

Class 3 (2 November 2011): Mental Health around the Globe: Different approaches to developing mental health in communities and individuals

In earlier talks I have dealt with some fundamental points about mental health, race and culture, in relation to Britain. To summarize, psychiatry and western psychology arose within a way of thinking – paradigm we call it – that developed in a western culture and so applying either as a system without modification across cultures is fraught. Today's talk goes global, mainly looking at the mental health scene in the 'third world' or 'developing countries' or to follow the World Bank classification, low-and-middle income (LMI) countries. Since I am more familiar with the situation in Sri Lanka than any other LMI country I shall refer quite a lot to the mental health scene there, as a sort of example.

The topic is not simple. For one thing it is almost impossible to set it in a proper historical context because information about the past is difficult to sort out, simply because the whole language of mental health and illness has come about in Western Europe. So, it is very difficult to fathom what exactly was going on in LMICs before western domination – for instance when India, China and parts of Africa were the developed countries – what happened then to people we now call 'mentally ill' or refer to as having 'mental health problems'. Further, there are major problem in carrying out international research.

Slide: Problems of cross-cultural international research

We know about the limitations of diagnosis in understanding the complex problems that we designate as 'mental', but when we look at this matter internationally and cross-culturally, the problems are greatly magnified. The main issue of international study has been called 'category fallacy' – the limitations of imposing a category of mental illness that may have some use in one cultural and social setting (say Britain or the US) in a very different location and socio-cultural context. This is because the meaning of 'mental health' and illness is largely culture-based, rather than biological. But as I have pointed out in early talks, there are similarities as well as differences across cultures and, moreover, cultures are not static entities. Various forces are in play - not least what we call 'globalisation' and of course imperialism and power-driven change (countries invading others for instance). But other issues too limit our ability to carry out proper international studies in mental health – observer bias, communication problems, variation in help-seeking practices and so on.

We have glimpses about 'mental health' in the past: Ayurvedic medical texts (Ayurveda being one of the Indian systems of medicine) Ayurvedic texts written 5000 years ago referred to forms of madness as illness. Hippocrates described melancholia and mania as illnesses in 400 BC and this system of classification was built upon in the mental hospitals (maristans) of medieval Islamic Empire of the 10th to the 13th Centuries. The first mental hospital was apparently founded in Bagdad in the year 705 AD.

Coming to more recent times, the popular idea that nothing much was done about psychological or mental problems in pre-colonial Asia and Africa is probably untrue - as untrue I would think as the popular idea that people we would call 'mentally ill' were invariably persecuted in these societies in the way (say) witches were burned in Medieval Europe. During most of the colonial period, indigenous medical therapies and even religious healing were actively suppressed in Asia, Africa and America, but some rudimentary mental hospitals (modelled on European asylums) were established in British and French colonies. In the 1950s, Margaret Field (1960), a doctor and anthropologist working for the British colonial office, described Ashanti shrines in Ghana where people with

'fear and guilt frenzies' and people who were (as she put it) 'indistinguishable from classical schizophrenics' benefitted from attending (1960: 1045). I remember being told about a Buddhist temple at Neelammahara near Colombo, Sri Lanka, where a healer-priest practiced Ayurvedic treatment for *unmada* (classical Ayurvedic equivalent to 'mental illness') using herbal therapies mainly combined with social care by local villagers boarding patients in their homes. Neelammahara thrived as a centre for the healing of mental illness well into the 1980s. It is well known that there are numerous centres in Asian and African countries where 'mad' people are taken for cures – usually around a temple, mosque or church – although there are hardly any recent reports on these services in medical or psychiatric journals except for two papers (Raguram *et al.*, 2002; Halliburton, 2004) which I shall refer to later.

In the 1970s, WHO conducted some studies across the world called IPSS (International Pilot Study of Schizophrenia) (WHO, 1973, 1975, 1979) and DOSMeD (Determinants of Outcome of Severe Mental Disorder) (Jablensky *et al.*, 1992) documenting two year and five year follow ups of people diagnosed as suffering 'schizophrenia' diagnosed according to standardized psychiatric criteria. The next slide shows the published findings on 5-year outcome.

Slide: WHO IPSS Study; Five year Outcome

The way that outcomes were presented meant that the best centres had to get say over 30% in the best column and / or less than 11% in the worst – India and Nigeria came out on top. Other ways of studying outcome too supported the general conclusion that people diagnosed with 'schizophrenia' had a better outcome in non-western developing countries, when compared to those in relatively rich western countries. The study was criticised as a waste of money by several transcultural psychiatrists because it failed to take on board 'category fallacy' (by imposing the 'schizophrenia' diagnosis as a measure of ill health) but the finding that outcomes for people seen as seriously mentally ill was actually better in non-western settings where (at that time anyway) the bio-medical model for mental health problems was not very popular, psychotropic medication was used in very small doses if at all - this finding made people think. Perhaps the therapeutic context for recovery may be better in those settings for some reason – and indeed there were articles on why this may be so - but on the whole the significance of IPSS findings had very little impact on the bio-medical revolution (search for better and better drugs) that was taking off at that time in the West.

Now, well into the 21st century WHO recognises that needs assessments in mental health is much more complicated than counting numbers of people with diagnosed 'mental illness'; and mental health, in LMI countries in particular, is seen as much broader than being just about illness, however this is identified.

Slide: Mental Health Recent Universal Definitions

At an official level, WHO appears to have moved away from emphasising the illness model for mental health problems towards a public health model for developing services in LMI countries. So we get a definition of 'health' as 'a state of complete physical, mental and social wellbeing' (WHO, 1988, 2001) being used to see mental health as 'a broad array of activities directly or indirectly related to the mental well-being component' of general health (WHO, 2008). I say at an official level because, what often happens in practice is that 'experts' with a WHO badge tend to be committed to traditional psychiatric ways of thinking

and merely try to impose traditional psychiatric systems, often encouraged by local experts trained in the West.

But today's social and cultural contexts of LMI countries are very different to that in the 1970s. We need to try and understand the current state of play because that is where we have to start from. But more importantly, development of mental health services, like development in any other field, must start by tapping into what people currently want and value.

Slide: Current Scene

The current scene (using Sri Lanka as an example) depicted in this slide shows primarily the plurality of systems that people access if they can afford it. And people frequently access several systems concurrently. I emphasise 'if they can afford it' because in many instances it is affordability and access that determines what is used not what is ideologically or theoretically preferred. Indigenous healers and religious healing are the most popular but (again quoting Sri Lanka) this is changing in some places because healing ceremonies are getting expensive while psychiatric medication marketed as 'scientific' and 'modern' is becoming the cheapest option. This works in various ways: An example I know is a psychiatrist who holds 'camps' – co-ordinated by an western NGO - where people identified as having certain symptoms on a check-list are brought to, and then given supplies of medications that 'suit' the symptoms – free at least to start with. Yet, at this point I would like to sound a word of warning about the danger of being carried away – the other way as it were - by idealizing what may happen in LMI countries. The reality for people who are very disturbed behaviourally – 'psychotic' or 'manic' in the language of psychiatry – in many LMI countries is that they are tied up or physically controlled in some way (Gilbert, 2002; and personal communications to author from various sources) until they quieten down or get transported to a mental hospital, if one is available. Of course similar methods are applied in western psychiatric settings in the UK (i.e. seclusion and heavy medication) but not because nothing else is possible. Conditions at some healing centres too may be inhumane – I observed this myself some years ago – but many seem very effective. But the big problem for planners – and for talks like this - is that reliable information on effective and culturally appropriate centres for mental health care in LMI countries is sparse.

In many LMI countries state services are free. But in Sri Lanka for example, state funds go almost entirely to services promoting traditional western-type psychiatry. But most rural people, and many city dwellers too, access indigenous healers and / or religious healing for many illnesses and certainly for situations that we would call 'mental illness' or mental health problems. Most people take a pragmatic approach – choice is made on the basis of affordability, ease of access and hear-say; the mental hospital (asylum) itself is often the last resort in terms of preference. Non-governmental agencies play some part in providing mental health and social care but often their work is geared to methods determined by western funding agencies rather than local needs.

Finally, as the bottom line of the table notes, although rapid social changes are occurring, it is fair to say I think that traditional emphasis on family involvement and commitment to community-feeling remains strong, not just in Sri Lanka but in most non-western LMI countries –but that is if families are there or within calling distance, for if a person has no close family there is almost total neglect and little means of accessing any services. In other words, in many LMI countries, there is virtually no welfare system of note that substitutes for family.

Slide: Healing systems in Sri Lanka

The list here shows the sort of systems that are actively sought by people in the central province of Sri Lanka. This sort of model applies generally in most of Asia and Africa I reckon, although clearly the particular form of religious healing or religious centre preferentially accessed would vary. But what is striking in Sri Lanka is that, in practice, there appears to be a vast overlap of religions in a sense. For example, a Catholic church in the Eastern province that I visited because it functions as a healing centre, this was accessed mainly by Hindus and Muslims; a traditional centre in the South that people go to for healing consists of both Hindu and Buddhist shrines and is accessed by people of all religions, including many Christians. This pluralism in accessing religious healing – as in accessing medical healing - is possibly common in many LMI countries.

The next two slides list some recent publications that are welcome additions to a sparse literature.

Slide: Recent publications

I believe that these publications (Desjarlais *et al.* 1995; Cohen *et al.* 2002; Patel and Thara, 2003) only touch the surface of what is happening. I shall not dwell on them but go on to list some recent papers (Raguram *et al.* 2002; Halliburton, 2004; Fernando, 2005) which are worth considering.

Slide: Some recent papers

The first paper in this list was published in 2002 in the *British Medical Journal* (Raguram *et al.*, 2002) and presents a study of healing at a Hindu temple in Tami Nadu (South India) known for helping people with mental health problems. It was the first such study to be printed in a prestigious western medical journal. The authors had elicited the views of both the patients and their carers about their experiences and also made psychiatric assessments (of the patients) on a standard scale before and after their stay at the temple. They found that most of the patients studied (a) suffered from psychotic illness and (b) showed a degree of improvement (judged by reduction of psychiatric symptoms and their own expressed views) that matched the sort of improvement that may be expected by traditional bio-medical therapy. I have visited a similar place – a mosque in Kerala (South India) - and I have heard of many others in South Asia that provide healing often by service-users just ‘being there’.

In 2004, the journal *Transcultural Psychiatry* carried a paper reporting research into experiences of 100 people who accessed treatment in three forms of therapy in Kerala (South India) – Ayurvedic, bio-medical psychiatry, and religious healing at one or other of three locations, namely a Hindu temple, a Muslim mosque and a Christian church, all of which had reputations for healing people who suffer from mental illness. All the patients had mixtures of symptoms which would give the diagnosis ‘schizophrenia’ or other severe mental disorder. Similar proportions of patients benefitted from each form of therapy, and several had changed from one to another until they derived benefit. This shopping around had resulted in a very high overall improvement rate. Incidentally I quoted this study in an article in *Openmind* in arguing for user-choice in our own British system (Fernando, 2005c), available on my website.

The last two papers in the list are discussions - both available on my website.

The next slide is meant to indicate how best LMI countries can progress in developing mental health services for the 21st century.

Slide: Home-Grown System

The present state of knowledge and experience in multicultural societies in the West suggests certain standpoints. The imposition of systems developed in one social-cultural framework and history onto others that are very different is as fallacious as imposing models of mental health and illness developed in western culture all over the world, disregarding cultural, social and political differences. There is no such 'thing' as a universal model that fits all and sundry, whether in mental health or in mental health systems. The recent project called 'Global Mental Health' (GMH), being popularised in the US, is as dangerous to the mental health of people and communities in LMI countries as imperialism and colonialism were to their political and social environments.

Yet development must be realistic and take on board whatever is meaningful and useful for the society concerned. It must be evidence based – based on the evidence of people who access services, and communities who have experienced various approaches. Most LMI countries have experience of a plurality of models that service users in western countries could envy – but only accessible to people who can afford them. So poverty reduction must go hand in hand with mental health development – perhaps actually lead mental health development.

We need to bear in mind that when last studied, what was identified as serious mental illness appeared to have a better outcome in LMI countries, so there may be something we should hold on to in their ways of life and cultures that promote recovery. Depression has been studied extensively across cultures and we could draw on the lessons from this.

Slide: Building Mental Health Services in Developing Countries

Developing services in LMI countries is not a simple matter of transferring established strategies commonly used in high income countries of the West. Mental health is not just a technical matter but is tied up with ways of life, values and worldviews that may vary significantly across cultures (Weerackody and Fernando, 2009). But in terms of practical politics, there are numerous challenges and limitations that have to be faced – and compromises may be necessary. Of the points in this list, sustainability and cultural acceptability may be the most important. But often, small beginnings lead to bottom-up developments that then get embedded in a social fabric. In Sri Lanka, I have sensed quite radical developments of this sort taking place – the main problem is of sustainability.

Slide: Some Projects in Sri Lanka (personal knowledge)

I shall not describe these projects in detail. They both have websites you can look up. One is locally controlled and the other internationally. Their origins are very different. Nest started as a response to recognised need by local people who then sought funding from abroad and locally. When prevented from being advocates for inpatients, the staff of Nest developed houses that gave refuge to people who would otherwise have been admitted to hospital or neglected in the community for various reasons. Finally, Nest managed to build

up an alliance with the statutory sector so that they were able to take over a ward in a hospital to run an occupational therapy service, thereby setting up a system that provides a model of care very different to that in the hospital.

Basic Needs started up in Sri Lanka with an ostensible aim of developing self-help by involving people who had used mental hospital services in the past. This NGO started by distributing prescribed medications to people who had been prescribed these but could no longer get them but wanted to take them and remain in their own homes. The NGO then started a gardening unit attached to a hospital. More recently, it has been concerned mainly with organising group activity in villages trying to empower people who are stigmatised because they had attended psychiatric facilities.

Slide: Some innovative developments in the statutory sector (personal knowledge)

The eastern region of Sri Lanka was severely affected by the civil war which is now over. During the war, the small group of people employed to provide mental health services established what turned out to be a unique model of care. The small mental hospital in Batticaloa became a place where patients, their relatives and employed staff worked jointly in an open and liberal system, contrasting with the violence going on around it in the community. From this, developed a system of care whereby carers – called ‘bystanders’ – were invariably admitted to hospital whenever a patient was admitted. The staff found that this system resulted in quick ‘recovery’ of patients and very rapid discharge, as well as easy after-care since relatives and staff had already established working relationships. Gradually, the staff found that they could spend time outside the hospital visiting people requiring help because in-patients were largely looked after by unqualified staff working with ‘bystanders’.

When new units were opened in Kalmunai and other places in the East, the ‘Batticaloa system’ was set up from the start. However, these new units developed further by establishing links with local indigenous healers and places where healing took place. There is now referral across between these ‘non-psychiatric’ systems and the local unit, both groups of therapists having evolved respect for each other. Even further, the psychiatric units have established connections with many other non-statutory local agencies so that they can call on community workers in supporting people in the local area over various problems. More recently help for employment and a micro-credit scheme has been developed.

Slide: Bottom-up development

The Shanghai model started in 1958 and I believe is being copied elsewhere in China. I think initially it was based on the network of communist party cells around the country. Using this established system in particular villages, the local authorities developed ‘guardianship networks’ – essentially volunteer committees of neighbours, retired workers like teachers, and community officials supporting patients identified by primary care staff. This local network (developed bottom-up) using what was available locally was linked to statutory ‘top-down’ systems like rehabilitation services in a nearby town and a hospital in the main city. I do not know how this functions now but it is the manner of its formation that I would draw attention to.

Slide: Extending from Social Care into mental health

Ashagram ('village of hope') is an NGO in Western Madhya Pradesh (India) (described by Sumit Jain with others in Vikram Patel and Thara's book) that started as a resettlement colony for the destitute and later took in people identified by local communities as 'ganda' or chronically mad. Now families of these people are a major resource. Rehabilitation and medication have been added but the basic support is via community and work in the centre.

I am sure there are many other similar systems in India – I am not so sure about China. Some are more successful than others. Some build around religious institutions, others, more recent perhaps, around humanitarian work or what is called psychosocial work – post tsunami work for example. The thing is that mental health care is not clearly distinct from social care, from human problems of living, from poverty.

I am nearly at the end of my talk. Although I think LMI countries are best advised to develop home grown systems of mental health care drawing on their own traditions and cultural knowledge, there is good reason for them to draw on others too. Psychiatry, developing within western culture, has over the years accumulated much knowledge – some of which is now very questionable, but other bits may well be useful globally. But other societies and cultures too have developed their own ways of doing things that may be as beneficial to mental health. As the book *Crazy Like Us* by Ethan Watters point out, it is to the advantage of all of us that we learn from each other and hopefully develop systems of care and 'therapies' that are culturally and socially suited to individual places. Developing plural systems with choice for service users and their carers is surely the way forward not just for LMI countries but for us here as well. However, this ethical and sensible way forward may not materialise. Western power has always backed psychiatry and now more than ever – probably for economic reasons. A movement calling itself 'Grand Challenges in Global Mental Health' (Collins and Patel, 2011) and coordinated by US NIMH and probably backed by Big Pharma, appears to be seeking to spread psychiatric therapies in LMI countries in a massive onslaught, not unlike perhaps the colonial onslaught of yester-year. I have written a short article in *Openmind* about this issue which I shall place on my website shortly. But now I leave you with a slide that I reproduce from a recent book published in Sri Lanka that indicates how best LMI countries – indeed all countries – could go forward.

Slide: Stakeholder for developing mental health services in the community

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