Table 2
Summary of ANOVA and adjusted mean scores of ADCQ[a] and BDI.

Source	df	F value							
		ADCQ total	Subscales of ADCQ				Items of ADCQ		BDI total
			Perceived doctor–patient relationship	Preserved autonomy	Positive beliefs regarding antidepressants	Partner agreement	Item 2	Item 33	
Between-subjects variable									
Group	1	1.31	1.75	0.15	0.06	1.91	0.03	0.10	1.26
Treatment duration	1	1.81	0.07	3.16	0.46	0.22	0.82	0.02	6.50*
Group × Treatment duration	1	0.02	0.04	0.08	1.48	0.39	1.37	1.65	0.12
Within-subjects variable									
Time	1	1.12	0.04	5.82**	0.10	0.42	0.16	0.80	1.00
Time × Group	1	6.84**	4.60*	2.31	9.95**	0.27	4.05*	6.15*	0.11
Time × Treatment duration	1	2.67	3.94	3.09	0.04	0.60	0.15	0.47	0.16
Time × Group × Treatment duration	1	1.89	6.50*	0.36	10.84**	0.37	4.14*	2.83	0.03
Mean score adjusted by treatment duration (SE)									
Intervention (pre)		12.0 (0.18)	3.3 (0.06)	3.0 (0.06)	2.8 (0.05)	3.1 (0.09)	3.5(0.09)	2.1(0.1)	16.9(1.4)
(post)		12.3 (0.19)	3.3 (0.06)	3.0 (0.06)	2.9 (0.05)	3.1 (0.09)	3.5(0.09)	2.3(0.1)	15.5(1.4)
Control (pre)		11.9 (0.18)	3.2 (0.06)	3.0 (0.06)	2.8 (0.05)	2.9 (0.09)	3.5(0.09)	2.0(0.1)	14.3(1.4)
(post)		11.7 (0.19)	3.1 (0.06)	3.1 (0.06)	2.8 (0.05)	2.9 (0.09)	3.3(0.09)	2.0(0.1)	13.6(1.4)

Item 2 : My doctor listens properly to what I think about antidepressants.
Item 33 : Antidepressants make me stronger so I will be able to deal more efficiently with my problems.
[a] The range of scores of ADCQ subscales and items were 1–4 and the range of total score of ADCQ was 4–16. For subscales and the total score, decimal figures are possible.
* $P<0.05$.
** $P<0.01$.

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Lessons learned in developing community mental health care in East and South East Asia

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This paper summarizes the findings for the East and South East Asia Region of the WPA Task Force on Steps, Obstacles and Mistakes to Avoid in the Implementation of Community Mental Health Care. The paper presents a description of the region, an overview of mental health policies, a critical appraisal of community mental health services developed, and a discussion of the key obstacles and challenges. The main recommendations address the needs to campaign to reduce stigma, integrate care within the general health care system, prioritize target groups, strengthen leadership in policy making, and devise effective funding and economic incentives.

Key words: Community mental health care, East and South East Asia, mental health policies, non-governmental organizations, human rights, family involvement, target groups, economic incentives

This paper is the seventh of a series describing the development of community mental health care in the various regions of the world (see 1-6), produced by the Task Force appointed by the WPA as part of its Action Plan 2008-2011 (7,8). The WPA Guidance on Steps, Obstacles and Mistakes to Avoid in the Implementation of Community Mental Health Care, developed by the Task Force, has been published in this journal (9). In this article, we describe these issues in relation to East and South East Asia.

The region includes 15 countries (4 in East Asia and 11 in South East Asia), with marked cultural, religious, and socioeconomic diversity. All these countries devote only a small fraction of their total health budget to mental health (less than 1% in low income countries; less than 5% in high income countries) (10). Because of varied historical backgrounds and colonial heritages, health care systems diverge even among neighbouring countries.

Overview of mental health policies in the region

Table 1 shows the presence of mental health policies and laws in the region. Despite 20 years of effort, China does not yet have a national mental health law, but it has instituted a mental health plan (15), while Hong Kong has a mental health ordinance (16). In Thailand, mental health legislation came into effect in 2008 (14).

Family involvement is a characteristic of the region. Even in Singapore and Malaysia, where the

Western influence is quite prevalent, the family plays a major role in the patient's admission and treatment. Involuntary admission with family consent is legalized in Japan and South Korea. China also permits involuntary admission with family consent, although the practice is not legalized, and the legal guardians include not only family members but also public officers (17).

The legislation ensures community integration in Japan, Malaysia, Mongolia, and South Korea, while the rest in the region has community-based mental health care policies or programmes, except for Burnei and Laos (12).

Overview of mental health services in the region

The number of psychiatrists and of psychiatric beds per 10,000 population are shown in Figure 1, except for East-Timor. Japan has the highest number of psychiatrists per 10,000 people in the region (9.4), followed by South Korea (3.5), Mongolia (3.3), and Singapore (2.3). Despite a recent decrease in admissions, Japan (28.4) has also the highest number of psychiatric beds, followed by South Korea (13.8). Mongolia also maintains a hospital-based care system with an occupancy rate of above 80% (15).

Non-governmental organizations (NGOs) have set up model mental health services, and trained both health care and non-health workers in post-conflict countries, such as Cambodia and East-Timor, where all mental health resources were destroyed (12,18,19). In Malaysia, local NGOs

provide residential care, day-care services and psychosocial rehabilitation services in the community (15). In the Philippines, collaborative activities between local NGOs and university groups compensate for the government's limitations (20). Most NGOs' activities cover screening and assessment, and talking treatments. Psychological, rather than Western-style phamacological treatment, is popular in these countries.

Home care and day hospital services are used as alternatives to hospital admission in several countries of the region. In Singapore, a mobile crisis team (community nurses assisted by a medical officer or a medical social worker) conducts home visits for crisis intervention, while community psychiatric nursing teams offer home care to discharged patients living in the community, including assessment and monitoring and psychological support to their caregivers (21).

In China, psychiatric hospitals send professionals to the homes of persons with severe mental disorders to provide "home-bed" services (22,23). For persons with chronic mental disorders, sheltered workshops for rehabilitation and a "rural guardianship network" for their supervision and management are also available, but their effectiveness is controversial (23,24). In China, non-government services such as private psychiatric clinics, non-professional counselling clinics, telephone hotlines, and folk treatments are becoming the dominant form of community mental health services, but their sustainability is of concern (25).

Most early intervention and assertive community treatments are provided in pilot specialized community mental health projects. In the Philippines, more than 7,000 patients were hospitalized in

the mental hospital in Manila; however, the introduction of acute crisis intervention services reduced this number by more than half (26).

Japan, South Korea, Singapore and Malaysia have introduced assertive community treatment (ACT) with cultural modifications. A Japanese study in pre- and post-pilot phase reports the reduction of length of stay, while a subsequent randomized clinical trial shows a decrease of inpatient days and higher Client Evaluation of Services-8 (CSQ-8) scores in an ACT group compared to a control group (27). In South Korea, in a pre-post comparison, the number and duration of the admissions were also dramatically reduced and the clinical and social outcomes were significantly improved (28,29). In Singapore, the ACT programme was effective in reducing the frequency and duration of admissions in a clinical trial. The employment status of patients also showed improvement over the course of study (30).

Chronic beds for long-stay patients are being converted into residential facilities and group homes in communities, such as the private nursing homes of Malaysia (31).

In Malaysia and Thailand, community mental health promotion and prevention activities are conducted through public places, such as schools, churches, temples, and community halls (15).

Asia is vulnerable to natural disasters, including earthquakes and floods. These tragic disasters often deepen awareness of the need to develop community mental health systems. Mental health and psychosocial support are included in disaster preparedness in Indonesia (32), Myanmar (33) and Thailand (34). In Indonesia, a community mental health nursing training programme was developed

after the Tsunami (35).

Obstacles and challenges

Human rights

Traditional beliefs that mental illness is caused by malicious spirit possession or weak character persist in several countries of the region. According to a national survey in South Korea, people often consider mental illnesses to be self-limiting disorders that will resolve on their own (36). Much stigma is still attached to persons with mental illness, as well as to psychiatric institutions and services (21). One study in Singapore found that the main predictors of people seeking help were not availability and access to care but perceptions of mental illness and health care (37). Public misconceptions about mental illness result in prejudice which leads to discrimination. There is a gap between the legal framework and the reality of the mentally ill, who are often abused in many countries (38).

Family involvement

Strong family involvement in mental health care is a characteristic of Asia (39). Family plays an essential role in the care of people with mental disorders in the community; however, the poor knowledge of mental illness and negative attitudes about the patient prevents many people in need

from seeking care (39). Many persons with mental illness are abandoned by their families. The establishment of partnerships with families and the assignment of necessary resources are priorities in the region.

Traditional healers

In many Asian countries, it is common for people to consult traditional healers for their health problems even if medical services are available. Healers rarely cooperate with each other, nor do they collectively work with formal health care providers (31). Cambodians often seek help from *Kru Khmer*, who are mainly herbalists (40), and it is also common to consult traditional healers in East-Timor (19). Families often bring the patient to religious healers first, although the government of Viet Nam prohibits this act (41). In Indonesia, up to 80% of people consult traditional healers as a first resort (42). The 1993 survey in Singapore shows 30% of patients in a national hospital visited traditional healers, *dukun*, before consulting physicians (43). Such behaviour is one of the reasons for the low formal service use in the region.

Distribution of services and continuity of care

Mental health services are available only in certain areas of a country. Most people with severe mental disorders are unable to access services in low-resource countries, and mental health resources are centralized in large cities in medium-resource countries. In Japan and South Korea,

policy proposals exist to convert current long-term psychiatric care beds to outpatient/ambulatory clinics or long-term community-based care, but in reality, many discharged patients have failed to make use of such services. A survey in South Korea shows a high readmission rate immediately after discharge (44), while one in Malaysia reports a lower rate of followed-up and treated patients at one year (45). South Korea is quickly developing a comprehensive mental health service system in each catchment area (46). In Japan, people lack an awareness of the "catchment area" due to the negative effects of the universal insurance system which is the greatest contribution to Japanese health (47).

Funding

Most of the countries in the region are seeking to balance the public and private financing and provision of care. Funds for development of community services usually come from savings made from the reduction of beds in hospitals, but such cutbacks and increasing community services are not always balanced. Furthermore, in rapidly aging countries, community services are urgently needed for people with dementia. There is a concern that most of the mental health budgets will be spent on treating those with this disease. If the boundary between mental health and elderly care becomes unclear, a smaller amount of money will be earmarked for people with severe and persistent mental disorders.

Lessons learned and recommendations

Legal process and anti-stigma campaign

A legal process is needed to protect the human rights of persons with mental illness in countries without appropriate legislation. In Japan, the mental health act legally acknowledges for the first time that mental illness is a disability, and stricter criteria and a psychiatric review board for involuntary admissions have been established after a series of scandals regarding human rights violation (48). In the context of anti-stigma campaigns, renaming schizophrenia has been well accepted in Japan and Hong Kong (49, 50). Similar movements are seen in other East Asian countries where Chinese characters are used.

Integration into the general health system

The best way to create a cost-effective system is to utilize the existing general medical sector, providing training of primary health workers. Singapore has been successful in preparing general practitioners for providing mental health care, with psychiatrists' support (51). Primary care is generally more acceptable by persons with mental disorders and their families (51). Collaborative networks are needed among stakeholders to avoid fragmentation and must include service-users/families, hospitals, community health workers, NGOs, and traditional healers.

Prioritization of target groups

Due to limited resources, we have to prioritize care. Compared to depression or mild mental disorders, which are generally more accepted and better funded, persons with severe and persistent mental disorders are often missed and left behind in planning and budgeting. Prioritized services should be provided to severely disabled persons.

Leadership and policy making

Strong leadership is needed to navigate changes. Very few mental health professionals are actively involved in policymaking. Consequently, the lack of leadership allows the allocation of more money or resources to general health care services rather than to mental health. It is not uncommon that non-mental health professionals have negative attitudes toward mental illness. It is necessary to change their ways of thinking.

Not only central but also local governments need to participate in the development of sustainable community mental health care systems. In recent times, former patients have more opportunities to speak publicly and participate in mental health policymaking (52).

Funding and economic incentives

The overall mental health budget should be increased. Financial insecurity keeps persons with mental illness and their families from seeking medical services. It is essential to develop a funding

system in which all people who need help are able to receive care.

Economic incentives are necessary to promote community-based mental care services. Hospitals and mental health professionals are reluctant to shift to the community because of poorer funding and lower salaries (23). Transitional costs may be necessary for retraining mental health workers. ACT and employment support are not fully covered by medical expenditures. A flexible financial structure over medical and social boundaries is required.

Conclusions

After a long history of asylum, a slow deinstitutionalization is occurring in East and Southeast Asia. Now this region is in a transition period from institutional to community care. Unlike the West, Asian countries fear the confusion engendered by rapid change; they are cautiously reducing psychiatric beds, and simultaneously trying to build community services. This attempt has not yet been successful, mainly because of system fragmentation. Role differentiation is required between the hospitals and community services, and the public and private services. Ensuring the quality of care is the next challenge for community mental health care. We can learn lessons from other regions in constructing the future of mental health care in East and South Asia.

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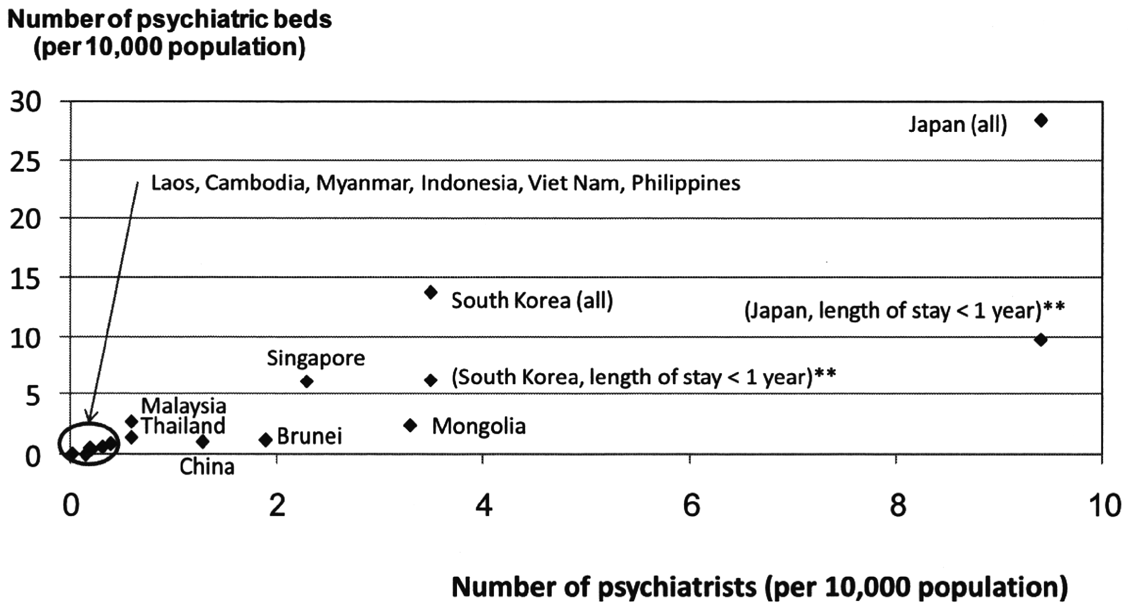
Table 1 Mental health policies and laws in countries of East and South East Asia

		Mental health legislation	
		Present	Absent
Mental health policy or programme	Present	Indonesia, Japan, Malaysia, Mongolia, Myanmar, North Korea, Singapore, South Korea, Thailand	Cambodia, China, Laos, Philippines, Viet Nam
	Absent	Brunei	Timor-Leste

Sources: Jacob et al (11), World Health Organization (12), Tebayashi (13), Thailand Mental Health Act (14)

Figure 1 Number of psychiatrists and psychiatric beds in countries of East and South East Asia



Sources: Jacob et al (11), World Health Organization (12)

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