

**Summary and Analysis:**  
*Mental Health Infrastructure in Ulaanbaatar*

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*Mom, Dad, thanks for everything, but especially for not having a stroke when I said I was going to Mongolia.*

*Hannah, I'm sure you're laughing at this wherever you are, but I hope you've found what you were searching for.*

*To Chinggis Khan, conqueror of the world, sorry your children couldn't keep it together.*

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## *Abstract*

Questions about the mind have been asked by a variety of peoples and cultures throughout the ages. While fields of psychiatry and psychology have developed in an effort to address these questions, the issue of how to best handle the mentally ill within the framework of society is ultimately a political one. While there has been work done in mapping the attitudes towards mental health, the level of awareness about mental health issues, and the quality of treatment in different institutions, little is known about these topics in a newly developing country like Mongolia. Much of the research on how countries choose to address the subject of the mentally ill has primarily been done in Western developed countries. This project examines the mental health infrastructure in Ulaanbaatar, the capital city of Mongolia. Private and public hospitals were examined and numerous interviews were conducted with doctors and experts in both sectors.

Data was gathered through a series of interviews including, but not limited to, those with the state mental hospital, private consultation clinics, staff members at the Department of Psychology at the National University of Mongolia, and the Ministry of Health. To get a rough idea about the quality of care from the patients' perspective, patient observation was conducted in the inpatient and outpatient wards of the National Center for Mental Health (a.k.a. Sharhaad Hospital). Background literature was consulted to gain a better understanding of the psychology/psychiatry aspects of the project. As research progressed, a clear consensus emerged; the quality of mental health care in Ulaanbaatar is still not up to international standards, the system is over-centralized and under funded, and

there is a desperate need to diversify treatment options. Almost unanimously, professionals in the field recommended that the government help rectify the situation by increasing funding for mental health in Ulaanbaatar, improving training for doctors at the local, district, and national level, and encouraging the development of the private sector as well as community based health care programs.

## *Methods*

Information was gathered through a series of interviews with NGOs, staff members of private consultation clinics as well as the state mental health facility. Approximately 10-15 standardized interview questions (see appendix) were asked in order to ensure baseline data was gathered from all interviewees. Each source was also asked questions specific to their organization in order to get a more complete picture of the situation. It should be noted that many of the interviews were translated and some quotes that appear subsequently are English translations from Mongolian. Patient observation was conducted in the inpatient and outpatient wards of the National Center for Mental Health in order to assess the mental health care system from the perspective of those it is designed to serve. Literary sources were consulted in order to determine the level of prior work in the field and also as a foundation for interview questions. The scope of the research was limited by factors of time; a comprehensive picture of the mental health situation in Ulaanbaatar is not presented here, instead it is an overview of the present day situation with recommendations for targeted improvements. Also, because of ethical restrictions, only patient observation was done. In order to get the most accurate picture of the quality of care in Ulaanbaatar, numerous patient interviews would need to be carried out.

## *Introduction*

Society has long struggled with questions about mental illness, particularly about where the responsibility lies for the treatment and care of the mentally ill. As the nation-state developed, expectations about the responsibilities of government also rose. Through the centuries a consensus was reached; while government is not solely accountable for the care of the mentally ill, it must play a role in their care. At its heart, mental illness is a scientific and spiritual concern, however because the mentally ill must continue to live within a social framework, mental health is forced to become a political issue. Despite varying levels of development and economic success, no country in the world can avoid the subject of mental illness for long. Unfortunately, developing countries tend to see mental health as a secondary or tertiary issue, placing physical health, along with economic, political, and security concerns higher on the agenda and Mongolia is no exception. However, mental health is fundamentally important to the stability of society, as well as to the individual, and it is vital that mental health infrastructure be examined and systematically developed.

The mental health infrastructure in Ulaanbaatar and in Mongolia is woefully understudied and under-documented. According to the WHO, mental health data is collected by a variety of organizations but “no report has been produced by the government based on these data”.<sup>1</sup> Without a compilation of statistics and research for policymakers and advocates to use, attempts at improving the mental health system are fundamentally incoherent. Limited

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<sup>1</sup> WHO-AIMS report 5



education and awareness of mental health issues among the populace further compounds the problem. Without pressure from the public to improve the situation, change is slow in coming. Mental health infrastructure in Ulaanbaatar is underdeveloped; the quality of care does not yet meet international standards and treatment facilities along with treatment options are limited. In order to improve the situation, a more cohesive approach towards reform is needed. Problems of funding for both the public and private sectors of the field must be addressed, more innovative treatments for patients like community based care need to be cultivated, and the standards of care must be aligned with international standards.

## *History*

Landlocked between Russia and China, over the course of its history Mongolia has been occupied by both of its larger neighbors. Over 200 years of Manchu repression and occupation ended in 1921 with help from the Soviet Union. In 1924 Mongolia came under Soviet rule. Although accurate population figures for 1924 are unknown, in 1918 the Mongolian population stood at 647,500 people.<sup>2</sup> Mongolia's per capita GDP in 1927 was 49 gold rubles.<sup>3</sup> While Mongolia was poor and considered a developing country, it was not the poorest country in the world and the economy was strong enough to guarantee "a good diet and adequate clothing and shelter to stand the rigors of [the] climate."<sup>4</sup> Due to the relatively strong economy, Mongolia was able to mostly avoid malnutrition based diseases as well as vitamin deficiencies.<sup>5</sup> Although it escaped problems of malnutrition, the Mongolian populace was heavily affected by "rheumatism, trachoma, syphilis, and epidemic diseases" and although there are no exact figures, it is assumed that life expectancy was low and the mortality rate was high.<sup>6</sup>

After taking control of Mongolia in the 1920's, the Soviet Union imposed western style medical practices. Before this time, medical care was mostly administered by Buddhist lamas and shamans. While health care in Mongolia under socialist rule was not up to the same standards as in the West, the system

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<sup>2</sup> Soviet Mongolia 180

<sup>3</sup> Soviet Mongolia 61

<sup>4</sup> Soviet Mongolia 61

<sup>5</sup> Soviet Mongolia 61

<sup>6</sup> Soviet Mongolia 61

was able to take care of most rudimentary health problems. Despite the population increase during the post-WWII era, doctor to patient ratios remained high and the number of medical support staff (nurses, midwives, physician's assistants) also kept pace.<sup>7</sup> The first western style general hospital was built in 1926 and was staffed by Russian doctors who then trained Mongolian doctors.<sup>8</sup> Mentally ill patients were served in that hospital although they were kept isolated from other patients. The first hospital devoted to the mentally ill was constructed in 1929 and contained 20 beds and in 1934 an outpatient ward was created at the hospital. Until 1971 mental health care in Mongolia was exclusively hospital based and it occurred only in this facility.<sup>9</sup> In 1971, the first outpatient psychiatric ward in the country was established in Ulaanbaatar.

Providing adequate medical care to countryside residents has been a problem Mongolia has struggled with for many years. Under socialist rule, physician's assistants (a.k.a. feldshers) provided general outpatient medical care to remote areas of the country, while *soum* centers had hospitals or clinics with up to 5 doctors each.<sup>10</sup> Also, the state provided transportation for patients who needed advanced care that could only be found in provincial centers or in Ulaanbaatar city. In terms of mental health, in 1974, 4 *aimags* organized ambulance services for outpatient wards that had 25-30 beds each.<sup>11</sup> Since 1985, all *aimags* have had psychiatric units in their provincial hospitals that have 5-10

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<sup>7</sup> Modern Mongolia 167

<sup>8</sup> Modern Mongolia 167

<sup>9</sup> Mongolian Psychiatry: History, Present and Subjects in the 21<sup>st</sup> Century

<sup>10</sup> Modern Mongolia 168

<sup>11</sup> Mongolian Psychiatry: History, Present and Subjects in the 21<sup>st</sup> Century

beds each.<sup>12</sup> After the democratic transition, health standards in Mongolia declined sharply. In 1991 the Asian Development Bank recommended that Mongolia switch from a health system with “free access to public health services to one that is priced and based on health insurance”.<sup>13</sup> Trying to privatize healthcare after more than 60 years of socialism, during which health services were provided free of charge, threw the health system into chaos.

In order to try and encourage the development of the private sector, the Mongolian government cut public health expenditures from 5.8% of GDP to 3.8% of GDP over a 9 year span (from 1991 to 1999).<sup>14</sup> These efforts largely failed and the private health sector has not been able to make up the difference in services except in the service of a tiny elite, primarily because the high cost of private services precludes a majority of the population from making use of them. Besides limiting the number of people with access to health care, government policies have also resulted in a sharp decline in the quality of healthcare services. Doctors have complained about the lack of up-to-date medical equipment and drugs. In the field of mental health specifically, while psychotropic drugs first began to be used in mental institutions in 1958, today those institutions are still using first generation drugs although second generation drugs have now become the international standard.<sup>15</sup> Hospitals now depend on foreign NGOs to try and meet the demand for equipment and medication. For example, Japan and the Rotary Club have provided a variety of medical equipment while Denmark has

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<sup>12</sup> Mongolian Psychiatry: History Present and Subjects in the 21<sup>st</sup> Century

<sup>13</sup> Modern Mongolia 168

<sup>14</sup> Modern Mongolia 169

<sup>15</sup> Mongolian Psychiatry: History, Present and Subjects in the 21<sup>st</sup> Century

donated X-ray machines.<sup>16</sup> Also, medical personnel experienced significant salary cuts and in 1999 doctors who had not been paid in 5 months went on strike.<sup>17</sup> Lower salaries in the health field have lowered incentives to work in the healthcare and resulted in less qualified individuals entering the field.

The field of mental health has been especially hard hit. The first psychiatrists in Mongolia were Russian, I. B. Strelchuk (the first director of the mental health hospital and an associate professor), A.B. Illyn (a professor), G.R. Zairov (a doctor), among other psychiatrists and specialists. MNMU (the National Health Sciences University) began offering a post-graduate program in psychology and psychiatry in the 1960's. However after the democratic transition mental health hospitals had "few medicines and scant supervision from trained psychiatrists".<sup>18</sup> While today the number of psychiatrists graduating from the university has increased, the number of specialists (for example, child psychiatrists, forensic psychiatrists, psychotherapists, etc) has not.

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<sup>16</sup> Modern Mongolia 169

<sup>17</sup> Modern Mongolia 169

<sup>18</sup> Modern Mongolia 171

## *Overview of Mental Health in Mongolia*

Today Mongolia's population stands at a little less than 3 million people with an average age of 24.9 years. The majority of the population is between the ages of 15-64 and the growth rate for the population is around 1.4%. Life expectancy has increased to an average of 67 for the total population (it is slightly higher for women than men). The five leading causes for mortality, according to data gathered in 2002, are diseases of the circulatory system (233.2/100,000 people), neoplasms (130.22/100,000 people), injury/poisoning and other external causes (80.7/100,000 people), diseases of the digestive system (47.74/100,000 people), and diseases of the respiratory system (44.29/100,000).<sup>19</sup> Mongolia's GDP, adjusted for purchasing power parity, is approximately \$8.542 billion.<sup>20</sup> Because it is a developing country, Mongolia's overall health expenditure is still low, only 6.4% of overall GDP (or approximately \$546 million) goes towards healthcare. Only 2% of the \$546 million (roughly \$10.9 million) goes towards mental healthcare.<sup>21</sup> In other words, Mongolia annually spends less than \$11 million on mental healthcare. The bulk of Mongolia's mental health expenditures, 64% or \$6.9 million, goes towards mental hospitals.<sup>††</sup>

In the year 2000 Parliament passed the National Mental Health Law of Mongolia (NMHL), which has set a new legislative framework for mental health.

The stated purpose of the NMHL is to:

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<sup>19</sup> Mongolia Health Profile

<sup>20</sup> CIA World Fact Book

<sup>21</sup> WHO-AIMS report 7

<sup>††</sup> see appendix for monetary values in tugrugs

“...define the state policy and principles on mental health protection and promotion and prevention of mental illness; to regulate the relations raised in connection with responsibilities of organizations, business entities and individuals in providing the people with mental illness and mental health problems with access to medical, social and psychological aid; to regulate legal framework of activities of mental health organizations and specialists thereof [*sic*].”<sup>22</sup>

Some of the main components of the mental health law include: provisions regulating the rights of mental health patients and their family members or caregivers, access to mental health care, competency and guardianship issues, involuntary and voluntary treatment, and law enforcement and other judicial system issues.<sup>23</sup>

As a result of this law, the National Programme on Mental Health (NPMH) was developed and implemented from 2002-2007. The stated purpose of the NPMH was:

“...the reduction of the prevalence of mental and behavioral disorders and solving of pressing mental health issues by reorientation of the mental health care in compliance with new trends in mental health care.”<sup>24</sup>

According to the WHO-AIMS report on Mongolia the NPMH achieved several of its objectives in the year 2004. The NPMH implemented a mental health training program for general health practitioners to help improve mental health services at the grassroots and primary healthcare level. It also developed a curriculum for the Health Science University of Mongolia and conducted post-graduate and refresher

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<sup>22</sup> National Mental Health Law 14

<sup>23</sup> WHO-AIMS report 7

<sup>24</sup> National Mental Health Law 50

training for specialists. The NPMH had an extensive mental health awareness and outreach program and conducted campaigns in newspapers, radio and TV programs, published books and distributed mental health pamphlets and posters to the population. In terms of treatment, it standardized diagnostic and treatment criteria for substance abuse and mental disorders and alcoholics anonymous (AA) treatment became available on the *aimag* level and city level.<sup>25</sup>

The general consensus among mental health professionals in UB has been that the program was well designed and well implemented, although a psychiatrist at the National Center for Mental Health, Narmandakh Altanzul criticized the program's goal of reducing the prevalence of mental and behavioral disorders, saying, "I don't know if its possible to reduce the *prevalence* of mental disorders [emphasis added]".<sup>26</sup> However she was quick to add that "there has been a good result [of the program], people understand they need to protect their mental health" and that "family doctors and general practitioners now have skills in mental health care".<sup>27</sup> A psychologist at Sharhaad and a lecturer at the Health Science University, Tsogzolma, noted that in order for maximum impact, the program should be renewed and that 5 years was not enough time to accomplish all program objectives.<sup>28</sup>

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<sup>25</sup> WHO-AIMS report 7

<sup>26</sup> Personal interview Narmandakh Altanzul

<sup>27</sup> Personal interview Narmandakh Altanzul

<sup>28</sup> Personal interview Tsogzolma



### *Overview of Treatment Facilities*

There are 35 outpatient facilities in the country, but the predominant one is that of Sharhaad hospital, located in Ulaanbaatar. Sharhaad is also the only mental hospital available in the country. The majority of psychiatric patients in the country are treated in outpatient facilities.<sup>29</sup> There are 21 community based inpatient psychiatric units in the country, and only 12 community residential facilities. Neither the community based inpatient units nor the community residential facilities have beds reserved for children or adolescents only. There are no hospitals reserved solely for forensic mentally ill patients. The bulk of beds in the country are provided by mental hospitals.<sup>30</sup> There is a national mental health authority that advises the government on mental health policy and legislation as well as monitors the quality of mental health services in the country.<sup>31</sup> The private mental health system in Ulaanbaatar and in Mongolia in general is sorely underdeveloped. According to Tsogzolma (who also consults for a private clinic), there are 4-5 private clinics that offer diagnostic services only. Uvdisht Car, Citgilig Tol, and Borjignii Otoch are just a few examples. Another private center, Tug-Sun, is also the only private inpatient/outpatient hospital in Ulaanbaatar.

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<sup>29</sup> WHO-AIMS report 13

<sup>30</sup> WHO-AIMS report 12

<sup>31</sup> WHO-AIMS report 7

## *Overview of Mental Health Professionals*

The number of health professionals working in mental health facilities is far below the number working in general practice. While there are 26 general medical practitioners per 100,000 persons there are only 17 mental health practitioners per 100,000 persons. The number of mental health specialists (child psychiatrists, forensic psychiatrists, psychotherapists, etc), is much lower. There are also no social workers working in mental health facilities, public or private. The distribution of psychiatrists and psychologists disproportionately favors government run facilities, 85% of psychiatrists work only in state run centers, 15% of them work in both public and private centers, and no psychiatrists work solely in the private sector.<sup>32</sup> In 2004, no psychiatrists, psychologists, or other medical practitioners with training in mental health graduated from educational or academic institutions. However, there has since been an increase in interest in mental health and there are 15 new psychiatrists in the residency program at Sharhaad Hospital.<sup>33</sup> Erdenchimig, a psychology professor at the National University of Mongolia, noted that there are more students interested in psychology, but their interest lies more in studying or examining patients than in working to help them.<sup>34</sup> She also pointed out that the quality of her students varied by their class year. The 3<sup>rd</sup> year students she had were more interested in the topic and in entering the mental health field, while 4<sup>th</sup> year students were

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<sup>32</sup> WHO-AIMS report 17

<sup>33</sup> Personal interview Narmandakh Altanzul

<sup>34</sup> Personal interview Erdenchimig, NUM

preoccupied with their upcoming graduation. According to her, only 2 fourth year students ultimately joined the mental health field.<sup>35</sup>

Part of the NPMH was greater training for family doctors and primary care physicians in order to better integrate mental health with general primary health care. It was also expected that better trained primary care physicians would be able to disseminate information about preventative mental health care and therefore reduce the number of patients needing treatment for mental health problems like stress, alcoholism, substance abuse, etc. In UB there are both physician based primary healthcare clinics and non-physician based clinics. According to the WHO, 81%-100% of all physician based clinics have at least assessment and treatment protocols available for major mental health conditions, while almost no non-physician based clinics have these in place.<sup>36</sup> As part of the NPMH, several books were published for general practitioners to introduce them to working with the mentally ill, including the *Diagnostic and Management Guidelines for Mental Disorders in Primary Care*, and *Community Based Mental Health Care Service*.<sup>37</sup>

Opinion is split among mental health professionals about the quality of primary care professionals who undergo these training sessions. Jaargal, a psychiatrist and lecturer at the Health Sciences University said that “there aren’t enough” family doctors and that they “don’t have enough training”.<sup>38</sup> She is echoed by Tsogzolma, who said “they aren’t well-trained enough... [they] only

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<sup>35</sup> Personal interview Erdenchimig, NUM

<sup>36</sup> WHO-AIMS report 15

<sup>37</sup> WHO-AIMS report 16

<sup>38</sup> Personal interview Jaargal

have general knowledge, not in depth” and pointed out that they usually refer patients to district hospital doctors.<sup>39</sup> While acknowledging that the quality of these doctors is still low, Nasantsengal, the vice-director of the National Center for Mental Health, pointed out that little training is better than no training and that the training program itself was surprisingly thorough. After completing the entire 2 year training program, doctors are able to diagnose 6 major mental disorders (stress, psychosis, alcoholism, bi-polar disorder, schizophrenia, and depression) and recognize when they need to refer patients to a mental health professional.<sup>40</sup>

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<sup>39</sup> Personal interview Tsogzolma

<sup>40</sup> Personal interview Nasantsengal

### *Profile of Family Hospital, Khoroo #3*

The family hospital is located in the Chinghiltei district behind the State Department Store in a small one story red brick building. This non-descript structure holds 4 patient rooms, a small waiting area, and a secretary's office. There are 6 doctors in the hospital and almost all of them are below the age of 30. The young age of the doctors is because all doctors in Ulaanbaatar are required to work for two years in family hospitals before they can go on to work in a larger hospital. The hospital is crowded and there are not enough seats in the hallway for all of the patients. Compounding the problem, there is no separate waiting area for patients; everyone must wait in the hallway, making an already tight space seem even smaller as doctors squeeze between patients to get to their rooms. The patient rooms themselves are little better. Two of the rooms have 3 doctor's desks in them along with an examination table, and height and weight machines. Privacy during examination is non-existent as both doctors and patients are constantly in and out of the exam room. The rooms are only modestly equipped with medical tools, an examination bed is present in all rooms, but one doctor complained that she didn't have any tools besides a stethoscope and blood pressure machine with which to diagnose patients.<sup>41</sup>

Speaking to the doctor in charge of evaluating mentally ill patients was revealing of the state of the primary care mental health system in UB. Janilgana, a doctor with 11 years of experience in the health field and a graduate of a Russian health university, reported that she had little to no experience in dealing with or

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<sup>41</sup> Personal interview Janilgana

diagnosing the mentally ill. When asked about the training program for family doctors that had been instituted by the NPMH, she responded that “there was no training program”. From her statement we can presume that since the end of the NPMH, few family doctors have received quality training in mental health. However she was quick to add that there was a refresher seminar taking place that day (11/20/2008), but the seminar was not mandatory and she had chosen not to go because of her busy schedule at the family hospital.<sup>42</sup> According to her, one doctor at every family hospital needs to have basic mental health training. However instead of a coherent training program for these doctors, training was on an ad-hoc basis, and some doctors, like her, were teaching themselves about mental health through pamphlets and books.<sup>43</sup>

This particular hospital is supposed to serve the needs of approximately 6000 people, although doctors only see about 500-600 patients per month. According to Janilgana, there were 16 mentally ill patients at the time and she saw 2-3 of them each month. Most of the patients had double illnesses, meaning that they had physical as well as mental disorders. When asked about the most common mental illness she encountered, she responded that she did not actually diagnose the patients with a specific mental disorder. She gave them a general diagnosis of “mentally ill” and then referred them to Sharhaad Hospital where psychiatrists diagnosed them with a specific disorder. The reason she refers patients to Sharhaad instead of the district hospital is a lack of mental health doctors at the district hospital level. In her opinion, the biggest problem in family

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<sup>42</sup> Personal interview Janilgana

<sup>43</sup> Personal interview Janilgana

hospitals was a lack of information and awareness. She commented that “information is very poor” and that doctors would “sometimes... hear new information from the patients.”<sup>44</sup> Specifically, she mentioned that doctors needed to be better informed about new diseases and new drugs. Concerning mental health, a formal training program in these issues would help primary care doctors to interact with the mentally ill. Along with being better informed, she believed that doctors needed to be better equipped. Doctors at the family hospital level frequently send patients to larger hospitals for diagnosis for lack of proper tools.

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<sup>44</sup> Personal interview Janilgana

### *Profile of Tug-Sun Center*

Tug-Sun Center was founded 3 years ago by a former psychiatrist of Sharhaad Hospital. Erdenchimig, the founder of Tug-Sun, has 16 years of experience in the mental health field and graduated from the Mongolian State Health University. Tug-Sun is both an inpatient and outpatient facility. It currently has 20 beds for inpatients, with 11 of them filled. There are currently 4 outpatients. The average age of patients at Tug-Sun is between 35 and 45 years of age and there are no child patients. More than half of the patients are staying at the center for the treatment of alcohol addiction, although the center is able to handle other mental disorders. There are currently 3 female patients and 8 male patients in the center. Like the state hospital, Tug-Sun uses the International Classification of Disorders X (ICD-X) as its diagnostic basis and the Mongolian National Standard for as its treatment basis. The center buys psychotropic drugs from Mon-Us Pharmacy and the Mongolian Drug Emimpex, so it is able to prescribe psychotropic medication to patients if needed, but like the state hospital, it is only able to procure first generation medication.<sup>45</sup>

When asked about her reasons for starting the private clinic, Erdenchimig immediately mentioned the difficulty in effectively treating patients at the state hospital. At the state facility, she worked with more than 30 patients at a time, most of whom were severely mentally ill and the work was “personally stressful”.<sup>46</sup> At the state facility, the large numbers of patients that doctors are

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<sup>45</sup> Personal interview Erdenchimig (Tug-Sun)

<sup>46</sup> Personal interview Erdenchimig (Tug-Sun)



responsible for, prevents them from giving enough personal attention to each individual patient. At Tug-Sun, the limited number of patients allows doctors to spend more time with each patient and increases the quality of care. Another incentive for her to establish Tug-Sun was state budget cuts in public health expenditure which resulted in low salaries for doctors.

These budget cuts were part of the state's attempt to encourage privatization of medical services; however conflicting policies within government actually hindered the development of private mental facilities. According to Erdenchimig, the director of health for UB was "uncooperative" and "didn't want to give permission for 20 beds".<sup>47</sup> In her opinion, government officials don't have enough awareness of mental health issues in UB and are reluctant to allocate money for mental health issues. The government is hesitant to give permission for private inpatient facilities and for private hospitals in general. In fact, Tug-Sun is not actually classified as a hospital; instead it is registered as a nursing center. This classification as a nursing center makes it difficult and expensive for Tug-Sun to buy psychotropic drugs.

Finding money to fund private facilities is another challenge in developing the private sector as banks are reluctant to give out loans. Operating costs for private centers are very high because these centers receive no government funds and they must pay out of pocket for rent, heating, electricity, water, etc. Tug-Sun's operating costs stand at approximately 2 million tugruks per month. As a result, private hospitals are forced to charge high fees for their services, which limit the segment of the population that they can serve. Patients pay between

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<sup>47</sup> Personal interview Erdenchimig (Tug-Sun)

20,000 and 25,000 tugrugs per day to stay at the center and this covers the bed, food, drugs, and therapy. The average length of stay is between 10-12 days for alcohol rehabilitation and 2 weeks to 1 month for other illnesses. Most of the patient fees at Tug-Sun go towards paying for overhead. The Asian Development Bank and other international NGOs wanted Mongolia to switch to a health insurance based healthcare system believing that it would improve efficiency. However, health insurance does not currently cover mental health services and at 30,000 tugrugs per month, government pensions for the mentally ill falls well below the minimum wage, which is 108,000 tugrugs per month. Meetings with MPRP membership and the Minister of Health to discuss raising the monthly pensions yielded few results.<sup>48</sup>

Funding issues aside, inertia among government bureaucrats and city planners impedes the growth of private mental health facilities. Lower level government employees are hesitant to work with private organizations and tend to refer these organizations to subsequently higher level officials, which lengthens the process of establishing a private facility. To increase efficiency, private organizations should be able to accomplish as much as possible at the lowest level of government and the amount of red tape that they need to go through needs to be drastically reduced. Erdenchimig identified four major features that would significantly improve the private mental health sector. First, the government needs to establish pro-private policies that would expedite the process of setting up a private hospital, especially in finding a location for the hospital. Second, the government needs to loosen restrictions on private centers and make it easier for

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<sup>48</sup> Personal interview Erdenchimig (Tug-Sun)

these centers to be classified as hospitals instead of nursing centers. Third, private organizations should be more transparent about their projects and share information with each other so that there is more horizontal cooperation between these organizations. Finally, there needs to be financial support from the government so that startup costs for private facilities are not prohibitively high.<sup>49</sup>

One reason to develop the private sector in Ulaanbaatar is to improve the quality of healthcare by introducing competition to the field. In Erdenchimig's opinion, the quality of mental health care in UB is "very poor" compared to international standards, but compared to previous years, quality has increased. One of the major areas of weakness is the training of new psychiatrists and psychologists. Echoing the sentiments of other doctors, Erdenchimig confirmed that doctors are not well-versed in international treatment standards and in order to improve the quality of care, doctors should be sent abroad to study.<sup>50</sup> She also referred to a shortage of doctors in the state hospital which has led to an emphasis on drug treatment over other types of non-drug treatments like talk therapy and group therapy. In order to survive, private facilities like Tug-Sun must offer high quality services; otherwise there is no way for them to compete with the state facility. Because of an inherent need to be competitive, a higher doctor-patient ratio, and the ability to set independent hiring standards for staff, Erdenchimig, along with several other psychiatrists have concluded that the quality of care in private mental health facilities is higher than that of the state mental hospital.<sup>51</sup>

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<sup>49</sup> Personal interview Erdenchimig (Tug-Sun)

<sup>50</sup> Personal interview Erdenchimig (Tug-Sun)

<sup>51</sup> Personal interview Erdenchimig (Tug-Sun)

### *Profile of the National Center of Mental Health (Sharhaad Hospital)*

The National Center for Mental Health, also known as Sharhaad Hospital, is now almost 80 years old and was founded in 1929. At the time it opened, it had only 20 beds and was staffed by Russian psychiatrists who later trained Mongolian doctors.<sup>52</sup> Until 2006, the inpatient and outpatient wards of the hospital were in separate locations, with the outpatient ward located close to the heart of the city, and the inpatient ward on the outskirts. In 2006, outpatient services were moved to the same location as the inpatient wards. The hospital currently has 450 beds which are divided among 11 inpatient wards. There are 435 personnel on staff, including 70 doctors, 13 nursing attendants, 120 nursing auxiliaries and 138 other specialists.<sup>53</sup> Five buildings and several gers constitute the hospital. According to its informational pamphlet, the hospital has 6 working principles:

- “1. To implement the state policy for protecting the mind of healthy person
2. To decide problems of people, who have the mental urgent questions together with governmental and non-governmental organizations
3. To provide early detection, treatment and rehabilitation for patient with mental illness
4. To develop the resources of mental service
5. To improve the doctors and medical workers responsibility
6. The service should be rely on public referendum, cheap and stable [*sic*]”<sup>54</sup>

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<sup>52</sup> Mongolian Psychiatry: History, Present and Subjects in the 21<sup>st</sup> Century

<sup>53</sup> Informational pamphlet: Sharhaad Hospital

<sup>54</sup> Informational pamphlet: Sharhaad Hospital

As mentioned, the hospital offers both outpatient and inpatient services. The outpatient services include counseling, access to free medication, education and awareness building programs, and identification of disabilities and forensic psychiatric services.

The outpatient ward is divided into offices based on city district. There are 6 district rooms and three to four doctors staff each district office. There is also an alcohol rehabilitation room, a quality control room, a medication room, and a forensic psychiatry room. Doctors see between 5-10 patients in an hour. They also perform most of their own secretarial work along with seeing patients. The district room itself serves several functions. It is used as an office space, a lounge, a storage space for patient files, and as an interview room. From observations of the Sukhbaatar district room at the outpatient clinic, it is clear that there is little to no privacy during doctor-patient interactions. Frequently, there would be other doctors and patients present in the room during an interview and at times they would interrupt the interview to interact with either the doctor or the patient.<sup>55</sup> Patients spend only a few minutes at a time with doctors, the longest interview observed was 6 minutes long. The 4 doctors of the Sukhbaatar district are responsible for approximately 800 patients, and some district offices are in charge of more than 1000 patients. Wait time to see a doctor is anywhere between 2 minutes to upwards of half an hour. Patients wait in the hallways where there are 20 seats. On a busy day like Tuesday, the hallway is crowded and cramped, and it is clear that discomfort is high among patients. The line to receive medication is long regardless of the weekday. Prescriptions for medicines are written into

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<sup>55</sup> Observation 11/14/08

patient files and patients carry these files with them when they go pick up their medicines. Doctors handwrite data from interviews into files that are color coded according to diagnosis: red- schizophrenia, grey- mental retardation, green- epilepsy, brown-organic mental disorder, pink-bipolar, purple-affective disorder and blue-neurotic/alcohol patients. By labeling the files this way, and making patients carry the files with them into a public hallway, there is little confidentiality in regard to diagnoses.

There are 10 inpatient wards at the hospital, with the primary divisions being based on pathology and gender. There are 2 acute women's wards, 2 acute men's wards, 1 forensic ward, 1 children's ward, 1 neurotic ward, 1 ward for alcohol and drug rehabilitation, 1 ward for physical therapy, and 1 laboratory for basic medical tests.

#### *Acute Men's Ward:*

The acute men's and women's wards are some of the most crowded at the hospital. In one of the men's wards, there were 6-8 beds in a room and only 40 beds for 54 patients. This men's ward was staffed by 3 psychiatrists who at any given time oversaw 10-15 patients. According to one of the doctors at the ward, there are not enough doctors to adequately treat patients and sessions with patients usually ran from 30 minutes to 1 hour. Also, since the WHO closed down the chronic ward at the hospital, the acute ward has been housing chronic patients, which then took doctors away from spending time with acute patients. Contributing to difficulties in treating acute patients is the lack of space in the

ward. The ward is filled to capacity and has no rooms devoted to isolation or patients on suicide watch. One patient who had recently attempted suicide, while still connected to an IV, was in a room with more than 7 other patients. However, according to the head psychiatrist of the ward, high-risk patients were monitored 24 hours a day by psychiatric assistants and checked on by a psychiatrist 3 times a day.<sup>56</sup>

*Acute Women's Ward:*

This ward was past capacity with 45 beds and 53 patients. This is a locked ward, like the acute men's ward. Also like the men's ward, there is no room for a separate isolation room, so suicidal patients are instead put on 24 hour watch, and there are currently 16 patients being monitored in this way. The most common diagnosis on this ward is schizophrenia and these patients stay on the ward for more than one month at a time. There are also epilepsy patients in the ward who only stay for approximately 2 weeks. Currently, the ward is home to 8 long term patients. One of these patients was found when she was 10 and is now 26; she has been at the hospital her entire life. Average age of patients is between 30-40 years old. The relapse rate for patients, especially for those with schizophrenia is very high, mostly due to environmental factors (they cannot receive adequate care at home), and so they often return to the hospital.<sup>57</sup>

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<sup>56</sup> Observation 11/11/08

<sup>57</sup> Observation 11/14/08

### *Forensic Ward:*

This ward houses the criminally insane. Unlike the acute wards, the forensic ward is not divided by gender. There are 20 beds in the ward and 20 patients. Sixteen of the patients are male, 4 of them are women. The most common diagnoses on this ward are schizophrenia, epilepsy, and organic mental disorders. The average age of the patients is between 30-40 years of age. Treatment on the ward includes both group and individual therapy, along with medication. The length of stay depends on the prison time of the patients. This is a locked ward with a police officer at the door to secure the premises. There are multiple psychiatrists on the ward, however none of them specialize in forensic psychiatry, their background is in general psychiatry.<sup>58</sup>

### *Children's Ward:*

The children's ward is also a locked ward. There are currently 25 children on the ward and like the forensic ward, the ward itself is not divided by gender, although the patient's rooms are. There are 13 long term patients in the ward, all children with no family and all children with a diagnosis of mental retardation that will live at the ward until they are 18, at which point they will be moved to another inpatient ward at the hospital. Aside from mental retardation, the most common disorders on the children's ward are conduct disorders, Tourette's syndrome, hyperkinetic disorder, and motor and tic problems. Average age of the patients is between 6-17 years. The average length of stay for the temporary patients is between 5-10 days. Like the forensic ward, the head psychiatrist

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<sup>58</sup> Observation 11/12/08



working with the children has not specialized as a child or adolescent psychiatrist. Instead, she has 24 years as a general psychiatrist and has been working on the children's ward for 6 years. Although there are no child specialists working on the ward, efforts have been made to cater the space to children. There are two large play areas along with a cafeteria, all brightly painted and decorated. According to one of the medical assistants, foreign NGOs have donated a large portion of the toys and equipment (like wheelchairs) found in the ward. One of the rooms even has a color television, a luxury not found in other wards at the hospital.<sup>59</sup>

*Neurotic Ward:*

Unlike other inpatient wards at the hospital, the neurotic ward is open and unlocked. The ward is filled to capacity, with 30 beds and 30 patients. Men and women are mixed on this ward, although they are separated by room. The average age for the patients is over 30 years old. The average length of stay is approximately 10 days. Like the acute women's ward, these patients have a high relapse rate because of environmental factors at home (for example, stressful home situations). There are 2 psychiatrists on staff who treat 15 patients each. The psychiatrists see all their patients daily and for about 30 minutes per day. One psychiatrist complained that they did not have enough time to see their patients and treat them well and that human resources on the ward were lacking. The most common diagnoses were insomnia and hypertension and while patients were able

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<sup>59</sup> Observation 11/12/08

to receive adequate medication for their conditions, the same psychiatrist added that they needed access to more modern medicines.<sup>60</sup>

*Alcohol and Drug Rehabilitation Ward:*

This ward is unique in that patients must pay out of pocket to stay here, it is not covered by the state. To stay in a room with 4-6 beds is 600 tugrugs per day, for a room with only 2 beds it is 800 tugrugs. There are 30 patients staying on the ward and most of them are men (3-4 beds are reserved for women). The most common problem on the ward is alcohol abuse, there are currently no patients in the ward for drug rehabilitation. When these patients are on the ward, it is usually for morphine addiction. Patients undergo detoxification, alcohol re-education, and cognitive and behavioral therapy. The average length of stay is at least 10 days. All of the patients in the ward are there for alcohol or drug rehabilitation only, no other mental illness is present on the ward. Interestingly, unlike most hospitals, smoking is allowed in the ward and in the words of one doctor, “patients come here to treat alcohol dependence, not smoking”.<sup>61</sup>

*Physical Therapy Ward:*

Doctors on this ward sometimes see upwards of 40-50 patients a day. They see a variety of ages and diagnoses, and they treat both genders. Almost all of the patients come from the inpatient section of the hospital. There are 2 doctors on staff in this ward and for first time patients the average amount of time for a

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<sup>60</sup> Observation 11/14/08

<sup>61</sup> Observation 11/11/08

doctor-patient session is 20-30 minutes. Subsequent sessions are much shorter. Some of the different types of physical therapy found in the ward include, an exercise room with ellipticals, treadmills, bikes, and yoga balls, an electrotherapy machine, acupuncture, massage, and an oxygen room.<sup>62</sup>

*Laboratory:*

The laboratory handles basic medical tests for the hospital like, blood tests, urine analysis, and biochemical tests. Ward nurses collect samples from patients in the morning for analysis. Lab equipment is old and outdated, most of it is from the 1990's, but there are even pieces of equipment from the 1980's. The lab is currently under construction, but since there is no space to house the laboratory equipment, tests and analysis are still being conducted in the same space.<sup>63</sup>

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<sup>62</sup> Observation 11/14/08

<sup>63</sup> Observation 11/14/08

## *Analysis of the Mental Health System in Ulaanbaatar*

The mental health system in Ulaanbaatar is almost exclusively hospital based. More specifically, the mental health system is constructed around the National Center for Mental Health. As mentioned, mental hospitals receive almost 64% (\$6.9 million) of all the money spent on mental health in the country. According to the General Director of the Financial Department for the state hospital, Enkh Jaargal, the annual budget for the hospital is 3 billion tugrugs (or approximately \$2.6 million).<sup>64</sup> All levels of healthcare facilities, from countryside clinics, to family hospitals, to district hospitals refer patients to Sharhaad. According to Nasantsengal, the vice-director of Sharhaad, the centralization and strong state control over the mental health system is a holdover from the communist era.<sup>65</sup> Sharhaad is also the only fully funded mental hospital and it can provide services free of charge, unlike smaller facilities, so people tend to go to the Sharhaad instead of their local hospital for financial reasons. Because the state financially favors Sharhaad over other public facilities, the hospital is also able to attract medical personnel. While overall the distribution of psychiatrists and psychologists is approximately proportionate between urban and rural areas, the *quality* of medical workers is greater in Ulaanbaatar.<sup>66</sup>

At Sharhaad, almost all of the psychiatrists interviewed agreed that the quality of the doctors working at the hospital was high, however they were quick to add that they were still understaffed and that each doctor was responsible for

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<sup>64</sup> Personal interview Enkh Jaargal

<sup>65</sup> Personal interview Nasantsengal

<sup>66</sup> WHO-AIMS report 17

too many patients.<sup>67</sup> Most doctors also agreed that the Health Sciences University prepares students well for a career in mental health, however the consensus was that recent graduates of the university were still too inexperienced to go straight to work at the state hospital.<sup>68</sup> The implication in this situation is that without smaller hospitals for new psychiatrists and psychologists to gain experience in, the quality of care at the state facility suffers because of the inexperience of some of its staff. Another human resource problem is the high turnover of family doctors trained in mental health. Often, the doctors that have undergone mental health training who are working in the countryside (and in the city for that matter), do not want to keep working at the local level, and want to move into regional hospitals or into the national hospital.<sup>69</sup> As a result there is a shortage of qualified mental health professionals at the local level which forces people to seek services at the national level. Finally, there is a nationwide lack of specialists in mental health, especially child and adolescent psychiatrists. Sharhaad is the only hospital in the city, and in the country, that accepts child inpatients, but even the head psychiatrist at the children's ward of the hospital is only a general psychiatrist. The quality of treatment of child mental patients in Mongolia lags even further behind than that of adults.

The centralization of treatment facilities around Sharhaad also influences the treatment options that are available to patients. The hospital is understaffed and doctors are overloaded with patients, so there is less emphasis on non-drug based therapies (like psychotherapy, group and individual talk therapy, etc) as

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<sup>67</sup> Personal interview Narmandakh Altanzul

<sup>68</sup> Personal interview Tsogzolma

<sup>69</sup> Personal interview Erdenchimig (NUM)

these therapies are much more time-consuming than simply prescribing medication. The lack of specialists (for example, psychotherapists) trained in alternative therapies further limits treatment options. Patients are also not in a position to demand alternative treatment options because services are so centralized they cannot threaten to go somewhere else, since there is no where else to go. The centralized system also puts strain on itself because it creates a situation where patients have to go to the state hospital in order to receive treatment, but having to be responsible for the entire population pushes the hospital's resources to the limit. One psychiatrist in the External Affairs division, Bayarmaa, said that the hospital is currently filled past its capacity and has 488 patients for 450 beds and that patients get less food and less medication a result of having too many patients and too few resources.<sup>70</sup>

The hospital itself is clearly cramped for space. Inpatients and outpatients must use the recreational rooms (fitness, arts and crafts, wood working etc) at the same time because there is not enough space to have separate facilities.<sup>71</sup> Most of the wards have more patients than they have beds. The acute wards are some of the worst off with too many patients and no way to isolate high-risk patients or patients that have survived suicide attempts.<sup>72</sup> The buildings themselves are old and energy inefficient, so a good portion of the hospital's budget is forced to go to heating and overhead costs. There are plans for a new hospital building to ease the burden; however the expected cost of the project is 3 billion tugrugs. The hospital is supposed to receive 1.6 billion tugrugs by the year 2009, but disagreements

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<sup>70</sup> Personal interview Bayarmaa

<sup>71</sup> Observation 11/10/08

<sup>72</sup> Observation 11/11/08

among the planning committees leave the fate of the remaining 1.4 billion tugrugs unknown.<sup>73</sup> In the outpatient ward, doctors' offices and interview rooms are combined, so patients have no privacy during their sessions. It is easy for doctors to become distracted during the interview sessions and without the assurance of confidentiality or privacy, patients are more likely to withhold information from doctors.

Doctors at Sharhaad agree that the best way to improve the quality of care at the hospital and raise it to international standards is to: 1. build another hospital building so that there is adequate space for patients and doctors, 2. improve training for new doctors so that they have on-the-job experience before working for the state facility, 3. increase the budget and change government policy so that they hospital can afford second generation psychotropic drugs along with other modern medical equipment, and 4. improve community based healthcare and develop the private sector in order to lessen the burden on the state facility and diversify treatment options for patients.<sup>74</sup> Improving community based healthcare and developing the private sector is especially important because it would not only improve the quality of treatment at the hospital, it would improve the overall mental health system in Ulaanbaatar and in Mongolia as a whole.

Some difficulties in developing the private sector have already been discussed, from government reluctance to give permission for private hospitals, to a lack of awareness and understanding in bureaucracies responsible for encouraging the development of the private sector, to the prohibitively high

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<sup>73</sup> Personal interview Enkh Jaargal

<sup>74</sup> Personal interview Nasantsengal

startup costs for individuals trying to start private facilities. However another impediment to the development of the private sector is a lack of awareness among the public concerning the need for mental health services at all. Erdenchimig at the National University of Mongolia noted that while awareness of mental health problems is increasing, only her psychology students could be called “aware” of mental health.<sup>75</sup> Without awareness and education programs to inform the public of the mental health situation in Mongolia, there is no way for reform to arise as a result of popular demand. The Mongolian populace, both in the countryside and in the city needs to acknowledge that mental illness is a pressing problem in Mongolia and push its lawmakers to create a more productive environment for the mental health system. A lack of education and awareness is also the hurdle that prevents the growth of community based healthcare. Many communities do not have the knowledge needed to care for the mentally ill and find it easier to send their ill patients to the hospital so that they do not have to deal with them. Basic training and facilities would go a long way in keep chronic patients out of the

One final step that would significantly improve the mental healthcare system in Ulaanbaatar, along with decentralization, the development of the private sector, and raising awareness among the populace, would be to create an independent, non-governmental organization to oversee and standardize mental healthcare practice in Mongolia, similar to an organization like the American Psychiatric Association. This organization would be responsible for the regulation of diagnostic and treatment bases, certification and registration of mental health practitioners in the country, and also the identification and targeted reform of

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<sup>75</sup> Personal interview Erdenchimig (NUM)



weaknesses in the mental health system in Mongolia. One way it could quickly and clearly identify these weaknesses would be to compile mental health data into one place, a function that no government agency performs.<sup>76</sup> It would also be made up primarily of mental health professionals and professors, instead of politicians, to ensure qualified representation from all segments of the mental health system. Unlike a governmental organization, whose agenda would inevitably vary from election to election, this organization's mission would be to raise Mongolia's mental health standards to meet and eventually exceed international standards, regardless of the political agenda of the participants. Instead of serving a particular constituency, it would serve the mentally ill, a demographic that is underrepresented and neglected.

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<sup>76</sup> WHO-AIMS report 5

## *Conclusion*

From observations of both a private hospital and the state facility, it is clear that the quality of care at the private hospital is higher than that of the state hospital, not because doctors are more qualified or devoted, but because they have more time to devote to each individual patient. Although the standard of mental health care in Ulaanbaatar is still far below international standards, it is clear that doctors are committed to serving their patients. However, personal commitment alone is not enough. Doctors and psychologists need funding, tools, and training to deliver the highest quality of care that they can, all of which they currently lack. Mental health needs to be a greater priority to Mongolia than it currently is. From local family doctors, to regional and district doctors, to doctors at the national level, basic mental health training is a must.

The mental health system is clogged because it is overly centralized and it is unsustainable. If these structural problems are not addressed, it will not be long before the system is overwhelmed and unable to care for patients. The incidence of mental illness in Mongolia, and worldwide, is increasing, and if these trends continue then it is only a matter of time before the mental health system here breaks down. It is imperative to develop the private sector; the competition that it would generate would vastly improve the quality of care, not to mention it would attract more qualified people to the field as financial incentives increase. Also, there must be a variety of treatment options available and medical personnel need to be careful about over prescribing medication; especially since the country is

still only using first generation psychotropic drugs. Finally, perhaps most importantly, mental health personnel in Mongolia must communicate and cooperate with each other in order to improve the healthcare system. The task of reform is far too big to leave to one organization or a small group of individuals alone. It is a collaborative effort, and if they are to fully serve the mentally ill, nothing less than productive cooperation can be acceptable.

## *Appendix*

†† With an exchange rate of \$1 / 1152 tugrugs

\$8.542 billion (GDP) → 9.84 trillion tugrugs

\$546 million (total health expenditures) → 6.28 billion tugrugs

\$10.9 million (total mental health expenditures) → 125 billion tugrugs

\$6.9 million (mental hospital expenditure) → 7.9 billion tugrugs

\$2.6 million (Budget, National Center for Mental Health) → 3 billion tugrugs

## *Glossary*

*Inpatient-* a patient whose condition requires them to be hospitalized; cannot leave at will

*Outpatient-* a patient who receives treatment but does not require hospitalization; can leave at will

*Pathology-* the study of disease, in this case it will be used to refer to a host of different mental disorders

*Psychiatry-* the branch of medicine dealing the study, prevention, and treatment of the mind and mental disorders (psychiatrists have the ability to prescribe medication)

*Psychology-* the study of the mind and mental processes, distinction between psychologists and psychiatrists being that the former cannot prescribe medication

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