Mental health and mental health care in Asia

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Asia is by far the largest continent in the world in terms of area and is covered by four of the World Health Organization (WHO)'s six regions (i.e., the Eastern Mediterranean, European, South East Asian and Western Pacific). With a population exceeding 3.5 billion, it is by no means a homogeneous continent. It has dozens of cultures, religions, languages and ethnic groups, that spread over climatic zones from the arctic and Himalayan to forbidding deserts of Mongolia and China and steamy tropical jungles of Malaysia and Indonesia. Asia is also a veritable chest of economic treasures and a collection of some of the poorest areas of the world. In political systems, it is no less varied, having a variety of both market economies and planned ones. As a result of these highly varied political systems, Asia also spawns a wide variety of health care systems, often based on historical roots and at times colonial heritages. Over 450 million persons are reported to suffer from mental or neurological disorders in the continent (1).

Mental health care is therefore by no means standardized and extremely varied. These are important points to note, as the many so-called norms of psychiatric care in many economically highly developed countries may not only be not applicable but highly detrimental to mental health care in many parts of Asia. This is particularly true of some aspects of mental health care that are taken for granted in many developed countries, such as community care for the mentally ill, social security for the disabled, hostels for discharged mental patients in the community, and free treatment for the mentally ill. These and many other aspects of mental health care are not available in vast areas of Asia and often substituted by a remarkably resilient, but not always highly successful, family care alternative and a strong heritage of traditional medical care for the mentally ill, that is very often the norm.

HISTORICAL ASPECTS

There is ample evidence that mental health care in the pre-modern age was largely in the community, and provided by members of the family with the help of traditional healers or religious persons in temples and other centers of religion (2). This practice continues in vast tracts of Asia and indeed in many parts of the world. The reasons for this are not difficult to find, as the provision of modern hospital- or clinic-based mental health services within reach of many parts of a developing country is the exception rather than the rule. In many countries there are today relatively good basic health services, but these do not include mental health care.

The reason for this lop-sided development of health care for the mentally ill can be traced to the development of mental health care in many of the poorer parts of Asia that came under colonial rule. The state of the art in mental health care, in the early 1800s and up to the late 1950s, was the mental asylum, usually situated far from the cities and towns, out of sight and often out of the minds of health care systems. These asylums grew up with different administrations and different budgets, similar to the provision for leprosy hospitals and tuberculosis hospitals of the day. Thus, for instance, the Chao Phrya Hospital in Bangkok was built at the turn of the 19th century across the river from the city center. The Woodbridge Hospital in Singapore was built in the 1800s on the far eastern side of the island, a good 10 km from downtown Singapore, where the Singapore General Hospital was sited. In Calcutta (Kolkata), the city's Gobra Mental Hospital built by the British was sited far from the center, where the Calcutta's Medical College Hospital was proudly sited. Hong Kong's Castle Peak Mental Hospital, built by the colonial government, was sited in the new territories rather than on Hong Kong Island. Even the new Kwai Chung Mental Hospital, built in 1982, is far from the city center. The well-known Angodda Mental Hospital outside of Colombo was built a good distance from the Colombo General Hospital.

These examples suffice to underscore the ignorance, fear and psychological prejudice against the importance of mental health and services for the mentally ill in the health care systems. Although the WHO, in its constitution (3), clearly defines mental health as an integral component of health, the historical place of

mental health services in the minds of medical administrators has for the most part remained well outside of the mainstream of health care. As health care developed through not only giant strides in medical discoveries but also health care delivery concepts, such as the shift from hospital to community, the care of the mentally ill has remained for the most part stagnant and behind locked mental hospitals and prejudiced in the minds of the public as well as the vast majority of non-psychiatric health personnel. This paradigm and its stigma has sullied all the advances that have taken place in the field of mental health in the past half a century.

TEACHING OF PSYCHIATRY

The root of all that is wrong with mental health cannot only be traced to the historical development of psychiatric care in the continent, but also in the equally slow changes in the teaching of psychiatry to medical students and other care professionals in most Asian countries. For decades since the late introduction of psychiatry as a subject in medical schools in Asia, all that was taught was 10 lecture-demonstrations of the severely psychotic or depressed mentally ill patients, more as oddities in medical practice than as ill persons who needed to be understood. Even today the teaching of psychiatry is in many medical schools done in large mental asylums, and the content geared to severe illnesses rather than primary care psychiatry as will be seen in the practices of most future non-psychiatrist doctors the medical schools are producing. The aim of teaching of psychiatry appears to be not so much to educate young medical students on how to detect and treat the mental symptoms in their patients, but to give students a superficial overview of the mental side of medicine. Most medical schools in Asia do not conduct formal examinations in psychiatry, and the ability to diagnose and manage a psychiatric patient is not a part of the requirement to become a doctor. The time spent in psychiatry in medical schools varies widely, from two weeks of psychiatry clerkship in most Indian medical schools, to three weeks at the National University of Singapore, four weeks at the Mongolian Medical University and the Beijing Medical University, six weeks in most Indonesian medical schools and nine weeks in the University of Science of Malaysia. The content of this teaching varies widely, but the teaching is largely in psychiatric wards, whereas most mental problems in the community in a country are seen in primary care clinics. The association of psychiatry teaching with the severest illnesses has a negative effect on the mind of the future doctor. In principle, the teaching of a medical discipline should not be exclusively limited to the most difficult cases with poorer prognosis, while the more common cases remain untreated. This type of prejudicial attitude perpetuates the marginalized state of mental health, at community and ministries of health levels, in many countries of Asia. Nursing and other health care professionals are often trained in no other ways either.

Postgraduate training in psychiatry is relatively new in Asian countries, having come about in less than the past 50 years. Most Asian countries have senior psychiatrists today who were trained in UK, France, Russia, Germany or USA. The recent advent of training in Asian countries has not changed significantly the practice of institutional psychiatry, that continues to hold sway over the profession in the developing countries. However, in countries with more established postgraduate training programmes in psychiatry, locally trained psychiatrists are starting to develop ideas and services that are innovative and less dependent on the countries where their senior colleagues were trained. Examples of these are Thai and Malaysian psychiatrists developing better nationwide training of medical officers in primary care psychiatry, and Indian psychiatrists, especially in South India, developing community-based psychiatric care.

MANPOWER IN MENTAL HEALTH CARE

The ratio of mental health personnel to population is nowhere near the WHO recommended levels in the less developed countries of the continent. In China there are about 15,000 psychiatrists for 1.2 billion people (about 1:80,000). In India, with 1 billion people, there are but 3000 psychiatrists (about 1:330,000), Indonesia has about 450 psychiatrists for 210 million people in over 13,000 islands. But numbers of psychiatrists alone do not tell the whole story, as the distribution of the psychiatrists is so heavily weighted in favour of the large and prosperous cities that the rural poor are not able to access even basic mental health care. Thus about 50% of the psychiatrists in Indonesia live and work in the mega-capital city of Jakarta, with an estimated population of over 12 million people (about 6.5% of the country's population). The story is not much different in India, Philippines or Thailand.

When it comes to sub-specialisation, the figures are even less encouraging. Thus in Malaysia, for 24 million people, there are seven child psychiatrists, not all of whom have had formal training. There are but three forensic psychiatrists in Malaysia. There are also many countries where the only psychiatrists are in the capital city, such as in Vientiane in Laos. Clearly, for lack of resources or lack of interest, mental health remains marginalized in the realm of health care in most countries in Asia.

STRENGTHS AND PROMISING TRENDS IN PSYCHIATRY IN ASIA

Despite these many problems facing psychiatry and mental health care in Asia, there are several strengths that cannot be ignored and indeed are worth preserving, if possible. Among these are the still largely intact family cohesion, that is a resource for support of the mentally ill. Most

mental patients in Malaysia are visited when admitted in hospitals on a daily basis and taken back to their own homes when discharged. Rejection of the mentally ill is still fairly uncommon and occurs in conditions of abject poverty and economic privation. This however may change rapidly with provision of insurance cover or reimbursement systems that are designed to encourage long hospital stays, as in Japan and Korea, where the average length of stay in private hospitals may exceed a year.

Traditional belief systems encourage care of the disabled and mentally ill in many cultures in Asia. Thus many mentally ill are said to be possessed by spirits and capable of special powers and sometimes even revered. While this may deny them access to treatment, their social status is elevated beyond the stigmatization that may otherwise occur. Religious practices and belief in religion are remarkably strong in most of Asia and this is another source of both caring and treatment for the mentally ill. Many treatment centers focus on prayers for the cure or well being of the ill person and this appears to be beneficial to some.

There are growing numbers of mental health non-governmental organizations (NGOs) in India, Thailand, Malaysia, Japan, Korea that have started dealing with numerous mental health problems in the community, mainly through public education, awareness raising and lobbying for better care. Some have set up their own training for volunteers, as in Korea, and day centers for rehabilitating mentally ill persons in the community, as in Malaysia and Philippines.

CONCLUSIONS

Mental health and mental health care have not become a high priority in most Asian countries, despite the recent emphasis at international level. The reform in mental health care will have to be preceded by the building blocks of change in training of health professionals in basic primary care mental health. Hopefully this will trigger the awareness that is lacking in health care planners to make provisions for the mental component of health that the WHO has been soliciting for several years. As long as medical schools keep repeating the same archaic ways of teaching psychiatry, with the most seriously ill in mental hospitals as examples, mental health will remain stagnant.

The institutional image of mental health has to change, with the provision of more small short-stay units for care of the seriously ill and more community based care. Lastly, public education and NGO work in mental health must be boosted to improve the understanding among all of the basics of mental health and mental illness.

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