



TCI Asia Action in Tonga

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This report is in 2 parts: First part is a backgrounder, it captures the mental health and allied systems in the Kingdom of Tonga. The second part reports on the TCI Asia action in the Kingdom of Tonga.

TCI Asia visit to Tonga was supported by CBM-Australia, in partnership with the Tonga mental health and disabilities Association [TMHDA, Nukualofa, Kingdom of Tonga]. TCI Asia is partner with the International Disability Alliance (IDA). IDA provides technical assistance and guidance to TCI Asia.

LANGI MA'A 2017¹

The visit to the Kingdom of Tonga was tied to speaking engagements in the Symposium, "LANGI MA'A 2017: TONGA MENTAL HEALTH AND DISABILITIES SYMPOSIUM, organized at the TANOVA INTERNATIONAL DATELINE HOTEL, NUKU'ALOFA, from October 9th to the 13th, 2017. Several email exchanges and skype calls facilitated by CBM-A, enabled TCI Asia's participation in the Symposium. 3 areas were identified as useful to the development of the sector:

- 1 - Brief overview of the CRPD
- 2 - Inclusion of persons with Psychosocial disabilities
- 3 - Programs development and available treatments/services compliant with the CRPD.

This was the very first mental health symposium in Tonga post independence, and TCI Asia was proud to have participated².

1. Background on Tonga³

Tonga was never colonized by any country. However, it had 'friendship' status for 70 years with Britain. It was a British 'protectorate' from 1900 until 1970, when it attained full Independence. It always retained its political sovereignty; however, many of its land, foreign, tax, trade, and various other civil policies were derived from the British. Therefore, along with other erstwhile British protectorates and

¹ <https://www.tmhdatonaga.org/>

² We thank CBM-A and Jillian Ferguson for great support to make our participation and our visit most meaningful.

³ Source: Kavita Nair, 2017, "Mental health systems in tonga- A background paper" for TCI Asia. Bapu Trust, Pune.

colonies in the Asia Pacific, Tonga is a commonwealth nation. Following the exit of the British in the 1970s, Tonga reinstated monarchy. It is the last Polynesian monarchy in the Pacific Islands. In 2010, the Kingdom of Tonga became a constitutional monarchy rather than being an absolute kingdom.

2. Development in Tonga

Tonga comprises of 169 islands, of which 36 are inhabited. It has a population of around 103000 people, of whom majority live in 'Tongatapu', the main island. Tonga is classified as "Lower / Middle" income country by the World Bank, in their classification of 2016 ⁴. The economy is aid dependent. Most aid assistance for Tonga comes from Australia, New Zealand and Japan. Environment, climate change, energy, agriculture, are attracting bilateral funding. The state continues to be the dominant service provider in the kingdom. There is no social protection scheme in Tonga, traditional social systems, extended family system and kinship ties however act as safeguards for socio economic adversity that individuals and families may be facing.

NGOs exist and women's empowerment is negotiated by the WIDC, which works from within the Prime Minister's office, and is involved in development activities and political decision making. There are 3 national disability organizations, trying to work out co-operations. There is good presence of UN Bodies such as UNDP who have contributed to Development projects in Tonga. Tonga has a history of signing international conventions and treaties, however, ratification is pending on several. CEDAW, until 2017, remains to be ratified. Similarly, Tonga has signed, but not ratified the UN-CRPD. Psychosocial disabilities and mental health remain on the fringes of policy. There is a national disability policy; as well as an Ombudsman as a process under the Public Relations Act.

3. The MH system in Tonga ⁵

One of the reasons that TMHDA invited TCI Asia was to share a community / arts based / support perspective into their public discourse. The system is medicalized, with no other available service. The provision of service is mandated by the Mental Health Act 1992 (Kingdom of Tonga, 2001c). There are no large, warehousing type of mental asylums, as usually found in the Commonwealth. Tonga's main and only psychiatric unit is attached to Vaiola Hospital (located in the capital city Nuku'alofa) and is a general hospital psychiatric unit (GHPU). However it has been called a "hotch-potch mini institution" by the senior psychiatrist Mr. Mapo ⁶. The unit is staffed by a medical officer, a mental health welfare officer, psychiatric assistants and a social worker, and is headed by the region's senior psychiatrist, Dr. Mapo. He has been appointed as Tonga's national focal point for mental health and disability by the Prime Minister. The facility has 12 beds, although it frequently exceeds this number of patients. The unit works to medically rehabilitate "chronic psychiatric patients" through outpatient review, continued psychosocial rehabilitation, home visits and "medication on wheels". The most common reasons for admission are "schizophrenia", occurring in almost one in every two persons, followed by "bipolar mood disorder" in roughly 30% of persons.

WHO Regional Office for the Western Pacific reports that many Pacific Island countries have suicide rates which are higher than the global average (WHO-WPRO, 2013). Break down of traditional family systems, out-migration, parenting issues, child abuse, suicidal thoughts, ideation and attempts among young people, alcohol and other substance use among the young, have become a major concern in the

⁴ <https://blogs.worldbank.org/opendata/new-country-classifications-2016>

⁵ Also, see <http://www.loauuniversity.edu.to/index.php/en/taught-courses/183-mental-health-related-problem-in-tonga>

⁶ *ibid.*

kingdom. However, psychosocial naming of people's concerns and community based support systems are not available in the literature.

While professionals advocate for a 'half way house' for those transitioning from inpatient mental health care, back to the community, the hospital unit has an open door policy whereby patients can drop in to seek respite and care on voluntary basis. However, coercion is practiced and numbers of involuntary commitment patients are recorded at 90%. The Mental Health Act also provides for compulsory community treatment orders, but the objective cannot be met as regulatory system cannot match up. It is recognized that "Institution based rehabilitation" must be replaced by CBR ⁷. Funding for mental health and wellbeing services is very low at only 1% of the Ministry of Health's total expenditure, dramatically below WHO recommendations, mostly for medical treatments and improving infrastructure for practice of psychiatry. There are no ECT facilities in Tonga, closest being Fiji Islands; and so the moral questions faced by other commonwealth countries around the use and abuse of this controversial procedure, is not found here.

4. The Langi-Maa symposium

The symposium had a diversity of presentations, that can be classed as:

(1) Bio-medical presentations which urged the importance of mental health and well being, in terms of the increasing prevalence of mental disorders in the kingdom; and the need for 'more beds' and treatment.

(2) Psychosocial references to the CRPD, and its adaptation to local social practices, psychosocial / community models. Also, several papers emphasized the importance of prevention work in communities.

(3) Cultural papers with strong focus on cultural formulation of distress and disability, local practices that can be adapted into mental health services, and strong cultural critiques of "western model psychiatry".

(4) Policy presentations, and 'what next' discussions.

"Langi Maa, 2017", an awareness video and a calendar supported by the WHO was released. The WHO officer shared the plan to draft the first Tonga mental health policy; and also implementing MH gap. WHO, in their mental health fact sheets for countries, also have one for Tonga⁸ within a larger concern for mental health in the Pacific.

5. TCI Asia contributions in the symposium

[Presentation 1]

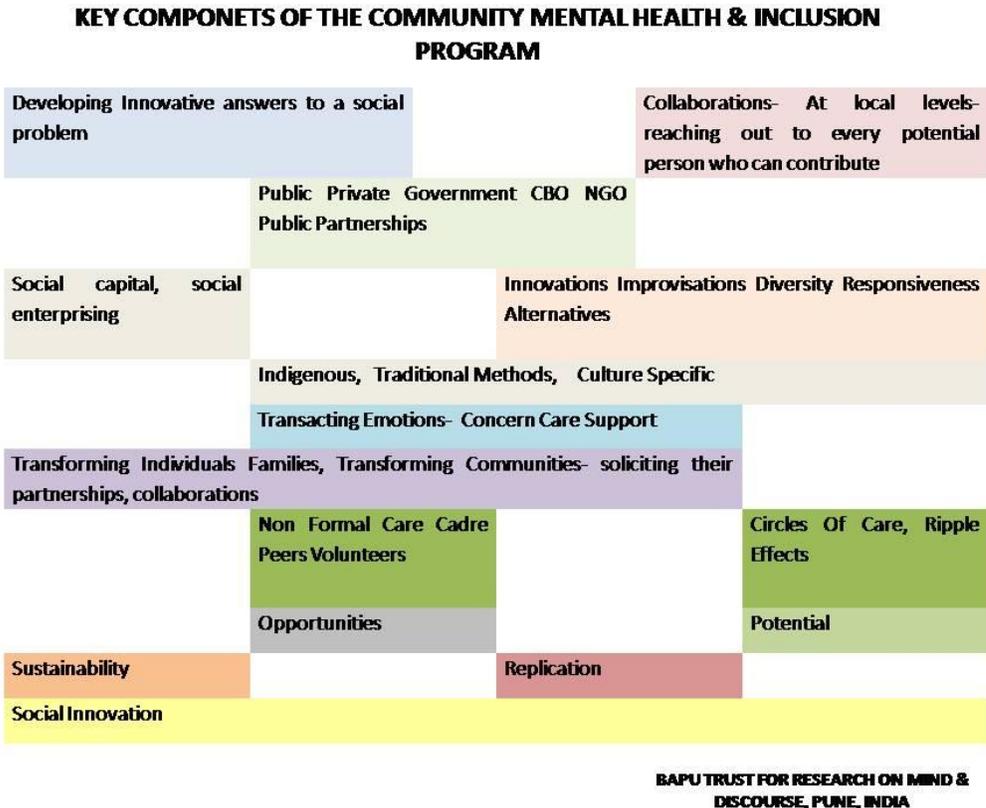
TCI Asia and Bapu Trust perspectives were represented in several of the sessions. We started with introducing Seher, the community mental health program in Pune, India, as a program on Recovery and Inclusion. Seher was presented as an illustration of what are the possibilities of working psychosocial health into community and development. The presentation gave an overview of the diversity of psychosocial needs in communities, intersectionality, and capturing knowledge on the spectrum of psychosocial wellbeing and needs within this diversity. The larger frames of CRPD and SDGs was

⁷ *ibid.*

⁸ WHO (2013). Towards healthy islands: Pacific mental health response. Geneva.

suggested, as ways to address the needs practically as well as on a principled basis, with a human rights based approach. Concepts used in the project Seher, such as 'social capital', 'circle of care', '8 point framework', etc. were illustrated, to summarize the differences between a bio-medical approach and a psychosocial approach. The need for inventiveness in concepts and practices was highlighted. The key components of an inclusion program, depending on the local context, was also suggested in this session.

Emphasis was on seeing culture and community as resource and not simply as 'targets' for interventions; keeping the action *local*, so that program can be adapted according to locally driven needs; and, having a diversity of solutions on offer, to truly enable choice.



[Presentation 2]

Since Day 1, we heard very little reference to the CRPD. A TCI Asia presentation introduced the Convention. The PPT enumerated the structure of the Convention, its purpose and principles, the definition of disability therein, the importance of Article 19, and its contents. We also shared information on the efforts by various UN human rights mechanisms to build flesh and blood into this article. Constructs of 'choice' and 'reasonable accommodation' were linked, programs may need sensitivity on developing a variety of supports as required by the person. The meaning of "paradigm shift" was discussed, as shifts from the medical model to the social model; from impairment / deficit to 'restriction of participation'; from individual focus to community focus; from welfarism to self-determination; from a 'mono-man' view to respect for diversity.

From discussions of the previous day, we reclaimed a CRPD language and insights into the second day's deliberations. Paradigm shift also meant making the following changes of language and practice.

- Where do 'they' belong? Within the Development sector!!
- How to refer to 'them'? – Persons with psychosocial disabilities
- Positive imaging in talk about 'them' - They can do, they have will and preference, they can act, they are capable, they can contribute, they can care, etc..
- Avoid evoking the 'suffering' or 'burden' of mental illness– It is a question of identity, even the pride for survivors.
- Imputing a 'mental illness' – is a commonwealth country peculiarity of having a colonial legal legacy. A person of 'unsound mind', so accused, will face all the stigma, discrimination and lack of equal opportunity of having a psychosocial disability. They too come within the disability spectrum because of severe restriction of participation.
- Avoiding over-protectionism, but provide support as needed.
- Holders of personhood and 'self', on equal basis as others, with associated concepts of respect, dignity and honour.
- Enabling participation – Providing a non-judgmental / inclusive environment so that people on their own can join in the social context and transactions.
- Holders of material things – property, bank accounts, job, money, family, children, home and hearth, cars, mobile phones, clothes, sporting equipment, dress with frills, bicycle, guitar, etc. like others.
- Right to decision making – no big or small decisions, taking risks is okay, making mistakes is okay.

We also shared, why a focus on Article 19 is important. Article 19 (Right to living independently and being included in communities) brings together all stakeholders and it gives some actions to do, for everybody. All stakeholders nod in agreement when establishing this human right. Article 19 is not only about the whole person, but it is about whole systems and whole communities. It creates new opportunities for rebuilding communities, in countries where institutions exist; and many new openings for countries which have no custodial institutions. Article 19 mandates intersectional linkages (public health, education, culture, development linked services, social networks), placing 'mental health' within the larger Development context. It opens several life opportunities for persons with disabilities, going beyond treatment. Spiritually, it reminds us of our common humanity, the common set of moral questions we share, and the need to share the planet in a just and fair manner; to be of use to others in simple and everyday ways (Interdependence).

[Presentation 3]

Continuing to 'reframe' articulation from mental health language to disability language, we presented on 'strategies for program development towards inclusion'. This was the 3rd and last substantive presentation at the symposium. Drawing from the thoughts shared the previous day, we highlighted the nature of 'institution', that, it is not only the physical structure, but the mentality which can happen anywhere in the communities. Examples of 'community support systems', new concepts available in the world today, practices, were shared. 3 key elements were needed to facilitate inclusion of persons with

psychosocial disabilities within communities - peer support, crisis support and community dialogue systems. They can be adapted to local communities.

Other impressions

TCI Asia speaker, Bhargavi Davar, also participated to give key message, on the 10th October, towards the World Mental Health Day program. [Annexure 1]

The symposium addressed mental health primarily from a public health perspective. Speakers also focussed on prevention aspects, life span approach, concepts of wellbeing going beyond mental illness, integrating mental health within primary health care, new ways of capturing knowledge about psychosocial issues, need for research, etc. Tonga also has large and string networks of complementary and alternative medicine. The social work model in Tonga is influenced by cultural concepts and strong resistance to western medicine. The positive role and language of traditional healers was brought up several times by speakers. There are strong sentiments about incorporating cultural healing systems within mental health care.

Meeting with DPOs

Tonga has 3 major DPOs at the national level. The leading activists from the DPOs arrived for a luncheon meeting during one of the days of the Symposium. We had a 2 hour meeting, exploring common concerns about inclusion of persons with psychosocial disabilities. We discovered that there was scepticism about CRPD. A lot of the discussion was around persuading the DPOs on the importance of the CRPD, and rallying in advocacy around it. We shared Asia / India experiences, about building co operations around the CRPD as a cross disability movement. Some codes of cross disability alliancing, how best to do this, was also discussed. We were satisfied from the steady flow of questions from the dozen or so participants, that the dialogue had been a mutually enriching one.

Recommendations

The "advanced" countries are today struggling with loss of communities, state control and over-institutionalization. In the global south, however, there are not so many 'mental' institutions, though thousands of unregulated social care institutions do exist. The 'custodial' mentality remains due to mental setbacks caused by colonialism in most post colonial countries in the Asia Pacific. Poor availability of community services, poor regulatory mechanisms, liberalising economies, have their impacts on communities and systems, with abuses happening in open communities. Mental health legislation, a product of colonialism, has been a recognized barrier worldwide, for the serious discrimination of persons with mental health problems and psychosocial disabilities. The Kingdom of Tonga, like many other lower / middle countries in the Asia Pacific, does not have many institutions, or special organizations built on principles of 'custody'. This is a huge opportunity to build communities around Inclusion.

1. Inclusion in Development and health care - Tonga has an impressive primary health-care system, good public health infrastructure, public health program features, comprehensive health care, urban development, civic administration, education, civic amenities, water, sanitation and waste disposal programs. Psychosocial perspective can be integrated into the already existing systems on Development,

including public health. Programs already in existence, offered in the kingdom, could be 'upgraded' to inclusion programs.

2. Preparing multiple stakeholders for Inclusion - Service providers in Tonga work in the remotest parts of the Kingdom closer to families and communities. The church is found in all parts of the Tonga human habitats. They are all stakeholders who could be trained in inclusion of persons with mental health problems and psychosocial disabilities. The policies in Development, as they are emerging, could already have a psychosocial wellbeing and inclusion component. Then, at the local level, partnerships for inclusion and mental health can be forged through many Development pathways.

3. Programming communities for Inclusion - Family and kinship structures, community networks, culture are strong sentiments in the Kingdom, as evident from Langi-Maa conference. Basic modules of non formal caregiving and support for persons with disabilities including mental health problems, can be offered for families and communities through the existing networks and systems. Local NPOs can be roped into the trainings. Training modules could be geared towards creation of support networks, family systems strengthening, community awareness and skills building, negotiation and arbitration techniques, peace building techniques, etc.

4. Strengthening mental health systems towards Inclusion: Existing medically orientated mental health systems could be 'upgraded' towards CRPD compliance, with a more holistic view of the person and their social environment. Mental health law and policies can be reframed to be in alignment with the CRPD. Goals of psychosocial wellbeing could be towards recovery and wellness promotion. The larger purpose of the mental health system would be to facilitate the inclusion of persons with psychosocial disabilities into communities.



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Annexure 1 - Message for Mental health Day

Bhargavi Davar

Sharing a bit of my story.... I identify as a 'survivor'. I have had early childhood exposure to the Indian mental asylums, where my mother was incarcerated and kept chained in a cage. When I was under 6 years of age, I was repeatedly exposed to many asylums, both private and public, to meet my mother. India is a part of the commonwealth, an erstwhile British colony. The British left behind a blueprint for such asylums, which continue to grow in India, post Independence.

I carried for several decades, traumatic memories from those days, the smell, the shackles, the shock treatments, the cages.... and my mother at the receiving end! Stigma and exclusion within family, poverty, and gender oppression in many ways through growing up years. I could not 'make sense' of those experiences, why my mother was in there, and I felt angry, guilty, helpless and powerless for years. And ofcourse I missed a nurturer in my early growing up years. My father could not fill the gap, though he tried! The memories of mental asylums haunted me for many decades into my adulthood, leaving me with a fierce will to change those systems into something more humane.

I have experienced long term trauma, and deep depression well into my adulthood, even while I was writing many academic papers and books. The depression was all consuming, but it gave me a lot of important learnings about how to live my life, and what choices I need to make. It was quite a spiritual, awakening experience, and lasted about a decade, through my 40s. It was also a good experience in terms of many lifestyle changes I needed to make - What food I ate, whether I got my dose of daily sunshine and exercise, and to pursue happiness and being useful to others, as important long term spiritual goals for my life.

I developed a deep hatred for closed door colonial type mental institutions, which continued the inhuman practices such as solitary confinement and restraints, and other unthinkable human rights violations. I devoted my life to saving people from such institutions, by creating a range of community based services through Bapu Trust (Seher program). Seher is now 12 years old, and doing very well, with support of the government. Now I carry my learnings to different countries in Asia, using the platform we created called TCI Asia.

I dedicate this day to people with mental health problems and psychosocial disabilities, their families and communities, in Tonga, the pacific island countries, to people living in Asia, and in all of the global south. Luckily many parts of Asia and the Pacific, despite being colonized, or being a protectorate, do not have many closed door lock up facilities for people with mental health issues; Nor, are there many countries with mental health laws through which people are forced into lock up / or forced to take their medications. I urge you not to bring practices of force and violence, into your amazing nation, where nature and community seems very strong, from all that I have read in the past weeks, while preparing for my sharings with you.

This is also the core message recently given out by Mr. Dainius Puras, the United Nations Special Rapporteur, Health, issued in June of 2017. I share some of the wordings from this

important report⁹. On the World mental health Day, it is really important to recall his words to the world. Briefly,

"Despite clear evidence that there can be no health without mental health, nowhere in the world does mental health enjoy parity with physical health in national policies ... "

"Forgotten issues beget forgotten people. The history of psychiatry and mental health care is marked by egregious rights violations, such as lobotomy, performed in the name of medicine. Since the ... adoption of international conventions, increasing attention has been paid to human rights in global mental health and psychiatry. However, whether the global community has actually learned from the painful past remains an open question. While mental health services are starved of resources, any scaled-up investment must be shaped by the experiences of the past to ensure that history does not repeat itself. [I have lived through this history, and completely agree with this sentiment.]

"Recently, through the disability framework, the limitations of focusing on individual pathology alone have been acknowledged, locating disability and well-being in the broader terrain of personal, social, political, and economic lives.

Finding an equilibrium between the extremes of the twentieth century has created a momentum for deinstitutionalization and the identification of a balanced, psychosocial model of care. Those efforts were reinforced by WHO in a report in 2001, in which it called for a modern public health framework and the liberation of mental health and those using mental health services from isolation, stigma and discrimination".

In my further interventions at this wonderful symposium, I will share what different organizations are doing in the area of psychosocial interventions. We expect 'inclusion' to be a favourable outcome for persons with mental health problems and psychosocial disabilities, not just 'reduction of symptoms'. We expect a good quality of life and standard of living, on a par with other citizens in nations, and not just 'cure' to our problems.

From my own experiences, and experiences of several peers in India and in Asia, I know that we can imagine together a better world that will include us, and will acknowledge our contributions. We can indeed share our insights about mental wellbeing, and illness, with the world; with our doctors, our family care givers, and with people in our neighbourhoods. We can share, what is the kind of services that we want, who we want be with, what we want to eat, where we want to live, who we want to marry, what work we want to do, what hobbies we want to pursue; all in all, how we want to 'live *our* lives'.

⁹ A/HRC/35/21 , Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN, Geneva, 2017