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A Preliminary Analysis of Securitising Mental Health in LAMICs Regional Groups: The Case of ASEAN

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ABSTRACT

The new century has witnessed unprecedented efforts by both international institutions and mental health movements to promote and prioritise mental health at the same level as other priority health issues, especially HIV/AIDS. The release of the highly influential *Lancet* series on global mental health in 2007 highlighted these efforts, and the slogan "no health without mental health" became widely known. Despite success in developed regions, mental health and illness have been largely neglected in lesser developed areas made up mostly of low- and middle-income countries (LAMICs). This preliminary research explored the efforts to prioritise mental health through securitisation and attempted to determine why such efforts are not successful in LAMICs regions, focusing on the Association of Southeast Asian Nations (ASEAN) as a case study. According to our findings, a primary reason mental health is not prioritised in ASEAN is the difference in the values and social norms of LAMICs versus liberal-Western values and norms. These liberal-Western values and norms are the root of securitising, prioritising efforts. Securitisation can be considered a humanitarian effort, because the process is grounded in moral arguments and a universal value of human rights and dignity. For such securitisation efforts to succeed, however, a region must share the values at its roots. The final recommendation is that mental health advocates find a more pragmatic strategy in order to make the efforts workable within LAMICs regions.

Keywords: Mental health, human security, securitisation, ASEAN

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INTRODUCTION

In the 21st century, mental health has gained attention in the context of global health, a critical component of human security. A report by the World Health Organisation

(WHO) in 2001 underlined an urgent need to handle mental health problems, particularly reducing the treatment gap between higher- and lower-income countries, since mental illness affects one in four people globally and increases the risk of other diseases. Thus, as Prince *et al*. suggested, there is "no health without mental health" (2007).

In a liberal-Western context, humanitarian securitisation is a process of shifting humanitarian issues out of the normal political realm into the realm of necessity and urgency by presenting such issues as an existential threat to the rights and dignity of human persons, for example, those with disabilities. This process is different from traditional securitisation in that the referent object is neither the state nor the community, but the individual; in addition, humanitarian securitisation efforts are mostly performed by international institutions and social or people's movements. Notwithstanding the growing international awareness, the concern over mental health issues has remained less substantial outside more developed regions.

This study aimed to investigate the relevance of humanitarian securitisation of mental health in regions with low- and middle-income countries (LAMICs) through a case study of the Association of Southeast Asian Nations (ASEAN). In Southeast Asia, mental health has long been neglected as low priority, even though the region's sociopolitical conditions may impact—or be impacted by—the population's mental health. Given the issue's sociopolitical significance, it deserves to be securitised throughout the region. Although some evidence suggests that mental health has gradually attracted more attention through ASEAN, it still remains insufficiently addressed.

This article is divided into three main sections. The first section examines contemporary attempts to prioritise mental health globally and regionally through the lens of securitisation. The second section explains the research methodology used in this study. The third section appraises efforts by non-state actors and ASEAN to address mental health issues and explores the possibility of a justification for securitisation within the organisation's framework. The final section provides some recommendations and concludes the article.

FRAMEWORK FOR ANALYSIS

In this analysis, the author draws primarily, but not exclusively, on the concept of "securitisation." Securitising refers to a security-making process and is one of the most innovative concepts to come out of the contemporary debate over the complexion of security (Peoples & Vaughan-Williams, 2010). The concept of securitisation was originally formulated by Wæver (1995) but became widely known in Buzan, Wæver, and de Wilde's *Security: A New Framework for Analysis* in 1998. They and their works are often called the Copenhagen School (CS) of security studies. According to the CS, no issue is a security problem per se. Rather, something becomes a security matter because someone identifies it as valuable and, therefore, of possibly being in danger,

requiring extraordinary means beyond the normal scope of the political system to protect.

The word "security," as argued by Wæver (1995, p. 55), is "not of interest as a sign that refers to something more real; the utterance itself is the act. By saying it, something is done." Briefly, security is a speech act (Buzan, Wæver, & de Wilde, 1998; Wæver, 1995). As security is, at heart, about survival; an issue becomes a security problem only after it is enunciated by the "securitiser" or securitising actors as an existential threat to the survival of a referent object, and this claim that the issue poses a threat is accepted by the audience (Buzan *et al*., 1998; Wæver, 1995). For this reason, securitisation is inevitably an intersubjective process; a successful securitising attempt is not decided by the securitiser but by the audience (Buzan *et al*., 1998). In short, "the issue becomes a security issue—not necessarily because a real threat exists but because the issue is presented as such a threat" (Buzan *et al*., 1998, p. 24).

Nevertheless, the social power relationship among securitising actors in the field is varied and asymmetrical. Some securitisers—for example, those nominated as experts in a given issue or in a position of sufficient social and political authority—have more power to convince the audience (Buzan *et al*., 1998; Peoples & Vaughan-Williams, 2010; Wæver, 1995). As a result, to study securitisation "is to study the power politics of the concept" (Buzan *et al*., 1998, p. 32).

Understanding the logic of security "in a way that is true to the classical discussion" is essential in examining how "the *same* logic" may apply to non-traditional security issues (Wæver, 1995, p. 51). Security, like all other concepts, has its own historical connotations, largely concerned with military security practices. Understanding these connotations allows us to examine how the traditional conceptions of security i.e. national security, state sovereignty and threat take on new forms under new circumstances (Buzan *et al*., 1998; Wæver, 1995).

In sum, security for the CS is a more extreme form of politicisation going beyond normal political procedures and practices. Accordingly, the process of securitisation can be considered in terms of the linear spectrum running from non-politicised through politicised to securitised (Buzan *et al*., 1998). When an issue (the existential threat) is successfully securitised as threatening to something that must be protected (the referent object), it is prioritised with the same degree of urgency as a military problem and becomes a security issue. Peoples and Vaughan-Williams (2010) reduce this to a brilliantly simple formula: "Existential Threat to a Referent Object = A Security Issue".

Apart from the securitisation concept, Acharya's "norm localisation", a concept developed from norm diffusion (Acharya, 2004), was also used in the study as a supplementary to discuss the outcomes of securitising process.

Traditional perspectives on norm diffusion often have a problem of binary opposition. Moral cosmopolitanism, for example, is premised on "good" universal norms prevailing over "bad" local values and practices. Liberal-Western norm entrepreneurs are seen as the key actors who influentially disseminate the norms. They also tend to believe that local norms are passive, and presume that a local society is receptive to the universal norms because of their more desirable values (Finnemore, 1996). In reality, however, such new norms are seldom entirely accepted. As indicated by Acharya (2004, p. 248), "[the] stronger the local norm, the greater the likelihood that new foreign norms will be localised rather than accepted wholesale."

Unlike norm diffusion, the concept of norm localisation emphasises the role of local actors and the linkages between the preexisting local norms and the emerging international norm. According to Acharya (2004), norm localisation is a process starting with the selection, reinterpretation and re-representation of foreign norms, which reconstructs such norms to make them harmonious with preexisting normative order. The localising process is facilitated or impeded by societal conditions, particularly the social credibility of local agents and the power of preexisting local social norms (Acharya, 2004).

POLITICIZATION OF (MENTAL) HEALTH ISSUES

The link between international relations and health is not new (McInnes & Lee, 2012), but the connection to mental health is. It was not until the early 1990s that mental health issues gained attention from international policy institutions. Nevertheless, it remained a relatively low priority. This growing interest in mental health was encouraged largely by the release of the Human Development Reports issued annually by the United Nations Development Programme (UNDP) during the first half of the 1990s, which articulated the so-called "human security" that shifted focus of security from the state to the individual in response to the changing nature of insecurity following the Cold War (Owen, 2010).

The attempt to promote human security can be traced back to the 1991 Pan African conference, co-sponsored by the United Nations (UN) and the Organisation for African Unity (OAU). It called for a major revision in the way of thinking about security:

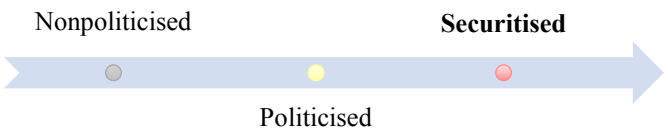

Fig.1: The spectrum of securitisation.

Adapted from Security: A new framework for analysis pp. 23-24, by Buzan *et al.*, 1998, Boulder, CO: Lynne Rienner

> *[the] concept of security goes beyond military considerations. [It] must be construed in terms of the individual citizen to live in peace with access to basic necessities of life while fully participating in the affairs of his/her society in freedom and enjoying all fundamental human rights.* (Hough, 2008, p. 14)

Accordingly, the concept "must change—from an exclusive stress on national security to a much greater stress on people's security, from security through armaments to security through human development, from territorial to food, employment and environmental security" (UNDP, 1993, p. 2).

It was the 1994 UNDP Human Development Report, however, that concretised the concept of human security, setting out the two main aspects: first, the freedom from chronic threats such as hunger and disease, and second, the protection from sudden and hurtful disruptions in daily life. The report identified the seven components of human security: economic, food, health, environmental, personal, community and political security (UNDP, 1994). The conceptual boundary, as Owen states, is "very [broad], clearly separating itself from past security reconceptualization" (2010, p. 43), thus broadening the security agenda.

Though mental health is always included in the term "health" as defined by the UN (Izutsu & Tsutsumi, 2014), more often than not its schemes are fragmented, residing within a wide range of UN initiatives. The new security paradigm proposed by the UNDP helps to consolidate the existing efforts in prioritising mental health within the UN system as well as integrating them into the human security discourse.

Like the UNDP Human Development Reports, the Millennium Development Goals (MDGs), the most recent human development project established by the UN, do not specifically include mental health. Some call this "a lost opportunity for mental health" (Minas, 2014, pp. 151) as it fails to generate an international political commitment (de Almeida, Minas, & Cayetano, 2014; Lund, 2012; Miranda & Patel, 2005; The PLOS Medicine Editors, 2013). Others argue that it is a considerable contribution to promote mental health as almost all of the MDGs are implicitly associated with social determinants of mental health and contribute to mental illness prevention (Jenkins, Baingana, Ahmad, McDaid, & Atun, 2011; Sachs & Sachs, 2007). Despite this indirect benefit, however, mental health and illness have not been specifically addressed (Miranda & Patel, 2007).

In recent years, health-security linkage has become more tangible. Health, as a component of human security, is now a security issue. Human security discourse, including health security, strongly connects to international languages of the new millennium i.e. human rights and human development (Koehler, Gasper, Jolly, & Simane 2012; McInnes & Lee, 2012) and has been adopted as an international political agenda. Considering that the MDGs target

health issues such as improving maternal health and combatting HIV/AIDS, malaria and other major diseases, securitising health is not exaggerated (Burgess, 2008; Mclnnes & Lee, 2012).

However, according to the CS, in an international interstate system, security is placed into five sectors on the basis of a particular type of interaction among its constituent units, reflecting different traits of an international security issue (Buzan *et al*., 1998); neither health nor human security are included. This might derive from the fact that human security, together with health security, comes with a domain contrasting with the CS concept; human security shifts the referent object away from the state and onto the individual. While this concept is contested and divergent, this shift in the referent object is always at the heart of human security discourse (Liotta & Owen, 2006; Owen, 2004; Owen, 2010). It is this deepening approach to the referent object i.e. the ordinary person that distinguishes human security from the security concept of the CS (Hough, 2008).

Due to the lack of consensus on the nature of threats to the individual, the concept of human security has been widely used as everything from a rationale for international institutions' policies and projects to a guiding principle for foreign policy to campaigns for non-governmental organisations (Owen, 2010). Japan's government, for instance, has made an umbrella of human security a basic official development assistance (ODA) policy (Gilsona & Purvis, 2003). The people-centric discourse of human security has usually been seen as a practice of humanitarian intervention – the "saving the strangers" trend of the 1990s (Wheeler, 2000). As health is closely linked to human security, if not one of its components, health security shares the same foundation of putting the focus on the individual. Moreover, some types of health problems apparently have been securitised at all levels; the global HIV/AIDS epidemic is a good example (Burgess, 2008; Hough, 2008; Mclnnes & Lee, 2012).

Mental health and illness have received much less attention than other kinds of disease in the international political agenda (de Almeida, Minas, & Cayetano, 2014; Lund, 2012; Miranda & Patel, 2005; The PLOS Medicine Editors, 2013). This leads to greater efforts among health professionals, mostly psychiatrists, to push the mental health agenda into national, regional and international platforms to prioritise, if not securitise, mental health. The new epoch of these efforts is marked by two milestones. The first is the release of the *Mental Health Gap Action Programme* (mhGAP) published by the WHO in 2008; the programme addresses the gap between the global need for mental health treatment with a special emphasis on LAMICs and the available treatments. This was followed by the mhGAP Intervention Guide (mhGAP-IG), which provided a model for the treatment of individuals with mental disorders and a framework for coping with disease entities. These show the WHO's efforts to systematically address the priority and importance of mental health problems

(Okpaku & Biswas, 2014).

The second milestone is the launch of the *Lancet* Series on Global Mental Health in 2007 (Okpaku & Biswas, 2014; Lancet, 2007). The series is grounded on the fact that "…disturbances of mental health remain not only neglected but also deeply stigmatised across our societies… Mental health disorders represent a largely hidden, if not substantial proportion of the world's disease burden. They can often be neglected, especially in [LAMICs]." Hence, "[the] Lancet Series on Global Mental Health draws together leading experts…to highlight the gaps in mental-health services worldwide, and to formulate a clear call to action" (Lancet, 2007).

The series calls for a new broad social movement aiming to strengthen mental health (Horton, 2007). This became the Movement for Global Mental Health (MGMH), a network of mental health professionals and allied experts. The MGMH consists of two fundamental principles: "scientific evidence and human rights" and has announced the commitment to improve the poor conditions of individuals with mental illness worldwide, especially in LAMICs. This movement has also contributed to the establishment of "global mental health" as a new field of study (Okpaku & Biswas, 2014; Patel & Prince, 2010).

In practice, global mental health is:

> *…a range of activities concerned mental health that meet five principal criteria: (1) The problem/ issue should have a universal or transnational aspect…(2)…The problem should have a population basis e.g., violence as a public issue. (3)…The composition of the stake holders should be international in either bilateral or multilateral arrangements…(4)…The problem should be owned by the recipient organization, institution, or country. (5) The team engaged in the project should be multidisciplinary and multi-party.* (Okpaku & Biswas, 2014, p. 2)

TABLE 1
Traditional vs. Human Security

Type of security	Referent object	Value at risk	Possible threats
Traditional security	The state	Sovereignty, territorial integrity	Interstate and civil war, nuclear proliferation, terrorism
Human security	The individual	Survival, quality of life, human rights and dignity	Globalisation, disease, poverty, natural disaster, human rights violation, violence

Adapted from "Why Human Security?" by P. H. Liotta and T. Owen, 2006, *Whitehead Journal of Diplomacy and International Relations*, *7*(1), p. 38.

Like the discourse on human security, this framework shows that the discourse on securitising mental health is made up of moral arguments and the belief in the value of human rights and dignity i.e. a people-centred security. Furthermore, almost all strategic campaigns calling for securitising mental health are rooted in such moral arguments and individual-orientated beliefs (Aggarwal & Kohrt, 2013). Kleinman, for example, strongly contends that it is essential to prioritise "moral transformation as the foundation for reform of global mental health, much as it was for the reform that spurred HIV/AIDS treatment in Africa and Asia" (2009, p. 603); otherwise, humanity's moral failure on mental health in the past might repeat itself. In the same way, but more radically, Abed (2004) calls for an amendment of the UN Charter allowing the international community to intervene in state-committed gross violations because tyrannical regimes typically cause citizens severe mental ill-health through various forms of violence. The discourse of mental health security is, therefore, considerably idealistic.

Although it is a specialised agency, the efforts made systematically by the WHO and the new social movement formed by mental health professionals can be seen as human securitisation since the security they believe is threatened by mental health and illness is that of the individual not the state (Hough, 2008). The author of this article termed such systematic efforts as the "humanitarian securitisation" to better reflect the visions and missions of the securitisers.

The humanitarian securitisation has been successful or, to large extent, prioritised, in developed countries. Nonetheless, this study argues that promoting the human securitisation of mental health in LAMICs would not lead to a favourable outcome since its basic arguments and premises are opposed to the idiosyncrasies of LAMICs, especially the countries in Asia and Africa where securitisation has been overshadowed by the state.

RESEARCH METHODOLOGY

The question of this study is whether the human securitisation of mental health is considered relevant under ASEAN, the case study representing regional groups of LAMICs. The following two hypotheses are proposed:

> *H1: With a less democratic regime, a country is less likely to securitise non-security issues at both national and regional levels.*
>
> *H2: With a lower freedom status, a state organisation is strong and has high social control. Hence, there is a lesser degree of openness for a country to participate with non-state actors from civil societies to international institutions in securitising non-security issues at both national and regional levels.*

A country's regime type is classified by its polity score, as recorded on 31 December 2013 in the Polity IV dataset of the Polity IV Project created by the Centre

for Systemic Peace or CSP. An upper case "AUT" indicates the country is governed by an institutionalised autocratic regime (POLITY -6 to -10); a lower case "aut" indicates that the country is governed by an uninstitutionalised, or weak, autocratic regime (POLITY -5 to 0). An upper case "DEM" indicates an institutionalised democracy (POLITY 6 to 10) and a lower case "dem" indicates an uninstitutionalised, or weak, democratic regime (POLITY 1 to 5). Countries listed with a "SF" (state failure) are experiencing a "collapse of central authority" such that the regime has lost control of more than half of its territory (Marshall & Cole, 2014, p. 53)

A country's freedom status is classified based on *Freedom in the World 2014* created by Freedom House (2014). "Free" indicates a country where there is a broad scope for open political competition, a climate of respect for civil liberties, significant independent civic life and independent media; "Partly Free" indicates a country characterised by some restrictions on political rights and civil liberties, often in a context of corruption, weak rule of law, ethnic strife, or civil war; "Not Free" indicates a country where basic political rights are absent and basic civil liberties are systematically denied (Freedom House, 2014).

Qualitative content analysis was used as a research method to collate and analyse the data, as this methodology might best address the research question. The data were derived from both primary and secondary sources (e.g., the ASEAN Secretariat website and the world's leading scholarly journals) and compared with observation implications (OI). OI are possible instances in which expected political outcomes ought to occur, or where significant relationships ought to be upheld, and include the following:

OI1: If a country's regime is not democratic, a priority of mental health is low, if not marginalised; key indicators for this include mental health policies and legislation.

OI2: If most of the member countries' freedom status is not "Free," the participation of non-state actors within the regional policy-making process to promote mental health is decreased; key indicators for this are the roles of non-state entities in the regional organisation.

OI3: If most of the member countries' freedom status is not "Free," a priority of mental health is low and unlikely to be politicised or securitised within the regional arrangement; key indicators for this include the strategic frameworks and the policies and projects.

RESEARCH FINDINGS

Southeast Asia is a heterogeneous region with distinct cultural, political and socioeconomic diversity. With the exception of Brunei and Singapore, all countries in the region are LAMICs.

Countries' healthcare systems diverge due to diverse backgrounds and historical legacies. The total health expenditure, as a percent of GDP, of Southeast Asian countries ranges from 1.9 to 17.7%. In spite of increasing risk factors, such as rapid urbanisation and sociopolitical change, mental health has been considered a low priority (Maramis, Tuan, & Minas, 2011). Both LAMICs and high-income countries allot only a small portion of their overall health expenditure to mental health (less than 1% and 5%, respectively) (Thronicroft *et al*., 2011); with 80–90% allocated to mental hospitals (Maramis, Tuan, & Minas, 2011).

Regarding the regime type of Southeast Asian countries, Lao PDR, and Vietnam are indicated as "AUT," institutionalised autocratic regimes, while Myanmar and Singapore are indicated as "aut," a weak autocratic regime. Philippines, Malaysia and Thailand are identified as "DEM," institutionalised democracy, while Cambodia is identified as "dem," weak democratic regime. The polity score of Brunei and Timor-Leste are not available (Marshall & Cole, 2014, pp. 45-51). However, considering both countries' freedom status, which is "Not Free" for the former and "Partly Free" for the latter, one could reasonably infer that Brunei is classified as "AUT" and Timor-Leste as "aut" or "dem." Apart from Brunei, the countries of Cambodia, Lao PDR, Myanmar and Vietnam are indicated as having "AUT" freedom status. The remaining countries are indicated as "Partly Free" (Freedom House, 2014).

In terms of legislation and policy, there are only six countries enacting mental health legislation or legal provisions concerning mental health: Brunei, Indonesia, Malaysia, Myanmar, Singapore, Thailand and Vietnam. In other countries, excluding Timor-Leste, some form of mental health policy and programme exists (Thronicroft *et al*., 2011). Interestingly, mental health policy and plans do not exist in Brunei, although the kingdom does have mental health legislation (WHO, 2011).

Apart from governmental neglect, non-governmental organisations (NGOs) and civil society organisations (CSOs) focusing on mental health advocacy are few and far between. Except for the professional association of psychiatry in each country, NGOs and CSOs working on mental health in Southeast Asia have gone mostly to Cambodia and Timor-Leste for post-conflict reconstruction purposes (Ito, Setoya, & Suzuki, 2012). Consequently, they lack the ability to share the work of government.

Despite such inadequacies, the international collaboration between national psychiatric associations in Southeast Asian countries is intriguing. Such collaboration efforts can be traced back to the idea of Asian Psychiatry uniting, which started in the late 1960s in Asia among the newly trained psychiatrists (Dev, 2008). In Southeast Asia, it was R. Kusumanto Setyenegoro, the Director of Mental Health in the Ministry of Health, Indonesia and professor of psychiatry at the University of Indonesia, who brought psychiatrists from the five founding ASEAN countries together to several meetings in the early

1970s, subsequently leading to a tentative proposal for the ASEAN Association of Psychiatrists. However, the proposal was eventually annulled (Dev, 2008; Udomratn & Deva, 2007).

In 1977, the ASEAN Forum on Child and Adolescent Psychiatry (AFCAP) was introduced for the first time in Jakarta. It was during the Third AFCAP held in Bangkok in 1981 that Setyenegoro's endeavours finally succeeded with the establishment of the ASEAN Federation for Psychiatry and Mental Health (AFPMH). The federation aims to improve "psychiatry and mental health in ASEAN countries through better collaboration between psychiatrists" (Udomratn & Deva, 2007, p. 36).

Although the door is always open to new ASEAN countries, they apparently lack interest in taking part in the AFPMH. Brunei and Vietnam have not officially joined the federation partly because they have no psychiatric associations (Udomratn & Deva, 2007).

The AFPMH is a non-governmental entity and can be categorised as either a CSO or an NGO. The structure of the federation is described by Udomratn & Deva (2007) as simple, less bureaucratic and apolitical, and the constitution is based on the principles of consensus and friendly compromise. In 1984, the AFPMH officially registered as an ASEAN-affiliated CSO and an ASEAN link body in the Senior Officials Meeting on Health Development (SOMHD; ASEAN Secretariat, 2008). Recently, the AFPMH expanded its cooperation with the national psychiatric associations of three ASEAN Dialogue Partnership countries i.e. China, Japan and South Korea in keeping with ASEAN's policy (Udomratn & Deva, 2007). The federation has indirectly collaborated with the ASEAN Secretariat for over three decades.

Despite relatively little recognition, mental health has been addressed within the framework of ASEAN, predominantly the ASEAN Health Ministers Meeting (AHMM), an ASEAN ministerial body on health, for more than three decades. It appeared for the first time in 1980 in the Declaration of the ASEAN Health Ministers on Collaboration on Health as one of the programme areas of technical collaboration. However, it took another twenty-two years for mental health to be mentioned again.

In 2000, Healthy ASEAN 2020 was proclaimed at the Fifth AHMM in Yogyakarta, corresponding with the ASEAN Vision 2020. The result of this was the Vientiane Declaration on Healthy ASEAN Lifestyles (2002), which refers to "basic human functions and the patterns linking various activities of everyday living in the ASEAN context ." Twelve health areas were identified as priority issues for promoting healthy lifestyle, including mental health (ASEAN Secretariat, 2002a). In support of mental health, indicated by the 2002 Action Plan, ASEAN committed to "collaborate on providing environments that promote social participation, minimise discrimination, and enhance economic opportunities." To operationalise this, a

five-year programme would be prepared by SOMHD, linkages and interactions between ASEAN and dialogue partners and other international institutions would be intensified, relationships with ASEAN-affiliated health professional associations would be strengthened and new partnerships with relevant partners such as the WHO would be initiated (ASEAN Secretariat, 2002b).

It was not until 2009 that ASEAN action on promoting mental health made further headway as policy advocacy was enacted into the blueprint of ASEAN Socio-Cultural Community (ASCC) under section B4, "Access to healthcare and promotion of healthy lifestyles." A year later, more progress was made by an endorsement of the ASEAN Strategic Framework on Health Development (2010-2015). The framework cites mental health as one of the "un-implemented areas needed to be focused" and places it under the same section of the ASCC Blueprint (Globinmed, n.d.). It is this framework that led to a significant step forward in the establishment of an ASEAN Mental Health Task Force (AMT), a health subsidiary body under SOMHD, in 2010. For the first time, an ad-hoc technical body was created to work specifically on mental health.

The AMT's mission is "to ensure access to adequate and affordable healthcare, mental and psychosocial services, and promote healthy lifestyles for the people of ASEAN" (ASEAN Secretariat, 2012, pp. 136-137). The task force also provides

> *...a unique policy-relevant and policy-led opportunity to engage actively and share experiences to develop and evaluate current programs, develop strategies to integrate mental health into general health care, and to strengthen capacity of researchers and decision makers at individual and organizational levels*. (ASEAN Mental Health Taskforce, n.d.)

Apichai Mongkol, Director-General of Thailand's Mental Health Department, was appointed as the AMT First Chair, and the First AMT meeting was held in Hanoi in May of 2012 (ASEAN Mental Health Taskforce, n.d.).

DISCUSSION

In order to test our hypotheses, this section will start by comparing the findings with OI1.

The empirical data in some measures disprove OI1. With the exception of Timor-Leste, all Southeast Asian countries do have either mental health legislation, legal provisions concerning mental health and/or mental health policy and programmes, regardless of their regime type. Accordingly, there is no direct relationship between a regime type and enactment of mental health law and policies.

However, law enforcement and policy implementation are a different story. In countries like Myanmar, mental health law is a colonial heritage and, therefore, is

outdated (WHO, 2006). Though progress has been made within some countries, such as Indonesia, it seems the benefits from the existing legislation and policy have largely remained on paper (Ito *et al*., 2012; Maramis *et al*., 2011). It is fair to say that for some, if not many, countries in Southeast Asia, a governmental commitment to mental health is a matter of form over substance. Furthermore, as Abed (2004) proposes, the countries with autocratic regimes likely cause acute mental ill-health due to the utilisation of physical force and coercion as a mode of ruling. By inferring Abed's argument, Southeast Asian governments may themselves be the root cause of psychological distress in their countries. This also may be true in countries with democratic regimes.

In contrast to North American and European democracies, in LAMICs, electoral democracy and liberties do not go hand in hand. Election with the absence of constitutional liberalism usually brings about illiberal democracy i.e. a centralised regime. The institutionalisation of an electoral democracy does not necessarily mean the democracy is a liberal one. The Southeast Asian states of Singapore, Malaysia and Thailand are an example of this illiberal form of democracy (Zakaria, 1997). Focusing merely on the formal-legal mode of regime type is therefore insufficient; rather, its actions in the state-society relations must be paid attention to.

For this reason, OI1 is not entirely contradicted. Rather, the key indicators, mental health legislation and policy, widely used by international institutions are deficient under LAMIC conditions, especially the countries whose regime is an institutionalised, or weak autocracy.

The data support OI2. As the findings demonstrate, the AFPMH is the only major CSO working regionally on mental health. Despite the AFPMH's remarkable effort, it is still far from successful since psychiatric communities in less developed countries are not convinced to play active roles in the federation's activities. More importantly, the AFPMH has no place within ASEAN's bodies and policy-making process since the establishment of ASEAN's policy on mental health advocacy has been overshadowed by technocrats from health and foreign ministries; this likely occurred because ASEAN is a community of the states rather than people.

As a securitising actor, the AFPMH has less power to prioritise or securitise mental health within ASEAN or even outside its federation. In the power structure of ASEAN, the only voices speaking out loud come from the governments, the solely authoritative actors. Even in Southeast Asian societies, the AFPMH's psychiatrists are unlikely to be capable of either prioritising or politicising mental health due to the common characteristics of the LAMICs. Thus, the power of the AFPMH and their psychiatrists is confined to communities of health professionals.

The data disproves OI3 to some extent, but, as with OI1, this is because of a problem with some key indicators. Like LAMICs, Riggs (1961) suggests that

regional organisations of such countries share the same complexion in that formal authority and power in implementing policy are somewhat disassociated: there is a high degree of formalism and a low degree of realism. Thus, policy and project, especially concerning non-traditional security issues, are a matter of form over substance.

In the case of ASEAN, although mental health has been significantly politicised for the last five years (as marked by creation of the AMT), it is not entirely appropriate to call this prioritisation. It is not mental health but communicable diseases like HIV/AIDS and the outbreak of H1N1 flu that actually have been prioritised (and securitised in the latter case).

There are several reasons for the failure of mental health to call for political priority from governments and intergovernmental organisations. Often cited is the way mental health is traditionally portrayed; the portrayal of mental disorders whose causes were contentious or unknown, making prioritisation impractical, creates an inability to see the current situation (de Almeida *et al*., 2014). Such oversight also results in overlooking the significant sociopolitical and economic burdens of mental illness (Jenkins *et al*., 2011; Minas, 2014). Also impactful is the fact that mental illness cannot be analogous to HIV/AIDS, a communicable disease frequently given as an example for securitising mental health, because of a simple but important distinction: that mental illness neither crosses borders (Aggarwal & Kohrt, 2013) nor constitutes an epidemic. In this regard, the referent object threatened by mental illness, articulated by the movement, is typically an individual, and the value at risk is human rights and dignity. However, outside developed regions, both have fewer facilitating conditions and are even antithetical to the nurture of security in Southeast Asian context.

Although the process of securitisation is by no means unique to Southeast Asia, the facilitating conditions, particularly social norms, are significantly different. Notwithstanding the diversities and disparities, common social norms do exist as "Asian values." These deny the norms of the liberal West, particularly the ethos of individualism, (liberal) democracy and human rights. Rather, Asian values emphasise order, hierarchism, discipline and the oneness of organic entities from community through society to state (King, 2008). Understanding the social norms, therefore, would offer more insight into the reason why securitising, or prioritising, mental health, morally based on universal norms, is unlikely to succeed.

As one in a domestic mélange of social organisations, local social norms are foundational to a state organisation i.e. the legitimacy of the regime to control and be autonomous of other, particularly liberal-Western norm entrepreneurs like NGOs, which compete with state leadership. As Southeast Asian historiographies suggests, the states in the region are not passively receptive to foreign norms (Acharya, 2004); this may derive from the fact that Southeast Asian nations have their own well-established social norms and identities.

Nevertheless, liberal-Western norm diffusion does take place but in the form of localisation. Take democracy for instance; it is reinterpreted and re-represented merely as an electoral system and is incorporated into a preexisting normative order. Singapore is a classic example.

Nonetheless, the state can benefit from selectively adopting the international norms, propounded by the UN specialised agencies, that inspire the role of the state in setting the rules within the state-society relations, hence increasing central power. The international prescriptions from those norms include issues of health (Migdal, 1995). However, as already indicated, such prescriptions do not necessarily lead to law enforcement and policy implementation. The raison d'être of the law and policy is rather for the sake of political interests both domestically and internationally. All of these make liberal-Western norm diffusion with its own form to Southeast Asia very difficult, if not impossible.

The author argues that it is the local social norms i.e. Asian values that are the footing of the Southeast Asian tradition of securitisation. Accordingly, an existential threat to the individual person, for the Southeast Asian states, is nonessential to be securitised at all. It would become a priority only for the sake of social order, political interest and economic progress, not because an individual is at risk. This is also true of ASEAN.

Apart from the aforementioned, the power of ASEAN to bring about securitisation is impeded by two long-cherished principles i.e. non-interference and consensus. In the regional, organisational level, it is ASEAN that is a securitising actor, while the member countries are the target audience. It is the task of the organs and bodies of the organisation for instance, the ASEAN Secretariat, to convince all governments to unanimously accept the proposed recommendation for the prioritisation of a specific issue (Yuk-ping & Thomas, 2010). A lesson learned from the history of ASEAN is that the organisation has not acted beyond the interests of its member countries. For this reason, the potential of the organisation to prioritise mental health is minimal at best. Thus, it is not an exaggeration to say that the word "priority" concerning mental health in the ASEAN context does not mean a priority in common sense; though something is done, nothing is considered urgent.

In sum, by comparing the findings to all the OIs, OI2 is supported, while OI1 and OI3 are disproved. In this case study, these OIs were not sustained because the key indicators were ultimately unsuitable to the reality of LAMICs and their regional groups, or Southeast Asia's ASEAN. However, as the discussion implies, the proposed hypotheses are almost supported if the formal legal forms were to be replaced with more fitting variables: the state-society relations and norm diffusion.

From overall discussion, the author argues that as long as humanitarian securitisation is grounded on moral arguments and a value of human rights and dignity, it will remain irrelevant within the context of the regional organisation of

the LAMICs, and a successful securitising attempt is far from being a reality.

CONCLUSION AND RECOMMENDATIONS

It is not the author's intent to be overly pessimistic. As one who has lived with a major depressive disorder for several years, the author wholeheartedly realises a desideratum to securitise mental health for the sake of humanity and sincerely encourages any attempts to promote better mental health and well-being. As an international relations scholar by training, the author has to recall Morgenthau's words that

> *...universal more principles cannot be applied to the action of states in their abstract universal formulation, but that they must be filtered through the concrete circumstances of time and place... while the individual has a moral right to sacrifice himself in defense of such a moral principle, the state has no right to let its moral disapprobation of the infringement of [such moral principle] get in the way of successful political action.* (Morgenthau, 1973, p. 10)

In international relations, there is only national interest "defined in terms of power." The findings of this preliminary study support this fact.

Despite such gloomy findings, the road ahead is not that murky. Mental health promoters must be less idealistic and more pragmatic to facilitate a viable solution in the context of LAMICs and their regional organisations. Such an achievable solution, the author proposes, is a compromise with the state. As the case study shows, the social power to securitise an issue is almost entirely in the hands of the state. Non-state entities have less, if not no, social power to do so. Insisting firmly upon the same maneuver (overemphasis on moral and humanitarian justifications for securitising mental health) is counterproductive. Rather, all advocates, particularly psychiatrists and experts in related fields whose voices are socio-politically louder, should flag the consequences of mental ill-health upon social order, political stability, and economic progress, the major security concerns for the LAMICs, based on scientific research. For example, an evident relationship must be spotlighted between mental illness, disability, a perpetual cycle of poverty and a loss of economic productivity. Furthermore, governments have received vast evidence that treatment of mental disorders generally improves physical health (remarkably in those with HIV/AIDS) and, often, economic efficiency. In short, mental health promoters have to adjust their strategies to meet the state halfway, maneuvering harmoniously with political interest and economic progress, the major ingredients of substantial security concerns for LAMICs. Doing this will create opportunities to negotiate with governments and, thus, a greater chance to successfully prioritise mental health.

Machiavelli may have been right that "the end justifies the means;" understanding that evil in exchange for the interest of humanity is perhaps the best possible solution for humanitarian efforts to securitise mental health and well-being outside developed countries.

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