnic minority issues in mental health service utilization*
Cultural competency performance measures*

ii) Managed Care & Insurance
Prepaid Mental Health Plan evaluation*
Public benefit corporations
Rate adjustment methods: classification, blended payments and step losses
Managed care taxonomy*
Managed care SAMHSA cost substudy*
Managed care research survey
Smart Buyer of Managed Care Services*
Impact of parity legislation on insurance premiums
Cost shifting: Private to Public Payers under Parity*
Continuity of and Satisfaction with Psychiatric Services: Pre and Post Managed Care

Navigating the Defacto MH System: Negotiating Lives in Communities

i) Residential Stability
Westchester County SHAC study
Westchester County homeless follow-up study
New York/New York: tenure in housing
Evaluation of a continuum of supportive housing options, Phase 1,2*

ii) Violence/Criminal Justice System
Community violence in persons with major psychiatric disorders*
Mental health status and low level offenders*
A blueprint for a model forensic mental health system*

Promoting Recovery

i) Special populations
PSMD-D
Treated prevalence, population profiles and system description
PSMD-D treatment innovation: Modified Johnson Intervention*
Peer led treatment for homeless PSMD-D*

Trauma Survivors
Survey of trauma interventions
Trauma advisory board

ii) Definition and Implications
Recovery conference
Recovery instrument
Recovery component of the WHO study
Self-help participants
Work and mental illness

Methodology

i) Statistical methods for improving services research
Differential treatment effects
Cost-effectiveness methodologies*
Counting methodologies
Quality adjusted time as an outcome measure*

ii) Instrument development
Managed care taxonomy*
Service network instrument
Recovery instrument
Outcome instrument for survivors of childhood sexual abuse
Social cost inventory: activity and utilization interview for persons with SMI

iii) Research procedures
Informed consent in field study research

Collaborations and Consultations
NYS Local Conference of Mental Hygiene
Directors: Public Benefit Corporations
NASMHPD RI:
Functional role of state hospitals
Managed care research survey
Substitution of long term beds for the elderly
Policy Research Associates: Involuntary outpatient commitment

Corporation for Supportive Housing:
Vocational interventions in supported housing
NIMH, DHHS, CBO: Parity issues
WHO: Rochester recovery study; D in DALYs
FMHO: Taxonomy of managed care
Managed care SAMHSA cost substudy

NYC Health and Hospitals Corporation: Mental health status and low level offenders
Maine Muskie Institute: Survey of trauma interventions
NYC Human Resources Administration/Center for Urban Community Services: Evaluation of a continuum of supportive housing options
VA: Cross walk of Veterans:OMH/VA MIREC

Dissemination

MHPOLICY Discussion Group (dishanded)
World Wide Web site
Center Update newsletter
Video on recovery
Legislative update on managed care
Legislative update on recovery

Agenda Building

Ethics in ethnographic research
Recovery conference
Multicultural research agenda
Interstate Trauma Work Group
VA (VISN3) workgroup meetings

* = year 5 and ongoing projects
Mission

To advance the understanding and the application of social and psychological factors to the prevention and treatment of somatic illness. This institute was formed to bring together scientists and clinicians with an interest in applying the extant knowledge base in Behavioral Medicine to patient groups and to develop new Behavioral Medicine interventions. The institute provides a forum for facilitating collaborating partnerships to enhance each member’s initiatives.

Recent initiatives and research

- **Factors in adaptation to chronic disease**: Coping strategies, social supports, health beliefs, self-efficacy.
- **Incorporation of psychosocial approaches into medicine**: self-management and cognitive-behavioral strategies.
- **Basic biopsychosocial process research**: Stress, psychoendocrinology, and psychoimmunology.
- **Development of novel assessment technologies**: Ecological Momentary Assessment
- **Collaborating Center**: World Federation of Mental Health
- **Innovative interventions on the experience of traumatic events for medical patients**.

Members

Joan E. Broderick, Ph.D., Program Director of ABMRI, Clinical Assistant Professor of Psychiatry & Behavioral Sciences.
Ronald Friend, Ph.D., Professor of Psychology
Peter J. Halperin, M.D., Director of Division of Behavioral Medicine, Assistant Professor of Psychiatry & Behavioral Sciences.
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Arthur A. Stone, Ph.D., Director of ABMRI, Vice-Chair for Research and Professor of Psychiatry & Behavioral Sciences.
James N. Weisberg, Ph.D., Assistant Professor of Psychiatry & Behavioral Sciences.
Appendix

MEXICAN INSTITUTE ON PSYCHIATRY
World Health Organization Collaborative Center on Drug Abuse and Mental Health.

The Mexican Institute on Psychiatry, a public, decentralized institution with budget and administration of its own, is one of National Institutes on Health, other institutes being Cardiology, Cancer, Neurology and Neurocircuitry, Nutrition, Pediatrics, Perinatology, Public Health, Respiratory Diseases and the Children’s Hospital, all coordinated by the Ministry of Health.

The functions of the Mexican Institute on Psychiatry are: to conduct scientific research, to instruct qualified personnel to conduct these investigations, to train professionals and technicians in these fields, to make a complete study of psychiatric patients and to act as an advisor to other official and private organisms.

The areas assigned are mental health and abuse of alcohol and of other drugs. As a priority and according to several specialties, problems such as the following are treated: alcoholism; drug abuse; affection disorders; psycho physiological disorders; functional psychosis; cerebral organic syndromes and other mental health disorders. Abuse of tobacco and its consequences has been assigned to the National Institute on Respiratory Diseases, though strong collaboration is maintained with this and other institutes on clinical, education and research programs.

To fulfill its obligations the Institute has three research branches, neuroscience, clinical and epidemiological and social research, a division of education, and the clinical services. 294 persons work at the institute, 190 of which have permanent positions, 85 researchers and 15 professionals participate in the research activities. During 1998, 72 persons were trained in specialization courses on clinical psychology, psychiatric nursing and psychiatric social work; 20 students were enrolled in the masters and 4 in the Ph.D. courses on Psychiatry and Public Mental Health offered by the Institute; 76 students worked in their dissertation thesis under the supervision of the research branch and 29 medical students conducted the psychiatric residence at the Institute.

CLINICAL SERVICES

The clinical services fulfill the functions of research, treatment and information through the study of the psychiatric problems more prevalent in the country, the study and integral treatment of the patients, acting as a reference center and working effectively with other national health institutions. Drug abusers and addicts are treated when psychiatric co morbidity is present.

Services are provided in three areas: outpatient, emergency, partial and complete hospitalization with a capacity of hosting a total of 40 patients (a new area with 10 more beds is being constructed). Other departments include brain images, psychotherapy, psychology and a laboratory where quantification of neurotransmitters, metabolites, hormones and drugs are routinely undertaken.

At present there are 4 specialized clinics on gerontopsychiatry, depression, squizophrenia, eating disorders and adolescent problems; at the moment alcoholism and emotional problems among this population and their families are treated in an outpatient community service, in the near future a specialized clinic on alcoholism is to be open at the institute.

Treatment of psychiatric problems of patients of the different Institutes of Health and hospitals located in the area, are covered through a program of liaison psychiatry. This program provides the participating institutions with qualified personnel in diagnosis and treatment of psychiatric problems as
well as training of their own personnel. In turn, health needs of psychiatric patients are covered by these other institutions.

RESEARCH PROGRAMS.

During 1998, 95 research projects were conducted in the three areas of research, neurosciences, clinical research and epidemiological and social sciences. A total of 105 scientific publications were produced.

CLINICAL RESEARCH.

Research in this area is directed to the acquisition of new knowledge in diagnosis, etiology and treatment of mental illnesses through the departments of psychopharmacology, psychology, genetics and other studies. Some of the programs include first psychotic episode, clinical trials of new drugs, drug side effects, molecular mechanisms of neurotoxic substances, mechanisms of addiction and biological markers for various mental diseases. Within the area of brain images projects dealing with residual attention deficit disorders, depression and Alzheimer diseases are conducted.

BASIC RESEARCH

Research protocols cover areas such as neurochemistry, neuropharmacology, neuro physiology, cronobiology, neurobiology, bioelectronics, electronic microscopy and ethology. Specifically on the field of drug abuse, this division has conducted research on effects of inhalant abuse on the central nervous system, on the hallucinogenic effects of different natural plants grown in the country, mechanisms of addiction, on the role of opioid peptides in epilepsy and sleep patterns, and on possible therapeutic effects of opioids (naloxone).

EPIDEMIOLOGY AND SOCIAL SCIENCES.

Obtaining and analyzing epidemiological data has been the way to know the magnitude and the social and cultural characteristics of the main problems of mental health that exist in the country. Areas of research include epidemiology, psychosocial and health services research related to the public health aspects of mental health comprising normal development, mental diseases, violence and substance abuse. Prevention, early intervention, treatment and rehabilitation models are included in the areas of interest of this division. It counts with a community treatment service for alcohol abusers and their families and three information centers on mental health, drug and alcohol abuse.

The first research programs of this division were oriented to the productions adaptation, validation and standardization of instruments and research approaches. The main strategies for epidemiological research have been household surveys, student's surveys, special studies conducted among high risk populations, study of the population detected in the health and justice systems, persons in treatment and statistical series. In 1986, a Drug Abuse Registration System was developed, information is gathered every six months from all cases who enter in 44 health and law enforcement institutions during one month.

Social research includes gender issues, characteristics and needs of street children, families of mental patients and of addicts, rural populations, migrants and non migrants, elderly population, persons in treatment, antisocial and delinquent populations, victims of violence, special populations such as persons under conditions of extreme poverty and indigenous populations, among others.

INFORMATION CENTERS ON MENTAL HEALTH DRUG AND ALCOHOL ABUSE.
Appendix H9

The information centers on mental health substance abuse were created as a response to the increasing demand of information on these topics. Their main objective has been to gather, analyze, classify and make available information of the status of the magnitude and trends of the problem in the country. Services include the assessment on the development of research protocols, data gathering including training on the use of research instruments, analyses of data and reporting of results.

EDUCATION

One of the institute's duties is to provide training courses and workshops to psychiatric, health personnel, teachers and other professionals that deal with these problems as well as to the general public. Strong collaboration is maintained with the psychiatry and mental health department of the medicine faculty of the National University (UNAM), the institute plays the role of being a university hospital, where medical students are trained in psychiatry.

The Institute education activities may be divided in formal and continuous education. Continuous education includes actualization, identification, prevention and treatment of mental disturbances including violence and substance abuse. Formal education comprehends specialization courses and master and Ph.D. degrees. The first type of courses are offered on psychiatry, liaison psychiatry, clinical psychology, neuropsychology, psychiatric nursing and psychiatric social work. Master and Ph.D. degrees on Psychiatry and Public Mental Health, are also offered.

The scientific information center has more than 5,400 volumes, receives periodically more than 140 specialized national and international journals and has links with the major data bases on the field. Different periodical publications are edited, the most important being the Journal on Mental Health, published since 1977, produces 6 volumes per year and the Clinical Research Newsletter published monthly.

LINK WITH OTHER INSTITUTIONS.

The institute keeps close working relationships with the National University (UNAM), with the center of advanced studies form the National Polytechnic Institute, the two mayor education institutions in the country and maintains a close relation to other research institutions in different countries.

The Institute provides advice to public and private institutions, contributes in the development of national programs and technical regulations. In the field of drug abuse, as a member of the National Council against Addictions in 1986, developed the projects of the National Health Programs to Combat Abuse and Consequences of Substance Abuse and has participated in them since then with a mayor role on research.

With the fulfillment of these activities, the institute contributes effectively to scientific development, improving the levels of medical care and promoting mental health of the population.

COLLABORATION WITH THE WORLD HEALTH ORGANIZATION

Collaborative projects have included the development and testing of instruments for general and special populations, including screening and diagnosis and of research approaches aimed to hidden or difficult to reach populations. The Institute participated in a WHO program on Research and Reporting Project on the Epidemiology of Drug Dependence, in the development and validation of questionnaires for conducting research among different populations. The core items for epidemiological surveys that were proposed during the WHO project, were included in most of the survey conducted since the 70's in the country by the Mexican Institute of Psychiatry and by other institutions, thus comparison of
survey data has been possible. In the field of Psychiatric Epidemiology the Institute participated in the WHO/ADHAMA joint project on Diagnosis and Classification of Mental Disorders, alcohol and Drug Related Problems and is part of the International Consortium on Psychiatric Epidemiology and of the group that is conducting the Beta-2 Field Trials. Other projects have been oriented toward the development and test of early intervention programs, test of models of intervention at the work place and among street children, cross cultural research on mental disorders, patterns on substance abuse and social norms and on families of drug abusers. The institute has participated in 34 international collaborative projects (see annex 1). The long history of collaboration with WHO has proved to be highly beneficial in the importance of the results obtained and in the training of human resources.
Appendix  H9
Instituto Mexicano de Psiquiatria - Mexican Institute of Psychiatry

WHO Collaborating Centre for Research and Training in Drug Dependence, Alcoholism and Mental Health

Country: Mexico
Town: Mexico City
Head of the Collaborating Centre: Dr. Gerardo Heinze
Director of the Institution: Dr. Gerardo Heinze
Name and Address of Institution:
Instituto Mexicano de Psiquiatria
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C.P. 14370
Mexico D.F.
telephone: ++ 52 5 6552811 / 6552816
fax: ++ 52 5 6550411 / 5732551
E-mail: auribe@unamvml.dgsca.unam.mx

Structure and Administration of the Centre

The Mexican Institute of Psychiatry is a decentralized public organization with its own budget and administration. It has the following functions: scientific research in the field of psychiatry and mental health; training of personnel, including research workers, professionals and technicians; conducting integrated studies of psychiatric patients; and advising other official and private bodies in the field of mental health and substance abuse.

The Mexican Institute of Psychiatry is part of the system of National Institutes of Health and coordinates its activities with those of other Institutes in their respective fields.

The Board of Directors of the Mexican Institute of Psychiatry consists of seven members under the chairmanship of the Minister of Health. Among other duties, the Board is responsible for approving the annual budget of the Institute and establishing its general policies. Implementation of these policies is the responsibility of the Director.

The Institute consists of six Divisions: epidemiological and social research; neurosciences clinical research; clinical services, training; and administration. For practical purposes, biomedical, sociomedical and clinical research projects are grouped together.

Brief History of Collaboration with WHO

In 1976, the body which preceded the Mexican Institute of Psychiatry was designated as a WHO Collaborating Centre for Research and Training in Drug Dependence and Alcoholism. Formal collaboration was initiated with participation in various epidemiological research projects, coordinated by WHO, aimed mainly at the development of prevention and treatment strategies based on data suitable for use in international comparisons. The Centre has collaborated in several WHO projects during the years, of which just a few are listed; community response to alcohol related problems; identification and treatment of persons with potentially harmful alcohol consumption; development of strategies for the implementation and assessment of national policies on alcohol-related problems; the risk to family health from alcohol and other drugs; the Alcoholic Anonymous Movement; and biological markers of alcohol dependence. Other areas of collaboration have included technical cooperation with
countries to reduce the demand for dependence producing drugs (WHO-UNFDAC project). Collaboration has included other projects in the field of mental health.

Terms of Reference for the Collaborating Centre

1) To collaborate with WHO in the implementation of the WHO medium-term programme in Mental Health.

2) To act as a reference centre for the collection and dissemination of information in the fields of psychiatry, mental health, alcoholism and drug dependence, particularly on innovative service programmes and research being carried out in Latin America.

3) To serve as a supporting body for the national coordinating mechanisms established for the development of mental health, alcoholism and drug dependence programmes.

4) To develop training programmes in the field of mental health, alcoholism and drug dependence adapted to the needs of the Latin American countries and place national and international candidates in the different affiliated training centres.

5) To develop instruments and methods for the implementation of research in the fields of:
   a) Epidemiology of mental disorders, alcohol- and drug abuse.
   b) Biomedical aspects of mental disorders, drug- and alcohol dependence.
   c) Identification of new drugs with dependence liability.
   d) Psycho socio anthropological aspects of alcoholism drug abuse and mental illness.
   e) Development of prevention, treatment and rehabilitation programmes in the fields of mental health and dependence control commensurable with the needs and resources of Latin America.

Recent/Current activities carried out in collaboration with WHO

The Centre has conducted studies for the WHO/UNICRI project on Regional Responses to Cocaine Problems; the WHO/PSA projects on Street Children and Solvent Abuse; the WHO/ILO project on Model Programs for the Prevention of Drug Abuse among workers and their families; and is collaborating in the Spanish adaptation of the International classification of Impairment Disabilities and Handicaps (CIDH); Monitoring Alcohol Consumption and Harm and is member of the WHO/NIDA supported international consortium on Psychiatric Epidemiology.
<table>
<thead>
<tr>
<th>NOMBRE DEL PROYECTO</th>
<th>RESPONSABLE EN MÉXICO</th>
<th>PERIODO</th>
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<tbody>
<tr>
<td>Community responses to alcohol related problems. Phase I</td>
<td>Dr. Guillermo Calderón</td>
<td>1975-1981</td>
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<tr>
<td>Community responses to alcohol related problems. Phase II</td>
<td>Dr. Carlos Campillo</td>
<td>1975-1981</td>
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<td></td>
<td>Psic. Cristina Suárez</td>
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<td></td>
<td>Dr. Carlos Campillo</td>
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<td>a) Epidemiological case reporting of drug users</td>
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<td>b) Drug use surveys of young people</td>
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<td>c) Drug use surveys of High-risk groups. Norrstudent youth</td>
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<td>d) Intensive case finding and monitoring of drug users in target communities</td>
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<td>e) Review of general population surveys of drug abuse</td>
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<td>Pilot study on public health aspects of alcohol marketing in developing countries.</td>
<td>Mtra. Haydee Rosovsky</td>
<td>1981-1983</td>
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<td>Identification and treatment of persons with harmful alcohol consumption. Phase I</td>
<td>Dr. Juan Ramón de la Fuente</td>
<td>1984-1987</td>
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<tr>
<td>Identification and treatment of persons with harmful alcohol consumption. Phase II</td>
<td>Dr. Carlos Campillo</td>
<td>1985-1990</td>
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<td>Project on Indentification and Managment of Alcohol Related Problems. Phase II</td>
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<td>Mtra. Martha Romero</td>
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<td>Dr. Ramón de la Fuente</td>
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<td>Dra. Ma. Elena Medina-Mora</td>
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<td>Adverse health consequences of volatil solvents/inhalants</td>
<td>Mtra. Guillermina Natera</td>
<td>1987</td>
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<td>Mtra. Haydee Rosovsky</td>
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<td>Alcohol and the family</td>
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<td>Potential contributions of state monopoly systems to the control of alcohol-related problems</td>
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<td>Family health risks related to alcohol and other drugs abuse: Comprehensive</td>
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<td>reinforcement of the natural methods that families uses and its application to</td>
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<td>the primary health care programs.</td>
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<td>International study on mental disorders and utilization of first level care</td>
<td>Dr. Jorge Caraveo</td>
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<td>services</td>
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<td>Study on Cross-cultural Applicability Research (WHO/ADAMHA Joint Proyect on</td>
<td>Dr. Carlos Campillo</td>
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<td>Diagnosis and classification of Mental Disorders, Alcohol- and Drug-Related</td>
<td>Mtra. Martha Romero</td>
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<td>Problems)</td>
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<td>Implications of Drug Use</td>
<td>Dr. Arturo Ortiz</td>
<td>1993</td>
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<td>Pre-testing of the Questionnaire of Knowledge, Attitudes Behaviors and Practices</td>
<td>Mtra. Martha Romero</td>
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<td>of Alcohol and Drug Abuse (KABPS)</td>
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<td>WHO/UNICRI (United Nations Interregional Crime and Justice Research Institute)</td>
<td>Dr. Arturo Ortiz</td>
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<td>Cacaine Project.</td>
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<td>Psychosocial characteristics of inhalant solvents abuse in homeless children.</td>
<td>Lic. Rafael Gutiérrez</td>
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<td>International Study. (OIT/OMS)</td>
<td>Lic. Leticia Vega</td>
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<td>Drinking and casualties. Accidents, poisonings and violence in an international</td>
<td>Mtra. Haydee Rosovsky</td>
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<td>perspective. (NIAAA/OMS)</td>
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<td>International consortium on psychiatric epidemiology.</td>
<td>Dr. Jorge Caraveo</td>
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<td>NIDA/OMS</td>
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<td>their families. (OIT/OMS)</td>
<td>Dr. Arturo Ortiz</td>
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<td>Alcohol Policies in Developing Societies (Addiction Research Foundation/OMS)</td>
<td>Mtra. Guillermiana Natera</td>
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<td>Evaluation of the Educational Package for Mental Disorders in Primary Care</td>
<td>Mtra. Sarah García</td>
<td>1997</td>
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<td>Combined utilization of an antidepressant (Amitriptyline) and an antioxidant (Gingko Biloba) in the treatment of therapy-resistant depression.</td>
<td>Dr. Gerardo Heinze</td>
<td>1997-1999</td>
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<td>Monitoring Alcohol Consumption and Harm</td>
<td>Dra. Ma. Elena Medina-Mora</td>
<td>1998</td>
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<td>Dra. Ma. del Carmen Lara</td>
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Texas/WHO Collaborating Center for Cross-Cultural Research and Training on Mental Health and Psychosocial Factors in Health In Mexico and the Southwestern United States

The University of Texas at Austin, Texas A&M University, UT Medical Branch at Galveston, and UT Health Science Center at San Antonio have joined with three universities in Mexico, the Universidad Nacional Autónoma de México, the Universidad Autónoma de Nuevo León, and the Universidad Autónoma de Tamaulipas, to promote collaborative efforts to improve mental health and the quality of life of populations in Texas, along the US-Mexico border, and extending into Mexico. This new center for collaboration in cross-cultural research and training in mental health and psychosocial factors in health was inaugurated in November 1993, under sponsorship of the World Health Organization and the Pan American Health Organization.

Goals of the coalition will be pursued through: (1) research on mental health epidemiology, service delivery, and psychosocial factors in health, (2) training to increase the capacity for high quality, culturally competent mental health care and the development of programs designed to decrease psychosocial risk factors in disease, (3) information dissemination, and (4) international collaboration and exchange.

Scientists associated with the Center already are pursuing a number of research projects in fields related to the coalition’s goals. Focus will be placed on the understanding of causes and manifestations of mental disorders in different populations such as the elderly, residents of rural areas, and refugees and immigrants.

Occasionally publications by scientists from the Center will be reprinted for wider distribution as a numbered series of monographs and articles dealing with the primary focus of the Center. Single copies of such publications may be obtained free of charge from the office of the Center director, as long as they last.

The Center has expanded in the past year by the election of 16 new scientific associates increasing the total number of participants to 48—19 in Mexico and 29 in Texas. A complete list of current scientific associates is given at the end of this report. It is anticipated that in 1999 additional scientific associates will be added to the Centers activities. With gradually improving economic circumstances in Mexico, increased attention within NIMH to the great need for further research, training and service activities for Mexican-origin peoples in the Southwest, and with increased support from the State of Texas, the future of the Center and its expanding activities is indeed bright.

Activities of the Center in 1998

Two activities during 1998 are closely focused on developments jointly sponsored by NIMH and WHO. First, is the further development and use of the Composite International Diagnostic Interview (CIDI) schedule for epidemiology studies in general populations throughout the world which has been translated into several
languages. The new development is the transformation of the hand-scored or recorded version of the CIDI into a computer-based system where it is automatically branched into the correct probes or skipped over, as designed. This computer-based system is more efficient and cost-effective than the traditional interview method, as demonstrated by Dr. Sergio Aguilar-Gaxiola in his Fresno, California studies. Second, is the development of the International Classification of Impairment Disabilities and Handicaps (ICIDH) with second and third versions of Spanish translations and refinements of the English version. There have been several meetings in the past years, and Aguilar-Gaxiola has been a key leader in this project as well. Center staff have sponsored two workshops on the CIDI and its uses in Texas and Mexico, as well as participating in the independent project on disabilities.

Report of the CIDI Workshops and Future Plans for Collaborative Studies

The CIDI workshop held in San Antonio last April focused on affective disorders, schizophrenia and schizophreniform disorders, phobia and other anxiety disorders that were of special interest to the 16 participants who attended the workshop. A primary goal of the workshop was to implement cross-national research between Mexico and the United States on the prevalence and incidence of mental disorders among the general populations, focusing in particular upon Mexican-origin people in both countries. Materials were sent to participants for review prior to the meeting. On-site technical assistance was provided to participants from Monterrey, Mexico prior to the workshop because of their special interest in undertaking a collaborative project with scientific associates in San Antonio. The workshop was enhanced by use of videotaped interviews and live patient interviews both in Spanish and English, as well as a demonstration of the “I-shell” for computer-based interviews such as the CIDI. Several collaborative research activities have already resulted from the spring workshop.

The second CIDI workshop was held just prior to the annual meeting of scientific associates in Cuernavaca, Mexico, December 4-5. Led by Drs. Sue Hoppe and Sergio Aguilar-Gaxiola, this second workshop featured hands-on demonstration of the CIDI when combined with the computer-based system. The computer framework known as “I-shell” consists of three different sections—(1) Probe or questions to be asked; (2) the Interview Writers Tool (IWT) by which one can make changes to the I-shell; and (3) the Translators Tool (TT) which places the text side by side for translation purposes. In addition to being more efficient and accurate, the computer-based system helps greatly with data management of interview responses and data storage. An attractive feature of the software is its flexibility to employ the I-shell with other interviews besides the CIDI, as well as to shift back and forth during the interview from Spanish to English. Most inexpensive laptop computers and some of the forthcoming smaller hand-held computers are powerful enough to handle the CIDI program.

Center staff have been invited by Dr. Ronald Kessler to participate in an international study of Post Traumatic Stress Disorder (PTSD) which would involve administration of the PTSD section of the CIDI to approximately 50 persons per site.
The Center is also participating in a special task force to develop an appropriate Spanish version of the WHO-DAS II for the purpose of assessing a variety of handicaps in different cultures. Recent meetings have been held in Mexico City, Mexico, and Santander, Spain. Aguilar-Gaxiola has been appointed director for a network dealing with Spanish-language impairment assessments in the United States among Spanish-speaking Hispanic people. The International Classification of Diseases (ICD-10) sponsored by WHO deals with a variety of conditions while ICIDH focuses on the specific functions and disabilities characteristic of different kinds of impairments. These two systems are complementary and the use of both are encouraged to give more integrated views of an individual’s functional capability. A specific project under Dr. Dawn Velligan of San Antonio has developed a highly structured assessment and training schedule that deals directly with functional impairments among schizophrenic patients. The system is now being adapted for use in Monterrey, and collaborative studies are underway to compare Monterrey and San Antonio with respect to this impairment training regimen.

Other studies undertaken by scientific associates of the Center deal with lifetime prevalence and co-morbidity of psychiatric disorders in Mexico City (Jorge Caraveo); the financing and delivery of mental health services between the US and Mexico, with special attention to Medicare in the future (David Warner); psychosocial health issues among rural populations in Texas (Ciro Sumaya); mental health research and policy planning in Texas in collaboration with the Texas Department of Mental Health and Mental Retardation, with special reference to Mexican-origin people (Delia Saldana); profiles of elder Mexican Americans in the Rio Grande valley (Elena Bastida and Genaro Gonzalez); teenage life survey assessments of Mexican-origin adolescents in the Rio Grande Valley and northern Mexico (Israel Cuellar and Hector Cappello); stress management for patients in Mexican intensive care units, and quality of life among HIV patients (Juan Jose Sanchez-Sosa); training of personnel for disaster assistance in Mexico and central American (Laura Hernandez-Guzman); community follow-up of antipsychotic treatment measures for Mexican Americans (Albana Dassori); and behavioral health approaches to the management of diabetes among Mexican-origin people (Graciela Rodriguez). Detailed reports of these various projects were given at the annual meeting in Cuernavaca, and summaries will be issued in an annual report early in 1999.

A new Regional Academic Health Center in the South Rio Grande Valley

The board of Regents of the University of Texas System has appropriated $55 million to establish a new medical complex in four counties as represented by the cities of Brownsville, Harlingen, Edinburg and McAllen. During the next several years the WHO Collaborating Center will play an important role in developing special initiatives and partnerships in the valley that will focus on mental health and psychosocial factors in health throughout the border region of Mexico and Texas. The regional academic health center will consist of four components (1) a new public health center in Brownsville that will be an arm of the School of Public Health at the UT Health Science Center in Houston, (2) a research center
with scientists and graduate students in fields such as epidemiology and preventive medicine near Texas Southmost College in Brownsville, (3) a medical research division near UT-Pan American in Edinburg, operated by the UT Health Science Center at San Antonio, (4) a medical school extension in Harlingen that will offer classes for third- and fourth-year medical students; and, (5) expanded medical residency programs in a new facility in McAllen. It challenges the local authorities and health care professional organizations to appropriate a similar amount of in-kind support and money. Over a period of years, the amount may well be over $100 million of investment in a regional health center in South Texas. This will be a real opportunity to bring behavioral medicine, and mental health research and training projects into the region.

Other Activities

This past October a meeting in Washington sponsored by PAHO was attended by Dr. Sue Hoppe for the purpose of exploring ways to foster collaboration between WHO centers in North America and South America. The conference discussed the strengths and weaknesses of PAHO and how they might improve further collaboration between the centers. A followup conference is scheduled for January 8, 1999, at the Nathan Kline Institute in New Jersey.

On June 25-26, 1998, NIMH sponsored a meeting held in Princeton, New Jersey which brought together Latino/Hispanic scholars in the United States, including scientific associates from the Center. The meeting focused on how to form more collaborative relationships and projects, consistent with what PAHO is doing. A solid network of persons interested in Hispanic mental health is being developed with a followup meeting planned for April 30 - May 1, 1999, in San Antonio, Texas. Perhaps some Mexican institutions might want to get involved as well. Dr. William Vega and Dr. Hoppe have been discussing how one focus of the Center might be the issues of co-morbidity involving mental illness, alcohol and substance abuse, or physical disorders among Hispanic people in Texas and Mexico. One of the strongest Latino/Hispanic centers for research is in Puerto Rico. Puerto Rico submitted a project proposal to NIMH in which San Antonio would also be a partner. Specialists involved who met in Washington for this purpose were representative of UCLA, San Diego, New Jersey (with its Puerto Rican populations), Puerto Rico and San Antonio. The feeling is very positive that something will materialize in the form of a national program in which scientific associates of the WHO Collaborating Center will be key participants.