Editors
Harry Minas
Global and Cultural Mental Health Unit,
  Centre for Mental Health
Melbourne School of Population and Global
  Health, The University of Melbourne
Parkville
Australia

Milton Lewis
The Menzies Centre for Health Policy, The
  Charles Perkins Centre
The University of Sydney
Sydney
Australia

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Chapter 12
From Centralized to Decentralized Service: Mental Health and Psychiatry in Malaysia

Heong Hong Por and Mohamed Hatta Shaharom

Abstract This chapter charts the formation and transformation of mental institutions, therapeutic concepts, and psychiatric practices in Malay(si)a from the early nineteenth century throughout the post-independence era. Introduced by colonial-nineteenth century throughout the post-independence era. Introduced by colonialists in the early nineteenth century, mental health institutions in Malaya started out as a colonial program that aimed to clean the colony of vagrants, starving migrants, paupers, drug addicts, convicts, and people afflicted with mental illnesses by confining them in gaols. It was not until the mid-nineteenth century that the mental asylum was separated from the gaol. At the turn of the twentieth century, an increase in the number of mentally ill patients coincided with the large influx of increase in the number of mentally ill patients coincided with the large influx of migrant workers from China and India. The overrepresentation of male Chinese patients mirrored the demographic structure of the immigrant population. Racialized medical comprehension of mental illness was not uncommon. Therapeutic practices included occupational therapy, shower baths or cold douches, and electroconvulsive treatment (ECT). These practices were an essential part of a broader process of molding the mentally ill into economically productive, morally useful and desirable colonial subjects. As a set of transplanted practices, colonial institutional mental health services did not automatically acquire legitimacy. The availability of traditional healing services, the public preference for traditional therapies, and social stigma and scarce modern psychiatric services jointly contributed to the unpopularity of these mental health institutions. Several changes and debates took place after independence. The government took the initiative to decentralize mental health services by setting up psychiatric units at district and general hospitals from 1958. Local medical education began to offer psychiatric training to overcome the shortage of professionals. The involvement of

H.H. Por (✉)
University of Malaya, Kuala Lumpur, Malaysia
e-mail: floody26@gmail.com; porhh@um.edu.my

M.H. Shaharom
Department of Psychiatry and Mental Health, Cyberjaya University College of Medical Sciences, Cyberjaya, Malaysia
e-mail: hattashaharom@yahoo.com

international bodies like WHO in modernizing the country's psychiatric services was met with a mixed response. While local psychiatrists welcomed more international assistance and resources, social scientists and medical anthropologists expressed alarm concerning the undesirable results of standardization and called for culture-specific procedures. There was also a movement towards community care, which was initiated by NGOs in the late 1960s and translated into a national community mental health program in the late 1990s. The program was compromised due to shortage of professionals, inadequate budget and stigmatization. Despite the promotion of the modern mental health service as more legitimate, modern–traditional, mixed consultation is not uncommon today.

Introduction

There are many ways to write about the history of mental health. This chapter will reconstruct the history of mental health and psychiatry by investigating the establishment of the first mental institution in colonial Malaya in the early nineteenth century and tracing the development of mental health services throughout the post-independence decades.

Like in many parts of the region, the evolution of Western biomedicine and mental health service in Malaysia is structured by various social, cultural, political, and economic factors. The import of biomedicine and modern mental health service was associated with colonial economic and industrial expansion. Initially, it was received with fear among the multicultural Asian community as modern hospital and mental institution were often associated with death. By promoting secular explanation of physical and mental diseases, modern healthcare forced a kind of "epistemological break" from the traditional notions of illnesses. The availability of various traditional healing services was an immediate rival to modern health care. Though the popularity of psychiatry grew over the years, psychiatric service has always been at once welcomed and unpopular due to many social and cultural factors.

As in the field of psychiatry elsewhere, therapeutic concepts are always subject to debates and tend to vary over time. These debates are often informed by changes in international trend. Placed against the background of colonial expansion, multicultural community and the dynamics of local and international environment, the narrative of this chapter is about the formation and transformation of mental institutions, therapeutic concepts and psychiatric practices in colonial and post-colonial periods.

Colonial Mental Health

The (Trans)formation of Mental Health Institutions and Laws

In the early nineteenth century, there was no separate asylum for the mentally ill in Malaya. The "insane," the "lunatics," and the "madmen" were placed under the charge of the police and confined in gaols with the convicts (Lee 1978). In 1814, John Erskine, Magistrate of Penang, wrote to the British government about the necessity of separating the lunatic asylum from the gaol (Suarn et al. 2011). Only in 1829 was the first "lunatic asylum" established near the regimental hospital in Penang. There were 25 inmates, of whom 23 were males and 2 females. Eleven out of the 25 were Chinese, one Portuguese and the rest Indian convicts (Tan and Wagner 1971). One asylum, however, was insufficient to serve the perceived needs of the entire colony. Many lunatics continued to be kept in gaols.

The poor treatment of lunatics did not attract the public attention until 1838 when a letter appeared in the *Singapore Free Press and Mercantile Advertiser (21/06/1838, p. 2)*, urging the Straits Authority to improve the treatment by separating the asylum from the gaol and the lunatics from the convicts.[1] Three years later, a 30-bed "Insane Hospital" was finally built at Bras Basah in Singapore. The hospital was later moved to a new site near Kandang Kerbau in 1862. Expanded to a 100-bed capacity, it was renamed the "Lunatic Asylum." In 1887, it was moved again to College Road, and this time it was enlarged to 300 beds (250 for male patients and 50 for female patients) (Ng 2001). On the mainland, a lunatic asylum was built in Taiping, Perak, in 1895. Three years later, a Gaol Quarter in Kuala Lumpur was transformed into an asylum and began to admit mentally ill patients.[2]

Corresponding to the construction of asylums was legislations made to regulate the lunatics and the administration of the asylum. The Lunacy Act (or Act 36) was passed in 1858. The preamble of the Act stated that it was "expedient to provide for the reception and detention of Lunatics in Asylums established for that purpose." The provisions of the Act, however, were not fully implemented until 1863, and the Resident Councilor, the Commissioner of Police, the Executive Engineer, the Residency Assistant Surgeon and Police Magistrate were appointed Visitors to the Lunatic Asylum ex officio. With the full implementation of the Act, the police were given wide power to admit patients to the asylum and hard pressed to clear the streets and markets of vagrants and those abandoned by their relatives (Lee 1978). A second law, the Lunatic Reception Ordinance, was passed in 1889 and later replaced with the Lunatic Asylums Ordinance (LAO) in 1920. The LAO also provided for reception and detention of criminal lunatics in accordance with Code of Criminal Procedures 1910 and Prisons Ordinance 1872 (Suarn et al. 2011).

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[1]"Correspondence", Singapore Free Press and Mercantile Advertiser (SFPMA thereafter), 21/06/1838, p. 2.
[2]"Beri-beri in the asylum", Straits Times (ST thereafter), 18/07/1899, p. 2.

Table 12.1 The number of patients, death cases, and death rate in Central Mental Hospital, 1924–1935

Year	Males	Females	Total	Deaths (N)	Death rate (deaths per 100 inmates)
1924	1183	397	1580	NA	NA
1926	1550	471	2021	132	6.53
1927	1699	521	2220	173	7.79
1928	1721	490	2211	174	7.86
1929	1785	559	2344	224	9.55
1930	1987	601	2588	197	7.61
1931	1862	644	2506	188	7.50
1932	1894	678	2572	181	7.04
1933	1827	679	2506	238	9.50
1934	NA	NA	2550	190	7.45
1935	NA	NA	2620	186	7.10

Source Federated Malay States Medical Report, 1924–1935

Towards the end of the nineteenth century, the number of lunatics increased (Suarn et al. 2011), which led to a complaint in an editorial in the Singapore-based *The Straits Times*:

> Whence come so many lunatics? Scarcely a week passes that there are not some brought before the magistrates by the police who have found them wandering about the streets. They are invariably Chinese. If these unfortunates belonged to Singapore, they would have some family connection, and would not be allowed to wander about, for the Chinese are careful of their family relations. It seems evident that the lunatics are imported, and it is difficult to understand how so many manage to find their way here without assistance. It is to be feared that they are purposely brought here, in order that they may become a burden on an easy-going good-natured Government.[3]

Although those mentally ill were viewed as "aliens" and the growing number of lunatics perceived by some as a burden, the colonial government began to consider establishing another asylum, the Central Lunatic Asylum, in the Federated Malay States (FMS)[4] in 1904. A committee, consisting of the Commandant, the Malay States Guides, the Director of Public Works, the State Surgeon of Perak, and the Federal Inspector of Coconut Trees, was formed to select a suitable site for the institution.[5] In 1911, the Central Lunatic Asylum, with three male wards and one female ward with a total capacity of 269 beds, was completed on a 573-acre land in

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[3]"Lunatics", ST, 18/05/1898, p. 2.

[4]The FMS, formed in 1895 and lasted until 1946, consists of four states: Perak, Pahang, Selangor and Negeri Sembilan.

[5]"F.M.S. Lunatics", ST, 20/08/1904, p. 10. In the 1920s, making brushes, ropes and other products from coconut husk with a husk mallet was one of the therapeutic activities in the Central Lunatic Asylum's rehabilitative workshops. This explains why the Federal Inspector of Coconut Trees was included in the committee.

Tanjung Rambutan, Perak.[6] Dr William Frederick Samuels was the first Medical Superintendent. It started out with a population of 45 patients, of which 30 were males and 15 females. By the end of 1911, the number increased to 287, of which 220 were males and 67 females. The total population rose to 520 in 1914, and 1580 (1183 males and 397 females) in 1924. The asylum was renamed the Central Mental Hospital (CMH) in 1922, showing a shift away from the use of "lunatics," which carried a negative connotation. The change in population in the CMH during 1924 and 1935 is shown in Table 12.1. Throughout the decade, there were two to three times more male than female "inmates." In race terms, Chinese and Indians occupied first and second places, respectively. The large number of Chinese and Indian male internees in the CMH coincided with the influx of Chinese and Indian male migrant laborers in the same period of time. In other parts of the mainland, a lunatic asylum was established in Johor in 1933, while another one was built in Malacca in 1935. In Sabah and Sarawak, two such asylums were established in the 1920s.

Overall, the health conditions in the lunatic asylums were deplorable and the death rate was high. Twenty-eight of the 32 cases of cholera reported in the Annual Medical Report on the Civil Hospitals of the Straits Settlements for 1890 were contributed by lunatic asylums.[7] In 1901, beriberi was the leading cause of death, accounting for 81 deaths in the mental asylums in the Straits Settlement.[8] In 1904, there were 3 deaths out of 12 beriberi cases in the Selangor Lunatic Asylum; the number reached 27 deaths out of 94 beriberi cases in 1905. The population was 193 in 1904, of which 33 died, contributing to a rate of 17.09 deaths per 100 inmates in the same asylum. In 1905, the number of inmates reached 219, of which 55 died, lifting the death rate to 25.11 deaths per 100.[9] The lower death rate in the CMH (see Table 12.1) was evidence of better health conditions than in the Selangor Lunatic Asylum. However, when compared to the average death rate of the Federal Malay States (FMS) population, which stood at 2.93% in 1926, 3.21% in 1927, 2.96% in 1928, 2.63% in 1929, 2.41% in 1930, 1.91% in 1931, 1.85% in 1932, 2.02% in 1933 and 2.14% in 1934, the CMS inmates were two to three time worse off than the general FMS population throughout the decade.

During the Japanese occupation in World War Two, the population in the CMH rose to 3164 in 1941. This growth was due to transfers from Johor and also from Sabang, Sumatra. Between January 1, 1942, and September 1945, a total of 5386 patients were treated at the CMH, of whom 3850 died. When the British Military Administration took over the mental institution in 1945, only 355 patients remained (Federated Malay States Medical Report 1946). Post-war healthcare reconstruction started with the assistance of international voluntary groups, such as the Red Cross Society, but was soon paused due to the outbreak of counterinsurgency, which lasted for twelve years from July 1948 to July 1960. In 1953, the colonial

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[6]"Untitled", ST, 26/05/1910, p. 6.

[7]"The Public Health in 1890", ST, 07/07/1891, p. 7.

[8]"Untitled", ST, 01/09/1901, p. 2.

[9]"Lunatics in Selangor", Eastern Daily Mail and Straits Morning Advertiser, 07/09/1906, p. 3.

government called for a "swing of emphasis from urban to rural health work" (FMSMR 1953). The call remained rhetoric, as most government resources were channeled to anti-communist activities, little were left for health care and welfare services, and not to say mental health service.

In 1952, the Mental Disorders Ordinance (MDO) was promulgated with rules regulating admissions, discharges, and management of civil and forensic cases. Special therapies like insulin treatment and electroconvulsive therapy (ECT) remained custodial as they were restricted mostly for the paying patients. Dr Stephen McKeith, a World Health Organization (WHO) mental health consultant, was invited to visit CMH in 1954. He criticized CMH for its lack of manpower, over-crowding, and employing doctors who were not conversant with Western psychiatry (Haque 2005). Poor ward condition of psychiatric institutions continued to be an issue throughout the 1950s. In 1957, Dr. S. Parampalam, Assistant Medical Superintendent of CMH, made allegations regarding poor food and corruption at the institution. A Royal Commission of Inquiry was formed to investigate the maladministration of CMH.[10] Though Dr Max Cocheme, then CMH Medical Superintendent, was later cleared of all allegations, he was replaced by Dr. A.S. Johnson in 1959. In Johor, Hospital Tampoi resumed its operation in 1952. In Borneo, the Lunatic Ordinance Sabah was promulgated in 1951 and the Mental Health Ordinance of Sarawak in 1961.

Concepts of Mental Illnesses and Racialized Comprehension

The definition of mental illness in Colonial Malaya was not entirely clear. People admitted to the "lunatic asylums" or "madhouses" came from a wide range of backgrounds, including convicts and criminals, old Chinese men, people moribund from chronic disease and want, vagrants, paupers, women afflicted with nymphomania, and people who used narcotic drugs (Lee 1978; Tan and Wagner 1971). "Lunatics, mania, maniacs, insanity and madness" were terms used to describe mental illness in the nineteenth century and early twentieth century. Main classifications of asylum admission in 1900 were "mental deficiency, general paralysis of the insane (GPI), mania, melancholia and dementia" (Teoh 1971). The classifications changed over time. In 1913, they include idiocy, mania, melancholia, delusional insanity, GPI, and dementia (FMSMR 1913). Lunacy and insanity were thought to be a hereditary "brain problem" in 1914.[11] From 1926 to 1932, confusional insanity, primary dementia, and melancholia headed the list of mental disorders in the CMH (see Table 12.2).

Given that the death toll caused by beriberi was high, the disease was once thought to cause insanity (Teoh 1971). But this changed once the causative factors

[10]"Commission Clears Dr Cocheme", ST, 05/12/1957, p. 1.

[11]"Hereditary Brains", ST, 10/06/1914, p. 10.

Table 12.2 The major forms of mental disorders treated in the Central Mental Hospital, Tanjung Rambutan, Perak, 1923–932

Year	Mental disorders				
	Confusional insanity	Primary dementia	Recent melancholia*	Senile dementia	Recent mania*
1923	NA	NA	102	NA	112
1924	53	50	115	NA	86
1926	97	457	90	99	110
1927	54	640	98	91	60
1928	122	345	135	74	49
1929	170	314	137	181	53
1930	348	195	140	104	68
1931	309	808	392	184	193
1932	339	824	399	193	178
1933	298	836	367	122	155
1934	315	815	353	241	154
1935	368	807	357	287	158

Source FMSMRs, 1923–1935. *The two categories, "recent melancholia" and "recent mania," were absent in the *FMSMRs* from 1931 to 1935. Rather, "melancholia" and "mania" became two subcategories under the category of "manic depressive"

were established. Other causes like opium smoking, other narcotic drugs and alcohol consumption, and syphilis, were also thought to be associated with or to cause lunacy (Lee 1978; Murphy 1971; Teoh 1971). One of the colonial reports said the prevailing form of insanity was mania, often induced by opium and other narcotics. However, not all doctors agreed on the causes. Gilmore Ellis, Medical Superintendent of the Lunatic Asylum at Singapore, commented in the annual medical report in 1892: "I think it most problematical that the smoking of opium was really the cause of their disease. I have never yet seen a case of insanity which I could, with any certainty, believe opium smoking to be the cause."[12]

By 1906, growth in alcoholic psychosis was attributed to the adulteration of alcohol with toxic methylated compounds as the surge coincided with the sale of cheap spirits. The toxic alcohol was expected to replace the traditional opium consumption (Teoh 1971). In 1924, W.F. Williams, Medical Superintendent of the CMH, explained the prevalence of alcoholism among Chinese patients in a racist narrative:

I, as last year, when dealing with alcohol differentiated between Chinese and Indians, found the startling figure of 34 Chinese and only 8 Indians. Last year we had 37 Chinese and 26 Indians so that, though the total number of alcoholic cases is down, we see that the reduction is due to an extraordinary fall in the number of Indians whose trouble can be attributed to alcohol. This to my mind bears out my contention that the Chinese have taken to alcohol, and I fear this will go on and increase. There is a conspiracy on foot to stop the Chinese smoking opium with the result that they are turning to alcohol as a substitute,

[12]"Lunacy in the Straits", SFPMA, 31/05/1892, p. 3.

which from my point of view is vastly more dangerous. All I can say is that the day opium is cut off and alcohol substituted will certainly be a bad one for the Chinese, and I fear we may find an increase in such crimes as murder and rape (FMSMR 1924).

A condition often associated with alcohol intake was infection with syphilis. In the Straits Settlement Annual Report 1906, Gilbert Ellis stated that "venereal disease (VD) was very prevalent and 25% of all [lunatic] cases admitted had syphilis…prostitution was rife and a visit to a brothel was no more shameful an act as an Englishmen visiting a public house for his regular pint of beer" (cited in Teoh 1971). The first Chinese general paralysis of insanity (GPI) was detected by Gilbert Ellis in the same year. Before this, syphilis was thought to be confined to Europeans and due to the high pressure of civilized life (Teoh 1971). The notion that syphilis was an affliction caused by "civilized life," a disease of Europeans, was further challenged two decades later, when the surge of Chinese admission infected with syphilis coincided with the influx of Chinese male migrant workers.

In 1926, the first five causative factors in admissions to the CMH were, in order, hemopoietic system, cardiovascular degeneration, syphilis, gastrointestinal system, and alcohol. Coincided with this trend was a rise in VD cases in the FMS. In the Town Dispensary and Venereal Diseases Treatment Center, Sultan Street, Kuala Lumpur, alone, a total of 2328 VD cases were treated in 1925, of which 1496 were Chinese. In 1926, the VD cases treated in the same VD treatment center surged to 3222, of which 2069 were of Chinese and 1962 were cases of syphilis. Among the 1962 syphilis cases, 1423 were Chinese. The number of VD cases reached 6234, of which 3222 were Chinese. About 2284 out of the 3793 syphilis cases were Chinese. At the same time, the main cause of death in the CMH was GPI in 1926 (see Table 12.3). In response to the rise of GPI as the leading cause of deaths, W.F. Samuels, again, blamed alcohol, together with the presence of syphilis, in a racist tone (FMSMR 1926).

What Ellis earlier thought a "European disease" now became a "Chinese problem," an affliction caused by "civilized life" now turned into a disease caused by "increased consumption of alcohol among the Chinese." Taking on new meaning of syphilis and the shifting explanation about what contributes to the rise of GPI not only indicates a racialized comprehension of mental illness by the British medical doctors, but also suggests that mental health is a discursive space

Table 12.3 The causes of death in the Central Mental Hospital, Perak, 1926–1928

Causes of death	1926	1927	1928
General paralysis of the insane	47	39	28
Pulmonary tuberculosis	16	24	23
Dysentery	13	26	31
Cardiovascular degeneration	6	14	14
Others	50	68	62
Total	132	173	174

Source FMSMRs, 1926–1928

for the construction of racial differences and identities, in the face of the large influx of Chinese and Indian laborers.

In the following year, the hemopoietic system, the gastrointestinal system, syphilis, cardiovascular degeneration, and alcoholism remained the top five causative factors, albeit in different order. Parallel with this was, again, a rise in VD cases dominated by syphilis and the Chinese. Of the 12,663 VD cases detected in the FMS, 7579 were Chinese, while 4240 of 7067 syphilis cases were Chinese. The order changed to syphilis (209 cases), gastrointestinal system (203), cardiovascular degeneration (165), alcohol (90), and the hemopoietic system (84) in 1928 (FMSMR 1928). In 1933 and 1934, the two major causative factors were syphilis and intestinal worm (FMSMR 1933, 1934); in 1935, the top five factors were syphilis (162 cases), malaria (92), other bodily affections (70), alcohol (55), and mental stress (40) (FMSMR 1935). Syphilis and alcohol were often, if not always, in the first five in the list of causes. W.F. Samuels wrote in 1928: "Syphilis and alcohol have each gone up…the rise in syphilis is due, to a certain extent, to more careful examination and a greater use being made of the Government laboratory; but the rise of alcohol is just the more or less steady rise it has maintained for some years. The alcohol question is becoming serious, and it will be seen that alcohol is noted as the cause in 21 females. This I think will bring home how serious a menace alcohol is becoming to the health of the country" (FMSMR 1928).

Economics in the Moral and Vice Versa: Therapeutic Concepts and Practices

Though there was no mention of occupational therapy during the nineteenth century, therapeutic practices that combined work and treatment were introduced by Dr. Thomas Oxley, senior surgeon in charge of the Lunatic Asylum in Singapore, as early as 1846 (Lee 1978). Following the expansion and relocation of the asylum in 1887, an editorial in the *Straits Times* urged the government to give more space to inmates for gardening and train the patients to use looms. The editorial argued that previous asylum management experience had proven that the inmates' participation in gardening, looming, and manufacturing was a way of restoring their health. The writer also claimed that these activities would not only provide foods needed in the asylum more cheaply, but would yield products for the commercial market.[13]

In the 1920s, therapeutic activities in the CMH included farming, bamboo works, tailoring, carpentering, and mending. The patients in the CMH cultivated 234 acres, produced 212,351 katies of vegetables, and generated $6617 by cutting firewood in 1922. Their work yielded 225,553 katies of vegetables in 1923 (FMSMR 1924). They built three new farms and produced 360,068 katies of vegetables in 1928 (FMSMR 1928); 17,639 katies of pork and 420,429 katies of

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[13]"The New Lunatic Asylum", ST, 10/08/1881, p. 10.

vegetables in 1930 (FMSMR 1930); 13,106 katies of pork, 1454 hen eggs, and 232 duck eggs in 1932; and 38,552 katies of pork, 4561 hen eggs, and 1929 duck eggs in 1933 (FMSMR 1933). The value of produce generated by the inmates in the CMH was $56,013 in 1926 (FMSMR 1926); $60,537 in 1927 (FMSMR 1927); and $72,570 in 1928 (FMSMR 1928). In defense of the benefits of these therapeutic activities, W.F. Samuels wrote: "in addition to the curative value of the farms, there is a considerable saving to the various votes due to the activities of the patients" (FMSMR 1926). The term "occupational therapy" first appeared in the 1933 FMS Medical Report, when Dr R.D. Fitzgerald, Adviser on Medical and Health Services in the FMS, wrote: "the farms have thus proved their worth from an economic point of view as well as providing an excellent form of occupational therapy."

The detailed calculation of the output of occupational therapy in financial terms revealed the economic reasoning behind the therapeutic measure, as the participation of the inmates in work and production helped to reduce the financial burden of running such institution. Occupational therapy is thus at the same time a treatment, a moral correction and a form of cheap manpower. If the import of cheap labor was fundamental in maintaining and expanding colonial capitalism, the establishment of a mental asylum was instrumental in clearing the unwanted migrant labor from wandering in the streets and occupational therapy essential in molding them into economically productive, morally useful, and desirable colonial subjects.

Other forms of treatment include shower baths or cold douches, a careful regimen and the free use of antimony with salines, and aversion therapy by electric shock for sexual "deviation," drug addiction, and alcoholism. Acriflavine injection was used in 1934 (FMSMR 1934). Insulin shock therapy was introduced in Singapore in 1936 and into the CMH in 1946 for acute psychotic patients. ECT was introduced in Tanjung Rambutan and Singapore in 1947 and applied to selected cases of schizophrenia (Suarn et al. 2011; Teoh 1971).

Indigenous Response to Colonial Psychiatry

Just like the import of Western biomedicine, the introduction of modern mental health service was a crucial tool of imperial expansion. The establishment of modern health care not only served the needs of European officers, but also maintained a healthy working population for the colonial economy in urban areas, mining towns or plantation estates (Manderson 1996). Nevertheless, as a transplanted practice, modern mental health service did not automatically assume its legitimacy. Rather, it had to compete with various forms of traditional therapeutic services like traditional Malay healing and traditional Chinese medicine (Buhrich 1980; Teoh et al. 1972). Indeed, different ethnic communities had their respective cultural views and explanations for mental illnesses (Dunn 1974; Gwee 1971; Resner and Hartog 1970). Modern psychiatry's secular discourse about mental diseases forced a kind of "epistemological break" with different traditional

conceptions of sickness found in many non-Western societies (Higginbotham and Marsella 1988). Western medicine's attack on indigenous healing further alienated the multicultural and multiethnic community from seeking modern secular health service. In the meantime, modern health care resources tended to concentrate in urban and town areas, and were too scarce to replace traditional practices.

Social stigma of mental illness and mental institution posed another barrier to popularizing modern psychiatric service. The high death rate in mental asylum and the use of police force to admit patients to the asylum formed a negative connotation around the mental institution. Modern psychiatric service was thus often a last resort and usually occurred after the individual or family has exhausted other means of help, or when alternative services are unavailable, not known, or have not met the needs of the individual in crisis. Seeking psychiatric consultation and admission to a mental hospital were often considered a failure, irresponsibility, and an invitation to family disgrace (Crabtree and Chong 2000; Teoh et al. 1972). The public perception, attitudes, and opinions towards psychiatry in colonial Malaya were not particularly different from those in many parts of the world. Taken together, availability of traditional healing services, public preference for traditional therapies, social stigma, and scarce modern psychiatric services jointly contributed to the unpopularity of modern mental health service in Malaya.

A new chapter of psychiatric service began after independence. Now we turn to look at the development of mental health service in post-colonial and post-independence years.

Post-colonial Continuities and Changes

From Centralized to Decentralized Service

Upon attaining independence in 1957, there were four government-run mental hospitals, the CMH, Tampoi Mental Hospital (TMH) in Johor, Hospital Bukit Padang in Sabah, and Hospital Sentosa in Sarawak. CMH and TMH was renamed Hospital Bahagia Ulu Kinta (*bahagia*, Malay term, meaning "happiness") and Hospital Permai (*permai*, Malay term, meaning "lovely" or "pretty"), respectively, in 1971 to give mental institution a more positive connotation.

Realizing the limitation of centralized asylum care, the government started decentralizing mental health service by setting up psychiatric unit at general hospital. The first such unit was opened in the General Hospital in Penang in 1958. By 1974, six psychiatric units had been established at different district or general hospitals (Buhrich 1980); in the early 1990s, there were 17 such units across the country (Deva 1992); by the end of 1990s, there were 30 general/district hospital psychiatric units (Deva 2004) and 80 community-based psychiatric clinics spread unevenly over the country (Crabtree and Chong 2001).

Given the shortage of psychiatrists, general practitioners and medical officers at the psychiatric units of district and general hospitals were expected to offer simple psychiatric care. The establishment of these units was to reduce hospitalization and to minimize social stigma associated with hospital admission.[14] In 2010, psychiatric services were offered in 84 hospitals in Malaysia, where 46 were in the public sector and 36 in the private sector. There were a total of 20,601 psychiatric admissions (or 7.3 admissions per 10,000 population) and 438,634 outpatient psychiatric visits (or 154.8 visits per 10,000 population) throughout the country in the same year (Suarn et al. 2012).

In terms of psychiatric manpower, Malaysia's first psychiatrist qualified with a diploma in psychological medicine, trained in Britain, and returned home in 1961. The country started to offer its own training of psychiatrist in 1973, and general psychiatric training had been extended into a 6- to 11-week program in the general medical degree courses in seven public universities and two private universities by early 2000s (Deva 1992, 2004). By 1980, there were 19 psychiatrists, among whom 4 were females and the rest males; 9 worked in government hospitals, 8 held academic posts, and 2 worked in the private sector. Approximately, 50 medical officers were employed in various psychiatric units and mental hospitals throughout the country (Buhrich 1980). By early 2000s, there were 145 psychiatrists, among whom 25 were trained overseas and the rest educated locally (Deva 2004).

In 2010, the total number of psychiatrists reached 229, of whom 179 (or 78.2%) practiced in the public sector and 50 (or 21.8%) in the private sector. In terms of ratio, the national average was 0.08 psychiatrist per 10,000 population in the same year. The State of Selangor, Federal Territory of Putrajaya, and Federal Territory of Kuala Lumpur had the highest density of psychiatrists, which was 0.14 psychiatrist per 10,000 population, whereas Sabah had the lowest, which was 0.02 psychiatrist per 10,000 population. A total of 1159 nurses worked in psychiatric care throughout the country, of whom 1144 were in the public sector and only 23.5% had post-basic training (Suarn et al. 2012). Psychiatric workers and caregivers, like their patients, also face stigmatization, which constitutes a challenge in recruitment (Crabtree and Chong 2000).

During the 1960s and 1970s, social issues and changes pertaining to industrialization and urbanization caught the attention of psychiatric researchers. Truancy, deviant behaviors, urban life adaptation, hysteria in schools and factories, and child mental health were among the researched topics. In the 1980s and 1990s, mental health focus shifted to the prevention of drug addiction, smoking, and suicide. Today, women and aging community become new subjects of concern, following demographic changes and newly emergent concerns in the country.

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[14]"Modernising Malaysia's care of the mentally ill", ST, 25/10/1969, p. 12.

From Institution to Community Care?

While old issues like social stigma and man power shortage persisted, new issues began to surface, including what counts as legitimate therapeutic concept and practice. There were reflections over whether it was appropriate to standardize diagnosis and treatment as mental illnesses are culture-bound (Resner and Hastog 1970). The involvement of international health organization like WHO in promoting information sharing, standardized classification of disorders, and uniform psychiatric training pressured local psychiatrists to follow and adopt standard language and procedures. For example, WHO sent its consultant Eric Cunningham Dax to evaluate the psychiatric service in Malaysia in 1962 and 1969, respectively. Dax proposed the expansion of psychiatric programs and suggested an ambitious building program for new mental health clinics and rehabilitation hospitals around the country. He even urged various types of cadre be sent abroad for training and recommended that consultants continue to visit Malaysia offering 2-week mental health courses to upper echelon staff. While the adoption of standardized language and technological norms allowed local professionals access to more international resources, it simultaneously downplayed culture-specific problem solutions. The call for culture-specific mental health approach, however, seems to be largely confined to the circle of social scientists and medical anthropologists as psychiatrists tend to embrace international recommendations as a way to boost their legitimacy (Higginbotham and Mersalla 1988).

Other lines of contestation over legitimate therapeutic concept and practice include the following: (1) institution versus community care, (2) the role of social workers, (3) the importance of psychosocial approach over medical treatment, and (4) patient-centered versus paternalistic approach (Crabtree and Chong 2000; Deva 2004). The debate has been informed by subversive and democratic psychiatric movement in the West. The emphasis on community care and social work was at the same time a call for psychosocial and patient-centered approach. It was first proposed by the NGOs since the late 1960s.[15] The first community-based rehabilitation and day care center was then opened in Ipoh, Perak, in 1967. In 1976, an outpatient follow-up service was started in the Kinta District in Perak (Suarn et al. 2011). The promulgation of Care Centres Act in 1993 was part of the wider effort to decentralize health care.

It was not until three decades later that community mental care became a national policy, as pronounced in the Community Mental Health Programme 1997–2002 and National Mental Health Policy 1998 (Jamaiyah 2000). The program, however, faced various challenges due to insufficient man power, inadequate financing, and persistent stigmatization and social exclusion (Chong et al. 2013; Crabtree and Chong 2000; Mubarak et al. 2003). Mental health budget only accounts for less than 1.5% of the total national health budget; accessibility of psychiatric service remains an issue (Deva 2004). In addition to community care,

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[15]"Rehabilitation centre needed for mentally ill, says Rotary chief", ST, 30/06/1969, p. 13.

the government also launched mental wellness promotion campaign throughout the 1990s and 2000s. How well did these campaigns improve the mental health of the population is yet to probe.

In 2001, the National Mental Health Act was passed to replace the 1952 MDO (Deva 2004). Though the Act is ambitious, it remains contentious as the psychiatrists feel they are not consulted. Despite the introduction of secular explanation of mental illness and the promotion of modern psychiatric health service over the past few decades, supernatural beliefs and traditional–modern mixed consultation are not uncommon among Malaysians (Edman and Teh 2000). With the passing of the Traditional and Complementary Medicine Act in 2013, the legitimacy of traditional healers is boosted. To what extent this will change the mental health service landscape deserves further attention.

Conclusion

Mental health service in Malaya started out as a colonial state program that aimed to clean the colony of vagrants, starving migrants, paupers, drug addicts, convicts, and people afflicted with mental illnesses by confining them in gaols. In the mid-nineteenth century, the mental asylum was separated from the gaol. Half a century later, the increased number of "lunatics" and the expansion of mental health services coincided with a large influx of migrant workers. As a major mode of treatment that contributed to the revenue of mental asylum, occupational therapy was at the same time a curative program, a moral correction and a form of cheap man power. It reveals the colonialist idea of desirable, morally useful, and economically productive subjects. The operation of mental hospitals was thus simultaneously a project of economic, moral, and political engineering, packaged in the merciful image of the colonialists.

In the aftermath of independence, the government started decentralizing mental health service by setting up psychiatric units at district and general hospitals. Local medical course began to offer psychiatric training. The involvement of international group like WHO in modernizing the national psychiatric service was met with mixed response. On the one hand, local psychiatrists welcomed more international assistance and resources; on the other hand, social scientists and medical anthropologists warned against the undesirable result of standardization and called for culture-specific procedures. There was also a movement towards community care. It was initiated and started by NGOs in late 1960s and later translated into a national community mental health program in late 1990s. The program was compromised due to man power shortage, inadequate budget, and stigmatization. Despite being promoted and branded as a more legitimate mental health service over the past few decades, modern–traditional mixed consultation is not uncommon today.

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