

Time to focus on institutional reforms in low and middle income countries

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Mental asylums, exported from Europe and implanted across the world as an integral part of the colonial enterprise, represent the most decisive instrument for the globalisation of psychiatry. In more recent times, while the narrative of deinstitutionalisation – closure of institutions and the move towards community-based services has been dominant in most high income countries (Fakhoury & Priebe, 2002), mental asylums (and later hospitals) in many current low and middle income countries (LMICs) have somehow been left behind to their country specific devices. In the context of minimal investments in mental health services in LMICs, many of these institutions, burdened by their history and institutional ethos, remain in a time warp.

The powerful themes of alienation, segregation and institutionalisation, inherent in the construct of mental asylums, have also cast a long shadow on the cultural landscape and popular imagination globally. The stigmatisation of these institutions and, by extension, people with mental disorders and those treating them, is a profound historical legacy that continues to be an important barrier for the social inclusion and citizenship of people with mental disorders. In the West, highly influential critiques of mental asylums by Basaglia (1987) challenged their legitimacy as curative facilities and identified the harms that came to be known as ‘institutionalisation’ (Chow & Priebe, 2013). These and other compelling criticisms provided the intellectual rationale and the ethical imperative for the social, and ultimately, political program of deinstitutionalisation.

In contrast, the issue of reform of mental hospitals was largely bypassed in most LMICs, possibly in the context of the very many other pressing national priorities. Consequently, many mental hospitals in these countries continued to be neglected, with dreadful conditions and, often, as places of profound human rights violations. However, human rights abuses are

certainly not unique to mental hospitals but are widely prevalent in traditional healing facilities, in social protection centres and communities. Indeed the more fundamental problem is the highly skewed mental health systems in many LMICs with tertiary care institutions being the major, or sometimes the only, treatment option available. Without a significant investment in developing concomitant and closely linked community services and social care, isolated reforms of mental hospitals are unlikely to lead to substantial changes.

In a welcome development, in the last two decades, there have been significant reforms in mental hospitals and other institutional care facilities in some LMICs. This has largely been in response to the growing global prominence of human rights and the broad international ratification of various binding instruments that uphold the citizenship rights of people with disabilities (Human Rights Council, 2016), including the right to receive treatment in the community. A good example is the Caracas Declaration, in 1990, which led to the large-scale reforms in mental health services in South America, especially in Brazil and Chile (Araya *et al.* 2006; Cavalcanti, 2008; Barros & Salles, 2011; Loch *et al.* 2016). In more recent times, similar institutional reform processes and provision of community care have spread to Greece (Loukidou *et al.* 2013; Fiste *et al.* 2015) and some Eastern European countries (Puzynski & Moskalewicz, 2001; Tomov, 2001; Aleksandrova, 2007; LecicTosevski *et al.* 2007) with the funding support of the European Union, although substantial challenges remain (Murawiec & Krysta, 2015). These provide striking illustrations of what can be achieved through adequate financing methods and political will. However, while there are such examples, in many other LMICs, the fundamental barriers to change, such as the critical absence of financial and human resources and political commitment, continue to persist (Saxena *et al.* 2007) as significant bottlenecks.

In this context, the two Editorials in this issue of *Epidemiology and Psychiatric Sciences* highlight the need for renewed attention – both global and within

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countries – to be focused on the issue of institutional care reforms in LMICs, especially since in many countries, mental hospitals continue to be the dominant component of otherwise scant mental health services. In the first of these, Cohen and Minas describe the temporal trends of scientific interest in mental asylums, the steep decline of interest in more recent times and the overwhelming lack of studies from LMICs. They go on to stress the need for greater engagement by the current global mental health movement in the institutional reforms process and, finally, point out that the binding human rights conventions that LMICs have agreed to implement can be a powerful catalyst for change.

Very importantly, both Editorials move beyond stating what should happen to describing what is being done with various degrees of success in LMIC settings, often in the face of formidable difficulties. Cohen and Minas describe two such initiatives- the transformation of the Angoda Mental Hospital in Sri Lanka from being an archaic and prototypical asylum to becoming the National Institute of Mental Health (NIMH) and the very important work on improving conditions in Social Protection Centres across Vietnam in a superbly coordinated effort between the various ministries of the Government with technical support from the WHO and the University of Melbourne and funding support from Atlantic Philanthropies.

In their Editorial, Murthy, Isaac and Dabholkar provide a comprehensive overview of the institutional reform process undertaken in India. They start with a historical sketch of the arrival of mental hospitals, their subsequent rapid spread across the entire subcontinent and the recurring descriptions of their abysmal conditions, which seem hauntingly familiar. Interestingly, the decisive impetus for the reforms of mental hospitals in India from the late 1980s came through the interventions of the Supreme Court and the continued monitoring by the National Human Rights Commission (NHRC). In the latest review by the NHRC's Technical Committee, there is evidence for a slow and steady, but certainly not uniform, improvement across the mental hospitals in the country (Murthy *et al.* 2016).

However, institutional reforms in India have almost exclusively been focused on improving only the internal resources of these hospitals without concomitant attention to the development of community-based services. In this regard, the ongoing INCENSE program, with two prominent mental hospitals in India, is an innovative example of multi-sectoral collaboration where the hospitals work in partnership with a broad range of local partners for developing community-based services to address the needs of highly vulnerable persons with severe and enduring mental disorders.

In conclusion, there is room for cautious optimism for two reasons: -first, reform of mental hospitals is being addressed in some LMICs; and, second, there is growing evidence that something can be done right now to improve conditions with a combination of commitment, resources, doggedness and local innovations. The glass though is, at best, half full. Clearly, much more needs to be done and, given the ethical and health imperatives, done urgently by governments, multilateral bodies, researchers, funding agencies and civil society working together. The time for a determined, concerted and coordinated push for action to improve conditions of mental hospitals and other tertiary care facilities in LMICs has come and we can ill afford to postpone it any more.

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Conflicts of Interest

None.

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