•COMMENTARY•

Practical Answers are Needed to Respond to the Myth of Mental Health Services in Tibet

Bin XIE

[*Shanghai Arch Psychiatry*. 2018; **30**(2): 131-132. doi: http://dx.doi.org/10.11919/j.issn.1002-0829.218020]

The article by Liang Xie et al. examines the current situation of mental disorders and mental health services in the Tibet Autonomous Region (TAR) of China, the part of China where mental health resources are the most scarce. [5] For quite a long time, the most frequently asked questions by people who were concerned about the phenomenon of this impoverished environment were: why are there no mental hospitals in Tibet? Why are there no psychiatrists?

When people discuss such questions in private, they often take it for granted that the answer is: Tibetans, who account for 90% of the Tibetan population, have strong religious beliefs, and thus may be psychologically immune to modern mental disorders; when suffering from some kind of mental disorder, they may be alleviated only by seeking the "treatment" of Buddhist monks, without the help of specialist psychiatry.

If such explanations are sufficient, all people with strong religious beliefs can solve their mental health problems by "healing themselves" like Tibet. However, no studies, so far, support this conclusion. Instead, a large number of studies suggested that relations between religious beliefs and mental disorders, and between religious activities and mental health services are not mutually exclusive but mutually dependent, which deserves special attention in service delivery.[1-3] Therefore, the phenomenon of Tibet cannot be explained solely by religion. To study and answer the Tibetan phenomenon, from the microscopic perspective, can help us scientifically understand the local prevalence of mental disorders, rationally plan mental health services, and improve the mental health level of local populations; from a macroscopic perspective, it is conducive to understanding and analyzing the impact of environment, culture, economy, policies and other factors on mental health services, and seeking some kind of "paradigm" for addressing similar issues elsewhere in the world.

By reviewing the literature, Liang Xie et al. found that there were people suffering from various types of mental disorders and psychological or behavioral problems, regardless of ethnicity (i.e. Han or Tibetan) in the Tibet Autonomous Region, and the psychological problems existing in some specific groups were still very prominent. Due to the general lack of modern mental health facilities and professional technical personnel, the needs of those with unsatisfied diagnoses and treatments are enormous. Although gratifying changes are slowly progressing since 2004, they are still not enough in terms of the coverage and feasibility for the services. Liang Xie et al.'s article showed that mental hospitals and psychiatrists were not unnecessary for Tibet, on the contrary, Tibet needed a relatively large number of specialized mental health resources. Liang Xie et al. also put forward good suggestions for establishing regional mental health centers, training grassroots and other specialized medical personnel, and conducting health education. But their article did not answer: what are the main factors that hinder the (sustainable) development of mental health services in Tibet?

In fact, there is a general shortage of mental health resources throughout China that present huge differences between regions.[4] The situation in Tibet is only more extreme. Therefore, the current difficulties facing China are also Tibet's difficulties that include discrimination and prejudice against mental illnesses and their medical services, inadequate attention to these issues from local governments, low prevalence of public mental health knowledge and so on. For Tibet, an

Shanghai Mental Health Center, Shanghai Jiao Tong University School of Medicine, Shanghai, China

correspondence: Bin Xie. Mailing address: 600 South Wanping Road, Shanghai, China. Postcode: 200030; E-Mail: xiebin@smhc.org.cn

area with a particularly extreme set of such conditions, it may seem necessary to study and analyze more factors, including the lack of continuity and stability of service that may result from policies of medical assistance by other provinces, the limited availability of services that have to focus on physical diseases due to the shortage of overall medical resources, the phenomenon of mental disorders being more culture-bound than physical diseases, the lower level of overall education, the inconvenient transportation and even the effect of talent "siphon" by "neighboring" resource-rich areas such as Chengdu. It is hoped that subsequent studies will provide more detailed (supportive or negative) information in these areas.

Based on the above current situation and potential causes, the solutions may only be a "multi-pronged combination" approach that focuses on both current and long-term needs. Apart from Liang Xie et al.'s suggestions, future targeted policies and measures may still need to consider the following: (1) making feasible development plans or even implementing local legislation to protect mental health service; (2) prioritizing the approval number of psychiatrists who can be financially supported by the government budget, as well as a stepwise increase in their income; (3) providing preferential support for doctors and patients, and supporting social resources investments in mental health services and benefits. Moreover, the projects, relating to telemedicine, distance education training based on virtual reality (VR) and other innovative service models combing local ethnic and religious characteristics are also worthy of research and exploration.

Funding statement

No funding was obtained for this commentary.

Conflict of interest statement

Author reports no conflict of interest related to this manuscript.

References

1. Koenig HG, Larson DB. Religion and mental health: evidence for an association. *Int Rev Psychiatry*. 2009; **13** (2): 67-78. doi: http://dx.doi.org/10.1080/09540260120037290
2. Behere PB, Das A, Yadav R, Behere AP. Religion and mental health. *Indian J Psychiatry*. 2013; **55** (Suppl 2): S187. doi: http://dx.doi.org/10.4103/0019-5545
3. Ventis WL. The Relationships Between Religion and Mental Health. *J Soc Issues*. 2010; **51**(2): 33-48
4. Xie B. Strategic mental health planning and its practice in China: retrospect and prospect. Shanghai Arch *Psychiatry.* 2017; **29**(2): 115-119. doi: http://dx.doi.org/10.11919/j.issn.1002-0829.217025
5. Xie L, Wei G, Xu Y, Huang Y, Liu X, Li T, et al. Psychiatric Epidemiology and Mental Health Service in Tibet Autonomous Region, P. R. China. *Shanghai Arch Psychiatry*. 2018; **30**(2): 127-130. doi: http://dx.doi.org/10.11919/j.issn.1002-0829.217148

Bin Xie is Chief Physician at the Shanghai Mental Health Center, Shanghai Jiao tong University School of Medicine; Director of the Shanghai Center of Mental Disease Control and Prevention. His main areas of academic research are forensic psychiatry, mental health policymaking, and legislation.