Ethical and sustainable services for mental health and wellbeing in non-western settings

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(20 minutes)

Talk

Slide 1: Heading: Title of talk

Good afternoon everyone. It's good to be here in Leicester for the first major conference for many years on topics very close to me heart. The focus of my talk is about developing mental health services in developing countries—I prefer the term Third World but will not go into that now. And in talking about this, I shall refer to some research in Sri Lanka between 2007 and 2012, looking at the way communities across the Island dealt with (or did not) the 'trauma' of the tsunami and civil war. Finally, if I have time I shall show a few pictures emanating from the research.

Much of what I say in this short talk is drawn from my last book *Mental; Health Worldwide; Culture, Globalisation and Development* published in 2014.

Slide 2: Book Title: *Mental Health Worldwide*

I called it Mental Health *Worldwide* and not *Global* because (as I argue in the book) in developing mental health services, what is very important is that we focus on *local* knowledge and *local* thinking—in other words the socio-cultural *context* of the services, and how mental health is seen by the people *using* the services. Mental health is something *local* not global; the talk of global mental health gives the wrong message. Also, we must learn from history—not least the disaster of having introduced asylum-psychiatry during colonial times and then, more recently, imposing culturally alien, medication-based psychiatry in post-colonial—some would say neo-colonial—times. All this is covered in some detail in my book.

First, a very short historical background to mental health and illness as we now tend to use these terms.

Slide 3: Heading: Short historical background

Slide 4: Mental health and service provision worldwide

a) Western psychiatry, western psychology and the meaning given to words / concepts like *mental health* and *mental illness* came out of the study of madness in the context of post-Enlightenment European thinking of 17 – 18 Centuries (objectivity, positivism, exclusion of religion and 'spirituality', focus on the individual, etc.).

b) Understanding of 'mind', problems of living, ways of interacting ways of experiencing and showing distress and so on—in fact understanding of what 'madness' is all about — developed very differently in non-western cultural traditions.

c) Medicalization of human problems in the Global North has resulted in numerous reductionist diagnoses and latterly a narrow bio-medical approach to treatment dependent on drug therapy. Medicalization is much less —and different—in non-western traditions.

d) Western systems were partially exported during colonialism (but with little cultural impact) and more so—perhaps more effectively— since 1980s, on the back of 'modernization' / 'globalization' in the context (and this is important) of geo-political power games, neo-liberalism, western funding agencies and big business interests especially big pharma.

Slide 5: Support for equivalents in the Majority World

When we search for what we may call 'support' for, or ways of helping people with, (what we call) 'mental health problems' in non-western cultural traditions, what we find is that, in very general terms:

1. What we (speaking in a Western idiom), call 'mental health' is equivalent (in non-Western cultures) to 'wellbeing' of people and communities; largely seen in terms of '*Balance*' & a holistic body-mind-spirit approach to the individual, and located in social-cultural context—'out there' (as it were) rather than just primarily inside the head.

2. There are many ‘psychologies’ (ways of understanding the psyche) worldwide that inform people daily lives —‘psychology’ located in Western knowledge is only one. Most are embedded in religion (which is integral to culture) and ‘work of culture’ (as Gananath Obeyesekere, eminent Sri Lanka-American anthropologist calls it), cultural structures, often handle problems that in the West are medicalised as ‘illness. Gananath wrote mainly about depression (Obeyesekere, 1985).

3. There is little medicalisation of ‘mental health problems’ in many non-western cultures but individual problems of living are often seen (for example) in ethical, spiritual, philosophical, and existential terms. However, a fair amount of medicalisation did take root for a while in (for example) medieval Islamic mental hospitals and perhaps Tibetan-Buddhist sort-of ‘psychiatric’ systems (Terry Clifford, 1984).

4. Indigenous non-Western *medical* systems deal primarily with bodily dis-ease and some ‘madness’ but are connect closely with religious healing, non-medical therapies of various sorts, faith-systems, and so on.

Now that in a nutshell is the background. The question is how best to develop.

Slide 6: Heading: ‘How best to develop’

Accepting that traditions have not stood still and there has been variable amount of mixing—cultural hybridity one could call it.

First a word of caution.

Slide 7: Dangers of mental health development

As Laurence Kirmayer (2006) says (about developing mental health services):

‘There is a danger that focusing attention on mental health needs only serves to divert attention from more difficult social problems that demand political and economic solutions.

Psychiatry may collude with those who benefit from the status quo, neutralizing political challenges by reframing problems as aspects of individual mental health and offering treatment to individuals who are, after all, expressing the pain of a system out of joint.'

One could enlarge on this if there is time, but I am sure you get the point.

If we turn to the literature, there are major problems in what is often written up as 'cross cultural research'.

Slide 8: Problems of cross-cultural research

I shall not go into these in detail but we can discuss these later if there is time. In particular the issue of 'category fallacy' (first described by Arthur Kleinman, 1977) —which means the imposition of a concept / category derived in *one* socio-cultural setting internationally across cultures is a major problem. And of course differences in health-seeking practices and illness behaviour worldwide.

So in the long term we need quite a lot of focused and sensitive research. But to be realistic, we cannot wait for the long term. We have to get on with development now, while making some progress in gathering evidence.

Slide 9: Lack of evidence

Judging from our observations in Sri Lanka that I shall refer to in a moment, I think we could do with even rudimentary information on:

Efficacy of systems and treatments as seen by service users

Local practices (religious, indigenous medicine etc.) appertaining to local understandings of 'mental health'

Idioms of distress and ways of identifying social stress. Here I would note the importance of (for example) 'collective trauma' in non-western settings as opposed to how trauma is generally conceptualised (e.g. Somasundaram, 2007).

How individuals and communities cope with social problems, distress, disability, and so on.

Hard data on indigenous systems in LMICs that still thrive in many places, although these were seriously under- developed, corrupted and distorted / suppressed during colonial times.

And, we could note in passing that there are some pointers to how we should go about mental health development.

Slide 10: Some pointers on how we should approach development

That there is some indication, for example:
that illness-outcomes of people diagnosed as 'schizophrenic' was better in India and Nigeria compared to USA and UK (WHO's IPSS study—see Hopper and Wanderling, 2000) at a time in the 1960s and early 70s when psychiatry was virtually absent.

That healing systems in some places may be as good as (or perhaps better) than bio-medical treatment even for mere symptom-relief.

That easy access to plurality of systems (so people can choose) may give best overall outcomes. A lesson for us here in UK too—*plurality of services with service-user choice* may maximise good outcomes.

These points refer to studies by Raguram and others in Tamil Nadu; and Halliburton's studies in Kerala. We could discuss these later if you wish.

Slide 11: Heading slide: Lessons from TGH Program

Now I would like to present very briefly some lessons from the Trauma and Global Health (TGH) Program in Sri Lanka that I was privileged to have been consultant to between 2007 and 2012.

First some acknowledgments.

Slide 12: TGH Program

The research in Sri Lanka was part of a wider program using participatory qualitative methods subsumed under the title PRA (Participatory Rural Development) and has been described elsewhere in detail (Weerackody and Fernando, 2011). And the core team ...

Slide 13: TGH Core Team in Sri Lanka

Slide 14: TGH Study Explored...

I have emphasised in red some of the important areas we focused on:

As a result of our research and incidental observations during the extensive work we carried out with various groups and in several locations, we were able to derive certain conclusions on policy and also on the process for development in Sri Lanka, which may have implications for other non-western low-income countries.

Slide 15: Some conclusions for policy

Training of professionals we thought needed attention. And there were other directions for policy. It seemed clear that planning had to take on board the fact that most people seemed to get the best help from indigenous healers and religious, or semi-religious, centres and wanted these to continue to be available, although sometimes reformed and regulated properly—as in the case of the rudimentary psychiatric services. The activities of big pharma, sometimes through NGOs, were another issue that needed regulation.

The best process for development that most people wanted was for this to be stakeholder-led and community-based. The current stakeholders varied from place to place but in the best served areas we found something like this:

Slide 16: Example of stakeholders

In other words, there was a variety of stakeholders, just as people generally benefitted if a variety of services were available to call on.

In conclusion, I would like to make some points, bearing in mind the lessons from history, not to speak of the neo-colonial forces that operate in the world today—some points about the *process* of development that should apply to post-colonial development in general and should apply to mental health development.

Slide 17: Ethical and Sustainable Development

As recognised in the wider world of development studies, two considerations should underpin mental health development in a post-colonial world: First, it must be '… for the benefit of people 'as self-defining *subjects'* rather than '*objects* of concern … entitled to choose their way of life themselves' (Gasper, 2004). And second, it must be sustainable '.. for present and future fitting into mainstream of the social and political (O'Riordian, 1998; Warburton, 1998). And for this, I suggest that the *process* is important. For example imposing a so-called western-evidence based system using (say) CBT and medication may *seem* to work to some extent in the *short term*; but in the medium term and long term they will become redundant or just mere drug-centres at best (we can discuss why).

Slide 18: Process of development

More generally, the process of development should be mainly *bottom-up,* supplemented by top-down actions to support the services.

Slide 19: Thank You!

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