Harry Minas
Milton Lewis   *Editors*

Mental Health in Asia and the Pacific

Historical and Cultural Perspectives

International and Cultural Psychology

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Editors

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Springer

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About the Editors

Harry Minas is head of the Global and Cultural Mental Health Unit, Centre for Mental Health, Melbourne School of Population and Global Health, and director of the Melbourne Refugee Studies Programme, both at The University of Melbourne. He is a psychiatrist who has worked in transcultural and global mental health over the past three decades. His mental health research, education and service development work has been in development of mental health services for multicultural communities in Australia and mental health system development in low-income and middle-income countries, and post-conflict and post-disaster settings in South-East Europe, Asia and the Pacific. He has had a particular focus on mental health and human rights, working with academic and government colleagues in several countries on improving human rights protections for persons with mental illness and psychosocial disabilities. At the University of Melbourne, he has developed graduate diploma and master-level programmes in transcultural psychiatry and global mental health and, through the International Mental Health Leadership Programme, has trained several hundred mental health leaders in more than 20 countries in Asia and the Pacific.

He has written on transcultural psychiatry and global mental health, including more than 250 peer-reviewed journal papers, books, book chapters, reports and multimedia teaching products. Among the books, he has authored or edited are as follows: Minas H (ed.) *ASEAN mental health systems* Jakarta: ASEAN Secretariat, 2016; Patel V, Minas H. Cohen A, Prince M. (eds.) *Global Mental Health: Principle and Practice* New York, Oxford University Press, 2014; Hung PM, Minas IH, Liu Y, Dahlgren G & Hsiao WC. (eds.) *Efficient, equity-oriented strategies for health: International perspectives, focus on Vietnam* Melbourne, Centre for International Mental Health, 2000. (*Cham Soc Suc Khoe Nhan Dan Theo Dinh Huong Cong Bang Va Hieu Qua*, Hanoi, Hanoi Medical Publishing Company, 2001); and Minas IH, Lambert T, Kostov S, Boranga G, *Mental health services for immigrants: Transforming policy into practice*, Canberra, Australian Government Publishing Service, 1996.

Between 1988 and 2015, he was founding director of the Victorian Transcultural Psychiatry Unit during which time he established, in 1996, the Centre for International Mental Health at the University of Melbourne. He has been a consultant to Australian Commonwealth and State Departments of Health, successive Australian Ministers for Immigration and Citizenship, the International Organization for Migration and the World Health Organization. He was co-chair of the Victorian Migration Mental Health Taskforce and chair of the executive of the Commonwealth-funded Mental Health in Multicultural Australia programme. He is co-director of a WHO Collaborating Centre for Mental Health and Substance Abuse and is a member of the WHO Director-General's International Expert Panel on Mental Health. He was founding editor of *Australasian Psychiatry: Journal of the Royal Australian and New Zealand College of Psychiatrists* (1993–2000) and, since 2007, has been founding editor-in-chief of *International*

Journal of Mental Health Systems. Between 2011 and 2013, he was head of the Movement for Global Mental Health Secretariat and was a member of the Lancet Global Mental Health Group that prepared the Lancet Series on Global Mental Health in 2007 and 2011.

Milton Lewis is an historian of medicine, public health and health policy; and is currently an Honorary Senior Research Fellow in the Menzies Centre for Health Policy, the Charles Perkins Centre, The University of Sydney.

As the book titles below show, he has written on a very wide range of aspects of medicine and public health, across the life cycle from infants to the dying and across a variety of medical specialties and health problems.

He has a long-term interest in the contribution history that can make to understanding better health problems and health policy and, more broadly, in how to apply what used to be called, especially in nineteenth-century Germany, the "human sciences" (history, anthropology, economics, politics, sociology and psychology) together with human biology, in an integrated way, to advance understanding of human affairs, a very much more difficult task but one essential to dealing with the growing complexity of a world where globalisation and the forces of economic "modernisation" interact with ancient cultures and "pre-modern" societies.

He has published 15 books (as well as book chapters, special issues of journals and journal articles). The three most recent books, including this book, *Mental Health in Asia and the Pacific: Historical and Cultural Perspectives*, reflect his concern with the impact of globalisation on the health of the peoples of the diverse polities, economies, societies and cultures of Asia and the Pacific, a region many see as the emerging centre of world affairs. The first two books—MJ Lewis and KL MacPherson, eds, *Public Health in Asia and the Pacific: Historical and Comparative Perspectives* (2008; 2011) and MJ Lewis and KL MacPherson, eds, *Health Transitions and the Double Disease Burden in Asia and the Pacific: Histories of Responses to Noncommunicable and Communicable Diseases* (2013)—cover communicable and noncommunicable diseases. This third book, in dealing with mental disorders, completes the coverage of the "total disease burden" of countries of the region.

Some of his other books are as follows:

MJ Lewis, *Managing Madness: Psychiatry and Society in Australia, 1788–1980* (1988);

RM MacLeod and MJ Lewis, eds, *Disease, Medicine and Empire: Perspectives on Western Medicine and the Experience of European Expansion* (1988);

MJ Lewis, *A Rum State: Alcohol and State Policy in Australia, 1788–1988* (1992);

MJ Lewis, S Bamber and M Waugh, eds, *Sex, Disease and Society: A Comparative History of Sexually Transmitted Diseases and HIV/AIDS in Asia and the Pacific* (1997);

P Setel, M Lewis and M Lyons, eds, *Histories of Sexually Transmitted Diseases in Sub-Saharan Africa* (1999);

MJ Lewis, *Thorns on the Rose: the History of Sexually Transmitted Diseases in Australia in International Perspective* (1998);

MJ Lewis, *The People's Health, Vol 1, Public Health in Australia, 1788–1950* (2003);

MJ Lewis, *The People's Health, Vol 2, Public Health in Australia, 1950 to the Present* (2003);

MJ Lewis, *Medicine and Care of the Dying: A Modern History* (2007).

In 2013, he was interviewed for the National Oral History Archive, the National Library of Australia (since 1960, the Archive has recorded interviews with Australians who have distinguished themselves in the arts, sport, politics, the law, media, education and science), concerning his "outstanding and pioneering career as an historian of medicine and public health".

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Chapter 1
Why Historical, Cultural, Social, Economic and Political Perspectives on Mental Health Matter

Milton Lewis and Harry Minas

Abstract We, the editors, have encouraged contributors to provide historical, cultural, social, economic and political perspectives on the development of mental health in the diverse nations of the Asia-Pacific region. Such a multi-pronged approach is required to understand this complex phenomenon. Most nations in the region were or became colonies of European powers. Just when psychiatry itself was being formed as a branch of medicine in Europe, it encountered non-Western cultures with deeply rooted, different approaches to mental disorders. Despite the subsequent growth of Western-derived psychiatry in such countries, cross-cultural issues remain significant for the current and future development of policy and services. Indeed, as those involved in the new effort to reduce the burden of untreated mental illness in low- and middle-income countries (LAMIC) realise, cultural appropriateness is central to success. In the last decade or so a debate has developed between epistemic and policy communities as to how best to do this. We believe it will advance understanding if we put the current situation in LAMIC, where globalisation is producing rapid, often disruptive, cultural, economic and social change, in a comparative historical context: the health effects, physical and mental, of this current transformation may be compared with the health impact of the 'modernisation' of the West in the nineteenth century. The rise of asylum psychiatry itself in Europe may be seen as an organised, expert response to the growth of mental disorders produced by the speedy, initially unregulated, impact of industrialisation and urbanisation on traditional ways of life, just as the rise of public health in the same era may be viewed as an organised, expert response to the growth of threats to physical health from 'fevers' and other communicable diseases.

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We need to apply what some health analysts have called the 're-socializing' disciplines—history, anthropology, sociology and political economy—to understand more fully mental health in the Asia-Pacific region, and so, hopefully, to contribute more effectively to its promotion.

Editors' Aims

We aim to present the reader with historically, culturally, socially, economically and politically informed accounts of psychiatry and of policy and service development in a number of the diverse nations of Asia and the Pacific. Many of these nations are former colonies of the British, French, Dutch, Spanish or German empires that flourished for a substantial part of the last 200 odd years during which psychiatry, like biomedicine, a product of the modernisation of the West, came into being. Having spread to the non-Western world, psychiatry now faces the issue of how best to respond to mental disorders on a global basis. But, we believe that if that is to be done properly, we need to employ analyses that draw on what Farmer et al. (2013) term the 're-socializing disciplines' in order to understand the complexity of mental health and its determinants in the current era, an era when the nation state and global forces coexist in a rapidly changing and often uneasy relationship.

For one of us (ML) this is the third in a series of edited books, together, addressing the full range of health problems in the countries of Asia and the Pacific. The first, Lewis and MacPherson (2008), is concerned with public health and highlights the large role still played by CDs (communicable diseases) in the disease burden of LAMIC (low- and middle-income countries) in the Asia-Pacific region. The second, Lewis and MacPherson (2013), focuses on the contemporary health transition in LAMIC and the accompanying double disease burden—the recent, speedy rise of serious, chronic NCDs (non-communicable physical diseases), while CDs remain significant. All three books emphasise the importance of understanding the historical, cultural, social, economic and political contexts of nation states if their contemporary health problems are to be addressed as well as possible. For the other (HM) this book is a contribution to building the still new discipline of global mental health (Patel et al. 2014), a process that must ensure that theory and practice are developed on the basis of an equal exchange among colleagues from all countries and all relevant disciplines and an understanding of the widely differing mental health system histories and contemporary contexts. In pursuit of these aims, in the present book on mental health we have tried, as far as possible, to engage as co-authors of particular chapters distinguished mental health specialists and historians or social scientists.

We have included chapters on the following countries: Cambodia, Indonesia, Malaysia, the Philippines, Singapore, Thailand, Vietnam, Taiwan, Japan, South Korea, India, Pakistan, Sri Lanka, Australia, New Zealand, Fiji, Papua New Guinea and the smaller Pacific Islands nations (SPIN). Each chapter focuses on a particular

country, except for the SPIN chapter that deals with a number of very small, new, island nations in the Western Pacific. While we commissioned a chapter on China, unhappily, it has never been delivered despite our efforts over a long period to achieve this end. Delay in production of the book has become such that we have decided we must proceed to publication despite this gap. We hope in having chapters on Singapore and Taiwan we have at least some coverage of Chinese cultural perspectives.

We attempt to show how the history and the changing cultural, social, economic and political contexts of these countries, have influenced the pattern of disorders and the development of therapies, services and policy. In addition, we look at the influence, in each country, of supranational forces such as colonisation and modernisation, the development of health policy through bodies like WHO, the spread of Western-derived, international classification and diagnostic systems (the successive versions of the relevant section of the International Classification of Diseases and of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders) and the global diffusion of Western psychiatry itself, as the source of modern, professional knowledge and training.

We are keen to introduce historical, as well as cultural, social, economic and political, perspectives to contextualise what clinical, epidemiological and health services research tells us about mental disorders and their treatment. To understand global health, including mental health, we need to take a biosocial approach where the application of the 're-socializing disciplines'—history, anthropology, sociology and political economy—is necessary to understand the causal complexity of contemporary diseases and disorders and so provide effective remediation (Farmer et al. 2013).

Epidemiology is a key discipline of population health inquiry. As an abstracting, universalising and quantitative discipline, it seeks to identify determinants of disease across time and place. In contrast, history focuses very much, but not wholly, on the particularity of phenomena associated with a specific time and place and employs a qualitative more often than a quantitative approach. It preferences particularistic and qualitative complexity over capacity to generalise. Epidemiology privileges generalisability. History examines the variety of human experiences of disease and disorder (including the attempts to explain and treat) over time as anthropology and sociology do across populations and space. These disciplines highlight the particularities of different cultures, societies, economies and polities in contrast to the universals of human biology.

Diversity in Asia and the Pacific

The Asia-Pacific region is characterised by remarkable diversity in political and economic systems, cultures and societies. Political systems include constitutional monarchies, parliamentary democracies, some recent and some long-established and one-party regimes. Nation states range in size from Leviathans like India

(population of 1.31 billion) to minnows in the Pacific. Six Pacific Island states (Palau, Cook Islands, Tuvalu, Nauru, Niue and Tokelau) have populations of fewer than 20,000.

As noted at the beginning of this chapter most of the countries included in this volume have a history of colonisation by one or other of the European powers or, more recently, by Japan and the USA, and many of the chapters pay particular attention to the influences of colonisation on the mental health of populations and on the development of mental health systems. In the post-colonial period some former colonial territories have broken up into separate nation states, such as India and Pakistan, Vietnam, Cambodia and Laos, and Malaysia and Singapore. While they have a common colonial history of psychiatry and mental health system development—the British in India and Pakistan, and in Malaysia and Singapore, and the French in the former Indochina—they have generally developed very different mental health system development trajectories in the post-colonial period. These trajectories have continued to be influenced by international forces, such as the long war in Vietnam followed by a 20-year trade embargo by the USA, and have been more directly influenced by national political, economic, social and cultural factors. Spectacular economic growth in some countries has enabled investment in health and education systems, while economic stagnation in others has resulted in relative neglect particularly of mental health. Some countries have enjoyed relative political stability, while others have experienced internal turmoil, armed conflict or human catastrophes on a massive scale, such as the Pol Pot era in Cambodia, and China's great famine and the cultural revolution. These and many other national developments have had a profound impact on the mental health of populations and on the development of mental health systems.

The Asia-Pacific region currently consists of countries at the lowest and highest levels of economic and social development. In purchasing power parity dollars (PPP$) Singapore has the highest gross national income per head (60,110), 25 times that of Cambodia or Papua New Guinea (less than 2500). Life expectancy at birth ranges from a high of 87 years in Japan to a low of 62 years in Papua New Guinea and below 70 years in Pakistan, India and the Philippines. In terms of the UN Human Development Index the region contains three countries ranked in the top 10 (Australia—2, New Zealand—7 and Singapore—9) and seven countries that rank below 100 among the 188 UN member states (Indonesia—108, the Philippines—117, Vietnam—121, India—135, Cambodia—136, Pakistan—146 and Papua New Guinea—157). In the Pacific, Palau, Fiji, Tonga and Samoa are ranked in the top 100, while Micronesia, Kiribati, Vanuatu, Solomon Islands and Papua New Guinea are ranked among the bottom 88 UN member states.

Regardless of their particular histories, or of their current size or resources, all countries in the region must deal with the economic upswings and downturns that are already a major feature of the new century and the direct impacts of massive economic transitions on the mental health of populations. They must also deal with the continuing and accelerating social and cultural changes that are wrought by the revolution in communications and related technologies, internal and international migration, global trade and other economic regimes and rising security tensions.

Political instability has been a prominent feature of the Asian and Pacific regions, for example in Myanmar and Thailand and in Fiji and the Solomon Islands. The current tensions arising from competing claims in the South China Sea may yet spill over into destructive conflict.

Such a variety of nations, and a variety of political, economic, social and cultural histories and contexts, offers a comparative perspective that may provide insights useful for development of better understandings of health and illness and for more effective and acceptable mental health policies and practices.

Major Themes in the History of Psychiatry

We believe readers will benefit if they read the nation-focused chapters of our book in the light of the following major themes in the history of modern psychiatry from its origins in Western Europe two centuries so ago to its globalisation in the last two and a half decades or so.

The Health Effects of the West's Modernisation in the Nineteenth Century

It is widely accepted that the rapid and massive, socioeconomic change produced in nineteenth-century Western Europe by, initially, unregulated urbanisation and industrialisation impacted, in the beginning, negatively on physical health status, as indicated by life expectancy at birth (LEB). But by late in the century, rising incomes (per capita income in England and Wales, where the process of industrialisation began, increased more than two and a half times between 1820 and 1900) translated into improved working class nutrition. This, along with development of public health regulation and infrastructure, especially provision of clean water and safe sewage disposal in urban areas (infrastructure made possible by the greater national wealth), promoted resistance to key CDs (then the primary causes of mortality); at the same time exposure was reduced.

From the 1880s or so LEB began a secular rise, as it did, in turn, in other Western European countries and in offshoots of Europe like Australia and the USA. Thus, in England and Wales, while LEB was 39 years in 1820 and remained 39 in 1850, it increased to 48 in 1900 and reached 71 in 1950 (Caldwell 2006; Lewis and MacPherson 2013).

What is less easy to demonstrate is the magnitude of the parallel, adverse effects of such rapid socioeconomic change on the mental health of Europeans and New World Europeans. This is partly because for mental disorders, unlike physical ones, there is no convenient, reasonably reliable, macroindicator like LEB.

Increasing Insanity or Growing Institutionalisation of the Insane, or Both, in the Nineteenth-Century West?

There is no doubt that during the West's modernisation in the nineteenth century, patient populations of lunatic asylums soared: in England and Wales, almost 300,000 committals and in the USA, by World War One, almost 250,000 patients were located in state psychiatric hospitals, while in New South Wales (Australia) and in Ireland about one in 300 people were asylum inmates. Asylums themselves proliferated and grew in size (Wright 1997).

Moreover, many psychiatrists of the time believed insanity was increasing due, they said, to the deleterious effects of urban, industrial society. Contemporary, Western civilisation was producing sensory overload and so mental illness. Distinguished alienists from across Europe like J.E.D. Esquirol, Jacques Moreau de Tours, Wilhelm Griesinger, Richard von Krafft-Ebing, Hack Tuke and Cesare Lombroso argued those unfortunates who could not meet the demands of civilisation for higher levels of mental organisation and production were filling the ranks of the mentally ill.

For eminent, American neurologist, George Beard, the characteristic mental disorder of the times was neurasthenia ('nervous weakness') the symptoms of which were variously anxiety, pains, headaches and sexual dysfunction. The disorder arose because the body's nervous energy was depleted by the following features of modern society: steam power, the periodical press, the telegraph, women's education and science. Alienists were also encouraged in this pessimistic view of the advance of civilisation by the French psychiatrist, Benedict Morel's influential doctrine of hereditary degeneracy and, later, by the eugenists' call for state measures to prevent reproduction by the unfit in order to halt an alleged decline in the physical and mental 'vigour' of the European 'race' (Lewis 1988; Rosenberg 1998; Raimundo Oda et al. 2005; Shorter 2005).

The connection between industrial civilisation and mental illness was as widely accepted in medical circles as that between industrial civilisation and leading causes of physical illness and of death—fevers, tuberculosis and the great killer of babies, summer diarrhoea. The psychological cost of progress was as real as the cost to physical health of urban population density, inadequate, working class diets and unhygienic dwellings and workplaces (Rosenberg 1998).

Many modern historians of psychiatry, influenced by the ideas of French philosopher, Michel Foucault, have not been concerned with whether the incidence of insanity itself was increasing, but rather with the proliferation of asylums and their populations; they see these phenomena as resulting from the all-powerful, modern state's plan to confine and control the unproductive and disruptive (including the insane) and so to regulate, and promote efficiency, in the new industrial society (Porter 2003). In this scenario, asylum doctors, eager to advance their own professional interests, were the agents of the control of the insane. Wright (1997) has argued, as a variation, this 'great confinement' was driven primarily not by these aspirational psychiatrists, but by working class families who, unable to

provide the family-based care of pre-industrial times (because of the demands of the new, industrial, labour regime), were themselves increasingly placing their mentally disordered members in asylum care.

Others believe patient populations grew dramatically at least in part because the population incidence of mental disorders was growing: especially, alcoholism (alcoholic dementia and delirium); general paralysis of the insane (neurosyphilis); and, possibly, schizophrenia (Shorter 2005).

Certainly, nineteenth-century European and American doctors voiced growing concern about the widespread, adverse effects of alcohol abuse. The cheapness of industrially produced liquor encouraged demand, and drunkenness became a major problem of urban social order.

Doctors identified alcohol abuse as an increasing source of physical and mental illness. Habitual drunkenness was, then, seen as a physical cause of insanity like trauma and syphilis.

Psychiatrists in particular were very concerned because so many of their cases seemed to be alcohol-related. Eminent American doctor, Benjamin Rush, claimed 33% of cases at the Pennsylvania Hospital were such; in England experts claimed 30–50%; in Hanover, Germany, 16% and Stephansfeld, France, 11%; in Sydney, Australia, 10% and Melbourne, 9%; although early figures from Yarra Bend asylum, Melbourne, were much higher—in the 1850s, 50–70% of admissions were said to be alcohol-related (Lewis 1992; Shorter 2005). But it was not only doctors who drew attention to the connection between illness and widespread alcohol abuse, especially among the poor. In 1850, **Punch**, the popular London weekly magazine, observed the filthy, urban environments in which the poor lived bred depression and despair, and many sought relief in heavy drinking (The Peel Web 2014).

Syphilis was widespread in nineteenth-century European and New World European populations. With no effective cure, a considerable number of the infected developed general paralysis of the insane (GPI) ten to 20 years after infection. They became asylum inmates because of symptoms like mania, and they eventually died from GPI. In 1838–1846, of 489 cases of insanity at Sydney's Tarban Creek asylum, 14 (all male; because of widespread female prostitution and the colonial population's high masculinity, most sufferers were male) were paretics. At Melbourne's Yarra Bend, in 1863, 28 of 52 male deaths were from GPI. In 1882–1894, 8% of admissions at Melbourne's Kew asylum had GPI, the high figure probably reflecting the fact of high syphilis infection rates among the men who had flocked in great numbers from overseas and other Australian colonies to the Victorian goldfields in the 1850s. In NSW, in 1883–1887, GPI was responsible for 3.5% of admissions, where in England the figure was as high as 8.4%.

There was a steady downward trend in GPI admissions (Victoria) from 1913, decades before penicillin became available as the first, effective cure for syphilis. The arsenical drug, Salvarsan, used on asylum paretics in Australia from just before World War One, was found to be ineffective against neurosyphilis, but may have had some effect in reducing early syphilis and so the incidence of GPI.

A major peak in GPI admissions occurred in 1913 and a much lesser one in 1935. The 1913 peak was probably the result of the exposure of Australian troops to syphilis in the Boer War (and possibly to the immigrant intake of the late nineteenth century). The 1935 peak was partly the result of very substantial syphilis infection rates among Australian troops during World War One, one of the highest among combatant nations: Australia, 178 hospital admissions per 1000 men in the field; Britain, 25 and Germany, 27 (Lewis 1988; Cumpston 1989; Lewis 1998; Shorter 2005; Noonan 2014).

Warner (1995) has argued the process of modernisation in Victorian England increased the incidence of schizophrenia as changing socioeconomic factors were mediated through biological mechanisms. At the early stage of industrialisation, because of better care, many brain-damaged, upper class babies survived where such lower class infants died. This led to higher rates of schizophrenia among the well-to-do. At a later stage, well-nourished, upper class parturients with well-formed pelvic cavities and better obstetric care produced fewer, brain-damaged children, and so the incidence of upper class schizophrenia decreased. Working class women had to wait some time longer for the benefits of better nutrition and obstetric care to reduce damage to babies and so to lower the incidence of working class schizophrenia.

Beginning in the 1970s, studies of schizophrenia in non-Western countries suggested its course could differ according to the country's stage of modernisation as well as the local culture. The character of schizophrenia might be a genetic-biological universal, but its course could apparently be influenced by modernisation and, perhaps, by cultural factors (Fabrega 2001). A recent overview of knowledge about schizophrenia noted, first, the incidence varies very much across locations; second, the risk increases linearly with the degree to which the environment in which children mature is urbanised; third, the risk is higher in some ethnic, immigrant groups. Poverty and social isolation may be the factors underlying this association with urbanisation and migration so that public policy aimed at reducing poverty and isolation may help reduce rates of schizophrenia (Van Os and Kapur 2009).

Western psychiatry emerged as asylum medicine just when nineteenth-century Europe was undergoing rapid and far-reaching, social and economic change. Arguably, it did so as a medical response to the mental health costs of modernisation. In the same way, public health was a response to the high costs to physical health of CDs. Both disciplines had become well established as medical specialties by the later nineteenth century.

The Spread of Western Psychiatry to the Non-Western World

The unprecedented economic and military power arising from the pioneering modernisation of the West enabled the creation or expansion of Western empires in Asia, the Pacific and Africa in 1850–1914. Along with empire came a belief in the

superiority of Western culture and especially its products, including science, medicine and psychiatry. The West saw itself as having a civilising mission, a responsibility to bring backward peoples into the modern world (Kirmayer and Swartz 2014).

The expansion of empire brought Western psychiatry into greater contact with the Asian, traditional, medical systems, as well as tribal and folk systems. In the colonies Western psychiatrists encountered culturally different disorders, different explanations and different therapies.

After World War Two, Western empires dissolved but Western psychiatry was, by then, firmly established as international psychiatry, with American and, to a lesser extent, British psychiatry the dominant forces. Even before the end of the nineteenth century France had forfeited leadership of Western psychiatry to the German-speaking world. The long period of German leadership ended with the triumph of Nazism in the 1930s, the Holocaust and the emigration (mainly to the USA) of many, leading, Jewish clinicians and scientists (Shorter 2005).

Globalisation, in an extended sense initiated by the West as long ago as Columbus' discovery of America and then greatly promoted by nineteenth century, Western industrialisation and imperialism, has in the last 25 years reached a new level of intensity, impinging even more on the cultures, economies, polities and social structures of non-Western, developing countries. Psychiatry as one of the West's cultural exports is becoming truly globalised, but in some non-Western countries attempts are being made to modify it and reconcile its theory and practice with major, indigenous, healing traditions.

Another expression of current globalisation is the depth and rapidity of social and economic modernisation in developing countries. The cost to physical and mental health is comparable to that experienced in the modernisation of the West in the nineteenth century. But this time psychiatry, as a response to the rising level of mental disorders in LAMIC psychiatry, will deal with cultural differences of a higher order than those it faced in its early years in Europe two centuries ago.

In the colonial era, European psychiatrists' contacts with indigenous approaches to mental disorders had challenged the universality of the classification and diagnostic systems of Western psychiatry, which owed so much to Emil Kraepelin's [1856–1926] work and particularly his description of the major disorders, dementia praecox and manic-depressive disorder. While Kraepelin's and Wilhelm Griesinger's [1817–1868] emphasis on the biological basis of psychiatry prevailed in Europe, after his contact with indigenous groups in Southeast Asia and the USA, Kraepelin himself accepted his system did not apply satisfactorily to their disorders; and that, moreover, culture seemed to have a significant role, shaping both the frequency and expression of disorders. Indeed, he believed a new comparative psychiatry had to be developed to deal with these matters (Marsella and Yamada 2010).

In the history of modern psychiatry, as it became a medical specialty, there have been two causal poles—one, the biological, looks to the brain (and genetic inheritance) to explain mental disorders, while the other focuses on the role of personal

and social context, and so the psychological and, to some extent, the social realm for its explanations (Grob 1998).

Although psychodynamics and psychotherapy became increasingly significant in the first six decades of the twentieth century (especially in North America), biology 'struck back' via pharmacology from the 1950s when an effective antipsychotic, chlorpromazine, became available. In the 1960s the anxiolytic benzodiazepines arrived, replacing the long-established but less efficient and problematic barbiturates. Influential 'neo-Kraepelinians', led by Gerald Klerman, sometime head of the American National Institute of Mental Health, called for a determinedly medical model of psychiatry in which the focus would be on the biology of mental disorders (Shorter 2005; Marsella and Yamada 2010).

Even while the psychodynamic and, then, the biological approach prevailed in the twentieth century, the importance of sociocultural forces was addressed by a number of psychiatrists in the USA and Canada. They could point to international studies that showed variations in psychiatric disorder rates, aetiology and manifestations across nations and cultures. In addition, anthropologists like Margaret Mead showed how culture influenced what constituted the normal and the abnormal in a particular society.

A great advance in transcultural psychiatry came in the 1970s because of the work of figures like Arthur Kleinman (Harvard psychiatrist and anthropologist) and Laurence Kirmayer (McGill University). As Kirmayer notes, the old transcultural psychiatry saw culture's effect restricted to pathoplasticity, while biology determined pathogenesis. The new view is cultural context, via systems of meaning, also influences symptom schema. But it goes further and says culturally determined behaviour patterns—diet being a good example—can influence biology; so that culture and biology interact. Psychopathologies arise not simply from malfunctioning brains but from defective learning and interpersonal relations in families and larger social groupings (Kirmayer 2006). They are not just localised in the brain and reducible in aetiology to biological or even biological and psychological factors. They are influenced by cultural (including religious), social, economic and political factors.

Marsella and Yamada propose that mental health can only be fully attained if the 'hopelessness' of poverty, the 'anger' arising from inequality, the 'despair' from powerlessness, the 'self-denigration' from racism and the 'confusion' from cultural disintegration are banished (Marsella and Yamada 2000). Like Kirmayer, they argue that life-changing events at the macrolevel, via sociocultural pathways, have impact at the synaptic level. Rapid, destructive, social changes set off a chain reaction. They induce, in turn, social stress (in families and other groupings), psychosocial stress (like alienation), identity stress ('who am I?'), psychobiological changes (like hopelessness), behavioural problems (like alcohol and other drug abuse, and interpersonal violence) and synaptic changes (in serotonin and other chemicals), even if we do not yet fully understand how these hierarchically ordered interactions specifically function (Marsella and Yamada 2010).

Mental and Physical Health Effects of Rapid Social and Economic Change in Asia and the Pacific

By the late nineteenth century the adverse physical health effects of Western modernisation were reducing as mortality from CDs began a secular decline; LEB began to rise to historically unseen heights. This was the first phase of the health transition in the West, a complex process of changes in health, disease and mortality resulting from demographic and associated social, economic, cultural and political changes.

The next phase in the health transition dates from the interwar period, when mortality from what became an 'epidemic' of major chronic non-communicable diseases (NCDS) like cardiovascular disease, cancer and diabetes began, retarding the advance in LEB. Only late in the twentieth century was the drag of NCDs reduced as mortality from some like heart disease declined.

Now such has been the speed and magnitude of the current modernisation process in developing countries (including those in the Asia-Pacific region) that for them the two phases of the Western health transition have been compressed. They are experiencing at the same time a double (physical) disease burden as mortality and morbidity from CDs remain high even as those from NCDs rise sharply (Lewis and MacPherson 2013).

From the 1950s, as NCDs came to dominate the patterns of mortality and morbidity in the developed world, epidemiology's 'causal' focus shifted to multiple, proximate, biological risk factors like high blood pressure, the presence of which increased the probability of disease in the individual. More recently, the role of macroeconomic, social and cultural factors has enjoyed greater recognition because of the persistence of a social gradient in mortality and physical health status across countries, even as health status at the national level improves. The work of contemporary investigators like Marmot et al. (2010) and Wilkinson and Picket (2010) strongly suggests physical and mental disease rates will change as their social, cultural and economic environments change and that the way a society is organised is itself a notable determinant of health status.

Even in richer countries, from where deep poverty has disappeared, significant socioeconomic inequalities continue; the social gradient persists because the psychosocial effects of relative deprivation mean anxiety, depression and insecurity—a sense of control over one's life—are experienced differentially according to level of socioeconomic status. The prevalence of illness and death is distributed differentially (Hunter and Tsey 2003; Lewis and MacPherson 2013).

In the same line of thinking, another distinguished investigator, Ezra Susser, proposes we look beyond concern with individual risk factors to an 'eco epidemiology' approach in which 'causality' functions at different levels—at the macrolevel, according to distribution of wealth and social status; at the individual level, via personal attitudes and behaviour; and at the micro level, via cellular and molecular events (Lewis and MacPherson 2013). This schema much resembles

Marsella and Yamada's hierarchically organised model of 'causal' pathways in mental disorders that we have outlined above.

In the early 1990s Sugar and colleagues drew attention to the exploding growth of 'social and behavioural pathologies' in developing countries as globalisation destroyed traditional, social, cultural and economic orders. They noted globalisation offered great gains like rising national wealth and falling infant mortality rates, but these were matched by great costs like increasing violence, substance abuse, mental disorders and family breakdown, as well as rising rates of NCDs like heart disease and diabetes. A major social and behavioural pathology like cigarette smoking addiction was wreaking havoc on physical health as seen in rocketing mortality and morbidity from cardiovascular disease and cancer in the developing world: in China, cardiovascular death rates increased 250% in 1957–1984, as cigarette production rose 10% each year. Mental disorders like suicide were often higher in developing countries: in the late 1980s where suicides of young men were 30 per 100,000 population in the USA, they were 75 (15–19 years) and 110 (20–24 years) in Micronesia; in 1967–1987 alcohol was implicated in almost half of suicides there (Sugar et al. 1994). Two decades of globalisation later, Marsella (2012) again addressed this issue of the various, globalisation-induced positives and negatives for individuals and nations. He lists among the negatives, rising 'social dysfunctions and disorders'. His list includes many of those identified by Sugar and colleagues in the earlier years of globalisation.

Marsella (2012) asks why psychology (as the study of mind and behaviour) has not contributed more to understanding of the connection between globalisation and mental health problems, especially suicide. In seeking to explain this, he points to, first, its historical focus on individual behaviour where causes are situated in the person whether they be neurobiological, personality-focussed or based on the person's particular developmental history; and located, also, only in proximate social environments like the family, school or workplace. Second, he points to the underlying assumptions of psychology, notably its individualism, materialism and reductionism. These derive from its origins in Western culture where an epistemological distinction between the individual and society is fundamental. They limit its capacity to advance understanding of behaviour in countries with non-Western cultures where this is not critical.

Summerfield (2012) and Kirmayer (2006) make similar points in relation to psychiatry. Summerfield says Western psychiatry is hampered in its cross-cultural applicability and efficacy by its 'foundational assumptions'. From the enlightenment on, the individual has been the prime focus of inquiry, and 'mind' is located in the head, while everything 'social', being outside the body, is a separate and less significant realm of explanation. This basic conceptual distinction produces in policy and practice a division of psychiatric from social interventions, even while social problems like violence, inequality and poverty are increasingly recognised as ultimate causes of mental disorders. At the least, a narrow, biomedical approach to mental disorders in the developing world reduces community mental health services, WHO's much advocated solution, virtually to the provision of medications (Summerfield 2012).

Kirmayer takes this last point about services further. Greater provision to poor populations of community mental health services and medications for depression and other significant disorders in order to reduce the suffering of a plethora of untreated people is to be applauded. But this must not become a substitute for the social and political reforms that need to be implemented to remedy the systemic inadequacies and injustices that, at some steps removed, produce the suffering. In the current, globalising phase of psychiatry, as universal mental health becomes a goal, two polarised approaches have developed. On the one hand, there are the clinically oriented who, firm in their belief in the transferability of Western psychiatry to other cultures, are focussed on practical achievements; essentially, 'scaling-up'—much greater provision—of services and treatments to the masses of neglected patients in developing nations. On the other, there are the social scientists and non-clinical researchers who, eager to advance the building of a coherent and self-reflexive, cultural psychiatry, tend to ignore the everyday demands and obligations of clinical practice (Kirmayer 2006).

Scaling-up of mental health services and a larger share of the health budget, in developing countries, is a necessary but not sufficient condition for improving mental health.

On the grounds of effectiveness (let alone equity), larger social and economic reforms are also needed to reduce poverty, because poverty in a rapidly changing society and culture involves not just material deprivation—poor nutrition, inferior housing, insanitary environments, dangerous workplaces and overcrowding—but associated interpersonal and psychological threats like violence, abuse of women and children, hopelessness and constant feelings of insecurity.

Another threat to material and psychological security is the heightened risk of physical illness when no financial safety nets exist and illness-induced inability to work means lack of income. Moreover, empirically, mental disorders cluster with physical diseases in the life world of the poor. Mental disorders increase the risk of CDs like TB and of NCDs like diabetes. Conversely, physical diseases like HIV/AIDs increase the risk of mental illness (Farmer et al. 2013; Becker et al. 2013). We should be talking, then, about the existence of a **triple**, not a **double disease burden** (our emphasis) in developing countries?

Of the ten leading causes of the global burden of disease, depression ranks third. Even in low-income countries it is as high as eighth. It is first in middle-income countries and, not so surprisingly, first in high-income countries: in the USA in 1980–2000, the reported prevalence of depression increased by 76%.

The global burden of disease is expressed in DALYS (disability-adjusted life years). The DALY was developed in the 1990s as a single, quantitative indicator that combines the traditional indicators, morbidity (disability) and mortality (premature death). It offers practitioners, policymakers and researchers alike a more reliable estimate of the total disease burden and how it is distributed among diseases and disorders (Becker et al. 2013).

By revealing the relative contributions of particular diseases and disorders to the total burden, the indicator much facilitates the establishment of priorities for remedial interventions and allocation of scarce resources. Further, the use of

DALYS can focus attention on diseases and disorders that have been neglected as neuropsychiatric disorders have been in LAMIC. These represent almost 27% of years lived with disability in such countries. Indeed, the largest, neuropsychiatric disability rates in the world are found in East and Southeast Asian nations. On the downside, the burden of disease approach, unintentionally, tends to highlight the distinction between physical and mental disorders, thereby reinforcing a long-standing failure to appreciate the way physical diseases and mental disorders cluster, especially in poverty-ridden environments (Becker et al. 2013).

As now constituted, the DALY does not capture the subjective dimension of illness: the individual suffering and what Arthur Kleinman has termed 'social suffering'—the suffering of whole families and communities. Since the DALY addresses years of disability-free life lost to individuals, it omits the negative effect at this collective level. Further, the DALY approach really measures the 'aggregate quantity of ill-health'. To establish fully 'the burden of disease', the support available to the sufferer from family, friends and public services would need to be included.

The subjective experiences of suffering, pain and stigma are missing because they are irrelevant to the concern of the DALY approach with the effect of diseases and disorders on human productivity and, so, on economic development. Further, a reliable count of cases cannot be assumed given the lack of services and other obstacles in poorer countries such as inadequate, large-scale collection of statistics.

The fact is the biosocial and cultural complexity of global health is such that we must employ the 're-socializing' disciplines (the social sciences and humanities)—history, anthropology, sociology and political economy—to provide the additional information needed to obtain a comprehensive, just and humanised picture of the effects of physical diseases and mental disorders in an increasingly globalised world (Becker et al. 2013).

We hope the combined efforts of the contributors to our edited volume constitute a useful step towards realisation of this aim of employing historically, culturally, socially, economically and politically informed accounts to help capture the full complexity of mental health and its determinants in the early twenty-first century.

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Chapter 2
Mental Health in Pakistan: Yesterday, Today and Tomorrow

Safdar A. Sohail, Akhtar A. Syed and Atif Rahman

Abstract Muslim communities have a peculiar mental health scenario. The Muslim communities in the precolonial Indian subcontinent did have mental health conceptions, later termed Muslim psychology. The introduction of formal mental health institutions implanted the Western notions and practices of mental health in British India. The Partition did not disturb the largely autonomous evolution of the two traditions. Drawing its sustenance from the West, Western style psychiatry and psychotherapy became an integral part of Pakistan's officially maintained public health system, whereas the alternative practices have continued in the informal sector and benefitted from the increase in Islamization initiatives. The disruptions in the traditional way of social life in Pakistan, produced by factors such as the growing (disorderly) urban development, poverty, unemployment, cultural conflict and snowballing mistrust in state institutions, have significantly increased the incidence of mental health problems in Pakistan. In the case of Pakistan, the narratives about the nature and quality of the social environment have become a site of contestation between modernists and traditionalists in Pakistan, where the former would like the traditional cultural environment to make place for a modern social environment, putting individual freedom above the family and community. As the modernists dominate the cultural discourse in Pakistan, particularly in modern, urban settings, in their zeal to create strong sentiments in people against the traditional culture, the 'everything is wrong and rotten in Pakistani society', aided by the media, is creating an acquired helplessness, aggravating the mental health picture in Pakistan. Such a situation is unique to Muslim societies and sets these

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societies apart from the other societies in engaging with mental health problems. At the same time, the modern, affluent, urban sections of society are experiencing newer kinds of globalized life style linked to soft social pathologies, which become a fertile medium for serious mental ailments of epidemic proportions. The polarization on the questions of aetiologies and remedies has created a stalemate, which is helping nobody. The vacuum thus created should better be filled by research than the quackery of healers of different hues and shapes. Different traditions of mental health conceptions and practices in Pakistan need to develop a policy and practice consensus, with retooled techniques by the mental health professionals, to start addressing the pain and misery of growing mental health problems in Pakistan.

Introduction

This chapter traces the history of mental health care in what is now the state of Pakistan, the sixth most populous country in the world. Pakistan won independence from Britain in 1947, when the Indian subcontinent was divided into the Muslim-dominated Pakistan and Hindu-dominated India. In many ways, the modern-day Pakistan is a successor state to the Mogul Empire which ruled almost the whole of the Indian subcontinent and parts of Afghanistan from 1526 to 1857. The chapter starts with a historical description of early influences on mental health traditions in the region that is now Pakistan. The remainder of the chapter is divided into a section on mental health establishments in the prepartition Indian subcontinent, followed by the development of mental health in Pakistan in its 67 years of independence. In the last three decades, the nation has faced major geopolitical, socio-economic and humanitarian challenges. The chapter explores the impact of these events on the current state of mental health of Pakistanis in the backdrop of the debates on causes and solutions of individual and collective psychological pathologies.

Sources of Mental Health Traditions Amongst Muslims: Precolonial Era to 1947

Arrival of Graeco-Arab Medicine with Muslims in Precolonial India

The Graeco-Arab approach has its own concept of aetiopathogenesis (Jamal et al. 2012). There are three major concepts in this approach; *Mizaj* (temperament) *Tarkeeb* (structure) and *Ittesal* (continuity of tissues). The aetiology of a disorder may be found in *altered temperament, altered structure* and *discontinuity in tissues.* The *Mizaj* in Graeco-Arab medicine is used to describe the state of neuroendocrine,

genatometabolic and somato-environmental balance in terms of individual's functioning level in the context of the given circumstances (Jamal et al. 2012).

Both Arab and Ayurvedic medicine are based on the Hippocratic theory of humours, which states that a healthy body should have a balance of four humours; *sodawi* (sanguine), *balghami* (phlegmatic), *safrawi* (choleric) and *saudawi* (melancholic). The imbalance of these humours can cause disorder or disease (Lone et al. 2011). The Greeks said that the melancholic humour was a trait of highly intelligent people. Subsequently, Ar-Razi said that melancholia and delusions are caused by excessive rational activities (Dols 1992). Galen described three different types of melancholia: cerebral, epigastric and bodily melancholia. In Galenic formulation, *melania chole* is a term for mental disorder, which involves sadness and fear and is caused by the excessive black bile in the body (Dols 1992). The earlier stages of melancholia, described later by *Ibn Sina* (Avicenna 980–1037), are similar to the features of anxiety, which include irrational thinking, phobia, irritability, avoidance of social interaction, palpitation, dizziness and tinnitus (Jamal et al. 2012), while severe forms of melancholia have been described by *Ali Ibn Al Abbas Al-Majusi* (died in 994) as inability to sleep, lovesickness, raving, reclusiveness and extreme restlessness (Dols 1992), which may resemble the current diagnosis of hypomania.

In Ar-Razi's opinion melancholia is caused either by the intensification or burning of black bile humour, which impacts and damages the brain. He advised two modes of treatment to address two levels of melancholic effect. For mild melancholia, he recommended keeping the body moistened by frequent baths and, for the severe form, he suggested evacuation of blood (Dols 1992). These treatments used to be given to inmates by frequent cold showers and through *bloodletting* and *leech therapy* (Weiss 1983; Patch 1939; Lone et al. 2011; Banerjee 2001).

The physicians who belonged to the Graeco-Arab tradition adopted the Hippocratic and Galenic approach and explicated and expanded it. Ishaq Ibn Imran's (died in 908) work 'On Melancholia' (*Miqala fi Malinhulya*) is an example. In Galen's view, the soul follows the body's influence, but Ibn Imran asserted that the opposite is equally possible (Dols 1992) and advocated for the possible role of non-pharmacological (psychological therapies) in the treatment of mental disorders.

Sciences of Soul in Muslim Lands

Parallel and intertwined with the psychiatry of the classical Muslim age, the philosophers and physicians continued with their efforts to define notions such as *normal* and *disorder* and to find effective remedies. For the Muslim psychologists, the theories of the soul underlining the dichotomy of the two natures of the things in the cosmos provide the clues to the remedies for problematic emotions. Muslim psychologists understood resentment in society as an aftermath of an imbalance of the equilibrium between soul and body. These forces can be disrupted when their

needs are not fulfilled either material or spiritual. The repercussions of such a disparity are protests, extremism, hue and cry, revenge, lethargy, apathy, lack of interest and lack of innovation and creativity.

The studies of an individual's psychology at a time when elsewhere the disorders were believed to be caused, more often than not, by external forces/spirits, remain a hallmark of Muslim psychological heritage. Muslim scholars studied the self and psyche (*al-Nafs*) to trace the source of disorder. In this regard, the Persian physician, Abu Zayd al-Balkhi (850–934) was amongst the pioneers who discussed disorders related to both the body and soul. According to Haque (2004), the Muslim scholar, Abu Zayd al-Balkhi was probably the first cognitive and medical psychologist to clearly differentiate between neurosis and psychosis. Al-Balkhi classified aggression and depression, in individuals and society at large, as endogenous depression, originating within the body, separately from reactive depression, originating outside the body. Such depressions contaminate the *self* leaving space for *Huzn* (sadness, sorrow or grief) and acute depression which, if not directed wisely, may lead to grievous reaction leading again back to heightened anger causing apathy and loss of hope. Such a dislocated equilibrium and the resultant social imbalance can lead to annihilation of a civilization. Al-Balkhi demonstrated in detail how rational and spiritual cognitive therapies can be used to treat each one of his classified disorders. He focused on the rational along with spiritual therapies because, according to him, a healthy individual always has healthy thoughts and feelings inside. For good personal health, balance between the mind and body is required while an imbalance between the two may cause sickness. Apart from his well-developed therapy for neurotics, Al-Balkhi also repeatedly refers to the emotional abnormalities of normal people, describing them as a diminished form of true emotional illness. He does not speak of the so-called neurotic as a patient, but rather as a person whose emotional overreactions have become a habit.

Emergence of Indian Mental Health Tradition During the Muslim Period in India

Muslim rulers and their armies were followed to India from the adjoining Muslim lands by a large number of traders, religious scholars, mystics and religious professionals. They brought with them the social, intellectual and spiritual baggage of Islam. Muslim rule in India is accompanied by a very rapid growth of cities, particularly in North India. These cities started having sizeable Muslim populations with their own network of mosques, *madrassas* (religious seminaries) and *khanqahs* (centres for spiritual training).

Muslim physicians came to India from Arabia, Central Asia and Persia with a theory and practice strongly impacted by Graeco-Arab medicine. Najib Ud Din Abu Hamid Muhammad Ibn 'Ali Ibne Umar Al Samarqandi (1222) was the one who, according to some researchers, established the Graeco-Arab tradition in India (Syed

2002; Nizamie and Goyal 2010). Najab was inspired by the great Umar Al-Razi's concepts of human nature. In his book, *Kitab Al Nafs Wal Ruh* (The book of Psyche and Spirit), Al-Razi discussed not only different types of human souls but also different types of pleasures (Haque 2004). Al-Razi was of the opinion that as physical human needs and desires cannot be gratified, the mental pleasures are more important to focus upon. By going beyond the desires, like eating, drinking and sexual intercourse (which he calls sensual pleasures), one can achieve the knowledge and excellence in *Ikhlaq* (Morals). Najab described seven types of mental disorders. *Sauda-E-Tabee*, *Muree Sauda*, *Ishk*, *Nisyan*, *Hizyan*, *Malikholia-E-Maraki* and *Dual Kulb*. Najab suggested *Ilaj-E-Nafsani* (literally psychotherapy) to treat these disorders.

Muslim saints in the Indian subcontinent preached humane and compassionate attitudes towards the disadvantaged segments of society. Their Khanqahs and shrines still provide food and shelter to those in need regardless of religious affiliation. Different rulers made efforts to provide care to the mentally ill as well. Some researchers (Sharma and Varma 1984; Krishnamurthy et al. 2000) have traced the earliest institutional care of the mentally ill to the fifteenth century when facilities were established by Mohammad Khilji (1436–1469) with the help of a physician, Maulana Fazlullh Hakimat Dhar, near Mandu in Madhya Pradesh.

Mental Health Problems in Colonial India

It is a widely accepted amongst historians that current services in mental health were set up initially by the British in colonial India (Nizamie and Goyal 2010; Ernst 1991), although there is evidence of a hospital for the mentally ill being established by the Portuguese in the seventeenth century in Goa (Sharma and Varma 1984; Somasundaram 1987; Jain 2003).

History of Modern Psychiatry in India

Mills (2001) traced four broad phases in the history of modern psychiatry in the Indian subcontinent. The first phase was from 1795 to 1857, the second was from 1858 to 1914, the third lasted from 1914 until 1947 and the fourth started at the Independence of India and Pakistan in 1947. Mills dated his history from 1795, as the first facility for the mentally ill was sanctioned by the Governor General in that year. However, for some others, the earliest facility was started in Bombay in 1745 (Sharma and Varma 1984; Weiss 1983; Nizamie and Goyal 2010). Some other scholars (Kumar 2004; Sharma and Varma 1984) report the establishment of a lunatic asylum in Calcutta in 1787 by an English surgeon, Dr. George M. Kenderline. The assistant surgeon of Calcutta, W. Dick Even, established a mental hospital in Kalipauk (Madras) in 1794. These centres were developed because the

British were focused on the coastal cities, Calcutta, Madras and Bombay, on the way to establishing their stronghold in the Indian subcontinent. Later, many more asylums were established but only two in those regions which were to be included in Pakistan, one in Lahore and the other in Hyderabad.

As far as the quality of treatment administered in asylums is concerned, we should remember that, historically, the development of mental asylums coincided with political development in India. In the second half of the eighteenth century, the Mughal Empire was in a decline. The Marathas in Central India, the Sikhs in the North and the French and English in the South were struggling to gain control of ever greater areas. The British East India Company in the South founded the asylums like those in other parts of the British Empire (Weiss 1983), and they intended primarily to segregate those lunatics considered as dangerous to others. The mental health facilities in Madras, Calcutta and Bombay were privately run until 1800 (Ernst 1991), and it was considered a lucrative business.

After control of most of the subcontinent was secured in 1857, new asylums were established (Mills 2001) and a Lunacy Act introduced in 1858. The Act was modified first in 1888 and again in 1912 (Somasundaram 1987). The number of asylums rapidly increased until 1914, after which the focus shifted to expansion of existing facilities and quality of treatment. In 1920, the ongoing efforts of a British Army Psychiatrist, Lt. Colonel Owen Berkeley-Hill, were successful and the term 'asylum' was changed to 'hospital'.

Ranchi European lunatic asylum started receiving inmates in May 1918. In October 1919, Berkeley-Hill was appointed as the medical superintendent (Nizamie et al. 2008). He remained in his post for fifteen years. As it was a hospital exclusively for Europeans, many new services were introduced to India from here. Treatments included rest, morphine and organo-therapy and also exercise, excursions and amusements. The facility for male–female socialization, occupational therapy, hydrotherapy, use of psychoanalysis and the use of cardiazol and the ECT were the salient features of Ranchi asylum. Berkeley-Hill founded the Indian Association for Mental Hygiene in 1922. In 1929, cottages were built to house inmates with their families. The facilities available in Ranchi were not comparable with any other asylum in British India.

Development of Mental Hospitals in Punjab and Sind

At the time of partition in 1947, there were about forty mental asylums in India. Northern India, which formed the current Pakistan, had only two; one in Lahore (established in 1840) and the other in Hyderabad (established in 1865).

Lahore remained outside of British control until ten years after the death of Maharaja Ranjit Singh in 1839. The psychiatric treatment of mentally ill had started in 1812, when a Hungarian physician, Dr. Johann Martin Honiberger, joined the Court of the Maharaja Ranjit Singh. This facility existed for few years but collapsed on Honiberger's return to Europe (Jain 2003). Dr. Honiberger passed on twelve

'epileptics and idiots', who were kept in a stable attached to Raja Suchet Singh's palace, to Dr. C.M. Smith, the first ever appointed civil surgeon to Lahore (Patch 1939; Banerjee 2001; Punjab Institute of Mental Health). Dr. Smith introduced hydrotherapy to Lahore. Between 1849 and 1857, the number of inmates increased from 12 to 85, but the stable could only accommodate 40 inmates. It became difficult to keep proper hygienic standards. These inmates were then moved to another building known as Congee House. Within only six years, the inmate population increased threefold. Due to the increased number of mentally ill, some were being kept in another facility, near the Anarkali Bazar, a well-to-do locality of Lahore. But their presence disturbed the residents of the area so they had to be moved again in 1863 to a place that had been an inn and then into a prison. This facility was uncared for during the period, 1863–1900. In 1900, Lieutenant Colonel George Francis William Ewens was appointed as the superintendent of Lahore mental asylum. He is best known for his report on the microcephalics of Shah Daula (The Chuas of Shah Daula). He wrote an account on insanity in India, published in 1908 under the title, *Insanity in India. Its Symptoms and Diagnosis, with Reference to the Relation of Crime and Insanity.*

The quality of administration and treatment was very low. Lt. Col. C.J. Lodge Patch was appointed as the medical superintendent of Lahore Mental Hospital in 1922. He describes his first visit to the hospital as horrifying (Patch 1939). The patients were naked and handcuffed. They were restrained and being put into seclusion for minor or no reasons. They would crawl on their knees like cringing dogs to touch the feet of the superintendent to avoid punishment.

The mental asylum in Hyderabad did not attract as much attention from researchers as did Lahore. The asylum opened in 1865; however, its building was further extended in 1871. A donation of Rs. 50,000 by a Parsi philanthropist from Bombay, Cowasji Jehangir Readymoney, funded construction when the Government of India provided only Rs. 8000 (Talpur 2007). The asylum was named after him as Cowsji Jehangir Mental Hospital. There were eight wards for natives and a separate ward for Europeans. However, the condition and size of building was considered inadequate in an 1874 report by W. Thom, Surgeon General of the Indian Medical Department (Annual Administration and Progress Report on the Insane Asylums in the Bombay Presidency 1873–1877). The report confirmed that the inmates worked as labourers in the extension of building. The Muslims comprised 66% of its population. In Sind, the Hindus used to keep their insane at home. Dementia and mania were the common forms of insanity. The majority of inmates were *fukeers* (beggars), others rarely were admitted. The treatment was described as a combination of kindness and firmness, known in Europe as moral treatment. However, as the superintendent reported, the main mode of treatment was physical labour. The annual report (1875) described employment in the garden for males and grinding of corn for females as the chief work. In a 1904 report, the inmates were listed as coming from distant regions of India, Kurrachee (Karachi), Rohri, Sukkur, Larkhana, Thar and Parkar, Baluchistan, Kandhar, Punjab, Marwar, Lucknow, Muradabad, Bombay and Savantvadi. The numbers fluctuated; 65 inmates in 1874, and 52 in 1904. In the 1904 report, the

inmates were listed by occupation: cultivators, clerks and artisans. However, mendicants (10) were the largest group. It is clear that the inmates come from lower socio-economic class (Annual Administration and Progress Report on the Insane Asylums in the Bombay Presidency 1904).

The superintendent's reports confirm the salient aspects of Ernst's (1991) study. First, the development of these asylums coincided with the advances of the British across India. Second, the focus was more on the custodial service than on curative. Third, the large asylums, initially built in Calcutta, Madras and Bombay, were to serve Europeans; natives were admitted but at later stages. Fourth, the natives were kept separately from Europeans. The development of Ranchi asylum as exclusively for the non-natives was an example of racial discrimination. Fifth Europeans were divided into first-class and second-class categories. The first class was drawn from the European officers who would have diagnoses such as *temporary weakness, nervousness, fatigue or affected intellect.* They would stay in India for brief treatment. However, second-class patients belonging to the working class were described as '*perfect Idiots*' and '*maniacs*'. Their presence in India did not support the idea of white superiority over the natives; so they were compulsorily repatriated to asylums in Britain (Ernst 1991).

Emergence of Modern Religion-Based Psychotherapy

The war of 1857 ended Muslim control and ushered in Hindu domination. The revivalist movements of Aligarh and Deoband show the process of consolidation and retorting simultaneously. Since the response was on religious lines, it generated a sense of community within religious communities. The multifaceted revivalist movement created a wide array of intellectual and political response, ranging from efforts of Sir Syed Ahmed Khan, the Kilafat movement and other pan-Islamist movements. That can be read as an attempt to put the trauma of losing power behind. However, continued colonization botched the process expansively. It was in this environment that we see the *Ulema* (religious scholars) and *Mashaaeikh* (spiritual gurus) engaging themselves with the Muslim community on mental health issues. While with the abolition of 'waqf/trust endowments' by the British, the endowments of Islamic institutions of learning and outreach suffered a great blow. The resurgence of Muslim community feeling and the somewhat improved economic condition of Muslims in some areas witnessed the emergence of Muslim philanthropy aimed at helping the destitute and needy, including the mentally ill.

Muslim religious scholars recognized the misery suffered by those with mental health problems and established the necessary facilities. One of the best examples is the *Khanqah Imdadia* established by a leading religious scholar of India, Ashraf Ali Thanvi (1863–1943). His methods of teaching spiritual enhancement are explained in his two books: *Tarbiat-Us-Salik* and ***Bawadir un Nawadar***. Dr. Azhar Rizvi (1936–2008) translated the salient notions of Thanvi into modern therapeutic terms (Umar and Tufail 1999; Rizvi and Tufail 2012).

In Thanvi's normative view, abnormality is caused by deviation from *Quranic* standards of good human beings. Deviation from them creates a distance between the Creator (God) and the creation, which is the root cause of all the sufferings. The foundation of mental health problems is laid down with irrational thinking and unreasonable behaviour (Rizvi 1999). A healthy person is one who is well able to differentiate the rational mode of conduct from the impulsive one. People suffering from some form of confusion or a mental disorder used to contact Thanvi for help in two ways; either by writing to him or by meeting with him.

A questionnaire was developed to collect basic information about the sufferer. Before talking to the individual, he would inform the person that his services neither guarantee any rescue for the day of judgement nor any benefit in this worldly life. The *Murshid* (spiritual guide) will neither pray for the cure nor do anything for the individual except referring him to the right instructions and resources. The cure would lie in individual's will and effort. He would recommend books to people, some of his own and some written by others, such as Abu Hamid Al-Ghazali (1058–1111), particularly *Kimiya As-Saadah* (Alchemy of Felicity). According to Rizvi (1999), Thanvi himself wrote around eight hundred small- and medium-sized books. Rizvi (1999) called this approach as *Khwanai Tareeqa-e-Ilaj* (Reading Therapy), which is very similar to contemporary 'bibliotherapy'. He emphasized the importance of the individual's own narrative, an account of his problems, desires, observation, thoughts and concerns, written daily, at a set time of his choosing. The individual would be asked to pay attention to suppressed expression.

Thanvi's approach to therapy for mental disorders provides the cognitive structure and emotional strength through faith in God. His advice to participate in all life's activities was meant to bring the individual out of disorderly inertia.

Mental Health in Pakistan: Post 1947

Institutions

Gadit (2007), charting the history of public psychiatric facilities, describes the state of affairs in 1947, when there was a total of 2000 beds for a population of more than 100 million. The asylums were in a neglected condition, there were few qualified psychiatrists, and patients were managed by minimally trained doctors. These hospitals were called 'Mad Houses' in the local languages and patients could be admitted in chains. There was very little change for the first 20 years of Pakistan's existence. Much of mental health care continued to be provided by unregulated practices based on concoctions of traditional influences described in previous sections. This continues to be the case for a large proportion of Pakistan's rural population today, as most modern facilities are concentrated in urban centres. Karim et al. (2004) divide such practices into religious and traditional. They

describe religious healers as usually the first healthcare contact, particularly for the mentally ill. The system has its own popular aetiologies, such as 'evil eye', bad wishes from others, and machinations of sorcery. Usually, the solution would involve religious talismans and reciting holy verses.

There are many types of traditional healers. Karim et al. (2004) describe the spiritual healing and healers. *Khalifas* and *gadinashins*—'the person who sits on the master's or teacher's seat' and commonly applied to people who have inherited the craft of healing. Magic and sorcery, as well as spiritual power associated with the saints, is used to 'heal' patients. *Hakims*, adherents of Ayurvedic or Greek medicine, are formally registered with the Pakistani Medical and Dental Council as practitioners of alternative medicine. Other 'alternative' healers include homeopaths, practitioners of Chinese herbal medicine and acupuncturists. The anecdotal evidence suggests that the number of these traditional healers has significantly increased, mainly due to the soaring costs of allopathic medicine and modern health services. There is a large increase in the demand for formal psychiatric services as well as traditional healers.

Concerning modern facilities, Gadit (2007) dates the beginning from the establishment of the psychiatric units at the Jinnah Postgraduate Medical Centre, Karachi, in 1965 and the Government Mayo Hospital, Lahore, in 1967. Although the shortage of mental health specialists was a problem, such units were set up all over Pakistan in large teaching hospitals. Currently, there are over 20 such 'teaching' departments (Gilani et al. 2005), with 4100 beds in the public and private sector, and about 342 practising psychiatrists, mostly located in major cities.

Many small psychiatric hospitals have been opened throughout the country, privately run in most cases by psychiatrists and allied mental health professionals. Though still very small, the private sector has started playing a major role. Lately there has been a significant increase in self-help techniques described through television and the emergence of 'soft psychotherapy' services in the form of courses like sleep management or 'yoga' as well as inspirational speakers.

Mental health care is therefore a patchwork of care. However, in the last three decades, influenced by the World Health Organization (WHO) and other developments in the field, primary care and community-based models have been tested. Karim et al. (2004) give two examples. The first is the community-based model established at the Institute of Psychiatry, Rawalpindi, in collaboration with the WHO (Mubbashar et al. 1986). The model grew out of dissatisfaction with centralized, urban, hospital-based models. Specialist professionals are in short supply, numbering less than one per million. The community or primary care model attempts to bring care within the reach of the mass of the population by integrating mental health care into the primary care network with support from specialized personnel. This approach has required changes in roles and training, and a focus of health workers on preventive aspects of care and community involvement. The second model is that of collaborative care in partnership with religious and traditional healers (Saeed et al. 2000). This was demonstrated in Rawalpindi where faith healers were given brief training in recognition of the more severe mental disorders (severe depression, psychosis and epilepsy) and referral to the specialist centre,

while continuing to help patients with common mental disorders. In one district, faith healers referred 25% of their clients to the specialist centre (Saeed et al. 2000). Unfortunately, these models have not yet been scaled up beyond the demonstration stage.

However, a lot of research has been carried out in Pakistan, which shows great potential for primary care and community-based services, demonstrating that it is possible to deliver effective interventions through non-specialist health professionals and community-based agents. The main challenge is the scaling up of these promising interventions.

Resources

Since independence, the number of trained mental health professionals has increased gradually, but has seen a much larger rise in recent years due to the introduction of postgraduate training programmes. Following the development of structured training programmes in teaching hospitals, the College of Physicians and Surgeons of Pakistan began to confer postgraduate psychiatry degrees in the 1980s. Similarly, many universities in Pakistan deliver training and professional qualification in clinical psychology. While this has led to a large increase in the number of mental health specialists, further improvements are needed, for example in uniformity of service delivery structures across the country.

Developments in Mental Health Policy and Legislation

A National Mental Health Policy (NMHP) was devised in 1986 but not fully implemented until 2001 (Karim et al. 2004). A National Mental Health Programme was also devised and implemented in 2001. Its strategic goals included the improvement of mental health and the reduction of related disability, mortality, suicide and substance abuse. It also aimed to prevent illness, promote mental health and care for the already ill. The programme emphasized community and primary care services, and it was envisaged that the departments of psychiatry would train and supervise primary care staff (physicians and community health workers) (Gilani et al. 2005). The importance of including spiritual healers in the mainstream health care and referral system has also been recognized in the programme as they are frequently the points of first contact. The programme also covered the links between the health sector and other organizations such as the police, prisons and social welfare organizations. In 2011, the Federal Ministry of Health, under whose authority the NMHP was to be administered, was abolished and all health matters were transferred to the four provincial ministries of health.

The evolution of mental health legislation demonstrates the low priority given to mental health. According to Gilani et al. (2005), until 2001 the relevant law was the

Lunacy Act of 1912. After the partition, Pakistani mental health law continued to be based on this relic, with sporadic changes made in the light of drastically changed conditions. The 1912 Lunacy Act, however, remained in effect, despite occasional protests by the medical profession and citizens. On 20 February 2001, the Pakistan Mental Health Ordinance came into effect, replacing the 1912 Act. The ordinance has brought about significant changes in the law 'relating to mentally disordered persons with respect to their care and treatment and management of their property and other related matters' (Gilani et al. 2005). For example, it is mandatory to have 'informed consent' for treatment; there are limits to the period of involuntary detention to a maximum of 72 h during which time examination by a qualified mental health practitioner is mandatory; and it is a criminal offence to make false statements about someone's mental state with the purpose of exploitation, punishable with up to 5 years imprisonment (Gilani et al. 2005).

Mental Health Challenges in Today's Pakistan

A Glimpse of the Contemporary Mental Health Picture

During recent years, many epidemiological studies have been carried out. A systematic review of prevalence and risk factors for anxiety and depressive disorders (Mirza and Jenkins 2004) found an overall mean prevalence in the general population of 34% (range 29–66% for women and 10–33% for men). Factors positively associated with these disorders were female gender, low level of education, financial difficulty and relationship problems, suggesting that social factors play an important part in the aetiology of anxiety and depression. There is a strong feeling in the research community that the exposure of Pakistanis to serious bouts of sociopolitical instability, economic uncertainty, violence, regional conflict and dislocation during the last three decades has contributed to these high rates. In Pakistan, an unusually high percentage of the population has been exposed to violence, related to wars in Afghanistan and to huge disasters such as the 2005 earthquake in which more than 78,000 people died and the massive floods of 2010 and 2011. All these events caused population displacement, producing post-traumatic stress disorder (PTSD). Pakistan now houses about five million refugees, the highest number in the world. The violence has also increased due to increased weaponization creating high levels of insecurity, particularly for high-risk communities. A cross-sectional survey of Afghan women in a refugee camp in North West Pakistan showed that 36% screened positive for a common mental disorder and over 90% of those screening positive had suicidal thoughts (Rahman and Hafeez 2003). In the tribal areas where the Pakistani army is engaged in the war against the Taliban, 65% of women and 45% of men suffered from severe mental distress (Husain et al. 2007). Karachi, the largest city of Pakistan, has been experiencing violence sporadically for the last three decades, with serious implications

for the mental health and morale of citizens, including medical professionals. A survey of medical students in Karachi found 70% to be suffering from anxiety or depression (Khan et al. 2006), compared to 13–25% in US and Canadian medical students (Dyrbye et al. 2006). A similar survey of Karachi's family practitioners found 39% suffering from these conditions (Khuwaja et al. 2004).

In the current context of conflict, natural disaster and fragile health systems, the most vulnerable groups are women and children. The rates of perinatal depression in Pakistani women are amongst the highest in the world (Klainin and Arthur 2009), ranging from 18 to 30% in urban areas and 28 to 36% in rural areas (Karmaliani et al. 2009; Husain et al. 2006). About 11% women in one urban sample of 1369 had contemplated suicide during pregnancy (Asad et al. 2010). Perinatal depression has been found to be strongly and independently associated with infant undernutrition in Pakistan, making it a public health priority (Patel et al. 2004). Half of Pakistan's population is below the age of 18. Estimations of the prevalence of emotional and behavioural problems in school children in the last two decades suggest an almost threefold difference from 9.4% (Javed et al. 1992) to over 30% (Syed et al. 2009). There are no reliable estimates for prevalence rates in children not attending school. The rate of severe intellectual disability (ID) in children is 1.9% and mild–moderate ID about 6.5% (Yaqoob et al. 2004; Gustavson 2005), both associated with very high levels of parental mental distress (Mirza et al. 2009). In the absence of child mental health professionals, general practitioners and paediatricians manage these disorders. But in one study in Karachi, over 80% of such professionals surveyed were found lacking the knowledge to diagnose attention-deficit disorder and learning disorders in children (Jawaid et al. 2008).

Socio-economic Backdrop of Mental Health Problems

Pakistan has witnessed the twin phenomena of rapid overall population growth and urban growth during the last four decades, which has increased urban poverty. In addition to the two high-risk groups identified above, urban youth could also become a high-risk group. The mental health of youth is crucially important for the future of the country since economic progress, national cohesion and social peace depend in substantial measure on the success of providing opportunities for them to enter into national life. It is a commonplace observation that the young people play an active part in political violence. The presence of a youth bulge in fact historically has been associated with the periods of political crisis. With a median age of 21 years, Pakistan's population is one of the youngest in Asia. About 65% of Pakistan's population is below 30 years, and those between 15 and 29 constitute about 30% of the population.

This surge of adolescents virtually guarantees that the number of educated youth will outpace employment growth, leaving even educated young men underemployed and resentful of those who enjoy the opportunities they lack. While not the

prime cause of armed conflict, these demographic factors can facilitate recruitment into insurgent organizations and extremist networks or into militias and political gangs. They can also promote the positive public action that is needed for a robust democratic system. Recently, a survey of youth and young adults aged 20–34 was conducted in Karachi (April 2011) seeking information on their demographic, economic, social backgrounds, religious practices, perception of the current conditions, future prospects for the country and for themselves, their opinions about the key players in the country (such as politicians, and the media figures) and attitudes about entrepreneurship and its potentials. The survey found the youth tended to be more tuned towards religious practices. The majority of them used and had access to the Internet and mobile phones. Most of those surveyed were single and living with their parents and let the latter make decisions for them and 31% of the males were unemployed. Most of the unemployed were uneducated, most wanted government jobs. An intention to start a business was not strong. Most respondents were very concerned about overpopulation. Almost 36% males and 36% females said that the situation in Pakistan is going to grow worse and that is the cause of anger amongst youth. With poverty and conflict deeply impacting the social fabric, such a bleak psychological picture presents a daunting public health challenge to the government and the health services.

Future Mental Health Policy Challenges for the Government

In spite of being a low priority for governments in Pakistan, mental health has seen positive developments in service delivery, policy, legislation and research. However, developments have been patchy and only a small proportion of Pakistan's population is able to access care. Researchers and policymakers will need to consider key issues, such as scaling up care services in areas affected by conflict and disaster; supporting and strengthening health systems; ensuring equity and quality of health interventions; and developing means of financing such programmes in a sustainable fashion. The needs of vulnerable groups, notably women, children and displaced populations, need to be given priority. Researchers should also explore alternatives to health systems for the delivery of mental health care, utilizing existing community and family support. The capacity of traditional healers to provide therapy for anxiety and depression (Saeed et al. 2000) and of the family to support the pharmacological treatment of schizophrenic patients has been researched and found to be effective (Farooq et al. 2011). However, much more needs to be done by researchers, policy experts and the international community before tangible relief can be provided to the millions suffering from mental health problems.

Contemporary Debates and New Research Challenges

Role of Colonialism and External Environment in Creating Mental Health Pathologies

Contrary to the traditional preoccupation of the psychiatric establishment in Pakistan with biological causes of mental health problems, for the past three decades more and more analysts seek to relate an increasingly dire mental health situation in Pakistan to the external environment of sociopolitical upheavals the people have gone through. There are several social scientists who go even further back in the history and propose that the state of mental health in Pakistan was an outcome of the perpetuation of colonial setting in today's Pakistan (Syed 2012b). The contributions of writers such as Mannoni, Fanon, Bhabha and Ashish Nandy are very popular with this group of Pakistani psychologists. At a more popular, one would say journalistic, level colonializm is considered responsible for the production of a shifty character which reduces the possibility of a consensus at the group level, eventually creating a split personality, with alienation embedded deep in the personality. Colonial oppression makes the individual an eternal disbeliever, a cynical manipulator, whose habit of using hypocritical coping mechanisms, learnt during the colonial experience, makes trust disappear from the community. As the successor to the British colonial empire in Pakistan retained most of the features of colonial governance, especially its civil service and natural leadership, the hypocritical coping mechanisms continued having a central place in the personality of many Pakistanis. Establishment of socially emancipating democracy could have supplanted this mindset, but it did not happen.

The issue of the nature of continuity between the structures of control from the colonial to the post-colonial periods has been tackled less in research than in disputational discourses. As a result, the debate has become more of a philosophical debate, unable to impact upon public health policy and practice in any significant way. One 'popular' view in this regard is that Pakistan qualifies as a neocolonial state, where former colonizers with the new emerging empires (particularly the US) would keep playing the key role in deciding economic systems and political and cultural structures. The new structures of control would exercise their control through non-governmental organizations and multinational corporations. These interactions and entanglements between the local, national, regional and international have produced a muddled, ambivalent, multilayered interdependence as suggested by Ashish Nandy in his book, *The Intimate Enemy*. The success of these neocolonial masters, armies and militias, as this narrative continues on, depends on their ability to maintain if not war, then this war-like situation, which they are doing in the streets of Pakistani towns and villages. Many consider this situation as the principle cause of post-traumatic stress (Syed 2012b).

Another popular view talks less about the international imperatives in Pakistan's affairs and puts the blame instead on a 'security oriented' state, which capitalizes on the tensions with India to justify its salience and the attendant anti-democratic

environment, inherently oppressive in nature. Both these narratives, however, agree that the local elites, who cooperated with the neocolonial masters and/or the security state, were allowed to continue with their own oppressive, feudal tradition and mindset. In the name of saving the country or Islam, the religious were found, more often than not, standing with the state and its elites than with the proponents of social emancipation. All these debates, ,however have not produced any significant call for collectively jettisoning these historical burdens. The Pakistani mental health establishment so far has been largely immune to these theoretical debates. However, as the now an extensive literature appears, particularly in the USA and Europe, relating the political environment to the incidence of mental health problems, Pakistani mental health professionals may rethink the situation and retool their techniques.

Cultural Conflict Causing Mental Health Pathologies

In the Pakistani context, traditionally, the oppressive family/community environment is identified by Western trained psychiatrists as an important cause of mental health problems in Muslim societies. The opponents of this view underscore the positive therapeutic role of the family and community in resolving conflicts and stresses which could otherwise grow into severe mental health problems. The narratives about the nature and quality of the social environment have become a site of conflict between the modernists and traditionalists in Pakistan, where the former would like the traditional cultural environment to make way for a modern social environment, putting individual freedom above family and community. As the feeling of living under an oppressive social environment can create politically inclined reactive sentiments such as anger, frustration, helplessness and apathy, these conflicts have become the means for winning the soul of Pakistanis. As the modernists dominate the cultural discourse in Pakistan, particularly in urban settings, and in their zeal to create strong sentiments against the traditional culture, the view that 'everything is wrong and rotten in Pakistani society' has possibly created an acquired helplessness, aggravating the mental health picture in Pakistan.

As the 'informal psychotherapy' market in the West flourishes with religion, religious and motivational authors/speakers and spiritual healers, Islamic psychotherapy is gaining respectability in Pakistan in rich urban settings too, complicating the relationship between tradition and modernity and instrumentalizing the faith in the process.

In case of the traditional, religiously embedded spiritual psychotherapy, individual agency and suffering are embedded in a paradigm in which most of the socio-psychic stresses are approached from a faith-based perspective, putting a premium on the family and predestination. As faith and family both exist in Pakistan in a fairly robust way, these may be preventing the individual's psychological problems from becoming severe, which in turn could lead to suicide or

rampant deviance and a heavy public health burden. One often hears, however, the lament that both the faith and family are becoming weak.

It is, however, an open question whether the incidence of mental health problems is greater in Muslim developing countries compared to non-Muslim ones, with whom they share more than they share with the West. Doing a different kind of typology may yield better insights into the management of mental health problems. In any case, emergence of modern technology-based fields of shared meaning in developing countries may result in the emergence of stronger social/mass pathologies, assuming oppressive characteristics; this requires much more cross-national research and learning.

Finding Common Ground for Better Mental Health Tomorrow

Despite the divergence in the general approaches towards mental health of the Western and Islamic traditions, they share many features. Thanvi's approach outlined above, for example, is close to the now widely practiced cognitive behavioural therapy (CBT). Both work to cure as well as to prevent. However, as the ethos of CBT could be vastly different as between a predominantly Muslim and a non-Muslim context, serious efforts have been made, particularly in the USA, to modify CBT and to embed it in the Muslim faith and social environment; many researchers have reported positive results (Hodge and Nadir 2008).

There is a popular adage in Muslim psychology literature that emotions should be subservient to reason and that reason should be governed by the revelation. This is also the reason that Muslim psychologists, believing that the emotions and moods are influenced by patterns of thinking, focus much less on past events in a patient's life, such as childhood experiences. They tend to put a premium on the here and now, helping the patient realize the spiritual relationship with God by explaining to him/her the limitations his/her agency as an individual. In the West also, there is a growing debate on the moral dilemmas caused by an unbridled freedom of the individual, a thing considered sacrosanct in the West.

Akhter Ahsen, an eminent American psychologist of Pakistani origin and the founder of eidetic psychotherapy, is an excellent example of someone who combines Eastern philosophy and Western methodologies in psychotherapy (Ahsen 1977, 1986, 1987, 2005, 2010; Hochman 1995). In his theory and therapy, he attempts to bridge the theoretical gaps that not only show the cross-cultural efficacy of his model but also to develop a holistic approach (Dolan 1997). His model has been adopted for a wide range of problems and populations, for example, people with intellectual disability both in the West and in Pakistan (Bent 1995; Syed 2012a).

The job of Western and developing country psychotherapists has, however, been made more difficult by the emergence of newer kinds of globalized lifestyle, linked

to social pathologies like negative thinking, which become a fertile medium for serious mental ailments in developed and developing countries. The political implications of cynicism in a society are quite well studied, but there is much less research on the linkage between cynicism and deviance on the one hand and depression on the other hand. Cynicism towards national institutions and desire to emigrate from Pakistan might represent a symptom of widespread anxiety; and acquired helplessness could be the deep cause of the anxiety.

The media and mass culture are producing a personality type which is given to satire, cynicism and hyperbolic language in which the words of killing and dying are used so easily. This language pervades magic realism, particularly in the lives of young inhabitants of the virtual world. The psychological impact of these new realities is also another common challenge for soft, socio-psychic pathologies. The linkage between the social environment and individual pathologies, where the former is so radically changing due to social media, remains an area which calls for much more research so that the epistemic frameworks used in training and practice can be better adjusted to the lived realities of the population.

In short, the political anthropology of mental health is a very controversial subject in Muslim countries due to a continuing conflict between tradition and modernity, and this needs much more research. In a globalized age, Muslim countries like other countries are subject to a plethora of influences for change. The polarization on the questions of aetiologies and remedies has created a stalemate, which is helping nobody. Indeed, it has produced policy paralysis. Further, legislation takes decades to change. The resources allocated to mental health establishments are meagre and very few doctors opt to become psychiatrists. The vacuum thus created would be better filled with scientific research than the quackery of healers of assorted types.

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Chapter 3
Psychiatry in India: Historical Roots, Development as a Discipline and Contemporary Context

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Abstract The authors provide an overview of the development of psychiatric services in India. They track the early developments in ancient and medieval periods, and after Western medicine made its appearance. Lunatic Asylums were established in India by the East India Company, and extended to various parts of the country, under British rule. The spread of medical education and services was quite slow, and there were very few psychiatrists, and a small number of beds by mid-twentieth century. Publicly funded universal health care, planned on similar lines as the NHS at the eve of Independence, did not develop sufficiently in subsequent decades. Economic and social disruption, and low priority to spending on health care thwarted efforts at extending the services. The development of pharmacological treatments in the 1950s raised the possibility of general hospital-based

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psychiatric services, at least of severe mental illness. Importantly, efforts to understand the psychosocial causes and correlates of both common and severe mental disorders were slow to develop. There was unease expressed with 'Western' models of psychopathology and intervention, and there were attempts at incorporating indigenous ideas and philosophical traditions. These remained sporadic, however, and did not give rise to any pan-Indian approach to understanding psychiatric illness or its cure. Although epidemiologic rates for psychiatric disorders are lower than in high-income countries, the rates in India are higher compared to other average Asian prevalence rates. However, there have been few concerted efforts at understanding these differences and the local psychosocial factors producing psychiatric illness. Further, inadequate human resources to deal with the existing problems and serious operational problems with the National Mental Health Programme are ground realities. The growing number of private for-profit and not-for-profit mental health facilities is welcome as some have innovative mental health care reach-out strategies. However, they also remain a cause for concern due to their poor regulation and sometimes human rights violations. The new mental health policy hopefully provides a framework for better partnership, quantity and quality of care. With the re-emerging interest in global mental health and 'universal' treatment guidelines, it is an appropriate time for serious reflection on the way forward and to examine the relevance of local and sociocultural contexts in understanding and treating psychiatric illnesses.

Introduction

The profession and practice of healing people with abnormal behaviours have been present, in some or other form, in all advanced civilizations from antiquity. The evolution of these disciplines has been influenced by, and has in turn influenced, social, political and scientific developments. Tracing the continuity and confluence of such ideas can help us understand prevailing notions of the mind and insanity, as well as the spread of concepts of mental health across cultures.

In this chapter, we trace the growth of psychiatric thought and practice in India from both a historical and contemporary perspective. We explore the indigenous concepts and approaches to mental illness in India, the impact of European colonialism and Western psychiatry, and, finally, the patterns of policy and care since independence in 1947. We look at the importance of transnationalism more broadly, from war and migration to the 'global mental health' movement of the present day, and examine major themes within India itself: provision of culturally appropriate psychosocial care and modern patterns of policy and practice. We finish by outlining the future prospects and challenges faced by psychiatry in India.

Traditional Conceptions of, and Approaches to Dealing with, Mental Illness

The notion of a disturbed mind occurs in the oldest texts in South Asia, the Vedas and the Upanishads, and the word 'Unmada' (disturbance of the mind) is mentioned in the Vedic texts. The Charka Samhita, the major text of Indian medicine, devotes a chapter to *bhutavidya* (roughly equivalent to 'demonology' in the pre-Renaissance period in Europe) and was already well known by 400 AD. It included separate sections on insanity and its diagnosis and treatment. These medical perspectives, from Buddhism, Jainism and Ayurveda strongly influenced each other, and travelled via Buddhist mendicants, merchants, craftspersons and soldiers as far as Mongolia in the east and Persia to the west (Jaggi 1977). Various other references to disordered mental states are made throughout India's classical literature, through to the Bhagvad Gita, which has been described as a 'classical example of crisis intervention in psychotherapy' (Thara et al. 2004).

The spread of Islam to India had a profound impact on several aspects of Indian society. The Arab world had long served as a conduit for ideas between India and Europe, and Muslim physicians continued to preserve the names of some of the foremost Indian healers—Charaka, Sushruta, Vagabhat and others—borrowing suitable material and incorporating it into their own systems. The works of Rhazes and Ibn-Sina were widely used in south Asia, as the Unani system evolved over the last millennium. Knowledge, and the work of medical professionals, tended to be restricted along caste, clan or religious lines, and divisive feudal social structures precluded the idea of public hospitals and public health services.

The Introduction and Growth in Influence of Western Psychiatry

By the time of the great Moghul emperor, Akbar, in the second half of the sixteenth century, European medical doctors had already made an appearance in India. Garcia da Orta, practising in Goa, had extensive contacts with Indian physicians. He published his *Colloquies* in 1563, which relied not only on Western and Arab teachings but also on the practical teachings of Indian indigenous practitioners known as vaidyas, munis, hakims and herbalists (Da Orta 1987).

The secularisation of the European mind over the next few centuries had a dramatic impact upon medicine both in Europe and, via colonisation, on the rest of the world. One of the outcomes was the setting up of European-style asylums around the world. The growth of contemporary psychiatry in South Asia is organically linked to the setting up of such asylums, which was one of the earliest forms of public health service in India. As the East India Company established itself

in India, the first asylum was set up in Calcutta in 1787, followed by others across the subcontinent, from Lucknow to Madras (Mills 2001; Ernst 1991, 2013).

This period was marked by a very rapid expansion of asylums for the insane and characterises the beginning of state involvement in the management of mental illness (Bhugra 2001). The East India Company also introduced specific laws relating to admission into asylums in India, earlier than several such laws in England (e.g. the Poorhouse Law). Asylum expansion, and the care on offer, mirrored to a large extent the situation in Europe at the time, with two notable exceptions: in India, such facilities were established by a corporate body rather than by local government, and Indians and Europeans often had different standards of care and facilities provided. The exclusive European-only asylums were established in the twentieth century, just 50 years before the end of a colonial period of 400 years. There had been suggestions for the building of a large, central, common asylum (guided by the idea of a panopticon) for both Indians and Europeans in the 1840s, but they were not acted upon on grounds of expense, with political, and racial concerns, likely also playing a role (Ernst 1991, 2001).

Conditions in asylums built for the Indian population were poor, with many of these institutions staffed by semi-trained or untrained personnel and functioning as little more than 'refuges or receptacles' (Ernst 1991). However, other evidence from annual reports of these hospitals suggests that recovery rates were good, and death rates declined and increased in tune with general population trends, especially in relation to epidemics such as cholera. In general, the conditions were comparable to general health of the country at that time, no better or no worse than rest of society. Inquiries into the running of these asylums were held at regular intervals after the transfer of power in India, in 1858, from the East India Company to the British crown. Inspections of these facilities were mandated by a new Indian Lunacy Act in 1912 passed in part as a result of public pressure for improving the conditions of these asylums. Yet despite calls for conditions to be improved—to be brought to the standards of English asylums—as soon as possible (Jain 2003), and suggestions that smaller, local facilities might be the way forward, there was neither the money nor the political inclination for wholesale reform.

The President of the Medico-Psychological Association in the UK, TW McDowell, described the state of psychiatric services in India at the end of the nineteenth century (by which time there were 26 asylums in India) as dismal (McDowall 1897), pointing to the extreme disparity in services between England and the subcontinent: 3–4 beds were available in England per 1000 of the population, while in India, the figure was 1 bed per 71,000. McDowall was specifically critical of the abuse of mentally ill women and suggested that separate asylums, staffed by women, be opened.

The social background of patients was frequently a concern for policy-makers and asylum staff, while rapid social change, the alleged indolence of the population, addiction (especially cannabis), grief and sudden stress were seen as important etiological factors contributing to the development of mental illnesses. The Indian asylum population was overwhelmingly poor and for the most part belonged to the lower castes—to the point where the British started to worry that 'their medical

institutions were being consciously incorporated into the survival strategies' of the economically and socially disadvantaged (Mills 2001). Although in some asylums caste rules interfered with the regimen, several superintendents noted that the mentally ill lost all sense of caste and religion, and could be accommodated together in shared buildings. This was an important step towards the secularisation of medicine in India.

The rise of Indians' involvement in science and medicine in the late nineteenth and early twentieth centuries was increasingly tied, by aspiring Indian politicians, to a nationalist cause, and conditions in India's asylums became part of nationalist critiques of British rule. Across this same period, Indian patients were becoming increasingly aware of the treatment options available to them, choosing pragmatically from amongst secular, religious and folk medical traditions according to cost, trust and reported efficacy. From the First World War to Independence in 1947, increasing numbers of people were placed in asylums by family members, where before it had tended to be Company, and, later state, officials who would make such decisions. This coincided with the entry into the Indian Medical Service, at senior levels, of ever larger numbers of Indian personnel and the provision of basic psychiatric training as part of many doctors' education. A notable example of Indian leadership in mental healthcare services from this period was J.E. Dhunjibhoy at the Ranchi Indian Mental Hospital. In his attempts at pioneering new treatments in India, and maintaining contacts with colleagues in Europe and North America, Dhunjibhoy represented an optimistic mood in India's medical community: a quest for modernity and the seeking of congruence with international standards for Indian healthcare (Ernst 2013; Sarin 2013).

One of the forms of treatment in which Dhunjibhoy showed a degree of interest was psychoanalysis, one of many signs of his privileged cosmopolitanism was that Dhunjibhoy had met Freud personally, in Berlin, and had attended a lecture by Jung (Ernst 2013). Freud's therapy took root in Calcutta, amongst other cities, where Girindrasekhar Bose became the 'father' of Indian psychoanalysis. In addition to treating a wide range of clients, both Indian and European, Bose and his circle were engaged, from the 1920s onwards, in psychological and anthropological research and in the treatment of patients at Lumbini Park Mental Hospital (Hartnack 2001; Basu 1999; Nandy 1995; Harding 2009).

Two British reports offer a window into the state of mental healthcare at this point in India: the Mapother report (1938) and the Taylor report (1946). Professor Edward Mapother was invited to the subcontinent in 1937 by colleagues who had trained at the Maudsley Hospital, and used the opportunity to offer his advice to the Health Secretary for India in London. His acerbic introduction, that 'It would be difficult for the most jingoistic to affirm that, in the matter of provision for mental disorder in India, the British "bearing of the white man's burden" has been quite adequate', sets the tone for his severe indictment of psychiatric care in India. He made sure that readers did not miss the point by emphasising that the state of affairs there 'sets an awkward task for the holders of the moderate view (that) British rule has been a benefit'. The report was severely critical of the facilities, noted the demoralization of many of the staff (who had lost interest in making any reform as

they knew 'their time was up'), and was gloomy about the scale of the problem and the difficulties of undertaking any attempt at improvement (Mills and Jain 2009). This report, and discussions with Moore-Taylor (Superintendent of the European mental hospital at Ranchi), formed the nucleus of the section on mental healthcare provision in the Bhore Committee (see below). Significantly, this blueprint drew heavily on the social psychiatry model developed in London and elsewhere in the UK, later considered to be the solution to problems of social psychiatry the world over (Jain and Murthy 2009).

The Bhore Committee, headed by Sir Joseph Bhore, an Indian Civil Service Officer, was set up by the British in 1943 to address healthcare needs of India. It boasted an impressive group of international advisors, including Weldon Dalrymple-Champneys, the deputy chief medical officer of the UK; John Ryle, the first ever chair of public health from Oxford; Henry Sigerist, medical historian from Johns Hopkins in the USA; JHR Cumpston, who was centrally involved in planning national health care in Australia; Dame J Vaughan, a well-known physiologist and transfusionist; and Joseph Mountin of the US Public Service, who later established the Centres for Disease Control in the USA. Their individual reports and discussions reflect the very poor standards of health care in India at that time, and the lack of public spirit and concern for welfare, particularly of the poor. The need to understand links between poverty, unemployment, inadequate housing and inadequate social security is underscored, as was the importance of not dissociating medical sciences from the biological sciences, the social sciences and the humanities. The critical need for reform in medical care and health services, for adequately trained doctors and specialist education, was another concern (Murthy et al. 2013).

However, as predicted by Dalrymple-Champneys himself, the Bhore Committee recommendations receded into the background after Independence and were only partially implemented. Instead, health care in India has become more and more a capital-intensive enterprise (and increasingly privatised), and all thoughts of a universal and socialised system of medicine have been buried by a succession of committees.

The Impact of Transnational Factors

Macro- and micro-transnational factors have had a significant impact on the growth of psychiatry in India. In the first instance, we briefly highlight the failure of the then practice of psychiatry to acknowledge the cataclysmic and defining moment of India's emergence as an independent country and, in the second, show how Christian missionaries brought new and influential institutions into the country.

The year 1947 was, and will be, memorable because of the fact of India achieving independence from its erstwhile colonial masters. What also needs to be remembered is that this was also the period that witnessed the partition of India.

This partitioning was also accompanied by what was probably the largest and bloodiest transmigration of populations that history had seen. While the accuracy of figures will forever be debated, 'thousands of women were raped, at least one million people killed and ten to fifteen million were forced to leave their homes as refugees' (Khan 2007). What continues to be intriguing to the historian of psychiatry is the fact that despite the cataclysmic nature of the event, and the very obvious fact that this clearly must have dramatically impacted the mental health of vast numbers of individuals, and perhaps be a major influence in the form of transgenerational transmission of trauma, it continues to be unaddressed by mainstream clinical psychiatry. Thus, the disciplines of social science such as sociology, psychology, anthropology and literature have all in their own ways visited the multiple traumas of partition, but psychiatry has been completely silent on this. The reasons for this and the 'unpacking' of this particular puzzle clearly led down many different paths. While an exploration of these may be beyond the scope of this chapter, it is certainly an issue that needs greater attention. An interesting substory is the partitioning of the mental hospitals, with Muslim patients in Indian hospitals being sent to Pakistan, and Hindu patients from Pakistan being sent to India (Jain and Sarin 2012).

Another major context for transnational networks in Indian mental health care around the time of Independence and afterwards was philanthropic and Christian medical care. Western Christian missionaries had been active in India for well over a century by 1947, but relatively little attention had been paid by such groups to psychiatric care. This changed in the 1950s with the establishment of two psychiatric institutions: the Nur Manzil Psychiatric Center in Lucknow that was set up by E. Stanley Hall, under Methodist auspices, and a Mental Health Centre was established as part of the Christian Medical College (CMC) in Vellore. Both institutions drew on extensive international networks for their funds, medical and administrative staff, technology, medicine and training. They were notable too for the fact that their major pioneers, early on, were women: the Swiss psychiatrist, Erna Hoch and, later the British psychiatrist, Margaret Foyle, at Nur Manzil; and the Canadian psychiatrist and psychoanalyst, Florence Nichols; and the child psychiatrist, Rose Chacko, at CMC. A number of Indian personnel received funding for training in the USA and elsewhere, and CMC especially became a centre for the training of Indian doctors in the latest psychiatric theory and techniques. Both institutions aimed to provide low-cost treatment to Indian communities, and both were involved in the advancement of new family and drug therapies (Harding 2011). Prompted by the recommendations of the Bhore Committee which had suggested a centre for postgraduate training for specialists in mental health services for India, the All India Institute of Mental Health (AIIMH) was established in 1954. This provided training in several disciplines, from nursing to biochemistry, and the teaching was broadly similar to the training at the Institute of Psychiatry in London. This became the first established postgraduate centre in post-Independence India and trained an entire generation of specialists in mental health services.

Post-independence Developments

The initial period after independence was too tumultuous, and health care was relegated to the background, as other economic and political issues of reorganisation of the administration took centre stage. In a surprising development, the Indian Medical Service was disbanded (the only erstwhile colonial service to meet this fate). The recommendations of the Bhore Committee were never implemented except in part. In fact, as early as 1951, not long after Independence, the secretary to the committee was already bemoaning the fact that somehow, 'primary health care had been transformed to a primary level of health care'. While there was some provision for those in the organised workforce, the vast majority of the populace were neglected, and equal access to health care was never envisaged. Psychiatric services, being heavily dependent on state support, fared particularly poorly.

As far as the pharmacological revolution of the late twentieth century was concerned, the research of G Sen and KC Bose, RN Chopra, S Siddiqui and RS Hussain on the use of drugs to control symptoms of insanity in the pre-Independence era and, later, clinical observations of RA Hakim and others were not followed up. The rapid availability of antipsychotics in the 1950s that fortuitously corresponded with the first decade after Independence made it quite obvious that mental illnesses could be treated cheaply and effectively by medicines. Thus, the major reason to establish institutional services was taken away, and 'general hospital' psychiatry, rather than 'mental hospital' psychiatry, was proposed to make treatments more accessible in less stigmatised public health facilities. Establishment of general hospital psychiatry units (GHPUs) quickly became the norm leading to a marked expansion in services and human resource development across the country.

The decisive shift towards more accessible mental health services from the late seventies in India was highly influenced by academic institutions and influential leaders who were linked very closely with the World Health Organization's contemporary views. Continuing with this theme of integration of mental health services in primary care, the 'Bellary Model' (training community workers and primary care physicians to manage mental disorders in primary care settings which was trialled for a few years in Bellary, a district in Karnataka, before being closed down) was instrumental in setting the trajectory of national planning of psychiatric services through the National Mental Health Programme (NMHP) initiated in 1982.

The other side of this move towards primary health care was the impact on mental hospitals which, till then, had dominated psychiatric care in India. The appalling conditions and the serious violation of human rights rampant in many of these institutions led to efforts at reforming these through a unique combination of civil society and judicial activism. In addition to the focus on developing services outside of these institutions, the NMHP also aligned itself with the mandate from the judiciary to transform them into more modern hospitals and centres of academic teaching. A few of these institutions have seemingly managed this transition well, though that change also needs to be further interrogated, and have become premier centres of training and academic excellence, but similar change in a substantial

number of other institutions has been painfully slow. In line with the dominant international narrative of deinstitutionalization of care, the number of beds was greatly reduced across the country. This was, however, not accompanied by any efforts to provide alternative housing and other basic social and clinical services in community settings. There is a remarkable absence of documentation of the deinstitutionalization process in India, and there is little information about what happened to the 'deinstitutionalized' residents after their relocation. The currently dominant rights-based policy and service planning discourse are also antagonistic towards these institutions without acknowledging that these are large service providers and repositories of scarce specialist resources that cannot be easily replaced.

There is a pressing need to develop an alternative narrative of change and transition of these hospitals from isolated and stigmatised entities to institutions that are closely linked to both the general health system and the community. In addition, these hospitals could develop and encourage multisectoral collaboration to address the substantial entry (like homeless persons and those in the catchment area) and exit (like supported housing, employment, social security) barriers that the most vulnerable persons with mental illness experience currently.

Trajectories of Social, Cultural, Economic and Political Change as a Context for Development of and Changes in Thinking About, and Responding to, Mental Illness

To illustrate the influence of local social and cultural factors in the evolution of psychiatry and treatment practices in India, we discuss the changing dynamics of a non-pharmacological treatment modalities, such as psychotherapy.

While colonial era psychiatry may be accused of paying too much importance to the exotic aspects of cultural diversity, to promote a notion of the 'native', contemporary ideologies have developed a mirror opposite. The native mind is now seen to need an indigenous framework free from the trimmings of "Western" influence. The links between social change and psychological symptoms have been inadequately addressed. The growth of psychotherapy, thus, has been a very different process from the treatment of the more clearly 'insane'.

Mesmerism had been practised in the 1850s in Calcutta by James Esdaille (Jain and Sarin 2000), while John Martin Honigberger, travelling in the Punjab, had observed healing by spells and suggested that this was much the same as mesmerism. The role of faith and religion in treating hysteria was suggested by some Indian medical practitioners in the nineteenth century. The beginnings of non-pharmacological treatments were thus evident quite early. However, in the twentieth century, except for grossly deviant symptoms, there was little indigenous effort to understand psychological symptoms as a 'given' description of distress, comparable to symptoms elsewhere. Psychological symptoms and signs were viewed with suspicion and often thought to be pretence. Faith healing, whether by

fakirs in Calcutta, or at seances in London, was worthy of contemptuous dismissal by medical authorities. In subsequent years, the progress of physiological and medical science became a focus of the emerging Indian State and the inner psychological space of the patient remained neglected by doctors.

In this context, the advent of Freudian theories and psychoanalysis had an influence on Indian practice. Girindrashekhar Bose's Indian Psychoanalytical Society was established in 1922, and a very small number of practitioners were trained. Bose corresponded with Freud, but differed on the issues of repression and the universal applicability of certain concepts. There were not too many adherents to the school, and its clinical impact has been limited. Others, like E. Berkeley-Hill, commented on psychoanalytic aspects of both Hindu and Muslim life and tried to find cures for that most troublesome of afflictions: Indianness. Practitioners like D Satyanand tried to develop models of dream analysis that included both religious and political overtones, but these remained very isolated developments. Scepticism regarding psychoanalysis was reflected in comments from various psychiatrists in India in the 1930s who variously called it a 'strain on one's credulity' or the 'cult of imagined memories' and went so far as to suggest that Bose posed an ideal example of the threats to the development of psychiatry in India Mapother (1938).

This dissatisfaction with psychoanalysis was made more explicit as colonial influence began to wane. In 1964, NC Surya and SS Jayaram opened the debate and considered the Indian therapist as an ineffectual caricature of Western psychiatric thought, trapped in 'conceptual frameworks, which are wholly foreign to the milieu of his birth and habitation'. In addition, the Indian medical intelligentsia, they felt, was alienated from its own roots, worsened by a partial training in Western psychotherapy and utterly confused. Continuing with this theme, AS Mahal, writing in 1975, was unconvinced about the universality of human nature and even suggested that therapist and patient should belong to the same caste, religion, language or locality because the patients were often more at home in an informal group and distrustful of formal relationships. Erna Hoch felt that 'sober, scientific' Western terminology could not understand the dramatic psychiatric phenomena in developing countries. However, she also opined that certain psychological truths, if suggestive of a sufficiently wide and open understanding of human nature, could be easily grasped by illiterate villagers. She also favoured using indigenous philosophical traditions, shorn of accumulated superstitions. She specifically warned against a 'pretentious therapeutic attitude and packaged management or treatment' programmes (so carefully thought to be teachable), which would be seen through as insincere.

Perhaps, the most thorough analysis of these issues was provided by Neki (1977). Neki addressed issues of dependence and suggested a detailed Guru/Chela (Teacher/Disciple) paradigm with specific analogies and metaphors to compare and contrast it to the psychoanalytic process. The high degree of dependency on the family in India, the lesser emphasis on personal autonomy as compared to the West and the inadequacy of libidinal theories as applied in the Indian context were highlighted.

Many eminent Indian psychiatrists, like MV Govindswamy, T Venkoba Rao and C Shamsunder, have at various points gone back to look for philosophical

underpinnings in Indian mythology and their possible use in therapy. Vedic and Upanishadic norms of ideal life and behaviour are sought for patient and therapist, and an attempt to find a universal therapeutic process, in consonance with the client-centred/humanistic schools. Despite the criticisms offered earlier, and during the past few decades, there has not been enough attention paid to develop a synthesis between the differing philosophical and medical traditions.

The Current Mental Health Situation: Epidemiology, Policy and Practice

Epidemiology

Several syntheses of epidemiological studies in India have been conducted, and all show that the overall prevalence rates of mental disorders are lower in India at around 52–73 per 1000 population (Ganguli 2000; Math et al. 2007) than in high-income countries (USA: 173–210 per 1000) or in Africa (Africa: 118–400 per 1000). However, these rates are substantially higher when compared to other average Asian prevalence rates of 10–18 per 1000 for rural and urban populations, respectively (Ganguli 2000). In addition, this prevalence profile seems to be fairly stable over time (Math and Srinivasaraju 2010).

The lower rates in the Indian population are not as yet fully understood, partly because too few large-scale studies have been done to date. The earlier studies, which tended to report lower prevalence rates, also used non-validated instruments. Throughout the years, there has been much under-reporting due to stigma, due to not adequately assessing common mental disorders and substance-use disorders particularly in primary care and general OPD settings (Math et al. 2007; 2010). It has also been suggested that the lower prevalence rates could reflect better coping skills, lifestyle factors, social or family support, cultural factors or genetic reasons (Math and Srinivasaraju 2010). These are, however, matters of conjecture and have not been subjected to rigorous examination. What is clear, as highlighted more recently by the India census, is that mental illnesses contribute very substantially to the public health burden in India. For example, suicide accounts for 3% of all deaths over the age of 15 years, which occur predominantly in women aged 15–29 years, which means death by suicide has now overtaken maternal mortality rates in India (Patel et al. 2012).

Current Mental Health Workforce

Mental healthcare coverage has certainly been limited due to the serious lack of human resources on both the specialist and the primary care fronts. A summary

indicator of the acute shortage of mental health professionals is that there are 3600 psychiatrists for a population of 1.2 billion (WHO 2011), most of whom are located in the private sector and in major cities. There is an even larger 40- to 60-fold deficit in the number of clinical psychologists, social workers and nurses available in the sector (WHO 2011). In addition, many questions still exist around the suitability both of primary care physicians as the main providers and coordinators of mental health care at primary care level, in terms of their workload, their competency and motivation to do so. A lack of motivation and incentivisation of psychiatrists to join the District Mental Health Programme (DMHP) compounds the problem of shared or supported care at primary care level (van Ginneken et al. 2014).

Policy and Practice

The National Mental Health Programme (NMHP) was adopted by the Government of India in 1982 as an integrated approach to mental healthcare delivery by utilising a mixture of specialist and non-specialist workforce. It was spearheaded by a small taskforce of psychiatrists, who were influenced by the apparently successful models of the WHO extension of mental health services programmes set up in 1975. Similar services that were inspired by global and national primary care developments which promised 'low cost' and accessible health care for all were developed by the National Institute of Mental Health and Neurosciences (NIMHANS). These were based on a model where primary care doctors were to be trained by psychiatrists who were then expected to provide basic mental health treatments in their facilities. Initially, specialist outreach clinics were established, but these were then withdrawn as specialist input collapsed due to several factors, including leaders moving abroad, but also in the 1980s, due to global and India-specific moves away from pro-poor and Alma Ata ideologies.

The NMHP was also not able to meet the other targets set for mental health service developments such as increasing the number of psychiatric departments in general hospitals and the number of acute and long-term beds for psychiatric patients. The NMHP was therefore 'restrategised' (tenth Five-Year Plan—2002–2007) to strengthen and modernise state-level administration, mental institutions and medical colleges. The new government officials were favourable to the NMHP and increased the NMHP budget seven-fold, though these funds were subsequently underspent. The NMHP was 'reinvigorated' in the eleventh plan (2007–2011), following some adverse evaluations of the NMHP/DMHP. With a budget increase to 10 billion rupees (still only 2% of public health expenditure in 2007), new elements were incorporated into the NMHP such as school and suicide prevention programmes.

However, in spite of being operational for three decades and, in more recent times, being substantially funded, the reach and impact of the public health sector in providing accessible, needs-based and quality-assured services have been highly unsatisfactory. Unfortunately, even when operational, initiatives such as the district

mental health programme tend to become medication dispensing programmes with a very limited focus on social determinants and social and other outcomes that are important to service users and their families (Jain and Jadhav 2008). Similarly, the ambitious District Mental Health Programme (DMHP), the primary vehicle for decentralised and accessible service delivery, was initiated in 1996 and was expanded to all districts within the following five years. However, this has yet to be achieved for a number of reasons including inadequate managerial or timely budgetary support; the telling of the DMHP story is something that has been done in many narratives and will probably continue to be told (Sarin and Jain 2013).

The not-for-profit NGO sector in India has been quite successful in developing innovative models of care for people with severe mental disorders in the community, for homeless persons with mental illness and more recently for a number of other mental disorders. Some of these innovations have also been subjected to a high degree of scientific rigour (Patel et al. 2010; Chatterjee et al. 2014). However, given that these initiatives have involved small population units and have been led by highly motivated individuals, the generalizability of these care models in routine care is untested. In the absence of initiatives from the government mental health sector, these small-scale innovations have been influential in framing more recent national policy efforts.

The conventional, for-profit private sector where services are provided by individual psychiatrists through out-of-pocket expenditure borne by patients is, by far, the largest service provider in India and the de facto face of community care. The range of services provided by the private sector includes outpatient and inpatient services, half-way homes, long-stay facilities, day-care facilities and other forms of rehabilitation. The very nature of out-of-pocket-driven care excludes a majority of people with mental disorders who need services the most, especially since this sector is largely financially unregulated and do not need to conform to quality assurance standards, a recipe for catastrophic financial expenditure that often drives families into debt and poverty. In the absence of effective regulation and monitoring, there are often gross human rights violations in some private sector treatment facilities, such as addiction treatment facilities.

In effect, this mixture of an unresponsive government health system, an unregulated and frequently inaccessible private sector and a few patchy NGO-led efforts means that most people with mental illness continue to be denied access to any form of treatment and poses a daunting challenge to contemporary Indian psychiatry.

Though a mental health programme has been in existence since 1982, it took till 2014 to adopt a national mental health policy in India. The policy was the result of a group of experts who were commissioned in 2010 to advise the government on priorities for the next funding cycle, the twelfth Five-Year Plan, and to draft a mental health policy (Mental Health Policy Group 2012). Based on their intensive investigations into various aspects of the NMHP implementation across India, their recommendations drafted in 2012 are now also features of the current policy: the main vision is to have a broad vision of mental health, thus to 'promote mental

health, preventing mental illness, enable recovery from mental illness, promote de-stigmatization and segregation, and ensure socio-economic inclusion of persons affected by mental illness by providing accessible, affordable and quality health and social care to all persons through their life-span, within a rights-based framework' (Government of India 2014). Specific recommendations included 1/leadership, coordination and technical support of mental health teams at the central, state and district levels; 2/detailed suggestions of different specialist and non-specialist cadres to be trained to fulfil promotion, prevention and treatment activities; 3/more focus on monitoring, evaluation and research, and ensuring continuity of care, as well as user/carer involvement in decision-making and intra- and inter-sectoral collaborations with the NGO and private sectors.

Other recent changes include the revision of the 1987 Mental Health Act in a Mental Health Care Bill 2013 which has a much broader remit for mental health care (i.e. not just focussing on legal reasons for involuntary treatment of mentally ill patients) and which takes a rights-based approach to wider accessibility and availability of mental health care (including community-based mental health care). There has been a lot of controversy over this bill, notably from psychiatrists who feel it has reduced their status to that of 'other mental health specialists', such as psychologists and psychiatric social workers (van Ginneken et al. 2014), and from the carer, disability and human rights lobby groups who feel that it still does not sufficiently address the human rights agenda.

Current Influences on Change, in Particular the Global Mental Health Movement, the Influence of WHO, Normative Frameworks and Professional Bodies

International Influences

In the 1970s, the most important influence was the WHO Mental Health Department. Though some critiques have suggested that the hegemony of the WHO was a form of neo-colonialism (Williams 2003), circumstances here in India were somewhat different. Since the 1960s, Indian psychiatrists worked within the WHO mental health department and influenced its strategies. Indian leaders at the time thought that the legitimacy of the WHO was essential, and as without its support, the Ministry of Health and Family Welfare would have never supported the NMHP (van Ginneken et al. 2014). However, while the continued and uncritical acceptance of the prevailing nature of international discourse might have been useful as a strategy to legitimize psychiatric services, this also hindered the cause of psychiatry as it prevented a concomitant serious and multidisciplinary effort to engage with the 'other', the diverse social context in which persons with mental illness are situated as well as the subaltern universe of folk understanding, language and help-seeking that exists in parallel with mainstream psychiatry. The same universalising theme is

inherent within the currently influential 'global mental health' and associated Grand Challenges movement (which is curiously, explicitly focused only on low- and middle-income countries) to scale up mental health services by using universal treatment guidelines and standardised psychological therapies. Efforts to scale up mental health services and care and to undertake health promotion and prevention activities in the community for large-scale impact cannot happen in the absence of a more inclusive and shared local language and dialogue. In the absence of such a linkage, global trends such as 'integration in primary care', 'global mental health' and 'rights-based' approaches will continue to decisively shape the contours of the Indian mental health system.

Influences Within India

One of the strongest drivers of change from within has been judicial intervention, extending from the 1980s to the present. The Supreme Court in India, in response to both public interest litigation and suo moto, has espoused the cause of the mentally ill, especially in institutions. The National Human Rights Commission (NHRC) initiatives brought about several mental hospital reforms through engagement with the mental hospitals through periodic inspections and collaborative engagement with the administration (NHRC). A recent technical committee review that the NHRC commissioned throws up the glaring lacunae in several aspects of mental health care, both in institution-based settings and in the community (NHRC 2015). The National Commission for Women is presently engaged in the rehabilitation efforts for long-stay women in mental hospitals (NCW 2016).

A useful example of the influence of various internal factors is the trajectory of human resource development for mental health service provision in the country. In keeping with the mandate to enhance the number of specialists, postgraduate training in psychiatry has expanded in India from just six institutes to 87 centres. Although norms for training are laid out by the Medical Council of India, there is a vast disparity in terms of training opportunities, facilities and assessments. The blueprint for enhancing seats for psychiatric training is not expected to improve the deficit of psychiatrists (the ratio of which stands at 0.2 per 100,000 population) in the foreseeable future. Debates regarding the way forward, whether to focus on developing specialists or to train generalists in mental health care, continue. Despite the attempts that began in the 1980s to train general practitioners in providing mental health care, huge treatment gaps in mental health care prevail. For non-specialist care providers, several critical questions remain unanswered: Are the current generalist cadres an appropriate choice for service delivery and not just a matter of convenience? Whether there are sufficient mental health specialists to provide back-up specialist care? Whether they are adequately trained to supervise the generalists? and finally, Whether there can be a standardised training or whether this needs to be adapted to local and sociocultural contexts?

There have been disparate professional tensions within the psychiatric profession between traditional hospital psychiatrists and those encouraging community mental health over the importance of community mental health in a hospital psychiatrist's role. There has also been poor acceptance of accrediting a minimalised psychiatric training for a non-specialist workforce, partly because the training has often been seen as inadequate and too short for a non-specialised workforce who also have very limited access to supervision. Overall, while there has been greatly improved training for psychiatrists, training for other mental health specialists such as psychiatric nurses and social workers remains woefully inadequate in comparison with that in high-income countries and some other low-income and middle-income countries (van Ginneken et al. 2014).

Conclusion and Future Prospects

Psychiatry in India uneasily straddles a divide between traditional folk and religion-derived ideas and more contemporary biomedical practice. Both have their roots in social and political processes of the past, over millennia in the case of the religious and folk traditions, and a just few centuries in the case of the biomedical enterprise. Contemporary 'Western' medicine did extend all over the world through colonial encounter, but its incorporation into the particular society has remained highly variable. The ex-colonies continued to struggle with systems which are often seen as being conceived by their ex-rulers and thus lacking legitimacy. Also, poor economic conditions have made investments in social welfare and health care low on the list of priorities in the developing world.

Another recurring and unresolved challenge for Indian psychiatry is to reconcile the issue of cultural specificity of treatments, particularly in the Indian context, where multiple cultures coexist. All concepts of psychological validity thus become, at one level, those of an outsider. Surprisingly, given the salience of the problem, there has been little attempt to understand the very obvious social, economic, political and cultural factors that influence psychiatric symptoms and access to care. Issues of poverty, landlessness, and disempowerment, and internal migrations necessitated by economic causes or calamities, have seldom been linked to mental health issues. The silence in Indian reports about the psychological distress is associated with Independence (Partition), or the numerous cultural and political changes that have followed is quite deafening. This kind of passive acceptance of wisdom from a 'foreign' source (in person or by training) has been a feature of both biological and psychosocial practices in India. There has been, despite all the early warnings, an unfortunate preoccupation with training in 'skills' as opposed to 'values' or 'ideas'.

The history of psychiatry in India could thus be seen as a product of the colonial enterprise which constructed an alien illness narrative that was profoundly disconnected from the complex and diverse indigenous narratives in existence. This was accompanied by a delegitimization of the existing healing practices in the name

of scientific and rational thought. This schism has not been addressed during the post-colonial and post-modern transitions in Indian society with the continued, uncritical acceptance of the prevailing universal and multilateral discourse around mental health in policy and planning efforts. In the meantime, older healing practices have not disappeared, but are now used almost entirely by the poor. Achieving a more harmonious balance between the global and the local is one of the most pressing challenges of contemporary Indian psychiatry.

At its core, psychiatry is a specialised medical discipline. However, the unqualified adoption of medical and psychological treatment modalities developed in high-income countries needs to be balanced by encouraging greater investment in developing locally appropriate medical treatments and psychological therapies, as well as a greater awareness of the relevant social determinants of mental illnesses. This approach could open the way for a new generation of rewarding collaborative endeavours in developing treatments and services that better address the multidimensional needs of people with mental illness in India and other low- and middle-income countries.

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Chapter 4
Mental Health System Development in Sri Lanka

Harry Minas, Jayan Mendis and Teresa Hall

Abstract Sri Lanka has been a model country for many decades in terms of quality of population health outcomes in a low- or middle-income country, with relatively small but smart investment in population health. It has, however, experienced 30 years of civil conflict, ending in a brutal civil war in 2009. The island's coastal regions were devastated, with massive loss of life and population displacement, by the Indian Ocean tsunami in 2004. The conflict and the tsunami brought to the fore the importance of renewed attention to the mental health of the Sri Lanka population, particularly among the most affected communities. While indigenous conceptions of mental health and illness, and strong Ayurvedic and other traditional forms of health practice, continue to be important across the Sri Lankan population, Western forms of psychiatry and systems of care have become dominant over a long period, particularly during the British colonial era. Human resources and physical infrastructure for mental health treatment and care have been very limited. Although general hospital, inpatient psychiatric units in several parts of the country were established much earlier in Sri Lanka than in many other countries, until recent times three national psychiatric institutions, all near Colombo, were the main locus of care and the main resource for psychiatric treatment. Conditions in these institutions were very poor. The impact of the tsunami, and the influx of aid and technical expertise, created an opportunity for major reform of the mental health system, with an orientation to community-based treatment and care, major improvements in Angoda Psychiatric Hospital, and establishment of small inpatient units in most district general hospitals across the country. Major innovations in dealing with the shortage of mental health human resources have been a particular

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feature of the mental health system development in Sri Lanka in the past decade. A focus on suicide prevention has yielded very positive results. These and other aspects of the process of reform of the Sri Lankan mental health system have generated international interest. This chapter provides a brief account of a very effective process of mental health system reform in a middle-income country.

Introduction

Sri Lanka is an island country located in the Indian Ocean in South Asia. The population of 21.27 million (United Nations Development Programme 2014) is comprised of four main population groups—Sinhala (74%), Tamil (18%), Muslim (7%) and Burgher (1%) (Marecek 1998). Sri Lanka has a democratic government and is classified by the World Bank as a lower-middle-income country (World Bank 2015). The country is divided into nine autonomous administrative provinces: Central, North-Central, Eastern, Northern, North-Western, Sabaragamuwa, Southern, Uva and Western (Lanka 2014). Approximately half of the population lives in the Central, Southern and Western provinces (Lanka 2014). Most people live in rural areas (urban-to-rural ratio: 1:4.4) (Ministry of Finance and Planning 2012). Poverty is three times higher in rural than in urban regions (Ministry of Finance and Planning 2012), and the Gini coefficient is 36.4 (World Bank 2015), reflecting the considerable income disparity, a feature of most of the Asia region (Gini coefficient = 40.4) (World Bank 2015).

Sinhalese recorded history begins in 543 BC. The country was colonised by Portugal in 1517 and later by the British from 1815 until 1948 when Ceylon, as it then was, achieved independence from the British Empire. Ceylon became the Democratic Socialist Republic of Sri Lanka in 1972.

Since the late 1990s, labour migration has become Sri Lanka's second largest export, an important strategy for impoverished families (Marecek 1998). Annually, 250,000 persons go overseas as migrant workers, of whom 65% are women (Senaratne et al. 2011). Nearly 80% of female migrant workers are married, 85% of them have children, and half of these children are aged 5–10 years (Senaratne et al. 2011). Migration patterns impact on mental health by changing the social fabric and family structures (Senaratne et al. 2011). A cross-sectional survey conducted among 253 children (aged 5–10 years) of female migrant workers found a twofold increase in mental health problems among these children as compared with children without an absent mother (Senaratne et al. 2011).

In 2013, the Human Development Index was 0.750, ranking Sri Lanka 73rd internationally (United Nations Development Programme 2014) and placing the country in the high human development group. Sri Lanka outperforms other South Asian countries with similar population densities (India and Pakistan), and is above the South Asia region average in terms of HDI, life expectancy and mean years of schooling (De Silva 2002; United Nations Development Programme 2014). Life expectancy at birth is 74.3 years (United Nations Development Programme 2014),

compared to 66.4 years and 66.6 years for India and Pakistan, respectively (United Nations Development Programme 2014). The infant mortality rate of 8 deaths per 1000 live births is well below the rates in India (44) and Pakistan (69), and the mean for the South Asia region (45) (United Nations Development Programme 2014). The Commission on Social Determinants of Health 2008 report noted that 'Sri Lanka [has] achieved a level of good health out of all proportion to expectation based on their level of national income' (World Health Organisation Commission on Social Determinants of Health 2008). These health outcomes may be explained by the implementation of a universal health care system in 1931. (Nerminathan 2003). The stability of this public health system has been linked to its alignment with the Buddhist belief in protection of life which supports social welfare (Nerminathan 2003; Ariyaratne 2011).

Sri Lanka has an ageing population, with 62.4% of the total population aged between 15 and 59 years, and 12.3% aged over 60 years (Department of Census and Statistics 2012). One-fifth of Sri Lankans are predicted to be aged over 60 by 2025 (World Health Organization 2006). During this transition to an older population, Sri Lanka is experiencing a 'demographic bonus' (Ariyaratne 2011)—an increase in the number of people of working age—with a concurrent reduction in the number of people aged five years or younger by one per cent per decade due to effective family planning (Ministry of Healthcare and Nutrition 2009).

Nine of the top ten causes of premature death as measured by years of life lost (YLL) are NCDs or injuries, with ischaemic heart disease (16.3%), self-harm (8.3%), stroke (6.6%) and diabetes (4.8%) responsible for the greatest burden. These causes and chronic obstructive pulmonary disease, major depressive disorder and low back pain are responsible for the greatest proportion of disability adjusted life years (DALYs) (Institute for Health Metrics and Evaluation 2011).

History of Mental Health System Development

Sri Lanka has a pluralistic mental health system resulting from the complex interplay of indigenous, Ayurvedic and Western biomedical medical models. The publically funded mental health system is based on Western medicine, while indigenous principles and practices have a strong continuing presence in the non-government and private sectors.

An indigenous medical model prevailed in Sri Lanka before the colonisation by the Portuguese (1505–1656), Dutch (1656–1796) and the British (1796–1948). Indigenous mental health care is informed by the Ayurvedic and Unani conceptualisations of mental illness, aetiological factors and accompanying treatments. Indigenous words for 'madness' are *issu* (Sinhala), *paithiyam*, *mananoi* and *ulanoi* (Tamil), and the direct translation of the English 'mental illness'—*mānasikaroga* (Sinhala) and *mananoi* (Tamil) (Weerackody and Fernando 2014). Beliefs about what Western medicine regards as mental disorder include attribution of causality to astrological factors, sorcery, demon possession and black magic (Marecek 1998).

Responses therefore focus on healing practices including herbal medicine, and astrological and religious ceremonies (De Silva 2002; Namali et al. 2012). In the late 1800s, under British rule, a public health system based on Western medical principals was established. This increasingly sidelined the indigenous health system to the non-government sector (Jayasuriya 2001). There is no publically funded or organised system for indigenous mental health service provision (De Silva 2002). Nonetheless, indigenous mental health care continues to comprise a large component of services, predominantly for the rural population (Jayasuriya 2001; Gambheera 2011).

Early development of the public mental health system occurred during the period of British rule in the late 1800s and was based on then dominant Western conceptualisations of mental health and illness (De Silva 2002). The 1873 Lunacy Ordinance Act focused mental health system development on the establishment of psychiatric institutions (Carpenter 1988; De Silva 2002). The first small lunatic asylum was opened in Borella in 1847 (Weerackody and Fernando 2014). Due to overcrowding, patients were transferred to prisons across Sri Lanka (Gambheera 2011). Treatment was limited to occupational therapy and protecting persons through institutionalisation (Gambheera 2011). In 1926, the larger Angoda mental asylum was built just outside the capital, Colombo, to accommodate 1800 patients and ease the overcrowding that had become problematic in the asylum at Borella (Weerackody and Fernando 2014). Despite the increased capacity, there was no expansion in treatment resources. An investigation in 1928 by British Psychiatrist Edward Mapother (Mills and Jain 2009) found a very low quality of services in the Angoda asylum due to a combination of overcrowding and understaffing [Mapother 1928 in Gambheera (2011)]. The Mapother Report recommended the de-centralisation of services and the development of a specialist medical service (Gambheera 2011).

The mental health system expanded significantly from the 1930s until the 1970s. Colombo General Hospital added the country's first outpatient clinic in 1939, a very early move—in international terms—of psychiatry into the general health system. After independence in 1948, a second mental hospital opened in 1957 in Mulleriyawa (Weerackody and Fernando 2014). Available public positions for psychiatrists in the country dramatically increased from four in 1953 to 20 in 1967, the same year that Colombo General Hospital opened a 25-bed psychiatric inpatient unit, establishing Colombo and its surrounds as the hub for psychiatric facilities in Sri Lanka (Weerackody and Fernando 2014). The increased number of positions for psychiatrists was supported by the development of the Department of Psychiatry at the University of Colombo in 1968. The Mental Disease Ordinance in 1956 (the second revision of the original Lunacy Ordinance) called for a shift towards community-oriented service delivery led by psychiatrists with support from psychologists, social workers, mental health nurses and occupational therapists (De Silva 2002). The move towards community-based mental health care in the 1970s saw the establishment of a community clinic by the University of Colombo, supported by the World Health Organisation (WHO), which aimed to re-integrate long-stay patients from Angoda back into the community. A particular challenge

during this period was the substantial numbers of psychiatrists leaving Sri Lanka to work in developed countries (De Silva 2002; Gambheera 2011).

The Sri Lankan National government was engaged in civil war with the Liberation Tigers of Tamil Eelam (LTTE) for 26 years from July 1983 to May 2009 (Government of Sri Lanka 2013). Armed conflict was mainly contained to the North-Eastern province, formed from the merger of the Northern and Eastern provinces, although insecurity and the trauma of war affected the whole country, with suicide attacks on civilians and military personnel by the LTTE, military operations by the government and civilian riots (Silva 2010). It is estimated that 75,000 people were killed and a far greater number were injured (Silva 2010).

The civil war further compromised the already-sparse human resources for mental health in Sri Lanka, particularly in the North-Eastern province (World Health Organization 2002), where large numbers of health facilities providing mental health care were destroyed or severely damaged, and the supply of essential resources including pharmaceuticals was severely disrupted or discontinued (World Health Organization 2002). The instability of the region also forced most health care staff to leave the north-east. For example, in 2003, there were only two psychiatrists continuing to practice with limited resources in the North-Eastern province, and only two districts had acute inpatient facilities (World Health Organization 2003). In comparison, there were 25 practising psychiatrists (66% of the national supply) in the Western Province (De Silva 2002).

The shortage of mental health personnel was in the context of greatly increased need for mental health support during and after the end of the conflict (World Health Organization 2002). The WHO report of Health System and Health Needs of north-east Sri Lanka attributed this demand to 'the psychological trauma associated with war, conflict and violence and the associated displacement, disintegration of families and communities together with the loss of property and kin' (World Health Organization 2002). In 2002, an assessment of mental health needs (World Health Organization 2002) was conducted by Medecins Sans Frontieres (MSF) of residents of 'welfare centres' after the onset of the conflict in Vavuniya in the north-east found high rates of attempted suicides, alcohol abuse, domestic violence, grief, suspicion and a sense of 'learnt helplessness'. The lasting effects of the conflict are seen in the 'collective trauma' experienced at the community level (Somasundaram 2007, 2010). The disruption of family and community relationships and networks has impacted on societal values and produced intercommunal mistrust among much of the population (Somasundaram 2007, 2010).

On 26 December 2004, the Indian Ocean tsunami hit the southern and eastern coast of Sri Lanka, killing an estimated 35,000 people, completely destroying 90,000 houses and displacing more than 516,000 from their homes (Minas et al. 2011). Relief efforts, led by the Sri Lankan government in collaboration with many international agencies, had important positive impacts on health systems and population health outcomes.

The 2004 tsunami directly impacted mental health in Sri Lanka by weakening the existing infrastructure for mental health care provision and increasing the population risk of mental health problems (Mahoney et al. 2006). This was

particularly the case for the north-east where the civil war had already compromised available human resources for mental health. The tsunami also served as a catalyst for increased attention to the need for mental health services. For example, several international non-governmental organisations (NGOs) funded several capacity-building programmes and built acute psychiatric units in many district general hospitals and contributed to the development of community mental health services in many districts (Minas et al. 2011; World Health Organization 2013).

The expansion of the mental health services was felt nationwide. Sixteen intermediate stay rehabilitation units were established; acute inpatient units were established in almost 80% of districts, and the majority of districts established mental health outreach clinics (World Health Organization 2006). In addition to psychiatric services and facilities, community-based psychosocial support was provided by lay health workers in tsunami-affected areas. Community support officers (CSOs) delivered psychosocial support to persons in hard-to-reach areas and acted as referral points to other health services (Minas et al. 2011; Murthy 2015).

Population Mental Health Problems

The prevalence of mental health problems is difficult to estimate due to the absence of a national mental health surveillance system. Nonetheless, cross-sectional studies conducted over the past 15 years have shed light on the burden of psychiatric morbidity. A high prevalence of depression and post-traumatic stress disorder (PTSD) has been found in samples of conflict-affected people. For example, 72% of landmine victims were found to have PTSD (Gunaratnam et al. 2003).

A household study conducted by the Ministry of Health in 2002 named depression as the eighth leading disorder affecting the population in urban and rural areas (Ministry of Health and Japan International Cooperation Agency 2003). The state of mental health in the conflict-affected Sri Lankan population was further compounded by the catastrophic 2004 tsunami. The prevalence of PTSD among the internally displaced adults was estimated to be 14–39% three to four weeks after the tsunami (Neuner et al. 2006), increasing to 56% at six months (Ranasinghe and Levy 2007) and decreasing to 25% at twenty months after the tsunami (Hollifield et al. 2008). Although these estimates are based on different samples, they are suggestive of a large burden of psychological distress in the aftermath of the tsunami.

Recent prevalence estimates reflect the cumulative effects of the conflict and tsunami on mental health. A household survey conducted in 2009 of 1517 houses in Jaffna, Northern Province, found a high prevalence of PTSD, anxiety and depression (7.0, 32.6 and 22.2%, respectively) (Husain et al. 2011). These estimates were replicated by the Household Income and Expenditure Survey 2012–2013 (Ministry of Finance and Planning 2012), the COMRAID study (Siriwardhana et al. 2011) and a large study of 12,841 hospital records in four districts in the Northern

Province (De Silva et al. 2011). The COMRAID study identified an increased risk for internally displaced persons who were unemployed, widowed or divorced and experiencing food insecurity (Siriwardhana et al. 2011).

Alcohol and substance use problems are increasing in Sri Lanka. Overall, alcohol consumption increased from 2.2 l per capita in 2003–2005 to 3.7 l per capital in 2008–2010 (World Health Organization 2014). Approximately, 4.9% of men are estimated to have alcohol dependence and a further 6% of men are estimated to have alcohol use disorder (World Health Organization 2014). The prevalence of dependence and alcohol use disorder in females is significantly lower, at 0.6% for both categories (World Health Organization 2014). The prevalence of heavy episodic drinking was 0.8% of the population for males and less than 0.1% for females in 2010 (World Health Organization 2014). Fifty-seven per cent of liver cirrhosis in males was attributable to alcohol.

A high prevalence of mental health problems has been found in adolescents (Perera et al. 2006) and children (Catani et al. 2008). For example, 36 and 28% of students aged 14–18 years exhibited depression and severe anxiety, respectively, with females at greater risk of both problems (Rodrigo et al. 2010). Older Sri Lankans are also at a higher risk of mental health problems because of chronic exposure to conflict-related trauma and the tsunami. The Sri Lankan Aging Survey conducted by the World Bank in 2006 detected a high prevalence of depressive symptoms of 27.8% in the 1181 elderly Sri Lankans surveyed. Elderly people with lower educational levels, physical disability and ethnic minority males were most at risk (Malhotra et al. 2010). A survey of elderly people admitted to hospital detected similar levels of depression and cognitive dysfunction (Weerasuriya and Jayasinghe 2005). Dementia is also estimated to affect 4% of people aged 65 years and older (De Silva et al. 2003).

The rates of mental health problems differ between men and women, with a higher burden of mental illness affecting women (excluding suicide and alcohol abuse, which are higher in men). For example, depression is more common in elderly women (30.8%) than elderly men (24.0%) (Malhotra et al. 2010). Traditional gender roles may impact on help-seeking behaviour and mental illness prevalence (Marecek 1998). Sri Lankan women have a limited social space in which to express their feelings, gender-related burden and mental health stigma and health-seeking behaviours (Guzder 2011). Women are particularly vulnerable to mental health problems as a result of increased alcohol consumption among men and high rates of domestic violence (Hussein 2005; Guzder 2011).

Sri Lanka had very high suicide rates in the 1990s and, despite a marked reduction in the suicide rate from 1995 to 2010, self-harm remains the second largest cause of premature mortality and morbidity (Institute for Health Metrics and Evaluation 2011). The suicide rate rose from a modest level of 6.5 per 100,000 persons in 1950 to 47.3 per 100,000 population in 1995—one of the highest rates in the world (Marecek 1998). The suicide rate in the Northern Province was particularly high, 53.5 per 100,000 in 1982 (Ganesvaran et al. 1984). Men were approximately at a threefold greater risk of suicide than women during the 1990s (Marecek 1998). In 2002, suicide disproportionately affected males aged over

40 years, with the highest rates of approximately 80 suicides per 100,000 persons detected in males aged 60–64 (Desapriya et al. 2004). The main methods of suicide are self-poisoning and hanging (Knipe et al. 2014). At its peak during 1994–1996, self-poisoning was responsible for approximately 79% of completed suicides (Knipe et al. 2014). The high suicide rate in Sri Lanka during the 1990s has been attributed largely to the availability of toxic pesticides in households, high levels of social, emotional and physical stress from war, and inadequate availability of supportive mental health services (Eddleston et al. 2006; Jayasekara and Schultz 2007). Alcohol misuse was found to contribute to 61% of male suicides (Abeyasinghe and Gunnell 2008). Restrictions on the importation and sale of WHO Class I toxicity pesticides in 1995, and Endosulfan in 1998, coincided with reductions in suicide rates. Specifically, there were 19,769 fewer suicides in 1996–2005 than in 1986–1995 (Marecek 1998). Nonetheless, self-harm through poisoning and excessive alcohol consumption continue to be reported at high levels (Jayasinghe and Pathirana 2011; Jayasinghe et al. 2012; Knipe et al. 2014).

Mental health stigmatising attitudes to and beliefs about mental illness continue to be prominent in Sri Lankan. Persons experiencing mental health problems are subject to discriminatory practices, including decreased employment options (Consumer Action Network for Mental Health 2015). Mental health stigma has been reported to affect health-seeking behaviours (Marecek 1998; Fernando et al. 2010a) and quality of treatment received (Fernando et al. 2010b). As in the general population, health professionals also frequently have negative attitudes towards people with depression, alcohol and drug addiction, and attempted suicide is often treated in medical wards for physical complications with no referral to psychiatric services for assessment and treatment of mental disorder (Marecek 1998).

The World Health Organisation estimates that 7% of Sri Lankans (more than 1.4 million people) live with a disability (World Health Organization 2011b). The most recent disaggregation of subtypes of disability from the 2001 census estimates (per 100,000 people) were vision (41.0), hearing or speaking (43.5), hands (28.5), legs (7.9); other physical disabilities (53.7) and mental disorder (40.9) (Peiris-John et al. 2013). Risk of disability increases with age (World Health Organization 2011a, b), with older people accounting for 22.5% of people with disabilities (Peiris-John et al. 2013). A recent narrative literature highlighted a dearth of research investigating disability in Sri Lanka (Peiris-John et al. 2013).

Sri Lanka has had a National Disability Policy since 2003, signed the Convention on the Rights of Persons with Disabilities (CRPD) in 2007 (United Nations 2007) and the National Action Plan for Disability is currently being revised to align with the WHO World Report on Disability (2011) (World Health Organization 2011a, b) and the CRPD (United Nations 2007). Stakeholders working on the current National Action Plan for Disability in Sri Lanka include the Ministry of Health, Ministry of Social Welfare, agencies of the United Nations, Sri Lankan and international NGOs, disabled persons organisations and health professionals. The Action Plan aims to address 'the empowerment of people with disabilities, health, rehabilitation, education, employment, social engagement,

mainstreaming and enabling environments'. Disability spans both the health and social care systems. A key challenge is to establish effective mechanisms for the coordination for these systems.

Mental Health System Governance and Financing

The Mental Health Act was most recently revised in 1956 (World Health Organization 2011a, b). The development of revised mental health law has been in progress for more than a decade. A draft revised for Mental Health Act is currently under review by government. As in every other country, there are several other laws with provisions that are relevant to mental health, including legislation on general health, welfare and disability (World Health Organization 2011a, b).

The first Mental Health Policy of Sri Lanka—2005–2015, adopted in 2005, aimed to develop a comprehensive network of services at the community level (Mahoney et al. 2006). The national mental health action plan, developed by the Mental Health Directorate, the NIMH and the Sri Lankan College of Psychiatrists in 2005 and revised in 2010 (WHO 2011), was the framework for implementing the mental health policy. The key components of the plan included timelines and funding allocation for the implementation of the mental health policy, a particular focus on the urgent need to strengthen human resources for mental health and clear shift in focus from mental hospital-based treatment to substantially increased community-based services and integration of mental health services into primary care.

The national mental health policy made provision for the establishment of the National Mental Health Advisory Council as the national authority charged with directing and overseeing implementation of the policy. The membership included staff from the Ministry of Health and representatives from other ministries, including the Ministries of Women's Empowerment, Social Welfare, Education and Justice. Professional representation included the Sri Lankan College of Psychiatrists and representatives of nursing, occupational therapy, psychology and social work. The Council also included service users, carers and representatives of relevant institutions as well as registered Non-Government Organizations.

The Directorate of Mental Health in the Ministry of Health is responsible for carrying through the decisions of the National Mental Health Advisory Council, particularly for managing and monitoring the implementation of the national mental health policy. The Directorate manages the mental health budget; develops and supports appropriate system development strategies; supports provincial and district levels of government to set and work towards achieving strategic mental health targets and specific mental health operational plans; develops and issues clinical and other guidelines; assesses and responds to requests for infrastructure and other mental health investment; receives periodic district and provincial reports; and fosters and sustains effective links at all levels between mental health and other

relevant sectors such as education, women empowerment and social welfare, local administration, poverty alleviation, child protection and developmental NGOs.

With the adoption of the national mental health policy and the mental health action plan, the Ministry of Health recognised that the implementation of the policy requires a significant increase in resources of all kinds, including mental health workers. Additional doctors and nurses with psychiatric training were appointed to work in the community, and training was proposed for a limited numbers of psychologists, occupational therapists and social workers. Efforts were also made to create new positions for psychiatric nurses, psychologists and psychosocial support workers in the public mental health system (Mahoney et al. 2006).

Mental health services are financed through government taxation, out-of-pocket personal expenditure, non-governmental funding sources and support from international development assistance agencies (BasicNeeds 2009). Current public mental health financing information is difficult to obtain because there is no identifiable global mental health budget in the national health budget (BasicNeeds 2009; Jenkins et al. 2012). The only readily identifiable mental health funding allocation is that for the two remaining psychiatric hospitals (NIMH-Angoda and Mulleriyawa) in the Western Province. While many general hospitals now have an inpatient psychiatric unit, the amount of funding allocated to these units is not separately reported and varies considerably between districts (BasicNeeds 2009). Estimates for out-of-pocket expenditure are also not available (WHO 2011).

A substantial proportion of mental health funding comes from the non-governmental sector (BasicNeeds 2009). In 2009, donor agencies contributed 55% of the funds for programs at the national level and 45% at the provincial level (Jenkins et al. 2012). The main donor agencies have been the World Bank, WHO, United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF) and the Volunteer Services Organisation (BasicNeeds 2009). Most donor funds go to national prevention and promotion programmes. For example, government financing accounted for 44.8% of the budget for mental health prevention and promotion activities in 2009, with the remainder provided by external donors, including World Bank (44.84%), UNFPA (6.73%) and WHO (3.59%) (Kitsiri 2009).

Government funding for mental health care is distributed directly from the national government or via the provincial councils (BasicNeeds 2009). The national mental health budget is comprised of both government and donor agency contributions. Funding for psychiatric treatment services (mental hospitals and general hospital psychiatric inpatient units) is managed by the Finance Department within the MoH. Financing for preventive and mental health promotion programmes is managed by the Mental Health Directorate (BasicNeeds 2009). Provincial mental health budgets are comprised of both national and provincial government sources and are managed by the provincial councils (BasicNeeds 2009).

The National Institute of Mental Health (NIMH), established as part of a process of radical reform and improvement of Angoda Mental Hospital, is the national treatment and training centre for psychiatry in Sri Lanka. The NIMH is responsible for providing specialist secondary- and tertiary-level psychiatric services and works

closely with the Mental Health Directorate, providing technical advice for policy and practice. The Sri Lankan Royal College of Psychiatrists is a small but influential stakeholder in the mental system. The College provides supervision and training for psychiatrists, contributes to development of psychiatry curriculum, manages membership of the profession of psychiatry and contributes to mental health strategic planning and policy. Various other international and local organisations provide financial and technical support for mental health in Sri Lanka. These organisations include the WHO, World Bank, VSO International, Basic Needs, the National Council for Mental Health (Sahanaya, Shanthiham) and the Association for Health and Counselling and Nest (World Health Organization 2011a).

Consumers and carers have a small but growing influence on the mental health system in Sri Lanka. The Consumer Action Network for Mental Health (2015) is the largest carer organisation, with approximately 10,000 members. The organisation works predominantly in the Central and Western provinces and carries out advocacy work in addition to service linkage and rehabilitation activities.

Mental Health System Organisation

Mental health care is provided through a combination of public, private and non-government services (Jenkins et al. 2012). The structure of the public mental health service system mirrors the public general health system. While policy and strategic directions are set at the national level, implementation is primarily the responsibility of the provincial and district levels of government.

The psychiatric treatment service system is comprised of a network of hospitals at national, provincial and district levels. Primary care is managed by the district hospitals, the peripheral units and the rural hospitals, with referrals to higher institutions when necessary. Secondary care is provided by the base hospitals and, increasingly, by psychiatric inpatient units in district hospitals. Tertiary and sub-specialty inpatient psychiatric care is provided by the National Institute of Mental Health (World Health Organization 2011a).

There is a small private psychiatric service sector. Psychiatrists working in the public sector may also carry out private practice out of public working hours and provide approximately 50% of outpatient care (De Silva 2002). There are no private psychiatric hospitals in Sri Lanka (De Silva 2002). Mental health care is also provided by Ayurvedic and other indigenous practitioners (Nikapota 1983; De Silva and De Silva 2001).

The non-government sector, consisting of national and international mental health NGOs, and families of persons with mental disorders make a substantial contribution to mental health service provision. The objectives and scope of the many NGOs vary considerably and include rehabilitation services for persons with severe and persistent mental disorder and disability, alcohol use problems, suicide prevention, trauma-related disorders, mental disability and mental health care for the elderly (De Silva 2002). The main burden of care falls on families and friends.

A central component of the National Mental Health Policy 2005–2015 was the commitment to strengthen the human resources for mental health (HRMH). The main categories of mental health workers are the same as in other countries—psychiatrists, psychiatric nurses, social workers, psychologists and occupational therapists. However, there has been a severe shortage of all of these categories of mental health professionals. Sri Lanka has been particularly innovative in responding to the fact of insufficient mental health human resources by developing new categories of workers—Medical Officer with Diploma in Psychiatry (MOPsyc), Medical Officer of Mental Health (MOMH) and Community Support Officer (CSO).

Medical Officer with Diploma in Psychiatry (MOPsyc) and Medical Officer of Mental Health (MOMH) are medical graduates who have completed either a one-year diploma in psychiatry from the Post Graduate Institute of Medicine (MOPsych) or a one-month certificate of psychiatry from the Royal College of Psychiatrists (MOMH). MOMH and subsequently MOPsych training was established to enable provision of basic mental health services in the community, particularly in the more remote and under-served regions of the country (Jenkins et al. 2012). The aspiration was that at least one MOMH would be posted to every sub-district (Jenkins et al. 2012). With the rapid increase in the number of acute psychiatric units in district hospitals, and the shortage of psychiatrists to manage them, the MOPsych training programme was a critically important strategy to enable such district-level services to be established, although now almost every district inpatient unit is headed by a psychiatrist.

The role of Community Support Officer (CSO), undertaken by community volunteers, was established in the immediate post-tsunami period in response to the massive need for psychosocial support in a traumatised population. The training received, though very brief, enabled the CSOs to identify and, when necessary, refer persons for mental health care and to support the re-integration in the community of people discharged from psychiatric inpatient treatment.

Human resources for mental health (HRMH) have rapidly expanded over the past decade. The majority of districts now have reasonably comprehensive mental health care facilities and services, including a psychiatric inpatient unit, an intermediate care unit and community outreach clinics, under the supervision of at least one psychiatrist or MOPsych, and an MOMH in most sub-districts. There are currently 89 consultant psychiatrists serving a population of 21 million; approximately 0.4 consultant psychiatrists per 100,000 persons (Mental Health Directorate 2015). This ratio is considerably lower than the 1.21 per 100,000 persons which is the mean for upper–middle-income countries (World Health Organization 2011a, b). Due to the introduction of the MOMH and MOPsych training programs, and the distribution of graduates of these programs to under-served areas of the country, there are now at least basic psychiatric treatment services provided by doctors with some training in psychiatry throughout the country (Mental Health Directorate. 2015). The numbers of other mental health professionals—psychiatric nurses, psychologists, social workers, occupational therapists and psychiatric social workers—are still very low.

'Brain drain' of qualified psychiatrists to OECD countries, mostly to the UK, US, New Zealand and Australia, has been a major issue for HRMH in Sri Lanka, particularly during the conflict years (De Silva et al. 2013). Compared to neighbouring South Asian countries, Sri Lanka had the largest exodus of trained health personnel, at a rate of 21% in 2008 before the end of the conflict (Jenkins et al. 2010). Despite a boost to the available HRMH, internal factors promoting migration of health workers include insufficient professional development opportunities, encouragement from universities for students to train overseas and compulsory appointment to a rural area at return from overseas training (De Silva et al. 2013). External factors that promote migration include higher salaries in high-income countries, more favourable working conditions, better education for children and greater access to higher education and continued professional development (De Silva et al. 2013).

Since the end of the conflict, however, a large number of psychiatrists have returned to work in Sri Lanka. Recently, a qualitative study of Sri Lankan specialists who had completed an overseas placement highlighted the importance of the dual practice policy (enabling a mix of public and private work) for retaining specialists (De Silva 2002). In addition, it is now required doctors going abroad for postgraduate training with support from the Post-Graduate Institute of Medicine pay a bond upon commencing their postgraduate training which is not reimbursed if they fail to return to Sri Lanka after overseas training. Furthermore, graduate specialists must work in a public position for four years for every training year they spend overseas (De Silva et al. 2013).

The still limited numbers and dual practice policy mean that the majority of practising psychiatrists have a heavy workload, consisting of full-time work in the public health system followed by work in private clinics. Due to available resources and time constraints, psychiatric treatment carried out by psychiatrists is mainly focused on biological treatments, and a multidisciplinary team is rarely involved (Mental Health Directorate 2015). As well as providing limited choice for patients, this also serves to restrict the level of occupation support available to psychiatrists (De Silva 2002; Gambheera and Williams 2010). Similar working conditions were reported by nurses in one study in which the 30 respondents expressed that heavy workload and a lack of communication between different health professional groups limited their capacity for effective work in preventing intimate partner violence (Guruge 2012). Currently, there is no standardised method for conducting and reporting mental health staff performance assessment.

There is a large disparity between the available mental health workforce in rural and urban areas. Sixty per cent of psychiatrists live in the country's three largest cities (Mental Health Directorate 2015). Recruitment and retention of health workers to rural areas is complex and has been a primary focus of government health policy since the HRH Strategic Plan 1999–2009. Rural hospitals tend to have poorer infrastructure and resources and, paradoxically, serve the majority of the population. As such, health professionals in rural areas experience less desirable working conditions and a heavier workload than their urban counterparts, and fewer opportunities for career development because educational facilities and training are

concentrated in cities (Ministry of Finance and Planning 2012). To compensate for some of these issues, the government provides incentives to encourage skilled workers to work in regional and rural areas, including priority in school admissions, duty concessions for importing a vehicle for personal use, a pension after retirement and other financial remunerations, such as loans at low interest (De Silva 2013). Health specialists who do work outside the major urban centres are also able to supplement their public salaries through private clinical work, achieving salaries close to that offered by developed countries (De Silva et al. 2013).

Mental Health Information System and Research

Mental health information is collected and collated by the Medical Statistics Unit (MSU) within the MoH (Medical Statistics Unit Ministry of Health 2012). Statistics are routinely collected from district and provincial hospitals for outpatient indicators and staff and specialist indicators. Historically, these data have been paper records which were entered into the MSU computer-based system to be cleaned and analysed for publication in the Annual Health Bulletin. An electronic reporting system—the Electronic Indoor Morbidity and Mortality System (eIMMR)—was developed and piloted in 2010 to improve the efficiency and accuracy of the health information reporting system (Medical Statistics Unit Ministry of Health 2012).

Currently, there is no systemic monitoring and evaluation mechanism for human resources for mental health. HRMH performance indicators were developed for the Health Master Plan (2007–2016), but until now there has been no national implementation. Contact points of each district are required to report basic HRMH data to the Mental Health Directorate but the regularity of reporting is not guaranteed. The communication between the contact points and mental health facilities and mental health professionals is often inadequate, resulting in inaccurate reporting. In addition, there is no mental health-specific breakdown of the health budget which prohibits any economic effectiveness evaluation of the utilisation and performance of the allocated mental health budget (BasicNeeds 2009).

There is a burgeoning body of mental health research in Sri Lanka that investigates a broad range of areas including epidemiology, mental health interventions, psychopathology and policy. A thematic analysis of 104 published articles listed in the Mental Health Research Repository 2013 produced by the Directorate of Mental Health (Directorate of Mental Health 2013) highlighted the current focus on the validation of psychometric instruments (17% of total), suicide and deliberate self-harm (16%) and anxiety and mood disorders (16%). Cross-cutting themes were trauma-associated with the war and tsunami. In addition to the general population, samples included conflict-affected people, soldiers, children, adolescents and older adults. Research was conducted by a number of prominent Sri Lankan psychiatrists in collaboration with Sri Lankan universities and overseas institutions.

A second thematic analysis was conducted of articles published in the Sri Lanka Journal of Psychiatry (titles and abstracts level) from 2010 onwards. In addition to

assessment and psychopathology (case reports), research covered forensic and liaison psychiatry (intersection of physical and mental health), mental health policy, psychological and pharmacological interventions, complementary therapies and the attitudes of medical professionals to mental illness. Taken together, this research suggests a high level of research capability within the Sri Lankan workforce.

Concluding Comment

Sri Lanka's performance on most health indicators—much better than would be expected based on its level of economic development—has for several decades been studied and commented upon. The country has been a standout in the region and among developing countries globally (Jones and De Silva 2013). Despite this remarkable success in general health attention to mental health of the population and the mental health system had languished. Conditions in the mental hospitals were among the worst in the world, and there were virtually no community mental health services in most of the country. Particularly over the past decade, following the devastation caused by the Indian Ocean tsunami, and following the end of the civil war, government has focused its attention on developing a comprehensive mental health system. In the process, the same capacity for innovation—and doing a great deal with very few resources—that was characteristic of the country's successful efforts in public health has been applied to the task of building a comprehensive and equitable mental health system. All of the basic elements are now in place. It is now necessary to further strengthen quality and accountability, focus on mental health promotion and prevention, continue to build a high quality workforce (Minas 2015) and develop expertise and services in child and adolescent mental health and other important sub-specialty areas. The revised Mental Health Policy 2016–2025 has a clear focus on priorities such as these in the next decade.

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Chapter 5
Mental Health in Korea: Past and Present

Min Sung-kil and Yeo In-sok

Abstract In pre-modern Korean society, mental illnesses were treated according to the concepts of Shamanism and Asian traditional medicine. H.N. Allen (1858–1932), the first missionary doctor, from USA, described mental illnesses including hysteria and delirium tremens. Western medicine brought a new way of perceiving physical and mental illnesses. From 1910 to 1945, the policy of the Japanese colonial government was to isolate patients in mental hospitals as they were considered to be harmful to society. This promoted stigma. The Government Hospital opened a special ward for mental patients in 1911. In contrast, the Australian medical missionary, Charles I. McLaren, believed in humane treatment in missionary hospitals including Severance Hospital. After the Korean War (1950–1953), psychiatry came under American influences. For the last several decades, the country has undergone a rapid and intense industrialization and democratization. Clinical and community services, as well as research and education in psychiatry, have been developed. In this brief period, the traditional agrarian, family-oriented, and collective social system has been transformed into a capitalistic, egalitarian, individualistic, high technological, and competitive one. An achievement-oriented lifestyle involving hard work, merciless competition, unstable employment and an uncertain future has created stress in many Koreans. Compounding this stress is the disintegration of the traditional, family support system. The consequence has been an exacerbation of *Haan* (suppressed anger and feelings of unfairness) related to a sense of historical suffering from colonialism and war, and the stress of rapid social change underlies various culture-specific mental problems. The burgeoning feelings of anger and depression are likely to contribute to the high rate of suicide. The challenges for the future include providing culturally relevant services and further

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promotion of the human rights of the mentally ill in the face of continued stigma. Another challenge is promoting the mental health of North Korean defectors, and marriage immigrants and their mixed-blood children. Finally, Korean psychiatry should prepare for reconstruction of psychiatry in North Korea after reunification.

Introduction

Mental illnesses are multi-dimensional disease entities that encompass both organic and sociocultural aspects. Although the organic features of mental diseases may appear the same, the social perceptions of mental illnesses and their representations differ from one society to another. Mental illnesses are more heavily laden with social values than any other disease entity. As a result, cross-cultural studies of mental illnesses in different societies may reveal the different value systems that operate in various societies. Not only geographical but also temporal differences result in significant variations in the social perception of mental illnesses. In "non-Western" countries, such as Korea, the introduction of Western medicine was a crucial event, heralding a new way of perceiving the human body and its illnesses, including mental ones.

In addition to the introduction of Western medicine, the historical experiences of the twentieth century also deeply affected collective sensibilities in Korea. Oppressive colonization (1910–1945) was followed by the Korean War (1950–1953), which had adverse effects on society. The subsequent acceleration in modernization, despotic rule, and democratization had a deep impact on the social and personal ego of Koreans. In this article, we aim to survey how these cultural and historical experiences have shaped the minds of Koreans and how they have affected their mental health.

Mental Health in Pre-modern Korean Society

As our main concern here is mental health in modern Korean society, we are not going to discuss in detail mental illness in pre-modern Korean society. However, it is necessary to provide a brief overview of traditional notions of mental illnesses and of the treatment of mentally ill patients to have a better understanding of mental illnesses in modern Korean society. In dealing with mental illness in pre-modern Korean society, we are going to examine the problem from two different aspects: One is the folk conception and treatment of mental illness and the other is how mental illness was conceived in traditional Korean medicine and what kinds of treatments it involved.

Concerning the first aspect, the folk conception of mental illness is quite similar throughout the world. It was once a widely shared notion that the possession by an evil spirit was responsible for mental illnesses. Although old, this notion persists in

some modern societies. If mental illness is regarded as being the result of possession by evil spirits, exorcism is viewed as the natural choice of treatment. Exorcism is practiced in many different ways. The most common exorcism procedure in Korea consisted of a blind sorcerer beating the patient with a peach club while chanting a spell to expel the evil spirits. The second most common practice was to perform an initiation ceremony, which aimed to expel the false master and bring the new pure spirit into the patient, while the patient was in a state of ecstasy (Rhi 1972).

In common with folk notions of mental illness, traditional medicine has its own notions of and treatment for such illness. *Dong Eui Bo Gam* (東醫寶鑑, Treasured Mirror of Eastern Medicine), the most famous encyclopedic medical text of Korean traditional medicine, deals with several mental illnesses. Most of the mental illnesses are described in relation to the spirit (神). According to the text, the heart stores the spirit, and the spirit commands the seven emotions of joy, anger, anxiety, thought, sorrow, fright, and fear. When there is an excessive level of any of these emotions, the spirit is affected, and the related viscera are, in turn, damaged. In addition to problems caused by emotional disturbances, other symptoms and diseases such as forgetfulness, throbbing, epilepsy, and manic psychosis are described. It is noteworthy that the mental symptoms and illnesses are explained in the same way as other physical symptoms or diseases. As seen above, emotions are viewed as part of a physiological process. It is quite impressive that almost all the treatments for problems of spirit, mental illnesses in the Western sense, consist of various kinds of drugs. For example, manic psychosis is treated with drugs, which cause severe diarrhea. Traditional Korean medicine does not distinguish the mental from the physical. It applies the same approach toward mental symptoms as physical symptoms.

After the opening of ports in 1876, Western medicine was introduced into Korea. Missionary doctors and Japanese doctors entered Korea, and they treated Koreans. Some of them left medical records of mental illnesses in Korea. Dr. H.N. Allen (1858–1932), the first missionary doctor in Korea, opened *Jejoongwon* (濟衆院), the first Western-style hospital in the country, with the help of King Kojong. His first-year report on the hospital contains information on the prevalence of diseases of in- and outpatients. Statistics entered under the title of diseases of the nervous system show the kinds of mental and neurological diseases that were treated at the hospital. Apart from neurological diseases, the most common diseases were those related to various kinds of pains and mental illnesses such as hysteria and delirium tremens (Allen and Heron 1886). Unfortunately, Dr. Allen left no comment on the diseases of the nervous system. Thus, we do not know what kinds of impressions or opinions he had concerning mental illnesses in Korea and what kinds of treatments he applied to the patients.

Compared to the records left behind by Dr. Allen, a Japanese doctor, named Koike Shojiki, left more informative and interesting records on mental patients in Korea (Koike 1887). He was an army doctor who treated Japanese inhabitants in one of the treaty ports, Busan. After his service in Korea, he wrote a book in which he described his medical experiences in the country. Although the majority of his

patients were Japanese, he also treated some Koreans. He provided comparative statistics of the diseases of the Japanese and the Koreans. Among various diseases, a significant disparity appears in mental illnesses. According to his statistics, the number of Korean mental patients with such illness was far below that of the Japanese patients. He attributed the small number of mental patients to the mental inferiority of the Koreans compared to the Japanese. According to his theory, Koreans were not yet freed from their savage state and therefore did not think very much about complicated matters. In other words, there were few mental patients in Korea because they were mentally primitive and naïve. It is interesting to note that the prevalence of mental illnesses was used to justify racial prejudice before anthropometric indices were introduced for the same purpose.

Mental Health During the Japanese Colonial Period (1910–1945)

After Japan annexed Korea in 1910, many changes took place in the field of public health, including mental health. Before the colonial period, mental patients had never been subject to special control by the government. They may have been the objects of personal treatment, but not collective treatment. However, during the colonial period, mental patients began to be perceived as dangerous individuals who needed special surveillance and control. Just as with patients with acute infectious diseases such as cholera and typhoid fever, the police were in charge of the control of mentally ill patients, and the mentally disordered were not allowed to wander around the streets. Primarily, the families of the mental patients were responsible for caring for the patients. However, patients were sent to an institution when they became unable to recognize their family members.

Coupled with this change in social perceptions of mental patients, special institutions for housing them were established. The Japanese Government in general established two different kinds of institutions. The first institution, *Jesaengwon* (濟生院), was opened in 1911. It was more like a general asylum in which not only mental patients, but also the blind, the deaf-and-dumb, and orphans were housed. Later, the mental patients in these institutions were treated by psychiatrists at the Colonial Government Hospital. In *Jesaengwon*, the Colonial Government Hospital opened a special ward for mental patients in 1913. The ward could admit 35 patients, which was one-tenth of the total number of inpatients at the hospital (Lee 2013).

The second institution, a public isolation hospital called *Soonwhawon* (順化院), was opened by the Japanese colonial government in 1911 (Park 1998). The idea of confining mental patients against their will in a special institution was foreign to Koreans. The idea probably came from that of isolating infectious patients. When infectious patients were detected by a policeman, they were admitted to an isolation hospital against their will. The compulsion was justified by the supposed danger

that the patients presented to general society. However, the main purpose of the isolation was to prevent potential infection of others rather than to treat the patients in question (Lee 2013). The police in particular were active in preparing the related law for admitting mental patients because they regarded them as one of the causes of social unrest. As a result, the police proposed establishing a special institution for mental patients under the direct control of the colonial government. However, their plan was not realized, and the number of beds for mental patients did not significantly increase throughout the colonial period. This is in contrast to the case of lepers in colonial Korea. The Japanese colonial government made Sorok-do, a beautiful island in the southern sea of Korea, a huge leprosarium, and sent thousands of lepers from all over Korea to the island. This difference probably reflects the fact that mental health was a low priority among public health issues during the colonial period, and therefore, the available sources for mental health were very limited. In addition, the colonial government treated the issue of public health as a matter of social order. So, the police were put in charge of mental health issues.

Missionary institutions had a different approach to mental health because of a different view of mental diseases and their nature. The medical view at the time was mainly biological. Psychiatry was not sharply distinguished from neurology, which was considered a branch of internal medicine. It was common for mental patients to be treated in the department of internal medicine in hospitals where there were no departments of psychiatry. The main therapies such as electric shock therapy and insulin coma therapy were based on the assumption that the basis of all mental diseases was biological. At least up until the 1950s, psychoanalytical or psychodynamic views of mental diseases were marginal in the medical world.

Mental diseases were also represented as spiritual problems in the Bible. As a result, Christian views on mental diseases differed in some cases from medical views of the time. It was persuasively expressed by the missionary psychiatrist, Charles I. McLaren (1882–1957). Dr. McLaren was an Australian missionary doctor who came to Korea in 1911. He took charge of the psychiatric department of Severance Union Medical College, the only Christian medical school in Korea. His views on mental diseases and their remedies are noteworthy. According to his view:

> Korea has its full share of the blight of neurasthenia, which is induced by perversions of sex ideals, unnatural practices, impractical marriage standards of concubinage, the anxieties of sordid and grinding poverty and pangs of a people fretting under an alien rule. Sympathy and understanding, and above all the good news of the Christian faith, are the sovereign remedies which prove time and again efficient to cure this disease (McLaren 1924).

Dr. McLaren had a deep interest in human nature and the mind. His thinking on these subjects was based on his Christian faith and philosophy. He claimed that the Christian faith played an important role in curing mental diseases. As a psychiatrist, his views on mental diseases were quite unique. Although he was very familiar with psychoanalytical theory, he was not very sympathetic to the theory of Freud. It is not very difficult to speculate about the reason why: Freud's focus on sexuality would make a devout Christian like Dr. McLaren uncomfortable. He had a more favorable opinion of Adler's view, which underlined not only sexuality but also

work and friendship. However, he was different from other psychoanalysts in that the spiritual dimension of the human mind had great importance in his theory. Although he laid emphasis on psychological and spiritual aspects, he did not forget the biological foundation of the human mind.

In addition, Dr. McLaren emphasized the humanitarian treatment of the insane. When he began to work at the department of psychiatry of Severance Hospital in 1923, there was no ward for the mentally ill. It was his dream to have such a ward, and this was realized in 1930. It is interesting to note that his desire to have a special ward was based on reasons different to those of the colonial government. For the latter, it was necessary to accommodate the mentally ill because they were seen as dangerous to society. For Dr. McLaren, it was necessary to accommodate them to protect them from a society that might persecute them. He said that he often saw them "wandering about the streets of cities or among the villages of the land, harassed too often by a cruel and jeering crowd" (McLaren 1924). As a result, he wanted to provide them with a kind of shelter in which they could rest secure. His main focus was the welfare of the mentally ill who were socially marginalized. Students of his who went on to become psychiatrists inherited his humanitarian attitudes. Among them was Dr. Lee Chung Chul who took charge of the department of psychiatry after the resignation of Dr. McLaren (Yeo 2008).

Post-colonial Period (1945–1960)

The Korean War (1950–1953) broke out following the invasion of South Korea by the communist North Korean Army on June 25, 1950. This civil war not only destroyed hospitals and dispersed doctors, but also caused great psychological trauma to Koreans. After the cease-fire, military and political tension and reciprocal hatred across the demilitarized zone (DMZ) between South and North Korea remained through the cold war period and continues today. However, this war provided Koreans with opportunities to interact with foreign cultures and to open their eyes on the outside world.

A few psychiatrists began to study psychoanalysis. In the mid-1950s, chlorpromazine was introduced by the Army Psychiatric Association. Fever therapy and insulin shock therapy disappeared, but ECT was still popular. In 1959, the number of beds for the mentally ill was estimated to be only about 580 in a population of 20 million.

In 1945, psychiatry lectures were given in only three medical colleges, and there was only one university-hospital-trained psychiatrist. During the Korean War, the medical system was destroyed, but American medicine and surgery were introduced to Korea by army doctors. From 1951, American Army psychiatrists helped Koreans to undertake psychiatry training at a US Army Hospital. In 1952, some young Korean army doctors were given the opportunity to go to the USA for several months of psychiatric training. In 1954, the Army Psychiatric Training Program ("division of psychiatry") was initiated at a central army hospital. It trained

45 psychiatrists for 3 years, while they were working at branch army hospitals or in army divisions. After discharge from the army, they set up psychiatric practices in private clinics or in newly established university hospitals around the country.

Economic and Political Development Period (1961–2000)

The period from the 1960s through to the 1980s in Korea was characterized by rapid economic development and industrialization under the military dictators' rule. GNP per capita had increased from about 70.00US$ in the 1960s to 11,160US$ by 1980. At the same time, the democratization movement had begun. The population had increased from 24.9 million in 1960 to 38.2 million in 1980. With the economic development, the number of doctors including psychiatrists gradually increased along with an increase in medical schools and hospital beds. The numbers of psychiatric beds in legal mental hospitals and asylums increased rapidly from 583 in 1961 to 3868 in 1978 (75% were private and illegal asylums were not counted). The number of psychiatrists increased from 93 in 1964 to 2258 in 1980.

By 1970, most types of first-generation psychotropic drugs had been introduced in Korea. Pharmacopsychiatry and biological aspects of psychiatry began to develop, although dynamic psychotherapy was still popular. Drug therapy and psychotherapy also increased (85 and 12.4%, respectively), but ECT was less frequently practiced (26%) than before (Oh 1973). Most inpatient service was still custodial. The first open ward was opened in 1960, and a day ward was opened in 1973. In rural areas, about 72.5% of psychotic patients were living in their hometown and they sought help mostly from traditional medical practitioners (20.0%), shaman practitioners (15.1%), and Western doctors (10.7%) (Lee 1972).

Previously, most patients with mental disorders were confined in their homes, asylums, or abandoned because of a lack of beds, poverty, or stigma. The national health insurance system (NHIS) was started in 1963, and its coverage was completed by 1989. The percentage of patients supported by Medicaid, Medicare, or the disability welfare system increased. During the economic development of the 1980s (economic development rate 6.8–13.0% every year), the numbers of psychiatric beds increased rapidly, with more than 50,000 (including 14,000 beds in asylums) available by 2000. In 1995, the number of psychiatrists was 1012. From the mid-1980s, a second generation of psychotropic drugs was introduced. These included Prozac and Risperidone. Pharmacotherapy became popular. New psychotherapeutic therapies such as cognitive behavior therapy also began to be introduced.

In the meantime, medical costs had increased rapidly. Families brought mental patients to less expensive, illegal asylums and asked to hold them as long as possible. The government was unable to develop countermeasures in advance of this rapid change. As a consequence, many quasi-Christian illegal asylums ("pray-houses") were established by non-medical owners. These heralded the so-called period of grand confinement in Korea.

A TV documentary on an illegal pray-house was broadcast, showing patients neglected and chained in dark isolated rooms, with iron bars on the windows. The horrific scenes shocked all Koreans (Association 2009). Stimulated by another TV documentary on human rights violations in an illegal asylum in 1983, together with increased pressure from psychiatrists and advocate groups, the Korean government provided a financial subsidy to improve illegal asylums and mental hospitals. Accordingly, the number of new mental hospitals and asylums increased rapidly in the private sector. They were generally devoted to cost savings and long-term institutionalization.

After the 1960s, there were several attempts by the government and psychiatrists to draw up a mental health act. Both were advised by the WHO. However, none of the proposals progressed due to budgetary constraints. Stimulated by the TV documentary about the illegal asylum in 1983 and pressured by psychiatrists and other mental health professionals, the government of the military dictator president proposed a draft of a mental health act in 1985. However, it was criticized because it violated human rights and because it could potentially be abused for political purposes. A revised draft was proposed in 1990. After a long and heated debate, the Mental Health Act was passed in 1995. In 1995, the Korean Family Association for Mental Health was founded.

Current Status of Mental Health (2000–Present)

By 2013, there were 3412 psychiatrists, and the number of psychiatric beds was estimated to be more than 90,000 (including about 10,000 beds in asylums). From 2010, any Korean with a mental disorder could receive proper psychiatric treatment from a team of highly educated professionals including psychiatrists, psychiatric nurses, clinical psychologists, and psychiatric social workers at any psychiatric institute regardless of the patient's economic status. Almost all types of psychiatric treatment methods are practiced in Korea. However, psychosocial rehabilitation and community services are yet to be developed.

In 2011, only about 7% of the general population consulted mental health professionals. Further, among people with mental illness, only 15.3% (11.4% in 2006) had used a mental health service and 11.9% had visited a psychiatrist. Regarding psychotic disorders, the duration of untreated psychosis (DUP) was 84 weeks and the duration of hospital stays was 166 days. These data suggest that there is a serious stigma attaching to mental disorders.

Community Mental Health Care System

With enactment of the Mental Health Act, the mainstream public mental health service moved gradually from traditional hospital-based psychiatric care to

community-based services and deinstitutionalization. In 1988, the first community mental health center was opened in Kanghwa Island by the Department of Psychiatry, Yonsei University College of Medicine. However, these significant attempts eventually failed due to a lack of financial support from the government.

Based on a model project of a community mental health center in 1995, 165 community mental health centers (65%) were established in 253 districts by 2012 and nine regional mental health centers were founded in 16 regions. Despite the deinstitutionalization policy, the number of beds in mental hospitals and asylums increased from about 30,000 in 1990 to about 90,000 in 2010 (Lee 2012). This increase was attributed to the uncontrolled governmental subsidy and a hasty, unplanned, not systemic, and bureaucratic policy based on convenience. The government had to revise once again the direction of reform. Since 2012, it has been developing the Comprehensive National Mental Health Promotion Plan.

Epidemiology

In 1960, a nationwide epidemiological survey was conducted (Yoo 1962). In the 1980s, epidemiological studies using DSM-III were conducted on a national scale (Lee et al. 1986) and on Kangwha Island (Lee et al. 1989). According to the Mental Health Act, nationwide surveys of mental disorders must be conducted every five years: in 2001, 2006, and 2011. The 2011 survey of a total of 6022 subjects revealed that the lifetime prevalence of all DSM-IV mental disorders was 27.6% and that the one-year prevalence was 16.0% (Cho 2011). In males, alcohol abuse disorder was the highest, whereas anxiety disorders were the highest in females. The lifetime prevalence of mental disorders (except alcohol abuse disorder and nicotine abuse disorder) increased from 12.6% in 2006 to 14.4% in 2011 (22.9% increase). In particular, major depression, specific phobias, GAD (general anxiety disorder), and PTSD (post-traumatic stress disorder) were the most prevalent disorders (Table 5.1), and their prevalence increased in the last five years. Somatization disorder increased 150%, but it accounted for only 0.1%. However, it should be noted that if criteria for Korean culture-related somatic symptoms were included in the diagnostic criteria, more patients (5.45%) would be diagnosed as having somatization disorder (Lee et al. 1989). However, alcohol and nicotine abuse disorders decreased.

Mental Health Issues in Korea

Suicide is one of the most significant current mental health problems in Korea. Suicide rates have increased from 8.7 per 100,000 in 1983 to 31.2 per 100,000 in 2010 (an increase of about 358.1%) (Ha 2012). A strong policy of prevention of suicide and follow-up care of the family has been developed. This includes the

Table 5.1 Lifetime prevalence rate of DSM-IV mental disorders in Korea (2011)[a]

Diagnosis	Lifetime prevalence rate
N = 6022	(%)
Schizophrenia[b]	0.2
Brief psychotic disorder	0.4
Major depressive disorder	6.7
Dysthymic disorder	0.7
Bipolar disorder	0.2
OCD	0.8
PTSD	1.6
Panic disorder	0.2
GAD	1.9
Agoraphobia	0.4
Social phobia	0.5
Specific phobia	5.4
Bulimia nervosa	0.2
Somatization disorder	0.1
Somatization disorder, Korean criteria[c]	5.45 (1989)
Conversion disorder	0.5
Pain disorder	0.3
Hypochondriasis	0.7
All	14.4
Alcohol dependence	5.6
Alcohol abuse	8.5
Nicotine dependence	5.5
Nicotine withdrawal	3.1
All	28.1

[a]Ministry of Health and Welfare (2011) National Survey of Mental Disorders
[b]Includes schizophrenia and schizophreniform disorders and delusional disorder
[c]Lee et al. (1989)

enactment of the Act for Suicide Prevention and Promoting Respect of Life in March 2011 and the establishment of a National Suicide Prevention Center.

Individuals over 65 years accounted for 11% of the general population in 2013. Depression was found in 10.1% of this aged group. There was also a high prevalence of dementia. In a national survey in 2011 of 6141 subjects aged over 65 years, 8.1% had dementia (30.5% in a group over 80 years) (Hong 2012). In 2006, the government launched a nationwide dementia early detection and early intervention project. A District Dementia Support Center was also established.

Although the proportion of young people in the population is decreasing, their mental health problems among this population including ADHD have increased

(Cho 2012a). Cho (2012a) reported the following prevalence rates: ADHD 13.25%, autism spectrum disorder 2.64%, depression 0.52%, juvenile bipolar disorder 1.09%, anxiety disorder 23.02%, conduct disorder 11.34%, and Internet addiction disorder 6–14%. In children and adolescents, bullying and suicide have become important school mental health problems. To address this issue, the government has established the National Bullying Prevention Program.

For a long time, alcohol drinking and smoking have been significant health problems. In addition, opium was a serious social problem during 1945–1960. Methadone and marijuana were popular in the 1970s. Methamphetamines, tranquilizers, and inhalants were included in the list of abused drugs in the 1980s, and dextromethorphan, cocaine, MDMA, and nalbuphine were included during the 1990–2000s (Cho 2012b). The government set up the Drug Countermeasure Council on April 18, 2002. The first narcotics anonymous group was started in 1996, and now, there are five such groups in Korea. According to a 2011 survey, the prevalence of pathological gambling was 1.0% (Joe 2012). As a countermeasure, the National Gambling Control Commission Act was passed on May 2, 2012. The prevalence of Internet addiction was 1.0% (males 1.4%, females 0.7%), with the prevalence highest in the 18–29-year-old group (1.9%) (Lee 2012).

Affect Haan and Korea-Specific Factors

How can the current increase in rates of depression, anxiety, and suicide be explained and how are they related to the economic and political development? First, the speedy development is related to Koreans' enthusiasm to work hard to be rich, "education fever" for their children, and an anti-dictator human rights movement that emerged from social suppression. These behaviors are commonly used to explain the affect *haan* (恨) (Park and Lee 2009).

Haan is a Korean traditional culture-related, collective affect of chronically suppressed and accumulated anger accompanied by feelings of unfairness. *Haan* is thought to develop as a result of victimization and poverty relating not only to Koreans' individual lives (e.g., traditional class and gender suppression) but also their national history of having frequently been offended (e.g., frequent invasions by neighboring countries, the Sino-Japanese War and the Russo-Japanese War in the Korean peninsula in the nineteenth century, Japanese colonial rule, WWII and consequent national division, and the Korean War). Accordingly, the affect *haan* is thought to have enabled Koreans to survive hardship and poverty in their personal lives and in their national history by drawing on their traditional culture of enthusiasm, humor, and art (typically the "art of sorrow"). Sometimes, suppressed anger and feelings of unfairness have erupted collectively and resulted in social reform. Accordingly, Koreans refer to their culture as a culture of *haan* and to their history as a history of *haan*. In a person, *haan* might be partly inhibited, partly expressed, and partly somatized. Koreans call this condition *hwa-byung* (火病), meaning anger (fire) disorder (Min 1991). *Hwa-byung* is seen as a Korean

culture-related anger syndrome, which is different from depressive, anxiety, or somatization disorders but can be comorbid with them (Min and Suh 2010).

In the twentieth century, when Koreans could realize through education their situation in personal and national history of unfair victimization, they began to work hard to emerge from poverty and to prevent future victimization and social suppression. During Japanese colonial rule, their enthusiasm was expressed in independent movements and education that resulted in industrialization and democratization. After these developments, a new *haan* developed again in the working class and the youth in reaction to relative poverty with widened economic parity, corruption, suppression in the labor market, and concerns about unemployment and future. Depression, suicide, anxiety, somatization, and alcohol drinking were attributed to this new *haan*. In contemporary Korea, the prevalence of even *hwa-byung*, an anger disorder, is reported to be 4.1% in the general population (Min and Namkoong 1990). In this regard, it seems to be a uniqueness of contemporary Korean situation that productivity and mental health problems may be sides of common affect *haan*, which is suppressed anger and feeling of unfairness.

Conclusion

Over the last 60 years, Koreans have achieved rapid, "condensed" development via industrialization and democratization after long endurance of past historical sufferings. However, the associated social changes have given rise to significant mental health problems among Koreans.

Unrelenting competition has become a daily part of life in Korea, as well as income inequality, which may be a source not only of sociopolitical frustration but also of increasing mental health problems such as a high suicide rate. Psychosocial stress associated with the rapidity of the social changes that have taken place and competition in a globalized world, in addition to the Korea-unique affective component, *haan* (chronic suppressed anger and feeling of unfairness), underlie the recent increase in mental health problems. In the near future, Korea will become an aged society, with an increase in the social burden of mental health of the aged.

In clinical and community services, Korean psychiatrists are challenged to develop Korean-specific ways of dealing with mental health problems. These should be based on the integration of cultural heritage, social resources, humanism, and advanced knowledge and skills. In particular, Korean psychiatrists should find ways for Koreans to overcome personal and collective *haan*, old and new and sublimate, and transform *haan* for creativity and productivity, as their ancestors once did. Some Korean psychiatrists are working on integrating traditional Asian philosophy with Western psychotherapy (Rhee 1985). The Korean government has already acknowledged that social and financial investment is needed to promote mental health. In addition, Korean psychiatrists are working with other scientists to identify novel psychotropic compounds in traditional herb drugs used for mental

illness (Min and Hong 2007). Korean psychiatry should take a role in the preparation for the future reunification of Korea and in the reconstruction of psychiatry in North Korea (Min 2008). Research over the last 20 years on early PTSD among North Korean defectors who lived in fear of detection, arrest, and punishment after defecting from totalitarian communist North Korea and their later adaptation problems in capitalistic South Korea will be of help in predicting possible conflicts between North and South Koreans before the process of reunification and after it (Jeon et al. 2013). The reunification of Korea in the future will be a crucial historical event in the future of the country (Min 2008). Another newly emerging challenge is that Korea is becoming a multicultural (multiethnic) society. The mental health of marriage immigrants and their mixed-blood children is closely related not only to cultural differences but also to discrimination (Kim et al. 2011). Given these challenges, mental health specialists in Korea need to be prepared for future social changes and for finding a path toward a better society.

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Chapter 6
Mental Health System in Japan After the Meiji Restoration: Historical Observations

Naotaka Shinfuku

Abstract Modern Japanese psychiatry began with a small number of Japanese psychiatrists who studied psychiatry in Germany more than 100 years ago. The Japanese Society of Psychiatry and Neurology (JSPN) was established in 1902. Before World War II, Japanese psychiatry was under the heavy influence of German psychiatry. After World War II, British and American psychiatry was introduced. Unlike other developed countries, Japan increased the private hospital beds financed by public funds. Currently, there are more than 1600 psychiatric hospitals with 300,000 psychiatric beds. Japan has the largest number of psychiatric beds in the world, both in absolute and in relative terms. The number of members of JSPN is approximately 16,000, second only to that of the American Psychiatric Association (APA) which has about 38,000. The JSPN is the biggest national psychiatric society in Asia. To date Japan has not played a due role in improving psychiatry and mental health services of neighbouring Asian countries. In this chapter, I present my personal viewpoints about the historical development of psychiatry and mental health services over the 100 years since the introduction of psychiatry into Japan.

Introduction

The Meiji Restoration (the *Meiji Ishin*, also known as the Renovation, Revolution, Reform or Renewal) was a chain of events that restored imperial rule to Japan in 1867. The Restoration caused many political and social changes in Japan, including moving the imperial palace from Kyoto to Tokyo (Reischauer 1990). This period, 1867–1912, covered the late Tokugawa Shogunate (Edo period) and the beginning of the Meiji period. The Meiji Restoration was instrumental to the emergence of Japan as a modern nation in the early twentieth century.

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In this chapter, I will consider a series of important events that occurred in Japanese mental health services after the adoption of Western medicine that largely replaced traditional Japanese medicine.

Foundation of Modern Psychiatry in Japan

Introduction of Modern Psychiatry into Japan

Modern Japanese psychiatry emerged in the late 1800s with the establishment of the Kyoto Lunatic Asylum in 1875 and the Tokyo Metropolitan Lunatic Asylum in 1879. The Tokyo Asylum was later renamed the Matsuzawa hospital and served as the leading psychiatric centre in Japan. During this period, the number of psychiatric hospitals throughout the country remained small. In reality, most persons experiencing mental health problems were cared for by family members (Okada 2002; Kazamatsuri 2012). In 1900, the "Home Custody Act of Mental Patients" was enacted which prohibited the vagrancy of mental patients, making family members responsible for their care. The purpose of the law was to ensure public security, but resulted in the mandatory home detainment of many mental patients in prison-like conditions (Kazamatsuri 2012; Kato 2000).

Academic psychiatry in Japan was nurtured by German psychiatry, with most psychiatrists referring to Kräpelin's (1899) textbook until World War II (WW2). The word "psychiatry" was translated to Japanese as *seishin-igaku* and "schizophrenia" as *seishin-bunretsu-byou* (Sato 2006; Shinfuku 2012). These terms were exported and adapted in Chinese, Korean and Taiwanese and remain in use.

Doctor Shuzo Kure—The Father of Japanese Psychiatry

Doctor Shuzo Kure has been called the "father of Japanese psychiatry" for his outstanding contribution to the improvement of care of mental patients in Japan (Okada 2002; Kazamatsuri 2012). Doctor Kure, an alumnus of German psychiatry, was a Professor of Psychiatry at Tokyo University from 1901 to 1925 and Director of the Tokyo Metropolitan Lunatic Asylum. As Asylum Director, Kure ensured that patients were unchained, a radical idea at the time (Okada 2002; Kato 2000). Additionally, in 1902 with colleagues from the University, he established the *Japan Society of Neurology* which later became the *Japanese Society of Psychiatry and Neurology* (*JSPN*), and started its official journal "Neurology". Throughout his career Kure was a vocal proponent of a human rights focus for mental health treatment in Japan. Kure started the Federation for the Welfare of Mental Patients in 1902. Later, Kure highlighted a double burden faced by Japanese people suffering from mental health problems, stating that "mental patients in Japan have double

miseries, one is to have a disease and the other is to be born in this country" (Okada 2002).

In view of the paucity of psychiatric beds, Kure set about promoting the building of public psychiatric hospitals. In 1919, the "Mental Hospital Law" was enacted. The Law recommended that all local governments build at least one psychiatric hospital in each prefecture. Despite this, the Law was implemented only in several prefectures due to the lack of financial resources and the strong stigma associated with mental diseases in local communities. The number of psychiatric beds per 100,000 people in 1930 was 32 in the UK, 24 in the USA and 16 in Germany. However, its number in **Japan was very small, about one-tenth of those figures**. In 1941, it was estimated that there were 11,139 psychiatric inpatients and 5997 patients in home custody (Shinfuku 2012).

World War II

During WW2 doctors and nurses were recruited for military service leaving psychiatric patients without sufficient food or adequate care (Okada 2002). Matsuzawa Metropolitan Psychiatric Hospital, a leading psychiatric centre in Japan, reported a high mortality rate of psychiatric inpatients during the War (Shinfuku 1998). Specifically, the mortality rates significantly increased from 13.63% in 1943 to 31.19 and 40.89% in 1944 and 1945, respectively. Many patients died from malnutrition, a condition which also impacted the general population. After the War, the rate was more than halved from 13.50% in 1946 to 5.05% in 1947. The situation in Matsuzawa Hospital was similar to that experienced in psychiatric facilities nationwide. The above figures are testimony to the hardships endured by psychiatric patients during WW2 (Okada 2002).

Restoration of Japanese Mental Health Services

Soon after WW2, the Ministry of Health and Welfare (MOHWEL) started to develop a new law covering mental health service under the guidance of the Occupation Force.

Mental Health in Japan Soon After World War II

In 1949, 81 private psychiatric hospitals formed the Japan Psychiatric Hospitals Association. The Mental Hygiene Law was presented to the *Diet* (Parliament) in 1950 and adopted. The new law prohibited the home custody of mental patients.

Local governments were made responsible for establishing facilities to take care of psychiatric patients. The facilities could be replaced by designated private psychiatric hospitals. As directed by this law, the National Centre for Mental Health was established in 1950. It was only in 1956 that the Ministry of Health, Labor and Welfare (MHLW) set up the Division of Mental Health as an independent division under the Bureau of Public Health (Shinfuku 2012).

The Mental Hygiene Law was also called the "Involuntary Admission Law". This law listed three kinds of hospitalization: (1) involuntary admission by order of the governor; (2) admission by family consent and (3) voluntary admission by the patients' will. The Government underwrote the fee for taking care of the patients with involuntary admission and admission by family consent (Shinfuku 2012).

The Mental Hygiene Law was not the same as those in the USA such that family members were able to consent to the admission of a psychiatry patient in Japan. Familial consent-based admission accommodated the family-oriented characteristics of the collectivist culture found in Japan. Nonetheless, it was later found that this form admission was being exploited, resulting in an extremely lengthy hospitalization of many inpatients. In addition, many family members, who were exempt from paying medical fees during the hospitalization, were reluctant for their sick family members to be discharged from the hospital.

Increase of Private Psychiatric Hospitals and Beds Since the 1950s

Starting from the 1950s, the private psychiatric sector in Japan has undergone significant expansion. Fewer than 30,000 patients were hospitalized in 185 psychiatric hospitals nationwide in 1953. Since then, there has been an increase by almost 10,000 psychiatric beds annually. In 1961, the number of psychiatric hospitals had risen to 543, providing more than 100,000 beds nationally. The ratio of psychiatric beds per 10,000 people increased from 2.30 in 1951 to 6.08 in 1956, and 11.27 in 1961 (Shinfuku 2012). This increase was led by the private sector and was coupled with the contraction of the public psychiatric sector. For example, the proportion of public psychiatric beds decreased yearly from 26.8% in 1955 to 20.5 and 15.1% in 1960 and 1970, respectively.

Accordingly, Japan now has the largest number of psychiatric beds in the world both in absolute and in relative terms. The aforementioned increase in psychiatric beds since the 1950s is a reverse of the trend shown in the US and many European countries since the 1960s to shift care from inpatient psychiatric facilities to the community (Shinfuku 2012).

Socioeconomic Context Surrounding The National Mental Health Policy

Several socioeconomic changes from 1950 to 1980 supported the expansion of the private psychiatric sector in Japan. First, the relaxation of regulation by MHLW in 1958 promoted the construction of new private hospitals. Specifically, the required ratios for the number of patients per doctor and nurse were reduced threefold in psychiatric compared to general hospitals. This served to reduce expenditure on human resources, thereby creating the opportunity for "mental hospitals [to make] money" (Shinfuku 1998, 2012). Private psychiatric hospitals were opened not only by psychiatrists but also by doctors of other medical disciplines and, in some cases, by business-minded entrepreneurs.

Second, the introduction of National Health Insurance to Japan in 1961 served to expand the demographic for whom private psychiatric care was available. Almost all expenses for psychiatric inpatients could be covered by several public financial measures. These schemes included the financial support regulated by the Mental Hygiene Law, the Livelihood Protection Law and the National Health Insurance Law. As such, private psychiatric hospitals were opened and managed by private entities, but financially supported by public funds (Shinfuku 1998, 2012).

Third, reductions in average family size and house size driven by population growth and increasing urbanization during this period meant that many patients no longer had a place to which to return. Fourth, patients seldom had the chance to complain and sometimes were easily institutionalized. Fifth, there was a lack of community services. Finally, a strong stigma concerning mental illness in Japan meant that persons experiencing mental health problems, especially schizophrenia, were excluded from their community (Shinfuku 2012; Asai 2009).

Visits of WHO Consultants to Japan

During the 1950s and 1960s, four WHO officials visited Japan to review the mental healthcare system (Clark 1968). During his visit in 1953, Professor Paul Lemkau from Johns Hopkins University stressed the importance of community-based mental health services, specifying that Public Health Centres strengthen their mental health activities. A year later in 1954, Daniel Blain, Director of the Mental Health Division in the State of California, recommended the establishment of day care services and psychiatric clinics at general hospitals, and the training of mental health workers. However, the recommendations of both these WHO officials were not implemented.

Professor Mortan Kramer, the third WHO official to visit Japan in 1960, under-scored the importance of a psychiatric epidemiological survey in Japan. In 1967, David Clark from the UK repeated the previous WHO call for a transition to community-based, mental health services in Japan. In addition, he highlighted the

need for: a review of quality of care in private psychiatric hospitals; aftercare and rehabilitation for patients; and an increase in the funding of care for psychiatric outpatients (Clark 1968). These recommendations, like the ones before them, were ignored by the Director of the Mental Health Division in the Ministry of Health (name needed here), who stated that "Japan has nothing to learn from this report" (Kato 2000). This statement reflected the reluctance of both the government and general population to treat psychiatric patients in the community. Such attitudes were inflamed by incidents such as the high-profile attack in 1964 of an American Ambassador (Reischauer, E.O) to Japan by a patient suffering from schizophrenia. At the same time, the Japan Private Hospital Association (*Nissei-kyo*) became a strong political player to protect the interests of members (Shinfuku 2012; Asai 2009).

Impact of ICD and DSM in Japan

Psychiatry in Japan remained heavily influenced by German psychiatry even after the end of WW2. Many senior Japanese professors and leading psychiatrists had studied in Germany before the War. Biological psychiatry was dominant and philosophical psychiatry was popular among non-biologically oriented psychiatrists. German psychiatry lost the power during 1980s with the revelation that several leading German psychiatrists were members of the Nazi party. Japanese psychiatry became increasingly influenced by American principles (Shinfuku 2012). It was during this time that the *International Classification of Disease* (*ICD*) and *the Diagnostic and Statistical Manual* (*DSM*) were translated into Japanese and widely adopted.

However, disputes ensued regarding the use of operational diagnostic systems. Opponents of the DSM/ICD approach, generally German-trained senior professionals, dismissed these manuals as "shallow", "lacking clinical realities" and with "no consideration to psychopathological aspects". Conversely, younger psychiatrists found the operational diagnoses had better inter-rater reliability among different doctors and nurses and allowed for greater opportunities for teamwork and international collaboration.

Japanese Culture and Psychotherapies

Since its introduction in the seventh century, Buddhism has profoundly influenced Japanese culture. A fundamental principle of Buddhism is the acceptance that ageing, disease and death are natural parts of life. Psychoanalysis was very seldom used in daily practice by Japanese psychiatristrs. Very few Japanese psychiatrists use Morita therapy and Naikan therapy as explicit methods. However, the philosophy and approach behind these two methods are used as common sense psychotherapies by Japanese psychiatrists in their daily practice. Two uniquely

Japanese psychotherapies have emerged from Buddhist teachings—*Morita* therapy and *Naikan* therapy. *Morita* Therapy is underpinned by *Zen* Buddhism which places value on "true experience" and devalues logical thinking. *Naikan* therapy was developed from the "*mi-shirabe*" method used to train monks in the *Pure Land Sect*, a variation of Buddhism to which many Japanese people subscribe. This method asks new monks to meditate on their relations with important persons in their lives such as their mother, father or teacher. Despite the importation of Western psychoanalysis into Japan at the beginning of twentieth century, the majority of Japanese psychiatrists did not accept psychoanalysis. They employ *Morita* or *Naikan* thinking as common sense psychotherapies (Shinfuku and Kitanishi 2010).

Psychopharmacotherapy

Psychopharmacotherapy has been the main treatment option for mental illness in Japan since *Chlorpromazine* was introduced in 1955 (Okada 2002) and H*aloperidol* in 1964 (López-Muñoz et al. 2005). The sedative effect of these psychotropic drugs eased the management of inpatients, and they were reportedly used at high doses to this end (Sim et al. 2004).

High-dose prescriptions and polypharmacy are recognized as issues in Japan. Since 2001, there has been a major shift from the prescription of first-generation antipsychotic drugs to second-generation antipsychotic drugs (Sim et al. 2004; Shinfuku and Tan 2008). This shift has been accompanied by changes in the profile of reported side effects of these medications alone and when used in conjunction with other medications. Recently, the MHLW has introduced measures to reduce the practice of polypharmacy in Japan.

Development of Community-Based Mental Health Services

In 1965, the Japan Association of Families of Mental Patients (*Zenkaren*) was founded. *Zenkaren* became a strong force to improve the care and rehabilitation of mental patients in Japan. In 1980, more than 300,000 patients with mental disorders were in psychiatric hospitals. Of them, more than 100,000 patients were in residence for more than 10 years. About 80% (240,000) were diagnosed as having schizophrenia.

Human Rights Violations at Private Psychiatric Hospitals

In 1984, a patient was maltreated by a male nurse and died at Utsunomiya Hospital in Tochigi Prefecture (Shinfuku 2012). This incident became famous as the

"Utsunomiya Hospital Scandal". The news drew attention to the miserable condition of some private psychiatric hospitals in Japan. Several similar violations of human rights were reported at other hospitals. The event also attracted the attention of international human rights groups. Special delegates from the World Psychiatric Association (WPA) and the International Jurist Organization (IJO) visited Japan to undertake an investigation.

Enactment of Mental Health Law in 1987

In response to pressure generated by the WPA and IJO inquiries, the MHLW changed the system of psychiatric services. In 1987, the MHLW adopted the Mental Health Law with a focus on the human rights of patients treated in inpatient wards and the promotion of community mental health services (Shinfuku 2012). At that time, several measures to ensure the quality of mental health services were introduced. Hospital staffs were no longer allowed to check the personal letters of inpatients. Voluntary admission was recommended as the norm of admission. The system of Qualified Designated Psychiatrists was also introduced. Only a Designated Psychiatrist who had completed training about human rights and had extensive clinical experience was permitted to commit and treat involuntary patients.

Training of Social Workers and Psychiatric Social Workers

From inception in the late 1800s until the 1970s, service provision in psychiatric hospitals in Japan was performed exclusively by psychiatrists and psychiatric nurses. In the 1970s, occupational therapists started to function as paramedical staff at psychiatric services. Psychologists were restricted to conducting psychological testing (Shinfuku 2012).

After the 1987 changes to the Mental Health Law to promote community-based service provision, there was an increasing reliance on paramedical staff as experts in the development of community-based care. A national licensure examination for psychiatric social workers (PSW) commenced in 2000. Every year, more than 6000 PSW become registered. PSW are now principally responsible for community mental health services in Japan, working in multidisciplinary teams with occupational therapists, and clinical psychologists to provide care in the community (Shinfuku 2012; Asai 2009).

Other important stakeholders are the service-users. Patients are now conceptualized as users of the psychiatric services. User participation in the planning of mental health services has gradually increased in Japan (Shinfuku 2012; Asai 2009).

Changes of Financing System of Mental Health Care

In (2010), MHLW introduced a reimbursement system so that long-stay patients pay lower user fees (Shinfuku 2012). At the same time, MHLW established several incentives for psychiatrists to set up outpatient clinics. These policies have resulted in an increase in the number of private psychiatric clinics which now exceed 6000 nationwide. Many patients with depressive and anxiety disorders are treated at these clinics. The policies have also served to shift the demographic profile of private psychiatric inpatients. For example, the proportion of inpatients suffering from schizophrenia decreased from over 80% to fewer than 60% from 1980s to 2010s (Shinfuku 2012). Group homes near hospitals have been built to accommodate these patients with a chronic psychiatric condition. Conversely, the proportion of patients with Alzheimer's disease and other forms of dementia has sharply increased to almost 20% of the inpatients (Shinfuku 2012). According to 2014 MHLW statistic, 77,000 patients with the diagnosis of Alzheimer diseases and dementia were hospitalized out of 300,000 psychiatric inpatients in Japan.

The Japanese Society of Psychiatry and Neurology

The JSPN is an organization of registered Japanese psychiatrists with a membership of 16,000 (Shinfuku 2012). The official English journal of the JSPN was *Folia* (later named the *Psychiatry and Clinical Neurosciences* [PCN]). First published in 1933, *Folia* was in circulation until 1975 except for a suspension from 1938 to 1946 during WW2. In 1975, the Board of Directors of the JSPN withdrew support for *Folia* as its official journal because the majority of JSPN board members were critical that *Folia* was influenced by the opinions of university professors who did not pay enough attention to the human rights of mental patients.

This decision reflected a tension more broadly found in Japanese psychiatry in the 1970s in which new waves of Japanese psychiatrists attributed blame to older colleagues for the poor condition of the Japanese mental health system (Shinfuku 2012).

From 1975 to 2007, *Folia* was published by the *Folia Publishing Society* led by senior university professors. In 2008, the *JSPN* resumed publication responsibilities to produce the *Psychiatry and Clinical Neurosciences* (*PCN*) as the official journal of the *JSPN*. This publication, it has been suggested, symbolizes the end of conflict within the *JSPN* dating from the 1970s (Shinfuku 2012).

WPA Yokohama in 2002

The 12th World Congress of Psychiatry: Partnership on Mental Health was held for the first time in Asia since the foundation of the WPA in 1950. The Congress was opened in the presence of the Crown Prince Naruhito and Princess Masako and

attracted more than 7000 participants from all over the world. The Congress adopted the Yokohama Declaration and awarded the *JSPN* with the responsibility of promoting mental health care in Asia. At the 12th WPA in Yokohama, the Japanese term for schizophrenia—*seishin-bunretsu-byo*—was renamed *tougou-shiccyou-syou* (integration disorder) to reduce stigma (Sato 2006; Shinfuku 2012).

The 12th WPA Yokohama introduced Japanese psychiatry to the world. In 2003, the *JSPN* allocated a separate budgetary resource to international activities. The budget enabled the *JSPN* to invite young Asian psychiatrists to its Annual Congress and organize international symposia. Subsequently, the *JSPN* started to have an official relationship with national psychiatric societies in Asia and the Pacific. In addition, many Japanese psychiatrists contributed to the formation of the *Asian Federation of Psychiatric Associations* (*AFPA*). The *AFPA* now has membership from almost all national psychiatric societies in the Asia region (Udomratn and Shinfuku 2013).

The Current Major Challenges

Patients with Chronic Schizophrenia

Almost 100,000 patients with schizophrenia remain hospitalized in private psychiatric facilities for more than five years (Shinfuku 2012). Despite government plans to develop community-based services for these patients, there are few incentives for the private sector to bring this to fruition. First, there is strong resistance from local communities to the setting up of facilities for mental patients in their neighbourhoods. Second, the revenue source generated by inpatients means that many private hospitals are not keen to discharge inpatients (Shinfuku 2012). The government has introduced several measures to reduce the long-stay patients by lowering the payment to providers for long-stay patients (Ito et al. 2012). The average age of these long-stay inpatients is high. Most long-stay patients are over 60 years of age.

Depression and Suicide Prevention

In Japan, there was a sharp increase in reported suicides in 1998. After the burst of the asset bubble in 1990, the Japanese government adopted several measures which affected the traditional working system. Life-long employment and promotion by seniority were abandoned. Under pressure of globalization, many workers lost their jobs. From 1998 until 2011, more than 30,000 persons committed suicide per year in Japan. Depression was advanced as the primary cause of these suicides. The Japanese government enacted a Suicide Prevention Law in 2001. The law

recommended that local governments take necessary measures for the early identification and treatment of depression as an important contributor of suicide. In 2012 and 2013, annual suicide rates dropped to below 30,000 due to comprehensive suicide prevention measures (Kato et al., in press). Home visits by public nurses to isolated elderly people in remote villages contributed to the reduction of suicide in this population. However, the suicide rate among younger age groups has increased recently.

Hikikomori and New Type of Depression

Hikikomori, or severe social withdrawal, in Japan's young people has been a prominent public mental health concern since 2000 (Kato et al. 1970). Another recent concern is a syndrome anecdotally referred to as "modern-type depression". Modern-type depression is characterized by a shift in values from collectivism to individualism; distress and reluctance to accept prevailing social norms; a vague sense of omnipotence; and avoidance of effort and strenuous work. It seems to affect mainly those who were born after the 1970s: the generation growing up with home video games in the era of Japan's high economic growth.

Young people experiencing modern-type depression report feeling depressed only when they are at work; at other times, they enjoy the virtual world of the Internet, video games and *pachinko* (similar to pinball). Therefore, people with modern-type depression have difficulties in adapting to work or school and participating in the labour market, similarly to those with *hikikomori*. Psychiatric treatments have been shown to be ineffective for these patients. Peer supports have been demonstrated to be effective in the rehabilitation of *hikikomori* and modern-type depression (Kato et al., in press; Kato et al. 1970).

Disaster and Mental Health

In the early morning of 17 January 1995, the Kobe city (1.5 million inhabitants) and surrounding urban areas were devastated by the Great Hanshin Awaji Earthquake. This earthquake killed more than 5500 people immediately, with a further 350,000 people displaced. Peoples in Kobe experienced various physical and psychological problems after the disaster. These problems changed over the time. After the initial trauma of the disaster, victims began to present with depressive symptoms, alcohol-related problems and "solitary death" (please explain further what this term means) Shinfuku (2002, 2011). After the Kobe Earthquake, post-traumatic stress disorder (PTSD) became accepted in the general population and accepted as a normal reaction to the disaster (Shinfuku 2002, 2011). This phenomenon has contributed to the reduction of the stigma attached to mental health problems.

In 11 March 2011, an earthquake and tsunami devastated the Tohoku area, killing almost 20,000 people and displacing a further 300,000 people. The subsequent radiation leakages due to damage to the nuclear plants forced people to relocate as they were unable to go back to their communities due to high level of radiation. The resources of local communities are unable to cope with the long-term and widespread problems caused by such complex disasters (Shinfuku 2002).

Ageing and Dementia

Japan has among the world's longest living people, with Japanese men living on average to 79 years and Japanese women to 86 years. More than 23% of the population is over 65 years of age, and more than 50,000 people are projected to be over 100 years in 2013. This projection increases every year (Shinfuku 2012; MOHWEL 2010). A growing elderly population is a major problem faced by many Asian countries. Among those who are over 70 years old, 10% are suspected of having dementia; the proportion increases to 20% for people over 80 years and 40% for people over 90 years. Currently, more than two million people have been diagnosed with Alzheimer's disease and other forms of dementia (Shinfuku 2012). Care for those with dementia has become a social issue beyond the realms of medicine and psychiatry.

This rapidly ageing population is accompanied by a reduction in the birth rate. A few decades ago, Japanese women had on average between two and three babies. At present, women have on average 1.3 babies. This demographic change means that the age group of people supporting the elderly is rapidly shrinking (Shinfuku 2012).

Conclusion

Modern Japanese psychiatry began with a small number of Japanese psychiatrists who studied in Germany more than 100 years ago. The Japanese Society of Psychiatry and Neurology (JSPN) was established in 1902. Before World War II (WW2), Japanese psychiatry was heavily influenced by German psychiatry. After WW2, British and American approaches to psychiatry were introduced.

Unlike other developed countries, Japan increased the number of private hospital beds financed by public money. Currently, there are more than 1600 psychiatric hospitals with 300,000 psychiatric beds. Japan has the largest number of psychiatric beds in the world, both in absolute and in relative terms. The membership of JSPN is approximately 16,000, second in size only to the American Psychiatric Association (APA) which has about 38,000 members. The JSPN is the largest national psychiatric society in Asia. To date Japan has not played an appropriately large role in improving psychiatry and mental health services of neighbouring Asian countries. This is a major challenge for the future.

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Chapter 7
A History of Mental Healthcare in Taiwan

Harry Yi-Jui Wu and Andrew Tai-Ann Cheng

Abstract This chapter examines the development of mental healthcare in Taiwan. We describe the century-long transformation of mental health services from a focus on custodialism to a wide range of community projects. Having benefited from infrastructure growth under the Japanese, Taiwan has become a leader in mental health development in the region. We first highlight the survey studies conducted by a National Taiwan University Hospital team, which enabled psychiatrists to participate in social psychiatry projects initiated by WHO. We also discuss the unique, hospital-based community services in a context of resource scarcity before the government provided greater support. In addition, we comment on the challenges of the Mental Health Law. Finally, we discuss how mental health has recently focused on responding to the effects of natural disasters. We argue, on the one hand, the development of mental health has relied on the gradual professionalization of personnel, the education of citizens about mental health and input from lay people including non-governmental organizations (NGO) and service users during the last two decades. On the other hand, we suggest despite its achievements regarding services, legal reform and NGO initiatives, the mental healthcare system still faces obstacles because of rapid, substantial changes in Taiwanese and global society. In the epilogue, we describe the dilemma of mental healthcare providers who are caught between the growing role of lay actors and the pharmaceutical industry against a backdrop of neoliberalism.

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Introduction

In the Asia–Pacific context, Taiwan is a pioneer of mental health development. The development of mental healthcare in Taiwan is not a recent phenomenon. It has been affected by the social and cultural heritage of Taiwan's colonial past, and it has been influenced by the development of state and global health governance since World War Two, which created a series of disciplines, institutions, services and policies that supported the mental well-being of Taiwan's citizens. On the one hand, the development of mental health in Taiwan has relied on the gradual professionalization of the psychiatric professions, the maturation of mental health as a form of common knowledge and the input of non-medical communities, including non-governmental organizations and mental health service users. However, despite its achievements regarding psychiatric services, legal supports and NGO initiatives, the mental health system in Taiwan still faces great challenges because of rapid, substantial changes in both Taiwanese and global society. In this chapter, we begin our analysis by briefly introducing the chronological history of mental healthcare, followed by important research, the implementation of the mental health laws and the noteworthy 'bottom-up' approach of mental health programs emerging in the civil society.

Between Colonialism and Philanthropy

The foundation of mental healthcare in Taiwan was established in conjunction with the development of modern psychiatry on the island. Modern psychiatry in Taiwan did not emerge until the end of World War Two. It was born in the shadow of post-war devastation, including various social, cultural and historical determinants. Mental health was not a part of the medical infrastructure from the outset of the Japanese colonial period. This was because psychiatry was regarded as a scientific discipline that could be used for colonial purpose, instead of part of a welfare system.

From the beginning of the Japanese colonial period, the central colonial government was aware of the existence of psychiatric patients in Taiwan. From the close of the nineteenth century until the 1920s, various authorities had been discussing, experimenting with and administrating social rescue services for the weak, the old and the handicapped. However, while only few official institutions were established for purpose of medical care and treatment, most of the institutions were founded by charities. In 1899, three local institutions *Renji Yuan* (仁濟院), *Cihui Yuan* (慈惠院) and *Puji Yuan* (普濟院) were established with the financial aid of local philanthropists in Taipei, Tainan and Penghu. Mentally handicapped individuals were admitted to these institutions, along with other inmates, although the criteria for the 'mentally handicapped' were not clearly defined. The services provided by these institutions for mentally ill patients were mostly custodial, and

their facilities were poor until Jō Nakamura, a Japanese forensic psychiatrist, opened the first specialized 41-bed Nakamura Yohoto Hospital (養浩堂) in Taihoku City (currently Taipei).

Although Nakamura's efforts partially transformed the management of the mentally disordered from custodial to medical therapy, the lack of staff, funding and resources hindered his aspirations to improve the situation of psychiatric patients and those who had not yet been identified as such but were potentially in need of treatment. A fire set by a 23-year-old female patient on 20 March 1930 caused five deaths in the hospital and raised public awareness of the importance of modern psychiatry (Jing 2012). The public discourse, however, did not change the public understanding of psychiatric disorders. Because psychiatric patients were perceived as 'loose cannons' in society, the colonial government actually strengthened the institutional management of psychiatric patients. Under great pressure, the first government-owned psychiatric hospital, *Yoseiin* (養神院), was finally opened in 1934, and a series of legal reforms occurred thereafter.

In 1936, the colonial government in Taiwan enacted two laws that had been created in Japan, the Law for Mental Patient Custody (精神病者監護法) (1900) and the Mental Hospital Law (精神病院法) (1919). The former was intended to allow family members of psychiatric patients to confine the sick in institutions, and the latter was intended to require local governors to establish psychiatric hospitals. Noticeably, Taiwan was the only colony within the Japanese Empire that enforced the laws, and the two laws were enforced at the same time. Nevertheless, because of the shortage of operational resources, the number of psychiatric beds available on the island was far smaller than the estimated number of sick individuals who needed them. According to a survey conducted in March 1929, 195 patients were admitted to a range of social rescue facilities in Taiwan. This comprised less than one-tenth of the 2256 individuals who had been determined as requiring psychiatric treatment (Jing 2012). In 1934, the number of psychiatric beds in Taiwan was 87 at the most, whereas the number of mentally ill individuals was estimated at more than three thousand (Liu 2005).

With regard to psychiatric research in colonial Taiwan, the primary theory applied was rooted in then popular concept of degeneration. Such theory was used to serve the Japanese Empire and further its colonial legitimacy. During the first half of Japanese colonization, the social unrest provided rich soil for Jō Nakamura to develop his theories in forensic psychiatry. He linked crime, alcoholism, child protection and adolescent delinquency with eugenics (Wang 2005). On the other hand, discourses about tropical neurasthenia and the practice of Morita therapy were developed by doctors at the Imperial Taihoku University. For example, Syuzo Naka reflected the anxiety of the Japanese colonizers concerning their susceptibility to psychogenic disorders. To some degree, such discourses were alternatives to the race degeneration theories of Europe, and they considered that these disorders would need to be overcome to defend the Japanese Empire (Wu and Teng 2004). The psychological well-being of the colonized, however, was not emphasized.

From Post-war Stumble to the Zest for International Collaboration

The development of mental healthcare in Taiwan in the post-WWII period was associated with the decolonization work of psychiatric theories and practices, the re-establishment of psychiatric facilities and the professionalization of the psychiatric and psychological disciplines. In contrast to the colonial period, psychiatry in post-war Taiwan favoured on promoting the mental well-being of the citizens. There was continuous expansion of psychiatric services and research in social psychiatry in the post-war decades. Policies in the 1990s much advanced mental healthcare. The following section describes development of mental healthcare in post-war Taiwan.

The Re-establishment of Psychiatry in Post-war Taiwan

After WWII, Japanese colonial medicine continued to influence Taiwan from the initial post-war political and social reconstruction phase until the 1950s, when medical aid from the USA and the support of the World Health Organization created new professional standards for the new generation (Liu 2011). The re-established National Taiwan University Hospital (NTUH) was the main stage for the remaking of psychiatry, indirectly facilitating the reform of mental health notions in Taiwan under the new Chinese Nationalist regime, arrived from the mainland after its defeat in the Chinese Civil War.

The new Chinese Nationalist Government downplayed the importance of mental health for several reasons. First, the new government was too busy dealing with other problems such as epidemics of smallpox, bubonic plaque and cholera (Chen 2000). Second, mental health issues had long been presumed to be unimportant by the Chinese. When it sought government funding to expand psychiatric facilities at NTUH, the hospital was rebuffed (Lin 1990). Third, because of the destruction caused by the war, few resources remained to redevelop psychiatry in Taiwan. When Tsung-yi Lin, the first Taiwanese psychiatrist, who trained in Tokyo during the entire war period, assumed his post as the head of the Psychiatric Department at NTUH in 1946, Taipei had 140 psychiatric hospital beds, but only one other qualified psychiatrist, who was waiting to be repatriated to Japan. The government estimated that there were nine institutions and 819 psychiatric patients, whether under professional care or not, in all of Taiwan (Lin 1990).

Under the leadership of Tsung-yi Lin, the Psychiatric Department at NTUH became the training hub for psychiatrists. Lin adopted three principles during the re-establishment of this department. The first was a focus on clinical work, the second was the pursuit of epidemiological field work in Taiwan, and the third was the effort to strengthen psychiatric education and training systems. The department received generous financial support, mainly from two resources: the American

Bureau of Medical Aid to China (ABMAC) and the World Health Organization (WHO). Much of the assistance was used in the training of personnel (Baker and Perlman 1967): for example, with a scholarship offered by the AMBAC, Tsung-yi Lin was able to further his postgraduate training at Harvard University. After Lin's return to Taiwan, with support offered by the Agency for International Development (based in the USA), the NTUH Psychiatric Department was able to expand. It became one of the five main specialities in the hospital and in the medical school.

In addition to receiving foreign support, Taiwan extended its own roots worldwide. Lin's followers were sent by the NTUH for various sub-speciality training, including individual and group psychotherapy, epidemiology, child psychiatry and neurology. Between 1950 and 1968, an additional 20 members of the department were sent overseas to further their studies. They obtained 22 different scholarships, 15 of which were offered by the WHO in an attempt to develop the department into the teaching and training hub of mental healthcare in Taiwan (Rin 1980). As such, NTUH was able to provide assistance to other institutions such as military hospitals and new convalescent hospitals. This assistance was provided from the mid-1960s onwards.

In addition to the development of the department, the original Syakkaw Sanatorium (錫口療養院), founded during the colonial period, was re-established in 1945. A number of private sanatoriums were established during the immediate post-war period in response to rapid population growth, although their facilities were poor and they lacked professionally trained medical staff (Yeh et al. 1987). In 1957, Yuli Veterans Hospital was established in Hualien for psychiatric patients who were in the military. During the 1960s, three large-scale sanatoriums were established in Kaohsiung, Yuli and Taipei to provide a long-term care service for chronic patients in the southern, eastern and northern parts of Taiwan. However, notwithstanding the large increase in the number of general hospitals, most of these hospitals were not interested in implementing psychiatric services (Chuang et al. 1995). For more than two decades, psychiatric services in Taiwan were almost exclusively limited to providing long-term care for chronic patients.

In the emergence of psychiatric sanatoriums islandwide, the development of Taipei City Psychiatric Centre (TCPC) was unique in its ambitions and achievements (Wu 2005). It was established in line with a policy of psychiatric service expansion. Its name suggests an exceptional aspiration: to become the centre for psychiatric training, research and teaching in the capital city. With the advancement of IT techniques and medical informatics, TCPC created a pioneering database of case notes and a monitoring system that was convenient for both clinical decision-making and epidemiological research. In the early 1990s, TCPC implemented 'crisis intervention' methods within its emergency services in response to the increasing number of involuntary hospitalizations. Furthermore, in 1993 it merged with the original Taipei Drug Abstention and Treatment Centre, transforming treatment of the addicted from penance to medical care.

TCPC was founded based on the concept of community psychiatry, which at the same time reached its pinnacle in the USA. Its achievement was later celebrated as the renowned 'Taipei Model' of community-based psychiatric rehabilitation (Wu 2008). From 1972 onwards, TCPC has devoted itself to combining hospital services and the local health office system in order to provide holistic modern psychiatry and increase the accessibility of services to a large population. It not only directly gave birth to the first patient and family self-help group, the Taipei Mental Rehabilitation Association, but also indirectly influenced the implementation of several city-based psychiatric centres in Japan (Yeh 1992).

Because of the lack of personnel and resources, the development of mental healthcare in post-war Taiwan was first focused on urban areas. Despite the authority's awareness of the need for public psychiatric services, psychiatric was assigned the lowest priority until 1980s; for example, the Provincial Committee for Mental Health established by Department of Health in 1968 to coincide with its Ten-Year Health Project was eventually disbanded (Higginbotham 1984). Similarly, the budget of psychiatry had been less than one per cent of the total healthcare budget until 1987 (Chen 1997). The development of the community rehabilitation movement for mental patients began more than one decade after community psychiatry began in the USA. In 1985, the Ministry of Health initiated the Medical Care Network Plan. Four years later, a trial phase for mental patients was implemented (Chuang et al. 1995). In 1995, in order to encourage active treatment and rehabilitation plans and curtail the institutionalization of mental patients, the newly administered National Health Insurance (NIH) system began to provide better incentives to community mental health and rehabilitation centres in order to counter the hasty growth of profitable institutions (Hsieh and Shiau 2006).

Mental Health Research in Post-war Taiwan

Mental health research in Taiwan is influenced by the Japanese colonial legacy and the international pursuit of psychiatric epidemiology after WWII (Wu 2016). In Imperial Japan, epidemiological studies on mental disorders among aboriginal communities are thought to have been influenced by Emil Kraepelin's transcultural psychiatry, which was notably applied in Uchimura Yushi's research on the Ainu people in Hokkaido (Uchimura et al. 1938). In 1942, an extensive psychiatric survey of Taiwanese indigenous populations was conducted, thanks to the aid of the *hōko* system, a community-based law enforcement and civil control system endorsed by the Japanese colonial government. Used to locate individuals with psychiatric disorders, this system was the same as the one used in the survey in Hokkaido. It involved police, administration and local assistants. Psychiatrists would diagnose the patients and ask villagers whether there were other such patients. They surveyed a population of 3864 and identified 49 people that were suffering from mental diseases. To the surprise of the psychiatrists, the rate of schizophrenia was extremely low among the aborigines, about one-third of the

figures from European surveys and one-seventh of the figures from Japanese surveys. They presumed that schizophrenics in the aboriginal society faced a higher risk of early death. This supposition, however, did not explain the low rate of schizophrenia (Nikichi 1944).

Advised by Ryosuke Kurosawa (黑澤良介), the Japanese psychiatrist hired by NTUH for the handover administration, Lin and his students completed the first survey of psychiatric disorders right before Kurosawa returned to Japan. As in other developing medical specialities, Lin's first psychiatric epidemiology study was based on previous research conducted by the Japanese. Beginning in 1946, Lin mobilized the local gentry, elders and police to help him investigate the distribution of psychiatric diseases in Baksa (木柵). During the next two years, two more townships were also surveyed by Lin's team who used the *hōko* system: Xinpu (新埔) and Anping (安平). These three areas were diverse in terms of social and economic development. Across the three surveys, 19,931 Chinese were examined using the census method (Lin 1953). In addition to analysing the dominant Han Chinese, the NTUH team also wished to survey other ethnic groups in Taiwan. Between 1949 and 1953, to obtain data for comparative research, Lin's student, Hsien Rin, conducted another survey using similar methods. This study surveyed 11,442 people in four indigenous groups with 'differing degrees of acculturation': the Ami, Saisiat, Paiwan and Atayal populations (Rin 1961, 1962). Investigative reports published by the Japanese in the early twentieth century provided the team with useful information on Taiwan's indigenous tribes.

In addition, like other postcolonial societies, a few culture-bound syndromes were identified during the survey works. Lin's (1953) team first found a culture-bound syndrome prevalent in Chinese populations, namely *Hsieh-Ping*, which means 'devil's sickness'. The syndrome was characterized by a trancelike state in which the patient identified with a dead person for a period between half an hour and many hours. The patient would speak in a strange tone of voice, and the content of his or her speech was mostly related to ancestor worship (Leff 1988). The syndrome often appeared among highly religious people. The team's findings constituted one of the main reports on culture-bound syndromes identified by the research efforts of East Asian psychiatrists. Other examples included the '*Utox* reaction' among the Atayal in Taiwan, '*Imu*' (Uchimura et al. 1938) among the Ainu in Japan and '*Koro*' (Rin 1965; Yap 1965) in various Southeast Asian countries. In the 1970s, cases of 'frigophobia' were reported by Hsien Rin and colleagues. In their observations, patients suffered from an extreme and morbid fear of cold. When these patients were brought to a hospital, they arrived in heavy clothing, usually having covered specific parts of their bodies that were considered weak in classic Chinese thought on health. Rin explained that their symptoms were closely related to the traditional Chinese concepts of vitality and the principle of *yin-yang* (陰陽) (Chang et al. 1975).

Early Surveys and Beyond

Lin and colleagues began their research based on their hypothesis that various ethnic groups would display different patterns of mental health problems. However, their statistical results indicated numerous similarities between the groups. Lin's team found similar lifetime prevalence rates of total mental disorders among the Chinese (9.4 per 1000) and indigenous populations (9.5 per 1000). The rates for psychotic disorders were also almost identical (3.9 per 1000 for the Chinese and 3.8 per 1000 for the indigenous Taiwanese). The team thus concluded that no particular ethnic community is necessarily mentally healthier than another (Lin 1953). However, the researchers found a significantly lower rate of 'schizophrenic reaction' among indigenous groups than among the Chinese. They reasoned that this was because of the proportionally larger number of deaths among indigenous schizophrenics owing to their limited capacity for adjustment to stress and deprivation during WWII.

The two large-scale surveys in Taiwan became important pioneering ventures in psychiatric epidemiology. They not only laid the foundation for Lin's team to conduct follow-up surveys regarding mental disorders in Taiwan, but also paved the way for the team to participate in international collaborative research. Fifteen years after the original survey of the Chinese population, Lin's students returned to the same three areas and repeated the study using the same techniques, finding that the total prevalence of psychiatric disorders had increased (Lin 1969). Researchers also analysed the relationship between the Taiwanese and the Mainlanders, who fled to Taiwan after 1949 with the relocation of the nationalist government. The study found that neurosis was more prevalent among the Mainlanders and less in the original residents. This study proved for the first time in Taiwan that the psychological stress brought about by migration influences the incidence, prevalence and prognosis of various psychiatric disorders.

As one of the nine Field Research Centers (FRC), the Department of Psychiatry at NTUH participated in the International Pilot Study of Schizophrenia (IPSS) conducted by the WHO. With the aid of a newly developed screening tool, the Present Status Examination (PSE), and advanced biostatistics techniques, the Taipei FRC helped to prove the feasibility of international collaboration in international mental health research. In addition, it also helped in the discovery that the prognoses of schizophrenic patients in developing countries are better than those in developed countries (Strauss and Carpenter 1974).

In 1980s, Taiwan government gradually recognized the importance of mental health research. Between 1981 and 1986, centrally funded by the Ministry of Health for the first time, the Taiwan Psychiatric Epidemiological Project (TPEP) revealed the fact that people who live in smaller cities or townships near larger cities are more prone to develop minor psychiatric disorders. Researchers believed that the drastic changes during the urbanization in suburban areas had caused such outcomes (Cheng 1988, 1989). To some degree, the study defied the previous consensus, which showed a higher proportion of minor psychiatric morbidity in cities

than in the country. The TPEP further concluded that social stresses in people's living environments have a greater impact on the prevalence of minor psychiatric morbidity and less impact on major psychosis. The various degrees of urbanization and industrialization in different areas also resulted in different degrees of socio-psychological stresses, thus influencing the prevalence of functional mental disorders and reflecting the unique landscape of mental health conditions in a developing country.

In several recent studies, researchers concluded that the increases in the prevalence of common mental disorders and suicide rates paralleled the increases in national rates of unemployment and divorce, suggesting the adverse effects of economic recession and social changes on mental health (see Fig. 7.1, 7.2 and 7.3) (Chang et al. 2010b; Fu et al. 2013). Findings from these time trend analyses suggest that population mental health is considerably influenced by changes in macro-level socio-economic factors in Taiwan, which has experienced rapid industrialization and urbanization over the past few decades. Alternatively, in the early 2000s, a sociologist re-examined similar queries in an area that was assumed to be pre-modern. She found that the high prevalence of psychiatric disorders on Orchid Island, an underdeveloped volcanic island off the south-eastern coast of Taiwan, was caused by the uneven acceleration of various modernities and social suffering caused by societal change, in addition to repeated mandatory relocations back and forth between Taiwan and Orchid Island by the aboriginal islanders (Tsai 2009). Her research filled a gap in traditional epidemiological catchment studies by
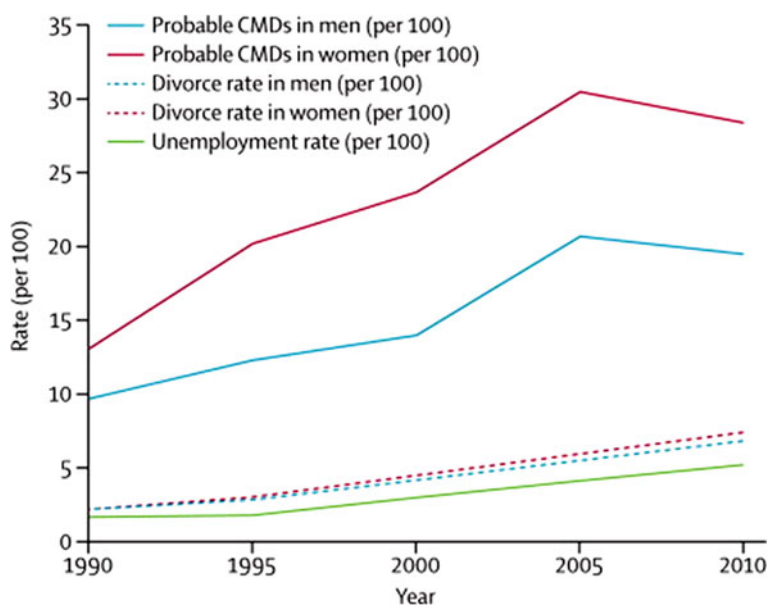
Fig. 7.1 Time trends for probable CMDs, divorce and unemployment in Taiwan, 1990–2010. From Fu et al. (2013)
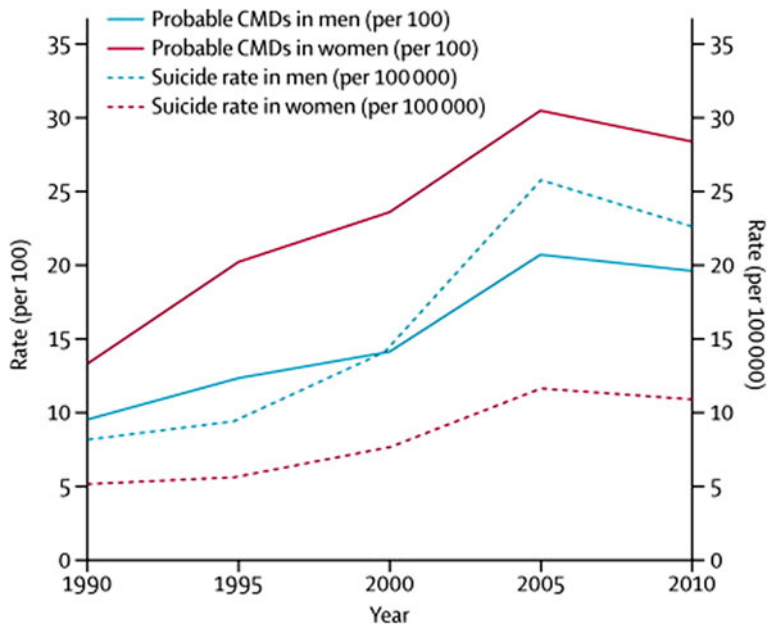
Fig. 7.2 Time trends in probable CMDs and suicide rates in Taiwan, 1990–2010 (Fu et al. 2013)
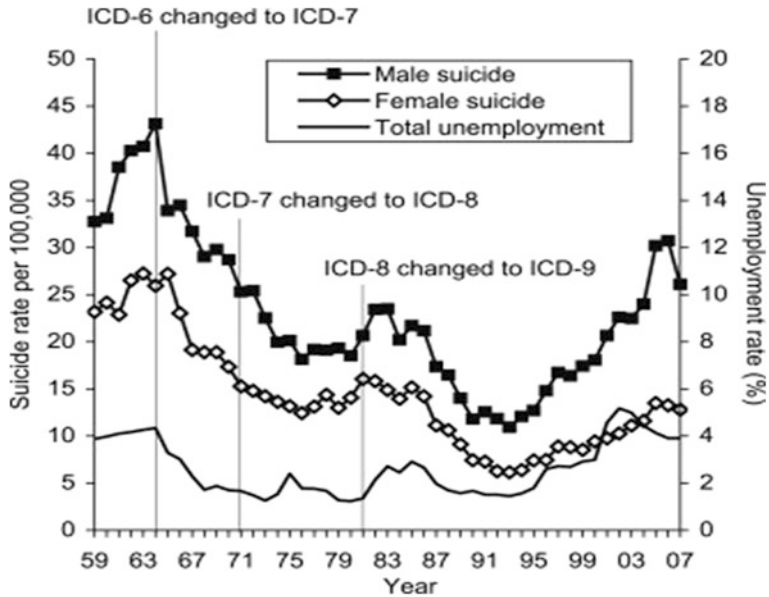
Fig. 7.3 Secular trends in unemployment and suicide rates in Taiwan, 1959–2007 (Chang et al. 2010a)

revealing more determinants of psychiatric disorders in areas that had long been neglected.

In addition, because of the increase in the suicide rate in Taiwan, the national Taiwan Suicide Prevention Centre was established in 2005 in order to facilitate efficient care-delivery system networks nationwide. By analysing patients who attempted and succeeded in committing suicide and patients with depressive disorders preceded by a celebrity's death, a research team showed that the media has a significant impact, that is, a modelling effect on suicidal behaviours among the public (Cheng et al. 2007a, b, c). In addition, as in other Southeast Asian metropolises, charcoal-burning suicide has become popular in urban areas of Taiwan. It is assumed to be encouraged not only by media reports, but also by the availability of charcoal associated with its socio-economic and spatial patterning correlates (Chang et al. 2010a, b; Tseng et al. 2010). In 2012, several county governments enacted a policy that restricts the open-shelf display of barbecue charcoal in order to curtail its availability for use in suicides.

The Mental Health Law in Taiwan

The 1980s were critical years in the development of mental health policies in Taiwan. As the government gradually realized the importance of non-economic planning, social, cultural and medical policies were listed among the country's long-term national development plans. In 1980, the Research, Development and Evaluation Commission of the Executive Yuan chose Taipei Municipal Psychiatric Centre to conduct a review and analysis of the mental health policy and care (Chuang et al. 1995). Based on Yeh and colleagues' conclusion, the Mental Health Law was first drafted by the Chinese Mental Health Association in 1981. The Mental Health Group of the National Health Consultation Commission was established in the next year. However, it should be noted that were it not for series of criminal cases related to public security and debates on the abuse of mental patients in a religious charity institution, the Hall of Dragon Metamorphoses (龍發堂), public appeals to accelerate the enactment of the Mental Health Law would not have occurred.

Like many other incidents accelerating the substantiation of mental health policy, in March 1984, an individual assumed to be mentally ill injured 39 teachers and students with sulphuric acid and then committed suicide at an elementary school in Taipei. This resulted in a debate by mental health workers concerning the need for the involuntary admission of potentially violent patients. In addition, a research team from Kaohsiung Medical College revealed the inhumane treatment of mental patients in the Hall of Dragon Metamorphoses, which had begun to admit mentally challenged individuals sent by their family members in southern Taiwan in 1970. Despite its illegitimacy, because it admitted the first mentally challenged individual in 1970, families in southern Taiwan continued to send their children to the hall. In addition, the accreditation of psychiatric institutions began in 1985, and extensive

psychiatric epidemiology surveys were conducted. Psychiatry was finally included as part of the core agenda of the Ministry of Health in setting up national medical networks.

The Mental Health Law in Taiwan was finally enacted in 1990. The enactment of this law was significant for the protection of patients' rights and the regulation of psychiatric services. The law detailed the differentiation of psychiatric systems and facilities, shifting the role of psychiatry from passive custody to active treatment. However, the process of legislation was criticized for being excessively medically oriented and not taking into consideration the voices of psychiatric service users (Tang 1997). The state structure and the preferences of government bureaucrats, which were decisive during the legislation, also restricted the depth and breadth of the Mental Health Law. In 2007, with more non-medical professionals involved in the revision work, the law was assumed to promote patients' rights and welfare. Mandatory community treatment was introduced in order to substantiate individual autonomy and personal protection in the community and to enhance preventive mental health. As the first and only country in East Asia to adopt mandatory community treatment, Taiwan still faces challenging issues concerning whether such measures fit modern societies that still emphasize the collective values of family (Wu and Soong 2008).

Civil Society and Public Mental Health Campaigns

In addition to the enforcement of the law, the development of mental healthcare, including the popularization of related concepts and the substantiation of its many programs, requires the involvement of civilians such as non-governmental and social organizations. The growth in non-government sectors of this kind is not only associated with greater knowledge of mental health among the public, but also with the changing external environment from the 1980s onward. The John Tung Foundation, which is known for its lobbying of Parliament, was established in 1984. Separate from its main campaign to prevent tobacco-related hazards, the foundation's mental health section was founded in 1990, focusing on the promotion of child development and mental healthcare, which was conducted through video broadcasting, oration, pamphlet distribution and various competitions. Emphasizing the impact of depressive disorders, in 2000 the foundation launched the 'depression screening day' campaign. Furthermore, the first decade of the twenty-first century saw the proliferation of community-based self-advocacy organizations such as Being In Life and Beeing House as part of the worldwide recovery movement.

Natural disasters also facilitated the bourgeoning of non-government mental health sectors. Despite the appearance of post-traumatic stress disorder (PTSD) in the DSM-III in 1980, mental health professionals in Taiwan did not fully understand the disorder until the occurrence of a major earthquake in the middle of Taiwan in 1999. The earthquake resulted in 2415 deaths and an estimated NT$300 billion (US$10 billion) in damages. In the same year, the Taiwanese Society of

Psychiatry began to emphasize questions related to PTSD in its board speciality exams. In the meantime, programmes were initiated by non-governmental organizations in response to the urgent need for psychological intervention among the earthquake victims. Within ten years, the strengthened communication between the governmental and non-governmental sectors and the integration of private organizations further popularized the knowledge of traumatic psychology and improved crisis response measures during disasters. For example, in August 2009 the Mental Health Action League reacted to the destruction caused by the typhoon Morakot.

Epilogue: A Happier Tomorrow?

Notwithstanding the advancement of mental health sciences, the development of mental health policies and the public reception of mental health knowledge, whether the Taiwanese people have developed sounder minds remains questionable. As aforementioned, a recent longitudinal study showed that the prevalence of common psychiatric disorders has drastically increased over the past two decades (see Early Survey and Beyond). This doubling of mental disorders implies that the rapid economic development of Taiwan did not improve the Taiwanese people's mental status. The unexpected worsening of labour conditions, the widening gap between rich and poor, and continuously bad employment markets all became factors that increased depression and anxiety among the population.

In the first decade of the twenty-first century, although Taiwan has gained pioneering status in mental healthcare in the Asia–Pacific region, several issues still reflect great challenges. The simultaneous growth of the state apparatus, professional organizations and the civil society in Taiwan demonstrated the tension between the ideological goals of civil liberty and community benefit. Still under debates are mandatory screening of certain mental disorders such as depression and ADHD, renaming of schizophrenia in Chinese language for the purpose of de-stigmatization, the call to cancel psychiatric certification for sex reassignment surgeries in pursuance of gender equality and the cry for long-term healthcare insurance to better distribute medical resources in the ageing society. Moreover, considering the politics of medicalization today, mental health planning no longer belongs exclusively to psychiatry. It is, on the other hand, framed by a bundle of institutions and actors including legal, industrial, pharmaceutical and administrative and countless forms of grassroots movements (Duclos 2009). They are persistently creating countermeasures in order to respond to the changing economic, political, social and cultural contexts that shape the mental health landscape in Taiwanese society.

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Chapter 8
Mental Health in Thailand: Historical and Cultural Perspectives

Apichai Mongkol

Abstract There is evidence from over two centuries ago of temple-based treatment of mental disorders with traditional medicines and massage. Western psychiatry (moral treatment) was introduced by missionary doctor, *Dan Beach Bradley,* in 1835. In the twentieth century, His Majesty, King Rama V, set up a special hospital for mentally ill patients. In 1929, doctors had been sent abroad to study psychiatry and came back to teach medical students and nurses. Mental health programs have spread from hospitals to become community based. Efforts have been made to educate the public about the importance of mental health and to reduce the stigma attaching to mental disorders. A national society of psychiatrists is very active; cooperation with WHO developed; and membership of the World Mental Health Federation obtained. However, many challenges remain if services are to be sustained.

Traditional Conceptions and Approaches to Dealing with Mental Illness

In traditional Thai society, there was no body of secular knowledge concerning mental illness. To explain the phenomenon of mental behavior, and to treat mental illness and promote mental health, religion was employed. However, this approach lacked reliable, evidential support, even though Buddhism long provided answers to the problem of sadness or feeling lost.

Temples of the early Ratanakosin era (1782–1851) provided treatment for mental breakdown. Recipes for medicines for physical and mental illness were collected and engraved on wooded structures or stones which were parts of the temple buildings. The collections were initiated under the order of the kings of this era and are still available to doctors. The first mental hospital used such methods for over three decades.

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The first evidence of treatment of psychosis dates from 1788. In the period of the first king of the Royal Chakri dynasty, King Rama 1, recipes for medicines from the Ayutthaya period were collected. In 1833, the medical recipes for particular diseases, including mental illness, were engraved on the temple stones or walls of and they were restored regularly. These included details of medical plants and herbs to prepare medicines to deal with symptoms such as violence or labile mood. Traditional Thai massage was also used. The aspects of human anatomy related to violent behavior were identified. The temple that housed these stones of learning has been described as "The First University of Thailand."

The Awakening of Official Awareness of Mental Health Problems and Introduction and Growth in Influence of Western Psychiatry

In middle of the Ratanakosin era, King Rama IV encouraged the introduction of western knowledge. The king himself was the first monarch in Southeast Asia who studied English and Latin and was interested in western technology and science. He approved of the Christian religion and allowed missionaries to settle in Thailand.

Among the missionaries was an American, *Dr. Dan Beach Bradley*, who introduced western psychiatry; even though he was not a psychiatrist himself, he introduced the concept of psychiatry. King Rama IV regarded him as a friend. Dr Bradley arrived in Bangkok on June 9, 1835, and lived in Thailand for 38 years. The king had established a publishing house located near *Wat Prayurawongsawat* temple. Dr. Bradley ran the house and published the first issue of the *Bangkok Recorder* newspaper on June 4, 1845. This newspaper published not only local news but news from the West including developments in medical and other sciences. Some articles were at odds with Thai tradition, but the king did not stop publication.

Foundation of the First Hospital for Mental Illness

King Rama V of the Royal Chakri dynasty or King Chulalongkorn set out to reform Thailand so that it would become equal to modern western countries; one of the reforms was establishment of a hospital. His majesty travelled abroad to study hospital facilities and their management.

His first overseas visit was in 1870: to Singapore, Java and India. In Singapore, he visited a hospital for the insane as well as a general hospital and in Java he also saw such facilities. He visited Singapore several times to gather information on hospital and prison facilities.

His Thai hospital for the insane was built in 1889 and was run by a committee set up by him. Many hospitals in Bangkok and in other cities were established by this same committee which consisted of royal family members, government officers and physicians with western experience.

At the outset, the hospital for the insane accommodated only 30 patients. Thai traditional treatments were used: Decoction, snuff or vermicide was prescribed according to symptoms and diagnosis. No plants or herbs were used except a deobstruent mixed with a decoction with included *Rauwolfia* root, well known for reducing fever, having a vermicide effect, lowering blood pressure and acting as a hypnotic and tranquillizer.

This hospital not only treated patients with traditional medicines, but keep them from harm, as described in the following:

> …patients… showed symptoms of infected wounds, scars from rope binding, wounds from a burning joss stick. The practice of putting a burning joss stick on insane people was based on a belief that it could bring back consciousness. Thais are not as cruel as the Chinese so that we whip them just to pretend that the spirit had fled. Their relatives told us 'If I could handle the patient, I would not come here' or 'I could not handle him/her at all so that I come here'. With patients who show some inner body disorder and cannot communicate, we have to receive them so they will not be abandoned… (Klainatorn 2007).

In 1910, control of the hospital was transferred to the Ministry of Interior and the first director of the hospital, Dr. H. Cambell Hyed, was appointed. He was also chief of the Public Health Unit, a branch of the Ministry of Interior. The report he wrote in 1910 condemned the awful conditions.

"Among all patients, 264 males and 32 females showed severe symptoms of insanity likely to lead to harm to other people; 54 patients require isolation in cells, but due to lack of accommodation they have to remain in crowded condition, resulting in fighting and injury. Some of them are chained like violent animals. Rooms are so unclean that many patients contract intestinal diseases. The state of the hospital is so disgraceful that the government should take action to improve this situation. I myself cannot find words adequate to describe my shame and disgust concerning this offensive place" (Anonymous 2002).

Professor Dr. Phon Sangsingkaew has likened Dr. Hyed's assessment to that of Dr. Philippe Pinel, the French psychiatrist, who is accepted as the pioneer of humane care and who unchained patients at the Bicetre hospital in 1794, an historical turning point in the care of the mentally ill (Dejatiwong 2000).

In 1907, Dr. Hyed asked for King Chulalongkorn's approval to visit mental hospitals in Singapore and Java to obtain ideas for building a new hospital on land in front of the Plague hospital (now the Tak Sin hospital) where the Somdet Chaopraya Institute of Psychiatry is currently located.

King Rama V sent senior physicians to the Third International Congress on the care of insane to let western countries know that Thai people were interested very much in improving psychiatric care. However, on October 23, 1910, His Majesty passed away without seeing the new era of the hospital he founded. As mentioned

earlier, he had travelled to Singapore and Java when only 18 years of age. After he had sent officers from the Department of Security to observe prison and hospital management in 1871, he himself returned to Singapore in 1890 and to Java in 1896.

He hired western physicians even though they were expensive in contrast to mission doctors who treated patients gratis in time of King Rama IV. King Rama V also provided pensions for western doctors like those given to Thai officers. He ordered investigations of possible sites for the new hospital and its proper construction, suitable for insane patients be cured properly and efficiency. Besides this, His Majesty requested an investigation into an incident reported in the *Bangkok Times* newspaper, telling a story of a negligent officer who allowed an insane patient to escape from the hospital.

Most patients in this hospital were impoverished. Some of them were Chinese patients who had come to Thailand seeking royal protection. These people received free care, whereas the Singapore took payment from European and Asian differently. This royal charity King Chulalongkorn reveals his kindness and compassion for any poor, socially rejected people in his country. King Chulalongkorn and the royal family members preferred to manage the mental health hospital independently and uninfluenced by imperialist countries. When His Majesty issued sanitary regulations for the Bangkok area, he commented that he preferred to provide such benefits unilaterally where in other countries people had to ask their government for them (Klainatorn 2007).

The Impact of Transnational Factors and Psychiatry Extension in Thai Society

King Rama VII ascended the throne on November 26, 1923, and abdicated on March 2, 1932. During the almost nine years of his reign, there were economic and political problems and a change from absolute monarchy to democracy.

Before his abdication, there were three of four Ministers of the Interior whose early resignations caused difficulties for the medical and public health unit. During the reign of King Rama VI, the public health units in Bangkok and other cities were requested to merge under the Ministry of the Interior, but this did not succeed. In the reign of King Rama VII, the Public Health Department was divided into 13 units, and the mental health hospital transferred to the hospitals unit. Its management improved under Professor Vichianpatayakom, from 1925 (Klainatorn 2007).

He was the first psychiatrist to study psychiatry in the USA, where he lived during 1929–1931. In 1932, he requested permission to change the name of the hospital from "Insane People's Hospital" to "Thonburi Mental Hospital" and also promote knowledge of modern psychiatry including community knowledge to help end prejudice about mental illness that led to the hospital being called the "Mad

house." He wrote many articles for journals and magazines and educational institutes. As a result, he was praised as "the best speaker of the decade on mental health matters" (Dejatiwong 2002).

In this period, there was an effort to give psychiatry university status, and in 1933 psychiatry was included in the last year of medicine. Medical students attended the course at the mental hospital for a total of 12 h under instruction. In 1940, postgraduate education in psychiatry commenced. Psychiatry was taught to nurses at the Chulalongkorn Hospital and also to teachers. Teachers, students, municipal officers and soldiers have visited the hospital ever since (Dejatiwong 2000).

Professor Vichianpatayakom introduced modern knowledge of intelligence assessment, the Stanford Binet test, to Thailand and requested Dr. Aree Sangsawangwattana to translate the test into Thai. This was the first psychological test used with Thai patients.

In 1936, Dr. Arun Parksuwan used insulin shock to treat patients and Doctor Aree Sangsawangwattana used Cold Pack technique. In 1937, Dr. Arun Parksuwan introduced ECT (electroconvulsive therapy) He used his own money, 250 USD, to purchase equipment (Dejatiwong 2000).

Thai Psychiatry in the Reign of King Rama IX, King Bhumipol Adulyadet the Great

In 1954 (2497 B.E.), the name, "Thonburi Mental Hospital," was changed to "Somdet Chao Praya Hospital," when Professor Dr. Phon Sangsingkaew was Director. He modernized this hospital in various ways: Physicians and nurses were sent to study abroad in many fields of psychiatry; the Psychiatrists Society of Thailand was founded; mental health clinics were set up in many hospitals across Thailand; cooperation between Thailand and the World Health Organization was promoted and the country became a member of the World Mental Health Federation; the psychiatry syllabus for medical schools was improved; and so Somdet Chaopraya Hospital became a prime center of education and training (Dejatiwong 2000).

Many new mental hospitals were founded, especially in central Thailand, such as Srithanya Hospital in Nonthaburi provience. Many hospitals were also founded in other cities, such as Suan Saranrom Hospital in Surat Thani Province, Suan Prung Hospital in Chiang Mai Province and Srimahabhodi Hospital in Ubon Ratchathani Province. Most of their directors came from staff of Somdet Chaopraya Hospital.

The Current Mental Health Situation: Challenges for Today and Tomorrow

In recent years, better health has reflected the significant progress of the National Health Care Services. The services have been well established for a number of years. There has been much evidence which supports the claim, the decline in major disease outbreaks, the longer life expectancy, the major decline in psychotic disorders, anxiety disorders and drug addiction. However, there is a worrying, sharp increase in depressive disorders.

The greatest shake-up of Thailand National Health Care Services was initiated by the previous government; the main focus was on an equal opportunity to access services; and to achieve this, the government have organized National Health Care Services to operate at three levels: primary, secondary and tertiary.

The First Challenge: The Mental Health Services in Primary Health Care

The primary service should be the first access point to health care service system. This access point has been created around local knowledge, understanding of the daily way of life and the culture of that particular location. This primary service is playing a significant part in providing health promotion and prevention.

The service consists of community health centers and community hospitals in almost every province in Thailand.

Nowadays, there are 9000 community health centers and 7000 community hospitals where almost every Thais can have direct access to this primary service.

Although the primary service has great coverage, there is still a negative perception among the majority of Thai people concerning community health centers and community hospitals as they still put their trust in the larger size provincial hospitals. As a result, there is still a large gap to fill in health promotion and prevention to persuade people to trust this primary service because prevention is much less costly than treatment.

The key to improving the National Health Services overall is to upgrade all the 9000 community health centers to sub-district health promotion hospitals as it is believed to be the major turning point in the development of the National Health Service system.

The best strategy for building the trust of the local people in sub-district health promotion hospitals is to use a multidisciplinary team consisting of practitioner nurses, community health personnel, a physiotherapist and most importantly a local health volunteer who understands the way of life of the local people. The more the teams get close to them, the more they will learn how to implement the most effective ways to improve the overall quality of life of people living in their particular areas.

For each of the sub-district hospitals, a database with the complete details of the health history for each family member in their area of responsibility must be available. With the information handy, planning and implementing measures to promote a healthy lifestyle would be more effective.

But physicians need not be permanently stationed in the hospital. Technology will enable multidisciplinary teams to consult via video link or real-time live online with the physicians from the main district hospitals.

Recovering patients can be transferred back to the sub-district health promotion hospital where they can carry on their recovery process under the care of a multidisciplinary team. It would be ideal for patients to be recovering near their homes and their family members rather than doing so in the distant main hospitals.

The Second Challenge: The Mental Health Fund

The greatest challenge for the current government is to sustain the social security system for the benefit of all Thais. In 2011, the government provided health care to all 48 million Thais gratis and the cost is estimated to be around 2456 baht per person or US$65 per person. The point is the budget provides for psychiatric treatment, and there is a special, reserved fund or mental health fund devoted exclusively for the financing of psychiatric treatment.

In the past, each of the psychiatric hospitals was allocated a budget which only allowed in-patient treatment for up to just 15 days. Unfortunately, chronic patients essentially need a longer stay to receive continuous treatment. However, with the new fund, there will be no time limit for those requiring in-patient care and the doctor will have the final say on how long each patient should be receiving the treatment.

Although there has been much supporting evidence of a significant decline in psychotic, anxiety and substance-related disorders, there is increasing concern from another finding that around 12 million Thais will develop an early stage of a mental health problem, that is, around 20% of the population. Included are around 300,000–600,000 people suffering from schizophrenia and around 600,000–1.2 million suffering from depressive disorder. However, only a small percentage of sufferers are actually aware of their condition and get access to treatment.

Nowadays, the problem of coverage and availability has long been solved. However, the issue of maintaining the quality of service is the one that needs constant attention. The Thai government has realized the importance of all the mental health sufferers having access immediately to proper treatment and proper medication to prevent progression to a chronic stage of schizophrenia, depressive disorder and dementia for which treatment will be far too costly.

Every holder of the universal health care gold card is entitled to psychiatric treatment and medication. However, the medications that have been prescribed are currently out of patent and they are cheap and being made locally. Therefore, it will not burden hospitals to bear the extra costs of the original version of the medicine.

Most antipsychotic drugs are conventional and are widely used. Of the atypical antipsychotics, only clozapine is being prescribed for gold card holders. For the medicines in the SSRI antidepressant series, nowadays there is only fluoxetine that being prescribed among gold card holders. Hospitals that prescribe original medicines to those gold card holders will have to bear the cost difference.

Some part of the fund will be used to purchase risperidone and sertraline for so patients who are gold card holders will be treated fairly and efficiently. Those patients will receive treatment until recovered fully and the fund will help subsidize those extra, high costs for the hospitals operating the gold card program, so reducing the burden those hospitals previously bore.

Thus, in a case of a patient suffering from schizophrenia, the person would be prescribed risperidone 2 mg twice daily; previously each pill costs 58 baht. Therefore, this patient would have had to spend 116 baht per day for the whole year, the total cost spiraling to 42,340 baht. Fortunately, the patent of risperidone has expired and so the price of the locally made version of this pill has been reduced to just 4 baht each. The good news is this patient would not have to spend more than 2920 baht annually compared to 42,340 baht prior to the expiration of the patent.

The Third Challenge: Access to Services by Depressive Disorder Patients

The problem of depressive disorders is another central concern. From a study in 2008–2009, it was estimated that there were around 1.3 million people aged 15 years or older suffering from some kind of depression. To make matters even worse, 11% of those sufferers have access to the appropriate treatment.

In 2004, depressive disorders were the main cause of disability-adjusted life years (DALYs) and were in fourth place after stroke, AIDs and DM.

According to WHO, depressive disorders will be in second place in 2020. This alarming prediction has led the Department of Mental Health to try to do everything in its power to prevent this from happening. The action plan for preventive measures is as follows:

1. Getting to understand all the possible causes and the widespread of this depressive disorder.
2. Developing technology to promote/prevent efficiently with the depressive disorder in parallel with the core treatment from service provider in Thailand.
3. Developing the system for monitoring/screening of an early development sufferer in order to evaluate/diagnose and allow continuous treatment to kick in full effect on each individual sufferer.

As a result of the action plans that have been carried out in full effect, there have been an increasing number of those sufferers who could get access to the treatment jumping from 27.69% in 2009 to 48.33% in 2010.

The next challenge for Department of Mental Health is to build up database information of all those depressive disorder sufferers all over the country; this would enable the actual finding of the main cause of the disorder and to understand the development process of the symptoms in each individual case. If this measure become successful, it would help analyze the timeline of how many new cases are being developed and how many of the existing cases that have been remissions.

The Fourth Challenge: Suicide Prevention Programs

Whenever depressive disorder is mentioned, it is always the case that issue of suicide will be followed in the discussion. In Thailand, the suicide rate is 6.02 per every 100,000 people. Although this rate is relatively low in comparable with the average rate of those all over the world, the problem of sufferers attempting suicide should not be neglected at all cost. The main targets to monitoring and preventing those sufferers who are at risk to attempt suicide in Thailand are as follows:

1. Successful suicidal rate not excess 6.5 for every 100,000 people.
2. 80% of those who attempted suicide must be screened out and closely monitored.
3. The repeated attempt suicidal rate should be reduced by 10% from the previous year.

Another big challenge is to instill awareness to those ordinary people to be realized and understand the symptoms of this depressive disorder and more importantly giving them precise information which they would understand and be able to spot the suicide warning signs and alert the authority to tackle the problem before it is too late. The sociocultural factors are related to the suicide, and according to the extensive study of Dr. Apichai Mongkol, the highest rate of suicide in Thailand came from the upper northern part of Thailand. The study found that social values in Thai culture have played important role in relation to the cause of suicide, and those social values are considerateness, inability to express their own true feeling, binge drinking, gossiping and the fear of humiliation and failure (Mongkol 2011).

Apart from those mentioned social values in Thai culture, excessive drinking, daily alcohol consumption and superiority of male gender are the main factors that support the high rate of suicide among people living in the Upper North of Thailand. According to the study of drinking behavior in these areas, the findings illustrate an alarming misconception of alcohol intake, and many people believe that drinking alcohol would help reduce stress, increase appetite and alleviate sleeplessness. Although these beliefs are absolutely false, they are still refusing to

accept the fact as they prefer to believe that drinking could cheer themselves up and the more they drink, the bolder they will be. This means while they are under influence of alcohol, they would be brave to do things that they are not able to do while they are sober. The findings are really the worrying concern that needs to be tackled strategically (Mongkol 2011).

The Fifth Challenge: Investigating Thai Mental Heath

Thailand has realized the importance and need of developing Thai mental health indicators to investigate the mental health for Thai people. In 2003, the latest version of Thai Mental Health Indicator (TMHI) was developed under the following definition of mental health: "good mental health or well-being results from mastering the competency of daily problem-solving, the potential to develop one's own quality of life, which includes intrapsychic wellness in a changing society and environment." From the above definition, Thai Mental Health Indicator (TMHI) was classified into four domains.

Domain 1: Mental state

- General well-being positive affect
- General well-being negative affect
- Perceived ill health and mental illness.

Domain 2: Mental capacity

- Interpersonal relationships
- Expectation achievement congruence
- Confidence in coping
- Inadequate mental mastery.

Domain 3: Mental quality

- Kindness and altruism
- Self-esteem
- Faith
- Creative thinking and enthusiasm.

Domain 4: Supporting factors

- Social support
- Family support
- Physical safety and security
- Health and social care.

The TMHI has been applied successively since 2000. In 2003, the study was done again with a study population drawn from all five regions of Thailand. This instrument was more complete because it was constructed with reference to the

context of Thai society, especially in the domain of mental qualities that emphasized kindness and altruism. This domain accords with the Buddhist principle that stresses the importance of enjoying good mental health and feelings of happiness a normal mind provides, or keeping one's own mind normal when encountering external stimuli; keeping one's own mind tranquil when facing a problem is (the following point needs to be better put) in accordance with the domain of supporting factors (Mongkol et al. 2007).

The TMHI has been developed into a reliable instrument for assessing the mental health of the Thai population within the context of Thai society and culture. It has been used to investigate national happiness in almost every year since 2001. The results can be used to build a policy to promote further the mental health and to prevent the mental ill health, of the Thai people.

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Chapter 9
Mental Health in Cambodia

Sotheara Chhim

Abstract Mental health in Cambodia has been largely influenced by the genocidal history of the Khmer Rouge regime that virtually destroyed the entire country between 1975 and 1979. After the first United Nations sponsored election in 1993, international sanctions were lifted and Cambodia was allowed to receive international assistance. Many international organizations established mental health programs and services including Oslo University's Cambodian Mental Health Training Program (CMHTP), Social Services of Cambodia, Transcultural Psychosocial Organization, Harvard Program in Refugee Trauma and Caritas Cambodia's Center for Child and Adolescent Mental Health. Many stakeholders recommended the Praek Thnoat Mental Health Hospital, which had been destroyed by the Khmer Rouge, should not be reopened and community services developed. Over the past 20 years, significant advances have been made due in large part to the collaborative efforts between the Ministry of Health of Cambodia and the aforementioned international organizations. Currently, the University of Health Sciences is responsible for providing specialist training in psychiatry. There are now 56 psychiatrists and 44 psychiatric nurses (0.33 and 0.26 per 100,000 people, respectively). There are also services available in many of the larger provincial hospitals as well as in some health centers in rural areas. However, the number of psychiatric beds in Cambodian hospital remains critically low: only 0.10 beds per 100,000 people. Despite the increasing availability of mental health services, many Cambodians living in rural areas still adhere to traditional beliefs to explain and cope with their mental health problems. They generally attribute their problems to ruptured relationships with the spirits of their ancestors. In addition, the Buddhist concept of *karma* is widely seen as a way of justifying current living conditions. To complicate matters further, culturally specific syndromes are also common. For these reasons, mental health services in Cambodia need to be culturally sensitive and contextually appropriate. Regardless of the progress in-service delivery, much more needs to be done to develop and improve care. Given the lack of resources, Cambodia should take the approach of the World Health Organization and shift the

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task of providing mental health services from highly qualified practitioners to less qualified, but adequately trained, individuals. This can add greater value and create a more integrated mental health care system. Finally, due to the complex needs of mentally ill persons, mental health workers should integrate aspects from other disciplines including community development, human rights, gender equality, social justice and vocational training. This will serve to enable and empower mental health patients to recover and lead more productive lives within their communities.

Historical Perspective

The history of mental health in Cambodia is closely linked to the political history of the country. The Khmer Rouge genocide regime that ruled Cambodia between 1975 and 1979 shaped how the mental health services in the country developed.

From 1935 until the start of the Khmer Rouge era in 1975, Cambodia had only one mental hospital called 'Praek Thnoat Mental Hospital', located near Praek Thnoat river in Kandal, a provincial town, approximately 15 km south of Phnom Penh. The hospital consisted of around 800 beds, and this number grew to around 2000 by 1975 (MacCable et al. 2011). The hospital covered a wide area of agricultural land to enable some patients to do agriculture work as part of their rehabilitation therapy. The hospital was run by two psychiatrists who studied in France, Dr. Chamroeun Sam Oeun and Dr. Sonn Mam, together with a number of nurses. There is no clear information about the number of nurses working in the hospital before the Khmer Rouge time.

Praek Thnoat Mental Hospital or '*Paet Chkourt—hospital for crazy people*' was well known to many people in Cambodia for treating mentally ill patients. People often used Praek Thnoat hospital as a place to tease their opponents '*I send you to Praek Thnoat Mental Hospital*' and '*receive electrocuted*' (electroconvulsive therapy—ECT) because the treatment at that time was ECT and conventional neuroleptic medication.

The Khmer Rouge communists destroyed all infrastructure in the country, evacuated people out of the city to live and work in the rice fields , and divided people into two categories. 'New people' were the people who lived under the government-controlled areas before the Khmer Rouge took over the country in 1975, while the 'old people' or 'based people' were the people who were under the control of the Khmer Rouge. The old people or based people had power over the new people. Praek Thnoat Mental Hospital was destroyed and turned into an education center for brainwashing the 'new people', similar in operation to a prison camp. All patients were freed and sent to the rural areas to undertake agriculture and other forced labor. Although the number is unknown, it is likely that all of them were murdered or died of disease, malnutrition and overwork.

By the end of the Khmer Rouge period in 1979, most professionals of all types across the country had been killed—only 43 doctors survived, none of whom were psychiatrists (Savin 2000). The two psychiatrists working in the above hospital

were probably murdered. Praek Thnoat hospital was reopened in 1979 as a general hospital called 'Chey Chum Nash Hospital—Victory Hospital' to service patients with physical health conditions. Between 1975 and 1994, there were no statutory psychiatric services and no mental health training in Cambodia (MacCable et al. 2011). Psychiatry was not included in the curriculum of training at medical school because there were no surviving psychiatrists to teach the medical students.

Postwar Reconstruction: Rebuilding Mental Health Infrastructure

Political and economic sanctions, imposed by the USA and its allies in response to the Vietnamese occupation of Cambodia, were lifted after the 1991 Paris Peace Accords and the deployment of a United Nations peacekeeping mission, the UN Transitional Authority in Cambodia. Cambodia reopened its doors to the Western world. Mental health services in Cambodia started to re-emerge during the period after the UN-sponsored elections in Cambodia in 1993. The international community returned to Cambodia in order to help rebuild the country after decades of civil war and genocide.

In an effort to rebuild mental health systems in Cambodia, international NGOs started different mental health services in this traumatized nation. The University of Oslo from Norway led by Prof. Edvard Hauff, through the International Organization for Migration (IOM), setup a postgraduate training program in psychiatry called 'Cambodian Mental Health Training Program—CMHTP' in 1994 in order to train medical doctors to become psychiatrists (Hauff 1996). Transcultural Psychosocial Organization (TPO), an organization based in Amsterdam, the Netherlands, began implementing community mental health and psychosocial services during 1994 (Somasundaram et al. 1997) and since 1992 Social Services of Cambodia (SSC) formerly known as Khmer Buddhist Society (KBS), based in Seattle, USA, has provided social services to mentally ill people. Harvard Program in Refugees Trauma, a program run by Harvard School of Public Health, led by Prof. Richard Mollica also setup a mental health clinic in Siem Reap province and trained hundreds of general practitioners from different provinces in primary mental health care. The training took place one week each month for 6 months, the period in between the training enabling trainees to apply what they had learnt in practice.

The Ministry of Health (MoH) setup a Mental Health Subcommittee (MHSC) led by Prof. Emeritus Ka Sunbaunat, who was then a psychiatric resident of the CMHTP, in order to coordinate with all stakeholders in the mental health field. The MHSC played a role in coordinating all mental health services in Cambodia up until around 2002 when MHSC was changed to the National Program for Mental Health (NPMH) which took a more leading role in developing mental health services in Cambodia.

History of Psychiatric Education in Cambodia

In 1993, there were consultative meetings organized by the Mental Health Subcommittee of the Ministry of Health, World Health Organization (WHO), International Organization for Migration (IOM), the University of Oslo (Norway) and mental health experts from the region in order to discuss how to setup a training program in psychiatry in Cambodia. Everyone in the meetings agreed that the training should be based in Cambodia, as it would make it easier for trainees to be able to apply what they learnt in real practice. This training program developed into a joint initiative between Oslo University and the University of Health Sciences in Cambodia.

The first Psychiatric Outpatient Clinic was setup in May 1994 at Khmer Soviet Friendship Hospital in Phnom Penh as a place for both training and clinical practice under close supervision from a Norwegian Consultant Psychiatrist.

A cohort of the first 10 doctors was recruited into this 3-year residency program in 1994; the author was one of them. The training adopted a problem-based learning approach which allowed residents to start seeing patients from the first day of their residency training, and the problems encountered were then discussed in the group under the supervision of the Norwegian Senior Consultant Psychiatrist. The psychiatric residents saw patients every day from 8 to 10 am and then attended case discussions from 10 to 12 pm. In the afternoons, there were lectures and self-study in the library.

Every year, there were three teaching blocks lasting 2 weeks in each teaching block. During the teaching block, the program invited professors/lecturers with different expertize in psychopathology, pharmacology and research to teach residents followed by examinations at the end of each teaching block. During the second year of the residency program, residents were sent to attend in-patient training at Somdet Chaopraya Hospital in Bangkok, Thailand for 3 months because the program could offer only outpatient training at the Khmer Soviet Friendship Hospital in Cambodia. During the third year of the program, residents were required to write up their theses, which accounted for partial fulfillment of the specialist qualification. The first cohort graduated in 1998.

In 1999, the Cambodian Mental Health Training Program (CMHTP) changed to become the Cambodian Mental Health Development Program (CMHDP) because the program not only trained psychiatric residents but also developed mental health services in the provinces as well. At the same time, a second cohort of ten psychiatry trainees also started, completing their training in 2001 bringing the total number of psychiatrists who trained under the CMHTP program to 26. In addition, 40 psychiatric nurses had also been trained in Cambodia by the same program of the University of Oslo. The CMHDP continued to train a third cohort of six who graduated in 2004.

After nearly 10 years of rebuilding mental health services in Cambodia, the University of Oslo transferred the psychiatric training program to be managed within the University of Health Sciences where Prof. Ka Sunbaunat was a Dean.

Since then, the University of Health Sciences has included psychiatry in the curriculum of all undergraduates in medicine and continues to run the residency program.

Traditional Beliefs and Mental Health

Due to the lack of sufficient mental health services in Cambodia and due to difficult road access to and from rural areas to seek health care, many Cambodians use cultural, religious and traditional methods in treating their mental distress. Common complaints include tiredness, 'thinking too much', feeling very insecure about the future and flashbacks or disturbing dreams of traumatic events.

According to traditional beliefs, Cambodian people explain their problems by relating them to supernatural forces. For example, many Cambodians attribute the cause of psychological and psychiatric problems with being incompatible with the spirit of ancestors from either their mother's or father's side (Eisenbruch 2000). Thus, they often seek help from either traditional healers or mediums to perform ceremonies that would appease the spirit of ancestors. They also believe that individuals who suffer from severe psychotic disorders, or '*Chhkuot*', such as schizophrenia or psychological distress, are believed to be possessed by a demon or cursed by a sorcerer. The word '*Chhkuot*' is used to describe madness derived from the possession of ghosts and evil spirits. Furthermore, the concept of '*trov am peou*' describes the process in which an individual might become physically or mentally ill as a result of a curse placed by someone he/she had a conflict with (Bini 2013).

In regard to religion, the popular Cambodian interpretation of the concept of Karma, the Buddhist law of cause-and-effect, results in the widely accepted belief that people who suffer from mental disability must have done something wrong in their past lives which justifies their current living conditions (Bini 2013).

Cambodians also express their psychological distress through the use of wind. Many patients diagnosed by psychiatrists with neurotic disorders such as anxiety and depression, presented their symptoms to the psychiatric clinic in Cambodia and overseas as having been caught up by the imbalance of inner wind which is called '*khyal chab or khyal attack*' or wind overload '*khyal goeu*' or weak heart '*khsoy besdong*' (Hinton et al. 2001, 2003, 2009, 2010). The treatment of this wind illness was through the use of coining or cupping in order to release of the overloaded wind. This expression of wind illness is shared by Cambodian people in both urban and rural areas and among those with all levels of education.

Cambodia and its people have experienced a long history of trauma, genocide and civil war. Some studies show a dose–effect relationship between the numbers of traumatic events experienced (Mollica et al. 1998) and the symptoms of trauma response. In particular, this can be seen with post-traumatic stress disorder (PTSD). However, the prevalence of PTSD in mental health clinics in Cambodia is very low. Reports from different mental health clinics in Phnom Penh and the provinces show that the prevalence of PTSD is around 1–2% (Chhim 2014). However, Cambodian

people express their emotional responses to traumatic events from the Khmer Rouge time and the time after the Khmer Rouge as *Baksbat*, literally translated as broken courage. Many Cambodian survivors who visit mental health professionals and who testify at the Extraordinary Chambers in the Courts of Cambodia (ECCC), a joint initiative between the Cambodian and the UN courts, express having *baksbat* from the Khmer Rouge time. According to the author who has studied this concept extensively, *baksbat* describes the trauma symptoms experienced by Khmer Rouge survivors much better than PTSD (Chhim 2012, 2013).

Training in Psychiatry at the University of Health Sciences

After the joint training program between the University of Oslo and the University of Health Sciences ended in 2004, the Department of Psychiatry at the University of Health Sciences in Cambodia assumed full responsibility for the residency training in psychiatry. Since the take over of the training program in 2005, the university has trained 30 psychiatrists. The university continues to recruit 2–3 young doctors every year into the psychiatric residency program. Currently, there are four psychiatric residents still in the program, who expect to graduate in 1–2 years.

The psychiatric residents were trained by local professors who graduated from the first or second group of psychiatrists trained under the project of the University of Oslo. Due to the lack of experienced trainers locally, the program outsources many trainers from overseas who voluntarily come to train residents. A group of Singaporean psychiatrists led by Dr Angelina Chan, a consultant psychiatrist from Changi General Hospital in Singapore, came to train residents over a 2-year period from 2006–2008. There were many psychiatrists from other countries such as from Europe, America and the Netherlands who also participated in this training voluntarily. In addition to classroom training, there was also clinical supervision of residents provided via teleconference facilities by University of Colorado Professor Daniel Savin (Savin et al. 2013).

In addition to the residency training program, the university has already included psychiatry in the undergraduate medical curriculum during years 3, 4 and 5. This enables medical students to acquire some basic knowledge in psychiatry prior to graduation.

There is also training in psychology and social work available at the Royal University of Phnom Penh.

Current Mental Health Service in Cambodia

The Ministry of Health of Cambodia has just setup the Department of Mental Health and Substance Dependence formerly known as National Program for Mental Health (NPMH) in order to be responsible for developing mental health services in

Cambodia and coordinate with other non-governmental organizations working in the mental health field in Cambodia. With help from WHO and collaborating closely with foreign aid organizations, the Department of Mental Health and Substance Dependence has had considerable success in developing psychiatric services in Cambodia.

Currently, there are 56 psychiatrists in the whole country, which make the ratio of psychiatrists to population 0.33 per 100,000. The number of psychiatric nurses is a bit lower, the ratio of psychiatric nurses to population being 0.26 per 100,000 because there was no more training of psychiatric nurses after the support from the University of Oslo ended. As far as the mental health services are concerned, there are 37 Mental Health Clinics in Referral Hospitals and 172 Mental Health Clinics in Health Centers across cities and provinces in Cambodia (DMHSD 2013). All of these mental health clinics are operating on an ambulatory basis; there are only 3 Mental Health Clinics that have inpatient beds. The total number of in-patient beds is 15 which is approximately 0.1 beds per 100,000 populations (WHO 2011).

According to the Department of Mental Health and Substance Dependence (DMHSD), of these numbers, only 3 Referral Hospitals in Phnom Penh (Khmer Soviet Friendship Hospital, Kossamak Hospital, and Phnom Penh Municipal Hospital) and five other Referral Hospitals in the provinces (Pursat, Battambang, Siem Reap, Kampong Thom and Kampong Cham provinces) currently have psychiatrists working with them. The rest of the Mental Health Clinics is staffed by primary care doctors and nurses who have received 3-month training on primary mental health care. It is not clear whether the quality of mental health services at these clinics meets the required standards because of the lack of close clinical supervision, monitoring and evaluation from the Department of Mental Health of the Ministry of Health. According to WHO country profile 2011, the majority of primary health care doctors had not received official in-service training on mental health within the last five years. At the same time, the majority of primary health care nurses have also not received official in-service training on mental health within the last five years (WHO 2011).

Due to the lack of human and financial resource support, the development of mental health services across Cambodia has also been undertaken by many non-governmental organizations such as Transcultural Psychosocial Organization Cambodia (TPO Cambodia), Social Services of Cambodia (SSC), Center for Child and Adolescent Mental Health (CCAMH) and Supporter for Mental Health (SUMH) who provide different community mental health services in different provinces in Cambodia, for the SUMH Mental Health Rehabilitation Centre in Siem Reap. The Ministry of Health of Cambodia always says that mental health is one of the top priorities within health sector in Cambodia; however, the Ministry of Health has not yet set aside budget to allocate for mental health services in Cambodia. It is estimated that the annual budget for mental health is roughly around 0.02% of the national health budget (McLaughlin and Wickeri 2012).

Transcultural Psychosocial Organization Cambodia (TPO Cambodia)

The Transcultural Psychosocial Organization (TPO) Cambodia is Cambodia's leading non-governmental organization (NGO) in the field of mental health care and psychosocial support. It was established in 1995 as a branch of the Netherlands-based NGO 'TPO International' in response to the need for psychosocial and mental health care of Cambodian people traumatized by decades of wars, genocide and socio-political upheaval. In 2000, it was registered as an independent local NGO, 'TPO Cambodia', run entirely by Cambodians.

Throughout the 20 years of its existence, TPO Cambodia has continued to work on alleviating psychological and mental health problems of Cambodians. Along with providing quality mental health care to Cambodians via a range of grassroots community-based projects in the provinces and a Treatment Center in Phnom Penh, TPO Cambodia also functions as a Training Center in the field of mental health care and psychosocial support. TPO Cambodia is the only psychosocial organization in Cambodia engaged in transitional justice activities in the context of the Extraordinary Chambers (ECCC) in the Courts of Cambodia. Since 2007, and based on a Memorandum of Understanding with the ECCC, TPO has been providing comprehensive psychosocial services to ECCC Civil Parties. These range from on-site support at the tribunal, culturally sensitive trauma therapy and self-help groups to truth-telling activities and research projects. Much of this work is also linked to—and contributes to—conflict resolution, peace building and social justice.

Another component of the daily work of TPO Cambodia is raising awareness across Cambodia about mental health, promoting mental health care and psychosocial well-being, and advocating for mental health services in Cambodia. In doing so, we aim to influence and bring about positive health policy change. TPO Cambodia also conducts research, undertakes training on a range of mental health issues to other NGOs, government and private sector organizations and offers consultancy, mostly in collaboration with partner organizations and research institutes.

TPO Cambodia has its headquarters in Phnom Penh and has branch offices in Battambang, Siem Reap, Kampong Thom, Kampong Cham and Tbong Khmum provinces.

Conclusion

The way mental health services in Cambodia have developed has been shaped by the lack of resources after the Khmer Rouge time. Despite the complete destruction of mental health infrastructure by the Khmer Rouge communist regime, mental health services in Cambodia have developed remarkably during the last 20 years,

thanks to the concerted efforts of Cambodian professionals with support from the international community. Starting mental health services again from scratch post-Khmer Rouge has enabled Cambodia to decentralize its mental health services from the institutional to being community based which fits very well with the Cambodian context where a large proportion of its people live in rural areas (Statistic 2009). Imagine if Praek Thnoat Mental Health Hospital continued to operate until today, the numbers of inpatient beds would have continued to increase, creating a great financial, skill and economic burden for this country, making it seriously difficult to move away from the institutionalization into much needed community care.

There is still a long way to go for Cambodia in developing quality mental health services in response to the demand that continues to outweigh the resources available. The future trend of Cambodian mental health should embrace the concept of an integrated mental health care approach where mental health clinics at hospitals and the communities have to work together. In addition, the mental health policy makers should also take up the WHO recommendations on transferring skills from highly qualified to less qualified people so that they may add value to the integrated mental health care systems (WHO 2010).

Furthermore, future mental health services in Cambodia should also be able to encompass a wide range of fieldwork such as community development, livelihood enhancement, gender-based violence, human rights and legal support as people with mental health problems often have other pressing needs that require attention in addition to mental health care, if they are to recover well and lead more productive lives.

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Chapter 10
Mental Health in Vietnam

Harry Minas, Claire Edington, Nhan La and Ritsuko Kakuma

Abstract French colonization had a profound impact on the development of mental health services well into the twentieth century. The mental health system has been, and continues to be, dominated by institutional approaches to treatment of mental disorders. Mental hospitals operated by the national and provincial government health authorities have been the main locus of treatment and care. Social care for persons with severe and persistent mental disorders is limited, with national and provincial social affairs authorities providing minimal subsistence and little else in large social protection institutions. Over the past two decades, the Government of Vietnam has devoted increasing attention to the mental health of the population and has initiated major programs of reform of both the mental health system managed by the Ministry of Health (MoH) and the social protection system managed by the Ministry of Labor, Invalids and Social Affairs (MOLISA). While the mental hospitals and social protection centers continue to be essential and major elements of the two systems, there is a strong and sustained move in both sectors to community-based programs. It is also particularly important that there is continuing improvement in the extent and quality of collaboration between the two ministries. These developments are supported by appropriate national policy and development of the legal frameworks for modern mental health service provision and for community-based social support. This chapter outlines these developments and

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identifies some of the continuing challenges and opportunities for sustained mental health system improvement in Vietnam.

Development of the mental health system in Vietnam may be productively considered in the context of several clearly defined historical periods (Nguyen 1996).

The first period considered in this chapter is from 1887 to 1954, when Vietnam was under French colonial rule, except for a brief period of occupation by Japan—with the French colonial government allowed to remain in place—from September 1940 to 1945. With the end of World War II in the Pacific, Ho Chi Minh proclaimed independence and the formation of the Democratic Republic of Vietnam. The First Indochina War, the armed struggle to end French rule in Indochina, ended with the Geneva Accords in 1954. French Indochina was split into Cambodia, Laos and Vietnam; a temporary division of Vietnam into North and South at the 17th parallel was made; and a roadmap for national elections in July 1956 and reunification and self-government was agreed.

The second period, from 1954 to 1975, is the period of the Second Indochina war. This deadly and massively destructive conflict followed the repudiation of the Geneva Accords by the political leaders of South Vietnam and the USA and ended with the reunification of North and South and the creation of the Socialist Republic of Vietnam.

The third period is from 1975 through to the present day. The first 20 years of this period were marked by extreme poverty and the early process of national reconstruction, which was considerably hampered by the American trade embargo from 1975 to 1994, when the trade embargo was lifted and diplomatic relations between Vietnam and the USA were re-established. During this period, Vietnam has played an increasingly active role in world affairs, gaining membership of key international organizations, including the United Nations, the Association of South East Asian Nations (ASEAN), the Asia Pacific Economic Cooperation forums (APEC), the International Monetary Fund (IMF), the World Bank, the World Trade Organisation (WTO) and the International Labor Organisation (ILO). In addition, Vietnam has signed and ratified many UN Conventions and Treaties, such as the Convention on the Rights of the Child (CRC), the Convention on the Rights of Persons with Disabilities (CRPD) and, most recently, the Paris Agreement on Climate Change. Through the World Health Assembly, Vietnam has endorsed the WHO Mental Health Action Plan 2013–2020 and many other global health agreements. This third period has also seen the most active attention given to the development of a national mental health system.

Mental Health and Psychiatry in the Colonial Period

French Indochina was officially made a colony of France in 1887. It was made up of modern-day Laos and Cambodia, as well as the three territories that now comprise Vietnam. When the French first arrived in Indochina, they encountered a preexisting legal framework around mental illness that reflected both local forms of social organization and Vietnamese understandings of mental illness. Whereas Western biomedicine defines health as the absence of illness, in Vietnamese culture the particular influence of traditional Chinese medicine can be seen in a holistic notion of physical and mental health; emotional states are closely tied to physical disturbances and vice versa. Furthermore, understandings of psychiatric health and illness in Vietnam, especially in rural areas, are often linked to beliefs about the deep relationships between the living and the dead (Phan and Silove 1997). Traced to divine retribution for a prior sin, mental illness in Vietnam is attributed to the work of those gods, genies and divine creatures that populate Sino-Annamite mythology. Highly stigmatized in Vietnamese society, mental illness implies not only a condemnation of the individual but also an indictment of the honor of the family as a whole which is charged with the duty of caregiving. These responsibilities were formally recognized by Vietnamese law, also known as the Gia Long Code, introduced in 1810, which specified the judicial procedures by which families could gain legal guardianship of an individual judged to suffer from mental illness. The family was charged with exercising the appropriate oversight and would be held responsible for any crimes or disturbances resulting from poor surveillance (Reboul and Régis 1912).

In the late nineteenth century, the popular belief among colonial administrators in Indochina was that native populations did not suffer from violent forms of mental illness, and therefore, local disorders failed to meet the French legal definition of insanity. Instead, the colonial government relied on local forms of care in the community that predated French occupation. One could say that colonial policy around mental illness represented more of a social order response than a medical one with the hospital used to segregate and confine rather than to diagnose and treat. To avoid burdening, local budgets with the cost of minor and easily managed problems remained the paramount concern for colonial officials. Most mentally ill people therefore remained at home with only the most extreme cases sent to hospitals. It would take a combination of local and international pressures finally to persuade colonial officials of the need to seek a more permanent solution.

So what changed? First, the early twentieth century marked a broad expansion of Indochina's colonial administration, including its health service and hospital network (Monnais 1999). Much of this growth occurred in large urban centers at the expense of rural areas. By 1910, hospitals in Saigon reported treating upward of twenty psychiatric patients per year and were soon forced to convert cabins reserved for criminals to the care of the mentally ill. That patient numbers had begun to exert pressure on the limited hospital-based services in major cities suggested to some colonial officials that the previously "hidden" problem of mental

illness in villages was becoming a public, urban issue for the first time. They attributed the increasing visibility of mental illness among the thousands of vagrants who flooded into cities such as Saigon, Hai Phong and Hanoi to the effects of dislocation and social upheaval under French rule. The heightened visibility reflected the widespread social change and deepening poverty in the colony that formed the critical backdrop for the emergence of the mentally ill individual as a responsibility of the colonial government. At the same time, international calls for the development of a colonial psychiatric assistance program culminated in a 1912 meeting of French psychiatrists in Tunis. This seminal meeting emphasized the role of psychiatry in France's civilizing mission and the risk of falling even further behind other European powers whose own programs were thought to be "growing more and more refined every day." The meeting prompted Indochina's government to authorize the construction of an asylum in 1912, and the government dedicated funds to its construction in 1914 (National Archives Center 1 1928). Importantly, this coincided with the doubling of the colony's health budget. However, World War I delayed the realization of this project for another four and a half years. In 1919, French officials finally opened Indochina's first asylum, Bien Hoa, outside Saigon.

Eleven years later, in 1930, the French law of 1838 regulating asylum care was officially extended and adapted to Indochina. The law included provisions for a psychiatric assistance program that would grow to include a network of open-door, psychiatric services in major hospitals and the establishment of a second asylum in the north, outside Hanoi, in 1934. While Algeria has received much more scholarly attention, it was Indochina that in the 1930s earned the praise of international observers for having made the most 'serious efforts' at psychiatric assistance across the empire.

Asylums in Indochina received European and indigenous patients. However, the asylum population remained overwhelmingly Vietnamese and male throughout the interwar years. In British India, by way of contrast, psychiatric institutions were racially segregated. The Indochina case also forms an important contrast with French Algeria where hospitals served far higher proportions of Europeans than North Africans (Keller 2007).

As in France, there were two principal ways people could find their way into the asylum. Placement could either be requested by the administrative authorities or initiated by the patient's family, relatives or friends. Each required a medical certificate confirming an insanity diagnosis and issued only on a temporary basis. At the end of six months, confinement could become permanent depending on the medical progress of the patient. Patients were diagnosed with a wide range of disorders, from chronic forms of dementia and depression to acute forms of epilepsy and mania. In terms of treatment, patients received a variety of drugs including sedatives and calming agents such as opium, chloral and bromides and were exposed to shock therapy and less intensive forms of hydrotherapy (Institut de médecine tropical (PHARO) 1934). As for those administering the treatment, asylum directors were chosen from among those French civilian or military doctors in service in the colony who had either served as a former chief doctor at an asylum

or psychiatric clinic in the metropole or had completed a "*stage*" or internship in psychiatry in a French asylum (National Archives Center 1). They were assisted by a corps of indigenous medical doctors trained at the Hanoi Medical University (where psychiatry was introduced into the curriculum in 1934), as well as a large staff of indigenous nurses, wardens and auxiliary staff of chefs, gardeners and maintenance workers.

Asylums in Indochina were organized as large agricultural colonies, where patients would work the land to promote healing and eventual discharge. These agricultural colonies offered a model of rehabilitation that connected strategies of social reform through labor across the imperial world. For colonial psychiatrists, agricultural colonies promised not only "cerebral hygiene" and discipline through physical labor but also a kind of moral re-education. Even for those with no hope of a cure, psychiatrists believed that approximating the habits of ordinary life would serve a kind of harmonizing function. This model of care was inspired by the efforts of Dutch psychiatrists in neighboring Java where French psychiatrists undertook a series of study trips throughout the early twentieth century.

Even at the height of psychiatric activity in Indochina during the 1930s, French experts continued to rely on family resources to support temporary or permanent releases for those patients deemed "sufficiently improved." Confronted with the pressure to treat more acute cases, psychiatrists grew anxious to relieve the serious problem of asylum overcrowding by getting rid of those patients who no longer seemed to benefit from confinement. Once the family agreed to assume responsibility for their care, the patient would be repatriated to their home village where they were put under a "medical surveillance" of either weekly or monthly visits by the local doctor who administered medicine, kept track of the patient's progress and eventually recommended a permanent release or reintegration back into the asylum. This period, referred to as a "test leave," was envisioned not as a break with asylum but rather an extension of it. While French psychiatrists relied on Vietnamese families, they also continued to compete with the services of indigenous healers well into the 1930s even as the colonial state worked to increasingly restrict the practice of traditional medicine and promote widespread and exclusive recourse to Western medical care (Monnais and Tousignant 2006).

With the Japanese occupation of Indochina in 1945, much of the activity of psychiatric hospitals ceased.

The period, 1949–1953, is marked by efforts at reorganization and rehabilitation with the assistance of American aid. At the conclusion of the First Indochina War in 1954, the French-trained psychiatrist, Nguyen Van Hoai was named the first Vietnamese director of the "Psychiatric Hospital of South Vietnam." The slow transition to clinical psychiatry began in the 1950s, and in particular the transition from hospitals as custodial wards to treatment centers. The advent of psychiatry as a medical specialty in Vietnam during this period is often associated with the emergence of socialist ideals which viewed mental illness as a national burden preventing individuals from fully contributing to the economic productivity of the country (Nguyen 2003).

Psychiatry in Vietnam After 1954

The period from 1954 to 1975 was marked by the Second Indochina War, concluding with the reunification of Vietnam. Despite continuing armed conflict and its impact on every aspect of social and economic life, there was substantial progress in mental health care in both the northern and southern regions of Vietnam. An example of that progress was the creation of psychiatric institutions, such as the Department of Neurology and Psychiatry of Hanoi Medical University, established in 1957 (Nguyen 1996), the Association for Neurology, Psychiatry, and Neurosurgery, established in 1962, and the National Psychiatric Hospital (now National Psychiatric Hospital No. 1), established in 1963 (National Psychiatric Hospital No. 1 2013). The government of the Democratic Republic of Vietnam also began building provincial psychiatric hospitals, for example the Hai Phong Psychiatric Hospital, established in 1960. These organizations enabled a more systematic approach to the provision of treatment services and training.

The Department of Psychiatry established in 1969 at Bach Mai Hospital became the National Institute of Mental Health in 1991. Efforts to develop a community mental health network were also initiated during this period. National Psychiatric Hospital No 1 piloted the network in Hanoi and the former Ha Tay province and subsequently expanded to other provinces.

Development After 1975

The unification of Vietnam in 1975 opened a new chapter for the whole country and facilitated the development of psychiatry. In addition to the continuing establishment of psychiatric institutions, development of the mental health sector included the consolidation and expansion of mental health services at the community level.

While the process of reform, or *Doi Moi,* initiated in 1986, created many problems for the health system, including the virtual collapse of the primary health care network and an initial decline in human development indicators (Read et al. 2000), the development of a market rather than a centralized economic system and the re-establishment of diplomatic relations with the USA and other countries opened up the possibilities for new forms of international exchange and cooperation. Multilateral and bilateral development support programs have included attention to mental health, accelerating the development of mental health services and mental health research in the country.

In 1998, the Ministry of Health (MoH) included mental health as one of the National Health Target Programs. The program focused on schizophrenia and epilepsy as priority disorders for attention at primary care level. The goal was to establish community-based mental health care for persons—schizophrenia or epilepsy at every commune health station (primary health center) across the country (Government of Vietnam 1998). The program has been implemented in more than

70% of communes (National Psychiatric Hospital No. 1 2015) and has laid the groundwork for a more comprehensive community-based mental health system. While a number of pilot projects have been developed to extend these services to people with depression and anxiety, the program has continued to be limited to a focus on services for schizophrenia and epilepsy. Nevertheless, implementation of these services has included community education about mental health and illness and about mental health services, training of community-based mental health workers and consolidation and expansion of mental health care facilities, resulting in some reduction of stigma and discrimination against people with mental disorders. The initiative has created a network of primary health care centers with some mental health expertise that can be further developed into a comprehensive community-based mental health service (National Psychiatric Hospital No. 1 2015).

Contemporary mental health services are managed by the MoH and the Ministry of Labor, Invalids and Social Affairs (MOLISA). MoH and Provincial Health Departments manage a network of national psychiatric hospitals, a National Institute of Mental Health, provincial psychiatric hospitals, psychiatric wards and outpatient clinics in general hospitals, and mental health services in primary care clinics. MOLISA manages a network of Social Protection Centers that provide residential care, rehabilitation and social support services for people with chronic mental disorders who do not have family or other social supports.

Mental Illness in Vietnam Today

While information on the prevalence of mental disorders is limited (Vuong et al. 2011), the contribution of mental disorders to the burden of disease is significant. An epidemiological survey conducted in 2000 showed that the ten most common mental disorders collectively affected 14.9% of the population, approximately 12 million people (National Psychiatric Hospital No 1 2002). Among them, the most prevalent disorders were alcohol abuse (5.3%), depression (2.8%) and anxiety (2.6%).

For depression, the Global Burden of Diseases, Injuries, and Risk Factors Study 2010 (GBD 2010) estimated that the point-prevalence of major depressive disorder was 4.0%. If its prevalence is applied to Vietnam, where good population prevalence data do not exist, it would translate to 3.6 million people in Vietnam who might benefit from mental health support for major depressive disorder alone. Depressive disorders account for close to 41.9% of the disability from neuropsychiatric disorders among women and 29.3% among men. Common perinatal mental disorders affect 15.9% of women during pregnancy and 19.9% postpartum in developing countries (Fisher et al. 2012) with adverse consequences for the infant's physical health, such as greater risk of low birth weight (Patel et al. 2004), mother–infant relationship, and for the child's psychological development. In Vietnam, 33% of women attending general health clinics in Ho Chi Minh City were found to have postpartum depressive symptoms and 19% explicitly acknowledged suicidal

intentions (Fisher et al. 2004). In northern Vietnam, 29% of pregnant women and mothers of infants in 10 communes were diagnosed with common perinatal mental disorder (Fisher et al. 2010). The prevalence was found to be more than twice as high in rural than in urban areas and among women exposed to intimate partner violence as compared with women who had not experienced such violence.

Evidence is also increasingly available concerning the mental health of children and youth. In 2003, the MoH and UNICEF jointly conducted a national community-based survey of 5584 young people aged 14–25 years and found that 32% of youth felt bored with their lives, 25% reported feeling so sad or helpless that they stopped doing their usual activities, 21% reported feeling hopeless about their future, 0.5% reported having attempted suicide, and 2.8% reported having self-harmed. Among 18- to 21-year-old females, almost 8% had considered committing suicide (General Statistics Office 2005). Five years later, another survey was conducted to examine changes over time and trends. This study found that 27.6% of study participants reported feeling sad or helpless to the extent that it affected their usual activities, 21.3% reported feeling hopeless about their future, and 4.1% reported having had thoughts of suicide (General Statistics Office 2005, 2011; Nguyen 2012).

Among children aged 6–16 years, a nationally representative epidemiological study was conducted to determine the prevalence of childhood mental disorders and risk factors. The prevalence of mental disorder in this age group was found to be comparable to that in other countries (Weiss et al. 2014).

While epidemiological evidence on child and adolescent mental disorders is increasing, there is limited evidence for the older population (Teerawichitchainan and Giang 2013). In a rapidly aging society, evidence to inform strategies to prepare for and meet the increasing demands on the health and mental health care system will be critical.

Nevertheless, based on available evidence from Vietnam and imputations from international data, the latest estimates on the magnitude and impact of mental, neurological and substance use (MNS) disorders for Vietnam show that MNS disorders accounted for 8.2% of the disability-adjusted life years and 18.1% of years lived with disability in 2013 (Table 10.1) (Institute for Health Metrics and Evaluation 2013; Murray et al. 2013a, b; Whiteford et al. 2013). The significant burden of MNS disorders on the country's health and well-being, and on the national economy, demonstrates the urgent need for government investment for an effective mental health policy and practice that is informed by up-to-date evidence from epidemiological, health services and policy research.

Table 10.1 Proportion of total DALYs and YLDs attributed to mental, neurological and substance use disorders (2013 estimates)

	DALYs (%)	YLDs (%)
Depression	2.88	6.83
Anxiety	0.58	1.37
Schizophrenia	1.10	2.62
Bipolar	0.59	1.14
Alcohol use	0.37	0.61
Drug use disorders	1.24	2.11
Epilepsy	0.57	0.69
Autistic spectrum disorders	0.5	1.18
Conduct disorders	0.27	0.63
Eating disorders	0.05	0.11
Attention deficit/hyperactivity disorders	0.03	0.06
Intellectual disabilities	0.03	0.06
Alzheimer's disease and other dementias	1.26	1.11
Other mental and substance use disorders	0.58	1.37
Total	10.04	19.90

DALYs disability-adjusted life years lost; *YLDs* years lived with disability
The source(s) of the table needs to be listed here

Current Mental Health Initiatives

Despite efforts and encouraging progress, mental health care in Vietnam continues to face major challenges. These include insufficient hospital beds for mental health care, limited availability of non-pharmacological interventions such as psychotherapy and psychosocial rehabilitation, shortages in skilled human resources at all levels of the system, inadequate access to medications, insufficient infrastructure for mental health care, limited and fragmented funding, and gaps in policy making and implementation. The lack of a mental health law has been a continuing problem that results in insufficient protection of the basic human rights of people with mental disorders. The growing complexity of population mental health, in the context of economic and social change and rapid industrialization and urbanization, and the increasing recognition of the substantial contribution of mental disorders to burden of disease have contributed to a clearer and more sustained focus by government on the need to develop an effective, accessible and equitable mental health system.

In 2014, the Minister of Health announced the development of a National Mental Health Strategy 2015–2025. A Drafting Committee for the National Mental Health Strategy was established in March 2014 which included key stakeholders from across Departments within MoH and established a Technical Experts Group, the membership of which includes Vietnamese and international experts from MoH, the University of Melbourne, UN agencies (World Health Organization, UNICEF) and NGOs (e.g., Vietnam Veterans of America Foundation) to facilitate the process

(Ministry of Health 2014). The process of developing the strategy has included wide consultation with all relevant stakeholder groups from across Vietnam. The draft strategy is fully consistent with the WHO Mental Health Action Plan 2013–2020. It is expected that, after a process of internal consultation across relevant ministries is carried out, the strategy will be submitted to the Prime Minister for approval by mid-2016.

The drafting of the National Mental Health Strategy has also ensured its consistency with other related health initiatives. Within the health sector, in 2015 the National Strategy on Prevention and Control of Non-Communicable Diseases (NCDs) for 2015–2025 was approved. This is particularly important because of the fact that people with mental disorders are at substantially higher risk of developing cardiovascular and other NCDs and premature mortality, and because people with cardiovascular, respiratory and endocrine diseases such as diabetes are at substantially higher risk of developing depression and other mental disorders. A substantial pilot project in a province close to Hanoi is exploring integration of mental health and NCD service programs.

In the social sector, a Prime Ministerial Decision was announced in 2010 approving the development of social work as a profession and the development of social service facilities at all levels to build an advanced, community-focused social support system by 2020 (Ministry of Labor Invalids and Social Affairs 2010). In 2011, a Prime Ministerial Decision initiated an ambitious national reform to develop community-based functional rehabilitation and social support services for people with mental disorders and made available substantial funds to implement this reform (Ministry of Labor Invalids and Social Affairs 2011). Vietnam ratified the UN Convention on the Rights of People with Disabilities (CRPD) in 2014. The planning for implementation of CRPD includes people with disabilities associated with mental disorders and provides another platform from which to advocate for better health, social and legal support for people with mental disorders. While MOLISA has primary responsibility for managing these programs, there is increasingly clear recognition, by both MOLISA and MoH, that close collaboration between the two ministries and their respective service agencies is essential for successful implementation, and for a comprehensive and community-focused mental health system.

Intersectoral Collaboration

In Vietnam, the lack of intersectoral collaboration and coordination of mental health care between MoH and MOLISA in the past has led to disjointed, inefficient and ineffective systems of care. More recently, the two ministries have begun working together to develop and implement a coordinated, integrated and comprehensive mental health care system that is able to respond to the clinical, rehabilitation and social service needs of people with mental disorders. For instance, MoH and MOLISA have developed a draft Joint Circular on the roles and functions of the

Social Protection Centers for providing mental health care. This is due to be finalized by 2016. The development of the National Mental Health Strategy 2016–2025 has been led by MoH, but has had ongoing input from MOLISA and other sectors such as education, finance and justice. Collaborative discussions on an integrated community-based mental health care system are occurring and are likely to continue into the phase of implementation of the strategy.

The current national initiatives for mental health system development are ambitious. The government has committed to (1) developing infrastructure and equipment; (2) developing human resources; (3) developing and implementing integrated and sustainable community-based service delivery models for promotion, prevention, early detection, treatment and recovery; (4) raising community awareness and participation; and (5) increasing accountability of government at all levels. While intersectoral collaborations are improving, establishing formal mechanisms to ensure such collaboration will be necessary to advance ongoing initiatives to strengthen the mental health care system.

International Collaboration

Numerous international collaborations in mental health have contributed to the advancement of the mental health services, training, policy and research. These include partnerships with universities, e.g., the Karolinska Institute in Sweden, Vanderbilt University in the USA, the Universities of Melbourne and Queensland in Australia, and with psychiatric hospitals and institutes in France, Australia and several other countries.

The University of Melbourne has collaborated with colleagues and institutions in Vietnam since 1994 (Hung et al. 2001; Minas 1994, 1996, 1997, 2007, 2009). In 1996, the University of Melbourne organized in Hanoi a collaborative workshop between the National Institute of Mental Health and the Royal Australian and New Zealand College of Psychiatrists (Minas 1996), the first significant international psychiatry conference to be held in Vietnam. The Vietnamese presenters at the conference gave a comprehensive overview of the state of mental health research, psychiatric training and mental health services in 1996 (Minas 1997).

Over two decades, the university's commitment has included collaboration in developing policies, research, training, funding and political support for the design and implementation of Vietnam's mental health care system (Minas 1997, 2007). Two major programs of work led by the University of Melbourne are the National Taskforce on Community Mental Health System Development in Vietnam Project (2010–2015) and the Vietnam Mental Health Consortium Project (2013–2015), which together have focused on strengthening the capacity of government to develop and implement mental health policy and plans, including community-based services, and develop the evidence base needed to inform policy and practice, strengthen research capacity, develop training programs and strengthen the mental health service network.

Through these two projects, the University of Melbourne and other national and international stakeholders have worked with MoH and MOLISA to mobilize additional funds for the program of work, develop the National Mental Health Strategy 2016–2025, conduct a comprehensive national survey on the mental health care system, develop and deliver together with NIMH a training program for decision makers and managers to develop community-based mental health care, develop and pilot service delivery models for mental health, and contribute to the better engagement and collaboration of key stakeholders from government, hospitals, UN agencies, non-government organizations, and universities to tackle the numerous challenges related to the mental health care system.

Work that began at the University of Melbourne nearly two decades ago and is now based at Monash University has built a substantial evidence base on women's mental health and perinatal mental health (Fisher et al. 2007, 2012, 2013a, b). The Queensland University of Technology has played an important role in strengthening research capacity, particularly in the area of adolescent and men's mental health (Nguyen et al. 2012, 2013; Phuong et al. 2013; Van Huy et al. 2015). The Karolinska Institute has had a long-running program in which many Vietnamese students have completed a PhD. Vanderbilt University has worked closely with the Ministry of Education and Training for many years and has contributed to the establishment in 2009 of a Master Program in Clinical Psychology and a doctoral program in 2015 at Vietnam National University. Vanderbilt University in collaboration with Vietnamese colleagues has also conducted many research projects on mental health, with a particular focus on children, adolescents and women (Do et al. 2013; Ngo et al. 2014; Weiss et al. 2012, 2014).

Non-government organizations have also contributed to numerous achievements. For instance, the Vietnam Veterans of America Foundation—International Centre has collaborated with mental health leaders in Da Nang and Khanh Hoa provinces to develop community-based mental health services for depression. Basic Needs, a UK-based NGO, launched a program in Vietnam in 2010 to support community-based mental health care.

Finally, Vietnam is a member of the ASEAN Mental Health Taskforce, which is a network of ASEAN member states that work together to address mental health in the region. Their work plan focuses on (1) developing an advocacy strategy for mental health; (2) facilitating the integration of mental health into the health care system and strengthening the capacity; (3) facilitating and strengthening the mental health information system; and (4) establishing an ASEAN network on mental health.

Mental Health Research

Mental health research has grown significantly in the last two decades with a greater understanding of mental health issues of women, especially during the perinatal period, children and adolescents, risk factors for mental disorders and mental health

services research. However, knowledge gaps and the still limited research evidence to inform mental health policy and practice remain a significant impediment to strengthening the mental health care system in Vietnam. Particularly important in this regard is the lack of a comprehensive mental health information system, making it impossible to systematically evaluate the impact of mental health policies and programs.

The national mental health system survey mentioned above will make a significant contribution to the understanding of the system and provide impetus for change. However, more targeted efforts to strengthen academic partnerships and research capacity are necessary to ensure up-to-date and high-quality evidence to inform policy and practice in Vietnam and to share lessons from Vietnam with the global mental health community.

Future Directions

Vietnam has made substantial progress in achievement of the Millennium Development Goals (MDGs), being an early achiever in a large number of indicators, and is on track to achieve most of the rest. Recent progress in mental health system development has been substantial. The progress that has been made in the past five years is illustrated by a comparison of the current situation (Luong et al. 2015) with that in 2010 (Niemi et al. 2010).

The inclusion of mental health in the Sustainable Development Goals (SDGs) of the United Nations 2030 Agenda for Sustainable Development presents substantial opportunities for acceleration in the development of a comprehensive, equitable and effective mental health system in Vietnam. Mental health leaders in MoH and MOLISA are increasingly aware of the opportunities that lie ahead and are actively seeking opportunities to build on existing achievements in developing the national mental health system and to improve the lives of people with mental disorders. A key goal of the new global development framework is to promote integrated development rather than the vertical programming that was a central feature of the MDGs. This goal is consistent with the fact that mental disorders, NCDs, disability and poverty are all closely interrelated (Eaton et al. 2014; Minas et al. 2015) and of the need to establish close collaboration between programs that are the primary responsibility of Ministries of Health, Social Affairs and economic development (Minas et al. 2015) and disaster response (Tsutsumi et al. 2015). The Vietnamese government has already embarked on a process of development that clearly recognizes these emerging development imperatives (Fig. 10.1).

There is now increased capacity in terms of the ability of mental health leaders to develop and implement policy, develop services, and to support mental health research and evidence-informed policy and practice. Mental health system governance is being improved. There is increased government investment in mental health, and increasingly strong intersectoral and international collaborations are being developed. It Includes an explicit commitment to protection of the rights of
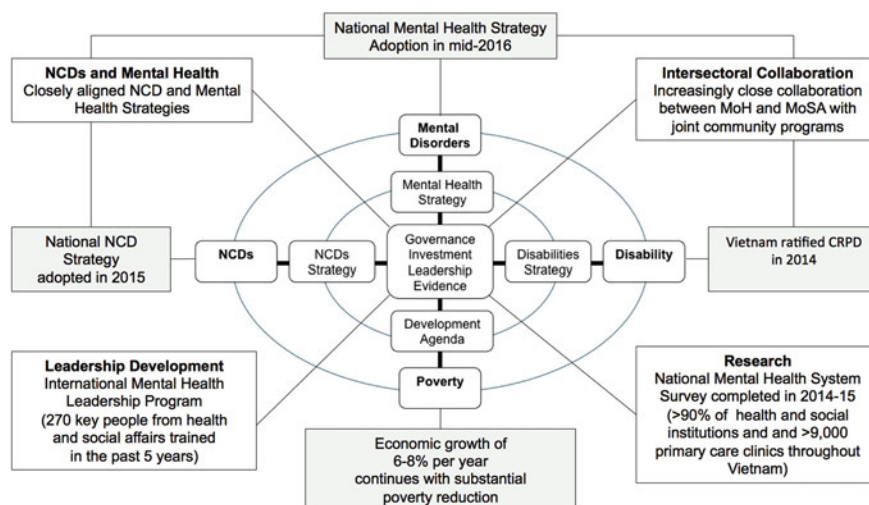
Fig. 10.1 Integrated mental health, NCDs, disability and economic development in Vietnam

persons with mental disorders. The more integrated model of mental health system development that is emerging in Vietnam may well prove to be an exemplar for other low- and middle-income countries in how to build strong, comprehensive, equitable mental health systems within the broader objectives of health, social and economic development.

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Chapter 11
Historical and Cultural Perspectives from the Philippines

Lourdes Ladrido-Ignacio, Michael Tan and Joffrey Sebastian Quiring

Abstract The Philippines' mental health situation is an amalgam of its rich pre-colonial history, the influence of Spanish and American colonization and the Filipinos' subsequent quest for identity and national consciousness. Beliefs attributing illness to changes in the natural environment, witchcraft and sorcery, transgressions of social norms and punishment by environmental spirits and the healing power of the shamans permeated the archipelago even before the colonizers came and continue to persist even up to this day. Spain left its imprint on the country through Roman Catholic teaching and rituals and the introduction of Western medicine and the hospital system. The Americans, on the other hand, introduced Protestantism, which had its own impact on the understanding of mental health, and reoriented the health-care system with the introduction of private institutions and the establishment of a system of health professional training based on that of the United States of America. In the 1970s, *Sikolohiyang Pilipino* (Filipino psychology) emerged and sought to probe into indigenous concepts and descriptions of personality and mental health at about the same time as when the country was put under an oppressive martial law regime that was ended by the 1986 EDSA People Power revolution. The earliest formal and institutionalized mental health services in the country were provided by the Hospicio de San Jose, a mental health asylum established in the mid-nineteenth century. Since then, the predominant system of mental health care has been mental hospital-based. A National Mental Health Program (NMHP) was set up post-1986 revolution to reevaluate the mental health situation and services in the country. Through the years, the NMHP

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met serious challenges in its implementation with the dearth of epidemiologic data on mental health, serious financial and human resources limitations, low government prioritization and the absence of a dedicated mental health law in the country. Despite being few and sometimes isolated, efforts to deinstitutionalize mental health care and bring programs to communities and special population groups, like migrant workers, have been documented. Among prevailing and emerging mental health issues in the Philippines at present are: (1) the inadequacy of work around the indigenous concepts of mental health; (2) disparities in mental health practices and care due to multiculturalism and economic differences; (3) the effects of the Overseas Filipino Worker phenomenon especially to families; (4) the gap between Western-trained professionals and popular culture; (5) the continuing predominance of custodial and isolated care; (6) mental health care in disasters; and (7) the need for reorientation of the teaching and practice of psychiatry. Psychiatry in the Philippines needs to face up to many old challenges as well as new ones. Filipino psychiatrists will need to take on multiple roles in relation to these challenges, not just as clinicians but also as community trainers, advocates, researchers, leaders and civil servants, with a sensitivity to culture and history.

Historical and Cultural Milieu

The Philippines is often described as having gone through "300 years in the convent and 50 years in Hollywood," (Karnow 1990) a reference to its colonial history of about 300 years under Spain and 48 years under the USA. Such descriptions can lead to an undervaluing of the pre-colonial period, which, from early Spanish chronicles, was already marked by extensive economic and cultural exchanges, within the archipelago as well as with neighboring states. It also presumes a wholesale adoption of culture brought in by Spain and the USA without considering how other external influences interact, in the past and at present, with the local milieu. Particularly important was the introduction of Islam in the fourteenth century. By the time Spanish colonization began in the sixteenth century, Islam had reached Manila in the northern island of Luzon (Majul 1973).

Scott (1994) and Reid (1988) both present a summary of the pre-colonial situation of the Philippines that includes glimpses into the health situation, as well as concepts around health and illness with great similarities across cultures. These include attributions of illness to changes in the natural environment, witchcraft and sorcery, transgressions of social norms and punishment by environmental spirits.

One of the most comprehensive accounts of life in the Philippines during the period of contact with Spanish colonialism appears in a seventeenth century account by Alcina (1668, 2005) a Spanish Jesuit friar. It includes several descriptions of "locura o furor" (madness or rage), using local terms and attributing the illnesses to demonic possession in concurrence with the native perspectives. He describes how these illnesses were treated by healers, some of whom were said to have suffered from these mental illnesses and became healers after they had

recovered. Such healers are referred to by anthropologists as shamans who treat illnesses by going into a trance and who claim to be able to communicate with the supernatural during this altered state of consciousness.

We get another glimpse into mental health in the Philippines in an essay written in 1895 by one of the country's national heroes, Jose Rizal, who was a physician. His essay "La Curacion de los Hechizados" (The Treatment of the Bewitched) was first intended as advice for the town's health and welfare inspector. Rizal is contemptuous of local practices, but toward the end of the essay, he also speculates that there may be "autosuggestion" involved and that this might be useful: "Should we find ourselves before a case of autosuggestion we would not hesitate to follow the principle on which the primitive treatment is based." (Rizal 1895, 1964).

Many of the rituals and traditional healers described by Alcina, other Spanish chroniclers, and Rizal continue to exist today in different parts of the country and in both rural and urban areas, Christian or Muslim.

Colonialism did leave its imprint on the Philippines, with Spanish culture, mainly through Roman Catholicism, blending in with pre-colonial religious beliefs and practices. Veneration of images and religious processions, for example, continue to remain an integral part of popular medicine; churches still draw hundreds of devotees each day, many appealing to religious images for recovery from illnesses. The Spaniards also introduced Western medicine, establishing a medical school and a nationwide network of hospitals, administered by the religious (Tiglao and Cruz 1975).

The Americans occupied the Philippines from 1898 to 1946. While Roman Catholicism remained the majority religion, the Americans introduced Protestantism, including many evangelical sects that have had their own impact on the understanding of mental health. The Americans reoriented the health-care system with the introduction of private institutions. They also established a system of health professional training based on that of the USA. Despite their attempts to introduce "scientific" medicine, many of the indigenous beliefs and practices persisted. Anderson (2006) describes resistance to western medicine for many different reasons ranging from its association with colonialism to a perception that local medicine was more effective or at least had greater explanatory power. This was probably the case for mental illnesses for which religious explanations, such as possession or witchcraft, seemed more convincing.

In the 1970s, Filipino psychology professor Virgilio Enriquez (1992) developed *Sikolohiyang Pilipino* (Filipino psychology), which sought to probe into indigenous concepts and descriptions of personality and mental health. Converging with the work of Salazar (1977) on *ginhawa* (loosely translated, the term denotes well-being), *Sikolohiyang Pilipino* spurred interest in situating mental health within Filipino culture (or cultures). It also highlighted the quest for identity and national consciousness and articulated Filipino values such as *kalayaaan* (freedom), *pag-kakaisa* (unity or consensus) and *kapayapaan* (peace). This was about the same time as when the country was put under an oppressive martial law regime that was ended by the 1986 EDSA People Power revolution. The restoration of democracy meant greater participation by various sectors in the formulation of government policies including those on mental health.

Mental Health Situation and Services

The earliest epidemiological data on mental health available were statistics of patients admitted to the Hospicio de San Jose. A total of 741 patients were documented from 1865 to 1898, mostly men, and the majority were diagnosed with "demente," an encompassing term for any mental disorder or abnormality in behavior. The Hospicio de San Jose, established in the mid-nineteenth century, is known to be the first mental asylum in the country. Treatment followed the European model. With the increase in the number of patients, those who were violent or had committed criminal acts were placed in prisons. These arrangements became an alternative to the predominant practice of consulting with shamans for healing rituals or Catholic priests for exorcism (Paular 1991).

From the 1900s to the present, the predominant system of mental health care has been mental hospital-based. As earlier mentioned, however, there was the post-1986 revolution reevaluation of the mental health situation, especially in concepts and services that led to the organization of a National Mental Health Program (NMHP). Initially a task force on mental health was formed to formulate a NMHP with the objective of generating the shift from the predominantly mental hospital-based services to a community-based mental health-care system and integrating mental health within the total health system (Salazar-Aleta 1999). Despite serious limitations in running the NMHP and low government prioritization, a national mental health policy was formulated in 2001. The policy served as a framework for developing mental health services in the absence of a dedicated mental health legislation (Conde 2004). Some legal provisions pertaining to mental health are currently contained in other laws, and the Philippine Mental Health Act of 2014 has been recently filed in the senate (Senate of the Philippines 2014). The NMHP also brought together stakeholders from government, non-government and academic groups, including returning psychiatrists and other mental health professionals trained overseas, for a fruitful collaboration. The landscape of mental health has slowly evolved to be more responsive to the country's needs, though at times it is still hampered by the bureaucratic structure of government agencies and subject to political maneuvers.

The current NMHP, as revised in 2013–2014 (Department of Health, Philippines 2014), includes the following priority mental health concerns:

1. Promotion of mental health and well-being
2. Program to address extreme life experiences
3. Program for the treatment and rehabilitation from mental disorders
4. Prevention and rehabilitation from substance use disorders
5. Community mental health programs
6. Program on the mental health information system.

This framework addresses the mental health situation in the country not just by treating disorders but also by promoting healthy mental practices and a holistic lifestyle, enhancing coping strategies and managing stress, especially during extreme life experiences such as disasters and other traumas. It also responds to the

evolving targets of psychiatry and mental health program development. Unfortunately, most of the existing government programs have still been centered on diagnosing and treating mental disorders.

There are few prevalence studies on the different psychiatric disorders in the general population. A local baseline survey in 1964–1967 in Sta. Cruz, Lubao, Pampanga by the Department of Health Division of Mental Hygiene found that the prevalence of mental disorders was 36 per 1000 population (Department of Health, Philippines 2011b, October). Then, the pioneering, seven-nation, World Health Organization (WHO) Collaborative Studies for Extending Mental Health Care in General Health Care Services in 1980, conducted in three primary health centers in an urban slum in Manila, revealed that 17% of adults and 15.67% of children had mental disorders (Climent et al. 1980; Harding et al. 1980; Ignacio 1984). In 1993–1994, a population survey of mental disorders in both urban and rural settings in three provinces in the Western Visayas region was conducted by the University of the Philippines Psychiatrists Foundation Inc. in collaboration with the regional health office (Council on Health Research for Development 1997). Table 11.1 lists the prevalence rates of the most frequent diagnoses among children and adults in the study.

Even in recent years, there has been a dearth of epidemiological data to document mental disorders. A few new studies tried to extract prevalence of specific disorders in different subsets of populations but do not give generalizable results. Census data from the Philippine Statistics Authority (2013) reported that in 2010 there were 16 per 1000 population who had a disability reported that in 2010 there were 16 per 1000 population who had a disability including mental disability, but did not identify the specific mental disorders. A Department of Health study in 2007 revealed that 15 out of 900 teenagers tried to commit suicide. The WHO, on the other hand, reported that in 2004 there were over 4.5 million cases of depression in the country but only three percent of which were clinically diagnosed. Among those who are depressed, only one-third will seek help, while the rest will suffer the symptoms but would either not know what is wrong with them or be ashamed to seek help (Department of Health, Philippines 2011b, October). The WHO—Assessment Instrument for Mental Health Systems (AIMS) Country Profile report in 2007 showed that the top three most frequently diagnosed cases in all mental health facilities were schizophrenia, mood disorders and substance abuse disorders, in that order.

On the other hand, resources for mental health have been very limited. Only 5% of the overall health expenditures of government is allocated for mental health; of this amount, 95% is spent on running mental hospitals. The national social insurance scheme, PhilHealth, covers mental disorders but is limited to acute inpatient

Table 11.1 Most frequent diagnoses seen among adults and children in Western Visayas in 1993–1994 (Council on Health Research for Development 1997)

Most frequent diagnoses among adults (%)	Most frequent diagnoses among children (%)
Anxiety (14.3)	Enuresis (9.3)
Panic (5.6)	Speech and language disorder (3.9)
Depression (5.3)	Mental subnormality (3.7)
Psychosis (4.3)	Adaptation reaction (2.4)
	Neurotic disorders (1.1)

care (World Health Organization and Department of Health, Philippines 2007). As for human resources in mental health, only 2.82 mental health practitioners are available per 100,000 population. Figure 11.1 depicts the breakdown of these workers according to professions. A larger number is shown to represent mostly medical assistants and non-medical auxiliary staff, manning facilities. According to the WHO-AIMS (World Health Organization and Department of Health, Philippines 2007), more than 50% of psychiatrists work in for-profit, mental health facilities and private practice. Numbers of social workers and occupational therapists are very low. Many trained community-based health workers no longer serve in their localities and the current primary health-care staff seem to have inadequate training in mental health and rare interaction with mental health facilities. Most primary health-care doctors and nurses have not received official in-service training on mental health within the last five years, and while manuals on the management and treatment of mental disorders exist, they are not necessarily available in the majority of primary health-care clinics (WHO 2011). Furthermore, although different psychopharmacological agents are available in the market, they are not necessarily accessible to or affordable by the general public (Asia Pacific Observatory on Health Systems and Policies 2011).

Community mental health programs have mostly been run by non-government organizations, such as the Philippine Mental Health Association (PMHA) and the World Association for Psychosocial Rehabilitation—Philippines (WAPR-P). Philippine Mental Health Association has been in existence for more than half a century and has run out-patient clinics, mental health programs in schools as well as
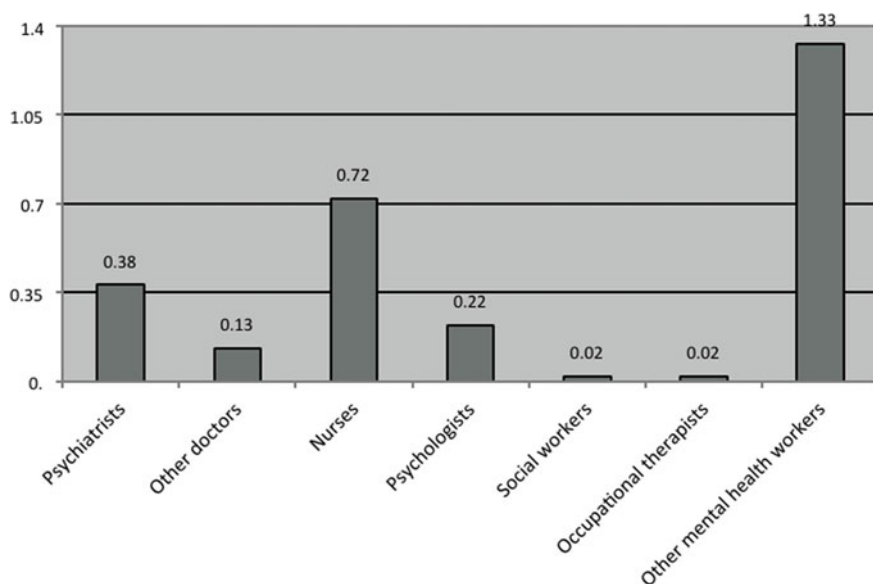
Fig. 11.1 Human resources in mental health (rate per 100,000 population). Adapted from WHO (2011)

public information and advocacy programs (Philippine Mental Health Association 2015). But its efforts have been rather isolated (Conde 2004). WAPR-P has undertaken projects on mental health in primary health care in coordination with local government units and academic institutions. Although still seen as demonstration projects and outside of the NMHP, local government enthusiasm for them increased after a project on the management of psychosocial problems among survivors of a disaster was awarded one of the ten best governance projects by the Galing Pook Foundation, working in coordination with the Department of the Interior and Local Government and the Office of the President (Galing Pook Foundation 2011).

Among government agencies implementing community-oriented efforts are those of the Department of Labor and Employment (DOLE) and the Department of Social Welfare and Development (DSWD). A welfare program for overseas Filipino workers under the DOLE and in cooperation with the Commission for Overseas Filipinos has been initiated. Psychological assessment of departing overseas workers and a pre-departure orientation seminar with a psychosocial orientation on the country of employment, work expectations and some ways to deal with stress, as well as families left behind, is carried out (Conde 2004). The DOLE also posts welfare officers to different embassies to address the concerns of these workers including psychosocial problems (International Organization for Migration 2008). The DSWD, on the other hand, provides mental health assistance through their program for the protection of children and another for the welfare of families, now primary priorities under the Pantawid Pamilyang Pilipino program (Official Gazette of the Republic of the Philippines 2015), a government poverty reduction program.

Prevailing and Emerging Issues

While interest in *Sikolohiyang Pilipino* (Psychology) was strong from the 1970s to the 1990s, the work around indigenous concepts of mental health remains inadequate. This is exemplified by the difficulties psychiatrists have in trying to understand local terms used to describe emotions and mental states. So far, only Luciano Santiago (1993) has produced an in-depth study probing into terms used to describe emotions, specifically around grief and mourning. Western psychology and psychiatry have certainly had an impact on Filipinos, who use English terms like "neurotic," "psychotic," "bipolar" and many other terms, though these terms often have local meanings. "Psychotic" or its fairly recent neologism "praning" is often used to refer to a drug-dependent person. In general, the terms have very negative pathological connotations: Mental disorder is still heavily stigmatized, resulting in a reluctance on the part of patients themselves and their families to seek professional help.

The terms "Filipino" and "local culture" are in themselves problematic because the Philippines is marked by multiculturalism. There are 149 languages spoken in the Philippines (Komisyon sa Wikang Filipino 2015), and there are many cultural divisions based on religion, socioeconomic status and even residence (urban and rural; Filipinos living in the Philippines and those living overseas). Today's

challenges in mental health are often described as economic in nature. No doubt, the gap between rich and poor does spell differences in access, further highlighting the effects of social determinants to mental health. It is important to note the phenomenon of Overseas Filipino Workers, numbering about 10 million (International Organization for Migration 2013) and comprising about 10% of the Philippine population (Philippine Statistics Authority 2012a, April 4). The changing family dynamics among families with migrant workers and their overseas experiences present additional challenges to their mental health. The psychological effects among the migrants and their families have been documented in several studies (Bhugra et al. 2011). Among studies on Filipino migrants' mental health, noteworthy are those done identifying stressors and coping mechanisms of domestic workers (van der Ham et al. 2014; Quiring 2011).

There is also the equally important problem of a gap between the professional sector trained in western psychiatry and popular culture. This popular culture is not necessarily defined by class, with even upper-class and highly educated Filipinos finding no conflict in regular visits to a psychiatrist, participation in healing prayer sessions and consultations with traditional healers.

The lack of research into the interfaces of mental health with culture and society has resulted in a strong tendency among mental health professionals to disregard local concepts of mental health and disease, not just by dismissing local explanatory models as "superstition" but also failing to consider the broader contexts of local beliefs around mental health. Beliefs in witchcraft, for example, have to be understood in the context of low levels of social affiliation. Trust levels will be high at the level of the family and, loosely, for people of the same ethnolinguistic group, but beyond these groups, there is much distrust. Thus, suspicions of witchcraft are quick to rise when illnesses strike, especially if they are psychological (Tan 2008).

Mention has been made of Rizal, writing in the nineteenth century about traditional healers and illnesses attributed to witchcraft and the need to recognize the role of "autosuggestion" and the possibility that the healers could be effective. Demetrio (1978) in a study on Philippine culture and folklore expounded on Rizal's observation and suggested that shamans may have the skills of psychologists. Psychiatrists might do well to consider how their patients' healing might involve these traditional health practitioners.

Another prevailing issue in the Philippines is the continuing predominance of the mental hospital-based system of custodial and isolated care despite the NMHP. In fact, mental hospitals in the country continue to face overcrowding (Asia Pacific Observatory on Health Systems and Policies 2011). While the country has been an advocate of "health for all" including mental health (World Health Organization 1978), the present system sustains such isolation and prevents universal access to mental health care. While there is appreciation of the need for deinstitutionalization, greater community-based efforts and integration of mental health in primary health care, these ideas have yet to be fully implemented. The establishment of some psychiatric facilities in provincial hospitals and the growth of home-care services for discharged patients have progressed slowly. The alternative solution to it happening in the grassroots is the engagement of local government units with private

groups or non-government organizations in integrating mental health care with their daily health-care activities, an action that makes care more accessible to their people, especially the less privileged ones. The development of community-based mental health programs, although included in the 2013 expansion of the NMHP, has yet to be operational.

In contrast to custodial care in institutions, there are social support systems, starting with the family, that are not being adequately tapped. Filipino families are extended and, frequently, relatives, especially the women, will give up their careers to care for someone with a psychiatric illness. More support needs to be given to train such family carers including the prevention of burn-out.

Another growing area of interest is disaster mental health. The Philippines is highly vulnerable to natural disasters because of its location along the Pacific ring of fire and typhoon belt, and on the Pacific tectonic plate. Devastating earthquakes strike regularly, and strong typhoons hit the country each year (United Nations 2015). These disasters such as the recent typhoon Haiyan, the strongest in history to make landfall and which devastated several eastern provinces of the Philippines, exposed the necessity and urgency of planning for and organizing psychosocial response programs in the country. Current efforts are at best fragmented as the national system for responding to such disasters has limited capacity for engagement and collaboration. Nonetheless, there has been greater recognition of the need to coordinate efforts, conduct collegial discussion regarding psychosocial concepts and strategies of psychosocial interventions and make relevant researches. Professional organizations have actively pursued post-disaster mental health work with a long-term perspective and have shown that this could become the door to the development of a community mental health service through capacity-building in mental health of existing health workers. This results in the integration of mental health care with general care.

In disasters, as well as all other extreme life events, mental health workers are confronted by the psychosocial reactions being experienced and observed among the survivors (Ignacio and Perlas 1994). Locally, there has been recognition that it is imperative to discern whether such reactions are pathological or just part of a normal process. A broader perspective of assessment and treatment is warranted when dealing with survivors of trauma to avoid medicalization. Will the view be clinical and therefore aim to detect symptoms of a disorder that must be treated? Or will the view be normative and promotive of psychosocial well-being and therefore non-clinical? The World Psychiatric Association has called attention to the psychosocial experiences of disasters and other adversities as the evolving targets of psychiatry (Maj 2012). Although these do not clearly fall under the official nomenclature and classification of mental disorders, they are of such intensity that they necessitate some kind of intervention and care from psychiatrists or if psychiatrists are unavailable, trained health workers or other mental health professionals.

Ignacio (2011) has compiled an anthology of case studies in post-disaster psychosocial rehabilitation, showing the importance of tapping into indigenous concepts of physical and mental well-being, particularly around *ginhawa,* earlier referred to as well-being. References to local descriptions of breath (*hininga*) like *habol hininga* (struggling for breath) and *buntong hininga* (sigh of frustration) can provide useful

indicators on the depth of psychological pain. *Ginhawa or kaginhawaan* (relief) has been used to describe healing and wholeness in a person in the aftermath of adversities. For it is also in *ginhawa* through which resilience is strengthened, *bayanihan* (cooperation and unity) is fostered and humor inevitably becomes a by-product. That is why the Filipino can laugh even amidst the storms of life.

Last, a reorientation of the teaching and practice of psychiatry is imperative. In the Philippines, although the mental health network is composed of practitioners and professional groups from other disciplines, psychiatrists are still recognized as leaders in mental health. This stems from the fact that, in the country, medical practitioners are still generally highly esteemed and assumed to take leadership roles. Psychiatrists, however, have their work cut out for them, as they take on the burden of addressing the mental health needs of the country, especially during these times of greater need and crises. More and more Filipinos are affected by various extreme life experiences (not only by natural or man-made disasters in communities but also neglect, violence and abuse in homes and localities) and not given adequate mental health care.

The training program for psychiatrists in the Philippines, currently in 12 accredited institutions mostly based in Metro Manila (Philippine Psychiatric Association 2015), has been designed by those trained in the USA and therefore carries a western framework, with its present strong emphasis on the neurosciences. Hence, a majority of Filipino psychiatrists have a strong biological orientation with symptom-relief as a primary objective. In most cases, this is driven by economics and limitations of the training programs which have been inadequate in providing knowledge and skills in other major components of psychiatry like social and community psychiatry. A majority do not regularly participate in programs for the management of mental health concerns in the community, even if there has been a recent increase in the number of those who have joined medical missions in disaster areas. The hesitation of psychiatrists to be involved in community mental health programs stems from the feeling of inadequacy and lack of technical know-how. Many have not sufficiently understood or internalized that social psychiatry, which focuses on the interconnectedness between the individual and the social environment, is an important component of general psychiatry. The introduction of social and community psychiatry concepts to provide psychiatrists with the conceptual foundation to be able to engage in community mental health programs has been minimal.

Psychiatry in the Philippines needs to face up to many old challenges as well as new ones that come with changing demographics. Urbanization is taking place at a rapid pace, with problems of congested living conditions, traffic congestion, and criminality, contributing to mental dysfunction. The country's age dependency ratio remains high, with the 2010 national census showing that 54% of the population was below the age of 15, and 7% above the age of 65 (Philippine Statistics Authority 2012b, August 30). The elderly population is increasing with many needs in mental health, particularly around dementias.

Filipino psychiatrists will need to take on multiple roles in relation to these challenges, not just as clinicians but also as community trainers, advocates, researchers, leaders and civil servants, with a sensitivity to culture and history.

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Chapter 12
From Centralized to Decentralized Service: Mental Health and Psychiatry in Malaysia

Heong Hong Por and Mohamed Hatta Shaharom

Abstract This chapter charts the formation and transformation of mental institutions, therapeutic concepts, and psychiatric practices in Malay(si)a from the early nineteenth century throughout the post-independence era. Introduced by colonialists in the early nineteenth century, mental health institutions in Malaya started out as a colonial program that aimed to clean the colony of vagrants, starving migrants, paupers, drug addicts, convicts, and people afflicted with mental illnesses by confining them in gaols. It was not until the mid-nineteenth century that the mental asylum was separated from the gaol. At the turn of the twentieth century, an increase in the number of mentally ill patients coincided with the large influx of migrant workers from China and India. The overrepresentation of male Chinese patients mirrored the demographic structure of the immigrant population. Racialized medical comprehension of mental illness was not uncommon. Therapeutic practices included occupational therapy, shower baths or cold douches, and electroconvulsive treatment (ECT). These practices were an essential part of a broader process of molding the mentally ill into economically productive, morally useful and desirable colonial subjects. As a set of transplanted practices, colonial institutional mental health services did not automatically acquire legitimacy. The availability of traditional healing services, the public preference for traditional therapies, and social stigma and scarce modern psychiatric services jointly contributed to the unpopularity of these mental health institutions. Several changes and debates took place after independence. The government took the initiative to decentralize mental health services by setting up psychiatric units at district and general hospitals from 1958. Local medical education began to offer psychiatric training to overcome the shortage of professionals. The involvement of

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international bodies like WHO in modernizing the country's psychiatric services was met with a mixed response. While local psychiatrists welcomed more international assistance and resources, social scientists and medical anthropologists expressed alarm concerning the undesirable results of standardization and called for culture-specific procedures. There was also a movement towards community care, which was initiated by NGOs in the late 1960s and translated into a national community mental health program in the late 1990s. The program was compromised due to shortage of professionals, inadequate budget and stigmatization. Despite the promotion of the modern mental health service as more legitimate, modern–traditional, mixed consultation is not uncommon today.

Introduction

There are many ways to write about the history of mental health. This chapter will reconstruct the history of mental health and psychiatry by investigating the establishment of the first mental institution in colonial Malaya in the early nineteenth century and tracing the development of mental health services throughout the post-independence decades.

Like in many parts of the region, the evolution of Western biomedicine and mental health service in Malaysia is structured by various social, cultural, political, and economic factors. The import of biomedicine and modern mental health service was associated with colonial economic and industrial expansion. Initially, it was received with fear among the multicultural Asian community as modern hospital and mental institution were often associated with death. By promoting secular explanation of physical and mental diseases, modern healthcare forced a kind of "epistemological break" from the traditional notions of illnesses. The availability of various traditional healing services was an immediate rival to modern health care. Though the popularity of psychiatry grew over the years, psychiatric service has always been at once welcomed and unpopular due to many social and cultural factors.

As in the field of psychiatry elsewhere, therapeutic concepts are always subject to debates and tend to vary over time. These debates are often informed by changes in international trend. Placed against the background of colonial expansion, multicultural community and the dynamics of local and international environment, the narrative of this chapter is about the formation and transformation of mental institutions, therapeutic concepts and psychiatric practices in colonial and post-colonial periods.

Colonial Mental Health

The (Trans)formation of Mental Health Institutions and Laws

In the early nineteenth century, there was no separate asylum for the mentally ill in Malaya. The "insane," the "lunatics," and the "madmen" were placed under the charge of the police and confined in gaols with the convicts (Lee 1978). In 1814, John Erskine, Magistrate of Penang, wrote to the British government about the necessity of separating the lunatic asylum from the gaol (Suarn et al. 2011). Only in 1829 was the first "lunatic asylum" established near the regimental hospital in Penang. There were 25 inmates, of whom 23 were males and 2 females. Eleven out of the 25 were Chinese, one Portuguese and the rest Indian convicts (Tan and Wagner 1971). One asylum, however, was insufficient to serve the perceived needs of the entire colony. Many lunatics continued to be kept in gaols.

The poor treatment of lunatics did not attract the public attention until 1838 when a letter appeared in the *Singapore Free Press and Mercantile Advertiser (21/06/1838, p. 2)*, urging the Straits Authority to improve the treatment by separating the asylum from the gaol and the lunatics from the convicts.[1] Three years later, a 30-bed "Insane Hospital" was finally built at Bras Basah in Singapore. The hospital was later moved to a new site near Kandang Kerbau in 1862. Expanded to a 100-bed capacity, it was renamed the "Lunatic Asylum." In 1887, it was moved again to College Road, and this time it was enlarged to 300 beds (250 for male patients and 50 for female patients) (Ng 2001). On the mainland, a lunatic asylum was built in Taiping, Perak, in 1895. Three years later, a Gaol Quarter in Kuala Lumpur was transformed into an asylum and began to admit mentally ill patients.[2]

Corresponding to the construction of asylums was legislations made to regulate the lunatics and the administration of the asylum. The Lunacy Act (or Act 36) was passed in 1858. The preamble of the Act stated that it was "expedient to provide for the reception and detention of Lunatics in Asylums established for that purpose." The provisions of the Act, however, were not fully implemented until 1863, and the Resident Councilor, the Commissioner of Police, the Executive Engineer, the Residency Assistant Surgeon and Police Magistrate were appointed Visitors to the Lunatic Asylum ex officio. With the full implementation of the Act, the police were given wide power to admit patients to the asylum and hard pressed to clear the streets and markets of vagrants and those abandoned by their relatives (Lee 1978). A second law, the Lunatic Reception Ordinance, was passed in 1889 and later replaced with the Lunatic Asylums Ordinance (LAO) in 1920. The LAO also provided for reception and detention of criminal lunatics in accordance with Code of Criminal Procedures 1910 and Prisons Ordinance 1872 (Suarn et al. 2011).

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[1]"Correspondence", Singapore Free Press and Mercantile Advertiser (SFPMA thereafter), 21/06/1838, p. 2.

[2]"Beri-beri in the asylum", Straits Times (ST thereafter), 18/07/1899, p. 2.

Table 12.1 The number of patients, death cases, and death rate in Central Mental Hospital, 1924–1935

Year	Males	Females	Total	Deaths (N)	Death rate (deaths per 100 inmates)
1924	1183	397	1580	NA	NA
1926	1550	471	2021	132	6.53
1927	1699	521	2220	173	7.79
1928	1721	490	2211	174	7.86
1929	1785	559	2344	224	9.55
1930	1987	601	2588	197	7.61
1931	1862	644	2506	188	7.50
1932	1894	678	2572	181	7.04
1933	1827	679	2506	238	9.50
1934	NA	NA	2550	190	7.45
1935	NA	NA	2620	186	7.10

Source Federated Malay States Medical Report, 1924–1935

Towards the end of the nineteenth century, the number of lunatics increased (Suarn et al. 2011), which led to a complaint in an editorial in the Singapore-based *The Straits Times*:

> Whence come so many lunatics? Scarcely a week passes that there are not some brought before the magistrates by the police who have found them wandering about the streets. They are invariably Chinese. If these unfortunates belonged to Singapore, they would have some family connection, and would not be allowed to wander about, for the Chinese are careful of their family relations. It seems evident that the lunatics are imported, and it is difficult to understand how so many manage to find their way here without assistance. It is to be feared that they are purposely brought here, in order that they may become a burden on an easy-going good-natured Government.[3]

Although those mentally ill were viewed as "aliens" and the growing number of lunatics perceived by some as a burden, the colonial government began to consider establishing another asylum, the Central Lunatic Asylum, in the Federated Malay States (FMS)[4] in 1904. A committee, consisting of the Commandant, the Malay States Guides, the Director of Public Works, the State Surgeon of Perak, and the Federal Inspector of Coconut Trees, was formed to select a suitable site for the institution.[5] In 1911, the Central Lunatic Asylum, with three male wards and one female ward with a total capacity of 269 beds, was completed on a 573-acre land in

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[3]"Lunatics", ST, 18/05/1898, p. 2.

[4]The FMS, formed in 1895 and lasted until 1946, consists of four states: Perak, Pahang, Selangor and Negeri Sembilan.

[5]"F.M.S. Lunatics", ST, 20/08/1904, p. 10. In the 1920s, making brushes, ropes and other products from coconut husk with a husk mallet was one of the therapeutic activities in the Central Lunatic Asylum's rehabilitative workshops. This explains why the Federal Inspector of Coconut Trees was included in the committee.

Tanjung Rambutan, Perak.[6] Dr William Frederick Samuels was the first Medical Superintendent. It started out with a population of 45 patients, of which 30 were males and 15 females. By the end of 1911, the number increased to 287, of which 220 were males and 67 females. The total population rose to 520 in 1914, and 1580 (1183 males and 397 females) in 1924. The asylum was renamed the Central Mental Hospital (CMH) in 1922, showing a shift away from the use of "lunatics," which carried a negative connotation. The change in population in the CMH during 1924 and 1935 is shown in Table 12.1. Throughout the decade, there were two to three times more male than female "inmates." In race terms, Chinese and Indians occupied first and second places, respectively. The large number of Chinese and Indian male internees in the CMH coincided with the influx of Chinese and Indian male migrant laborers in the same period of time. In other parts of the mainland, a lunatic asylum was established in Johor in 1933, while another one was built in Malacca in 1935. In Sabah and Sarawak, two such asylums were established in the 1920s.

Overall, the health conditions in the lunatic asylums were deplorable and the death rate was high. Twenty-eight of the 32 cases of cholera reported in the Annual Medical Report on the Civil Hospitals of the Straits Settlements for 1890 were contributed by lunatic asylums.[7] In 1901, beriberi was the leading cause of death, accounting for 81 deaths in the mental asylums in the Straits Settlement.[8] In 1904, there were 3 deaths out of 12 beriberi cases in the Selangor Lunatic Asylum; the number reached 27 deaths out of 94 beriberi cases in 1905. The population was 193 in 1904, of which 33 died, contributing to a rate of 17.09 deaths per 100 inmates in the same asylum. In 1905, the number of inmates reached 219, of which 55 died, lifting the death rate to 25.11 deaths per 100.[9] The lower death rate in the CMH (see Table 12.1) was evidence of better health conditions than in the Selangor Lunatic Asylum. However, when compared to the average death rate of the Federal Malay States (FMS) population, which stood at 2.93% in 1926, 3.21% in 1927, 2.96% in 1928, 2.63% in 1929, 2.41% in 1930, 1.91% in 1931, 1.85% in 1932, 2.02% in 1933 and 2.14% in 1934, the CMS inmates were two to three time worse off than the general FMS population throughout the decade.

During the Japanese occupation in World War Two, the population in the CMH rose to 3164 in 1941. This growth was due to transfers from Johor and also from Sabang, Sumatra. Between January 1, 1942, and September 1945, a total of 5386 patients were treated at the CMH, of whom 3850 died. When the British Military Administration took over the mental institution in 1945, only 355 patients remained (Federated Malay States Medical Report 1946). Post-war healthcare reconstruction started with the assistance of international voluntary groups, such as the Red Cross Society, but was soon paused due to the outbreak of counterinsurgency, which lasted for twelve years from July 1948 to July 1960. In 1953, the colonial

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[6]"Untitled", ST, 26/05/1910, p. 6.

[7]"The Public Health in 1890", ST, 07/07/1891, p. 7.

[8]"Untitled", ST, 01/09/1901, p. 2.

[9]"Lunatics in Selangor", Eastern Daily Mail and Straits Morning Advertiser, 07/09/1906, p. 3.

government called for a "swing of emphasis from urban to rural health work" (FMSMR 1953). The call remained rhetoric, as most government resources were channeled to anti-communist activities, little were left for health care and welfare services, and not to say mental health service.

In 1952, the Mental Disorders Ordinance (MDO) was promulgated with rules regulating admissions, discharges, and management of civil and forensic cases. Special therapies like insulin treatment and electroconvulsive therapy (ECT) remained custodial as they were restricted mostly for the paying patients. Dr Stephen McKeith, a World Health Organization (WHO) mental health consultant, was invited to visit CMH in 1954. He criticized CMH for its lack of manpower, over-crowding, and employing doctors who were not conversant with Western psychiatry (Haque 2005). Poor ward condition of psychiatric institutions continued to be an issue throughout the 1950s. In 1957, Dr. S. Parampalam, Assistant Medical Superintendent of CMH, made allegations regarding poor food and corruption at the institution. A Royal Commission of Inquiry was formed to investigate the maladministration of CMH.[10] Though Dr Max Cocheme, then CMH Medical Superintendent, was later cleared of all allegations, he was replaced by Dr. A.S. Johnson in 1959. In Johor, Hospital Tampoi resumed its operation in 1952. In Borneo, the Lunatic Ordinance Sabah was promulgated in 1951 and the Mental Health Ordinance of Sarawak in 1961.

Concepts of Mental Illnesses and Racialized Comprehension

The definition of mental illness in Colonial Malaya was not entirely clear. People admitted to the "lunatic asylums" or "madhouses" came from a wide range of backgrounds, including convicts and criminals, old Chinese men, people moribund from chronic disease and want, vagrants, paupers, women afflicted with nympho-mania, and people who used narcotic drugs (Lee 1978; Tan and Wagner 1971). "Lunatics, mania, maniacs, insanity and madness" were terms used to describe mental illness in the nineteenth century and early twentieth century. Main classi-fications of asylum admission in 1900 were "mental deficiency, general paralysis of the insane (GPI), mania, melancholia and dementia" (Teoh 1971). The classifica-tions changed over time. In 1913, they include idiocy, mania, melancholia, delu-sional insanity, GPI, and dementia (FMSMR 1913). Lunacy and insanity were thought to be a hereditary "brain problem" in 1914.[11] From 1926 to 1932, con-fusional insanity, primary dementia, and melancholia headed the list of mental disorders in the CMH (see Table 12.2).

Given that the death toll caused by beriberi was high, the disease was once thought to cause insanity (Teoh 1971). But this changed once the causative factors

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[10]"Commission Clears Dr Cocheme", ST, 05/12/1957, p. 1.
[11]"Hereditary Brains", ST, 10/06/1914, p. 10.

Table 12.2 The major forms of mental disorders treated in the Central Mental Hospital, Tanjung Rambutan, Perak, 1923–932

Year	Mental disorders				
	Confusional insanity	Primary dementia	Recent melancholia*	Senile dementia	Recent mania*
1923	NA	NA	102	NA	112
1924	53	50	115	NA	86
1926	97	457	90	99	110
1927	54	640	98	91	60
1928	122	345	135	74	49
1929	170	314	137	181	53
1930	348	195	140	104	68
1931	309	808	392	184	193
1932	339	824	399	193	178
1933	298	836	367	122	155
1934	315	815	353	241	154
1935	368	807	357	287	158

Source FMSMRs, 1923–1935. *The two categories, "recent melancholia" and "recent mania," were absent in the *FMSMRs* from 1931 to 1935. Rather, "melancholia" and "mania" became two subcategories under the category of "manic depressive"

were established. Other causes like opium smoking, other narcotic drugs and alcohol consumption, and syphilis, were also thought to be associated with or to cause lunacy (Lee 1978; Murphy 1971; Teoh 1971). One of the colonial reports said the prevailing form of insanity was mania, often induced by opium and other narcotics. However, not all doctors agreed on the causes. Gilmore Ellis, Medical Superintendent of the Lunatic Asylum at Singapore, commented in the annual medical report in 1892: "I think it most problematical that the smoking of opium was really the cause of their disease. I have never yet seen a case of insanity which I could, with any certainty, believe opium smoking to be the cause."[12]

By 1906, growth in alcoholic psychosis was attributed to the adulteration of alcohol with toxic methylated compounds as the surge coincided with the sale of cheap spirits. The toxic alcohol was expected to replace the traditional opium consumption (Teoh 1971). In 1924, W.F. Williams, Medical Superintendent of the CMH, explained the prevalence of alcoholism among Chinese patients in a racist narrative:

> I, as last year, when dealing with alcohol differentiated between Chinese and Indians, found the startling figure of 34 Chinese and only 8 Indians. Last year we had 37 Chinese and 26 Indians so that, though the total number of alcoholic cases is down, we see that the reduction is due to an extraordinary fall in the number of Indians whose trouble can be attributed to alcohol. This to my mind bears out my contention that the Chinese have taken to alcohol, and I fear this will go on and increase. There is a conspiracy on foot to stop the Chinese smoking opium with the result that they are turning to alcohol as a substitute,

[12]"Lunacy in the Straits", SFPMA, 31/05/1892, p. 3.

which from my point of view is vastly more dangerous. All I can say is that the day opium is cut off and alcohol substituted will certainly be a bad one for the Chinese, and I fear we may find an increase in such crimes as murder and rape (FMSMR 1924).

A condition often associated with alcohol intake was infection with syphilis. In the Straits Settlement Annual Report 1906, Gilbert Ellis stated that "venereal disease (VD) was very prevalent and 25% of all [lunatic] cases admitted had syphilis…prostitution was rife and a visit to a brothel was no more shameful an act as an Englishmen visiting a public house for his regular pint of beer" (cited in Teoh 1971). The first Chinese general paralysis of insanity (GPI) was detected by Gilbert Ellis in the same year. Before this, syphilis was thought to be confined to Europeans and due to the high pressure of civilized life (Teoh 1971). The notion that syphilis was an affliction caused by "civilized life," a disease of Europeans, was further challenged two decades later, when the surge of Chinese admission infected with syphilis coincided with the influx of Chinese male migrant workers.

In 1926, the first five causative factors in admissions to the CMH were, in order, hemopoietic system, cardiovascular degeneration, syphilis, gastrointestinal system, and alcohol. Coincided with this trend was a rise in VD cases in the FMS. In the Town Dispensary and Venereal Diseases Treatment Center, Sultan Street, Kuala Lumpur, alone, a total of 2328 VD cases were treated in 1925, of which 1496 were Chinese. In 1926, the VD cases treated in the same VD treatment center surged to 3222, of which 2069 were of Chinese and 1962 were cases of syphilis. Among the 1962 syphilis cases, 1423 were Chinese. The number of VD cases reached 6234, of which 3222 were Chinese. About 2284 out of the 3793 syphilis cases were Chinese. At the same time, the main cause of death in the CMH was GPI in 1926 (see Table 12.3). In response to the rise of GPI as the leading cause of deaths, W.F. Samuels, again, blamed alcohol, together with the presence of syphilis, in a racist tone (FMSMR 1926).

What Ellis earlier thought a "European disease" now became a "Chinese problem," an affliction caused by "civilized life" now turned into a disease caused by "increased consumption of alcohol among the Chinese." Taking on new meaning of syphilis and the shifting explanation about what contributes to the rise of GPI not only indicates a racialized comprehension of mental illness by the British medical doctors, but also suggests that mental health is a discursive space

Table 12.3 The causes of death in the Central Mental Hospital, Perak, 1926–1928

Causes of death	1926	1927	1928
General paralysis of the insane	47	39	28
Pulmonary tuberculosis	16	24	23
Dysentery	13	26	31
Cardiovascular degeneration	6	14	14
Others	50	68	62
Total	132	173	174

Source FMSMRs, 1926–1928

for the construction of racial differences and identities, in the face of the large influx of Chinese and Indian laborers.

In the following year, the hemopoietic system, the gastrointestinal system, syphilis, cardiovascular degeneration, and alcoholism remained the top five causative factors, albeit in different order. Parallel with this was, again, a rise in VD cases dominated by syphilis and the Chinese. Of the 12,663 VD cases detected in the FMS, 7579 were Chinese, while 4240 of 7067 syphilis cases were Chinese. The order changed to syphilis (209 cases), gastrointestinal system (203), cardiovascular degeneration (165), alcohol (90), and the hemopoietic system (84) in 1928 (FMSMR 1928). In 1933 and 1934, the two major causative factors were syphilis and intestinal worm (FMSMR 1933, 1934); in 1935, the top five factors were syphilis (162 cases), malaria (92), other bodily affections (70), alcohol (55), and mental stress (40) (FMSMR 1935). Syphilis and alcohol were often, if not always, in the first five in the list of causes. W.F. Samuels wrote in 1928: "Syphilis and alcohol have each gone up…the rise in syphilis is due, to a certain extent, to more careful examination and a greater use being made of the Government laboratory; but the rise of alcohol is just the more or less steady rise it has maintained for some years. The alcohol question is becoming serious, and it will be seen that alcohol is noted as the cause in 21 females. This I think will bring home how serious a menace alcohol is becoming to the health of the country" (FMSMR 1928).

Economics in the Moral and Vice Versa: Therapeutic Concepts and Practices

Though there was no mention of occupational therapy during the nineteenth century, therapeutic practices that combined work and treatment were introduced by Dr. Thomas Oxley, senior surgeon in charge of the Lunatic Asylum in Singapore, as early as 1846 (Lee 1978). Following the expansion and relocation of the asylum in 1887, an editorial in the *Straits Times* urged the government to give more space to inmates for gardening and train the patients to use looms. The editorial argued that previous asylum management experience had proven that the inmates' participation in gardening, looming, and manufacturing was a way of restoring their health. The writer also claimed that these activities would not only provide foods needed in the asylum more cheaply, but would yield products for the commercial market.[13]

In the 1920s, therapeutic activities in the CMH included farming, bamboo works, tailoring, carpentering, and mending. The patients in the CMH cultivated 234 acres, produced 212,351 katies of vegetables, and generated $6617 by cutting firewood in 1922. Their work yielded 225,553 katies of vegetables in 1923 (FMSMR 1924). They built three new farms and produced 360,068 katies of vegetables in 1928 (FMSMR 1928); 17,639 katies of pork and 420,429 katies of

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[13]"The New Lunatic Asylum", ST, 10/08/1881, p. 10.

vegetables in 1930 (FMSMR 1930); 13,106 katies of pork, 1454 hen eggs, and 232 duck eggs in 1932; and 38,552 katies of pork, 4561 hen eggs, and 1929 duck eggs in 1933 (FMSMR 1933). The value of produce generated by the inmates in the CMH was $56,013 in 1926 (FMSMR 1926); $60,537 in 1927 (FMSMR 1927); and $72,570 in 1928 (FMSMR 1928). In defense of the benefits of these therapeutic activities, W.F. Samuels wrote: "in addition to the curative value of the farms, there is a considerable saving to the various votes due to the activities of the patients" (FMSMR 1926). The term "occupational therapy" first appeared in the 1933 FMS Medical Report, when Dr R.D. Fitzgerald, Adviser on Medical and Health Services in the FMS, wrote: "the farms have thus proved their worth from an economic point of view as well as providing an excellent form of occupational therapy."

The detailed calculation of the output of occupational therapy in financial terms revealed the economic reasoning behind the therapeutic measure, as the participation of the inmates in work and production helped to reduce the financial burden of running such institution. Occupational therapy is thus at the same time a treatment, a moral correction and a form of cheap manpower. If the import of cheap labor was fundamental in maintaining and expanding colonial capitalism, the establishment of a mental asylum was instrumental in clearing the unwanted migrant labor from wandering in the streets and occupational therapy essential in molding them into economically productive, morally useful, and desirable colonial subjects.

Other forms of treatment include shower baths or cold douches, a careful regimen and the free use of antimony with salines, and aversion therapy by electric shock for sexual "deviation," drug addiction, and alcoholism. Acriflavine injection was used in 1934 (FMSMR 1934). Insulin shock therapy was introduced in Singapore in 1936 and into the CMH in 1946 for acute psychotic patients. ECT was introduced in Tanjung Rambutan and Singapore in 1947 and applied to selected cases of schizophrenia (Suarn et al. 2011; Teoh 1971).

Indigenous Response to Colonial Psychiatry

Just like the import of Western biomedicine, the introduction of modern mental health service was a crucial tool of imperial expansion. The establishment of modern health care not only served the needs of European officers, but also maintained a healthy working population for the colonial economy in urban areas, mining towns or plantation estates (Manderson 1996). Nevertheless, as a transplanted practice, modern mental health service did not automatically assume its legitimacy. Rather, it had to compete with various forms of traditional therapeutic services like traditional Malay healing and traditional Chinese medicine (Buhrich 1980; Teoh et al. 1972). Indeed, different ethnic communities had their respective cultural views and explanations for mental illnesses (Dunn 1974; Gwee 1971; Resner and Hartog 1970). Modern psychiatry's secular discourse about mental diseases forced a kind of "epistemological break" with different traditional

conceptions of sickness found in many non-Western societies (Higginbotham and Marsella 1988). Western medicine's attack on indigenous healing further alienated the multicultural and multiethnic community from seeking modern secular health service. In the meantime, modern health care resources tended to concentrate in urban and town areas, and were too scarce to replace traditional practices.

Social stigma of mental illness and mental institution posed another barrier to popularizing modern psychiatric service. The high death rate in mental asylum and the use of police force to admit patients to the asylum formed a negative connotation around the mental institution. Modern psychiatric service was thus often a last resort and usually occurred after the individual or family has exhausted other means of help, or when alternative services are unavailable, not known, or have not met the needs of the individual in crisis. Seeking psychiatric consultation and admission to a mental hospital were often considered a failure, irresponsibility, and an invitation to family disgrace (Crabtree and Chong 2000; Teoh et al. 1972). The public perception, attitudes, and opinions towards psychiatry in colonial Malaya were not particularly different from those in many parts of the world. Taken together, availability of traditional healing services, public preference for traditional therapies, social stigma, and scarce modern psychiatric services jointly contributed to the unpopularity of modern mental health service in Malaya.

A new chapter of psychiatric service began after independence. Now we turn to look at the development of mental health service in post-colonial and post-independence years.

Post-colonial Continuities and Changes

From Centralized to Decentralized Service

Upon attaining independence in 1957, there were four government-run mental hospitals, the CMH, Tampoi Mental Hospital (TMH) in Johor, Hospital Bukit Padang in Sabah, and Hospital Sentosa in Sarawak. CMH and TMH was renamed Hospital Bahagia Ulu Kinta (*bahagia*, Malay term, meaning "happiness") and Hospital Permai (*permai*, Malay term, meaning "lovely" or "pretty"), respectively, in 1971 to give mental institution a more positive connotation.

Realizing the limitation of centralized asylum care, the government started decentralizing mental health service by setting up psychiatric unit at general hospital. The first such unit was opened in the General Hospital in Penang in 1958. By 1974, six psychiatric units had been established at different district or general hospitals (Buhrich 1980); in the early 1990s, there were 17 such units across the country (Deva 1992); by the end of 1990s, there were 30 general/district hospital psychiatric units (Deva 2004) and 80 community-based psychiatric clinics spread unevenly over the country (Crabtree and Chong 2001).

Given the shortage of psychiatrists, general practitioners and medical officers at the psychiatric units of district and general hospitals were expected to offer simple psychiatric care. The establishment of these units was to reduce hospitalization and to minimize social stigma associated with hospital admission.[14] In 2010, psychiatric services were offered in 84 hospitals in Malaysia, where 46 were in the public sector and 36 in the private sector. There were a total of 20,601 psychiatric admissions (or 7.3 admissions per 10,000 population) and 438,634 outpatient psychiatric visits (or 154.8 visits per 10,000 population) throughout the country in the same year (Suarn et al. 2012).

In terms of psychiatric manpower, Malaysia's first psychiatrist qualified with a diploma in psychological medicine, trained in Britain, and returned home in 1961. The country started to offer its own training of psychiatrist in 1973, and general psychiatric training had been extended into a 6- to 11-week program in the general medical degree courses in seven public universities and two private universities by early 2000s (Deva 1992, 2004). By 1980, there were 19 psychiatrists, among whom 4 were females and the rest males; 9 worked in government hospitals, 8 held academic posts, and 2 worked in the private sector. Approximately, 50 medical officers were employed in various psychiatric units and mental hospitals throughout the country (Buhrich 1980). By early 2000s, there were 145 psychiatrists, among whom 25 were trained overseas and the rest educated locally (Deva 2004).

In 2010, the total number of psychiatrists reached 229, of whom 179 (or 78.2%) practiced in the public sector and 50 (or 21.8%) in the private sector. In terms of ratio, the national average was 0.08 psychiatrist per 10,000 population in the same year. The State of Selangor, Federal Territory of Putrajaya, and Federal Territory of Kuala Lumpur had the highest density of psychiatrists, which was 0.14 psychiatrist per 10,000 population, whereas Sabah had the lowest, which was 0.02 psychiatrist per 10,000 population. A total of 1159 nurses worked in psychiatric care throughout the country, of whom 1144 were in the public sector and only 23.5% had post-basic training (Suarn et al. 2012). Psychiatric workers and caregivers, like their patients, also face stigmatization, which constitutes a challenge in recruitment (Crabtree and Chong 2000).

During the 1960s and 1970s, social issues and changes pertaining to industrialization and urbanization caught the attention of psychiatric researchers. Truancy, deviant behaviors, urban life adaptation, hysteria in schools and factories, and child mental health were among the researched topics. In the 1980s and 1990s, mental health focus shifted to the prevention of drug addiction, smoking, and suicide. Today, women and aging community become new subjects of concern, following demographic changes and newly emergent concerns in the country.

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[14]"Modernising Malaysia's care of the mentally ill", ST, 25/10/1969, p. 12.

From Institution to Community Care?

While old issues like social stigma and man power shortage persisted, new issues began to surface, including what counts as legitimate therapeutic concept and practice. There were reflections over whether it was appropriate to standardize diagnosis and treatment as mental illnesses are culture-bound (Resner and Hastog 1970). The involvement of international health organization like WHO in promoting information sharing, standardized classification of disorders, and uniform psychiatric training pressured local psychiatrists to follow and adopt standard language and procedures. For example, WHO sent its consultant Eric Cunningham Dax to evaluate the psychiatric service in Malaysia in 1962 and 1969, respectively. Dax proposed the expansion of psychiatric programs and suggested an ambitious building program for new mental health clinics and rehabilitation hospitals around the country. He even urged various types of cadre be sent abroad for training and recommended that consultants continue to visit Malaysia offering 2-week mental health courses to upper echelon staff. While the adoption of standardized language and technological norms allowed local professionals access to more international resources, it simultaneously downplayed culture-specific problem solutions. The call for culture-specific mental health approach, however, seems to be largely confined to the circle of social scientists and medical anthropologists as psychiatrists tend to embrace international recommendations as a way to boost their legitimacy (Higginbotham and Mersalla 1988).

Other lines of contestation over legitimate therapeutic concept and practice include the following: (1) institution versus community care, (2) the role of social workers, (3) the importance of psychosocial approach over medical treatment, and (4) patient-centered versus paternalistic approach (Crabtree and Chong 2000; Deva 2004). The debate has been informed by subversive and democratic psychiatric movement in the West. The emphasis on community care and social work was at the same time a call for psychosocial and patient-centered approach. It was first proposed by the NGOs since the late 1960s.[15] The first community-based rehabilitation and day care center was then opened in Ipoh, Perak, in 1967. In 1976, an outpatient follow-up service was started in the Kinta District in Perak (Suarn et al. 2011). The promulgation of Care Centres Act in 1993 was part of the wider effort to decentralize health care.

It was not until three decades later that community mental care became a national policy, as pronounced in the Community Mental Health Programme 1997–2002 and National Mental Health Policy 1998 (Jamaiyah 2000). The program, however, faced various challenges due to insufficient man power, inadequate financing, and persistent stigmatization and social exclusion (Chong et al. 2013; Crabtree and Chong 2000; Mubarak et al. 2003). Mental health budget only accounts for less than 1.5% of the total national health budget; accessibility of psychiatric service remains an issue (Deva 2004). In addition to community care,

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[15]"Rehabilitation centre needed for mentally ill, says Rotary chief", ST, 30/06/1969, p. 13.

the government also launched mental wellness promotion campaign throughout the 1990s and 2000s. How well did these campaigns improve the mental health of the population is yet to probe.

In 2001, the National Mental Health Act was passed to replace the 1952 MDO (Deva 2004). Though the Act is ambitious, it remains contentious as the psychiatrists feel they are not consulted. Despite the introduction of secular explanation of mental illness and the promotion of modern psychiatric health service over the past few decades, supernatural beliefs and traditional–modern mixed consultation are not uncommon among Malaysians (Edman and Teh 2000). With the passing of the Traditional and Complementary Medicine Act in 2013, the legitimacy of traditional healers is boosted. To what extent this will change the mental health service landscape deserves further attention.

Conclusion

Mental health service in Malaya started out as a colonial state program that aimed to clean the colony of vagrants, starving migrants, paupers, drug addicts, convicts, and people afflicted with mental illnesses by confining them in gaols. In the mid-nineteenth century, the mental asylum was separated from the gaol. Half a century later, the increased number of "lunatics" and the expansion of mental health services coincided with a large influx of migrant workers. As a major mode of treatment that contributed to the revenue of mental asylum, occupational therapy was at the same time a curative program, a moral correction and a form of cheap man power. It reveals the colonialist idea of desirable, morally useful, and economically productive subjects. The operation of mental hospitals was thus simultaneously a project of economic, moral, and political engineering, packaged in the merciful image of the colonialists.

In the aftermath of independence, the government started decentralizing mental health service by setting up psychiatric units at district and general hospitals. Local medical course began to offer psychiatric training. The involvement of international group like WHO in modernizing the national psychiatric service was met with mixed response. On the one hand, local psychiatrists welcomed more international assistance and resources; on the other hand, social scientists and medical anthropologists warned against the undesirable result of standardization and called for culture-specific procedures. There was also a movement towards community care. It was initiated and started by NGOs in late 1960s and later translated into a national community mental health program in late 1990s. The program was compromised due to man power shortage, inadequate budget, and stigmatization. Despite being promoted and branded as a more legitimate mental health service over the past few decades, modern–traditional mixed consultation is not uncommon today.

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Chapter 13
Mental Health and Psychiatry in Singapore: From Asylum to Community Care

Kah Seng Loh, Ee Heok Kua and Rathi Mahendran

Abstract The history of mental health and psychiatry in the city-state of Singapore is shaped by political, economic and social developments that are both international and local. Compared to other countries in Asia and the Pacific, Singapore has been more open to external ideas and practices of mental health. On the one hand, in both the colonial and postcolonial periods, Singapore has had a diverse multicultural population, which historically comprised migrants from different parts of Asia and beyond, and which held different views of mental illness. On the other hand, the dominant model of mental health and psychiatry in the city-state is the Western one: namely the British influence in the colonial and immediate post-independence periods, and increasingly from the Second World War, the prevailing American model. Thus, the openness of Singapore to Western ideas and expertise, while beneficial in some aspects, is not without difficulty and ambivalence. The shift from asylum-based institutionalization to community psychiatry and the recognized importance of mental health are definite signs of progress. However, the continuing dominance of Western frameworks of psychiatry ignores both the rich experience of clinicians based in Singapore as well as the varied customary ways in which Singaporeans have viewed and treated mental illness. History thus provides insights not only into the social impact of a Western-centered psychiatry in Singapore. It also highlights the need for a more grounded paradigm that is appropriately attuned to local circumstances and experiences.

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Introduction

The history of mental health and psychiatry in the city-state of Singapore is shaped by political, economic and social developments that are both international and local. This chapter charts the establishment of a modern, Western-based system of public healthcare spanning the colonial and postcolonial periods. There are differences and similarities between Singapore and other countries in the Asia-Pacific region. The differences stem from Singapore's geographical and political status as a small island and city-state without a physical hinterland. The city-state is located at the intersection of busy trade routes and trans-national networks of ideas and people linking the West and the Asia-Pacific. Compared to many other countries in the region, Singapore has been more open to external ideas and practices of mental health. In Singapore, the Western model of mental healthcare has been imposed on a diverse multicultural population, which originally comprised migrants from China, Southeast Asia, India, and beyond, and which held different views of mental illness.

The similarities between Singapore and many other countries in the Asia-Pacific lay in the continuities in mental healthcare between the colonial and postcolonial periods. In 1819, a trading post was founded on Singapore by the British East India Company and the island became a thriving *entrepot* for Western manufactures and primary products from the Asia-Pacific region. This lasted until 1942 when another form of colonialism—Japanese—briefly intruded into Singapore history. The British returned to Singapore in 1945 and began an ambitious attempt to modernize social services, including mental healthcare. This period crucially laid the foundation for healthcare in the postcolonial years beginning in 1959, when the first locally elected government of the self-governing state of Singapore took over responsibility for public health. In 1965 Singapore became a sovereign nation-state but continued to expand upon Western precedents and influences in mental healthcare. In the postcolonial years, a new American influence on mental healthcare emerged, a manifestation of the 'soft power' of American cultural hegemony.

In the colonial and postcolonial periods in Singapore, as elsewhere in the Asia-Pacific, mental disorders were classified and psychiatry and mental healthcare were taught and practiced from Western perspectives. Conversely, local beliefs and therapies for mental illness were termed 'alternate and complementary medicine' at best and were often deemed less scientific than or even inferior to Western medicine, particularly in the colonial period. The dominance of British or American models of mental healthcare created difficulties in Singapore as in other Asian countries. Not only was mental healthcare plagued by overcrowding and the lack of human and financial resources in the colonial period, cultural differences, such as language and local attitudes toward mental illness, made the practice of psychiatry particularly challenging up to the present day.

Still, the modern system of psychiatry has made progress over time. The tectonic shift of mental healthcare from the colonial asylum to community care after World War II, which occurred in Europe, the USA and Australia, also became acceptable in Singapore. The greater interaction between mental patients and the wider

community that first occurred in the postwar period has helped to reduce some of the prejudices against mental illness. Many mentally ill people have had to cope with stigmatization (and they still do), and among those who succeeded in doing so, their resilience is a testament to an undefeated mind.

The Colonial Asylum

Mental health in colonial Singapore was largely influenced by the self-interested, economically-driven nature of British colonial rule. This can be seen in British policy toward the sale of addictive consumables in Singapore that contributed to mental health problems. From 1820, the British auctioned monopoly rights for opium, arrack (a form of Asian spirits) and gambling dens to Chinese businessmen (Turnbull 1977). This gave London a lucrative source of revenue but the scourge of addiction spread to the local population. Social activists in Singapore like Dr Lim Boon Keng petitioned the British to ban opium without success. Colonial interests trumped societal good.

Similarly, the early colonial state was largely *laissez faire* and the British were unwilling to devote adequate resources to improving the welfare of the population, including their mental health. Western healthcare usually benefited only Europeans and upper-class Asians, and mostly in the cities and major sites of economic production, such as plantations and mines. For the first half century of British rule, mental patients were detained in the Convict Gaol, a jail for Indian prisoners who were brought to Singapore as laborers for public works. Most early mental patients were vagrants and destitutes periodically removed from the streets by the police. This revealed the thinking of the colonial mind that associated mental illness with the morals (or lack thereof) of people without homes, clothing and proper sanitation. It also indicated a desire for spatial control at an early stage of colonial rule. The British focus was not on mental health but more narrowly on mental illness, that is, on the perceived socio-cultural deficiencies of the people they ruled.

On the other hand, subsequent British policy toward mental health was not altogether uninterested or minimalist, for it was also an expedient instrument of power. British policy was shaped by the colonial system and also helped to consolidate it. In the first half of the nineteenth century Western medicine had co-existed with indigenous medicine in Southeast Asia. Following a series of pathbreaking discoveries of pathogens after this period, however, Western medical experts began to view their field as superior to indigenous medicine. This perceived superiority of Western medicine was transplanted to the colonies in the latter half of the nineteenth century, when it helped legitimize Western domination of the local peoples.

In colonial Singapore, a variety of local attitudes towards mental illness existed among the different ethnic groups. Most people in Southeast Asia viewed mental illness in a spiritual frame, where the sufferer was possessed by a spirit that had to be exorcised by a traditional healer or physician, such as the Malay *bomoh* or Hindu priest. The early British settlement in Singapore was inhabited by Malays, among

whom persons with mental illness were tolerated and cared for in the community by the *bomoh*. The Malays accepted mental illness as 'odd behavior' and sufferers would simply be given less demanding jobs on the farm (Kua 1991). Correspondingly, Chinese medicine eschewed the Cartesian dualism of Western medicine: it viewed mental illness as no different from bodily ailments, both of which were due to an imbalance of the cosmic forces, *yin* and *yang*. Portraying itself as superior and universal, Western medicine had the effect of causing ill Asians not to seek treatment at the hospital or asylum. British administrators in the asylum wrote disapprovingly of local beliefs concerning mental illness, where '… all coolies—Chinese, Klings [Indians] or Malays—thoroughly believe in witchcraft' (1892). By declaring local beliefs as inferior Western medicine further reduced its reach among the migrant population.

Language was another barrier to mental sufferers who needed help, and the colonial authorities complained frequently about their ignorance of the medical histories, folk beliefs, cultures, and languages of the vagrants and destitutes they rounded up (1896). But the problem of a cultural disconnect ran deeper, beyond language or insufficient interpreters: there was the basic difficulty of translating Western concepts of mental health when people held very different beliefs about health and illness. There was a further problem for the Malays, who continued to avoid seeking treatment at the asylum even after general living conditions improved in the twentieth century. For much of the colonial period, pork was the staple meat since the majority of patients were Chinese, but almost all Malays were Muslims.

The dual views of mental illness as both economic liability and an instrument of colonial rule can be seen in the ambivalent British attitude toward immigration. Migration of people—mostly single, working class males from China, India and Southeast Asia—increased the population of Singapore and provided the manpower needed to turn the wheels of commerce and to work in the plantations and mines in Malaya. However, the British also viewed the migrant flows as a threat to the colonial order. A report of the British medical authorities in 1937 stated, 'The movements of the immigrant population are therefore the major factor in determining the number of mental cases. Each flood of immigration brings in a proportion of potential lunatics, and they remain when the tide turns' (Straits Settlements 1937).

British interest in mental illness can be seen in the building of asylums in both Britain and throughout the empire. The first mental asylum in Singapore was built in 1841, the Insane Hospital at Bras Basah in the town area. In 1861, as the number of patients rose from 30 to over 130, the asylum was moved to a 100-bed site near the Kandang Kerbau Maternity Hospital and renamed the Lunatic Asylum. The institutions built in the nineteenth century were small, poorly funded and rudimentary, indicative of the self-interested nature of colonial rule. The death rate in the asylums was high throughout the nineteenth century. A major cause of death was the epidemic outbreak of cholera, which occurred in the overcrowded and insanitary wards. In 1887, after a particularly severe outbreak, the medical authorities hurriedly moved the asylum close to another hospital, the General Hospital at Sepoy Lines, the main public health institution in Singapore. Another

scourge was beri beri: in 1899, 29 of the 65 deaths in the asylum were from this disease. High death rates gave the asylum, as with the Western hospital, a reputation in the minds of migrants as a place to die and further reduced the reach of mental healthcare. From the beginning of the twentieth century, however, living conditions improved and the mortality rate in the asylum was gradually brought down.

In 1928, the asylum finally moved from Sepoy Lines to the completed new premises at Yio Chu Kang outside the town in the rural north-east of Singapore. Like most mental hospitals built in the previous century, it was sequestered at a corner of the island away from the populace. It had a larger farm for vegetables and coconuts, which engaged a substantial number of patients. An aural marker of the asylum's routines was the bell in the clock tower, which marked the time for meals, festive occasions and changing work shifts. It also warned of patients escaping from the asylum. The British Governor stipulated that the Medical Superintendent should be an officer 'with some taste for gardening and farming who will help to make the patients interested in such pursuits. Must have attended lectures at the Mental Hospital (Maudsley), Denmark Hill. Must possess the Diploma of Psychological Medicine.' Almost all local Medical Superintendents had training at the Maudsley mental hospital and possessed the DPM or MRCPsych qualifications (Kua 2004).

Despite the asylum's limited reach, Western mental health afforded the colonial regime the allegedly scientific classifications and vocabulary to distinguish Europeans from 'inferior' Asians and to divide the latter into distinct races. In the 1890s, the superintendent of the Singapore asylum viewed general paresis to be a disease of more advanced peoples, and thus unlikely to afflict Asians with 'their simple life, few or no worries' (Straits Settlements 1896). Specific claims like these, however, were tenuous and likely to be disproved by subsequent developments. By the 1910s, general paresis had become recognized as a leading cause of mental illness in Singapore.

Racial classifications were an important basis of colonial rule and helped to perpetuate the British system of divide and rule. The British were deeply interested in the racial dimensions of mental illness, particularly among the Chinese, the majority group in Singapore. In 1908, the medical authorities warned that 'The occurrence of cases of alcoholic insanity among Chinese is increasing' (Straits Settlements 1908, p. 552). British views of suicide in the asylum were also racially inflected. In 1896, the superintendent surmised that 'the Chinese are without exception, when suicidal, the most persistently suicidal of any of the numerous races with whom I have had any dealings.' He blamed suicides on the placement of barred windows above the bed from which patients could easily hang themselves (Straits Settlements 1896). This was a clear reference to Chinese patients who attempted suicide: in 1914, the administration stated that 'Ninety percent of their number had attempted suicide by hanging' (Straits Settlements 1914).

The colonial system inadvertently created transnational social histories of mental illness in institutions located in different places and in different countries. One aspect of this was the repatriation of patients to their country of origin (usually China or India), as a means to reduce overcrowding in the asylum. In 1895, 57

Chinese patients were repatriated to China, and four Tamils to Madras. The Singapore asylum also received patients from asylums in Malaya. In 1914, an amendment to the ordinance allowed the transfer of patients from Singapore to asylums in Malaya.

British colonial rule in Singapore was interrupted in February 1942 when the island fell to the Japanese invaders. For more than three years, until the British returned in 1945, the mental asylum was used by the Japanese military regime as a civilian and military hospital. Mental patients were allowed to leave the institution, transferred to Tanjong Rambutan asylum in north Malaya or removed to St. John's Island. Japanese rule was a harsh experience for the patients who survived, marked by deprivation and lack of treatment.

Post-war Colonial Singapore and Exhilaration of the Modern

The post-war colonial years were a period of modernity redoubled, expanding upon the development of the asylum before the war. The new colonial policy derived from several influences. First, it was part of an ambitious program to develop the social services in Singapore. Post-war Britain witnessed the emergence of the welfare state, vested with the belief that robust state intervention in people's lives would help defeat the perceived five 'giant evils' of the time: idleness, squalor, want, ignorance, and disease, as stated in the 1942 Beveridge Report in Britain (Loh 2013). Mental health was seen as a serious social issue, as a drain on the country's economic and human resources and as contributing to the incidence of crime (Medical Department 1954). Second, the new welfare state socialism coincided with the modernization theory that prevailed in economic and social policy thinking in the USA and Western Europe after the war. The new wisdom held that modern methods of development were universally applicable regardless of the local context and would eradicate the world's pressing social, economic and health problems (Amrith 2007). Finally, the 1950s and 1960s were also a period of imperial retreat, as a near bankrupt Britain sought to organize an orderly process of decolonization, which would turn colonies into friendly nation-states. Between the seemingly contradictory British impulses to spend money to intervene and reform, and to refrain from spending as a measure of austerity, late-colonial mental healthcare entered an accelerated phase of development that would lay the foundation for the programs of the post-colonial state.

The official records of the immediate postwar years expressed the practical-minded exhilaration of the mental asylum's administrators, who genuinely believed in their ability to supersede the past and forge a new future. Rational science, medicine and administration were the instruments of change. Compared to the prewar period, becoming 'modern' became a basic term and theme in the vocabulary of the colonial bureaucracy. In 1951, the authorities hailed the new role

of the asylum: 'In past decades the idea was mainly incarceration: today this includes modern treatment and an attempt to cure as many as possible' (Medical Department 1951).

The cornerstone of the postwar policy toward healthcare in Singapore was the ten-year Medical Plan, approved in 1948. The Plan aimed to bring the public health system 'up to modern standards' (Medical Department 1947). Its aim was not simply to address the neglect and damage caused by the war but also to plan ahead of social and economic development in order to provide for a new polity, economy and society in the future. The authorities conceded that its hospitals were only capable of serving a quarter of a million people, while Singapore's population had swelled to nearly a million in 1947 (Medical Department 1947).

The mental asylum underwent the continuous repair of old wards and building of new ones. New physical methods of treatment were introduced, such as the use of electro-convulsive therapy and insulin coma therapy. There were also efforts to increase the small number of nursing staff and attendants by offering better pay and promotion prospects. In 1952, there were only six doctors, a matron, eight nurses, and ten hospital assistants to serve some 1,700 patients throughout the year. From 1954, there was a push to recruit Chinese speaking psychiatrists to replace expatriates and non-Chinese doctors, as part of the Malayanization of the civil service.

To reduce prejudice against mental illness, and to encourage patients to seek treatment, efforts were also made to create a more open physical and social environment in the asylum. The institution unlocked more of its accommodation and removed bars from most windows, although wire mesh was still used in some windows. In 1955, a social work department was established in the asylum and in 1958 social therapy was introduced, enabling patients to take part in a range of social and recreational activities, such as group singing, group and individual discussions, group dances, film shows, and listening to music. As in the pre-war era, occupational therapy included carpentry work, basketry and weaving. In 1949, a farm garden was established for growing vegetables and fruit. The work was still gendered as it had been prior to the war—men worked in 'the grounds, garden, kitchens,' while women 'in sewing room, in the female laundry or in cleaning duties' (Medical Department 1949).

In 1951, trying to remove the stigma of danger associated with mental illness, the Mental Hospital was renamed Woodbridge Hospital after a bridge in the area (which the Chinese called '*pang kio*,' or wooden bridge). However, politically correct euphemisms are not immune to old stigma, and Woodbridge Hospital soon acquired the familiar connotations associated with madness and danger.

As the colonial state gradually gave way to the nation-state in the 1950s, so the scope and reach of mental health policy expanded. The asylum—the mainstay of a colonial policy to isolate the ill from the healthy—saw its role reduced after the war. Institutionalization gave way to an emphasis on patients recovering in their community while adapting to the demands of social life. The classic example here was outpatient treatment for less serious cases. In 1953, the first outpatient psychiatric clinic was established at the General Hospital and became 'increasingly popular' (Medical Department 1953). Four more clinics were established in the decade at

other hospitals outside the town area. The clinics possessed a wide social reach, visited by 'juvenile delinquents, orphans and misplaced children in need of care and protection, young prostitutes under rehabilitation, elderly men and women and mentally defective children' (Medical Department 1956).

Post-colonial Continuities and Community Care

From self-government in 1959, and particularly after independence in 1965, the government magnified the postwar colonial programs: the development planning, physical expansion of the hospital, outpatient treatment, community-based rehabilitation, focus on mental defectives and young patients, occupational therapy, training and education. Increasing numbers of patients visited the outpatient clinics from the 1960s onwards. Postcolonial mental health retained the colonial way of dividing the general population, and mental patients, into races. In contrast with other ethnic groups, a 1965 report opined, '[The] Malay is more conservative and prefers to seek native treatment.' In the same report, the authorities stated, 'Alcoholism is rarely encountered among the Chinese and Muslims … the Chinese usually drink with their meals or when entertaining their guests and here again food is served. Perhaps this social habit of drinking while eating prevents them from becoming chronic alcoholics' (Ministry of Health 1965).

But the government also initiated new policies of its own. One major change was administrative centralization, with the government abolishing the elected city council and integrating municipal services into the work of the national government. Mental health thus came under the central government, as did other social services. In 1960, an amendment to the mental health law allowed medical officers to admit patients into Woodbridge, as increasing numbers of patients were now going directly to government hospitals. In 1965, of the 2,797 patients admitted into the hospital, 581 were voluntary cases, compared to four vagrants, although this shows that the vast majority of admissions were still involuntary.

Another change was a gender emphasis in the classification of mental illness, alongside the racial one. In 1965, the government claimed that there were more males than females in the hospital because 'females are in a more protected environment' (Ministry of Health 1965). The medical report of 1968 stated that 'In Singapore, mental health problems are not marked in any of the ethnic groups. Instead, they tend to categorization by sex rather than by ethnic origins' (Ministry of Health 1968).

In 1968, a child guidance service (later called the Child Psychiatric Clinic) was established in Woodbridge for children with emotional problems. An Association for Mental Health was formed as a non-governmental organization to promote mental health and provide daycare facilities for discharged patients. Another important initiative was the training of mental health professionals to assume leadership positions. As an institution, the hospital's history was tied to educational facilities and funding in Britain (partly under the Colombo Aid Plan) and the World

Health Organization (WHO), which provided fellowships and scholarships for locals.

In 1979, there was accelerated progress in psychiatric education with the establishment of the Department of Psychological Medicine at the National University of Singapore to teach medical students and coordinate research. The department was first based at the Singapore General Hospital and moved in 1987 to the National University Hospital. This was the first general hospital department of psychiatry.

Most Singapore doctors were sent to the Institute of Psychiatry (IOP), London, for post-graduate training in psychiatry. Although there were excellent teachers and clinicians at the IOP, there were questions raised about the relevance of the training programs to Singapore psychiatric practice. The organization of psychiatric services in the two countries was different and IOP was a research center. Psychiatry was, however, culture- and language-related and there were nuances in psychopathology in different cultural settings. The government decided that the training of psychiatrists should be localized and in 1983 the National University of Singapore with assistance from the Royal College of Psychiatrists in the UK started a training program for the Master in Medicine (Psychiatry).

In 1993, a new Woodbridge Hospital was built at Buangkok Green near the old premises. It was renamed 'Woodbridge Hospital and Institute of Mental Health,' signifying the state's intention to go beyond the preoccupation with illness. As the 1992 official report declared, the hospital was 'designed to facilitate modern psychiatric practices which emphasize on therapeutic rather than custodial management of mental illness' (Ministry of Health 1992). In 2000, the governance of the hospital was restructured and it became part of the cluster of hospitals called the National Healthcare Group. The training and research units amalgamated to form the Institute of Mental Health. With the closure of asylums in Europe and Australia, the Ministry of Health began to rethink the future of psychiatry in Singapore, and community psychiatry was on the agenda. In 2001, two community services—the community addiction medicine program (CAMP) and early psychosis intervention program (EPIP)—were started (Kua 2009). During this period, more day care centers were set up for psychiatric patients. Some of these services were staffed by nurses, psychologists or social workers and managed by non-governmental organizations (NGOs) or Muslim, Christian and Buddhist religious groups. Because there was always a long wait for consultation at the public clinics, many patients would seek advice from mental health professionals (psychiatrists, psychologists and therapists) in the private sector. By the end of the 2002, there were psychiatric departments in all the general hospitals.

In the last two decades, American 'soft power' has dominated global psychiatry through research and educational programs (Menninger and Nehemiah 2000). The rise of American psychiatry paralleled its dominance as a superpower in military, economic and cultural terms. The American Psychiatric Association's Diagnostic Statistical Manual has been used by many psychiatrists in Singapore, and there has been a shift in training of psychiatrists to the American residency program.

Although politics and economics may continue to dominate issues in healthcare, it is societal attitudes that can change opinion on psychiatry. Besides stigma and prejudices, family and cultural beliefs determine health-seeking tendencies (Kua et al. 1986, 1993). Patients admitted to the mental hospital and general hospitals are usually those with severe illnesses like schizophrenia, bipolar disorder, and depression with suicidal ideation. However, there are many people with 'mental health problems' living in the community who may not be classified as mentally ill but who need psychological help or psychotherapy.

In 1999, a Graduate Diploma of Psychotherapy course was conducted by the Faculty of Medicine of the National University of Singapore. Types or models of psychotherapy reflect the cultural milieu in which they are developed. In Western psychotherapy, the focus is on the individual struggling with biological urges and social constraints. In Asian culture, the emphasis is on the individual as a member of a family. In traditional Chinese medicine, psychotherapy is part of holistic care which includes herbs and acupuncture. The healer understands the ethos and explains the symptoms using the belief systems the patient is familiar with. Cultural differences mean that there should be different approaches in psychotherapy. The Brief Integrative Personal Therapy (BIPT) has been introduced as a method of psychotherapy more appropriate in a busy clinic (Lei et al. 2011). Embedded in BIPT is mindfulness practice which originated from India and is now accepted in America and Europe.

The rise of American psychiatry is mainly because of the surge of research publications and new ideas from the field (Menninger and Nehemiah 2000). However, the marketplace of ideas should not merely be sacrosanct to research centers in America or Europe and ignore the rich experience of Asian clinicians (Ang et al. 1995). Research interest has grown gradually over the past two decades in Singapore contributing to a different perspective of Asian psychiatry. For example, an outstanding project on the long term follow-up of schizophrenia initiated by Dr Tsoi Wing Foo showed that the outcome was not bleak after ten years (Tsoi and Kua 1992). Another study on alcoholism in Chinese had a good result of 68% abstinence after a year of treatment (Kua et al. 1990). The first epidemiology of dementia in elderly Chinese in Singapore was conducted as part of the WHO international study in 1990 (Kua 1992) and the first National Mental Health Survey in Singapore was completed in 1996 (Fones et al. 1998). Such research has provided important data for planning future services in the community.

Future Trends

The Ministry of Health in Singapore has created an Agency for Integrated Care to coordinate community psychiatric services. Hopefully it can link up the various services scattered in the community to enhance comprehensive care. The provision of community services should be a tripartite endeavor involving the government, NGOs and the private sector. This is especially crucial with the aging of the baby

boomers that will result in a rise in the number of frail elderly and a need to rethink psychogeriatric services (Kua 2010, 2012).

As psychiatric services expand into the community, mental health professionals must be trained in working in a milieu different from the mental hospital and general hospital. It means dealing with not just the families but also community leaders and people at the 'shop floor' level. Therefore, the training of psychiatrists for the future has to be re-organized (Sartorius 2009), because the training today is still hospital based.

Because of the volatility of geopolitics and economics in Asia, a small nation like Singapore will have to be vigilant. The implosion in Wall Street in 2008 affected Asia and the resultant economic crisis had psychiatric consequences (Phua and Kua 2009). Will the rise of China, too, have an impact on psychiatry? Observing with intense interest from the other side of the globe in 2009, a British practitioner boldly predicted: 'In the 2059 equitable world order we might expect to see the Chinese Journal of Psychiatry heading the list of mental health journals by impact factor…and the British Journal of Psychiatry in the second division' (Tyrer 2009).

Academic psychiatry in Singapore is growing with humble aplomb (Kua 2011). The relevance of psychiatry in clinical medicine today is incontrovertible, although a century ago, psychiatry as a science was perceived with incredulity and cynicism. Psychiatry today has made inroads into the general hospitals and primary care practice, underlining the totality of health as not merely the absence of physical illness but also the presence of mental well-being.

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Chapter 14
Psychiatry and Mental Health Care in Indonesia from Colonial to Modern Times

Hans Pols and Sasanto Wibisono

Abstract During the first part of the twentieth century, the colonial administration of the Dutch East Indies developed an extensive mental healthcare system consisting of four large mental hospitals and about a dozen psychiatric clinics located in the major urban centres. The colony ultimately had the highest number of beds per capita in psychiatric institutions in Southeast Asia. After Indonesia gained independence, the psychiatric infrastructure built by the Dutch remained in place and formed the basis for the Indonesian mental healthcare system. Unfortunately, only a relatively small part of the already modest health budget is dedicated to mental health; existing facilities are inadequate to meet demand.

In the 1860s, the colonial administration of the Dutch East Indies started to develop a mental healthcare system that eventually consisted of four large mental hospitals and about twelve psychiatric clinics located in the major urban centres. In the 1930s, the colony had the highest number of beds per capita in psychiatric facilities in Southeast Asia. These facilities generally had a custodial function: individuals were institutionalized when they displayed violent, aggressive, or suicidal behaviour and a physician testified that this behaviour was the consequence of a mental illness. After Indonesia's Declaration of Independence in 1945 and the transfer of sovereignty from the Netherlands to the Republic of Indonesia in December 1949, the psychiatric infrastructure built by the Dutch remained in place and formed the basis for the Indonesian mental healthcare system. A key goal of modern Indonesian psychiatrists has been the expansion of mental health care beyond the confines of the mental hospital. Today, only a relatively small part of the already modest health budget is dedicated to mental health and existing facilities are

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inadequate to meet demand. In this chapter, we will provide an overview of the development of psychiatry and mental health services in Indonesia from colonial to modern times and highlight a number of recent innovative practices.

Mental Health Care and Psychiatric Education in Colonial Times

The establishment of mental hospitals in the Dutch East Indies followed reforms in the care of the mentally ill in the Netherlands which had begun in the 1840s (de Waardt 2005; Gijswijt-Hofstra 2005). After observing that insane individuals often spent considerable time in prison without receiving appropriate care, a few colonial physicians advocated for the establishment of hospital facilities. In 1866, the Dutch government instructed two physicians, one associated with a mental hospital in the Netherlands and one working in the Dutch East Indies, to survey the state of mental hospitals worldwide and to ascertain the number of insane individuals in the Indies who required institutional care. Using somewhat arbitrary methods, they estimated that there were 550 individuals on Java in need of institutionalization, 300 of whom were located in military hospitals and prisons. They recommended that two large pavilion-style mental hospitals be established with a combined capacity of 600 beds (Bauer and Smit 1868). They also recommended the extensive use of labour therapy; to this end, large agricultural colonies were to be constructed adjacent to mental hospitals.

The first mental hospital in the Dutch East Indies began admitting patients in 1882 and was located near Buitenzorg (Bogor); a second one was established near Lawang (just south of Surabaya) in 1902. Two additional mental hospitals were built near Magelang and Sabang (North Sumatra) in 1923. In addition to these large mental hospitals, the Dutch colonial administration established twelve acute care facilities (*doorgangshuizen*) in large urban centres where patients could be treated for periods up to 6 months (Travaglino 1919). In the 1930s, a leading psychiatrist, van Wulfften Palthe (1933), again advocated the establishment of agricultural colonies for long-term chronic patients who would no longer benefit from medical treatment and who did not pose a danger to the community by private initiative. He argued that these institutions could be cheaply run by nurses (*mantris*) and Indonesian physicians. Under his direction, a privately run institution for long-term patients was established in 1935 at Lenteng Agung (near Batavia). During the second quarter of the twentieth century, four psychiatric wards in general hospitals were established for European patients. A small number of private sanatoria that catered to wealthier Europeans existed as well, but little is known about them.

The architecture and design of the mental hospital near Buitenzorg followed the example of the most modern institutions around the world. It consisted of a number of separate pavilions for Europeans (divided into three classes) and indigenous patients (divided into quiet and restless groups). Europeans were admitted as

patients when they could no longer be maintained at home; they received a variety of treatments, including continuous baths, bed treatment, and open air treatment. Because of their status in colonial life, labour therapy was not considered suitable. Indigenous patients were admitted after becoming a public nuisance, displaying violent or aggressive behaviour, or disturbing the social order. When they were no longer considered to be a risk to the people around them, they were housed in an adjacent agricultural colony where they tended the gardens or discharged in the care of their families. Physical restraint and isolation were rarely used (Travaglino 1923). No expense was spared to build the mental hospital near Buitenzorg. At the same time, military and civil hospitals were in a dreadful state, which motivated one critic to argue that the mental hospital should be transformed into a military one since soldiers were more deserving of good care than the insane (A. 1881).

Despite the fact that a significant part of the health budget was allocated to mental healthcare, mental hospitals in the Dutch East Indies encountered the same challenges as similar institutions elsewhere. These included lack of funding, overcrowding, and the difficulties involved in managing a patient population suffering from severe and persistent forms of mental illness. These factors resulted in poor care, neglect, and the failure to relieve prisons of insane inmates (Engelhard 1925). Even though the four large mental hospitals continuously expanded, the demand for beds in mental institutions always exceeded supply throughout the colonial era. In the 1930s, the four large mental hospitals housed more than 2000 patients each. During the economic depression of the 1930s, superintendents of mental hospitals expanded labour therapy by planting a greater variety of crops, by employing female patients in hospital laundries and clothing workshops, and by employing male patients to repair buildings and construct furniture. Physicians started to investigate alternatives to care in mental hospitals, such as housing indigenous patients in simple bamboo buildings in line with what they were used to in the villages they came from (Pols 2012). Further, agricultural colonies were proposed as well.

Medical care in the Dutch East Indies was provided by physicians from various European countries supplemented by graduates from two local medical schools. In 1851, the colonial administration established a school to train Indonesians to become vaccinators and assistant physicians in Batavia. During the following decades, the medical curriculum was improved several times (Hesselink 2011). In 1913, a second medical school was opened in Surabaya. In 1920, F.H. van Loon was appointed as the first instructor in neurology and psychiatry at the Batavia medical college. In 1927, a Medical Academy was established in Batavia offering degrees equivalent to those awarded in the Netherlands. P.M. van Wulfften Palthe taught neurology and psychiatry at this institution from 1927 to 1942. The large civil hospital adjacent to the Medical Academy refused to open a psychiatric ward on the grounds that the sick and the insane should be kept separate, indicating negative attitudes towards mental illness even among physicians. As a consequence, patients had to be brought in from the Grogol psychiatric clinic 10 km away for teaching demonstrations (Latumeten 1928; van Loon 1926). Several Indonesian physicians educated at the colonial medical schools specialized in

psychiatry; of these, J.A. Latumeten, Mohammad Amir, Radjiman Wediodiningrat, and Slamet Imam Santoso are the best known.

Colonial Psychiatric Views on Insanity in Indonesians

Like their colleagues in other colonial empires, European psychiatrists working in the Dutch East Indies assumed that the prevalence of insanity in the indigenous population was low. They believed that mental illness, as a disease of civilization, barely affected individuals from less developed societies. In their publications, they explored whether manifestations of mental illness in the Indies varied from those they had observed in Europe. In 1904, the influential German psychiatrist Emil Kraepelin, famous for formulating the classification principles of modern psychiatry, visited the Buitenzorg mental hospital to investigate ethnic differences in the incidence and the manifestation of mental illness by consulting the records of patients from indigenous, Chinese, and European backgrounds (Bendick 1989). He concluded that the symptoms of schizophrenia were less severe in indigenous patients, that they displayed significant emotion lability, and that their prognosis was much better (Kraepelin 1904a, b). Apart from providing observations for comparative or cross-cultural psychiatry (Jilek 1995), Kraepelin aimed to contribute to a larger project of *Völkerpsychologie* (comparative anthropological psychology), which consisted of a systematic analysis of ethnic groups in various stages of social and cultural development. Inspired by Kraepelin, a number of Dutch colonial psychiatrists articulated theories on the nature of normal indigenous minds, which they characterized as emotional, lazy, deceptive, and childlike, thereby providing a justification for colonial society with its inherent inequalities and power differences (Pols 2007a). According to Megan Vaughan (1991), the views colonial psychiatrists formulated about normality in indigenous individuals were far more influential than their ideas on mental illness and its treatment.

Psychiatrists working in the Dutch East Indies described a number of culture-bound syndromes unique to the region, including amok, latah, and koro (van Loon 1927; van Wulfften Palthe 1935). Amok is a sudden violent outburst in men after severe embarrassment which can last for several hours, after which amnesia occurs (for a critical view on amok, see Carr (1985)). Latah is the compulsion to imitate movements and utter offensive language generally found in older women [see also Geertz (1968) and Winzeler (1995)]. Koro is the fear that the penis will retract into the abdomen (Crozier 2011). Apart from amok, these conditions were of little significance for psychiatric care in the Dutch East Indies. However, because these conditions illustrate the significance of cultural factors in the nature and expression of mental illness and pose interesting challenges to the assumed universality of psychiatric diagnostic categories, discussions about culture-bound syndromes continue to fascinate psychiatrists.

J.H.F. Kohlbrugge was the first European physician to analyse the mental life of the Javanese. According to Kohlbrugge (1907a), the Javanese functioned at a primitive level of mental development because of the pervasive presence of animism and superstition in Javanese culture, and the oppressively hot climate compounded this by deterring hard work and impeding intellectual development. Kohlbrugge argued that the Javanese were suggestible, emotional, erratic, primitive, and childlike, and characterized their mental life as completely lacking in individuality combined with an intrinsic laziness, an inability to plan ahead, a lack of fully developed rational abilities, and a dominance of the emotions. Kohlbrugge warned that Western-style education would erode traditional culture and cause the fragmentation and eventual dissolution of traditional communities. Advanced Western education would eventually lead to the formation of a discontented and uprooted class of urban intellectuals which could be expected to foment social dissent. According to Kohlbrugge, the colonial government should limit itself to maintaining law and order, and study the psychology of the Javanese to develop a colonial policy suitable to the nature of the mental life of the indigenous population (Kohlbrugge 1907b).

In the 1920s, psychiatrists F.H. van Loon, instructor at the Batavia medical school, and P.H.M. Travaglino, medical superintendent of the Lawang mental hospital, expressed similar views. Following Kraepelin's lead, Travaglino had investigated the manifestations of schizophrenia in indigenous patients and claimed that visual and auditory hallucinations were rare among them. According to Travaglino (1920), these patients were unusually emotionally expressive and displayed symptoms ranging from talkativeness and screaming to singing, cursing, and tearing up their clothes. According to him, these patients were disoriented, lacked concentration, and were highly agitated and expressive; at times, they would engage in aggressive and destructive behaviour. Unlike European patients suffering from schizophrenia, most of these patients recovered relatively quickly. On the basis of these observations, Travaglino drew conclusions about the nature of the normal Indonesian psyche and concluded that Indonesians were at a more primitive phase of mental evolution; emotion instead of reason predominated. Van Loon (1924, 1928) reiterated these views by arguing that the indigenous population of the Indies was primarily emotional, suggestible, and guided by instinct rather than reason. The theories promulgated by both psychiatrists evoked strong protests from Indonesian physicians who formulated coherent and well-argued critiques by arguing that no conclusions on normal individuals could be drawn from investigations of the insane. They also criticized the generalizations made by both psychiatrists about the hundreds of ethnic groups of the archipelago, and argued that comparisons between Eastern and Western minds lacked meaning. Lastly, they argued that research on Indonesian individuals with mental illness should be conducted by physicians who speak their language and who are aware of their cultural conventions (Pols 2007b).

Mental Health Care in Indonesia After Independence

During the Japanese occupation and the Indonesian Revolution, the military req- uisitioned most mental hospital buildings; most of them were severely damaged during hostilities. During the 1950s, Indonesia was plagued by high inflation, social unrest, and economic problems; it was therefore only possible to keep the existing mental hospitals operating (the Sabang mental hospital closed). In 1950, Marzuki Mahdi, a physician previously associated with the Buitenzorg mental hospital, became the first chairman of the Bureau of Mental Health in the Ministry of Health of the Republic of Indonesia. From 1958 to 1963, Salekan, previously director of the psychiatric clinic in Grogol in Jakarta, transformed the Department of Mental Health into a directorate within the Ministry of Health. He also implemented a system storing data on all mental hospital patients in Indonesia. Under his guidance, the Grogol psychiatric clinic was extensively renovated. Lenteng Agung was taken over by the military in the early 1960s. During the 1950s, Indonesian mental hospitals only provided custodial care since opportunities for treatment were extremely limited. However, labour therapy was used widely and electroconvulsive therapy (ECT), which was administered under primitive conditions, was used extensively. Medication was supplied only when the family could afford it (Kline 1963).

In the 1960s, Kusumanto Setyonegoro, an extraordinarily energetic and deter- mined psychiatrist, became a leading figure in Indonesian psychiatry [for a biog- raphy, see Thong (2011)]. In 1961, he established the first private mental hospital in Indonesia, the Dharmawangsa Sanatorium in South Jakarta, from where he laun- ched his efforts to reform Indonesian psychiatry. In 1968, *Jiwa*, the Indonesian psychiatric quarterly, commenced publication. From 1972 to 1980, the Dharmawangsa Mental Health Broadcasting Station provided public mental health education. The psychiatrists associated with this sanatorium organized short courses for government officials and local community leaders on the nature of mental illness and the need for improved mental healthcare facilities.

Psychiatric Education in Indonesia

During the Japanese occupation (1942–1945), the Batavia Medical Academy was closed; in its place, a Japanese Medical School named Ika Daigaku was opened in 1943. The Indonesian physicians who had previously assisted in medical teaching became responsible for medical instruction. During the Indonesian Revolution (1945–1949), a number of Indonesian physicians set up a medical school near Yogyakarta, which became the Faculty of Medicine at the University of Gadjah Mada in 1950; H.R.M. Soejono Prawirohadikusumo was the first professor of psychiatry at this institution. After the transfer of sovereignty on 27 December

1949, most of the European teaching staff at the University of Indonesia returned to Europe; most Dutch psychiatrists followed as well. In 1950, the University of Indonesia organized a Faculty of Medicine where Slamet Imam Santoso became the first professor of neurology and psychiatry [for a biography, see Santoso and Oemarjati (1992)]; Santoso was later involved with the establishment of the Department of Psychology [see Santoso (1959)].

Through a collaborative project with the University of California at San Francisco (UCSF), lasting from 1954 to 1964, medical teaching at the three leading medical schools in Indonesia (University of Indonesia, Jakarta; University of Gadjah Mada, Yogyakarta; and Airlangga University, Surabaya) became more efficient and practice-based. Entrance examinations limited the number of medical students and regular examinations checked the academic progress of students (Smyth 1957, 1963; Wellington 1970). The graduates of these schools staffed several new medical schools that were founded in the 1950s and 1960s to increase the number of physicians in Indonesia. In 1961, neurology and psychiatry at the University of Indonesia were established as two different departments. R. Kusumanto Setyonegoro became the chairman of the Department of Psychiatry (a position he held until 1972). In 1961, there were 32 psychiatrists in Indonesia (Kelman 1968). Inspired by American psychiatry, Kusumanto advocated a holistic approach which encompassed biological, psychological, and social factors in the aetiology of mental illness (Setyonegoro 1965), which became the foundation of psychiatric thinking in Indonesia. In 1967, he introduced a structured three-year residency training programme in psychiatry (which was extended to four years in 2000).

Postgraduate education in psychiatry has been available to Indonesian psychiatrists on a limited scale in the USA, Canada, Australia, the UK, and the Netherlands. The collaborative initiative between the University of Indonesia and the University of Hawaii between 1972 and 1973, which focused on community child psychiatry, deserves special mention (McDermott and Maretzki 1975; McDermott et al. 1974). Five Indonesian psychiatrists spent a year in Hawaii for advanced training; after returning to Indonesia, they established child psychiatry as a subdiscipline. Thomas Maretzki, an anthropologist who was involved in this project, emphasized that the successful development of mental healthcare services in Indonesia would depend on a sensitivity towards the specific Indonesian cultural understanding of mental illness and an awareness of the current organization of healthcare services in general (Maretzki 1981a, b). In the 1970s and 1980s, postgraduate medical training in psychiatry was organized in Indonesia.

In 1972, the Society for Indonesian Neurology, Psychiatry, and Neurosurgery was established; in 1983, this society dissolved and the Indonesian Psychiatric Association, initially named *Ikatan Dokter ahli Jiwa Indonesia*, was founded. Today, it is named *Perhimpunan Dokter Spesialis Kedokteran Jiwa Indonesia* (PDSKJI).

Mental Health Care in Indonesia After 1960

In 1966, the Ministry of Health organized a national meeting of psychiatrists to discuss the future of mental health care in Indonesia. At this meeting, three basic principles were adopted: prevention, treatment, and rehabilitation. Attendees agreed that mental health care needed to expand beyond hospital treatment to include prevention and rehabilitation. In the same year, the Indonesian parliament passed a separate mental health law which provided significant opportunities for the expansion of mental healthcare services (this law was withdrawn in 1993 and integrated into general health legislation; a new mental health law was passed in August 2014). The 1966 law mandated an integrated community approach to mental health care. In 1969, a comprehensive mental healthcare system was introduced. It integrated mental health care into the primary healthcare centres (*Pusat Kesehatan Masyarakat* or *puskesmas*). Existing mental hospitals offered both inpatient and outpatient services, consultation to general hospitals, and public health education.

In 1971, Kusumanto was appointed Director of the Directorate of Mental Health (a position he held until 1989), which allowed him to lay the groundwork for the modernization and renewal of Indonesia's mental healthcare system. Under his guidance, Indonesian psychiatry flourished; some commentators have designated the period from 1970 to 1985 as the golden age of Indonesian mental health and dubbed Kusumanto the godfather of Indonesian psychiatry. During this time, twenty-two new mental hospitals were established; as a result, 26 out of Indonesia's 31 provinces now have a mental hospital. In the 1970s and 1980s, Indonesian psychiatry provided a model for the region. Kusumanto established the ASEAN forum on child and adolescent psychiatry in 1977 during a meeting in Jakarta. In 1981, at the first meeting of the ASEAN Association of Psychiatrists in Bangkok, Kusumanto was elected the founding president of the ASEAN Federation for Psychiatry and Mental Health.

By 1975, every province in Indonesia had established a Board of Community Mental Health and developed integrated plans for the organization of mental health care. Mental hospitals still occupied a central position, and psychiatrists in their employ were tasked with providing consultations to hospitals, local health centres, and schools, and with developing programmes of public health education. In 2002, the central government embarked on a far-reaching process of decentralization, which transferred the responsibility for mental health from the central government to the provinces. The Directorate of Mental Health was reorganized and became the Division of Community Mental Health, which was subordinate to the Directorate of General Community Health. The health policies that were implemented as part of the process of decentralization led to a period of decline of psychiatry. Most mental hospitals were underfunded and it became more difficult to integrate psychiatry into general health programmes. In 2006, these organizational changes were partially

reversed and the Directorate of Mental Health was placed under the Directorate of General Medical Care. The central government now provides technical assistance to all mental hospitals, although the provinces remain responsible for them.

Research Initiatives

From 1975 to 1982, when the Indonesian Directorate of Mental Health was a collaborative centre of the South East Asia Regional Office of the World Health Organization, a number of innovative research projects were initiated. In 1983, Indonesian psychiatrists undertook the first community-based mental health survey to ascertain the prevalence of mental illness using a sample of 100,000 individuals; it concluded that the prevalence of the major psychoses was 1.44 per thousand. A comparative study with sites in London and Indonesia concluded that Indonesians diagnosed with schizophrenia displayed higher levels of overactivity and experienced fewer delusions of persecution, visual hallucinations, and depression (Salan et al. 1992). In the 1980s, research focused on the care provided by traditional healers (*dukun*). In some areas, up to 80% of Indonesians consulted *dukuns* first when they experienced mental health problems (Setyonegoro and Roan 1983). Psychiatric researchers conducted surveys on the use of traditional healers in several provinces (Salan et al. 1982; Setyonegoro and Roan 1983). Kusumanto and his colleagues proposed a policy of coexistence between traditional healers and regular physicians. Unlike the extensive public health initiatives to train traditional midwives in modern hygiene birthing practices, few attempts have been made to provide training to traditional healers or to incorporate them in the mental health-care system.

Only a few studies exist on the treatment *dukuns* and religious teachers provide for mental health problems. Horikoshi (1980) investigated the practices at an Islamic *asrama* in West Java where individuals with mental afflictions resided under the guidance of religious teachers (see also Horikoshi-Roe (1979)). According to her, traditional spiritual beliefs define health as the outcome of a harmonious balance between hot and cold substances in the body, between individuals and the community, and between individuals and the cosmic order. Mental disorder implies a disturbance between the soul and the flesh, which can be cured by religious training, moderation, baths, massages, and diet. In the symptomatic expression of mental illness, religious beliefs, spiritual ideas, and modern medicine each play a role (Good and Subandi 2004). Several psychiatrists and anthropologists have emphasized the importance of cultural factors in the symptomatology and experience of mental illness in Indonesia (Gunawan-Mitchell 1969; Maretzki 1981a). Recently, the American anthropologist and film-maker Robert B. Lemelson has made a series of documentaries with the title *Afflictions: Culture and Mental Illness in Indonesia* following several individuals suffering from mental illness. Lemelson explores the everyday life of Indonesians with severe forms of mental illness, the reactions of their families, and their interactions with traditional healers

and the mental healthcare system (Lemelson 2011). These documentaries provide a vivid portrayal of the subjective experience of mental illness in Indonesia (Lemelson and Tucker 2015a, b).

Denny Thong, a psychiatrist who worked from 1968 to 1986 on Bali, has experimented with ways to integrate the activities of traditional healers (*balian* on Bali) in the mental healthcare system (Thong et al. 1992). According to Balinese traditional beliefs, mental disorder is a result of a violation of the harmony of the community, the environment, or the gods and can be remedied through meditation, offerings, or other rituals. Thong had a temple (*banjar*) built next to the Bangli mental hospital to encourage locals to use the services of the latter. He invited *balians* to become involved in psychiatric treatment, which de-stigmatized mental illness and made mental health interventions more acceptable to the local population. Thong's initiative was highly successful (Dean and Thong 1972; Thong 1976). Thong also organized a family ward, following the example of local *balians* or the *asrama* on Java, to involve family members in the treatment of patients. Anthropologist, Connor (1982), has argued that involving traditional healers is the only feasible way to make mental health care available to all Indonesians because of the shortage of physicians. Initiatives involving traditional healers and the exploration of traditional understandings of mental disorder continue to be undertaken on Bali (Suryani and Jensen 1993).

Popular Psychology

In Indonesia, popularizations of psychiatry and psychology are not as prevalent as in some Western countries. Recently, a number of popular Indonesian Muslim preachers and self-help gurus have incorporated Western pop psychology in their sermons, management training seminars, media presentations, and televised addresses by presenting a psychological interpretation of the religious and civic virtues of the Prophet Muhammad (Hoesterey 2012). Titles in the genre of Islamic popular psychology constitute a fast-growing segment in Indonesia's publishing industry. Protagonists of Islamic psychology herald the scientific merits and the relevance of Islamic teaching as presented in a modern psychological vocabulary. They use psychobiographical accounts of the Prophet to inspire contemporary Muslims to be successful as corporate leaders, teachers, and citizens. Anthropologist James B. Hoesterey has followed the moral movement of Abdullah Gymnastiar (popularly known as Aa Gym), who has developed a large business empire propagating an Islamicized version of Western self-help psychology (Hoesterey 2008). Daromir Rudnyckyj (2009) has analysed how Daniel Goleman's concept of emotional intelligence has been popularized by so-called spiritual trainers in translated form as spiritual intelligence or prophetic intelligence. These spiritual trainers aim to offer an alternative for the corruption, cronyism, and patronage (generally referred to by the acronym KKN, which stands for *korupsi, kolusi dan nepotisme*) that are pervading Indonesian society.

Psychiatry and Mental Health Care in Indonesia Today

There are close to 900 psychiatrists in Indonesia today, which is a very modest number for a population approaching 250 million people. In Southeast Asia, Indonesia ranks near the bottom with respect to the number of psychiatrists, mental health personnel, and psychiatric beds per capita. In recent years, Indonesian psychiatrists have expressed concern about the decline in funding for mental hospitals which has led to a reduction in service quality. Funding for mental hospitals, which has always been inadequate, has declined over the last twenty years, and has led to a reduction in levels of service. The Indonesian government only spends approximately 2.4% of its budget on health; only 1% of this amount is spent on mental health. The current condition of psychiatry in Indonesia contrasts with the state of the discipline in the 1970s and 1980s, when Indonesia's mental healthcare system was considered to be an example for Southeast Asia.

Research in several developing countries has demonstrated that there is a significant relationship between poverty and common mental disorders (Patel and Kleinman 2003). In Indonesia, poorer mental health is found in individuals who have received little education, live in substandard housing, and live below the poverty line. Individuals, whose standard of living had improved, on the contrary, experienced fewer symptoms of mental disorder (Bahar et al. 1992). Over the last several decades, the differences between rich and poor in Indonesia have increased. Wealthy individuals can consult psychiatrists in private practice or receive treatment in private mental hospitals; they receive psychiatric care that matches that of any Western country in quality. Unfortunately, most Indonesians suffering from mental illness will never see a physician, let alone a psychiatrist, or receive appropriate medical care. Many suffer in silence, consult traditional healers, or are placed in institutions of very poor quality.

In the last decade, the plight of individuals with severe and persistent forms of mental illness outside mental hospitals has received more attention by physicians and policy-makers. Because the number of beds in mental hospitals falls far short of demand, several private facilities have been opened to institutionalize the mentally ill. These facilities are often run by individuals without medical training who advocate a religious approach towards mental illness. In their facilities, patients are housed in deplorable conditions, receive inadequate nutrition, suffer from a variety of ailments, and are often restrained. A recent photo-essay in *Time LightBox*, for example, exposed the conditions of neglect in private facilities (Reese 2013). One of these institutions, the Galuh Foundation for Mental Illness and Rehabilitation in Bekasi, has received ample adverse media attention. In this facility, most patients are chained, a practice which was banned in 1997 but which persists today. Patients do not receive sufficient food but only occasional medical attention. In Jakarta's severely overcrowded municipal shelters, death rates among psychiatric patients are unusually high as a consequence of diarrhoea and malnutrition (Minas 2009a, b). Irmansyah et al. (2009) have issued a call for action by arguing that Indonesia is not meeting its requirements for fulfilling the human rights of the mentally ill.

Popular attitudes of Indonesians towards various forms of mental disorder have been characterized as tolerant (Kline 1963; Kurihara et al. 2000) as long as affected individuals are not violent or too difficult for the family to maintain. According to an observer in the late 1920s, violent and aggressive individuals were either confined in locked rooms or placed in wooden blocks, a practice that has been remarkably persistent (Latumeten 1928). In recent years, it has been observed that these practices, called *pasung*, persist (Minas and Diatri 2008). It is estimated that 20–30,000 individuals are currently confined in this way. In 2010, psychiatrists initiated an Indonesia-wide campaign called *Bebas Pasung* [Beyond Restraints], which has received media coverage internationally (Puteh et al. 2011). Affected individuals receive medication and are transferred to mental health facilities when needed, and family members are educated on the nature of mental illness.

The 2004 tsunami had a devastating effect on several countries around the Indian Ocean. Psychiatrists and several non-governmental organizations focusing on mental health organized programmes aimed at relieving post-tsunami trauma in survivors (Miller 2005). In Indonesia, the province of Aceh in northern Sumatra was the hardest hit and suffered an estimated 170,000 casualties while more than half a million individuals were displaced and almost all infrastructure near the coastline was destroyed. International aid efforts to rebuild the affected areas by the United Nations, international aid agencies, the World Health Organization, and various non-governmental organizations commenced soon after. A number of participating agencies focused on the adverse mental health consequences of the tsunami in the form of trauma and post-traumatic stress disorder (Kua and Iskandar 2005). In the Aceh region, many individuals had also been traumatized during the conflict between the Indonesian armed forces and the Free Aceh Movement that had taken place during the preceding decades. Surveys assessing the prevalence of symptoms associated with trauma found very high levels in displaced individuals whose villages were destroyed by the tsunami (Irmansyah et al. 2010) and in areas that were highly affected by the military conflict (Good et al. 2006, 2007). In both groups, symptoms of trauma and levels of disability associated with mental health conditions were elevated. In areas affected by conflict, for example, 78% of individuals reported having witnessing violence, 38% having fled a burning building, and 41% having a friend or family member killed. The mental health initiatives in Aceh provided training to general physicians, nurses, teachers, and, at times, volunteers to assess and treat mental health problems. After a brief training period, they visited the villages that were most affected and provided basic forms of treatment. Initiatives to eliminate *pasung* have been implemented in Aceh as well (Puteh et al. 2011).

Dealing with the aftermath of the tsunami and the Civil War in Aceh led to a greater awareness within Indonesia of the nature of trauma and the need for post-disaster and post-conflict psychosocial and mental health support. The initiatives undertaken in Aceh also indicate ways in which mental healthcare services could develop further in Indonesia. Because of the great shortage of psychiatrists, the training of general physicians, auxiliary health personnel, and volunteers appears the most promising avenue by which to make mental health care available

to the general population. It is also recommended that mental health be integrated in primary health care (Good et al. 2013).

Conclusion

During the colonial era, mental health care was provided in large mental hospitals and acute care clinics located in the larger urban centres. After independence, Indonesia inherited the mental health infrastructure and initially continued to rely on these hospitals and clinics for the provision of care. In the 1970s, Indonesian psychiatrists, led by Kusumanto Setyonegoro, successfully strengthened the mental hospital system and expanded psychiatric care beyond its walls by integrating mental health into primary health care and liaising with hospitals, schools, and government agencies. The results they achieved were partially reversed when the Indonesian government embarked on the policy of decentralization, which transferred mental health to the provinces. There is an urgent need for more funding for mental health initiatives and for health care in general. Today, there is a need for further training opportunities for physicians and psychiatrists, as well as opportunities for exchange and collaboration with psychiatrists from other countries. Recent initiatives have focused on abolishing restraint [*pasung*] in rural communities and exposing inadequate, privately run facilities for the confinement of individuals with mental illness. The mental health initiatives developed in Aceh after the 2004 tsunami, which relied on training general practitioners, nurses, and volunteers and the integration of mental health into primary health care, can serve as an example that can be applied across Indonesia.

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Chapter 15
The History of Mental Health in Papua New Guinea

Graham J. Roberts

Abstract Papua New Guinea, with over 840 languages, presents the most complex of situations for transcultural understandings of what it means to be mentally ill. The earliest comments on a Papuan population suggest the possibility of a Rousseauian ideal of the natural human condition devoid of mental pathology, where psychoses occurred as a result of the stresses set up by white influence. The theme that the stresses associated with cultural transition were causative of acute psychosis recurs throughout the early PNG literature. The first government-initiated investigation into mental illness in 1957 produced a report that initiated much of the subsequent development in mental health in PNG. Soon after, an admission facility was established at Laloki 10 miles north of Port Moresby near the Bomana Correctional Facility, where psychiatric patients had previously been held in indefinite detention in an annex. Laloki continues to provide an inpatient service today. Subsequent policy has supported the development of general hospital psychiatry units in provincial hospitals, although staffing them with qualified mental health staff has not been achieved and several units have closed in recent years. In forecasting culturally relativist approaches, the report stated that 'the mental health of an individual can be assessed only in relation to his culture and environment'. Dr. Burton-Bradley, appointed as the territory's only psychiatrist, struggled with this concept over the next three decades. While modern anthropology argues for culturally relevant understanding of behaviour based on the social structures in which it occurs and the suspension of the explanations of an observer's own culture, psychiatry found this difficult to achieve in Papua New Guinea. Burton-Bradley's view of clinical psychiatry, his training of clinicians and his prolific writing and teaching shaped the development of psychiatry in PNG and established the medical model as the dominant explanatory paradigm. In 1975, PNG gained independence and many positions were nationalized. Dr. W. Moi was appointed as medical superintendent of the Laloki psychiatric centre and head of mental health services and stated that 'culture and language represent a way of

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thinking and of understanding …and there are real advantages of being able to choose your frame of reference' forecasting the accommodation of the culturally relevant diagnoses now in use in PNG. The 2010 mental health policy recognizes PNG's cultural diversity and refers to a 'home-grown policy' to address the 'complex cultural circumstances and other related factors which contribute to the origin of mental and neurological disorder unique to Papua New Guinea', which confirms that European theories of aetiology and psychiatry's medical nosology have not achieved complete acceptance, even at the policy level. Current traditional beliefs concerning both mental and physical illness are still widely centred on sorcery, witchcraft, spirit possession/supernatural agents and violations of social norms and taboos. But the inclusion into psychiatry of metaphysical conceptions, and beliefs and actions based on factors that are not empirically verifiable, calls into question psychiatry's place within science. This perennial issue for psychiatry is brought into sharp focus in PNG.

Overview

Papua New Guinea, (PNG) with over 840 languages, presents the most complex of situations for transcultural understandings of what it means to be mentally ill. Within the multiple languages and cultures of Melanesia, we could expect that many indigenous explanations for mental illness would exist concurrently and that the European observer would have little chance of identifying anything that was not overtly expressed in some behavioural manner. Certainly, the subtleties of psychotic conceptions could not be understood without an understanding of both language and cultural usage.

It is important to remember that psychiatry's own explanatory models have evolved through various demonic, moral, neurological, developmental and organic paradigms; that psychiatry is a relatively recent science arising from a European culture in which the Cartesian dualism of mind and body was a philosophical fundamental; and that it continued to develop during the period under review. Likewise, anthropological theory has shifted from the evolutionist theories of the early twentieth century (Frazer 1922) in which cultural features such as belief in sorcery or magic were considered survivals of more primitive states, to the structural-functionalist theories of pragmatic meanings and culturally relevant social understandings (Burrow 2009).

The understanding of how mental illness is manifested in PNG has progressed through several positions: it has suggested hysteria or quasi-religious mania, made ethnographic comparisons with other cultures, particularly the Malay and the phenomenon of Amok, struggled with the cultural reality of ancestral and animistic spirits, considered the pathology manifest in cult leadership, explored the nature of 'culture-bound syndromes' and struggled to bring Melanesian distress within the Western medical paradigm.

The various discourses evident in the PNG academic literature mirror those in the international arena and have had their various impacts on service provision, while some remain as policy rhetoric. Internationally, changes to treatment technologies in the 1950s enabled medical control of the most overt of psychiatric manifestations and social behavioural breaches. The discourse on transcultural psychiatry engaged with the cultural relativist theories arising from the anthropology of the 1960s and 1970s. From the early 1970s, we see the impact of the social sciences on policy with more humanitarian approaches to care, support for deinstitutionalization and the integration of the mentally ill into the general community. The discourse on the relative merits of theories of developmental or organic aetiologies adopted a pragmatic acceptance of significant overlap and supported the provision of admission facilities and liaison psychiatry in general hospitals.

The earliest comments on a Papuan population (Seligman 1929) suggest the existence of an ideal state: a Rousseauian ideal of the natural human condition devoid of mental pathology, where psychoses occurred only as a result of the stresses set up by white influence. While the ideal has been dismissed, the theme that the stresses associated with cultural transition were causative of acute psychosis recurs throughout the PNG literature. Although it is never empirically substantiated, it reflects the Territory Administration's attempt to understand a complex social phenomenon from its own perspective.

The early focus on cultural transition is supplanted by culturally relativist approaches in the 1970s and the dilemmas of determining whether the nosology of psychiatry could be applied in PNG. It has not succeeded, or if so, only for clinical theorists. Koka et al. (2004) confirm that traditional beliefs concerning both mental and physical illness are widely centred on sorcery, witchcraft, spirit possession, supernatural agents and violations of social norms and taboos.

Frankel (2005) confirmed the pluralist understandings of the aetiology of illness and the necessity of pluralist responses among the Huli of the Southern Highlands. The Kakoli of the Western Highlands (Goddard 2011) had no concept of 'mental' illness, as they understood it as a disjuncture of a social force emanating from the chest and had classified madness according to behaviour that was 'out of place'. Frankel (2005) had found that health was considered as much a social as a physical state and that care for oneself was associated with ideas of social effectiveness and the attraction of wealth and influence. Cawte et al. (1967) had earlier identified the limitation in the use of Western diagnostic terms for understanding and management and that more realistic diagnoses were based on the twin factors of social inefficiency and personal discomfort.

Conceptions of mental illness in PNG remain pluralist today, not only in their cultural origins but also in their adaptation to foreign religions, particularly Christianity, with its own dualisms of body and soul, and good and evil; and through its syncretic assimilation into Melanesian metaphysics (Goddard 2011). The antipsychiatry debate has been revisited as psychiatry's essential misunderstanding of cultural conceptions of aetiology, resulting in the medicalization of behaviours that were locally understood to have sociocultural origins. To most

Papua New Guineans, a Western medical diagnosis still only provides part of a more complex explanation and medical treatment still only provides part of an effective response.

Early Impressions of the Mental State of the 'Indigenes'

In 1899, C.G. Seligman, a medical anthropologist working in Papua, was the first to write on mental disorders in PNG. Dr. B.G. Burton-Bradley, the first psychiatrist to be employed in PNG (in 1959) as the Chief of the Division of Mental Health and the dominant figure in this history, provides a synopsis of the early history of psychiatry in PNG. He (Burton-Bradley 1976) reported that in his 1899 work, Seligman had seen the psychological problems of the people lying more in the area of emotion and motivation than cognition. Subsequently, Seligman (1929) stated that 'no cases of mental disorder were observed in the villages among natives leading their own normal life … apart from the brief maniacal attacks the psychoses do not occur except as a result of stresses set up by white influence'. This comment has given rise to the concept of the 'Seligman Error' (Lucas and Barrett 1995): 'the failure to recognize mental illness by falsely attributing bizarre behaviour to other peoples' culture'.

'Vailala madness' (Williams 1923) was the first manifestation of such behaviour brought to the attention of the Territory Administration. Mass hysteria was evident on the coast of the Gulf Division in 1919 and 1920: a quasi-religious movement 'due in its beginning to the inability to digest the strong meat of certain mission services' (Lett 1944). It was considered to have features consistent with the Amok syndrome, characterized by multiple violent acts and thought to be peculiar to the Malays (Dennys 1894). Burton-Bradley supported the view that Amok among the Malays was a form of emotional release from a socially intolerable position of shame or embarrassment arising from strong social kinship ties. Monckton, a magistrate writing in the 1920s, reported that he had seen Amok among the islanders of the d'Entrecasteaux group and that it seemed to be accepted by both the village and the sufferer. Yet Patrol Officers' reports, mission reports, media and anecdotal reports related episodes of disturbed behaviour extending to homicide followed by amnesia, of behaviours without apparent motivation, of cultist extremism and of suicide conducted in ritualized fashion.

The Sinclair Report of 1957

The first government-initiated investigation into mental illness in PNG (Sinclair 1957) was commissioned by the Australian Minister for Territories, Paul Hasluck, 'to make a three month field and clinical survey and to report on the mental disease pattern of Papua and New Guinea, the effect of culture on this pattern, plans to

improve the wellbeing of the native inhabitants and an organisation necessary to promote mental health'. Sinclair, a physician with a doctorate in medicine, acknowledged the shortcomings of the survey methods and, with the assistance of two psychologists, (D.W. McElwain and E.F. Campbell) produced a report that initiated much of the subsequent development in mental health in PNG.

Sinclair's report, *Field and clinical survey of the mental health of the indigenes of the Territory of Papua and New Guinea*, included comments of key informants and a summary of a 140 person case review. Sinclair defines his approach to interpreting behaviour as reactions to 'pressures inherent in native culture' or 'pressures which have been superimposed by Europeanization'. This approach is based on the premise that tension is the root cause of behavioural and mental pathology. Sinclair's description of 'mental maladjustments' is all based on the failure to deal with tension. The distinction between culture and urbanization rested on the rationale that the destruction of the cultural belief in supernatural agencies would lead to an increase in the European reaction to stress: a change in symptomatology towards physical complaints. Within the context of plural aetiologies, this position now appears simplistic in that it assumed a single and universal recourse to supernatural explanations for what Europeans conceptualized as mental disorder.

The summary of 140 case reviews of persons attending medical outpatient clinics, receiving treatment or being cared for at home, or who were hospitalized, was supplemented by case reports from medical officers and European medical assistants. Sinclair describes three levels of services: in village communities, in forward administration areas and regional hospitals and in Bomana mental hospital, the only mental hospital in the territory. Bomana mental hospital was in charge of a competent and empathetic, resident European medical assistant with experience in general nursing and was also served by a visiting medical officer with little experience in psychiatry.

Sinclair writes his description of the referral process for a male patient. We must assume that he was using the male gender generically, although the referral process for females may have been quite different. He describes how the 'patient' was protected by 'his' culture and family. Psychoses that remitted quickly were not regarded seriously. If he became unmanageable, he would be taken to a forward administration area and placed in gaol to be seen by a medical officer or a European medical assistant. If his condition deteriorated and violence continued, he would be sent to the subdistrict hospital for sedation. Few medical officers were found to be familiar with the intravenous sedation techniques using Amytal and Largactil. Unfortunately, he does not comment on the availability of or competence in administration of the oral forms of Largactil in use internationally at that time.

Sinclair makes the remark in relation to areas beyond administrative reach that 'it is still possible that should he prove very violent he will be destroyed', indicating a limit to cultural acceptance of deranged behaviour. The present author can verify that this occurred as late as 1972. After entering a tribal area unexpectedly from Mt Sugarloaf in the Western Highlands, I chanced upon a funeral of a man who had

been mentally ill and repeatedly violent towards women. It was explained to me that he was killed yet deserving of the full set of traditional funerary rites.

Sinclair cites considerable difficulties in transporting patients by air from the regions to Bomana and a consequent large number of patients in regional hospitals without adequate treatment. Rabaul and Wewak had small cells available to contain 'restless psychotics'—both deemed unsuitable. Sinclair also deemed Bomana mental hospital a 'highly unsuitable institution for the treatment of native patients' and that 'it would seem to be an unsuitable location to make any extensions or further developments'. Yet in the same year the Laloki psychiatric centre was established near Bomana.

In proposing incidence rates of 0.4 per 1000 for 'psychotic patients requiring hospitalization', Sinclair acknowledged sampling biases and his access to only a small portion of the population: as have most subsequent attempts at a descriptive epidemiology of mental disorders been limited to small surveys.

The most interesting comment Sinclair makes on diagnostics is that 'most cases could not be fitted into any nosological entity, principally because it was impossible to separate hysterical components from psychotic reactions'. In forecasting culturally relativist approaches, Sinclair stated 'the mental health of an individual can be assessed only in relation to his culture and environment'. Burton-Bradley, appointed two years later as the territory's only psychiatrist, struggled with this concept over the next three decades.

The Ubiquity of Culture

The discussion of cultural relativism arises as early as Socrates who was aware that different cultures defined things differently, but that without a universal reference point, everything would be relative to culture and of no use as principles to guide human behaviour. This characterizes Burton-Bradley's dilemma—how to achieve a universal reference point in this most culturally diverse of countries. Modern anthropology since the 1970s has argued for culturally relevant understanding of behaviour based on the social structures in which it occurs, requiring the suspension of the explanations of an observer's own culture. Psychiatry found this difficult to achieve in Papua New Guinea.

Burton-Bradley's (1976) position on cultural relativism illustrated the tension associated with changing paradigms, as the medical model was challenged by the social sciences of the 1970s. While lauding cultural relativity as having 'tremendous value in assisting us all to overcome our ethnocentricities and pseudo-speciations', he also comments that 'overemphasis … has led to many difficulties from the psychiatrist's point of view'. Having previously stated (Burton-Bradley 1963) that he did not believe that there were 'psychiatric entities' specific to any one cultural group, nor 'that cultural factors were of primary aetiological importance', cultural relativism was a point of tension with his view of how to roll services out. He remained a supporter of institutional care

(Burton-Bradley 1990) while he also acknowledged that Western nosologies were valuable but had their limitations.

In defending his research findings of a significant amount of mental pathology in PNG, he characterized his approach to research as employing both anthropological and psychiatric techniques, with diagnosis defined by both the psychiatrist (heteropathology) and the people themselves (autopathology).

Goddard (2011) argues that the culturally relevant psychiatry of PNG's mental health policy is rhetoric that has failed to be implemented, overwhelmed by Western conceptions of mental illness as a medical problem and with interventions based in health facilities. However, in what appears to be an emerging pragmatic synthesis, Koka et al. (2004) have described how the recent use of diagnostic labelling by mental health workers (albeit with little or no training) includes culturally relevant and traditional beliefs, the culture-bound syndromes and the common use of diagnostic categories of sorcery and witchcraft (not all of which is bad), and the use of sorcery to treat illnesses believed caused by sorcery.

The 'cargo cult' phenomenon of PNG, arising from exposure to a materially wealthier culture and the intent to redress the imbalance through supernatural means, presented a subject for the diagnostic scrutiny of both the collective behaviour of cultists and the charismatic appeal of the cult leader. Burton-Bradley (1970) built on his previous observations that 'delusions of grandeur are not infrequently associated with cargo cult activities' (Burton-Bradley 1963) and discusses nine cases, concluding that the 'recruitment to leadership does not exclude the person with psychotic disorder'. In relation to cult leaders, he concluded that 'grandiosity and the grand delusions are invariably associated with cult behaviour and that 'cargo thinking colours the symptomatology of many psychiatric disorders'. He states that people with existing psychiatric disorders were attracted to and rewarded with prestigious tasks within the cult system and were thus consolidated in their mental disorder (Burton-Bradley 1975).

The Roll-Out of Mental Health Services

Following the Sinclair report, the Laloki psychiatric centre was established in Central Province 10 miles north of Port Moresby near the Bomana Correctional Facility, where psychiatric patients had previously been held in indefinite detention in an annex, referred to by Sinclair as the Bomana Mental Hospital. By 1967, Laloki was able to house 90 patients and continues to provide an inpatient service today.

Burton-Bradley was its first medical superintendent, appointed in 1959. His authority as the Chief of the Division of Mental Health and the only psychiatrist during the establishment of clinical psychiatry in PNG, his training of clinicians and his prolific writing and teaching shaped the development of psychiatric practice and services in PNG and established the medical model as the dominant explanatory paradigm.

Arthur (1967) reports on the emergency management of psychotic disorders in PNG and refers to a district hospital standing order that mental patients were to be 'locked up at all times'. He saw this as self-defeating, as the patient's condition was invariably made worse, or they escaped. Forecasting the future of a community-based model of care, he recommended that patients be treated close to their home and that acute psychotic episodes be treated quickly.

Burton-Bradley (1969) described the first 1000 cases referred to him over a ten-year period. The cases had been seen at Bomana, Laloki, the Boroko Clinic and Taurama Hospital in Port Moresby, the Angau Hospital in Lae and the hospitals at Rabaul, Madang, Wewak, Goroka and Samarai, indicating that patients were being treated in general hospitals during that period. He stated that the cases seen were defined as such by representatives of both European and indigenous cultures.

By applying diagnoses for 95% of patients seen, he appeared to have achieved the elusive ideal of a transcultural psychiatric nosology for application in PNG. He found that 'schizophrenia was the commonest form of mental disorder (35%) referred to psychiatrists'. He states that the nosology he uses 'would appear at first sight in many ways similar to that elsewhere and the range of disease entities not unlike that of the developed country' (Burton-Bradley 1969) but then enlarges on the need for the psychiatrist to consider the concept of normality and abnormality, language, custom and social organization. He goes on to state the perceived differences in symptoms and signs between an acculturated indigene (thought disorder, affective incongruity, withdrawal from reality, hallucinations, delusions and catatonia) and a 'bush individual' who very rarely presents with the signs of schizophrenia, hypothesizing that 'the cultural influences of the town and the confusing effect of alien values may act as a precipitating factor in a predisposed person'. He also identified a culture-specific category he called 'Taboo Transgressions' related to incest and post-partum sex taboos which 'varied considerably' and the spirit possession syndromes related to acute manifestations.

While suicide was not perceived to be common, and was not considered to be associated with depression as in European cultures (Parker and Burton-Bradley 1966), it had initially received attention by Malinowski (1959) who had detailed the ritual nature of Trobriand Islander suicide and its social function. Parker and Burton-Bradley, in agreement with Malinowski and with Sinclair (1957), considered shame to be the main factor, along with sorcery, in the cases of suicide (predominantly by hanging) they reviewed. They also considered that PNG had the lowest rate of reported suicide in the world (0.7 per 100,000), although this finding was based on a small sample of the population.

Marking the beginnings of general hospital psychiatry in PNG, a psychiatric ward at Port Moresby General Hospital (PMGH) was commissioned in 1969 to serve the purposes of admission, diagnosis and management of patients, teaching and training of medical and nursing students and for psychiatric research (Johnson 1997). Subsequent policy has supported the development of general hospital psychiatry units in provincial hospitals, although staffing them with qualified mental health staff has not been achieved and several units have closed in recent years (WHO 2013).

By 1976, Burton-Bradley described how the mental health services were 'directed to five different types of programmes: mental health education, medico-politics, the law as an instrument of prevention, transcultural research and a system of services 'based on social realities rather than the preferred fashions of our day'. This last comment reveals some disaffection with changing policy and service models. The subjects he identified (Burton-Bradley 1976) for research and policy attention reveal his continuing interest in finding a transcultural nosology and in maintaining the predominance of the 'modern mental health system'. They included beliefs and customs in relation to aetiology and treatment, epidemiological surveys separating custom from psychopathology, the role of the folk healer ('and the advisability or otherwise of his syncretic integration into the modern mental health system') and the adaptation of psychological test procedures to local cultural circumstances.

In 1975, Papua New Guinea gained independence from colonial rule and many positions were nationalized. Dr. W. Moi, a Papua New Guinean, was appointed as medical superintendent of the Laloki psychiatric centre and head of the mental health services of the National Department of Health (NDOH), replacing Burton-Bradley. He commented that 'culture and language represent a way of thinking and of understanding … and there are real advantages of being able to choose your frame of reference' (Moi 1976), forecasting the accommodation of the culturally relevant diagnoses now in use in mental health services (Koka et al. 2004). Moi proposed a model of service that would 'develop and communicate with non-medical community agencies' and in which mental health workers devote the greatest part of their work to health education of the general public and following up discharged patients.

Prior to 1968, all mental health staff had been orderlies, but by 1978, 35 trained psychiatric nurses had been deployed across the country. By 1980, postgraduate training in psychiatry had commenced at the University of Papua New Guinea (UPNG). In 2001, the NDOH established a Division of Social Change and Mental Health and the National Health Plan (2001–2010) included goals and strategies for mental health service developments and legislative and policy reforms (WHO 2005, 2013).

In 1987, a new consultation-liaison psychiatric service was started at PMGH (Johnson 1990). Johnson found some differences from the case mix described 30 years earlier by Burton-Bradley (1969), with schizophrenia at 17% and organic psychosis at 10% of all. He suggested that some differences were due to sampling, others to changes in diagnostic criteria or changes to presenting symptomatology over time. Neither author identified the system of classification they used, although Johnson used three (psychiatric syndrome, physical condition and psychosocial situation) of the five diagnostic axes in the American Psychiatric Association's diagnostic and statistical manual of mental disorders (American Psychiatric Association 1980).

Buchanan (1992) described the level of contact with health services by the mentally ill in the Ialibu District of the Southern Highlands. He took two years to identify 31 subjects and found that Western medicine and the work of traditional

healers were thought by villagers to be of little benefit. Just over half of the sample had had some contact with Ialibu Health Centre, and five had been treated elsewhere in larger centres and had returned. A small number of the more disruptiveness had been rejected by their villages and received little care from the local community. Most of the study population had little contact with health services, and relatives said that taking a mentally ill relative to hospital was a major undertaking.

In 2000, Laloki was upgraded to Laloki psychiatric hospital with the appointment of a chief executive officer to oversee the running of the hospital under the Public Hospitals Act 1995 and with a budget allocation from the NDOH. In 2000, a mental health policy was developed based on advocacy, promotion, prevention, treatment and rehabilitation. Services were integrated into the primary health care system, although a lack of trained staff limited its effectiveness (WHO 2005). By 2002, four national psychiatrists were employed and a postgraduate mental health nursing programme was running at UPNG. By 2005, four regional and nine provincial hospitals had psychiatric admission beds, and Laloki had 60 beds. WHO (2005) reported there were 0.17 mental health beds in mental hospitals and 0.07 in general hospitals per 10,000 population.

However, infrastructure does not last long in PNG and requires continual reinvestment in maintenance. In 2006, the mental health unit in East New Britain Province closed due to a volcanic eruption. In 2010, the mental health unit in the Eastern Highlands Province closed due to renovation and the mental health unit in Morobe Province closed due to termite damage (WHO 2013). The implementation of the national mental health policy has failed to provide infrastructure, relying as it has on the service delivery through the primary healthcare system. *The National* (8 May 2013) reported that Parliament's Public Accounts Committee had described the Laloki psychiatric hospital outside Port Moresby as a 'national disgrace'.

Legislation and Policy

The Insanity Ordinance of 1912 provided the authority for involuntary and prolonged care. The ordinance was succeeded by the Mental Disorders and Treatment Ordinance of 1960, which was annulled in 1997 and replaced with a chapter in the Public Health Act: the Public Health (Mental Disorders) Regulation (Ghodse 2011). Laloki psychiatric centre had served as an admission centre for prolonged stay, but a rehabilitation annex was established where social and life skills were encouraged. The introduction of the phenothiazines and changing social policy in Western countries contributed to the progressive closure of psychiatric hospitals worldwide. Internationally, deinstitutionalization began in the 1970s as a socially democratic and humanitarian approach to treating psychiatric patients in 'the least restrictive environment'.

Late in his career, Burton-Bradley (1990) expressed great antipathy to deinstitutionalization considering it to have been 'an enormous disaster' internationally and stated his preference for institutions developed along humanitarian lines. He opined the emphasis should be on training, in particular in medical anthropology. He

commented that the three-tiered system of concentric circles that had evolved in PNG (a small central circle of highly trained clinicians, a wider circle of psychiatric nurses and medical officers in hospitals and the largest circle made up of diagnostician healers, commonly aid post orderlies or 'almost anybody') was eroding, due to the massive social changes following independence in 1975, the decline in national revenues after the 1988 Bougainville crisis and the fall in international copper prices. Although it is difficult to see, he claimed (Burton-Bradley 1990) that the three-tiered system was derived from the system 'already present before the advent of medical technology', by which we must infer that he was referring to referral processes established since white contact but before the advent of the phenothiazines.

The Alma Ata Declaration of 1978 saw a worldwide emphasis on primary health care for the next two decades. The main social target was 'the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life' (WHO 1978). Primary health care in PNG was functioning well before the Alma Ata Declaration and, ironically, suffered from the additional policy attention, as it did also in Fiji (Negin et al. 2010). The present author remembers well the many maternal and child health clinics and health patrols conducted on outreach visits from mission and government stations, and the aid post orderlies serving in remote locations throughout the country. As in Fiji, the system that was previously operating well was eroded when resources for training, infrastructure and logistics were not maintained.

In 2007, PNG joined the Pacific Islands Mental Health Network (PIMHnet). The aim of PIMHnet is 'to enable Island countries … to establish mental health systems that can provide effective treatment and care' (Adu Krow et al. 2013). In reference to PNG, mental health services had 'deteriorated over the years due to challenges associated with leadership and governance as well as financial and human resources at district levels'.

A new Mental Health Act was passed in 2010 and was followed by the National Mental Health Policy 2010 (Ministry of Health 2010), which contained the objectives of 'improved access and quality, client focused services, prevention of mental disorders, integration of mental health into general health and to promote the human rights of people with mental disabilities'. The policy commits the government to 'establish national and provincial mental health units in general hospitals, psychological rehabilitation centres and a national referral specialist psychiatric hospital to provide high-level quality mental health care' and to 'ensure adequate funding'. In recognition of PNG's cultural diversity, the policy states: 'our home grown, unique mental health policy will … endeavour to identify the correct spectrum of sensitivity to complex cultural circumstances and other related factors which contribute to the origin of mental and neurological disorder unique to Papua New Guinea'.

This statement confirms that European theories of aetiology and psychiatry's medical nosology have not achieved complete acceptance, even at the policy level. The policy is one of an uncomfortable fit between a medical psychiatry influenced by the rhetoric of social democracy (point about rhetoric needs be explained, meaning not obvious) and the realities of pluralist indigenous understandings of aetiology and effective response. Like Goddard (2011), I regret that Melanesian understandings were not further explored earlier, as they may have contributed to a

more effective form of psychiatry suited to indigenous conceptions and social structure.

Conclusion

This history is made even more dramatic when one considers the speed of the cultural transition that PNG experienced in the twentieth century. It would be wrong to think that the Melanesian cultural ontology has been destroyed by this onslaught, or that the medical model had completely supplanted traditional beliefs about mental illness. What remains within PNG's mental health system are the culturally relevant meanings and a reliance on family and culture to provide social supports. The degree to which they are supported by access to basic psychopharmacological technologies and to knowledgeable medical, nursing and primary healthcare staff now depends on the realization of PNG's mental health policies. Given staff and skills shortages, the role of staff will be to support the actual primary care givers: those providing the social and cultural therapies that predate psychotherapy in PNG and endure in culture and of which we know little.

But the inclusion in psychiatry of metaphysical conceptions, and beliefs and actions based on factors that are not empirically verifiable, calls into question psychiatry's place within science. This perennial issue for psychiatry is brought into sharp focus in PNG. The potential these inclusions now have to influence psychiatric theory, practice and clinical effectiveness remains to be seen, but they certainly do provide very rich grounds for further study and evaluation.

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Chapter 16
The History of Mental Health in Fiji

Graham J. Roberts, Jacqueline Leckie and Odille Chang

Abstract That cultural transition entailed risks of mental illness remained a favoured theory well into the twentieth century and effected the early development of mental health services across the Pacific. Fiji has a distinct form of Melanesian culture, although ontological beliefs are based on a similar integrative physical and metaphysical model of life where spirits and ancestors play an active part according to the conduct of the people. In the early years of British Administration Fijian secret societies and cannibalism were outlawed, but many still believe in and fear the sorcery of 'drua ni kau', which means 'a leaf' and refers metaphorically to personal items left behind that could be used in ritual sorcery to generate a curse to induce weakness, insanity, illness or death. The colonial administration sought to protect the indigenous population from the effects of cultural transition and brought indentured Indian labourers to Fiji's sugar farms between 1879 and 1920. The plurality of Indian deities and cultural beliefs found resonance with *i-Taukei* beliefs of heath and illness, including the potential to incite malicious spirits. This highly exploitative labour scheme entailed profound disruption to the lives of people from disparate regions, castes and cultures. In 1890, suicide rates among indentured labourers were close to 16 times those in the Indian provinces from whence they had come. Now, after 100 years of cultural interaction, many folk beliefs are held in common. That the metaphysical world is potentially malevolent, all of the major communities of Fiji agree. During the colonial era, Fiji became a major regional hub as the headquarters of the British Western Pacific High Commission

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(1877–1953) and the major regional provider of health practitioner training. The introduction of psychiatric hospitalization in 1884 shaped Fiji's mental health services during the entire colonial era and beyond. Fijian villagers had long experience of mental distress and had been unable or unwilling to cope with the severely mentally ill. Hospitalization provided a new alternative based on the authority of the administration and its legitimization of medical interventions. For the last 130 years, St. Giles Hospital has been the locus of changing psychiatric practice. There is little evidence of traditional concepts of aetiology having any influence on the application of psychiatry in Fiji; however, at the community level, 'witchcraft' is often the first-line treatment for mental disorders, while demonic possession, not fulfilling customary obligations or being cursed, is still thought to be the common causes of mental illness. Recent mental health policy favours the establishment of general hospital psychiatric units and community care, now articulated in the 2010 Fiji Mental Health Decree (MHD). Incrementally, Fiji is moving towards a more humane and integrative approach to treating the mentally ill. Recent legislative and reform developments have been supported by training and capacity building and active membership of international mental health advocacy groups, resulting in strengthened consumer and caregiver rights and the application of principles of international practice.

Overview

Fiji is the easternmost extent of Melanesian populations and cultures. The adoption of the Polynesian chiefly system, with hereditary chiefs believed to be descended from Gods, produced a distinct form of Melanesian culture, although fundamental ontological beliefs remained distinctly Melanesian. These are best expressed in Fiji through the Vanua, an integrative physical and metaphysical structure of life inclusive of the land, the people (*i-Taukei*), their ancestors, plants and totems. The Vanua is an active contributor to daily life and may act in a benevolent or malevolent manner according to the conduct of its members. As elsewhere in Melanesia, such beliefs were not seen as inconsistent with Christianity, although the more severe applications of them were outlawed under the British Administration.

The British Administrations' introduction of the Indentured Labourer Scheme that brought Indian labourers to Fiji's sugar farms between 1879 and 1920 produced a demographic transition of historical importance. With the labourers came the plurality of Indian deities, cultural beliefs and practices that found some resonance with *i-Taukei* beliefs of health and illness, including the potential for shamans and traditional sorcerers to incite malicious spirits. The introduction of Western psychiatry in Fiji and the relative roles of *i-Taukei* and Fiji Indian explanatory models of mental disorder are discussed, as is the role of the British Administration in exercising its civil and perceived technical authority and for institutionalizing treatment responses.

Among Pacific countries, Fiji had the earliest contact with Western medicine. The introduction of psychiatric hospitalization moulded Fiji's mental health services during the entire colonial era (1874–1970) and beyond. St. Giles Hospital, established at Suva in 1884 as the Public Lunatic Asylum (Leckie 2004a), was renamed the Suva Mental Asylum in 1935 and, in 1960, became St. Giles Hospital. As lunacy legislation applied universally, a separate mental hospital for Europeans was not established, although Europeans, dominant in the colonial political economy, claimed special privileges, including treatment within the asylum (Leckie 2012).

In providing both therapeutic and custodial roles for the last 130 years, St. Giles was the focus of changing psychiatric practice, from the moral treatments of the ninetieth century, electroconvulsive therapies in the early twentieth century, psychotropic medications in the 1950s, outpatient services in the 1960s and, more recently, community outreach and general hospital psychiatry. Despite a 'strong beginning with an outpatient service' in the early 1960s (Wilson 1965), Fiji was slow to adopt deinstitutionalization, general hospital psychiatry and community care and continued to rely on hospitalization, based on the acceptance of the medical model of mental illness and pressure from communities unable to manage disturbed individuals.

After 100 years of cultural interaction, many folk beliefs are now held in common, including concepts of illness, wellness and treatments (Leckie 2004b, Parke 1995). Like many Pacific peoples, the *i-Taukei* has incorporated Christian beliefs into their culture, such as the power of prayer in overcoming illness or to negate demonic intrusions. The Indian community is largely Hindu, and its eclectic belief systems incorporate all metaphysical powers, including Fijian witchcraft. The Muslim community's faith requires ritualized defences against evil. That the metaphysical world is potentially malevolent, all of the major communities of Fiji appear to agree.

Fijian Pre-colonial Belief Systems

The pre-colonial *i-Taukei* culture entailed some brutal practices that must have generated considerable stress in individuals. The anthropological literature identifies ritual practices of cannibalism and the ceremonial disposal of human life, and secret societies with intricate initiation rites. Lester (cited in Whitman 1950) quoted a Fijian chief in 1909 describing the strict taboos governing initiates, the strictest being that, 'No man may tell of his experiences. The penalty of breaking any of the sanctions is insanity followed by death'. European accounts of Fijian pre-colonial belief systems need to be treated with caution as they overlooked the everyday practices of caring and healing.

Secret societies and cannibalism were outlawed by the administration, although Thompson (1908 cited in Gluckman 1969) stated that witchcraft was 'never absent from the mind of a Fijian'. Gluckman (1969) discussed 'drua ni kau' which, in

Fijian, means 'a leaf' but refers metaphorically to personal items left behind that could be used in ritual sorcery. Drua ni kau could include any item such as leftover food, hair, clothing or any personal item over which a curse could be generated. William (1860) and Lambert (1942), both cited in Gluckman (1969), listed several forms of drua ni kau that could be used to induce the death or illness of a victim.

The Era of Colonial Administration

During the colonial era, Fiji became the crossroads of the peoples of the Pacific and a major regional hub as the headquarters of the British Western Pacific High Commission (1877–1953). Many developments in Fiji impacted on the countries of the region. In the health sector, Fiji became the major regional provider of health practitioner training, after the acceptance of regional students in 1929 at the Central Medical School, the former Suva Medical School and subsequently, in 1961, the Fiji School of Medicine.

The Commission's approach to native administration meant that the bulk of the *i-Taukei* population would retain a rural subsistence economy and lifestyle, although the well-connected and educated could enter the waged economy. This paternalism was premised on the idea that the native population could be insulated from the pressures and evils of modernization. Tuke (1878) had expressed the opinion that cultural transition entailed risks of generating irresolvable stresses and would result in madness among those exposed. This notion remained a favoured theory well into the twentieth century and is also evident in the early Papua New Guinea literature (Seligman 1929).

Fijian villagers had long experience of mental distress and at times had been unable or unwilling to cope with the severely mentally ill (Leckie 2004a, 2010). Hospitalization provided a new alternative based on the authority of the administration and its legitimization of medical interventions. Fijian officials, with either state or customary roles, were assisted by providing the evidence needed for the certification of an individual as insane and requiring hospitalization, exemplifying the pivotal role that Fijian administrators had in support of the authority of Western medicine.

Indentured Indian Labour

As the *i-Taukei* remained in the subsistence economy, the administration imported labour to drive economic development. Between 1879 and 1916, 60,965 *Girmitiyas* were indentured from India to work in the Fiji sugar industry (Lal 1983). This highly exploitative scheme entailed profound disruption to the lives of people from disparate regions, castes and cultures. Most migrants were Hindu although approximately 15% were Muslim. Cultural estrangement, the traumatic recruitment

process, the voyage to Fiji, separation from family and the hardships of plantation life compounded their vulnerability to mental illness (Lal 1985; Leckie 2012).

Lal (1985) found that the annual death rates during the indentured period reached 0.83 per 1000, the highest among all colonies employing indentured Indian labourers. In 1890, suicide rates were close to 16 times those in the Indian provinces from whence they had come. After their period of indenture expired, many were repatriated to India (until 1951), some became destitute and some were committed to the asylum, while the majority who remained formed new communities and a distinctive Fiji Indian culture and language. They continued as the mainstay of the sugar industry, but were unable to own the land they farmed. In recent years as the sugar industry has declined, many have moved to peri-urban squatter settlements to seek employment.

Concepts of Mental Illness and Treatment

Fijian words for mental disturbance predated contact with Western medicine (Capell 1941). Early accounts of mental illness in Fiji have focussed on the supernatural. Missionary and colonial officer accounts highlighted the malevolent side of some healing rituals (Thomson 1908; Brewster 1922), which fell under the British prohibition on sorcery and witchcraft. Traditional healing secretly persisted, as documented by Spencer's (1941) fieldwork in the interior of Viti Levu during 1935–6. Diseases (*mate ni vanua*) caused by ancestral spirits (*vu*) included 'disease of the head' and madness. Illness was attributed to a disturbance of the spirits, but Spencer (1941) identified the primary cause as sociological or a failure to fulfil obligations or conform to cultural norms, a view of disease aetiology common in Melanesia. Personal psychological distress was embedded in the community, and although illness was embodied in individuals, its expression was a component of a 'community forum' (Becker 1995).

Less literature is available on Fiji Indian concepts and practices of health and illness (Singh 1986), but belief in spiritual causes and spirit possession were prevalent, as in India (Fabrega 2009). Although they might attribute madness to malevolent gods and goddesses (Kali among the Hindu, or Shaitan among the Muslims), they, at times, believed they were victims of *drau ni kau*.

I-Taukei and Fiji Indian healers (*vuniwai and ojha*) applied spiritual interventions as treatments and used herbs, medicines, massage, fasting and diet to treat the mentally unwell. Narayan (1974) listed treatments for mental illness that included prayers, worship, holy scripture, talismans, drinking the washings of sacred writings and offering *yaqona* to the Vanua (Singh 1986). Indian immigrants brought Ayurvedic treatments to Fiji during the indenture period. Women have played a key role in the continuation of *i-Taukei* medicine through *Wainimate*, the organization representative of traditional healers. Herr Harthorn's (2005) research in Lau during 1979–1980 on anxiety and depression suggested status and gender-based manifestations of anxiety and depression.

The Advent of Western Psychiatry

Western medicine was introduced by Christian missionaries and then institutionalized by the colonial state. Fiji's colonial health systems and institutions emerged from Victorian Britain was influenced by colonial experience elsewhere. The discourse and practices of colonial psychiatry were applied across the transnational colonial service. Dr. William MacGregor's pivotal role in establishing Western medicine in Fiji reflected his previous appointments at the Aberdeen Royal Lunatic Asylum and as Superintendent of the Lunatic Asylum in Mauritius. While serving as Fiji's Chief Medical Officer (1875–88) and as Colonial Secretary, he established the Fiji Native Medical School and recruited Scottish medical graduates to Fiji (Joyce 1971).

MacGregor and his colleagues implemented what they considered a humane, civilized health system. The 1884 Public Lunatic Asylum Ordinance mirrored developments in Britain, Australia and New Zealand and legislated against illegal detention, requiring detailed certification from a doctor and a stipendiary magistrate, or two doctors for private patients. Testimony of madness might include evidence from patient and family histories and from the *i-Taukei* provincial or district administrator, village chiefs, religious leaders, police, local magistrates, teachers and employers.

Patient admissions to St. Giles before World War I comprised relatively similar proportions of *i-Taukei* and Fiji Indians. Europeans and other ethnic groups accounted for around 15% of admissions before 1900 but decreased thereafter. After 1914, the number of Fiji Indian admissions was higher than for other ethnicities until the 1960s, possibly reflecting the destitution and family disruption among former *Girmitiyas*. MacGregor (Ministry of Health 1967) attributed rise in the admission of Indians to their greater urbanization and 'pre-eminence in all business matters' and characterized them as 'acquisitive, litigious and hypochondriacal', although many were tenant farmers and labourers, vulnerable to suicide (Price and Karim 1975; Ree 1971; Haynes 1984; Lal 1985).

Wilson (1965) suggested that Fiji Indians were more 'Europeanized' and lacking the communal support within Fijian villages and hence more likely to access medical facilities (Leckie 2010). The question of the impact of transition to the modern world was raised again. Macgregor (Ministry of Health 1967) suggested that the *i-Taukei* had preserved a 'peace of mind' because they were unwilling to enter the commercial 'rat race'. After World War II, the *i-Taukei* were admitted to St. Giles at a higher rate than Fiji Indians and other ethnicities. From the early 1960s, Fiji Indians accessed hospital outpatient services, which may account for their declining rate of hospitalization. The Director of Medical Services suggested that by the late 1960s St. Giles was 'becoming not merely a place of detention but a place of cure and rehabilitation among Fijians' (Legislative Council Paper 39/69 1969).

By the 1970s, the admission numbers in the two major ethnic groups (Murphy and Narayan 1979) were more comparable. By 1970, Fijians were increasingly

participating in the paid workforce and migrating to urban areas. Historical evidence (Leckie 2004a, 2010) points to shifting assumptions about mental illness, the boundaries of tolerance of unacceptable behaviour and the provision of care: consistent with the increase in Fijian admissions.

Epidemiology of Mental Disorders

Hospital admission statistics offered a limited epidemiology as they covered only the small percentage of the population certified as insane or of unsound mind. Inpatient numbers were small because bed numbers were capped, although often exceeded. Fiji conducted a crude attempt to determine the extent of mental illness in the population by a question in census collections in 1911, 1921, 1936 and 1946 (Berne 1959a). The censuses between had contained the question: *'State the name of any person in this dwelling or establishment who is (a) Totally blind (b) Nearly blind (c) Dumb (d) Lunatic, imbecile or feeble-minded.'* Despite significant limitations, Berne considered the figures for this 'psychiatric census' to be the best available anywhere in the world for large 'primitive' populations' (Berne 1959b).

Berne calculated that the prevalence of psychiatric disorders fell between 1911 and 1921 and remained fairly constant for the next 25 years. As the *i-Taukei* had undergone greater social change than Fiji Indians, he was perplexed as to why the prevalence of psychiatric disorders had decreased among the *i-Taukei* (Berne 1959a), contrary to Tuke's (1878) theory of the risks of cultural transition. Berne then incorporated various official data to determine an incidence rate of mental illness—concluding similar rates of psychiatric disorders among Fiji's two main ethnic groups (Berne 1959a, b), which reinforced his position of no causative link between culture, history or geography and mental illness.

No national epidemiological data on the prevalence of mental disorders exists in Fiji. Using WHO estimates, approximately 14,000 people will have a severe mental disorder (3% of the adult population) and approximately 48,000 people will have some form of a mild-to-moderate mental disorder (10% of the adult population) (Sing et al. 2013) in their lifetime. As a crude measure, the comparison of these WHO estimates to the number of people attending clinics at St. Giles Hospital suggests a 90% treatment gap for mental disorders in Fiji, compounded by local misconceptions surrounding mental illness that lead people to seeking alternative treatments first (Chang 2011).

Aetiology and Nosology

Concepts of aetiology and nosology in colonial Fiji reflected changes in Europe, where during the late nineteenth century both organic and moral explanations of insanity coexisted and in the early and mid-twentieth century functional

psychodynamic aetiologies were proposed. The scientific classifications of mental disease have reflected changing theory within psychiatry itself (Berrios 1996). In 1938, Fiji's patients were categorized under a 'modern classification' that recognized manic depression (Ministry of Health 1939), and the subsequent global shift in nosology from manic depression to schizophrenia was replicated in Fiji as schizophrenia leapt from four cases in 1944 to 1996 in 1956.

There is little evidence of traditional concepts of aetiology having any influence on the application of psychiatry in Fiji; however, the culture-bound syndromes were studied as elsewhere in the Pacific. In 1965, a syndrome was reported as 'on the borderline of clinical acute mania' (Ministry of Health 1965). MacGregor interpreted this as a form of transient mania, which had been observed in Malaysia and Papua New Guinea and variously described as amok, hysteria or mania. Similarly, the condition known locally as *Matiruku* (Price and Karim 1978) was defined as a manic condition.

Transcultural psychiatrist, H.B.M. Murphy, was commissioned by the South Pacific Commission to survey mental health conditions in the region during 1977. Murphy and Narayan's (1979) study of hospitalization between 1972 and 1975 found that the *i-Taukei* were more likely to be admitted for mania, while Fiji Indians were more prone to depression. Macgregor (SPC 1967) provided an example of how different cultures exhibited depression: '*I have found that depressive illness is very liable to present as something else: the Fijians start off with a fighting frenzy, the Indians with a paranoid reaction and the Europeans with a severe anxiety*'. Karim and Price's (1976) study of psychiatric patients, followed up between 1965 and 1971, suggested that schizophrenia was more common in the Indian population, although hospital-based studies do not describe population prevalence.

Although researchers were intrigued by the racial dimension to psychiatric epidemiology, they paid less attention to gender (Leckie 2005a, 2007). Before World War II, women comprised about 25% of admissions, but between 1955 and 1960, males and females had almost equal admission rates. Women tended to have shorter hospital stays than men. Gender and mental disorder followed similar patterns to elsewhere, except in Fiji it intersected with ethnicity. More Fiji Indian than *i-Taukei* females were admitted to the hospital during the colonial era and gendered differences figured prominently in aetiology and evidence. Women's mental instability was linked to gendered and ethnic role expectations of family and work and linked with reproduction.

Medical and nursing programmes in mental health used the American Diagnostic and Statistical Manual of Mental Disorder (DSM) classifications. St. Giles Hospital also used DSM classification until the development of the Patient Information System (PATIS) in 2004, which uses the International Classification of Diseases (ICD 10), in line with the Ministry of Health's classification of other medical conditions.

Changing Treatment Responses

Fiji's medical experts reflected global psychiatric treatments, from occupational and craft therapies to the biomedical revolution of interventionist therapies (Leckie 2005b). Electroconvulsive therapy (ECT) was in use by 1947 and insulin and cardiazol coma therapies followed. These were administered to patients with a wide range of conditions, including epilepsy. Coma therapies fell out of favour internationally, but ECT has remained a key psychiatric therapy at St. Giles.

As theories of the organic aetiology of psychiatric disorders gained strength after World War II, doctors ordered more laboratory tests to determine organic causes of mental illness, but few of the psychological tests for functional aetiology were applied. These were expensive, time-consuming and required expertise and methodological validation for cross-cultural application. Treatment depended on pharmacology and socialization was provided though hospital activities of occupational and group therapy. Little was offered in the way of psychotherapy.

Psychotropic drugs became the cornerstones of the 'therapeutic revolution', as reported by Macgregor (Legislative Council Paper 39/62 1962). The major tranquilizer and antipsychotic drug chlorpromazine, introduced to Fiji in 1955, offered the possibility for many patients to be discharged from hospital and treated in communities and was an effective tool for inpatient management. The downside, as Macgregor found, was 'numbing patient motivation' (Ministry of Health 1967). New drugs introduced during the 1970s included lithium carbonate and the injectable phenothiazine, fluphenazine. International pharmacology efforts continued, driven largely by the need to reduce the side effects of the phenothiazines, and in 1999, olanzapine, an atypical antipsychotic drug, was introduced and registered on Fiji's essential drug list, followed by fluoxetine in 2006; risperidone (an antipsychotic) in 2012; and sertraline (an antidepressant) and lorazepam (an anxiolytic) in 2013 .

However, at the community level, witchcraft are often the first-line treatment for mental disorders, while demonic possession, not fulfilling customary obligations or being cursed, is still thought to be the common causes of mental illness (Aghanwa 2004).

Suicide and Ethnicity

Fiji has also long offered a case study in the correlation between suicide and ethnicity. During the period of indenture, the higher suicide rates among *Girmitiyas* of Fiji compared to indentured Indian labourers in other colonies were attributed to gender disparity and sexual jealously due to an imbalance of the genders (Lal 1985; Leckie 2012). Lal found that 300 Indians had committed suicide between 1884 and 1925, that the suicide rate for males was twice that for females and that the high rate of 78 per 100,000 in Fiji compared to a low 5 per 100,000 in the provinces in India

from whence they had come, and that the rate was higher among Hindus than Muslims.

Suicide was not only limited to the Fijian Indian population, as Gatty (2010) found historical evidence of suicide among indigenous Fijians and Europeans as well (Leckie 2012). Although researchers have used different approaches, they agree on the high rates of suicide among Fiji Indians in the twentieth century (Haynes 1987; Price and Karim 1975; Ree 1971) increasing between 1965 and 1990, especially among young Indian women (Booth 1999).

This raises the question as to whether or not suicide among the Indian population of Fiji's past has had an intergenerational effect. Roberts et al. (2007) reviewed a caseload of 132 persons who had attempted suicide in the two-year period 2004 and 2005 in Western Viti Levu. Seventy-five per cent were under age 32, 90% were Indo-Fijian and 66% were female, all of these characteristics significantly over-represented compared to the source population.

The Post-independence Period from 1970 to 1987

In 1970, C.H. Gurd, the Secretary of Health, declared that 'medicine in Fiji is on the march'. He also warned that although Fiji had not yet reached the dimension of psychiatric diseases experienced by developed countries, 'the dark clouds are gathering on the horizon and there is no room for complacency in the matter' (Parliamentary Paper 17/72 1972). During the decade prior to independence, localization was apace in the public sector, albeit slowly within the professional levels. Dr. Issac Karim was the first full-time Fiji Indian medical officer at St. Giles in 1962, but it was not until 1982 that an indigenous Fijian joined the staff.

The prognosis of a brave new future for Fiji's medical services was challenged after independence. Health funding was stretched, including for mental health, despite the demands of a growing population, urbanization and widespread economic and social change. Centralized psychiatric facilities continued, but with a growth of outpatient services and an emphasis on community care. As in colonial times, district nurses with no training in mental health provided much of the front-line care throughout Fiji's islands.

More biomedical psychiatry was introduced into the curricula for doctors and nurses. The first qualified psychiatric nurse was appointed to St. Giles in 1970, and during the following decades modern nursing techniques were introduced as more nurses joined staff. Fiji was also emerging as a leader in the Pacific and participated in psychiatric symposia. Linkages with Australia and New Zealand became more significant after 1970 with staff from Fiji training there and overseas consultants working in Fiji.

Dr. Ram Narayan, appointed in 1974 as the first local medical superintendent at St. Giles, made significant observations on the persistence of traditional healing and how this fused with psychiatric therapies. 'The element of suggestion plays a large

part as it has done in Western medicine; and an intelligent doctor recognizes this
and uses it to make his treatment more effective' (Narayan 1974).

Recent Policy and Legislative Developments

After the 1987 *coups d'etat,* mental health services remained centralized at St. Giles
Hospital, run by local medical practitioners without any formal training or quali-
fications in psychiatry. Since then, there have been two periods of rapid develop-
ment in mental health. The first was from 1997 to 2000 and the second, from 2006
to 2010, which continues to a lesser extent to date. These phases of advancement
were due to the individuals who headed mental health services during these times.
In 1997, a Nigerian psychiatrist, Dr. Jude Ohaeri, took charge and was instrumental
in providing a vision of services that extended beyond treatment at St. Giles
Hospital. While the use of medications and ECT was foremost, a new focus began
on developing community and rehabilitative services through a community psy-
chiatric nursing team (CPN) and a day care centre, both commenced in 1997 but
were still based at the psychiatric hospital.

In 1997, a Technical Working Party on Mental Health (TWPMH) was formed
and continued as the National Advisory Council for Mental Health (NACMH). This
was the first time in recent years that mental health had been formally represented at
Ministry of Health executive level and that serious consideration was given to the
advancement of Fiji's mental health services. In 2001, the five-year mental health
plan formulated by the TWPMH was finalized. During this time, the National
Committee for the Prevention of Suicide (NCOPS) was first convened to combat
the growing epidemic of suicide among young people. NCOPS was formalized in
2003 and provided with annual government funding.

The WHO-sponsored mission to Fiji to discuss the revision of the Mental
Treatment Act 1978 identified the need for new mental health legislation and for
service reform. The Cruz Report (2004) reviewed existing functions and respon-
sibilities of the Ministry of Health in relation to the care, treatment and rehabili-
tation of the mentally ill. The necessity to strengthen and expand already existing
community mental health services and the need for a national mental health advisor
to coordinate mental health activities were also identified.

The second phase began in 2006, led by Fiji's first local female psychiatrist, Dr.
Odille Chang, and focused on the development of new mental health legislation,
decentralizing mental health services by strengthening and expanding community
services and staff capacity building in mental health and mental health awareness
and destigmatization campaigns.

The 2006 *coup d'etat* led to the withdrawal of donor funding for legislative
reform, which delayed the development of new legislation. To a large extent,
service developments became focused on integration with general health services
and the establishment of mental health non-governmental organizations (NGOs).
These include the Psychiatric Survivors' Association (PSA) in 2004, Youth

Champs for Mental Health (YC4MH) in 2007 and the Fiji Alliance for Mental Health (FAMH) in 2009, all supported by St. Giles Hospital. The formation of these groups has highlighted the need for community support and mental health education and awareness; consumer and caregivers' rights; and the need for preventative and rehabilitative services.

The most important achievement has been the formulation of new mental health law reflecting much of the work of NACMH and NCOPS, which is now articulated in the 2010 Fiji Mental Health Decree (MHD). The Mental Treatment Act 1978 is only related to treatment within St. Giles Hospital and included few references to patients' rights. The MHD also focuses on the prevention of mental disorders and on mental health awareness and encourages the development of psychosocial, rehabilitative and community psychiatric services. It places strong emphasis on consumer and caregiver rights and incorporates basic principles of international practice concerning human rights and disability.

The 2010 MHD also formalized the beginnings of general hospital psychiatry through the creation of 'Stress Management Wards' (SMW) in each of the three main divisional hospitals, and the Ministry of Health has set up community rehabilitation centres to work in conjunction with the SMWs. The 2010 MHD also introduced the Mental Health Review Board (MHRB) which allows for regular review of inpatient and community treatment orders and for appeals against involuntary treatment orders.

Recent Hospital and Outpatient Services Use

Admissions to St. Giles from 1994 to 2007 showed a 53% increase in outpatients and a 56% increase in total admissions (Singh et al. 2013). These large increases have been attributed to increased public awareness of mental disorders and improved diagnosis and referral systems. *i-Taukei* males account for the highest proportion of admissions (30–40%) annually, while Indo-Fijians predominate in outpatient services, accounting for almost 50% of all outpatient contacts (Ministry of Health 2010, 2011). The predominance of *i-Taukei* male inpatients is attributed to their more disruptive and aggressive presentation and to increased referrals from the judiciary and prison services.

Regular outpatient clinics are held at the western and northern divisional hospitals with support from St. Giles Hospital. Outreach mental health clinics are conducted at health centres and subdivisional hospitals in the central, western and northern divisions. Outreach is supported by the Mental Health Clinical Services Network formed in 2007 of staff of St. Giles Hospital, the divisional hospitals and the community health services (WHO MIND series 2009).

Staff Development and Regional Networking

Recent legislative and reform developments have been supported by training and capacity building. From 2006 to 2008, AusAid supported modular training in mental health for public health nurses and the appointment of mental health project officers in each medical division. James Cook University commenced a post-basic nursing certificate in mental health from 2006. A postgraduate diploma in mental health nursing is now available. The training of nurses is crucial to strengthening the care for psychiatric patients in the community, although delays in deploying graduates are due to systemic nursing shortages in other areas.

In addition to nursing programs, the Fiji National University has commenced a postgraduate diploma in mental health for doctors, social workers, counsellors and nurses, and work has commenced on preparing a Master of Medicine (Psychiatry) for doctors.

Fiji is a member of the Pacific Mental Health Network (PIMNet) established in 2007 which supported the first national consultation on mental health policy and supported community outreach clinics by visiting psychiatrists. In 2009, Fiji was recognized by the Asian Federation of Psychiatric Association (AFPA) of the World Psychiatric Association (WPA) with an excellence award for its role in improving mental health services through basic training (Singh et al. 2013).

Conclusion

British colonial Fiji adopted Western medicine and psychiatry without any community discussion, and so many traditional beliefs remain. The alternative to coping with a disturbed person in the community determined St. Giles Hospital's role as a repository for difficult people, many of whom were perceived from a traditional perspective to be the victims of sorcery. St. Giles Hospital has been the mainstay of mental health services since their inception, but incrementally, Fiji is moving towards a more humane and integrative approach to treating the mentally ill. As public awareness increases, we can reasonably anticipate that services will move closer to communities, support families and reduce the reliance on psychiatric hospital admission.

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Chapter 17
Mental Health in the Smaller Pacific States

Jacqueline Leckie and Frances Hughes

Abstract This chapter traces changing patterns of mental health and its provision within the smaller Pacific Islands. Although small and distant from Europe, some people living within precolonial Pacific cultures suffered from stress and mental illness. This chapter emphasizes indigenous conceptions of Pacific minds and mental health and the entanglement with Western biomedicine, psychiatry and global mental health structures. The smaller nations in the Pacific are covered—American Samoa, Cook Islands, Federated States of Micronesia, French Polynesia, Kiribati, Marshall Islands, Nauru, NewHawai Caledonia, Niue, Northern Mariana Islands, Palau, Tokelau, Tonga Tuvalu, Samoa, Solomon Islands, Vanuatu, Wallis and Futuna—but not Fiji, Papua New Guinea and Hawai'i. This chapter begins with the discussion of indigenous conceptions and treatment of mental illness within the Pacific Islands. We then examine the introduction of mental health infrastructure and biomedicine into the region. The Islands also attracted researchers who offered divergent interpretations of mental health epidemiology among Pacific cultures. The second half of this chapter focuses on contemporary health provision in the Pacific. Global mental health structures have been directed through the Pacific Islands Mental Health Network (PIMHnet), launched in 2007. Despite this, mental health within the small islands of the Pacific region continues to receive low priority, competes for scarce resources, faces problems of isolation and struggles to be recognized at all levels of government and society. Indigenous communities still rely heavily upon traditional treatments and support—offering some resilience but also presenting challenges for contemporary health initiatives.

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Introduction

The Pacific Islands are still marketed as a faraway destination where the stresses of modern life, often considered conducive to mental illness, can be escaped. Europeans during the nineteenth century held similar stereotypes, but they also speculated about the nature of the 'primitive mind'. Pacific Islanders were variously conceived as innocent, in harmony with nature, unfettered by madness or pathologized as malevolent, savage, uncivilized or insane. These contradictory representations reflect the mindset of the writer.

This chapter emphasizes indigenous conceptions of Pacific minds and mental health and the entanglement with Western biomedicine, psychiatry and global mental health structures. This bears the legacy of European historical representations of the Pacific. Smallness is a key feature of how the Pacific Islands have been viewed—and indeed frames this chapter—the smaller Pacific states. Although the Pacific Ocean constitutes almost half of the globe, many see it as made up of peripheral, remote, and tiny islands. Anthropologist and novelist, Hau'ofa (1993), instead envisioned the Pacific as a holistic and inclusive 'sea of islands'.

This chapter includes American Samoa, Cook Islands, Federated States of Micronesia, French Polynesia, Kiribati, Marshall Islands, Nauru, New Caledonia, Niue, Northern Mariana Islands, Palau, Tokelau, Tonga, Tuvalu, Samoa, Solomon Islands, Vanuatu, Wallis and Futuna. Today, most are sovereign nations or in free association with a former colonial power. Although Tonga was an independent monarchy, it was influenced by colonialism, including a Treaty of Friendship with Britain between 1900 and 1970. Several Pacific Islands remain as dependent territories: New Caledonia, French Polynesia and Wallis and Futuna with France, Tokelau with New Zealand, Norfolk Island with Australia, Pitcairn Island with the UK and Guam, Northern Mariana Islands and American Samoa with the USA. Our information on mental health in the smaller states is fragmentary (see also Allen and Laycock 1997), compared to that in the chapters of Fiji and Papua New Guinea in this book. Hawai'i, although a Pacific state, is not addressed because health practices there are enmeshed with mainland USA (for historical background on the Pacific, see Denoon and Firth 1997; Howe et al. 1994; Lal and Fortune 2000).

Smallness is relative within the states covered here. There is a huge variation in land mass and terrain between, for example the tiny atolls of Tuvalu and that of Grande Terre, the mountainous island in New Caledonia. Tiny pockets of land can embrace vast maritime resources. Kiribati (formerly Gilbert Islands) spans 32 atolls and an island comprising 811 km^2 but commands a maritime zone of 3.55 million km^2. Pacific Island communities have been dependent upon the sea, sometimes more than land, for livelihoods and resources (D'Arcy 2006). Demographics are also deceptive. Today, the Solomon Islands has over 500,000 inhabitants, while the figure of approximately 15,000 in the Cook Islands does not include an estimated 62,000 in New Zealand and 30,000 in Australia of Cook Islands Māori (note Macron) ethnicity.

The perceived and real remoteness of the Pacific from Europe had implications for how Western biomedicine and psychiatry were transferred there. The late coming of this intervention replicated the region's late entry into the history of colonial exploitation. The Pacific colonies were considered peripheral to metropolitan centres preoccupied with larger, richer colonies. Perceived tiny populations, living traditionally and in harmony with nature, did not warrant substantial investment on medical infrastructure. Some colonial officials did urge attention to mental health—initially to manage 'lunatics' and later to address mental illness that was exacerbated by dislocation and modernization after World War II.

This chapter traces changing patterns of mental health and its provision within the smaller Pacific Islands. It begins with a consideration of indigenous conceptions and treatment of mental illness and then examines the introduction of Western mental health infrastructure and biomedicine. The Islands also attracted researchers who offered divergent interpretations of mental health epidemiology among Pacific cultures. The second half of this chapter focuses on contemporary health provision in the Pacific. Global mental health structures have been directed through the Pacific Islands Mental Health Network (PIMHnet), launched in 2007. Despite this, mental health within the small islands of the Pacific region continues to receive low priority, competes for scarce resources, faces problems of isolation and struggles to be recognized at all levels of government and society. Indigenous communities still rely heavily upon traditional treatments and support—offering some resilience but also presenting challenges for contemporary health initiatives.

Indigenous Conceptions and Treatment of Mental Illness

Hau'ofa (1993) inverted Eurocentric stereotypes of the Pacific as small separate small islands to emphasize the ocean's material and symbolic connectedness and the ecological, genealogical, cultural, linguistic and spiritual commonalities between Pacific peoples. This embraces indigenous concepts of mind, body and health. Capstick et al.'s (2009) review of health beliefs in Polynesia found similarities in health conceptualizations throughout Pacific cultures as distinct from biomedicine. Pacific views of health are often termed traditional but this suggests timeless, unchanging cultures. It assumes past concepts, and practices were the same as today—overlooking change, indigenous agency and the entanglement and hybridization of local and extesystems (Hau'ofa 2000, Stuart 2006).

European representations of Pacific cultures as primitive and innocent corresponded with assessments that madness was rare in primitive societies. Transcultural psychiatrist, Murphy and Taumoepeau (Vaiola Hospital, Tonga) (1980), quoted Daniel Tuke (1878): 'A South Sea Islander might be much more ignorant than the Wiltshire labourer and yet not so circumscribed that he would transgress the laws of mental health'. How prevalent then was mental illness among the Pacific cultures before European contact?

Common assumptions about mental illness extended across most Pacific cultures. As is common today, the diagnosis and treatment of mental distress depended

upon assessing the social and spiritual and ancestral worlds, to restore individual and community wellness. Disease and disability are rarely separated from social life within Kanak society (Mouchenik 2007). Similarly, 'doing sickness' among Samoans aims to re-establish spiritual wholeness, for the sick person and the social group, through the process of caring for and curing the individual (Kinloch 1985). This applies to several Pacific cultures. Concepts of individual and group emotional conflict were entangled among the A'ara in Santa Isabel, Solomon Islands, where White (1985) found similarity between 'disentangling' emotions and Western psychotherapy or group therapy.

Linguistic evidence of mental disorder was recorded within Polynesian languages. It is impossible to identify similar details from all the indigenous languages in Melanesia and Micronesia that were home to hundreds of distinct languages. Anthropologist, Poltorak (2007), discusses early nineteenth-century Tongan terms for mental illness—*i fakasesele* 'to act in a silly or eccentric manner' and *vale,* foolish, silly, ignorant, unskilled, incapable, incompetent (Churchward 1959), translated as mad, insane, crazy and delirious. Other terms less common today included *faha* (mad or insane), *'atamai vale* (dull or stupid) and *mahaki sesele* (to suffer from mental disease or insanity). Tongan psychiatrist, Mapa Puloka, rejects the term *fakasesele*, preferring *uesia faka'atamai* ('mental suffering') (Poltorak 2007). This indicates the problems in applying historic terms to the present and transferring indigenous concepts of mental states into psychiatric diagnoses.

Differing terms have also been applied to Samoan concepts of mental distress. Dorothy Clement's (1982) study in Tutuila, American Samoa, reported severe mental illness as *mai valea*, also glossed as mad, insane or stupid. *Mai'i o le māfaufau* were conditions due to brain abnormalities and *ma'i aitu* or *ma'i fasa* were caused by spirit possession. Terms for conditions of 'excessive emotion' included *ma'i popole* (worry sickness or depression), *ma'i manatu* (sadness, depression) and *ma'i ita* (excessive anger) (Clement 1982).

Noricks (1981) identified *fakavalevale* as a generalized term for 'crazy' in Niutao, Tuvalu (formerly Ellice Islands), that embraced social transgressions, inability to work, spirit possession and more bizarre behaviour.

Mental distress within Pacific cultures is still widely associated with supernatural or ancestral spirits, despite condemnation by some Christian churches (Clement 1982) and cynicism among many medical practitioners. Puloka (1999) qualifies *avanga*, the popular term for spirit possession in contemporary Tonga, as *avanga musiku*, emphasizing an acute psychological nature. The more chronic *avanga motua* is considered by some Tongans as a form of lunacy and can be caused by a curse. *Tūpāpaku* (spirit illness) among Cook Islanders may also be inflicted by a curse (Baddeley 1985).

Although crazy behaviour associated with spirit possession could reflect an individual's past wrong actions or moral transgressions, the blame was usually attributed to the spirit, which reduced individual stigma (for Tonga, see Cowling 1990; Puloka 1997). Treatment of *avanga musiku* centred on breaking the connection between the 'possessed' and the spirit. This might involve squeezing plant extracts into the eyes, nostrils, mouth and ears of sufferers , massage or engaging

Christian healers (Cowling 1990; Jilek 1988; Parsons 1983; Poltorak 2007, 2010). Indigenous healers were widely utilized throughout the Pacific to treat not only spirit possession but also other forms of mental illness (Murphy 1978). (For accounts of healers elsewhere, see Baddeley (1985)—Cook Islands; MacPherson and MacPherson (1990)—Samoa; Wilson (1980)—Trust Territory of the Pacific Islands; Petrosian-Husa (2006)—Marshalls; and Mouchenik (2007) and Salomon (1993)—Kanaks in New Caledonia.) Wolfgang Jilek (1988) suggests that in Tonga, epilepsy was untreated because it was considered a hereditary condition and not amenable to therapy. In many Pacific cultures, the mentally disturbed were tolerated and left alone especially if their behaviour was not troublesome (Cowling 1990). Violent behaviour may have warranted physical restraint.

Suicide is an extreme of mental suffering but not necessarily linked with mental illness. In the nineteenth century, Europeans reported instances of suicide by Pacific Islanders (Hezel 1984). Hezel (1987) observed that suicide was an established cultural response within Micronesian cultures, especially when withdrawal rather than confrontation was a response to serious interpersonal problems.

Psychiatry's Foothold: Colonial and State Structures

Today, the small Pacific states offer limited facilities for the care of the mentally ill. This is a legacy of colonial neglect of mental health when other health issues were prioritized within meagre budgets. The relegation of health care to communities, churches, healers and families continued within newly independent states. Islanders often avoided hospitals that were considered sites of death.

Although fragmented, colonial health structures were the conduit through which psychiatry gained a foothold in the Pacific. Discourse and practices were transferred from the metropole via colonial offices, medical personnel and visiting experts. Linkages with Hawai'i, Fiji, Australia and New Zealand were significant, especially when staff trained there. Colonial authorities were concerned with the establishment of law and order. Lunacy legislation facilitated the confinement of the seriously mentally disturbed within mental hospitals.

The Pacific's earliest asylum was Oahu Insane Asylum, established in 1866, long before Hawai'i's annexation to the USA in 1898. France annexed New Caledonia in 1853, and l'hôpital du Marais, founded in 1868, treated migrant convicts. These included mentally ill patients, and in 1936, this hospital became the Nouville Asylum. Patients were European (Caldoche), Métis (mixed ethnicity) and, since World War II, Kanaks (Melanesian indigenous). In 1975, there were 52 Melanesians among 153 inpatients (South Pacific Commission 1976). It was renamed the Centre Hospitalier Spécialisé Albert Bousquet and today operates as a psychiatric and geriatric hospital (Leckie 2010). By the 1960s, a neuropsychiatric ward also functioned at Noumea's main hospital (South Pacific Commission 1967). Despite these psychiatric facilities, mental health care for most Kanaks was neglected until the 1980s (Mouchenik 2001–2002). In Tahiti, the other main French

Pacific colony, an asylum and lunacy ordinance was introduced in 1884–1885, soon after the colony's annexation in 1881 (Berne 1960b).

Colonial officials also pressed for the establishment of asylums in the British Pacific colonies. After a request in 1917 from the Gilbert and Ellice Islands, a mental hospital was built at Tarawa. The associated lunacy ordinance was revised in 1977, after the Gilbert and Ellice Islands became independent from Britain. Within the Solomon Islands, a lunatic asylum operated on the island of Tulagi from around 1933 until 1942 when Tulagi was bombed. A mental institution constructed in 1945 at Auki soon fell into disrepair. In 1956, the colony's mental health facility was established at Kukum near Honiara, but by 1978, the central psychiatric unit was relocated to Kilu'ufi Hospital in Malaita (Murphy 1978). District medical services treated psychiatric patients locally. Decentralization has been a feature of the post-colonial Solomon Islands administration, but this has resulted in fragmented psychiatric services, with the National Psychiatric Unit located some distance from the National Referral Hospital in Honiara (APCMHDP 2011). In the Condominium of the New Hebrides (1906–1980), health facilities were divided between French and British colonial rule, and a joint administration presided over by the King of Spain. This complicated arrangement separated health facilities, although a Joint Regulation for Restraint of Lunatics and a Condominium Mental Hospital on Efate were functioning by the early 1960s. Samoans were also divided between colonial administrations—American Samoa in 1899 and Western Samoa under German rule until 1914, then under New Zealand administration until 1962. In the latter, a 1961 Mental Health Ordinance was provided for involuntary treatment. A mental health unit was opened at Tupua Tamasese Meaole Hospital in 1970 (Tafuna'i et al. 1972) only to be dismantled by the 1980s and replaced mainly by a Home Care system, following practice in New Zealand and Australia (Peteru 1996). Insecure and violent patients were detained, sometimes for several months, at Apia prison. In Tonga, the police controlled a lunatic asylum in 1964–1976 (Jilek 1988) that was replaced by a psychiatric ward at the hospital. Incarceration of the mentally ill remains in today's Pacific Island states where psychiatric inpatient facilities are lacking.

Between 1947 and 1986, the Trust Territory of the Pacific Islands (TTPI) in Micronesia, a United Nations trust territory, was administered by the USA. The Division of Mental Health, created in 1969, instituted training programmes for indigenous personnel. Robillard (1987) argues that mental health services took a low precedence because of external and local influences. The replication of American federal services failed to meet local needs. Micronesian health coordinators found their work affected by local and hospital political alliances, clan or caste rivalries and family status. Although traditional healing practices were documented, they failed to be utilized by medical administrators (Murphy 1978). The American territory of Guam has also followed federal trends in mental health provision, and deinstitutionalization and community care were introduced much earlier than in other Pacific Islands, under the Community Mental Health Act 1963. Mental health funding throughout the American Pacific has been dependent upon

the US economy, and by 1979, services were slashed because of a federal fiscal austerity drive (White 1981).

The mental health legislation in the Pacific region introduced during the colonial years varied in comprehensiveness and coverage with some countries having minimal or no mental health legislation to protect the rights of people with mental illness. Legislation was fragmented and restricted to specific issues such as involuntary commitment. Mental health legislation could be implicated in other areas—in the Cook Islands, mental health law was embedded in the Crimes Act, while in the Marshall Islands, it was in the National Mental Health Planning Council By-Laws.

Islands of Research

By the 1950s, researchers and psychiatrists began to investigate the epidemiology of mental illness in the Pacific to test the hypothesis that modernization increased the rates of mental illness. Transcultural psychiatrists also investigated the universality of mental conditions, whether certain cultures were more prone to specific types of mental illness and the existence of culture-bound syndromes. Psychiatrist Eric Berne, who established transactional analysis, studied patients at mental hospitals in Fiji and Papeete during the late 1950s (Berne 1960a, b). This confirmed his view that there was no causal link between culture and mental illness and that aetiology, symptomatology, diagnosis and therapy could be transferred between cultures: 'Principles learned in the treatment of young women in Connecticut or California were just as effective in the South Pacific' (Berne 1960b). It seems he instructed Papeete physicians in cardiazol therapy. Berne acknowledged that 'Local prejudices are of great importance administratively, politically, sociologically, and economically, but there is no evidence that they are of psychiatric significance at the hospital level'(Berne 1960b).

In contrast, Murphy (1978) emphasized the cultural nuances of universal mental disorders, possibly because he included fieldwork in his survey of mental illness in the Pacific. He found much lower incidence and prevalence of major mental disorders than in many other parts of the world, especially developed countries. Murphy correlated the wide variations in admission rates of mental illness in the Pacific territories to the degree of modernization and social stress. He argued that higher rates prevailed in more modernized or individualistic (e.g. Guam, New Caledonia, American Samoa, Niue and the Cook Islands) as compared to 'communally orientated' societies (e.g. the Solomon Islands, Samoa and Tonga) (Murphy 1978). High rates of hospitalization in Kiribati were attributed to modernization via temporary domicile from seamen from international ships (Elisaia 1976). Overseas migration was also implicated in precipitating 'psychiatric morbidity' among Samoans, Cook Islanders and Niueans (Murphy 1978). Thus, 'rates (of mental illness) appear lowest where the percentage of the population following a subsistence economy is highest and tend to increase as the percentage in the cash

economy rises' (Murphy 1978). Murphy also tested the distance between admitting districts and hospital admission rates in Fiji, Solomon Islands, Tonga and the New Hebrides to dismiss inaccessibility as an explanation for the low Pacific Island rates and suggested that reluctance to hospitalize was not a sufficient explanation. Murphy (1978) admitted that 'acute transitory psychosis' was probably more common in the Solomon Islands than statistics indicated. Walters (1977), like Murphy (1978), suggested that mental illness was also under-reported in American Samoa. Jilek (1988) cautioned against relying upon psychiatric admission figures as indicators of the extent of psychiatric disorders in Tonga.

Researchers in Micronesia also attributed the gendered patterns of mental illness in the Pacific—notably higher reported rates, especially of psychosis, among males —to modernization. Hezel (1993) endorsed anthropological studies that argued that men faced greater social pressures, had less support and were subject to greater role changes and social dislocation than women. Women's domestic roles were considered protective from mental stress, while men were more likely to seek relief through substance abuse. Frank Kauders made similar assumptions from a study of persons with schizophrenia in Palau (Kauders et al. 1982). Researchers concluded that the wide variation in the rates of schizophrenia and psychosis between different island groups reflected the greater incidence of social disruption in, for example, Palau and Yap compared to Chuuk (Dale 1981; Hezel 1992, 1993; White 1981).

Psychiatric researchers associated an increase in alcohol abuse with modernization, especially in the American territories (Hezel 1981; Murphy 1978; Walters 1977). Rubenstein and White (1983) provide a comprehensive bibliography on alcohol and drug use. Alcoholism was also serious in New Caledonia, but this was hardly new among Europeans there. More alarming were increasing admissions during the late 1970s of alcohol-related psychiatric cases among Kanaks (Murphy 1978). Drug use, especially marijuana, attracted some attention from mental health practitioners within Pacific nations during the 1970s. The presence of military bases in Guam, especially during the Vietnam War, was linked with drug use, including use of heroin.

Westernization and modernization were also considered by some mental health experts and researchers to be at the root of the 'suicide epidemic', especially among young men, that swept through Micronesia from the late 1960s and Western Samoa from the mid-1970s to early 1980s (MacPherson and MacPherson 1987; Rubenstein 1983, 1992). More suicides were recorded in Western Samoa than in American Samoa, but during the 1980s, there were few suicides in Tonga (Cowling 1990). Hezel (1993) was emphatic that mental illness was not a major cause of Micronesian suicides, instead emphasizing changing family structures and roles that intensified intergenerational conflict. Traditional structures for dissipating tensions had become obsolete. Macpherson and Macpherson (1987), echoing Durkheim, suggested that increased youth suicides in Western Samoa were anomic rather than the altruistic type of the past. They do not mention mental illness, but Hezel (1984) differentiated Micronesian suicides associated with anger, shame and psychosis. He cautioned that people with mental illness were at a far higher risk for suicide than the general population. Depression attracted little attention in the earlier psychiatric

literature. Murphy (1978) acknowledged that acute anxiety was probably common but linked the cause of this to traditional beliefs such as 'witchcraft' rather than modernization.

Early Regional Mental Health Initiatives

The development of regional intervention in Pacific health after World War II followed earlier initiatives such as that of the Rockefeller Foundation (Stuart 2006). The South Pacific Commission (SPC), established in 1947, became pivotal to a regional mental health approach. By 1952, the SPC 'was concerned about the problems of mental health which would undoubtedly become more and more acute in the years to come' (South Pacific Commission 1967). SPC workshops on mental health were sponsored during the 1960s and 1970s. An environmental model of mental illness was pursued with modernization identified as the primary determinant of increased rates of mental illness.

Regional experts on psychiatry identified components of modernization that adversely impacted upon mental health. Urbanization was first with 'the rapid and irreversible acculturation of islands peoples' (South Pacific Commission 1967). The South Pacific Conference at Lae in 1965 recommended 'that governments inquire into the causes of urbanization and promote measures to minimize the serious social and sanitary problems (physical and mental health) which it creates' (South Pacific Commission 1967). The following year leading regional psychiatrists—D. F. Macgregor (Fiji), B. G. Burton-Bradley (Papua and New Guinea) and G. Zeldine (New Caledonia)—met in Noumea. They brought different psychiatric perspectives: Macgregor from clinical psychiatry, Burton-Bradley (1973) from ethnopsychiatry and Zeldine from public health and quantitative research. They endorsed the linkage between pathological mental states and the stressful conditions of urbanization that they identified as 'over-urbanization', 'migrant rootlessness (anomie)', discrimination, educational and cultural disparities between spouses, problems of retirement, intergenerational conflicts, 'faulty race relations' and the negative effects of tourism. Delinquency, alcoholism and prostitution were also correlated with mental illness (South Pacific Commission 1967). Some ethnopsychiatrists added decolonization to the list of psychological stress factors (Murphy 1978).

Medical experts represented the post-war decades as a period conducive to stress, manifested through social and mental pathologies. This model juxtaposed modernity with a stress-free 'primitive world' (Leckie 2005).

Although global theories of modernization dominated mental health research in the Pacific, by the mid-1960s, recognition of local psychiatric issues began to emerge. The SPC was a catalyst and sponsored a mental health workshop in Noumea in 1966, which recommended the appointment of an ethnopsychiatrist (Tsai 1967; Schmidt 1970). Karl Schmidt, the Commission's mental health specialist during the early 1970s, presented sociological research into the primary prevention of 'psychiatric, psychosomatic and psychosocial disorder in the South

Pacific' at a World Psychiatric Association and SPC symposium in 1976 at Papeete (WPA/SPC 1976). This conference placed Pacific issues on the global psychiatry stage through attracting several international experts to debate the problems of adaptation to rapid social and cultural change. It also signalled the tensions between sociological/contextual and individual/biomedical approaches to mental health in the Pacific. The keynote speaker, Henri Laborit, identified sociocultural disintegration as an undeniable factor in the increase in mental disorders but favoured a biobehavioural approach to preventive social psychiatry (WPA/SPC 1976). Although the talkfest identified problems and goals, Murphy (1978) saw few practical outcomes from the conference.

Pacific Mental Health by the New Millennium

In 2004, the World Health Organization (WHO) conducted a situational analysis of mental health within nineteen Pacific countries (Centre for Mental Health Research, Policy and Service Development 2005). It found that services were extremely limited, poorly distributed and staffed, and underfunded. Several countries had no mental health policies or legislative frameworks for mental health. Many people with mental disorders were unable to receive the treatment and support they needed and experienced discrimination, stigma and social isolation (Government of Samoa 2006). This was largely due to misunderstandings about the causes and nature of mental illness. There was limited and uneven research on the nature of mental health and mental illness in the Pacific region, and by the twenty-first century, this was seriously out of date.

Treatment available within the Islands was hugely variable and ad hoc. In many areas, there was minimal service availability at secondary level (hospital and community-based services) for people with mental illness and extremely limited mental health services in primary care. Inpatient services across the region were inadequate, and where treatment was provided, it was often in the general medical ward at the local hospital. In many cases, these wards failed to meet basic standards for privacy and security for people with mental illness. The limited specialist services available in many countries across the Pacific could lead to detention without treatment, sometimes in police custody and prisons (Funk 2009). Alternatively, in some countries, people presenting with acute symptoms received treatment in prison and once stable were transferred to the hospital. In 2005, inpatient facilities were only provided in Kiribati, Tonga and Vanuatu. Kiribati has a large facility attached to a general hospital.

Facilities or services have tended to be provided in the main urban areas. This has meant that for many people access is often limited because of geography and transport (Hughes 2009). In reality, this means that people in many areas rely on primary health care workers to address their mental health needs. Mental health has not been well integrated in primary care, with communities, churches and families being important in terms of care arrangements for people with mental illness.

In some instances, health professionals experienced in mental health attempted to improve access to appropriate mental health services and develop policy and legislation. These isolated attempts often failed. For example, in Rarotonga, in the Cook Islands, a mental health unit was constructed close to the main hospital, but it could not be used because of concerns about the structure's physical safety (World Health Organization 2012). In Vanuatu, a ward was built but was used for other purposes due to a lack of staff to provide appropriate treatment in the ward (Hughes 2009).

Access to appropriate medications to treat mental illness in the Pacific is limited because of unreliable supply, increasing costs and difficulties relating to the provision of counterfeit and time-expired medications. Because historically most Pacific countries have not considered mental illness to be a health priority, funding has not been allocated to provide appropriate treatments. This results in major illnesses such as schizophrenia and depression remaining untreated, or reportedly being treated with inappropriate medications such as diazepam. Some of the more effective treatments, such as clozapine and lithium, cannot be used because they require regular monitoring to prevent life-threatening side effects and there is a lack of skilled laboratory staff across the region.

Governance of mental health services has not always been clear, and while all countries have a health ministry or something similar for administering services, most countries bear the legacy of no identifiable division or specified role dedicated to mental health.

There continues to be few formally qualified mental health professionals in the region, with doctors and nurses having minimal experience or training in mental health. Access to ongoing mental health training is limited. Although there is a strong primary health basis in most Pacific countries, it does not include the delivery of mental health services (Centre for Mental Health Research, Policy and Service Development 2005). Because in many islands there is no mechanism to collect information, either about the health workforce or about the prevalence of mental illness, it is difficult to determine workforce requirements or training needs.

In the new millennium, cultural beliefs continue to result in widespread stigma and discrimination towards people with mental illness and their families—acting as a barrier to treatment and care. During the 1990s, steps were taken to address this in Samoa through AIGA—A Partnership in Care through Continuous Collaboration— a culturally appropriate family focused, community-based mental healthcare service (Enoka 1997). The Samoa Nurses' Association was proactive in this and promoted an indigenous nursing philosophy.

Informal mental health services often provide a significant component of mental health care in the region, filling the gap in specialist and primary services. This includes non-government organizations (NGOs) such as Te Kainga o Pau Taunga, established in 2004 in the Cook Islands to supplement the limited mental health services there. It had only one trained and experienced psychiatric nurse, but it did provide psychological support and counselling, follow-up care and monitoring of medications, home treatment, support for caregivers, respite for clients, advocacy, a drug and alcohol programme, counselling, family and children's services and supported accommodation.

Traditional healers continue to be active across the region (Puloka 1997). Their approach mainly involves spiritual beliefs and herbal remedies for all types of mental illness, and they are not integrated into mainstream mental health services. The widespread use of traditional healers generally results from the belief that mental illness is not a condition originating within the person, but a manifestation of an external spiritual force (Ellis and Collings 1997) and a community matter.

Mental health promotion and service delivery have not been seen as priorities, with other health issues such as tuberculosis or HIV/AIDS taking precedence (Hughes 2009). There has also been a lack of support for mental health services at government level and little interest by health professionals in tackling mental health issues. Minimal funds have been allocated for mental health, and there is a strong emphasis on curative services (Hughes 2009). In 2005, Cook Islands, Guam, Kiribati, Nauru, Niue, Palau, Samoa, Tokelau, Tuvalu, Vanuatu, and Wallis and Futuna provided no funding for mental health services. Marshall Islands, New Caledonia, Northern Mariana Islands, Solomon Islands and Tonga were provided between 0.4 and 1.7% of their health budget for mental health services (Centre for Mental Health Research, Policy and Service Development 2005). New Caledonia allocated 5.5% of the total health budget to mental hospitals (WHO 2011).

As discussed, most legislation was enacted under colonial regimes. Since the 1990s, some countries, such as the Northern Mariana Islands, Tonga and Vanuatu, have reviewed their mental health legislation. Consultants to the Solomon Islands recommended consolidation of the law relating to 'persons of unsound mind', better provision for the care of people who have mental illness and changes regarding custody and the management of mental hospitals. Samoa introduced a Mental Health Act in 2007. In New Caledonia, a Mental Health Plan was drafted in 2003 but rejected by the government. A new plan is being developed (WHO 2011).

Contemporary Mental Health Epidemiology

Very limited epidemiological data are available regarding the national prevalence or burden of disease of mental disorders in the Pacific. Generally there is little systematic collection and analysis of information about mental illness in the region. Inferences can be drawn from wider demographic and social patterns. The disease burden from mental health in the region is expected to increase because of dramatic social change, rapid population ageing, and the increasing gap between socioeconomic groups (WPRO 2013b). WHO estimates that in the Western Pacific region the burden of mental illness (including neurological disorders) accounts for as high as 27% of the total disease burden in 'affluent countries' and 15% in others (WHO/WPRO 2013b).

Suicide is a significant public health problem, closely linked to mental health. From a global study, mental disorders (particularly depression and substance abuse) are associated with more than 90% of suicides, with WHO estimates of 63–83% of suicides in the Pacific linked to mental disorders (WHO/WPRO 2014b). This is a much stronger correlation than that reported by the researchers on suicide discussed

earlier in this chapter. Higher suicide rates than the global average are now reported in many Pacific Island countries. The earlier alarming rates of youth suicide continue with the median age of suicide notably lower in Guam (27 years), Tonga (22 years), and Vanuatu (21 years) than in countries such as Australia (41 years) (WHO/WPRO 2013b). The significant lack of community awareness and education in relation to mental health perpetuates a cycle of undiagnosed mental illness, which can lead to suicide. One global response is the WHO/WPRO Study of Suicide Trends in At-Risk Territories (START) (De Leo et al. 2009). It aims to apply methods of the global WHO/EURO Multi-centre Study of Suicidal Behaviour by initially amassing data on the Pacific. Future work will monitor repetitive suicidal behaviours and research interventions with suicide attempters. Suicide awareness is also tackled by local voluntary groups, such as SUICIDE Association SOS, founded in 2001 to promote the prevention of suicidal behaviour in French Polynesia. (The objectives of the association are available at http://www.sossuicide. pf/?page_id=23.)

Substance abuse is now recognized as a growing and widespread mental health issue but data on the use of alcohol and other substances remain sketchy. Substance abuse, particularly alcohol and marijuana, is a common cause of morbidity and can cause a range of social problems including violence and other criminal behaviour. Reports suggest that in some communities in Kiribati alcohol consumption can begin by the age of eleven. Excessive alcohol consumption there is an increasing problem, linked to road traffic accidents and domestic violence (WHO/WPRO 2014a). Police reports show that alcohol abuse is a factor for many patients who present to mental health facilities. In Kiribati alcohol abuse is often misdiagnosed as schizophrenia because of acute behavioural changes and visual hallucinations that may occur during alcohol withdrawal (WHO 2013a).

Global and Regional Mental Health Initiatives in a Sea of Islands

A major influence on mental health awareness and service provision in the Pacific region has been the involvement of WHO and the establishment of the Pacific Islands Mental Health Network (PIMHnet). At the 2005 meeting of Ministers of Health for Pacific Island countries, the idea of a country-driven network was discussed as a means of progressing mental health policy and regulatory frameworks to overcome geographical and resource constraints. The New Zealand Ministry of Health submitted a proposal to New Zealand International Aid and Development (NZAID) and secured three years funding to establish a mental health network for twelve Pacific countries. Governments from each of these countries nominated a national focal person to represent them for mental health. They in turn were required to develop an in-country network to ensure that information sharing and networking occurred.

The Pacific Islands Mental Health Network (PIMHnet)

In 2007, PIMHnet was launched as a joint initiative of the WHO regional office for the Western Pacific and the WHO headquarters in Geneva. Through this, network participating countries were supported to develop national mental health policies and plans. The overall purpose of PIMHnet is 'to facilitate and support cooperative and coordinated activities among member countries and to contribute to better health outcomes for people with mental illness'. PIMHnet worked with the New Zealand Ministry of Health to secure funding for a period of five years from NZAID.

PIMHnet provided an opportunity for Pacific countries to develop shared goals, aiming for all people to enjoy the highest standards of mental health and well-being through access to effective, appropriate and quality mental health services and care. It worked with member countries (American Samoa, Australia, Cook Islands, the Federated States of Micronesia, Fiji, Kiribati, Marshall Islands, Nauru, New Zealand, Niue, Northern Mariana Islands, Palau, Papua New Guinea, Tokelau, Tonga, Samoa, Solomon Islands and Vanuatu) on advocacy, policy, legislation, planning and service development, human resources and training, research and information and access to psychotropic medications to help in the development of mental health services. Activities included a detailed assessment of the current mental health workforce situation and needs in each country and across all health system levels; providing clinicians with best practice guidelines for improving their patients' mental health; engaging with strategic partners who could provide expertise, resources and support to ensure the sustainability of mental health services in the region; conducting a training workshop on mental health policy and planning with PIMHnet member countries (e.g., Benson et al. 2011); and annual meetings and a mental health workshop with Pacific Island NGOs. PIMHnet developed a comprehensive mental health information package for Pacific countries that aligned best practice guideline materials with local needs, as well as information for social services. The package was distributed as a working tool, and feedback from countries has indicated the value of this resource. This reflects the collaborative approach of PIMHnet with the objective of developing sustainable capacity and capability building. The profile of mental health issues in Pacific countries was raised largely through the dedicated and enthusiastic national focal contacts, appointed to work with a wide range of stakeholders in their own countries.

PIMHnet operated at various levels from basic communications to developing policy. It ensured that members remained well informed and supported through newsletters and teleconferences, encouraging and facilitating the establishment of national PIMHnet committees and determining the most appropriate mechanisms for communicating with each country (in some islands, postal communication was preferable over unreliable email services) (Hughes 2009). PIMHnet closely assisted countries to develop mental health policy and strategic planning. PIMHnet's facilitator, Dr Frances Hughes, conducted training in the region with primary

healthcare personnel in the provision of mental health services. International strategic partners also spent time within countries to assist in the development of mental health policies. While PIMHnet was not successful in securing ongoing funding from New Zealand International Aid and Development (NZAID) in 2012, it is now managed from the WHO regional office in Fiji.

Mental health has also been included on other regional agendas, such as the Pacific Health Ministers' meetings. At the Ninth Meeting of Ministers of Health for Pacific Island Countries in 2011, mental health was identified as a top health priority. Ministers agreed that if mental health issues were not addressed, they would continue to grow and cause a significant adverse effect on health and socio-economic development (WHO 2013b). The Foundation of the Peoples of the South Pacific International (FPSI), a network of nine Pacific NGOs founded in 1974 funded by NZAID, has also partnered a regional youth and mental health project. Between 2003 and 2006, this focused on masculinity, mental health and violence in Papua New Guinea, Vanuatu, Kiribati and Fiji (Roberts 2007). The second phase of youth and mental health project included Tonga, Solomon Islands, Tuvalu and Samoa (Guttenbeil-Likiliki 2009; Jourdan 2008; Morris 2009). In this phase, it collaborated with the NGO, O Le Siosiomaga and the Samoa Nurses' Association (Hope and Enoka 2009). The influence of the global mental health movement is also expressed through bodies such as the Australia-based Black Dog Institute. It specializes in mood disorders such as depression and bipolar disorder and has provided training programmes for health professionals from Island nations. The Australian Agency for International Development has provided funding (Black Dog Institute 2010).

The Western Pacific region of WHO now takes a proactive role to work with Pacific countries to develop Mental Health in Development Country Profiles, documenting needs, challenges, resources and services. Training initiatives have been implemented to address human resource constraints such as a one-year postgraduate diploma in mental health established at Fiji National University; fellowship programmes on community mental health and depression; and technical support visits by mental health professionals and national workshops (WHO 2013b).

Conclusion

We end by returning to the representations that opened this chapter—of small Pacific Islands—far removed from stress and mental illness. This was and remains erroneous. Mental suffering existed within precolonial Pacific cultures, which drew upon the spiritual and social contexts for understanding and treatment.

The incidence and range of mental distress accelerated under colonialism, capitalism and urbanization as well as with the impact of introduced diseases. Colonial states established custodial structures to contain extreme mental disorder, and in some islands, medical officers applied what they considered humane management as well as

biomedicine. The transfer of Western psychiatry to the Pacific was piecemeal, and mental health provision was generally neglected in islands considered small and remote from global centres. World War II destroyed that illusion, especially in Micronesia, where the Americans boosted health efforts. Social and economic change intensified during the later decades of the twentieth century along with decolonization in the Pacific. These processes attracted some mental health researchers.

Self-determination for island states offered the possibility of shaping more appropriate development, including health. Instead, these nations were beset with internal political and economic problems, and mental health remained a low priority despite an increasing incidence of mental disorders. Mental disorders are now a significant cause of the burden of disease in Pacific Island countries. Mental disorders contribute to high rates of suicide, drug, alcohol and social problems, and in turn, these generate mental illness. Increasing hardship and poverty within parts of the Pacific adds to this cycle. Other pressures that will impact upon both mental illness and care include climate change and migration from villages to urban areas.

The future of addressing mental health issues lies within global, regional and local channels. Global perspectives are directed through WHO and the Western Pacific regional office. Earlier regional efforts to consider mental health (such as the SPC) were somewhat uneven. WHO PIMHnet has adopted a far more cohesive approach. Its strength was derived from active local participation and embracing the realities of small islands including those of isolation, poor health resources and few trained personnel. However, PIMHnet and similar initiatives are dependent upon international aid. When this is cut, local communities look to civil society groups, churches and the timeless sources of health care—families and traditional medicine. This can perpetuate misconceptions about mental illness. Local solutions do offer resilience but are limited and stretched when dealing with the complexities of mental health within contemporary Pacific cultures. It is unlikely that progress can continue without the support of wealthier countries outside the Pacific region. The difficulties that are faced by the Pacific in terms of mental health are the same as those experienced in other developing nations and include limited appropriately qualified health professionals, social conflict and political instability.

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Chapter 18
Grafting and Crafting New Zealand's Mental Health Policy

Warwick Brunton and Peter McGeorge

Abstract The legal and institutional foundations of the New zealand system were laid by Pakeha (European) settlers with scant regard for Maori insights on mental illness. The colonial system was eclectically British. Colonial conditions favoured direct state management. Bureaucratic continuity prevailed with inquiries held only when publicity exposed unacceptable conditions. There were positive initiatives within the institutional environment. Nevertheless, vested bureaucratic and industrial interests upheld a system insulated from mainstream health services. Those features were largely unchallenged until the notion of integration appealed to hard-pressed ministers to explain systemic deficiencies. Leading officials reluctantly followed suit. In the period after World War Two, the therapeutic revolution, prosperity, growing social acceptance, voluntary organizations and international trends were transforming the character of mental hospitals. Perhaps the greatest example of departmental leadership was a moratorium on further institutional accommodation in 1973. This foreshadowed the last phase of deinstitutionalization. Hospital closures were largely driven locally by a mix of ideology and economy. Nevertheless, the lamentable saga begot a new, post-institutional, policy framework. Moreover, the process has spawned a very diverse policy community. Advocacy groups, voluntary service providers, mental health consumers, Maori organizations, along with longstanding interest groups of professionals and service providers, have all found an effective voice. A great deal was achieved by a synergistic partnership between the Ministry and an independent Mental Health Commission (MHC). Successful change in policy and services needs a sustained, incremental approach under stable organizational conditions. Ring-fenced funding

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and wise stewardship must protect new initiatives. Widespread political, community, sectoral and intersectoral support is vital. Effective implementation needs detailed planning statements of resource costs and organizational responsibilities. Outcomes should be owned by service users, families and carers.

The history of mental health services internationally has attracted considerable interest and controversy in recent decades, notably in medical-progressive, revisionist and post-revisionist interpretations. The New Zealand story has largely been told from the perspective of social history and individual institutions in academic research, commemorative publications and institutional studies. A national and public policy perspective, derived from the police and welfare functions of governments, complements such studies because policy interplays with personal and clinical decision-making.

Mental health policy refers historically and euphemistically to the care and treatment of mental disorders. New Zealand's policy, like that of other British imperial offspring, has been dominated by the institutional approach (Brunton 2004). This chapter will outline the changing pathway and main features of New Zealand's policy since Crown colony times (1840–1852), explore the changing nature of recent policy and its translation into new services, a new paradigm and philosophy of care.

Foreshadows (1840–76)

New Zealand is a nation of settlers. Maori (indigenous New Zealanders) boldly ventured here from East Polynesia several centuries before European navigators visited in the seventeenth and eighteenth centuries. Maori held a supernatural view of mental aberration and distinguished between insane, demented, intellectually disabled and spirit-possessed persons. Early Pakeha (non-Maori New Zealanders) visitors generally observed very few cases of insanity among Maori (Buck 1910; Gluckman 1976). British settlers usually described insane persons as afflicted by misfortune or divine visitation. Traditional sociocultural perceptions coexisted with ancient medical entities like mania, melancholia, dementia and idiocy (Busfield 1986). Mental disorder in both Maori and Pakeha societies was managed within a whanau or family.

New Zealand became a British colony in 1840. Devolved imperial administration meant that policy was largely self-determined, according to colonial circumstances and politics. Like settler governments elsewhere, New Zealand muddled through by pragmatically adapting metropolitan precedent, and cribbing legislation and ideas from neighbouring colonies. This was a recipe for comparable solutions (Brunton 2015).

Asylums typified the Victorian British approach to social problems—an appropriate moral regime in specialized residential facilities. The concept of a

public lunatic asylum was upheld as the enlightened and proper venue for moral management from 1842, when New Zealand's first officially recorded cases of insanity came to notice. The notion was enshrined in law (1846) and reiterated periodically by references to the writings of the eminent English alienist, John Conolly. Scotland's mixed model of institutional and supervised community care (boarding out) aroused curiosity but was never considered to be viable. By 1886, all but a handful of lunatics, to use the contemporary official nomenclature, were in asylums.

Moves to establish institutions resembled those of most self-governing British colonies. Lunatics were initially kept in gaols, lock-ups or hospitals. At best, they were segregated. Mixed-purpose institutions satisfied neither gaolers nor doctors whose complaints were reinforced by humanitarian sentiment. Temporary and purpose-built provincial asylums duly followed (1853–1876). State intervention was inevitable. Public asylums epitomized a popular colonial ethos of egalitarianism and benevolent government intervention. Neither the marketplace nor philanthropy could meet the need; only one private asylum, now Ashburn Clinic, Dunedin (1882), was ever licensed. Institutional systems were monoculturally Pakeha but lacked the racial underpinnings of policies in British India or colonial Africa.

In 1858, New Zealand seemed set to build a national asylum near Nelson, but in 1861 a new ministry declared asylums to be a provincial government responsibility. That policy steered New Zealand towards a network model of government asylums in the larger provinces. First-generation asylums, on the outskirts of provincial capitals, encouraged community interaction and some agricultural activities.

Provincial governance made for markedly differing standards and funding levels, so when provincial governments were scrapped, institutions were managed directly by the central government under a psychiatrist-led department (1876–1972). Medical leadership was extended to larger (by 1882) and all institutions by 1921. Top-down medical control and bureaucratic continuity gave the departmental system a strong somatic orthodoxy in treatment. Psychotherapeutic techniques were generally considered to be too time consuming and impractical except for a few. They developed, however, in the private sector and in academic psychology, from the 1920s (Cook 1996).

Centralized management allowed for nation-wide, consistent and ultimately fair application of new policies and resources, but it entrenched the institutional system. The Department was the consistent advocate because there was no identifiable mental health policy community. Mental health featured very rarely in election manifestoes. Reliant on their expert official advisers, ministers rested content with the general course of national policy, as shown by the rarity of general policy inquiries and generational intervals between revisions of the core statute (Brunton 1985, 2005).

The Department was founded on the fraught premise that mental disorders were distinct from physical disease and social problems. Functional and administrative insulation followed. Remote second- and third-generation asylums added geographical insulationism to the mix after 1879. Separate law and organization made

for a statutory fiefdom and a specialized national career service accountable within the public service and not to local communities. Institutions had a virtual monopoly over compulsory treatment.

Meridian (1876–1972)

The national system eventually comprised thirteen psychiatric hospitals and four 'psychopaedic' (mental deficiency) hospitals. Scottish psychiatrist, Lauder Lindsay (1829–1880) rightly predicted that 'after money has been sunk and laws have taken hold, it is not easy to undo and substitute, however desirable progress or reform may be' (Lindsay 1872). Institutions dominated with 32% of all public hospital beds and an a priori claim on funding (Department of Health 1969). Institution-centricity permeated the system. Career progression meant acculturation into the institutional ethos and provided a vested interest in preserving it. Institutions gave medical officers a status when psychiatry was a lowly and unpopular specialty. Attendants developed industrial muscle to obtain favourable employment conditions and promotion pathways (Prebble and Bryder 2008).

Asylums worldwide began as curative establishments but were soon overwhelmed by the long-term care and safe custody of vast numbers of therapeutically discarded and institutionally aging patients. Committal provided 'a strong inducement to allow the elastic term "insanity" to be applied with the utmost latitude' (AJHR 1881) to deal with various social cast-offs. Definitional elasticity was then rationalized therapeutically, categorized and legitimated within the fashionable and umbrella eugenics term 'mental defective' (Brunton 1985, 1986).

Institutions simply expanded like inflated 'India-rubber balloons' (*Southern Mercury*, 14 April 1877) to handle the influx of compulsorily admitted patients. Bed limits, intended to safeguard individual care and homeliness, became meaningless. Major institutions steadily exceeded the acceptable level which eventually stood at 1000 beds. A nexus of intractable accommodation and staffing pressures, along with sociopolitical indifference, trapped the system in 'The Present' with less attention to 'The Future' (Department of Health 1967).

The severity of accommodation and staffing pressures fluctuated according to economic and fiscal conditions and the political visibility of the problems. They probably reached their nadir in the 1950s. Systemic overcrowding reached 14.7%—one large institution. At worst, overcrowding reduced things to a hand-to-mouth existence with minimal classification. 'Shakedowns' (improvised beds made up on the floor) were squeezed between the rows of beds. Day rooms sometimes doubled as dormitories. Only 18 medical staff had solely clinical responsibilities—1:545 resident patients. Little wonder that patients saw the fleeting daily ward round as carefully managed to minimize patient contact with overstretched doctors (Frame 1961). Effective nursing staff strength fell below 50% of the authorized establishment in most institutions, making it difficult to meet 'basic essential needs, let alone anything else' (AJHR 1950). The shortage of all-purpose nurses was ameliorated

only by using the large pool of patient labour (unpaid under the guise of work therapy) that was indispensable to institutional functioning.

The effects of these pressures were timeless but well documented for the 1940s and 1950s by a patient, Janet Frame, and a nurse, Marion Kennedy. Their first-hand literary accounts show how first-order social and professional values, like order, neatness, cleanliness or work (however menial or tedious), were generally honoured. Other values, like dignity, individuality, privacy, variety, fashion, or homeliness, were subject to staffing and accommodation pressures, architectural limitations and prognostic assumptions.

The system was not intentionally callous or indifferent because top administrators wanted to uphold both sets of values to attack the insidious effects of institutionalization (Brunton 2003). Long-term policies associated with inreach and outreach can rightly be called deinstitutionalization in its correct usage as the antonym of institutionalization. Mitigatory inreach policies improved patient classification, upgraded living conditions and cultivated institutional community. Preventive outreach policies included rebranding asylums, enhancing the therapeutic environment, destigmatizing admission procedures, nurturing general hospital psychiatry and establishing rehabilitation and extramural services. Many innovative ideas reflected the Scottish training or experience of most departmental heads before 1947 (Brunton 2011).

Inreach initially involved grand schemes for a national chronic asylum to make other asylums curative. Porirua (1887) and Tokanui (1912) were earmarked for that purpose before the impractical idea was abandoned, just like experimental national colonies for inebriates (1901–04) and epileptics (1907–16) and psychogeriatric rest homes (1929). Four colonies for mentally deficient children, established between 1929 and 1963, survived until recently, although psychiatric hospitals also cared for many intellectually disabled adults.

Local schemes were far more successful. Cottage care pioneered at Hokitika (1879) was adopted elsewhere and led to the policy decision in 1903 to build all new accommodation on villa lines. Self-contained villas, eventually standardized at 40–50 beds, provided a quasi-domestic environment, classification of patients with similar conditions or needs and appropriate degrees of liberty or security.

Priority went understandably to the 'best medical attention and treatment of recoverable cases' but, starting in 1947, the convergence of therapeutic breakthrough with post-war prosperity brought a suite of general improvements and new staff categories to offer 'the best institutional care' for other patients (Department of Health 1947). Clothing was modernized. The dietary scale offered greater variety. Hairdressing salons were built. The National Library Service stocked hospital libraries. Patients were given pocket money. Dormitories and day rooms were modernized with comfortable furnishings. Recreation halls, canteens, libraries and chapels followed as 'the architectural expression of the concept of a therapeutic community' (AJHR 1961).

Outreach policies were intended to encourage early treatment. Lunatic asylums officially became mental hospitals (1905) then psychiatric hospitals or simply hospitals (1946). Statutes were periodically purged of archaisms. Attendants were

given formal training as specialized nurses (1895) with a form of state registration (1907). Nurses were favoured for their feminine and domestic touch, although male attendants were never dislodged. Separate 'reception homes' (admission units) that mirrored the clinical atmosphere and concentrated staffing of general hospitals were built at each psychiatric hospital (1898–1925). Self-referral was mandated (1911) and surpassed committals after 1959. Categories of informal admission created in 1928, 1954 and 1961 also tackled the stigma of committal. Financial barriers were removed. Free care in public mental hospitals was the first part of the social security medical scheme to be implemented (1939).

Outreach began within the institutional system where specialist resources were concentrated. General hospital psychiatry had a few proponents, but hospital boards were slow to accept the idea before 1925 and until various national associations lobbied for 'halfway houses' to treat vaguely named nervous conditions and 'shell shock'. Queen Mary Hospital, Hanmer Springs (1916), set a precedent for providing psychiatric treatment outside mental hospitals (Parsons 2012). Local happenstance and the availability of medical staff made for haphazard development until the 1960s. Bureaucrats manoeuvred to safeguard institutional pre-eminence although latterly regional psychiatric units acquired their own identity and emphases.

Inreach and outreach policies originated long before insulin coma (1938), pre-frontal leucotomy (1942), electroconvulsive therapy (1943) and psychopharmacology (after 1952) put the 'hospital' into institutions. Modern treatment shortened the length of stay generally and reduced behavioural difficulties among long-stay patients. More wards were unlocked, parole extended and greater use made of trial leave and probation. Multidisciplinary teamwork became the buzzword for interprofessional dynamics among staff employed to activate, rehabilitate and support patients for life and work outside hospital. These included occupational therapists, social workers, clinical psychologists, chaplains and domiciliary psychiatric nurses. Institutions were encouraged to employ former patients rather than nurses for non-nursing work (1960).

Once institutions identified themselves as a health service, a rubric of integration removed the main prop of their hegemony. Ministerial portfolios were easily aligned (1907), but departmental merger (1947) was badly managed. Regional service integration under boards was hastened in 1965 when, without warning, the minister declared that mental hospitals would be better off the sooner boards ran them. The division then adroitly extracted a large boost in funding to bring conditions and staff levels up to a standard acceptable to boards. Neither national industrial action by psychiatric nurses nor the resulting public inquiry thwarted the transfer (1972).

Fleeting Shadows (1972–84)

The institutional regime peaked in the 1960s. With three-quarters of psychiatric inpatients, institutions were expected to handle the majority of psychiatric patients 'for many years to come' (Department of Health 1969). The seeds of institutional

doom, however, were already being sown. Frame and Kennedy provided the local version of literary critiques of institutional care. The institutional model was also attacked by academic psychiatrists and the Intellectually Handicapped Children's Parents' Association (1949). Internationally, Barton's concept of institutional neurosis offered a pathological framework. Revisionist histories of psychiatry by Foucault, Scull and others questioned progressive and medical accounts. Goffman and Illich challenged the role of total institutions and medicine in society.

Community care began smoothly enough. In 1963, the Department dropped plans for more mental hospitals. Systemic overcrowding was over by 1970. Local initiatives were encouraged and flourished, including day hospitals, industrial units, domestic rehabilitation units, domiciliary psychiatric nursing services and post-discharge hostels. Acting on departmental advice, the government halted the construction of any more mental hospital beds (1973). Every patient was then personally assessed to establish future needs. Alternative accommodation was recommended for 26% of all psychiatric and 46% of intellectually handicapped patients (Department of Health 1974).

The twilight years of post-war prosperity were the time to have used the survey to launch a far-reaching and managed transition with a new policy framework, proper planning, funding and legislative support. That prospect receded under the impact of sluggish economic growth and oil price shocks, although some additional revenue from tobacco and alcohol (1977) was channelled into local community-based projects and support for new, national non-governmental organizations (NGOs) like the Schizophrenia Fellowship (1977) and Richmond New Zealand (1978), which rapidly became key service providers.

The Department's want of policy leadership can be explained. Stan Mirams, Director (1964–1979), was a product of the *ancien regime*. He had misgivings about the 'community mental health myth' (Department of Health 1969) and refused to extend the rest home subsidy scheme. The Department was reluctant to interfere in its old patch after mental health was incorporated into the planning, funding and administration of the general health system. Mirams' key tasks—the policy and legislative frameworks, upgraded institutional services, administrative devolution, and dismantling the division—were successfully accomplished by 1972. Mirams became a victim of his success. Despite these achievements, he was not promoted. He served out his career in the downgraded job of director.

After a lengthy interregnum, Professor Basil James was appointed director (1981–1990). With wider sectoral experience, James enthusiastically instigated largely in-house national stock-takes of legislation, services and daily life in psychiatric hospitals. The legislative review led to the current core statute (1992), which focuses specifically on the symptoms of mental illness. Intellectual disability and personality disorders are excluded. The Act applies only to persons under a phased compulsory assessment or treatment order, not to self-referrals. The Act also established new processes to formally review the legal status of patients.

The Gloaming (1984–1996)

The other national reviews were swallowed up amid frequent ministerial reshuffles and waves of management and structural change that rocked the health and state sectors from 1984 to 1999. Neo-liberalist economic policies shifted the paradigm of government involvement. General management was imposed ubiquitously. Contractual responsibility largely replaced statutory accountability. Competition supplanted collaboration. Agencies performed functional splits. The foundations of New Zealand's welfare state were shaken by a declining role for the public sector and a corresponding increase in private roles. Purchasing power was expected to get better value from the health dollar (Kearns et al. 2009). Barnett and Newberry (2002) concluded that the quasi-market approach was particularly flawed when applied to community mental health services through hollow state mechanisms.

For nearly a decade, corporate introspection and constant 'restructuritis' affected departmental business-as-usual. High staff turnover, loss of institutional memory and the breakdown of sectoral and intersectoral relationships were inevitable. Moreover, departmental energy and leadership were diverted to address the management dysfunction in the Auckland board where activist Maori leadership isolated Carrington Hospital's Whare Paia Maori mental health unit from general programmes and management accountability (Mason 1988). The aberration detracted from the increasing acknowledgement of Maori perspectives after 1984, when the government transformed the Treaty of Waitangi (1840) between Maori and the Crown into an enduring bicultural partnership based on principles of protection, partnership and participation. This was important given the surge in Maori ethnic identity (now one New Zealander in seven). Maori health became a general health care priority. Maori aspirations and involvement in policy and services were recognized; culturally appropriate services were affirmed and strengthened, a Maori health workforce was nurtured, and high Maori mental health admission rates were addressed (Pomare and de Boer 1984). Maori psychiatrist, Sir Mason Durie, gained widespread acceptance for an understanding of *te hauora hinengaro* (mental health) as one of the four foundations of Maori health symbolized by *Te Whare Tapa Wha* (meeting house) (Durie 2011). Such insights informed the increased cultural sensitivity of most psychiatric hospitals as they built relationships with *iwi* (tribes) and *whanau*, incorporated Maori values and beliefs into treatment programmes and supported Maori health professionals.

The impact of organizational and management restructuring cannot be underestimated. The resulting vacuum shifted initiative from the centre to the periphery and from the bureaucracy to the mental health sector. Institutions ran down and closed through poorly coordinated local initiatives driven by a potent mixture of conflicting ideologies and budgetary pressures. Such wholesale change required much greater and coordinated high-level support, sustained and dedicated hump funding and practical expertise than occurred. Two health ministers expressed alarm about the apparent fixation upon institutional closure rather than strengthening alternatives. Budgetary restraints saw boards accused of siphoning mental health

funds elsewhere (Mason 1996). The media presented high profile incidents to highlight a disturbing picture of runaway agencies, poor coordination and cracks in support services. Rather than moving into a network of safe and accredited alternatives, patients were often transferred from one institutional setting to another. Issues that involved forensic patients aroused public safety concerns and resulted in a public inquiry (1987) after several residents in a halfway house were killed. Mason I, one of several independent inquiries chaired by Judge Ken Mason, was the first of 67 investigations into service shortcomings from 1987 to 1996. Fifty-one involved psychiatric hospitals (Mason 1996). Mason I expedited a national forensic psychiatry service, boldly emphasized the significance of Maori mental health issues and the need to strengthen culturally appropriate and community-based services.

Yet devolution significantly shifted systemic and public thinking and increased the opportunities for local community initiatives and collaboration. Several board-run services formed consultative committees with key interest groups (John Crawshaw, personal communication). Needs-based planning and financial support by boards and government agencies enabled NGOs like the Walsh Trust and Framework Trust (Auckland), Pathways (Waikato), Wellink (Wellington) or Comcare (Christchurch) to establish highly innovative options for supported accommodation, social enterprises, drop-in and support centres (Derek Wright, personal communication). Regional mental health consortia, a new template for collaborative planning, service delivery, monitoring and advocacy, were endorsed nationally (1989) but overtaken by reorganization. The Ministry's Mental Health Advisory Committee and the Platform Trust, an umbrella organization to coordinate and politicize the work of NGOs, increased sectoral cohesion nationally (Marion Blake, personal communication).

The proliferation of advocacy groups was another important game-changer. The Mental Health Foundation (1977) was particularly influential in changing public attitudes and in promoting a broad concept of mental health. The consumer movement nationally and internationally owes much to the Foundation's employee, Mary O'Hagan. She was instrumental in forming the national organization, Psychiatric Survivors, which has been the basis for many consumer initiatives and recovery-oriented services.

Despite the trying times, nearly all institutional services were devolved to sector-defined services and community mental health centres from 1984 to 1996. National deinstitutionalization guidelines (1993) appeared, ironically and belatedly, when institutions were largely history (Kearns et al. 2009). Nevertheless, those guidelines began a steady stream of national policy statements, standards, protocols and guidelines (Wilson 2000). Responding to sectoral pressure, the Ministry's national objectives and strategic directions aimed to decrease the prevalence and burden of mental disorders by 'community mental health teams'. Prevention, early intervention, treatment, support and destigmatization were emphasized. Community-based services, backed by specialist units, would be the 'linchpin' and primary focus of a new system. Priority was accorded to these teams, respite care facilities and meeting the needs of highly dependent people, Mäori and young

people. The strategy envisaged a greater role for primary health services through closer links with the new services (Ministry of Health 1994). The strategy was backed by the first mental health plan (1997).

The Ministry's efforts to guide the post-institutional system were interrupted by yet another high profile tragedy and inquiry. Mason II (1995–1996) focused on consumer and family perspectives about access and quality. The inquiry relied entirely on the extraordinary and unprecedented level of public concern contained in 720 submissions. Mason II bitingly criticized services and the Ministry's leadership. Noting that problems identified by Mason I remained unfixed, Mason II recommended an independent Mental Health Commission (MHC) be formed as a watchdog to ensure implementation of the Ministry's national strategy, standards and guidelines. The Commission was expected to produce an overriding and practical national blueprint to provide vision and purpose (Mason 1996).

The Morrow (1996–)

Like its predecessor, Mason II was a decisive turning point. The wide membership of the MHC (1996–2012) reflected the changing nature of the sector. The synergy that resulted from the Commission's decision to work with the Ministry as a partner rather than a watchdog was dramatically seen in the Commission's national blueprints. The first (1998) reframed the Ministry's strategic directions and specified sectoral workforce needs. A three-percent access rate to services for serious mental disorders was specified with corresponding benchmarks for inpatient and community residential services and the staffing of community teams. The blueprint also addressed discrimination. It was the first national document to highlight and advocate a 'recovery approach' as 'the new post-institutional values base for good mental health services' (Mental Health Commission 2007). Recovery, consumer-informed and peer-led services were touchstones. Blueprint (Mason II) funding was directed towards the establishment of new public mental health services.

The blueprint fitted comfortably with the less overtly commercial system restored by Labour-led governments (1999–2008). Centralized planning, policy and funding functions returned to the Ministry. District health boards resembled area health boards but were made explicitly accountable to the centre. Mental health funding was ring-fenced. Boards gave priority to child and adolescent, general adult and aged care services, and to alcohol and drug community centres. Regional hubs of specialist services for early intervention psychosis, maternal mental health, dual diagnosis, Maori, Pacific Island and Asian consumers supported clusters of district health boards. Forensic services continued to evolve with court liaison, minimum secure facilities and regional inpatient services for adolescents. Some existing services and staff levels were modified to meet the blueprint requirements.

The Ministry's role was crucial to the transformation. With greater organizational stability, strengthened senior staffing, and the inescapable public prominence

of mental health after Mason II, Janice Wilson's team produced the first national mental health plan and standards in 1997. Both documents informed and facilitated the blueprint. The mental health information management system was revamped. Centres for grass root mental health workforce research and development were established. Information for people with mental illness was greatly improved. The first national mental health and well-being survey was reported (2006). The national plan was updated in 2005 and 2012.

The blueprint's architecture was supported by a thirty-percent shift of total mental health funding towards NGOs by 2006 (Mental Health Commission 2006). NGO services have shifted towards meeting the social needs of people who live in the community but whose conditions would have once meant long-term hospitalization. These services are increasingly consumer (peer)-led and delivered. That represents the next major wave of change in New Zealand.

General practitioners provide an estimated 50–70% of all mental health care (Rodenburg and Dowell 2008), but received limited government subsidies. Following a prevalence study of mental disorders in general practice (MaGPie Research Group 2003), however, around eighty primary mental health care projects have been funded. Some larger primary health organizations now deliver sophisticated early intervention and integrated care.

The MHC was always time-bound. After its residual monitoring and advocacy, functions were transferred to the Office of the Health and Disability Commissioner in 2012, and the Ministry and boards resumed dominant roles in shaping and guiding policy and services, although strategic provider alliances increasingly influence the configuration of local services. Hope is engendered by the quintupling of investment in mental health and addiction services to 9.5% of government spending under Vote: Health in 2010/11 (Ministry of Health 2012). Three-quarters of that proportion went to community services. Specialized service use grew 51% from 87,724 people in 2002/2003 to 132,682 in 2010/2011. Some 30% of mental health and addiction funding was allocated to 395 NGOs whose services were accessed by 32,655 people in 2010/2011 (Platform Trust 2013). Services are culture-specific, recovery-oriented and focused on supporting people with the highest needs. Increasingly they support and involve families or *whānau* and primary care initiatives. Cultural services are inspired by and aligned with the principles of the Treaty of Waitangi. Services run by Maori for Maori were established as were Pacific Island services and latterly specific Asian services for their various diaspora. The Like Minds Like Mine, an anti-stigma and discrimination programme, is internationally significant.

New Zealand's experience offers some pointers for successful and durable major change in policy and services (McGeorge 2012). Sustained incremental change is preferable to hasty reaction. Stable organizational and management conditions are important. Planners and policy-makers need to obtain and maintain widespread political and community support for and throughout major transitions. The integrity of collaborative planning or policy-making is characterized by a clear mandate, ongoing, genuine and transparent consultation, and a process and outcomes owned by service users, their families and carers. Broad-based networks of consumer,

sectoral and intersectoral interests should ensure that the needs of service users and families remain paramount. Commitment to models of collaborative care and to new and clearly defined pathways should nurture a process steered by good management as well as solid, inspirational and continuous, administrative and clinical leadership. Effective planning or policy-making must be underpinned by best-practice, conceptual, practical, financial and technical support. Major change cannot be done on the cheap or without transitional funding and wise stewardship. Ring-fenced funds protect new initiatives. Detailed plans should set out clearly the costs and allocation of resources (including particularly an adequate quality, mix and number of staff), action schedules and the roles of each agency. Finally, a policy or plan needs capacity and flexibility to avoid derailment.

Conclusion

New Zealand's policy and system belongs historically to the family of British systems. They were a product of empire. Colonial policy-making mimicked that of early Victorian Britain: political pressure and legislation led to inquiries, an inspectorate and uniform national standards (Henriques 1974). New Zealand added direct state management and an overwhelmingly institutional approach to the mix. The Department became the predominant source of policy advice to governments. Ad hoc formal inquiries periodically supplemented bureaucratic continuity.

While the system trumpeted modifications like the villa system or voluntary admission, the basic colonial foundations of policy and the institutional model were upheld by vested interests and by mental health's lowly place on the political agenda. Biculturalism, multicultural populations and service pluralism have helped shape a more distinctly New Zealand system more recently. As close ties with Britain faded, New Zealand has drawn increasingly from trans-Tasman connections, international trends and social movements. The insularity and insulation of the old model have been eroded through integration with and exposure to the wider health system.

The apparatus of government holds considerable sway over policy decisions but is tempered now by an effective policy community galvanized by deinstitutionalization. Such a policy community is perhaps one of the institution's greatest legacies, a silver lining to the dark clouds that surrounded the massive change. The ubiquitous institutional approach is over, yet the psychiatric hospital's evocative mix of nostalgia, difficult memories, recrimination or mythology can still haunt national policy. The new policy that has risen from the gloaming reflects pluralistic, primary care and community-based orientations, more specialized and culturally alert services, good, continuous and coordinated care, and strengthened safeguards for consumers and professionals. Knee-jerk policy-making by public inquiry has subsided with greater organizational stability in the Ministry and the sector. Time will tell whether the new approach will break the traditional cyclical policy-making

pattern of peaks and troughs interspersed with long periods of incrementalism (Armour 1981).

Note on Administrative Nomenclature

Boards refer to ad hoc local authorities that provided and ran publicly funded general hospital and related services, i.e. hospital boards (1885–1984), area health boards (1984–1993), Crown health enterprises (1993–2000) and district health boards (2000–).

Core statute means New Zealand's principal mental health statute: the Lunatics Ordinance 1846, Lunatics Act 1868, Lunatics Act 1882, Mental Defectives Act 1911, Mental Health Act 1969 or the Mental Health (Compulsory Assessment and Treatment) Act 1992.

Department means the Lunatic Asylums or Mental Hospitals Department (1876–1947), the Health Department's Mental Hygiene/Health Division (after 1947). The Health Department became the Ministry of Health (1993). The Department was headed by an Inspector-/Director-General (1876–1947) or Director (1947–1992).

The Health and Disability Commissioner independently investigates and resolves complaints or institutes proceedings about breaches of the generic Code of Health and Disability Consumers' Rights. The Commissioner also has general educational and advocacy functions.

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Chapter 19
Mental Health in Australia, 1788–2015: A History of Responses to Cultural and Social Challenges

Milton Lewis and Stephen Garton

Abstract The history of mental health in Australia may be usefully viewed as responses to a succession of cultural and social challenges. The earliest challenge involved development of a colonial psychiatry from the 1800s when psychiatry itself was just emerging in Europe as a branch of medicine. This was the era of public asylums that commenced with optimism but ended with pessimism as they became custodial rather than therapeutic. Basic reform in Australia was delayed until the 1950s when the challenge of developing an independent Australian psychiatry began to be answered. From the 1960s, new factors came into play including effective medications, recognition of patient rights and deinstitutionalisation. A new, cultural and social challenge presented with the massive, post-war inflow of non-British, European immigrants and, later, Asian immigrants. Cross-cultural competence was now essential. From the 1970s, refugees arrived in growing numbers, and from the 1990s, mental health professionals made public the adverse effects of their detention in isolated camps. Another challenge to present in this period was how best to remediate the mental disorders of Indigenous Australians; again cross-cultural competence was necessary. Recently, Indigenous researchers have been developing culture-specific, diagnostic and treatment approaches. The latest challenge is how might Australia best assist in reducing the burden of untreated mental disorders in low- and middle-income countries (LAMIC). This fundamentally cross-cultural enterprise of global dimensions has evoked a vigorous, international, epistemic and policy debate. While the debate has been located mainly in Europe and North America, some Australian psychiatrists have been very active participants.

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Psychiatry as a specialty within Western medicine began with the claim by physicians that only they could run the new therapeutic asylums that appeared in Europe from late in the eighteenth century. They advocated moral therapy, which, seen in modern terms, was the practice of interpersonal psychodynamics. The work of French physician, Philippe Pinel (1745–1826), on moral causation and non-restraint was translated into English, Spanish and German. In Italy, Vincenzo Chiarugi (1759–1820) and in Germany Johann Christian Reil (1759–1813) put forward a similar approach. In England, moral treatment was first developed at the small Quaker asylum, the York Retreat, and described by Quaker layman, Samuel Tuke (1784–1857) (1813, 1964) in *Description of the retreat*. Physician John Conolly (1794–1866) (1856, 1973), superintendent of the very large, public Asylum at Hanwell, Middlesex (1839–1844), trialled non-restraint and also advocated moral therapy in his *Treatment of the insane without mechanical restraints.*

The medical advocates of the new moral treatment (where moral means psychological but with ethical overtones) asserted they had the requisite knowledge to induce healing, employing a kind but firm relationship with the patient in a tranquil and ordered asylum environment. The aim was to strengthen the patient's reason, will and character in the fight against the 'animality' of madness. In Australia, medical control of asylums dates from the 1840s when a layman, Joseph Digby, was replaced as the superintendent of Tarban Creek Asylum, Sydney, by a doctor, Francis Campbell (Lewis 1988; Porter 1995, 1997). Efforts to plant European ideas and practices in colonial soil confronted a range of social and cultural challenges, which, in turn, produced distinctive antipodean traits in the larger story of Western psychiatry.

The First Cultural and Social Challenge: Development of an Australian Psychiatry

Developing a Colonial Psychiatry

In April 1787, when Arthur Phillip received his commission outlining his responsibilities as the Governor of the proposed colony at Botany Bay, his many instructions included one conferring the power to make provision for 'lunatiks'. The exercise of this power had to await 1805 when Governor King issued a writ *de lunatico inquirendo* to detain a free settler, Charles Bishop. The bulk of early colonists, however, were convicts, and 'deranged' convicts could be controlled through routine measures of confinement. Here, at the foundation of colonial settlement, were some long-term themes: mental health largely became a concern when it threatened public order and governments were particularly prominent in the management of the insane (McClemens and Bennett 1962; Bostock 1968).

By 1811, the number of colonists requiring care led to the establishment of the first asylum at Castle Hill and by 1825 overcrowding necessitated a move to the old

Court House at Liverpool. Within a few years, it was also overcrowded. A new asylum was opened at Tarban Creek (1838), while the convict barracks and female factory at Parramatta were also transformed into an asylum (1848). Tasmania housed lunatics at the old Invalid Depot from 1834. Other colonies began to follow suit: in Victoria, Yarra Bend Asylum in 1851 and twenty years later the imposing Kew Asylum, in Queensland, Woogaroo Asylum (later Goodna) in 1865, and in the same year Fremantle Asylum was opened in Western Australia. In South Australia, an asylum near Adelaide's Botanical Gardens was opened in 1852, and a new one, Parkside, in 1870. As the nineteenth century progressed, further asylums were established throughout all the colonies. Like their counterparts overseas many of these institutions were established in areas removed from city centres, to create institutions in secluded areas where large, park-like grounds might promote moral therapy and the mental well-being of inmates. By the early twentieth century, there was a well-established network of institutions in all states of the newly federated nation of Australia (Lewis 1988; Shorter 2005).

In the first half of the nineteenth century, prominent clergymen such as the Reverend Samuel Marsden, drawing on the ideas of English reformers, were advocates for the humane treatment of the insane. Moral treatment was applied by both Digby and Campbell. But use of restraint increased as asylums grew in size.

Until the 1870s, the asylum doctors followed the established English practice of classifying causes of insanity into 'moral' (such as anxiety) and 'physical' (such as syphilis). But by the 1880s leading alienists such as Frederick Norton Manning asserted insanity was best understood as a physical disorder—a disease of the brain. Many colonial alienists, while educated in Britain, were also alive to developments in North America and Europe. Manning, the dominant figure in colonial psychiatry, travelled around Europe and North America in order to discover the latest developments in treatment (Manning 1868; Garton 1988; Lewis 1988; Coleborne 2010).

Colonial psychiatrists, however, were constrained by local circumstances. The small population of the Australian colonies could not sustain a large private system, and governments provided the bulk of mental health services. By the late nineteenth century, many of the newer asylums were at the forefront of therapeutic interventions. Alienists explored the efficacy of physical therapies and new drugs—Turkish baths; massage; electrical stimulation; chloral hydrate; and bromides—and discussed the causes of insanity at the regular Australasian Medical Congresses. Serious attention was given as well to improving the training of asylum nurses and attendants. The founding legislation governing confinement for the insane, beginning with the 1848 Dangerous Lunatics Act, was primarily concerned with protecting the populace from the dangerous and drunken lunatic (Garton 1988; Lewis 1988; Monk 2008).

In other respects, however, the colonial system differed from overseas precedents. In Britain and New England, workhouse authorities were integral in referring inmates to asylums. In the Australian colonies where the poor law workhouse was anathema, police were far more prominent. Outside the major metropolitan centres police and magistrates were responsible for two-thirds of all admissions into

asylums. The other third came from families who sought out doctors to certify relatives and friends they felt unable to care for.

The central role of the police in lunacy incarceration (along with the underlying fact of the population's high masculinity) was instrumental in shaping a distinctive characteristic of the lunatic population. In Britain and New England, the majority of the insane were women, whereas in Australia, as in other frontier societies such as California, they were men.

By the early twentieth century, these colonial practices began to change. Psychiatrists were influenced by international debates about the importance of hereditary degeneracy, as espoused by the French psychiatrist, Bénédict Morel, and Henry Maudsley, founder of the famous London hospital bearing his name, and by the growing popularity of eugenics. They sought to create separate facilities for the chronic incurables and the 'mentally deficient' (intellectually handicapped) while advocating the importance of early treatment through voluntary admission. The first government outpatient clinic was opened in 1908 and the first voluntary hospital patients were admitted in 1915 (Lewis 1988; Garton 1988; Wyndham 2003; Garton 2010).

Another challenge was the significant increase in the number of institutionalised insane. Patient numbers rose dramatically from the late nineteenth century. Indeed, local psychiatrists, such as colleagues across the Western world, worried about an increase in insanity due to the deleterious effect of 'civilisation'. Some historians have argued the increase was due to the unprecedented institutionalisation of the insane (drawing on the ideas of Michel Foucault). Others have claimed there was a real increase in prevalence because of rising rates of alcoholism, neurosyphilis and, perhaps, schizophrenia. But the building of new facilities in Australia fell far behind admissions, resulting in overcrowding and increasing use of restraint.

Attracted to the new theories about the importance of nervous illness—Freud and Jung both had papers read at the 1911 Australasian Medical Congress—some psychiatrists left the public system to establish private practices treating a well-to-do clientele. In the state hospitals, the back wards became notorious places of restraint, doctors focussing their attention instead on clinics for voluntary patients. Mental hospital psychiatrists experimented with radical forms of therapy in a desperate effort to discover a breakthrough: during the interwar years malaria therapy, cardiazol shock treatments, insulin coma therapy and, by the early 1940s, electroconvulsive therapies without the benefit of muscle relaxants leading to significant injuries and occasional deaths (Lewis 1988; Garton 1988; Porter 2003; Shorter 2005; Damousi 2006; Garton 2009).

The Great War revealed that under the stresses of war many could succumb to 'nervous' illness, promoting greater psychiatric interest in these disorders. Moreover, care and pensions were provided for disabled returned servicemen (Garton 1996; Larsson 2009). But by the 1940s, the mental hospital system itself was in crisis—poorly funded, suffering worsening conditions, poor therapeutic capability and inadequate staffing.

Psychiatrists who remained in the government service lobbied governments for improved conditions to little avail. There were no votes in helping patients with

stigmatised illnesses not easily 'cured'. On the other hand, the language of nervous illness became pervasive as popular magazines trumpeted the new interest in 'nervous conditions' (Matthews 1984; Garton 1988).

Creating an Independent Australian Psychiatry

In the early decades after the Second World War, Australian psychiatry became a more independent centre within international psychiatry. As in other Western countries from the 1950s, new psychotropic drugs—such as the antipsychotic chlorpromazine, the antidepressant monoamine oxidase inhibitors, the tricyclic antidepressants, and the anxiolytic benzodiazepines—allowed many patients to leave, and others not to enter, the public psychiatric hospitals. In 1955, the first national report on the state of Australian psychiatric facilities revealed their quality was inferior to those in the UK and North America, and there was an urgent need for facilities for early treatment.

Patients began to be treated in general hospitals and clinical psychiatry thus connected with general medicine, helping reduce the historical stigma associated with asylums. This long-term process, known across the Western world as 'deinstitutionalisation', saw open-door policies in hospitals begin in the 1950s. The new drugs reinforced rather than initiated the process because the wartime experience of preparing military patients to re-enter civilian life and experiments with 'therapeutic communities' within hospitals had already shifted emphasis to the re-socialisation of patients.

Increasingly, voluntary alternatives became popular. Voluntary admissions had grown—for example, in South Australia from 29 in 1955–56 to over 1000 ten years later. At the same time, discharges increased—from the main West Australian hospital, for example, from 90 to 100 per year in the mid-1950s to almost 190 in 1960. Pioneers of community psychiatry in the USA in the 1960s such as Gerald Caplan claimed early treatment together with the primary preventive effect of community mental health education would reduce hospitalisations. Australian enthusiasts had the same high expectations.

As early as the 1870s and, again, in the 1900s, Victorian governments had supported the idea of general practitioners becoming involved in care of the mentally ill—as well as the establishment of psychiatric wards in general hospitals. This community-based care was not realised in the face of opposition from practitioners themselves, hospitals and citizens. They were united in the belief that the more difficult patients could only be treated in an asylum.

Eric Cunningham Dax, the innovative British psychiatrist who was foundation director of Victoria's Mental Hygiene Authority, set out in the 1950s and 1960s to shift the focus of services from the asylum to the community. But his community-oriented initiatives such as regional day hospitals and general hospital outpatient departments remained very much institutionally based.

Moreover, the prospects of community services dimmed in the course of the 1970s.

Part of the problem was reduction of federal funding. The Whitlam's Labour Government (1972–1975) had introduced comparatively generous funding for community mental health services, and under Medibank, the first national health insurance scheme, rebates for specialist services allowed patients to see private psychiatrists at no cost. However, the conservative Fraser Coalition government devolved funding to the states in the later 1970s, reducing support for the community health centres. It soon became clear that deinstitutionalisation frequently meant that patients were inadequately supported in the community. The number of mentally ill in prisons increased. Many chronically ill people were living on the streets or housed in urban 'ghettos'.

In the 1960s and 1970s, in Australia, as in the USA and Britain, the theory and practice of psychiatry was strongly criticised by a number of movements—feminists, students, blacks, gays and lesbians—and by psychiatrists and psychiatric patients. Seeking sociocultural change rather than the economic and political reforms of the traditional left, liberationists saw psychiatry as a form of social control, buttressing a male-dominated, heterosexual, white, inequitable, social order.

They drew on the arguments of the American psychiatrist, Thomas Szasz, and British psychiatrists, Ronald Laing and David Cooper, that psychiatry was inherently oppressive. The antipsychiatrists were joined by sociologists, notably American, Erving Goffman, critical of psychiatric hospitals as dehumanising 'total institutions', while revelations of state misuse of Soviet psychiatric institutions to silence political dissidents further discredited psychiatry. French philosopher, Michel Foucault, and Italian psychiatrist, Franco Basaglia, inspired the antipsychiatry movement on the continent. After Laing's laudatory 1967 review of Foucault's (1965) *Madness and civilization*, the philosopher came to enjoy global fame, although the movement in Australia was never as visible as in the USA or Britain.

Law reformers and civil libertarians were also opposed to the degree of discretion allowed psychiatrists in patient management. They wanted legal recognition of the patient's right to freedom, maintenance of reputation and independent representation. An international language of human rights was already permeating Australian political discourse: in 1966 Australia had signed the International Covenant on Civil and Political Rights and in 1979 the Fraser government set up a human rights commission. Under Federal Labour Governments from 1983, the commission became more ambitious, even looking into state responsibilities and from the 1970s the states began enacting legislation giving more recognition to patient rights: for example, the 1974 Queensland Act restricted detention of involuntary patients to 21 days after which an appeal could be made to the mental health review tribunal; the 1983 New South Wales Act provided legal assistance to patients in pursuit of their rights.

In 1993, human rights commissioner, Brian Burdekin, conducted a national inquiry into the human rights of the mentally ill that revealed contraventions of the

1991 United Nations' Principles for the Protection of Persons with Mental Illness. The inquiry and report did much to elicit the first national mental health strategy (1992) under which federal, state and territory governments agreed on reforms embodied in a national mental health policy and plan that reflected the UN principles. The first national plan focussed on transfer of chronic patients to community care. The later five-year plans focussed on new concerns such as prevention and early intervention (Lewis 1988; Edwards 1994; Lewis 2001, 2003b; Chesters 2005; Shorter 2005; Singh 2006; Henderson 2008).

Over the next two decades, a few notable advances in services were made. In the early 1990s, the Keating Labour Government made available more funding for community-based services, while from 2001, with the aim of reducing the growing number of suicides, the Howard Coalition government funded psychological services through Medicare, the national health insurance scheme; in 2005, it established a network of youth services across the country. However, too many people living in regional and remote areas, younger people and people without the capacity to purchase private care still did not enjoy the level of care available for those suffering serious, chronic, physical, non-communicable diseases (NCDs) such as heart disease. Moreover, the issue of dealing with the high level of NCDs that coexist with mental disorders has hardly been addressed. A 2010 survey of adults with mental disorders found they were 1.5–3 times more likely to suffer from NCDs. Although the Council of Australian Governments (2012), in its *Roadmap for National Mental Health Reform 2012–2022,* pointed to the issue of prevention as something demanding urgent attention and a national mental health commission (NMHC) has at last been set up, many reformers remain unconvinced such needs will be speedily addressed.

The review of mental health programmes and services by the National Mental Health Commission (2014), commissioned by the Australian government, identified many continuing deficiencies, despite more than two decades of national and state and territory level mental health-system reforms. The government accepted the Commission's findings, acknowledging the 'existing complexity, inefficiency and fragmentation of the mental health system' and the 'compelling case for long-term sustainable reform'. The process of developing an implementation plan for the commission's recommendations has been commenced.

Since the Second World War, the development of psychiatry in Australia has broadly reflected that of psychiatry in USA and Britain. By the end of the twentieth century, whether in state policy and legislation, treatments and services, professional education and organisation, or in patient populations and lay 'consumer' bodies, a mature Australian psychiatry had undoubtedly become an independent player in world psychiatry. The process of achieving maturity was uneven. Thus, as late as 1980, British graduates filled many of the most senior academic posts: for example, the professor at Melbourne University had trained at London's Maudsley Hospital; at Queensland University, the chair was held by a Cambridge graduate; and at the University of Western Australia, the three holders of the chair had come from Britain. But the fourth occupant of the oldest chair in Australia, at Sydney University, was an Australian, as were the holders of new chairs at Newcastle and

Flinders Universities. This continuing academic dependence on Britain reflected the lack of a strong research tradition and the small size of the academic establishment in Australian universities until the post-war years. PhD degrees were not even available until the later 1940s and candidates for training in medical specialties commonly went to Britain and, from the 1950s, also to America. The process of gaining independence in psychiatry was a prolonged, untidy affair.

Only after the Second World War were postgraduate qualifications in psychiatry offered in Australia and into the 1960s the locus of training was usually a medical school department with three years of experience in psychiatry in 'mental hospitals' being a requirement. The Australasian Association of Psychiatrists was established in late 1946 and its successor, the Australian and New Zealand College of Psychiatrists (ANZCP), in 1963; while in NSW, the Institute of Psychiatry was set up in 1964 to train mental health professionals and promote research. The title of the college acquired the 'Royal' prefix in 1978, indicating its rise in status. From 1965, and more emphatically from 1977 (when a five-year training was introduced), college membership became the basic qualification (Edwards 1994; Rubinstein and Rubinstein 1996; Lewis 2001).

By the late 1980s, however, there was a shift in the balance between biological and psychological and social approaches, as well as the share of therapy performed by psychiatrists. A survey of college members in the early 1970s found 55 of 112 respondents had a special interest in psychotherapy while 95 practised some psychotherapy; 59% tried to balance biological and psychodynamic approaches, while 35% focussed more on the latter. The profession's journal, *The Australian and New Zealand Journal of Psychiatry,* noted a resort to 'eclecticism' in therapy. One New Zealand psychiatrist, Peter Joyce, pointed to the need for a biopsychosocial model (a new concept advanced by American physician, George Engel); since the biological was integral, Joyce argued, psychiatry was necessarily part of medicine (Lewis 1988; Shorter 2005).

From the 1980s, however, there was a notable shift towards biological aetiology. From 1971 to 1980, 26% of articles in the journal concerned with aetiology-favoured biology—mostly neurophysiology, neurochemistry and the effects of illegal drugs. This had grown to 42% by 1986–1990, and 50% by 2001–2005. From 1971–1980, 74% of articles focussed on social and psychological causes: 35% located aetiology in family relations and 40% listed other social factors, most often socio-economic status. Socially focussed articles had fallen to 58% by 1986–1990 and 50% by 2001–2005. Further, from the 1980s, concern with social factors was expressed in terms of risk factors; social aetiology was now being reconstructed around epidemiology's concept of risk; and social factors were not seen as direct causes of illness.

This change is evident in the dominant theories concerning the aetiology of schizophrenia. In 1971–75, journal articles focussed on the relationship between parenting and pathology, and the relationship was typically seen as causal, whereas in 1996–2000 the connection between social factors and mental illness was expressed as statistical correlation and risk factors included parental illness, age, gender, class and place and month of birth. Moreover, a history of mental illness in

the family was now seen as due to an enhanced genetic risk of schizophrenia. Through neuroimaging and genetic technologies, it became possible to identify biological markers present in schizophrenia. By 1996–2000, all aetiological factors in schizophrenia were based in biology (Henderson 2008).

In 1990, leading psychiatrist, Gavin Andrews, claimed that such was the diagnostic reliability of the DSM-3; the third revision of the American Psychiatric Association's (1980) *Diagnostic and Statistical Manual,* that not only could psychiatrists across cultures generally agree on diagnoses but other mental health professionals could reliably carry out diagnoses. An estimated 2.75% of Australians were at any time under treatment (excluding drug and alcohol disorders). Of 2750 patients, 50 were in hospital; 150 were outpatients; 450 seeing private psychiatrists; 1000 seeing community services professionals; and 1100 seeing general practitioners. Psychiatrists, then, treated only 20% of all patients. Moreover, said Andrews, since the great bulk of the work of dynamic psychotherapists was with anxiety and depressive neuroses and personality disorders, dysfunctions having a high, natural remission rate, dynamic psychotherapies could simply be viewed as a sophisticated placebo (Andrews 1991; Shorter 2005).

Although Australian psychiatry has been, and continues to be, profoundly influenced by American and European psychiatry, there are several areas in which Australia has had considerable international influence, particularly in population mental health and mental health services. After periods as Director of Mental Health in Queensland and at the national level, Harvey Whiteford was the first mental health advisor appointed in the World Bank. His work there and his continuing work on global burden of disease attributable to mental disorders has had a major influence on the level of attention given to mental disorders globally (Whiteford et al. 2013). The work of Patrick McGorry (2015) on early intervention for psychosis and other mental disorders, and the service systems that have been developed in Australia, have been adopted in Europe, the USA and Asia. The role of the general community in mental health has been the focus of the work of Anthony Jorm and Betty Kitchener (Mental Health First Aid 2015). More than a million members of the general Australian community have been trained in Mental Health First Aid and the programme has been implemented in North America, Europe and Asia. The work of the Victorian Transcultural Psychiatry unit (VTPU) has contributed to shifting the focus of transcultural psychiatry from the person of the immigrant to the mental health system and its deficiencies and the space between immigrant and refugee communities and mental health policies and mental health-system capabilities (Kirmayer and Minas 2000; Minas et al. 2013). In the field of global mental health, the directors of mental health in the Ministries of Health in Cambodia, Indonesia, Sri Lanka and Vietnam, and many other senior psychiatrists and other mental health professionals throughout Asia and the Pacific, are alumni of the International Mental Health Leadership Programme, established in 2001 by the Centre for International Mental Health at the University of Melbourne (Minas 2012).

The Second Cultural and Social Challenge: Promoting Immigrant and Refugee Mental Health

From the beginning, Australia has been a country of immigration: in the nineteenth century, English, Irish, Scottish and Welsh, but also Chinese (to the goldfields); Pacific Islanders (labourers on sugarcane farms) and Japanese (pearlers). When Australia achieved nationhood in 1901, non-Europeans were excluded under the 'White Australia' policy, an imperative that only began to crumble in the 1960s. Between 1947 and the 1970s, there were two important waves of migration: the first was of migrants from Europe from the early post-war years and the second was created by wars and political and religious persecution in Southeast Asia, the Middle East and Latin America. After the end of the Vietnam War, in addition to authorised refugees, many Vietnamese arrived by boat seeking asylum—the first 'boat people'.

From the late 1960s welfare inquiries, community bodies such as the NSW Mental Health Association and the emerging ethnic lobby called for specific health services for migrants, although they were more concerned with physical than mental health. Further, the historical security enjoyed by Australians blinded them to the deep mental traumas of refugees from total war, genocide and political and religious persecution. In any case, migrants with mentally ill kin were deterred from seeking help by the fact that those hospitalised within five years of arrival could be deported under the Migration Act (1958), a measure not repealed till the 1980s. Official and popular lack of interest in migrant mental health continued even as Vietnamese refugees continued to arrive after 1975 (6000 from Vietnam, Cambodia, Laos and East Timor in 1975–76 alone).

Concern about the national origins of the insane had already been an international preoccupation in the later nineteenth century. Immigrant countries such as Australia, the USA and Canada feared European countries were exporting their 'degenerates' to the New World. Eager to build a healthy, white population from a small base to defend and develop the vast continent, Australian colonists were particularly susceptible to these fears. In 1889, Chisholm Ross, medical officer at Sydney's Gladesville asylum, concluded more Irish were admitted than other British 'nationalities' and Chinese patients represented only a proportion of the actual Chinese insane because many were cared for by their compatriots. He pointed out as many as 15% of the insane were born overseas but the foreign born were under 4% of the population (Burvill 1973; Hastings 1977; Jupp 1990; Lewis 2003b; Coleborne 2012).

In his critical review of Australian research for the Bureau of Immigration Research Australian sociologist, Laksiri Jayasuriya (Jayasuriya et al. 1992) noted that 'Australian studies relating to immigration, ethnicity, and mental illness are characterised by two distinct trends: The dominance of epidemiological research, carried out by Jerzy Krupinski and his Victorian colleagues from the 1960s through to the early 1980s. The emerging impact from the late 1980s of transcultural

psychiatry and medical anthropology associated in particular with the work of Harry Minas and his colleagues.' Minas (1990) published an overview of this new approach in 1990.

The Victorian Transcultural Psychiatry Unit (VTPU), referred to by Jayasuriya, was the first Australian research, teaching and service unit focusing on population cultural diversity and mental health, contributed to the establishment of similar units in New South Wales, Queensland, South Australia and Western Australia and put transcultural psychiatry on the national agenda. A report (Minas et al. 1993) commissioned by the Commonwealth Department of Health resulted in the establishment of the Australian Transcultural Mental Health Network in 1995, which is still currently operating as Mental Health in Multicultural Australia.

The VTPU (Minas et al. 1996) and the national programme had considerable influence on the development of state and territory and national mental health policies, and had considerable international influence in other settler countries such as Canada (Kirmayer and Minas 2000). It became standard practice to acknowledge the cultural and linguistic diversity of the Australian population, to point out the specific needs of immigrant and refugee communities and to assert that mental health services should develop the necessary expertise to provide culturally appropriate services. The latest example of this is to be found in the National Mental Health Commission (2014) report on the national mental health system. However, none of these policy commitments has been adequately funded and, when it comes to creating implementation plans and budgets, other priorities have prevailed (Minas et al. 2007, 2013).

The lack of attention, at national and state levels, to mental health service reform and capability-building that would create mental health services capable of functioning effectively for a multicultural population has resulted continuing under-utilisation of mental health services by most immigrant and refugee communities, particularly those from Southeast Asia, more common diagnosis of psychotic disorders (probably because those with less severe and pressing problems choose to stay away from mental health services), and substantially higher rates of involuntary admission to psychiatric inpatient units (Stolk et al. 2008).

As noted earlier, asylum seekers from Southeast Asia arrived from the mid-1970s and most obtained permanent residence. In the last two decades, the boat people phenomenon, now involving people from the war-ravaged Middle East, Afghanistan, Sri Lanka, Somalia and Burma, has developed into a politicised and socially divisive issue. Australia has for some years been running an offshore programme of resettlement for authorised refugees, with an annual quota of 13,000 (then increased to 20,000) places out of an international total of 80,000 on offer. A national network of centres treating survivors of torture and trauma was set up for them.

The first large-scale Australian study of the mental health of refugees was published in 1986 (Krupinski and Burrows 1986) by the aforementioned Jerzy Krupinski and Graham Burrows (then a professor of psychiatry at the University of

Melbourne). It showed the subsequently much studied negative mental health consequences of the refugee experience and the remarkable resilience and generally successful settlement of young refugees from Vietnam and Cambodia. More recent studies have continued to examine the mental health of refugees and asylum seekers and have been more concerned with the development of services that are capable of engaging the disparate refugee communities in effective partnerships to protect their mental health (Colucci et al. 2014, 2015).

While Australia was one of the small groups of countries that advocated for and framed the Refugee Convention, and has in the past been seen as a welcoming destination for refugees, the growing number of asylum seekers arriving by boat over the past decade has resulted in ever harsher and more exclusionary policy responses by both labour and conservative governments. These have included a regime of mandatory detention in Australian immigration detention centres and more recently detention centres in Nauru and Papua New Guinea which are paid for and effectively run by the Australian government. These policies and practices have given rise to an increasingly acrimonious debate about whether Australia is discharging its international human rights obligations, and have drawn adverse comment from both the United Nations High Commissioner for Refugees and the Special Rapporteur on the Convention Against Torture. The detention centre network, both onshore and offshore, has seen protests, hunger strikes, riots and acts of self-harm. Under the conservative government's more restrictive Operation Sovereign Borders policy (introduced in September 2013), the flow of unauthorised boats has ceased, but the problems in the detention centres and opposition to the policies have not.

The adverse mental health consequences of prolonged immigration detention have been clear to mental health professionals from the early 1990s (Van Wyk et al. 2012). Two inquiries carried out by the Australian Human Rights Commission, the more recent in 2014 (Australian Human Rights Commission 2014), on the impact of detention on the well-being and mental health of children in detention, and a great deal of independent research (Silove et al. 2007), have provided unequivocal evidence of the damage done to children, adults and families. Despite the mounting evidence and sustained advice from the Ministerial Council on Asylum Seekers and Detention to successive Ministers of Immigration concerning the harm caused by detention, the policies have grown harsher (Newman 2012).

The Third Cultural and Social Challenge: Indigenous Mental Health

Alex Cohen (1999), the author of an international review of the mental health of indigenes in over 70 countries, has pointed out 'first peoples' are the survivors of a 500-year process of European and North American economic integration of the rest

of the world into a global system. The process was destructive of the culture and the physical and mental health of indigenes. Everywhere, the legacy is evident in high levels of substance abuse, mental illness and suicide. Cohen concluded that, while necessary, pharmacological and psychotherapeutic treatments are insufficient response because recipients continue to confront dysfunctional social environments. Social, cultural and economic reconstruction is required to create the supportive environment traditional society had provided. This reconstruction is proving difficult to effect in Australia, as elsewhere, especially if meaningful, Indigenous cultural values (traditionally linked to a hunter-gatherer way of life) are to be preserved at the same time as effective participation in the mainstream economy, as Indigenous leaders propose, is promoted via the teaching of those skills (including adequate English literacy and numeracy) needed for employment in a developed economy.

The scarifying historical experience of Australian Indigenes was typical of the post-contact history of 'first peoples' elsewhere: new deadly diseases (including sexually transmissible diseases), alcohol and tobacco abuse, frontier violence and loss of land, produced social and cultural collapse and a major decline in health status. Population plummeted initially, steadying around 1880 as birth and death rates balanced at about 35 per 1000. In the 1940s, the birth rate rose to 40 per 1000. The Indigenous population today is still much younger than the non-Indigenous while constituting only about 2.5% of the national population (with almost 70% in regional and remote locations). Lifestyles range from remote semitraditional to modern urban. A comfortable urban middle-class lifestyle of an elite contrasts with the very low socio-economic and educational status of regional and remote people, although some city dwellers also suffer from deprivation.

As with immigrant health, much more government, professional and media attention have been given to physical than mental health. Indigenous health of both types was long neglected and this has to be understood in the context of historical changes in the official, professional and popular views of the future of indigenes.

From the 1840s into the twentieth century, it was believed a 'dying race' should be protected from the ravages of civilisation. In the interwar period, there was a shift to a policy of assimilation, reinforced by awareness sustained population growth meant indigenes were not dying out. From the later 1960s, as Aboriginal activists reacted against assimilation, self-determination and recognition of cultural difference came to the fore. These goals were challenged by the Howard Coalition (1996–2007) government's emphasis on integration.

Only recently has the gap in life expectancy between indigenes and other Australians begun to narrow, although it is still 11 years lower for the former. Research shows 30–50% of the gap is due to economic and social disadvantage and the rest to poorer health services access and cultural and environmental factors (Lewis 2003a, b; Lewis and Leeder 2013).

Until the 1960s, there are only a few instances of psychiatrists showing interest in Indigenous mental health. In 1889, Manning noted in the two decades from 1868 that there had been only 14 Aboriginal patients in Queensland and 18 in NSW asylums. Most were detribalised males, and he explained their condition as the

result of civilisation's pernicious effects. As observed earlier, Western psychiatrists in this era of Social Darwinism were much concerned about an alleged increase in the insanity rate and the mental 'degeneration' of the European 'race' due to the survival of the mentally disabled. In 1891, Manning's colleague, Chisholm Ross, also blamed civilisation, adding in precontact times insanity in Aborigines was apparently rare: the 'demonstrative maniac' would be killed, while the quieter sufferer was allowed to live on or if 'melancholic' commit suicide. In 1924, Queensland University Professor of Psychological Medicine, John Bostock, discussed 64 cases of psychosis from Claremont (Perth) and Gladesville (Sydney) asylums, stating 'tribal' Aboriginals had not 'evolved' to a point where they suffered from the neuroses common in Europeans, while those in urban areas needed to be studied before the 'race' died out.

The beginning of sustained study of Indigenous populations can be dated from 1963 when South Australian psychiatrist, John Cawte, presented a paper on psychosis as a maladaptive reaction to assimilation. Having set up the school of psychiatry at the University of NSW in the early 1960s, in the 1970s he established the still extant *Aboriginal Health Worker*. In 1976, he and colleagues pointed out remote-area Aborigines did not use mental health services even when available, suggesting the middle-class providers were unable to reach across the cultural gap.

Using a programme developed for Arizona Native Americans, they trained five Indigenous 'behavioural health workers'. Unhappily, six months after the project ended, they had to report no salaries were being provided because of an ideological conflict between the Queensland Aboriginal Affairs Department and Townsville Aboriginal community health services. The larger political context is that in the 1970s the conservative Queensland National Party government of Premier Johannes Bjelke-Petersen stood against the growing movement for Aboriginal land rights and autonomy. When land was placed under Indigenous administration, the government retained an overriding control. The 1982 Queensland Aboriginal and Islander Land Grants Act made the former reserve lands the subject of deeds of grant in trust with no practical limit to the power of the Governor-in-Council. This meant future governments could revoke the grants and remove the trusteeship vested in an Indigenous community council.

Cawte had a long-standing interest in traditional healers (advocating cooperation between them and Western doctors) and in 1974, he reported on a decade of experience with two modes of mental health care. The first involved studies by visiting psychiatric teams who applied 'first aid' to 'defensive and adaptive problems'. The second (from which more durable results were expected) involved the long-term presence in communities of specialists in 'developmental medicine' (inspired by D.C. Leighton's Harvard work on sociocultural integration). Max Kamien, qualified in psychiatry and internal medicine, pioneered the role of developmental medicine practitioner in a remote Bourke (NSW) community, visiting Aboriginal families with a female Aboriginal 'health aide'. The key idea was to replace the disappearing, traditional healer, a force for social integration in precontact society, and assist the community to advance its physical and mental health in the face of stresses arising from rapid cultural and social change.

In the early 1970s, studies of urban Aboriginal health also appeared. Norelle Lickiss reported on problems of Aboriginal children in Sydney and Alan Stoller and colleagues reported significant levels of mental disorders in Melbourne Aboriginal teenagers. Lickiss identified factors interfering with the children's capacity to thrive: parental mental illness, problem drinking, domestic disruption, lack of continuity in child care, too many changes of residence, unsatisfactory father and mother figures (for sexual development), racism, frustrated aspirations, and identity problems (Cawte and Kamien 1974; Lickiss 1974; Kahn et al. 1976; Lewis 1988, 1992; Coleborne and Mackinnon 2006; Duke 2007; Ellis and Kamien 2012).

In the late 1990s, psychiatrist, Ernest Hunter suggested Cawte's ethnopsychiatric approach was flawed because it imposed Western psychiatric categories on the Aboriginal experience of mental health and treated Indigenous patients as passive recipients of care.

From the 1960s the struggle for land rights, separate organisations for community control and cultural separatism intensified. In 1980, Indigenous delegates to a national conference on mental health organised by the National Aboriginal Mental Health Association (founded in 1978 by Cawte and Cyril Hennessy, an Aboriginal colleague) expressed opposition to the presence of mental health professionals. This was an early sign of a shift in the relationship as professionals accepted a consultative and, later, a collaborative role. In the late 1980s, issues of ethical accountability in research were addressed in guidelines developed under the auspices of the National Health and Medical Research Council (NHMRC). Moreover, a number of Indigenous professionals including anthropologist, Marcia Langton, psychologist, Pat Dudgeon, and medical practitioner, Ian Anderson, began addressing the issue of equity in services.

Mental health professionals embraced the collaborative approach, symbolised in 1993 by the first national mental health conference under the joint sponsorship of the College of Psychiatry and the community-run Redfern Aboriginal Medical Service. But the downside was a split between commonwealth-funded, Indigenous organisations focussed on social justice and a traditional, holistic concept of mental health and state services concerned with efficient resource allocation to improve treatment of specific mental disorders in accord with the practice of Western psychiatry.

Hunter made the significant point that while development of health care services was very important, raising social and economic conditions from the low level that produced mental (and physical) illness was even more important; a point made repeatedly by Aboriginal Activist, Noel Pearson (Hunter 1997; Lewis and Leeder 2013). In 2013, Hunter suggested the high and rising prevalence of psychoses among Indigenous adults in Cape York from the 1990s might well be an indicator of the impact of lifelong disadvantage on mental health in a period of great social and cultural change (including alcohol availability since the 1980s; more latterly, cannabis)—just as high rates of NCDs indicate the impact on physical health.

Other psychiatrists supported Hunter's proposal Indigenous mental health inequality be investigated as much as physical health inequality. Part of the problem has been Indigenous people use broad notions of social and emotional well-being

that extend beyond the individual to the collective rather than psychiatry's diagnostic categories focussed on specific disorders of individuals. However, a promising new framework for evaluation, based on the concept of social and emotional well-being, has been constructed recently by the Australian Indigenous Psychologists Association with the assistance of the Australian Institute of Health and Welfare (Australian Institute of Health and Welfare 2009; Hunter 2013; Jorm et al. 2012).

Indigenous Australians have reported considerably greater stress levels than other Australians. In a 2002 national survey, 44% said during the previous year they experienced three life stresses, and 12%, at least seven. Stresses included overcrowded homes, unemployment, major illness and problems involving alcohol or other drugs. A West Australian survey found many younger people were in families that experienced seven or more such stresses in the previous year. Continuing stresses produce a cumulative unresolved grief, termed 'malignant grief'—perpetuating individual and communal dysfunction that can lead to mental disorders and premature death.

Suicide appears not to have been common in traditional society. But in 2001–05, the second greatest cause of Aboriginal mortality was death from 'external causes', a category that includes intentional self-harm: 16% of Aboriginal deaths but 6% of deaths of other Australians.

Substance abuse is commonly implicated in suicide and mental illness. Children witnessing heavy drinking and associated behaviours such as violence towards others (or self) accept them as normal. In recent years, greater restrictions on alcohol availability have been introduced, as evidence of the deleterious effects of the Indigenous right to drink—more violence, serious mental and physical illness and poverty—has become overwhelming. The rights-based approach pervading Indigenous policy since the 1970s, based on belief in the efficacy of autonomy and cultural renaissance, has failed to stem the destructive impact of alcohol abuse. In 2007, the Howard Federal government banned alcohol in Northern Territory Aboriginal communities, something largely retained by subsequent labour governments. Nonetheless, there are high and growing levels of chronic cannabis use in Northern Territory communities with psychiatric comorbidity and concurrent over-use of other drugs such as tobacco, alcohol and kava; and very recently, 'ice' (Lee et al. 2007; Parker 2010; D'Abbs 2011).

The New Cultural and Social Challenge: Promoting Global Mental Health

In the last half of the twentieth century, Australia developed into a significant Asia-Pacific state, recognised globally for high educational and professional standards. Professional contacts in psychiatry developed beyond the UK and USA to encompass Southeast Asia and the Western Pacific. In 1948, soon after its creation,

the Australasian Association of Psychiatrists, the forerunner of the ANZCP, joined the World Federation of Mental Health and in the early 1960s joined the World Psychiatric Association. In 1960, WHO-sponsored doctors from the Philippines underwent training in Victorian psychiatric hospitals and in 1963, the first international psychiatric conference in Asia, a joint meeting of the American Psychiatric Association and the Japanese Society of Psychiatry and Neurology, attracted several Australian psychiatrists.

In the 1980s regional connections grew: the international liaison committee of the college provided textbooks for psychiatrists in China and prepared a catalogue of Australian and New Zealand psychiatry. Annual congresses of the college took place in Singapore (1978), Hong Kong (1981) and Honolulu (1989). College membership examinations were held in Singapore in the 1980s and a college travelling professorship, to be awarded biennially in Southeast Asia and the Southwest Pacific, was set up (Rubinstein and Rubinstein 1996). The New South Wales Institute of Psychiatry has for many years offered training and national mental health programme support for Pacific Island countries, especially Papua New Guinea. Mental health services in Sydney under the direction of Dr Marie Bashir, a child psychiatrist who is the immediate past Governor of New South Wales, has had a close relationship with mental health institutions in Vietnam for more than two decades.

Australian psychiatry's involvement in the development of the profession and mental health services in the Asia-Pacific region expanded notably in the new century. A breakthrough in bringing mental health to the attention of key global institutions was the appointment of Professor Harvey Whiteford to the position of mental health advisor to the World Bank. Whiteford had previously been the Director of Mental Health in Queensland and subsequently in the Commonwealth Department of Health, and has continued to make a global contribution leading the team working on the global burden of disease attributable to mental disorders.

Australian mental health professionals, as well as governments and NGOs, face a new cultural and social challenge beyond that of establishing fruitful regional and international relations: how best to contribute to the task of improving mental health globally when there is so much untreated mental illness in low- and middle-income countries (LAMIC).

Use of the term, 'global health', itself, has in the last two decades become common. This certainly reflects the globalisation of international relations, especially in financial and economic affairs. But it also has a history in relation to health. From around 1990, a few health experts, usually on the political left, began to talk about **global** health interdependence: for example, Americans, Milton and Ruth Roemer, talked of raising the level of 'global health' through public rather than private services. At the same time, environmentalists were making familiar a global perspective when arguing degradation of the world's physical environment would produce a massive, adverse effect on human health.

Committed environmentalist, public health physician and sometime Prime Minister of Norway, Gro Harlem Brundtland, who became head of WHO in 1998, sought to make WHO a more influential force at the global level. Already in 1993, a

WHO working group, concerned about the organisation's capacity to retain leadership in health in the face of challenges from the World Bank, had recommended it to increase its focus on issues at the global level (Brown et al. 2006). In countries such as USA, significant health policy bodies began to discuss health problems in global terms: for example, in the later 1990s, the Institute of Medicine (1997) supported publication of *America's vital interest in global health*.

Epidemiologists have through the World Mental Health survey initiative been constructing, since the early 2000s, a detailed, quantitative map of the distribution of the burden of mental disability, revealing the plight of millions of untreated sufferers, particularly in LAMIC. Mental disorders account for 32% of all years-lived-with-disability worldwide to which unipolar depression contributes 11.8%, alcohol abuse 3.3%, schizophrenia 2.8%, bipolar depression 2.4% and dementia 1.6%. They figure more prominently among the poor, and within that class, women and youth. Thus, it is also a matter of equity of access to care. The WHO *World Health Report 2001* (World Health Organization 2001) did focus on mental health and called for national mental health systems to be made more effective by introducing national policies, treatment to be part of primary care, available from health personnel other than psychiatrists (of whom there are few in LAMIC), greater provision of psychotropic drugs, community-oriented services and more involvement in care of patients and their families. But the full emergence of global mental health as a distinctive field of policy advocacy and development is more recent.

While sporadic and largely uncoordinated efforts to engage with the region had been going on for several decades, the establishment of the Centre for International Mental Health (CIMH) in the University of Melbourne in 1996, and the location of the Centre in a School of Population Health rather than a Department of Psychiatry, marked the beginning of a coherent and sustained programme of engagement with Asia and the Pacific, and to a lesser extent with Africa, and with Eastern Europe following the Balkan Wars. CIMH focussed from the beginning not on clinical training but on the problem of developing effective mental health systems in low- and middle-income countries, and in countries and regions affected by conflict or natural disaster.

The critical role of leadership and the location of effort in a broader development context rather than as an extension of psychiatry informed the development of the centre's programmes (Minas 2012). The International Mental Health Leadership Programme (Beinecke et al. 2010) was established jointly with the Harvard Medical School in 2001 and continues to be offered annually in Melbourne. The programme has several hundred alumni in more than 18 countries and territories across the Asia/Pacific region, among whom are the current Directors of Mental Health in Ministries of Health in Cambodia, Indonesia, Sri Lanka and Vietnam, heads of relevant departments in Ministries of Social Affairs in Indonesia and Vietnam and many other senior mental health professionals in ministries, universities, hospitals and other health and social services.

In addition to the Centre's development programmes in several countries, and as a WHO Collaborating Centre for Mental Health Research and Training, staff of the

Centre have contributed as members of the Lancet Global Mental Health Group, as the Secretariat for the Movement for Global mental Health (MGMH), on the WHO Director-General's International Expert Panel on Mental Health, as advisors to the ASEAN Mental Health Taskforce and as coeditor and authors of the key textbook in the field of global mental health (Patel et al. 2014).

The series of papers on global mental health published in a special edition of *The Lancet* in 2007, and a second series in 2011, constituted a 'Call for Action' from the 'global health community'. From this initiative, the MGMH, a network of experts and institutions sprang. Its most visible proponents have been clinicians inspired by the Treatment Action Campaign saving lives of HIV sufferers by increasing worldwide access to antiretroviral drugs. In a second *Lancet* series in 2011, the MGMH presented research on global mental health. It also hosted global mental health summits in Athens (2009), Cape Town (2011), Bangkok (2013) and in Mumbai (2015), advocating 'scaling up' of services to deal with the vast amount of untreated illness in poorer nations, protection of the human rights of sufferers and promotion of research in LAMIC (when the vast bulk of research has been and is still done in high-income countries).

Australia has played a significant role in the MGMH. From 2011, psychiatrist, Harry Minas, Director of Melbourne University's Centre for International Mental Health, hosted the secretariat of the MGMH and has contributed to the further development of MGMH. About 100 universities, NGOs and other bodies across the world have become supporters of the movement.

Moreover, the MGMH has important allies. The World Federation for Mental Health (WFMH), a global NGO, founded in 1948 to advance the prevention, treatment and promotion of mental health and with members in over 100 countries, has joined with the MGMH in a 'strategic alliance' to advance the cause of global mental health. It has recently launched the 'WFMH Great Push for Mental Health', a substantial advocacy initiative. Following from the 2001 report on mental health, WHO (2002) produced a document, *Mental Health Global Action Programme* (*mhGAP*). It became a 'flagship' programme, and later provided non-specialists with evidence-based guidelines on how to treat in primary-care facilities a number of significant mental, neurological and substance abuse disorders (Kessler et al. 2011; Patel and Prince 2010; Patel et al. 2011a, b; MGMH 2012; WFMH 2012a, b).

The next challenge and opportunity in the further development of global mental health is ensuring that the mental health of populations is a key consideration in most of the domains of activity that will constitute the United Nations Sustainable Development Agenda 2030 (Eaton et al. 2014; Izutsu et al. 2015; Minas et al. 2015). While mental health and well-being are included in Goal 3 of the Sustainable Development Goals (the health goal), it is by no means certain that adequate attention will be given to mental health by national governments and by major development funders. Australia has led the way in developing the approach of disability-inclusive development. While disability has a prominent place in the Sustainable Development Goals and has been incorporated into the UN's Sendai Framework on disaster response (Tsutsumi et al. 2015), the challenge in resource-poor settings of ensuring that mental health and psychosocial services are

fully compliant with the rights protections embodied in the Convention on the Rights of Persons with Disabilities will be very substantial. The CIMH is working directly to support Ministries of Health and Ministries of Social Affairs in Asia and the Pacific to meet these challenges.

Some Final Observations

Australia like the other countries discussed in this book advanced from colonial to independent, national status within a world in which Western psychiatry (supported by the global hegemony of the West) was the dominant source of the theory and practice of treating mental disorders. But unlike all but New Zealand, Australia was settled by people who shared a British and, more broadly, European culture. Not until after the Second World War was there a sufficiently large inflow of Europeans of non-British background and, even more pertinently, migrants of Asian and African background for cross-cultural issues to become important in Australian psychiatry. Therefore, responding successfully to the challenge of constructing a national psychiatry was less demanding than was the case in the non-Western countries of the region because the cultural and social distance to be travelled was shorter.

Moreover, Australia from the mid-nineteenth century was a comparatively wealthy country in a region where most countries were, and some still are, poor. Even so, the goal of providing good care for all Australians suffering a mental disorder has by no means been achieved and this is because of the substantial cost to the public purse as well as the priority still given to physical over mental health in government funding.

The cross-cultural issue of Indigenous mental health only began to be addressed in the 1960s and while the response has intensified recently, it cannot yet be said to be successful, in part because of the rapidity and extent of cultural, social and economic change confronting Indigenous communities—and in part the difficulty of devising culturally appropriate but effective instruments for understanding mental suffering as well as delivering care and promoting emotional well-being. Clearly, deep cultural values divide two such utterly different societies as mainstream Australia with its Western focus on individual autonomy, personal property rights and an ever-growing economy, and traditional Indigenous cultures with their focus on interdependence, community 'ownership' of material resources and a 'steady-state' economy. In this respect, psychiatry (like all cultural constructions) has to overcome the limitations set by its specific cultural origins. If it is to help reduce the mental suffering of Indigenous and other non-Western societies challenged by global forces of a modernisation process that began in the West two centuries ago, it will have to self consciously grapple with and adapt to the perspectives and practices of other cultures.

Australian psychiatrists and other mental health professionals have contributed to the development of global mental health and engaged in international efforts to

respond to the emerging global challenge of reducing the great burden of untreated mental suffering in LAMIC. While the claim by more stringent, transcultural psychiatry critics like Summerfield (2012) that global mental health is a form of neocolonialism has been heard loud and clear—after all this is a very active debate —it needs to be said that many of the 'Western' leaders of global mental health are fully committed to human rights as a core principle, have direct and long-term experience of working in transcultural mental health, are cognizant and respectful of cultural and other forms of diversity, and work in full partnership with colleagues in LAMIC.

The very active debate between MGMH and transcultural psychiatry critics about the role of culture in psychiatry and the role of local communities in provision of care as well as efforts to improve services does not have to be polarising. As Campbell and Burgess (2012) have noted, respectful alliances between vulnerable communities and an energetic and internationally influential MGMH—integration of bottom-up, lay and top-down, professional efforts—are not only possible but have already been successfully modelled in the South African Treatment Action Campaign (TAC) concerning HIV/AIDS. TAC linked local, largely marginalised groups of people living with HIV/AIDS with a range of national and global supporters. The alliance produced greatly improved access to effective treatment and highlighted how social injustices added to the suffering of those infected with the virus.

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