12

TOWARDS AN INTEGRATED AND ACCESSIBLE MENTAL HEALTHCARE SYSTEM IN TIMOR-LESTE

Susana Barnes, Lisa Palmer, Ritsuko Kakuma and Benjamin Larke

Introduction

Transcultural psychiatric studies have long shown that culture shapes illness, including its symptomatic display, diagnoses, treatment and prognosis (Kleinman 1980). Most illnesses in Timor-Leste are attributed by sufferers to specific natural and supernatural causes and people (more so in rural areas) prioritise treatment by customary healers (Graves 2003; Kakuma et al. 2015). In more urban contexts, approaches to health and healing have been shaped by the influence of Christianity and particularly charismatic (and universalising) faith-healing practices common to both the Catholic and the Protestant traditions. Both customary and 'modern' informal healing practices are used interchangeably with clinical health systems (Edmonds et al. 2005; Graves 2003; Zwi et al. 2009).

Although there is a high level of informal awareness amongst the Timorese themselves of these complementary practices, to date there has been only limited recognition of these within the formal healthcare system (Graves 2003; Hawkins 2010; MOH 2010). In this chapter, we first explore diverse understandings of health and healing in Timor-Leste and consider how these play out in the context of mental health. We then identify the range of customary and religious faith-based healers and healing practices commonly consulted by patients with mental illness and their families. Finally, we ask, if and how might customary, other religious and clinical approaches to mental health be woven together to improve equitable access to culturally competent and context-appropriate health services.

Research background

This chapter brings together the results of different research projects on mental healthcare systems conducted by the authors in Timor-Leste.[1] Between 2013 and 2015, Barnes, Palmer and Kakuma initiated an interdisciplinary scoping study together with the Ministry of Health (MOH) and the National University of Timor-Leste. The study aimed to improve understanding of Timor-Leste's diverse customary and religious health and healing practices and explore the potential of integrating these practices with modern psychological and clinical approaches (Kakuma et al. 2015; Palmer et al. 2015a, forthcoming).

Research for this study was developed from a diversity of sources including the work of two of the authors (Palmer and Barnes) who have each carried out long-term ethnographic research in diverse locations across Timor-Leste (Barnes 2011, 2013, 2017; Palmer 2007, 2010, 2015). Targeted research for the present study was conducted in three main locations, the capital Dili, the regional town of Baucau and the rural community of Venilale in the municipality of Baucau. Study participants, however, were drawn from 12 municipalities of Timor-Leste representing a variety of socio-cultural and linguistic groups.[2] In-depth interviews and focus group discussions were conducted with key stakeholders, including policy-makers (MOH and World Health Organization/WHO), mental health workers (including from the MOH, Psychosocial Recovery and Development in East Timor (PRADET) and *Centro São João de Deus*), patients and their family caregivers, as well as customary and faith-based healers. Data for this project were also collected through participant observation at a national-level forum in 2015 that brought together over 60 Timorese participants representing government, international agencies, academic and community stakeholders from across the country to present the preliminary findings of our scoping study and stimulate dialogue on mental health policy and practice in Timor-Leste. In 2016, Larke conducted further research focusing on the prevalence and nature of stigmatising attitudes amongst service providers in Timor-Leste towards mental illness and the interactions between stigma and other factors, including knowledge about mental illness and contact with people with mental illness (Larke and Bartik 2017).[3] Study participants included mental health service providers from PRADET; the emergency department of the MOH's Guido Valdares National Hospital, the Ministry of Social Solidarity's Directorate of Social Development; the Bairo Pite Clinic – a non-governmental health clinic; and Klibur Domin, a local non-governmental organisation (NGO) that incorporates services to people with a mental illness as part of broader community health services.

Mental health services in Timor-Leste

Evidence suggests that the most effective and comprehensive mental health service consists of a combination of both community- and hospital-based services (Thornicroft and Tansella 2009). Whilst considerable effort has been made since independence to develop community-based mental health services that are integrated into the mainstream health sector, the mental healthcare system in Timor-Leste faces numerous challenges.[4] At present, there is one national hospital located in Dili at which the only national psychiatrist in the country is based, one large regional hospital and four smaller hospitals. No public inpatient mental health care is currently available in the country although there are plans to roll-out such services at both the national and regional levels in the future. The only inpatient mental healthcare facility in the country is delivered by an NGO - the *Centro São João de Deus* run by The Hospitaller Order of St. João de Deus (*A Ordem Hospitaleira de S. João de Deus*).

Each municipality has an allocated mental health caseworker with basic training in mental health and a background in nursing or public health. Primary healthcare doctors and nurses are authorised to prescribe and/or renew prescriptions for some psychotherapeutic medicines. Primary healthcare nurses with mental health training are also authorised to diagnose or treat mental disorders. In terms of training, the majority of primary healthcare doctors have not received official in-service training on mental health within the past five years.[5] Referrals for initial assessment can be made to counsellors working with one of two NGOs providing specific mental health services (PRADET based in Dili and the *Centro São*

João de Deus in Laclubar). Priests and nuns in the Catholic Church also provide informal care through a range of pastoral services.

Given the limited human and material resources available in Timor-Leste, both government and non-governmental mental health organisations recognise the central treatment and supporting role of community and family in the care of mentally ill (Hawkins and Tilman 2011; MOH 2010; Silove et al. 2008). Moreover, they also recognise the advantages of integrating local understandings of health and wellbeing into mental health policy and practice (Graves 2003; MOH 2010; Rodger and Steel 2016; Silove et al. 2008). At family and community levels, customary and religious (faith-based) health and healing practices often operate as alternative or complementary care to formal health services (see Graves 2003; Zwi et al. 2009). Yet, there have been few systematic attempts to document these practices, or determine the effects of specific therapeutic interventions or treatments in relation to mental health.[6]

Health-seeking behaviours and local understandings of mental health and wellbeing

A 2004 epidemiological study found that 81% of those diagnosed with psychotic disorders consulted a 'traditional' or 'customary' healer (Silove et al. 2008). A preference for customary healers, however, is not necessarily specific to cases of mental disorder nor is it necessarily an indication of a conflict with clinical care. East Timorese populations draw on a range of sources of health-related knowledge and practice including 'modern' clinical, 'customary' ethnomedical, family-based or faith-based approaches (Graves 2003; Loch 2007; McWilliam 2008; Zwi et al. 2009). In fact, studies suggest that most individuals and families choose a combination of treatments, or may even switch between treatments if deemed ineffective (Edmonds et al. 2005; Graves 2003; Kakuma et al. 2015; Palmer et al. forthcoming; Rodger and Steel 2016). However, it is also the case that recourse to formal health services is often seen as a last resort (Graves 2003; Palmer et al. forthcoming).

Individual and collective decisions about seeking health services and what particular form of treatment to follow are influenced by a range of factors. They include long distances and poor roads to health centres or regional hospitals, the costs associated with procuring transport and accompanying family members to health facilities, the attitude of health workers, the availability of medication and perceived efficacy of treatments offered (Zwi et al. 2009). The decision to consult a traditional or indeed a religious faith-based healer over a formal health worker is further motivated by considerations of the perceived underlying cause of illness, familiarity and trust (Edmonds et al. 2005; Graves 2003; Kakuma et al. 2015; Palmer et al. forthcoming; Rodger and Steel 2016).[7]

Whilst the treatment and/or eventual recovery of a patient may be enabled by either clinical or traditional means, the perceived causes and consequences of illness are greatly shaped by cultural attitudes and expectations, and healing often requires not only physical but also spiritual attention. For many East Timorese, notions of health and wellbeing are based on specific ontological and cosmological assumptions about the person in society (Martins et al. 2008; McWilliam 2008; Palmer et al. forthcoming; Trindade 2015). Consequently, diseases, disorders or accidents affecting the 'body-self', be they natural or 'supernatural' in origin, are related to transgressions against the 'body-social' (see Hoskins 1996; Scheper-Hughes and Lock 1987).

There are many different local idioms used to describe mental illness in the various languages and dialects of Timor-Leste. Rodger and Steel (2016: 8) identify the commonly used Tetun terms, including (1) *bulak* – a generic term which is often used in a derogatory

manner; (2) *pontu* – also a general term often used to describe individuals who behave or speak in an erratic, absurd or non-sensical manner, also associated with senility or dementia; (3) *hanoin barak* – 'thinking too much' (see below) associated with stress but sometimes also used in conjunction with *bulak*; (4) *bilan* – used to describe persons in a confused state or 'empty mind', also used to denote persons with intellectual disability; and (5) *fulan lotuk* – literally meaning 'slim moon' and associated with causal explanations for intermitting disorders that coincide with the late waning/early waxing of the moon (Silove et al. 2008; see also Graves 2003).

Many people recognise that mental disorders may have natural, biological or physical causes;[8] the result of physical trauma to the head, a consequence of malaria or genetic inheritance (Graves 2003). Local explanations also take into account social causes such as poverty, exclusion or general trauma from the experience of war and violence, including domestic violence (Graves 2003; Rodger and Steel 2016; Sakti 2013; Toome 2013). Disorders in Western clinical terms that are considered non-psychotic, such as depression, anxiety and post-traumatic stress disorder, are usually linked to the notion of 'thinking too much' (Tetun: *hanoin barak*) or 'fright' (Tetun: *hakfodak*), brought about by broken, fragmented or blocked social and spiritual relations which can produce feelings of 'sorrow' (Tetun: *laran moras*), anger (Tetun: *laran hirus*) or nausea (Tetun: *laran sae* or *laran beik*) (Rodger and Steel 2016; Sakti 2013). Unusual behaviours associated with psychotic mental disorders or disability, such as an inability to control one's body, unusual speech patterns, violent out-bursts or even prolonged silence, on the other hand, are more commonly (but not exclusively) thought to have 'supernatural' origins (Rodger and Steel 2016).

'Supernatural' causes of illness can be ambiguous or malevolent and may be attributed to witches (Tetun: *buan*), non-human entities that enliven the natural world (Tetun: *rai na'in*), ancestral animal species (Waima'a: *dai*, Tetun: *malae*) or ghosts (Tetun: *matebian*) (Barnes 2017; Hicks 2004; Palmer 2015). From a more Christianised perspective, 'supernatural' causes are linked to 'demons' and other manifestations of evil. Witches stand out as being essentially anti-social, they enter one's dreams, enter bodies, cast spells (Tetun: *fekit*) or entice others to harm often using some organic substance belonging to the victim (nail, hair, blood etc.) (Hicks 2004). The action of witches is seldom considered to be the direct cause of illness but the result of broken or strained social relations. As experienced in other contexts, a witchcraft diagnosis is often fatalistic as it is not possible to establish relations with witches (cf. Strathern and Stewart 2010: 110–111). In such cases, people may consider treatment or cure of illness to be beyond the reach of introduced or 'Western' medicine, requiring the intervention of healers capable of mobilising ancestral spirits strong enough to counter the action of witches (Hicks 2004; Palmer et al. forthcoming).

Illnesses attributed to the intervention of non-human 'spirits' or *rai na'in*; ancestral animals and ghosts, on the other hand, are associated with social and environmental transgressions. These can include entering sacred sites without performing the appropriate rituals, eating taboo foods, contravening marriage rules between lineage groups and houses, or cases of 'bad death' and outstanding burial rites (Barnes 2017; Bovensiepen 2015; Palmer 2015; Palmer et al. forthcoming). In all such cases, for illness to be treated successfully, it is believed that reciprocal relationships across the social, spiritual and ancestral realms must be properly addressed.

Stigma is attached to certain behaviours associated with mental illness, including a fear of violence or being drawn into relationships affected by 'supernatural' causes of illness (Graves 2003; Palmer et al. forthcoming). Such attitudes and beliefs manifest themselves in several ways ranging from avoidance to physical violence or abuse and, in the absence of viable care

alternatives, some people are shackled or otherwise restrained (UNMIT 2011).[9] A recent study by Larke found that, in the case of mental health service providers in Timor-Leste, stigmatising attitudes and beliefs were more likely to be related to the conception of people with mental illness as a source of threat or violence (Larke and Bartik 2017). Rodgers and Steel (2016: 139–140), however, note that cultural explanations that attribute the cause of illness to external sources may play a role in reducing personal and social culpability, notions of *lulik* and *rai na'in* in particular, they suggest, are 'inclusive idioms', universally acknowledged as having the potential to impact on any member of society. Such socio-cultural characteristics, they argue, contribute to ongoing family support for relatives and increase probability of recovery.

Individual, family and community attitudes and behaviours in relation to mental illness are influenced by culture, and healthcare providers, particularly those who are themselves immersed in the same culture, often appear to accommodate patient beliefs in custom as the underlying cause of illness (Zwi et al. 2009). As McWilliam (2008: 236) suggests, this sensitivity to the cultural realities of health practices across the country highlights the possibility of incorporating or translating clinical concepts and treatments into more 'culturally familiar formats'. Greater attention to local explanatory models and expressions of distress may in fact help improve engagement with mental health services (Rodger and Steel 2016). Given the important role they play in identifying causes of mental illness and enabling patients and families to think about and frame the meaning of illness in both mundane and cosmological terms (Rodger and Steel 2016), the role of customary and religious faith-based healers needs to be acknowledged (Graves 2003).

Customary and religious healers and healing practices

Across Timor-Leste, there exist a range of different types of 'traditional' or customary and religious faith-based healer and healing practices (Kakuma et al. 2015). These practices include customary approaches to healing generally associated with ancestral origin houses (*uma lulik*)[10] and nature spirits, religious healing practices of both the Catholic and the Protestant traditions as well as syncretic indigenous derivatives thereof, Timorese-Chinese folk-medicine and Islamic healing traditions.

In most language groups, a range of terms are used to describe customary healers who may be either male or female. In Tetun, these include *liman urat* (diviner), *badaen liman* (masseur, or also traditional midwife), *kukun na'in* (ritual specialist) and *matan dook* (diviner, soothsayer).[11] At the origin house level, it is often the case that either the ritual elders of the house or the spokesperson for the house (Tetun: *lia na'in*: keeper of the words) takes on responsibility for the spiritual care and protection of their kin. 'Specialist' healers may or may not have kin relations with a patient. These healers draw their powers from a variety of sources, including their own ancestral house, nature or the divine. The healing gifts of these 'specialists' may be received as a hereditary gift, through dreams or acquired through life experience and practice. It is also common for those who are said to have been afflicted by an adverse spirit possession to become healers if they are able to overcome and control the cause of their affliction (cf. Hatala et al. 2015; Palmer et al. forthcoming; Rodger and Steel 2016).

In relation to customary healers and practices, McWilliam (2008) notes that therapies for specific illnesses, including mental illness, form part of wider range of strategies and practices aimed at restoring individual health and establishing community wellbeing. Customary healers concern themselves with determining and resolving the social origins of illness and misfortune as much as addressing the physical symptoms. Different diagnostic techniques

are linked to specific healers' practice, including watching the patient, listening to their life history, divination, augury and prayer. Customary healers use a complex vocabulary for describing illness, symptoms and causes. They employ different therapies or treatments based on diagnosis including invocation; laying of hands, manual techniques including massage often with areca nut spittle (*bua malus*), animal sacrifice, candles and herbal medication.[12] Often the therapeutic process focuses on repairing relations and repaying debts to ancestors, family, house and fertility-givers/fertility-takers, particularly through animal offerings and sacrifice (Kakuma et al. 2015).

In more urban contexts, approaches to health and healing have also been shaped by the influence of Christianity and charismatic (and universalising) faith-healing practices common to both the Catholic and the Protestant traditions (Palmer et al. forthcoming). Individuals and families seeking assistance for themselves or mentally ill relatives may consult their parish priest and seek improvement through Church attendance and prayer, often this is done whilst at the same time consulting a customary healer (Graves 2003). Those who seek out charismatic healers, on the other hand, tend to draw on visiting foreign teachers who often express disdain or outright objection to engagement with customary healing practices (Wiyono 2001). They seek instead a break with ancestral religions and associated customary practices, radically refashioning newer traditions based on individualism and a direct spiritual relationship with God. Within the Catholic charismatic tradition, there is a distinction made between physical healing of the body, the inner healing of emotion and the deliverance from evil spirits (Csordas 1997). Physical illness arises from disease and accidents whilst spiritual or emotional illness is the result of personal sin, or less frequently demonic possession (Chesnut 2003; Csordas 1997). Emphasis in this type of religious healing is placed on the transformative rather than the restorative effects of healing, the ultimate aim of which is to realise the 'sacred self', a sense of being 'in Christ' (Csordas 1997: 18).[13] Healers in this context do not possess 'powers of healing' but rather are enabled to make interventions on the patient's behalf through prayer, laying of hands or anointing.

There also exist in Timor-Leste a range of more syncretic healing practices such as *oratorio*.[14] Practitioners of *oratorio* use candlelight as part of divinatory practices, pray over patients and conduct separate private rituals (Palmer et al. forthcoming). Whilst these syncretic practices draw on certain Catholic rites and saints, they are in fact appropriating (drawing in) their symbolic powers and attributing new meaning to them (see Fidalgo Castro 2012). There is also a rich tradition of Chinese folk-medicine amongst the Chinese-Timorese and healers also operate within the Islamic community in Dili.

Patients, health workers and bureaucrats within the formal health sector have raised concerns regarding the effectiveness of customary and religious healers and healing practices, suggesting that they provide short-term fixes but not long-term treatment or solutions. They argue that customary practices in particular can have a high financial cost to the family and their unregulated nature is perceived to be more vulnerable to harmful practices and abuse (Kakuma et al. 2015; see also Graves 2003). Amongst health workers it is also felt that interactions with the customary sector delay engagement with the formal health service, resulting in their patients' condition being more severe when they arrive in the formal sector (Kakuma et al. 2015). Despite these criticisms, some mental health experts make the case that recourse to customary or religious healers may have positive impacts on patients insofar as healers act as an external locus of control, people who take on and confront the causes of illness head on, on behalf of the patient (Rodger and Steel 2016). Moreover, health workers also agree that in approaching customary and religious healers, patients and families demonstrate a desire to take responsibility for themselves and seek diagnosis/treatment. In doing so, they are also

more likely to address any problematic relations within the family and others which may influence long-term health outcomes.

Patient, families and health workers recognise that customary and religious healers and practices are often essential to 'opening the path' to healing processes of all kinds, including mental health disorders (Palmer et al. 2015a; see also Martins et al. 2008). However, this recognition is qualified. Health workers across both government and NGOs emphasise the need to make a clear distinction between clinical treatments and therapies and customary or religious faith-based forms of healing to ensure that patients and families can distinguish the basis of effective outcomes.[15] They also call for the regulation of 'informal' healers and investigation into the efficacy of treatments they provide. Such attitudes, in particular amongst specialist mental health workers, are reflective of processes of professionalisation and bureaucratisation within the MOH and the formal health sector that serve to reinforce the social and cultural authority of clinical approaches to health. Yet, these differences need not be an obstacle to co-ordination and collaboration. Customary and religious healers are included in the National Mental Health Strategy's referral system for mental health and considered an important partner in this regard. Mental health workers recognise the need to create pathways for communication and dialogue with the 'informal' sector to build up knowledge and understanding of customary and religious (faith-based) diagnostics, therapy and treatment in order to provide the best care options to those in need (Palmer et al. 2015b).

Integrated, accessible and culturally competent mental health care

The National Mental Health Strategy 2011–2015 called for an integrated and comprehensive health system that embraces both 'modern' and 'indigenous' models of care (MOH 2010). Despite some of the challenges described above, co-ordination and collaboration of care across these two sectors can be complementary and could enable a more comprehensive, effective and efficient community-based set of services that better meet the needs of the population whilst respecting/protecting local customs.

An effective mental healthcare system requires appropriate and timely mental health promotion, prevention, early detection, diagnosis, treatment, rehabilitation and social support (WHO 2010, 2013). Ideally, interventions should include professional training and community education for early detection, treatment that includes both pharmacological and non-pharmacological interventions such as psychoeducation and psychotherapy (e.g., behavioural activation, cognitive behaviour therapy, interpersonal therapy), and rehabilitation and social support to facilitate recovery and reintegration back home, at school, at work and in the community (Patel et al. 2007). Whilst the ability to provide such non-pharmacological services is desirable for many current mental health workers in Timor-Leste, most do not have such training and there is currently insufficient human resource capacity to provide such support.

The shortage of mental health specialists or training opportunities is not specific to Timor-Leste. No nation has sufficient human resources to meet all of the mental healthcare needs of its citizens and most low- and middle-income countries face significant shortages (Kakuma et al. 2011; Scheffler 2011). Most countries will never have enough specialists and therefore strategies that effectively make the best use of specialists and trains/mobilises other human resources, across sectors and systems (health and non-health, formal and informal, private sector, industry, community members) - known as task-shifting - are essential to develop adequate human resources to meet mental healthcare needs (Kakuma et al. 2011; Scheffler 2011). Whilst some of the more complex tasks require specialists such as psychiatrists,

neurologists and psychologists, other tasks can be delivered by non-specialists. For instance, general physicians, nurses and community volunteer workers can be trained to detect, diagnose and treat common and less complex disorders such as mood and behavioural disorders whilst the specialists focus on diagnosis and treatment of more severe and complex cases. Similarly, community members, customary healers, religious faith-based healers, teachers and others can also be trained to detect and refer someone with a potential mental disorder to a clinic or hospital, to use a screening tool, to provide basic counselling, to follow up and ensure patients are taking their medication properly and practicing other recovery regimes such as self-monitoring.

Currently, there are no formal mechanisms for collaboration between health workers, mental health specialists and customary or religious faith-based healers (Hawkins 2010), at the day-to-day level. Usually, these relationships are facilitated and fostered through family ties and extended networks of kin. For example, mental health caseworkers working together with health staff in rural health centres in Venilale sub-district have engaged with local customary healers, raising awareness of mental illness and encouraging them to refer patients to the local health post. Mental health case workers argue that local healers command substantial authority within the community and patients are more likely to comply with medical treatments and therapies if they are supported and reinforced by healers (Palmer et al. 2015b; see also Graves 2003). Further research is required to document and verify these claims; however, experiences from the area of maternal reproductive health suggest that dialogue between clinical and non-clinical approaches have the potential for providing better outcomes for patients and their families. For example, traditional birth attendants were introduced into the national health system as 'family health promoters' to perform a range of tasks including outreach and case finding, health and patient education, referrals, home visits and care management. Through this collaboration, traditional birth attendants significantly improved their knowledge, attitude and behaviour, and their capacity to provide appropriate advice for antenatal care. Furthermore, this new model of care has increased access to reproductive health services particular for women in rural communities and reduced maternal mortality rates (Sarmento 2014).

Moving beyond the practical and pragmatic advantages of increased co-ordination and collaboration between customary and religious faith-based healers and the formal health sector, paying closer attention to the way culture and customs shape understandings of disease and illness, healing and curing can only enhance current mental health programme planning, development and implementation (see Guarnaccia and Rodriguez 1996; Incayawar et al. 2009; NPY WCAC 2013). These initiatives could include culturally sensitive approaches to mental health promotion, training and programming including the use of appropriate language and terminology in education programmes, incorporating local cultural categories of illness and an understanding of the cultural resources available to people in distress within training programmes, and the documentation and development of guidelines to interpreting culturally influenced expressions and understandings of mental illness (Graves 2003; Rodger and Steel 2016; Silove et al. 2008).

It is likely that in the future, patients and families in Timor-Leste will continue to draw on multiple health systems to seek help with recovery or cure from mental illness. Studies suggest that the availability of a variety of treatment options may be beneficial to patients in the long-run (Halliburton 2009; see also Rodger and Steel 2016). As such, initiatives that foster respectful and considerate dialogue, build trust and share knowledge between health systems can only be of benefit to patients and their families. The MOH with the support of WHO organised a forum in July 2015 and, in collaboration with the University of

Melbourne, brought together over 60 government, international, academic and community stakeholders, including traditional healers. The forum aimed to stimulate dialogue on mental health policy and practice in Timor-Leste and to consider how inter-sectoral partnerships might be realised within an integrated system of care. An enactment by customary healers of contemporary customary practices and role plays based on their interactions with local and district mental health nurses was a highlight of the forum and produced lively discussion regarding capacity building, research needs and policy changes required to develop an integrated approach to mental health care in Timor-Leste. The demonstrated openness and desire to engage in dialogue between the formal and informal sector suggests that Timor-Leste is in an ideal position to take the lead on research and development in this area.

Acknowledgements

The authors wish to thank Dr Herculano Seixas, Dr Helder Juvinal, Mr Luis da Cunha, Mr Francisco Almeida and Mr Egas da Silva from the Ministry of Health of Timor-Leste; Dr Rajesh Pandav and Mr Leoneto Soares Pinto from the World Health Organisation Timor-Leste Country Office for their guidance and support; and Mr Mateus da Costa, Mr Mateus Belo and Mr Mariano Dionesio for sharing their knowledge and expertise on customary healing practices.

Notes

1 All the authors were involved to varying degrees in assisting the MOH in the development of a draft National Mental Health Strategy 2016–2020.
2 For logistical reasons, no participants from the Special Economic Zone of Oecussi were able to take part in the study.
3 This research was conducted using an existing stigma measurement tool, the Mental Illness Clinician's Attitude Scale – Version 4 (Gabbidon et al. 2013), translated and adapted to suit the Timorese context through the guidance of a six-person panel of senior figures within the Timorese Mental Health services. Along with additional demographic data, two additional multiple-response questions were also included that explored participants' beliefs about the causes of mental illness and their preferred treatment approach.
4 Prior to independence, there were no state-sponsored mental health services available in the country. In the aftermath of the violent withdrawal of the Indonesian military-administrative apparatus following the UN-sponsored ballot in August 1999, an organisation called Psychosocial Recovery and Development in East Timor (PRADET) was established with funding from Australian government funding. Under the auspices of PRADET, the first Timorese nurses and midwives received mental health training and began to provide treatment of severe mental disorders to people in the capital city Dili. In 2002, this programme formed the basis for the East Timor National Mental Health Project (ETNMHP) which was completely transferred to the MOH in 2005. In 2008, mental health services became a unit under the directorate for 'non-communicable diseases' (Hawkins and Tilman 2011), now called the Department of Non-Communicable Diseases and Mental Health.
5 Training was initially provided through PRADET and ETNMHP in 2004. Since then, ad hoc training has been provided by the MOH and the *Instituto Nacional de Saude*, but this focuses mainly on protocols surrounding the provision of medication (pers. comm. Herculano Seixas).
6 An exception to this case is the work of Rodger and Steel that explores the relationship between culture, trauma, dissociation and brief–chronic psychotic states (see Rodger and Steel 2016). Research on family system and community care models was identified as a priority research area in the 2011–2015 Mental Health Strategic Plan.
7 For example, there is a reluctance to seek hospital care due not only to a fear of dying but also linked to experiences of difficulty in recovering bodies of deceased and to cultural funerary practices and beliefs (Edmonds et al. 2005).

8 Larke and Bartik (2017) found amongst health service providers attributions to the origins of mental illness were as follows: psychological = 34.3%; biological = 28.8%; environmental = 25.8%; spiritual = 11.1%.
9 Here we refer in particular to elements of interpersonal stigma: knowledge, attitudes and behaviours.
10 Across Timor-Leste social life is organised around origin groups linked to particular ancestral origin house (Tetun: *uma lulik*) and local spirit ecologies which embed these in intimate, intergenerational social, political and economic relationships with their extended consanguineal and affinal kin. Links between these lineages and with the surrounding environment are embedded in a life world of obligation and reciprocity built around socio-cosmic dualisms such as male/female, fertility-giver/fertility-taker, younger sibling/older sibling, indigene/newcomer, political authority/ritual authority, as well as a suite of botanical metaphors such as trunk/tips – the harmonious (or conflictual) relations between which ensure the 'flow of life' (Palmer 2015).
11 Of these terms, Kakuma et al. (2015) found that *matan dook* solicited most negative reactions with some customary healers themselves using this term to describe charlatans. As *matan dook* practices will usually involve divination through animal sacrifice, these negative reactions are often also attributable to the embarrassment felt at being linked to such 'primitive' and non-Christian ways.
12 The knowledge of herbal medication is not exclusive to healers but may be cultivated in home gardens or sourced from forests. Collins et al. have documented over 40 distinct medical plants in Fataluku and Idate-speaking area (see Collins 2005; Collins et al. 2007).
13 In Pentecostal tradition, this transformation is commonly described as being 'born again in Christ'.
14 The term *oratorio* is derived from the Portuguese word meaning 'oratory', place of prayer.
15 Larke and Bartik (2017) found that amongst the Timorese mental health service providers surveyed, only 11.1% attributed the origins of mental illness to spiritual causes. Correspondingly, only 20% of respondents selected a treatment model based on a spiritual approach (either conducted through a traditional or Church-based healer) as representing what they considered to be the most efficacious.

References

Barnes, S. (2011) 'Origins, Precedence and Social Order in the Domain of Ina Ama Beli Darlari', In *Land and Life in Timor-Leste Ethnographic Essays*, A. McWilliam and E.G. Traube (eds), pp. 23–46, Canberra: ANU E-Press.

Barnes, S. (2013) Gift Giving and Gift Obligations: Strategies of Incorporation and Accommodation in the Customary Domain, Paper presented at the European Southeast Asian Studies Association Conference, 2–5 July, Lisbon.

Barnes, S. (2017) Customary Renewal and the Pursuit of Power and Prosperity in Post-Occupation East Timor: A Case Study from Babulo, Uato-Lari, Unpublished PhD thesis, Melbourne: Monash University.

Bovensiepen, J. (2015) *The Land of Gold: Cultural Revival and Post-Conflict Reconstruction in Independent Timor-Leste*, Ithaca, NY: Southeast Asia Program Publications (SEAP) Cornell University Press.

Chesnut, R.A. (2003) 'A Preferential Option for the Spirit: The Catholic Charismatic Renewal in Latin America's New Religious Economy', *Latin American Politics and Society*, 45: 55–85.

Collins, S. (2005) The ethnobotany of East Timor, Unpublished MSc Thesis, Ottowa: University of Ottowa.

Collins, S., X. Martins, A. Mitchell, A. Teshome and T. Arnason (2007) 'Fataluku Medicinal Ethnobotany and the East Timorese Military Resistance', *Journal of Ethnobiology and Ethnomedicine*, 3: 5.

Csordas, T.J. (1997) *The Sacred Self: A Cultural Phenomenology of Charismatic Healing*, Berkeley: University of California Press.

Edmonds, A., R.P.D. Jesus, M. Lindelow and I. Morris. (2005) *Health Service Delivery and Utilization in Timor-Leste: A Qualitative Study*, Dili: World Bank.

Fidalgo Castro, A. (2012) 'A Religião em Timor-Leste a Partir de Uma Perspectiva Histórico-Antropológica', In *Léxico Fataluco-Português*, A. Fidalgo Castro and E. Legaspi Bouza (eds), pp. 79–118, Dili: Salesianos Dom Bosco Timor-Leste.

Gabbidon, J., S. Clement, A. van Nieuwenhuizen, A. Kassam, E. Brohan, I. Norman and G. Thornicroft. (2013) 'Mental Illness: Clinicians' Attitudes (MICA) Scale—Psychometric Properties of a Version for Healthcare Students and Professionals', *Psychiatry Research*, 206: 81–87.

Graves, J. (2003) *Knowledge, Attitudes and Responses to Mental Health, East Timor National Mental Health Project*, Dili: Ministry of Health.

Guarnaccia, P.J. and O. Rodriguez. (1996) 'Concepts of Culture and their Role in the Development of Culturally Competent Mental Health Services', *Hispanic Journal of Behavioral Sciences,* 18: 419–443.

Halliburton, M. (2009) *Mudpacks and Prozac: Experiencing Ayurvedic, Biomedical and Religious Healing*, Walnut Creek, CA: Left Coast Press.

Hatala, A.R., J.B. Waldram and T. Caal. (2015) 'Narrative Structures of Maya Mental Disorders', *Culture, Medicine and Psychiatry*, 39: 449–486.

Hawkins, Z. (2010) 'A Decade of Mental Health Services in Timor-Leste', *International Psychiatry*, 7: 11–13.

Hawkins, Z. and T. Tilman. (2011) '"The Family is the Clinic, the Community is the Hospital": Community Mental Health in Timor-Leste', *Australasian Psychiatry*, 19: S95–S97.

Hicks, D. (2004) *Tetum Ghosts and Kin: Fertility and Gender in East Timor*, Long Grove, ILL: Waveland Press.

Hoskins, J. (1996) 'From Diagnosis to Performance: Medical Practice and the Politics of Exchange in Kodi, West Sumba', In *The Performance of Healing*, C. Laderman and M. Roseman (eds), pp. 271–290, New York: Routledge.

Incayawar, M., R. Wintrob, L. Bouchard and G. Bartocci. (2009) *Psychiatrists and Traditional Healers: Unwitting Partners in Global Mental Health*, Singapore: John Wiley and Sons.

Kakuma, R., H. Minas, N. van Ginneken, M.R. Dal Poz, K. Desiraju, J.E. Morris, S. Saxena and R.M. Scheffler. (2011) 'Human Resources for Mental Health Care: Current Situation and Strategies for Action', *The Lancet*, 378: 1654–1663.

Kakuma, R., S. Barnes, H. Seixas and L. Palmer. (2015) 'Towards an Integrated and Accessible Mental Health Care System in Timor-Leste', In *Timor-Leste: The Local, the Regional and the Global*, S. Smith, N.C. Mendes, A.D. Silva, A.X.D. Costa, C. Fernandes and M. Leach (eds), pp. 272–278, Dili: Swinburne University Press.

Kleinman, A. (1980) *Patients and Healers in the Context of Culture: An Exploration of the Borderland between Anthropology, Medicine and Psychiatry*, Berkeley: University of California Press.

Larke, B. and W. Bartik. (2017) Stigma, Faith and Mental Illness: Investigating Service Deliverers' Attitudes in Timor-Leste, Paper presented at Intersections of Knowledge Postgraduate Conference, 17–18 January, Armidale: University of New England.

Loch, A. (2007) *House, Mobile Phone and Halleluja: Psychosocial Reconstruction in Timor-Leste. An Ethno-Psychological Study on Post-Conflict Dynamics and Tensions in the Intersection of Identity, Trauma, Culture and Development*, Frankfurt/London: IKO.

Martins, N., J. Grace and P. Kelly. (2008) 'An Ethnographic Study of Barriers to and Enabling Factors for Tuberculosis Treatment Adherence in Timor-Leste', *The International Journal of Tuberculosis and Lung Disease*, 12: 532–537.

McWilliam, A. (2008) 'Fataluku Healing and Cultural Resilience in East Timor', *Ethnos,* 73: 217–240.

MOH (Ministry of Health). (2010) *National Mental Health Strategy 2011–2015 for a Mentally Healthy Timor-Leste*, Dili: Ministry of Health.

NPY WCAC (Ngaanyatharra Pitjantjatjarra Yankunytja Women's Council Aboriginal Corporation). (2013) *Traditional Healers of Central Australia: Ngangkari*, Broome: Magabala Books.

Palmer, L. (2007) 'Developing Timor-Leste: Recognising the Role of Custom and Tradition', In *Exploring the Tensions of Nation Building in Timor-Leste*, L. Palmer, S. Niner and L. Kent (eds), pp. 7–8, Proceedings from a Forum, 15 September 2006, SSEE Research Paper No. 1, Melbourne: University of Melbourne, Available at http://profiles.arts.monash.edu.au/sara-niner/files/2012/03/2007-Tensions-Nation-Building-Proceedings.pdf (accessed 1 December 2017).

Palmer, L. (2010) 'Enlivening Development: Water Management in PostConflict Baucau City, Timor-Leste', *Singapore Journal of Tropical Geography*, 31: 357–370.

Palmer, L. (2015) *Water Politics and Spiritual Ecology: Custom, Environmental Governance and Development*, London and New York: Routledge.

Palmer, L., R. Kakuma and S. Barnes. (2015a) Opening the Paths to Healing: Approaches to Mental Health in Timor-Leste, Paper presented at the Australian Anthropological Society Conference, 1–4 December, Melbourne: University of Melbourne.

Palmer, L., S. Barnes, R. Kakuma and H. Seixas. (2015b) Towards an Integrated Mental Health Strategy in Timor-Leste: Preliminary Findings, Paper presented at Timor-Leste Mental Health Forum, Dili: Ministry of Health.

Palmer, L, Kakuma R and Barnes, S, 2017, Opening the paths to healing: approaches to mental health in Timor Leste, *Third World Thematics*, Received 18 Sep 2016, Accepted 26 May 2017, Published online: 12 Jun 2017.

Patel, V., R. Araya, S. Chatterjee, D. Chisholm, A. Cohen, M. de Silva, C. Hosman, H. McGuire, G. Rojas and M. van Ommeren. (2007) 'Treatment and Prevention of Mental Disorders in Low-Income and Middle-Income Countries', *The Lancet,* 370: 991–1005.

Rodger, J. and Z. Steel. (2016) *Between Trauma and the Sacred: The Cultural Shaping of Remitting-Relapsing Psychosis in Post-Conflict Timor-Leste*, Cham, Switzerland: Springer.

Sakti, V.K. (2013) '"Thinking Too Much": Tracing Local Patterns of Emotional Distress after Mass Violence in Timor-Leste', *The Asia Pacific Journal of Anthropology,* 14: 438–454.

Sarmento, D.R. (2014) 'Traditional Birth Attendance (TBA) in a Health System: What Are the Roles, Benefits and Challenges? A Case Study of Incorporated TBA in Timor-Leste', *Asia Pacific Family Medicine,* 13: 12.

Scheffler, R.M. (2011) *Human Resources for Mental Health: Workforce Shortages in Low-and Middle-Income Countries,* Human Resources for Helath Observer, Issue No. 8, Geneva: World Health Organization, Available at http://apps.who.int/iris/bitstream/10665/44508/1/9789241501019_eng.pdf (accessed 1 December 2017).

Scheper-Hughes, N. and M.M. Lock. (1987) 'The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology', *Medical Anthropology Quarterly,* 1: 6–41.

Silove, D., C.R. Bateman, R.T. Brooks, C.A. Fonseca, Z. Steel, J. Rodger, I. Soosay, G. Fox, V. Patel and A. Bauman. (2008) 'Estimating Clinically Relevant Mental Disorders in Rural and an Urban Setting in Postconflict Timor-Leste', *Archives of General Psychiatry,* 65: 1205–1212.

Strathern, A. and P.J. Stewart. (2010) *Curing and Healing: Medical Anthropology in Global Perspective*, Durham, NC: Carolina Academic Press.

Thornicroft, G. and M. Tansella. (2009) *Better Mental Health Care*, Cambridge: Cambridge University Press.

Toome, E. (2013) 'All in the Mind? The Pathologization of Trauma in Timor-Leste', In *Proceedings of People and the Planet 2013: Transforming the Future*, P. James, C. Hudson, S. Carroll-Bell and A. Taing (eds), pp. 1–11, Melbourne: Global Cities Research Institute, Royal Melbourne Institute of Technology (RMIT).

Trindade, J. (2015) 'Relational Dimensions within Timor-Leste Customary Society', In *Fifth Timor-Leste Studies Association Conference*, H. Loney, A.B. da Silva, A. da Costa Ximenes and N. Canas Mendes (eds), pp. 239–243, Dili: Swinburne Press.

UNMIT (United Nations Mission in Timor-Leste). (2011) *Report on the Rights of Persons with Disabilities in Timor-Leste*, Dili: Office of United Nations High Commissioner for Human Rights, Available at https://unmit.unmissions.org/sites/default/files/final_unhr_report_2011_eng_for_web_.pdf (accessed 1 December 2017).

Wiyono, G. (2001) 'Timor Revival: A Historical Study of the Great Twentieth-Century Revival in Indonesia', *Asian Journal of Pentecostal Studies,* 4: 269–293.

WHO (World Health Organization). (2010) *Community Based Rehabilitation Guidelines*, Geneva: World Health Organization, Available at www.who.int/disabilities/cbr/guidelines/en/ (accessed 1 December 2017).

WHO (World Health Organization). (2013) *Mental Health Action Plan 2013–2020*, Geneva: World Health Organization, Available at www.who.int/mental_health/action_plan_2013/en/ (accessed 1 December 2017).

Zwi, A.B., I. Blignault, D. Glazebrook, V. Correia, C.R. Bateman Steel, E. Ferreira and B.M. Pinto. (2009) *Timor-Leste Health Care Seeking Behaviours Study.* Sydney: University of New South Wales.