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Mental health system development in Asia: Does Australia have a role?

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Abstract

Background: Socioeconomic trends herald what many describe as the *Asian Century*, whereby Asian economic, political and cultural influence is in global ascendency. Broadening relevant ties between Australia and Asia is evident and logical and may include strengthening alliances in mental health systems.

Aim: We argue the importance of strengthening Asian mental health systems and some of the roles Australian mental health workers could have in promoting strengthening the Asian mental health system.

Methods: This paper is a narrative review which sources data from reputable search databases.

Results: A well-articulated Australian strategy to support strengthening the mental health system in Asia is lacking. While there are active initiatives operating in this space, these remain fragmented and underdeveloped. Coordinated, collaborative and culturally respectful efforts to enhance health education, research, policy, leadership and development assistance are key opportunities.

Conclusion: Psychiatrists and other mental health professionals have a unique opportunity to contribute to improved mental health outcomes in Asia.

Keywords

Asia, Australia, mental health, policy, leadership, psychiatry

Australia's opportunity in the Asian Century

We are living in the Asian Century, a time likely to become dominated by Asian economics, politics and culture (Pan, 2013). The Asian region comprises 48 nations, covering a land area of 44.58 million km^2, equivalent to 8.8% of the Earth's surface area (United Nations, 2015). Asia is home to 4.4 billion people and 60% of the world population (Department of Economic and Social Affairs: Population Division, 2015). Asia also espouses significant economic diversity with nations across the income spectrum, from high-income countries (HIC) (e.g. Singapore and Korea) to low and middle-income countries (LMIC) (e.g. Laos and China) (The World Bank, 2015). The region is an economic powerhouse and by 2025 is projected to account for almost half the world's economic output (The Australian Government, 2012).

Australia is now ideally situated to benefit from the current and projected economic growth of the Asian region. The Gillard Government paper, *Australia in the Asian Century*, outlined these benefits, and, relevant to health, called for building on our leadership in public health (The

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Australian Government, 2012). This now-outdated paper only briefly touched upon improvements to Asian medical healthcare systems and neglected mental health entirely. Encouragingly, as an example of State government leadership, the Victorian Government has recently produced a 'Global Health Melbourne Plan' (Department of State Development Business and Innovation, 2014). This plan offers a clear strategy for leveraging strengths in the health sector and exporting health-related goods and services globally, hence strengthening the quality and accessibility of local Asia-Pacific health services. Mental health and neuroscience are notable inclusions in the strategy, which highlights the Asia Australia Mental Health (AAMH, 2015) consortium as a key driver of mental health policy and training in the region.

Herein, we outline the importance of Asian mental health and some of the roles Australian mental health professionals could play in promoting mental health system development.

Global mental health issues

The global burden of mental illness is the largest cause of disability in the developed world, and as the economies develop, this pattern of disease burden is likely to emerge in Asia. Mental and substance-use disorders currently account for 8% of the global burden of disease, afflict around 700 million people and were estimated to cost the global economy US$4.6 trillion in 2010 (Gilbert et al., 2015). The Organisation for Economic Co-operation and Development (OECD) estimates that the costs of mental illness are up to 4% of gross domestic product (GDP) in terms of healthcare costs, lost productivity and disability benefits (OECD, 2014). Mental health disorders also carry a steep mortality burden; those with serious mental disorders die up to 20 years earlier than the general population (OECD, 2014).

Around 80% of people living with mental illness reside in LMICs and have limited access to care due to significant under-resourcing in this area (AAMH, 2008; Gilbert et al., 2015). HICs spend on average 5.1% of their health budget on mental health (Gilbert et al., 2015) compared with 0.5% spent in LMICs (Gilbert et al., 2015). These rates of funding are less than half the cost of those needed to deliver a basic mental healthcare package.

The World Health Organization (WHO) Health Systems Framework nominates six domains as the building blocks of a health system – leadership and governance, healthcare financing, health workforce, medical products and technologies, information and research and service delivery (WHO, 2007). 'Health system strengthening' is therefore the enhancement of the building blocks with the goal of improving health outcomes, health system responsiveness and efficiency, and protecting patients from the financial burden of disease and care (WHO, 2007). Wide disparities in the building blocks exist in mental health systems and are particularly significant in LMICs.

Global policy and leadership approaches to mental health

The global mental health community has made major headway in developing coordinated approaches to raising the profile of mental health. The Movement for Global Mental Health (Movement for Global Mental Health [MGMH], 2014) emerged from a 2007 Lancet Series on global mental health (Horton, 2007), which included a Call for Action (Lancet Global Mental Health et al., 2007). This series was convened by the Lancet Global Mental Health Group. The publication of this series in a high-impact factor, highly read and cited journal was deemed a major success.

In 2014, mental health took centre stage at the World Economic Forum (WEF) in Davos, after a WEF-commissioned study identified mental illness as the single most costly health issue and a major barrier to development and productivity (Bloom et al., 2011). The establishment of the WEF Global Agenda Council on Mental Health has cemented the place of mental health on global health and development agendas (WEF, 2014). Experts in psychiatry and mental health policy have established *www.mhinnovation.net*, an online database of evidence-based mental health innovations that facilitates knowledge synthesis and exchange between policymakers, researchers and practitioners globally (Patel and Saxena, 2014).

The mental health community has long called for explicit mental health targets to be set (Minas et al., 2015b). This year, the United Nations Sustainable Development Goals for the period 2015–2030 included mental health for the first time (United Nations Department of Economic and Social Affairs, 2015). The mental health goals are to reduce premature mortality attributable to mental illness by one-third by 2030, broaden prevention and treatment of mental illness and substance abuse, and general promotion of mental health and wellbeing (United Nations Department of Economic and Social Affairs, 2015). More specific outcomes metrics will be developed on these goals.

Numerous organisations exist that seek to improve mental health service availability, accessibility and quality in LMICs. These organisations have multiple collaborations with Australian-based mental health professionals, leaders and researchers and include the Asian Federation of Psychiatric Associations (www.afpa.asia/en/index), the WHO (www.who.int/mental_health/en/), the World Psychiatric Association (WPA; www.wpanet.org) and the Pacific Rim College of Psychiatrists (www.prcp.org).

The Pacific Islands are noted as a key region, close to Australia, where mental health systems are significantly underdeveloped. A conservative estimate suggests >90% of people in Pacific Island Countries do not receive any care or access (WHO, 2013b). This region is outside the scope of

our review; however, we acknowledge the importance of mental health system strengthening in this region. Key examples are the WHO Pacific Islands Mental Health Network which is funded by the New Zealand Agency for International Aid (WHO, 2015). The New South Wales Institute for Psychiatry has provided support and projects in the Pacific Region for the past 20 years (Fung and Montague, 2015). One such example is the Leadership Development Programme for mental health workers, recently analysed as a successful programme for enhancing leadership confidence (Fung and Montague, 2015). The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has developed the Pacifica Study Group, in collaboration with the WPA, which aims to develop child and adolescent mental health services within the Pacific Region (WPA, 2015).

Mental health issues in Asia

The treatment gap for mental health care between Australia and Asian countries is significant. For example, in China, 91.8% of all individuals with any diagnosis of mental disorders never seek help (Liu et al., 2011); for psychotic disorders, 27.6% never sought help and 12.0% saw non-mental health professionals only (Phillips et al., 2009). Asia accounts for 60% of the world's suicides, with a suicide rate of 19.3 per 100,000 (Chen et al., 2011) compared to the global rates of 11.4 per 100,000 (WHO Department of Mental Health and Substance Abuse, 2011). Suicide attempts remain a criminal offence in many Asian countries (Chen et al., 2011). Furthermore, approximately 20% of Asian countries do not collect suicide data (Chen et al., 2011). While Australia has 12 psychiatrists per 100,000 population, India and Indonesia, respectively, have 0.3 and 0.01 psychiatrists per 100,000 population (WHO Department of Mental Health and Substance Abuse, 2011). Furthermore, there are important cultural complexities in the region. Shame, stigma, traditional spiritual notions of aetiology and treatment, and concerns over family reputation combined with low mental health literacy are barriers to seeking mental health care in many Asian communities (Wynaden et al., 2005). Culture-related challenges to service delivery include language, especially in nations like Myanmar where over 100 languages are spoken, and the presence of culture-specific mental health syndromes like *amok* and *qi-gong*. The pattern of help-seeking behaviour is reflective of the cultural considerations, with individuals more likely to seek help within the extended kin, through traditional healthcare methods and through consultation with community leaders before accepting referral for empirically validated psychiatric treatments, if at all (Ng, 1997).

Asian policy and leadership approaches to mental health

Mental illness remains an underappreciated contributor to the healthcare economic burden in Asia. In India, alongside the big four non-communicable diseases (NCDs) – cancer, cardiovascular disease, respiratory disease and diabetes – mental illness will cost an additional US$6.2 trillion between 2013 and 2030 and in China US$27.8 trillion, roughly three times its 2013 GDP according to a study by the National Bureau of Economic Research (The Economist Intelligence Unit, 2015). In the context of these concerning findings, *The Economist* journal has called for greater investment in mental health treatment and research to counter impacts on GDP and public health.

The call to act on mental health inequalities gained further momentum at the 26th Asia-Pacific Economic Cooperation (APEC) meeting, where it was identified as a priority (Minas et al., 2015a). Since the 2014 meeting, the Ministers of the 21 participant nations have endorsed the APEC Roadmap to Promote Mental Wellness in a Healthy Asia-Pacific, a strategic plan to address mental health inequalities, to be implemented over the next 5 years (APEC Life Sciences Innovation Forum and APEC Health Working Group, 2014).

AAMH initiatives

Australia can further contribute to improving mental health outcomes in the Asian region alongside existing initiatives through coordinated collaborative efforts in education, research, policy, leadership and health system strengthening assistance. Australia has modern mental healthcare system; however, sharing the lessons, both success and failures, offers an opportunity to teach and to learn from the best practices in the Asian region. Here, we outline examples of existing collaborative efforts and opportunities for the future. Unfortunately, there is no Government strategy or unifying body that oversees or coordinates efforts in mental health in Asia, and these partnerships remain fragmentary and underdeveloped as a whole and are unable to collectively benefit from the lessons of operating in this space.

Research and policy development partnerships

The AAMH, a consortium of the University of Melbourne's Department of Psychiatry, St Vincent's Health and Asialink (non-academic, leadership and business development organisation within the University of Melbourne), is heavily involved in regional partnerships and provides clinical, research and policy development support to 15 Asian countries (AAMH, 2015). The University of Melbourne's Global and Cultural Mental Health Group provides health system strengthening support to Indonesia, Sri Lanka, India, Philippines, Japan and Vietnam (Melbourne School of Population and Global Health, 2015). The University of New South Wales also has strong partnerships in Asia with both Timor Leste (Silove et al., 2009) and Cambodia (Jegannathan et al., 2015).

The evidence base for mental health interventions in Asia is still evolving. Research is needed to evaluate and adapt mental health interventions designed for developed health systems to low-resource settings (Divan et al., 2015). For example, in adapting the UK-designed Preschool Autism Communication Therapy (PACT) to South Asia, a process called 'task shifting' was required, whereby tasks were redistributed to non-specialist health workers (Divan et al., 2015). Task shifting forces the decentralisation of mental health care. In India, the involvement of community healthcare workers in the management of individuals with Schizophrenia was moderately more effective than inpatient treatment alone (Chatterjee et al., 2014). A randomised control trial of depression and anxiety disorder management led by lay health councillors was conducted in Goa, India (Patel et al., 2010). Interestingly, the concept of task shifting is best developed in LMICs, so much can be learned from this concept by HICs. Due to geographical challenges, Australia has embraced task shifting through the development of a rural generalist programme that enables general practitioners (GPs) to develop skills in a specialist discipline, thereby making rural practices more self-sufficient (OECD, 2015). Expanded roles for nurses, psychologists, pharmacists and allied health practitioners are another method of supplementing workforce in the areas of greatest need (OECD, 2015).

Given the rapid development in Asia, the Asian mental health research sector is likely to become a leading player in mental health research globally, and capacity development is likely to have global benefits. China is now contributing highly significant papers to major journals and Asian countries are now well represented at international symposia on mental health and clinical psychiatry (Wu and Wang, 2010). Reflecting this, the RANZCP will host the 2016 International Congress of Psychiatry in Hong Kong in association with the Hong Kong College of Psychiatry, in acknowledgement of the regional challenges and partnerships in mental health (RANZCP, 2015). Recognition of the key role of regional partnerships in supporting clinical research and mental health policy development is encouraging. A further key development to support ongoing research collaborations and research capacity building is the Melbourne-Peking Centre for Psychiatry Research (2016).

Health professional education

Educating Australian psychiatrists on global mental health is important for their contributions to mental health system development in the Asian region. Australian psychiatrists need to be equipped with relevant skillsets and expertise, including cultural formulation (Datta, 2015), which are also highly relevant to Australia's own multicultural population. Calls for greater opportunities for doctors-in-training to learn about global mental health are noted and encouraged (Aggarwal et al., 2015). Greater integration of global mental health training into postgraduate medical education reflects trends occurring overseas (Mitchell et al., 2013). Psychiatry may take lessons from emergency medicine in Australia, given better-developed processes for global health placements (Jamieson et al., 2014). One such global mental health educational opportunity for Advanced Psychiatry Trainees is the Leadership and Management Training Workshop (Melbourne School of Population and Global Health, 2014).

Similarly, access to skill training opportunities for psychiatry colleagues in Asia is important in building mental healthcare capacity in the region. There is concern about the lack of opportunity for subspecialisation, which leads a large number of Asian psychiatrists moving abroad for additional training. Inevitably, many choose not to return to their country of origin, aggravating chronic workforce shortages (Singh and Ng, 2008). Establishing regional partnerships while developing structures that protect source countries will provide psychiatry trainees an opportunity to develop clinical expertise and experience abroad while also ensuring that the workforce is retained in their home country (Singh and Ng, 2008). An example of this is the Postgraduate Overseas Specialists Training (POST) programme, a collaboration between the Department of Psychiatry, University of Melbourne and St Vincent's Mental Health, which invites psychiatry fellows from the Asia-Pacific region to undertake up to 12 months of their subspecialty training in Australia (Merner et al., 2011).

Education and training can also be delivered through conferences, courses and workshops led by local, regional and international experts (Singh and Ng, 2008) and should be extended to allied mental health professionals given the recent development of community mental health services throughout Asia (Ng et al., 2010, 2014a, 2014b). The China–Australia–Hong Kong tripartite training programme, developed through a partnership between AAMH, Peking University Institute of Mental Health (PHUIMH) and the Chinese University of Hong Kong (CUHK), has contributed to clinical and research workforce capacity building in community mental health in China (Ng et al., 2009). The programme utilises a model that emphasises mutual respect, exchange of knowledge and appreciation of cultural context (Ng et al., 2009). This programme marks a useful example of international collaboration in mental health.

Mental health literacy

Stigma towards individuals with mental illness in Asia is as substantial (if not more so) to that in Western countries (Lauber and Rossler, 2007); hence, upstream interventions like psychoeducation and stigma reduction are essential. Findings from HICs demonstrated that social contact between individuals with and without mental illness is associated with greater social acceptance (Semrau et al.,

2015; Thornicroft et al., 2015). Studies in Hong Kong, Turkey and Nigeria have drawn similar conclusions (Thornicroft et al., 2015). Among school-aged individuals, psychoeducation in schools is superior to other interventions in raising mental health awareness and in combating stigma (Fazel et al., 2014; Semrau et al., 2015; Thornicroft et al., 2015).

Australia has well-developed mental health governance support and community services. KidsMatter and MindMatters assist schools in developing their own mental health strategy (KidsMatter, 2015; MindMatters, 2015). Headspace, the National Youth Mental Health Foundation, offers community mental health clinical and education services to school-aged students free of charge (Headspace, 2015). Kids Helpline and, adult counterpart, Lifeline are telephone counselling and crisis support services that can be accessed 24/7 (Kids Helpline, 2015; Lifeline, 2015). New Zealand's highly successful 'Like Minds, Like Mine' stigma reduction campaign has significantly improved public attitudes towards people with mental illness among those aged 15–44 years and boasts an estimated economic benefit of US$13.80 for every dollar spent (Ministry of Health and Health Promotion Agency, 2014). Internet-based interventions allow global scale and reach at low cost, efficacy questions notwithstanding. Australia is a global leader in this area, and this can contribute to global mental health initiatives (Gilbody et al., 2015).

Stigma-reducing interventions in LMICs have been poorly studied (Semrau et al., 2015; Thornicroft et al., 2015). Some insights that may come from de-stigmatisation campaigns in other disorders such as leprosy suggest that integration of leprosy services into the mainstream healthcare system, increasing health literacy and in particular the knowledge that these disorders are treatable, and socioeconomic rehabilitation are among the more effective de-stigmatisation strategies (Sermrittirong et al., 2014).

Infrastructure, technology and innovation support

Digital psychiatry promises to help transform psychiatric practice by bringing information and services to patients' fingertips, enabling telepsychiatry access and enabling earlier intervention (Hollis et al., 2015). Fortunately for this field, Asia represents nearly 50% of the global mobile phone market (GSMA, 2013); hence, digital psychiatry represents an opportunity for delivering psychiatric services to the most populous region in the World in a rapidly scalable and cost-effective manner.(Muñoz et al., 2015). One way to deliver digital psychiatry is through Massive Open Online Interventions (MOOIs) or evidence-based online mental health and substance-use interventions available to an unlimited number of users without cost (Muñoz et al., 2015). Some Australian mental health organisations have developed mobile phone *apps* as an avenue for education, symptom relief and referral to care (Mind Health Connect, 2015); however, caution must be exercised as we continue to gather evidence to support their use (Donker et al., 2013). A notable example is MoodGYM, a cognitive behavioural therapy tutor for managing symptoms of depression, which is now available in several languages including Chinese (National Institute for Mental Health Research, 2015). Mobile interventions come with challenges of knowledge of their existence, compliance and efficacy. Of the 58,398 community users registered for MoodGYM, less than 7% progressed beyond the first two modules; those who did received the greatest mental health benefit (Muñoz et al., 2015). Efforts to replicate the promising initial findings to date have been disappointing (Gilbody et al., 2015).

The ethics of Australia's involvement in Asian mental health

The ethical challenges in global mental health merit consideration. Given efficacious and cost-effective interventions for mental illness exist just out of reach of many developing nations, there is a moral argument to act to aid their implementation (Patel et al., 2006). Western psychiatry is an inexact science, based on socioeconomic assumptions and modelling which may not be transferrable to the plethora of Asian contexts (Summerfield, 2012). Informed consent becomes a complicated issue when traversing language and cultural barriers, and we must not cultivate mono-cultural over-valued priorities about Western psychiatry as an ethical imperative (Summerfield, 2012). Other concerns include the re-allocation of scarce resources away from areas like infectious disorders, the language and cultural barrier that may impair the quality of services, the involvement of foreign workers on a short-term basis where the success of an intervention relies on long-term involvement, premature adoption of technologies that remain unproven in culturally diverse settings and the unintended consequences of challenging local concepts of mental illness and replacing them with Western ones (Datta, 2015). Australia itself struggles with culturally diverse health interventions given ongoing challenges in addressing health inequalities in Indigenous and migrant populations within its own boundaries, which may represent a hurdle to involvement at the global level.

There is no escaping that human rights violations of individuals with mental illness occur throughout the developing world, connected to outdated or poorly developed psychiatric practices in a setting of scarce resources, stigma and discrimination (Patel et al., 2006). North Korea has poorly developed mental health services and fundamentally breaches human rights (Noh et al., 2015). In many Asian countries, patients with mental illness can be detained in chains or cages (WHO, 2013a). In Indonesia, the WHO Chain-Free Initiative led to collaboration between local

health services, health authorities and Australian psychiatrists, where the provision of basic psychiatric treatments to patients with Schizophrenia enabled them to be released from physical restraint and confinement, known as *pasung* (Minas and Diatri, 2008; WHO, 2013a). This highlights the need for international advocacy in placing mental health issues on the agenda of Governments. Australia has significant representation to the WHO and WPA and hence advocates strongly via these mechanisms. Akin to the programme of de-institutionalisation, this needs to be buttressed by access to basic treatments, many of which like generic antipsychotics are affordable even in environments of resource limitations.

It is also important to consider that mental health is steeped in the social determinants of health, which are not addressed by purely mental health interventions (Kirmayer and Pedersen, 2014). Culture influences the social determinants of health by moulding personal health expectations, the perception of illness and treatment and more broadly may create selective disadvantage to groups of people in a community, through a historic class or caste system (Kirmayer and Pedersen, 2014). It is therefore paramount that any intervention is considered within the wider sociocultural context.

Future directions

Australia's role in supporting Asian mental health system strengthening requires respective, reciprocal cooperation. A common thread is that our work must be culturally and locally appropriate, locally led and founded in equal contribution in all collaborative endeavours, both in development and in implementation. This point is absolutely fundamental in ensuring our involvement in Asia does not lead to more harm in the long term.

Our core recommendations to be completed, collaboratively with local partners in this area, include the following:

- Support the primary leadership role of local experts;
- Utilise local clinicians and consumers to aid priority, strategy and implementation choices;
- Support and promote the collection of epidemiological data to understand mental health prevalence, incidence and burden;
- Introduce the use of ethnographic research methods to better understand mental health, illness behaviour and care-seeking patterns to inform future mental health approaches. Understanding the cultural context and healthcare delivery in Asia is indispensible to creating effective mental health policy;
- Encourage the development of de-stigmatisation and workplace mental health campaigns;
- Assess interest of various cultures in engaging, adapting and validating digital and online therapies;
- Support the further development of regional clinical, research and policy training partnerships for mental health professionals, researchers and policymakers in Asian countries;
- Develop a unified Australian Governmental strategy for mental health system strengthening in Asia;
- Continue to support and engage with pan-Asia, Australasia and Asia-Pacific leadership and policy bodies.

It is socially and economically important for Australia to take interest in the mental health of our near neighbours.

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