The development of a mental health service in East Timor: an Australian mental health relief project

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East Timor (the Democratic Republic of Timor-Leste) occupies the eastern half of the island of Timor, which lies between North Western Australia and the Indonesian archipelago. East Timor has a population of around 860 000. It is predominantly rural and there are few large towns. The country has a largely subsistence agricultural economy; coffee is the principal cash crop. The population is extremely poor, and transport and communications are primitive.

Recent political history

The country was a Portuguese colony until 1975, when Indonesia invaded and annexed the territory. The indigenous resistance movement fought a low-grade guerrilla war for the next 24 years, a period which saw the widespread displacement of villagers. Throughout the 1990s Indonesia faced mounting international pressure over East Timor, until it finally allowed a referendum in 1999 on the future of the country, in which full independence was strongly endorsed.

Following the referendum, pro-Indonesian militias engaged in a campaign against the pro-independence majority. Most of the country's infrastructure was destroyed at this time and over 30% of the population was forcibly transported to West Timor, a province of Indonesia. An Australian military contingent supported by the United Nations (UN) secured stability and the UN administered the territory until 2001, when full independence occurred. The UN has continued to support the indigenous government since, but began to reduce its presence in Timor from May 2004.

Health services at independence

Government buildings, schools, universities, hospitals and houses are now starting to be rebuilt. At the time of independence there were but a handful of doctors in the country. There were two small hospitals capable of carrying out limited surgery, but even these were very poorly resourced in terms of pathology, radiology and other services. The country had no mental health services and no psychiatric in-patient beds (Silove, 1999).

Religious practice and healing

Timor's traditional religion is an animistic but mono-theistic one in which God is believed to dwell in and around the sun. Spirits of the dead dwell in and around the village and each is represented by a specific stone placed in a sacred house after the person died. Each village or clan has its own living totem, such as a specific snake, dog, crocodile or other animal. The appearance of a totem (inhabited by some ancestral spirit) is a religious sign of 'unhappiness' in that ancestral spirit. This appearance requires interpretation by the clan's religious leader. Special ceremonies and sacrifices are used to placate these spirits.

Catholicism was introduced with Portuguese colonisation and now the two religions coexist comfortably, with most people practising both.

There is a strong belief in traditional health practitioners. The traditional healer is someone who has, in effect, undergone an 'occupational conversion' to become a healer and he begins practice with traditional medicines and sacrifices. Patients are expected to pay for treatment, usually with payment in kind, such as chickens or goats.

Mental illnesses are treated within this system. The traditional view of depression, for example, is that it is caused by the patient being tortured by a spirit and so 'thinking too much'. Themes of punishment are involved. Mania is believed to be caused by people 'talking too much', while psychosis is tantamount to 'losing your soul' and, again, being punished by some spirit. Treatment of such conditions by traditional healers involves returning to the scene where an ancestral spirit might have been 'insulted', the use of traditional herbs, negotiating with the spirit, physically hitting the patient and animal sacrifice.

Humanitarian mental health relief project

A humanitarian mental health relief project was initiated in 1999 by a multidisciplinary Australian coalition of mental health practitioners, PRADET (Psychosocial Recovery and Development in East Timor), through the University of New South Wales and funded by the

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Diagnostic efficiency, furthermore, is somewhat restricted by the fact that while the culture is highly verbal, the local languages are not rich in vocabulary relevant to mental health constructs and translation is imprecise. Time concepts differ so that it can be difficult to specify the onset or course of symptoms, and a large emphasis is placed on 'the social story' and less on symptoms and disability.

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Australian government's overseas development agency, AusAID. The project included some dozen general nurses and a doctor, who were quickly trained in basic psychiatric skills, including diagnosis and psychopharmacology, so as to be able to treat the low-prevalence serious mental disorders, such as psychoses, affective disorder and epilepsy. They were equipped with a small selection of generic psychotropic drugs. The nurses were based in the capital, Dili, since their ability to travel into the outlying regions was severely limited (Zwi & Silove, 2002).

Following the success of this pilot programme, AusAID funded an East Timor national mental health project through a management company, AusHealth International. This project employed 16 nurses, this time mostly based in rural areas, a national coordinator and two mental health trainers. A nurse was attached to each of the 12 rural health centres, two to ones in Dili, and two in the enclave of Oekussi, which is within Indonesian West Timor. Eight vehicles were provided to the service, and in addition the nurses each had their own motorcycle. The Australian expatriate team included the Australian-based project director (the second author), the project manager, an in-country team leader, a trainer, a health promotion adviser and three rotating visiting psychiatrists.

Nurse education under Indonesian rule had consisted of a very basic 2-year training programme. Nurses were trained in a model where they were passive handmaidens to doctors and so had very limited independent case management skills. The 16 project nurses, who had no psychiatric training or experience, were given intensive preliminary training by Australian clinicians over 10 days, in the recognition of major psychiatric disorders and in managing these conditions with generic drugs, including chlorpromazine, depot fluphenazine, haloperidol, sodium valproate, carbamazepine, amitriptyline and diazepam. Nurses earn approximately US$40 per week but, commonly, each may be supporting a large extended family of up to 20 individuals, as unemployment is in the order of 40% and underemployment is far more common.

The community mental health nurses carry caseloads of between 60 and 120 patients. Broadly, psychiatric presentations are of acute psychosis (50%), untreated chronic psychosis (10%), acute mania with psychosis (30%) and severe (usually psychotic) depression (10%). In addition, the psychiatric case managers have taken on the task of treating epilepsy in the community; many such patients have had untreated epilepsy over many years and a significant proportion have hypoxic brain damage. Post-traumatic stress disorder is rarely seen in the core mental health service but there are other non-governmental organisations dealing with trauma. Most Timorese people lost relatives or close friends in the hostilities, and many women were raped.

The Australian psychiatrists visit for 2 weeks each month. Every 3 months, each psychiatric case manager (the project nurses) receives 1 or 2 days of clinical supervision in the field, from the same clinician. Personal observations by visiting psychiatrists and a formal review (by the first author) indicate that the diagnostic and management skills of these minimally trained nurses, for the conditions that are presenting, are excellent.

There are, however, significant barriers to efficient service delivery. Roads are in major disrepair, breakdown of the motorcycles is common and vehicles need to be sent to Dili for major repairs. In addition, there are communication problems between the nurse trainers and managers in Dili and the case managers in the rural areas; there is no effective telephone service available to nurses.

Diagnostic efficiency, furthermore, is somewhat restricted by the fact that while the culture is highly verbal, the local languages are not rich in vocabulary relevant to mental health constructs and translation is imprecise. Time concepts differ so that it can be difficult to specify the onset or course of symptoms, and a large emphasis is placed on 'the social story' and less on symptoms and disability. Patient consent is difficult to obtain and confidentiality is virtually nonexistent; consultations take place in the open and generally many members of the village are 'involved'. Consultation is often disrupted by the presence of children and wandering animals. For the visiting psychiatrists, translation from a regional dialect to the main dialect and then into English is often required.

It is not uncommon for patients with acute psychosis and mania to be chained, or put in foot-stocks, in order to prevent them behaving dangerously or fleeing and so becoming lost and perishing in the jungle. Chaining is thus an act of altruism, and families are actually very tolerant and take great care of the severely ill. Many patients have been managed in this way for several years as there has been no alternative, given the absence (until recently) of any treatment facilities or drugs.

Budgetary issues

The total health budget for East Timor in 2004 was approximately US$8 million. Some US$200 000 per annum (largely provided by the Australian government) is dedicated to mental health services (2.5% of the total health budget). It is apparent that a highly effective service is run on this very small sum.

The future

East Timor faces many problems. There remains a considerable lack of infrastructure. There has recently been civil unrest, partly as a result of the widespread unemployment. Militia activity continues. There is ongoing 'tension' within the country between the desire for total independence from external agencies and governments, and yet an economic dependence on such benefactors. Transportation, communication and trade are underdeveloped and there will be major budgetary problems at least until 2008. At this point in time, oil revenues will begin to flow, although there is widespread recognition that East Timor has done poorly in its agreement with

Australia on the joint development of this resource, which lies geographically between the two countries.

The government has decided that Portuguese and Tetum should be the 'official' and administrative languages, respectively. Indonesian (Bahasa) is widely spoken and, while English is not discouraged (indeed, it is called a 'working' language), the development of the nation, especially in education, will be restricted by lack of easy communication with external agencies and internet use.

At present the country has some 30 indigenous medical practitioners; half of them appear to be employed in an administrative capacity, running rural clinics. The country still depends on the provision of medical practitioners from countries such as the Philippines to support rural health clinics. In terms of developing a medical infrastructure and ongoing medical education, East Timor will require support from nations such as Portugal, Australia and Japan. East Timor will train nurses locally, initially with international support, and, despite the earlier problems with Indonesia, will need to train doctors at Indonesian universities because of their proximity, cost and cultural and linguistic compatibilities.

Conclusions

East Timor is emerging from a period of chaos, which saw the destruction of most of its infrastructure during the post-election turmoil in 1999. A mental health service has recently been established, with 16 nurse case managers employed largely in rural centres, within general medical clinics. These nurses have received 10 days of intensive formal training in psychiatry and ongoing intermittent supervision to equip them in a basic way to deal with the more serious, low-prevalence disorders using a handful of generic psychotropic medications. It is our experience that training a small cadre of specialist nurses was essential to initiating mental health services. The task remaining is to transmit the skills acquired by these specialist workers to a wider array of generic nurses in the community.

A recent formal review of this mental health service indicates it is functioning in an effective and cost-efficient fashion, treating serious mental disorders for the first time in a very impoverished nation. The health service faces many long-term problems in delivering healthcare to a very dispersed rural economy with extremely limited resources. The challenge is to institutionalise mental health as a priority service in East Timor and to ensure its sustainability with minimal external support.

References

Silove, D. (1999) Health and human rights of the East Timorese. *Lancet*, **353**, 2067.

Zwi, A. & Silove, D. (2002) Hearing the voices: mental health services in East Timor. *Lancet*, **360** (suppl.), s44–s46.

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ASSOCIATIONS AND COLLABORATIONS

The European Society for Child and Adolescent Psychiatry (ESCAP): history and challenges for the future

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The European Society for Child and Adolescent Psychiatry (ESCAP) assembles 29 national societies of child and adolescent psychiatry of several countries belonging to the European Union or to its cultural and geographical area. It is the only association that gathers European psychiatrists who work with children and adolescents.

European child psychiatry is a dynamic entity. Its richness is progressively increasing, following the enlargement of the European Union. ESCAP includes among its membership countries that have joined the Union recently (such as Estonia, the Czech Republic and Hungary), some other countries that have not yet joined (such as Iceland and Turkey) and others that share similar cultural roots (such as Israel). The Association also publishes a scientific journal, *European Child and Adolescent Psychiatry.*

Origins and congress

ESCAP has its roots in the UEP (Union of European Paedopsychiatrists), an association whose first meeting was held in Magglingen (Switzerland) in 1954 and that was officially established in 1960, during its first congress in Paris. Since then, congresses have been held regularly every 3–4 years and have focused on the more clinically relevant, complex and current topics. During each congress, a general assembly takes place to

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