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# JOURNAL OF SOCIOLOGY AND SOCIAL WELFARE

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## Foreword

The purpose of this issue is to examine the mental health systems of countries in regions of the world which have not received much attention in the professional literature. The countries were selected to represent geographic, economic, and cultural diversity as well as the likelihood that they would bring a variety of responses to problems of mental health. The development of this issue was a complex task that included the initial identification of authors, the process of translation, the management of the uncertainties of international mail service, and the coordination of three guest editors. The project took the effort and cooperation of many people.

We thank the Editorial Staff of the Journal of Sociology and Social Welfare for dedicating this issue to papers on international mental health perspectives. We also want to express our appreciation to the contributing authors who have worked with us patiently during the last two years. Thanks to Eugene Brody, Secretary General, World Federation for Mental Health for his assistance in recommending contributors and to Norman Sartorius, Director, Division of Mental Health, World Health Organization, for both his personal consultation and the vision of mental health policies contained in his writings.

We are grateful to the people who assisted in the preparation of manuscripts: Western Michigan University (WMU) Research and Sponsored Programs for financial assistance in the translation of a manuscript, Ms. Kristin Ruehl of the WMU Translation Center for her translation assistance, and Cheryl Bowne, Margarita Campos, and Lauri Holmes for technical assistance in manuscript preparation.



# Mental Health Services: An International Perspective

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*This paper provides an introduction to this special edition on international mental health perspectives. The importance of an international perspective is discussed and key questions are raised to provide the reader with a frame of reference for examining the mental health systems in the countries presented. An orientation to some of the current mental health issues in Europe, the United States, and developing countries is given as point of comparison for the reader. Questions discussed relate to the status of institutional care, outpatient services, the composition of mental health staff, the role of community interventions and prevention, and the availability and accessibility of mental health services.*

As we begin the countdown to the 21st century, it becomes increasingly important to include an international dimension in an examination of any arena in the health and human services. Like economic development or environmental impact issues, health and welfare problems and programs are becoming progressively international in their scope. Health problems such as Aids necessitate a global response. Welfare programs such as refugee resettlement require cooperation and interaction across nations. Clearly as the world becomes more and more of a global village, there must be increased knowledge about the international reach of social welfare.

Even in arenas where there is less apparent immediate need for a collective response among nations, there is considerable value in an international perspective. World-wide information about problem indicators provides an appreciation of scope and an understanding of prevalence across countries and continents.



Global overviews of program provision and service delivery offer insights into the stage of development and the area of emphasis in different parts of the world. Still much of the value in such a perspective rests with the identification and examination of commonalities and differences across nations. Such comparisons can expand and deepen out knowledge about health care and human services in the United States as well as in other societies.

Mental health is an area where much can be gained by an international perspective. Certainly the problems addressed by mental health services are of global concern. Throughout the world there are at a minimum of 40 million people who are seriously disabled because of mental disorders and another 250 to 300 million who suffer from less severe but still incapacitating disorders including alcohol and drug dependence (Sartorius, 1988). The incidence of such disorders is spread throughout the world and is at least as frequent in developing countries as in industrialized nations. Thus mental impairments and disorders are a world-wide public health problem and a threat to social productivity in addition to individual health in all regions of the globe.

Sartorius (1988) points out that many contributing causes to mental problems are similar world-wide while others are more apparent in either developing or developed countries. Accidents, genetic problems and the effects of alcohol and drug abuse cut across all countries. In developing countries malnutrition, inadequate prenatal care and early brain damage by infection are more prevalent causal factors although they certainly are not absent in industrialized countries with major concentrations of poverty. Mental impairment linked with aging is currently a more major concern in the developed world although the greying of the population is now a demographic fact in all societies.

Mental health services and service systems designed to address both mental problems and their causal factors also can be addressed and analyzed from an international perspective. Many societies have a long history of providing such services. There are similarities in service provision across nations, but also major differences based on culture, stage of economic

development and perceived needs of the society. It is to this examination of services in several countries that we now turn.

This special issue of the *Journal of Sociology and Social Welfare* centers attention on mental health systems in a number of non-western countries. The cultural context, historical development and current operation of mental health services for each of these nations are examined in the articles. The countries selected for this issue include Rwanda in Africa, Israel and Egypt in the Middle East, Japan, India and Hong Kong in Asia, and Mexico in Latin America. They are a culturally, geographically and developmentally diverse group of nations which provide interesting comparisons and contrasts among themselves as well as differentiation from the westernized countries of Europe and North America.

While a number of these countries are not highly industrialized many of them have long histories of providing mental health services. For example, the history of mental health services in Egypt can be traced back for thousands of years and Mexico had the first mental hospital in the new world. Other countries represented, such as Japan, Hong Kong and Israel have very modern and sophisticated service delivery systems which in many ways resemble those found in Europe and the United States. Still their services include unique features which result from differing historical, cultural and situational factors. Such features add to the richness and value of comparisons across nations.

Cross national comparisons of mental health policies and programs must be approached with caution because policy choices and programs models for different countries are made in different demographic, historical and social-political contexts. The historical trends and cultural contexts provided in the following articles serve as a background for program comparison. Still there is much to be gained by comparing similarities and differences across nations. Higgins (1981) points out that comparative analysis can widen understanding of the range of policy options and provide lessons based on the experience of others. It, also can offer a selective understanding of program impact on social problems and increased insight into the likely outcome of difficult policy choices. While technology transfer

must be approached cautiously in mental health as in other human service arenas, comparative analysis can provide a foundation for improving programs as well as choosing policies.

One particular value of an international perspective is a more comprehensive view of current trends and issues in mental health. Some recent policy and program trends and issues in the United States are familiar to all of us. They include deinstitutionalization of patients, medicalization of treatment, privatization of programs and targeting of services. They have been widely analyzed and debated in the literature. Also, much of the recent research in mental health services attempts to shed light on the impact of such policy and program directions. Examinations of the availability, accessibility, quality and effectiveness of services as well as outcome studies of various approaches to providing care often are initiated in order to review policy impact and recommend program directions.

Countries represented in this volume face similar issues. Deinstitutionalization is a challenge in Mexico. The direction and degree of medicalization are debated in Israel. Privatization of services in both a trend and a concern in India. Case management, crisis intervention and other developing approaches to the provision of care are being utilized and evaluated in some non-western countries. Different national approaches to these and other issues and directions are apparent in the following articles. The insights they offer in addition to the information they provide should be of interest to policy makers and practitioners alike.

### *A Frame of Reference*

Review and comparison of the articles from various countries and the trends and issues which they identify and discuss will be covered in the concluding article of this special issue. This article will concentrate instead on providing background information to give the reader a frame of reference for the remainder of the discussion. To provide this reference point, we have posed a series of questions which cover some of the key dimensions to be considered in the examination of mental health services in developed or developing countries. The questions address both the organization and delivery of services and the

focus and staffing of mental health programs. Information in response to the questions is drawn from a review of recent reports by the World Health Organization and other international bodies about the status of mental health programs in different parts of the world.

Questions which are addressed include the following:

- (1) What is the status of institutional care? What is the extent of movement towards deinstitutionalization and decentralized services?
- (2) What is the status of mental health services outside of institutions?
- (3) What is the configuration of mental health care staff?
- (4) What is the role of community interventions in prevention and mental health promotion?
- (5) How available and accessible are mental health services?

Each of these questions are answered in a general way for Europe, the United States and the nonwestern world. In some cases distinctions are made between developed and developing countries but often this dichotomy is too simple so examples are given from a range of countries. The intent is to provide an orientation for the reader, rather than a comprehensive overview of world-wide directions in mental health.

- (1) What is the status of institutional care? What is the extent of movement towards deinstitutionalized and decentralized services?

A primary goal of mental health planners in many of the developed countries is to reduce the size of large institutions. In the WHO European Regional Report (1985) it was recommended that the size of large mental hospitals be reduced and that residential care should be located as close to the population as possible. A suggested means of accomplishing this was to provide alternative inpatient treatment in general hospitals along with other medical specialties. This recommendation echoes earlier WHO recommendations and reflects a trend in both Europe and U.S. to move away from the huge institution

of 1000 or more patients and towards medium-size institutions. The European Regional Report shows that in Italy and the United Kingdom where deinstitutionalization has had very high priority, the number of institutions with over 1000 patients dropped dramatically between 1972 and 1982, from 55 to 20 in Italy and from 65 to 23 in the United Kingdom (WHO, 1985, pp. 36–37). Though the decline in most European countries was not as dramatic as this, most showed a decline in the number of the 1000 bed plus psychiatric hospitals. In the United States between 1955 and 1989 the number of patients in public mental hospitals went from 559,000 to 110,000 (Mechanic and Rochefort, 1990). Many of the patients who would have been served in public institutions are now served in the community or in private hospitals.

As part of the move from large institutions, general hospital psychiatric beds were on the increase. In Europe between 1972 and 1982 the majority of countries showed an increase in the number of psychiatric beds available in general hospital units. The increases ranged from a minor change in a country like Ireland with 1.2% of psychiatric beds in general hospitals in 1972 to 1.8 in 1982 to the most dramatic changes in a country like Sweden which moved from 6.4% in 1972 to 17.8% in 1982 (WHO, 1985 pp. 38–39). This is comparable to the change in the United States during this period of time which saw an increase from 4.3% to 14.8% of the psychiatric beds being located in general hospitals (NIMH, 1987). From 1970 to 1984 the number of psychiatric beds in state or county mental hospitals went from 2.07/1,000 to .49/1,000 and the number of psychiatric beds in general hospitals went from .11/1,000 in 1970 to .16/1,000 in 1984. There was a corresponding increase in the number of general hospital admissions from 31% of the total psychiatric admissions in the United States during 1970 to 44.1% of the admission in 1984. Similar significant changes occurred in the United Kingdom during this period of time. In 1972, 22% of the admissions were through general hospital psychiatric units while in 1982 this rate rose to 32%. In Sweden the rate rose from 30% to 48% and in Norway from 11% to 38% during the same time period (WHO, 1985).

While most other European countries showed minor changes in the direction of increasing the percentage of general hospital psychiatric units, several countries reported a reduction in the number of general hospital psychiatric units because of the development of nonhospital alternatives to psychiatric care. Twelve countries reported more nonhospital than general hospital beds. Making significant progress in this arena were Iceland, which reported that 75% of all psychiatric beds were of this nature, Czechoslovakia, which reported 49%, and the Netherlands, where 42% of all psychiatric beds were nonhospital beds (WHO, 1985). Thus a straight comparison of the number of general hospital psychiatric beds may not be an accurate indicator of the most deinstitutionalized systems if other psychiatric alternatives are not included in the analysis.

Developing countries are difficult to analyze on the issues of institutional care. Some are in the process of developing a basic level of psychiatric institutions where none existed. Others are moving away from highly centralized facilities developed by the colonial governments, to more regional facilities or to the development of psychiatric wards in general hospitals. This was the case for countries such as Zimbabwe, where until independence in 1980 there was a system highly centralized around a central hospital in Bulawayo built during the British Colonial period. Since 1980 a more decentralized system has been developed around 6 smaller mental hospitals and psychiatric units in some general hospitals (Chikara, 1990). The deinstitutionalization trend is much further along in countries such as Egypt and Mexico. The article on the mental health system in Mexico by Lartigue and Vives points out a very complex network designed to provide services at a more local and less institutional level. In the article on Egypt Dr. Okasha points out that, as in many countries in the West, mental health planners are questioning whether deinstitutionalization has created a revolving door syndrome which serves neither the patient nor the community. In his article he gives a detailed analysis of recent changes in the characteristics of hospitalized patients in Egypt.

In many countries, including the United States, patients have been released from or diverted from the hospital setting

without having suitable alternatives. The move towards deinstitutionalization has raised considerable controversy and raised ethical issues which are many, complicated and need careful analysis by mental health planners. A detailed analysis of the ethical issues related to deinstitutionalization can be found in a article by Douglas Polcin (1990). Some in the mental health field also believe that many patients who are released might be better treated in a hospital setting. These questions are addressed repeatedly by the authors in this special edition.

Though the trends of mental health services in Europe and the United States are clearly moving toward decentralized care, the rates of change are slower than many health care planners had hoped and vary greatly from country to country. Still, once a large centralized system is in place it takes many years to transform it to a decentralized system. Countries which have not yet developed extensive institutional networks may be able to build a decentralized network of graded institutional care from the beginning, rather than having to undo a costly and slow-to-change system in later years.

(2) What is the status of mental health services outside of institutions?

The European Regional Groups working with WHO recommended that "outpatient facilities and day care should be available wherever patients' needs can be met without admission to hospital" (WHO, 1985). Comparisons of the development of outpatient care have been difficult because of the great diversity which occurs in the form and funding of outpatient services. The European Regional Report (WHO, 1985) shows a general trend toward increased outpatient and decentralized services. Countries having made outpatient services available to most of their population are France, Norway, Sweden and the United Kingdom and countries showing considerable progress were Finland, Italy, Morocco and Poland. Other countries such as the Netherlands and Germany may be providing considerable service in this area, but the nature of the provision of these services has made their level difficult to assess. WHO has piloted outpatient services in Austria, Greece and Spain and in those pilot regions the services appear strong. In the United

States the number of people receiving outpatient services more than doubled between 1969 and 1983 moving from 1,146,612 in 1969 to 2,665,943 in 1983 (NIMH, 1987, pp. 37). This period of time also saw a shift in the location of these services away from state and county hospitals to a diverse group of community based-programs.

Dr. Lartigue's article on Mexico, a country which is somewhere between developing and industrialized, provides a good example of how complex a system of outpatient services can be. Outpatient mental health services are found in a variety of settings, in many local health centers, in many general hospitals, in the national social security program, the national program supporting families, and many other health care networks. In countries such as Mexico and in developing countries as a whole the nature of community based programs varies greatly just as it does in Europe.

In many countries in Africa much of the outpatient services are provided through public health nurses trained in providing mental health services, but their number is generally inadequate. In Zimbabwe, for example, the Ministry of Health has deployed two community psychiatric nurses as administrators in each of the eight provinces. Each of the fifty-five districts has at least three nurses dealing with the mentally ill in and out of hospital. In addition, there is an active in-service training program for nurses to increase the number of mental health workers. In Zimbabwe as in many other African countries traditional healers are widely utilized by persons experiencing mental problems. Since independence, the government of Zimbabwe has attempted to optimize the work of the traditional healers by establishing an organization to support their work. The Zimbabwe National Traditional Healers Association (ZINATHA) has over 20,000 members and it is reported that they are quite effective in the treatment of nonpsychiatric disorders (Chikara, 1990).

### (3) What is the composition of mental health care staff?

Dr. Sartorius, Director of the Division of Mental Health at WHO, emphasizes the importance of replacing the use of descriptive roles of member professions, i.e., psychiatrist, psychologist, psychiatric nurse, social worker, with definitions of



mental health tasks, regardless of who does them. This would mean that rather than having interdisciplinary teams consisting of professionals from each of the groups, the teams would consist of professionals with skills to perform specific functions and their profession would be secondary. This is particularly important in developing countries where this model of staffing has already had dramatic positive effects on the service delivery (Sartorius, 1987). This approach was put forward in 1975 by an Expert Committee on Mental Health of the World Health Organization which observed that in developing countries there is often less than one trained mental health professional per million population and that if mental health services were to be brought to the masses it would have to be done by non-specialized health care workers at all levels, from primary health care workers to nurses and doctors. The trained mental health worker would have more of a role as trainer and consultant (WHO, 1975, p. 33).

The World Health Organization has been successful in introducing this model in many countries. In reporting on the progress of these projects Dr. Wig (1990) emphasizes the importance of multisectoral teams, teams consisting of staff from medicine, social science, psychology, education, legal specialist, and religious leaders, to plan and provide mental health services (Wig, 1990). The multisectoral nature of the teams is emphasized because it provides a more comprehensive approach and promotes the definition of team members by their function rather than by a professional identity. Dr. Wig believes this approach avoids some of the professional rivalries which have developed between psychiatrists, psychologists, social workers, and nurses.

The European Regional group recommended that "mental health personnel should work as much as possible in multidisciplinary teams, serving defined populations" (WHO, 1985 p. 29). The multidisciplinary team concept they are referring to is a treatment group consisting of a psychiatrist, psychologist, a psychiatric nurse and other auxiliary staff. The auxiliary staff includes social workers, occupational therapists, psychiatric aides etc. In spite of the orientation articulated by Dr. Sartorius regarding the conceptualization of service by task and function

rather than professional title, the staffing continues to be described according to the tradition professional grouping in Europe and most countries with highly developed mental health systems.

Staff for mental health services in developing countries are often in acute shortage and vary greatly in terms of their professional makeup. For example in Algeria the number of psychiatrists was only 0.3 per/100,000 population in 1982, yet this showed a tremendous gain since in 1962 after gaining independence, there were no native-born psychiatrists. There are now 52 psychiatrists in the country and psychiatric training is available at four universities (WHO, 1985, p. 59–62). A more acute lack of psychiatrists is found in many other developing countries. For example, in Zimbabwe there are 10 psychiatrists for a population of 10 Million, that is .01 per/100,000 and most of these are not native-born and often only remain in the country for the duration of their contract. Most of the mental health services are provided by the psychiatric nursing staff whose numbers vary between 600 and 700. There are five clinical psychologists in public service and fifteen in private practice and there only a few social workers in mental health services in Zimbabwe (Chikara, 1990). While the numbers and ratios of staff will vary from country to country this is a common pattern in many developing countries and provides an interesting area for comparison among the countries represented in this edition.

Personnel issues are extremely varied across European countries. Traditionally the number of psychiatrists available to the population has been an indicator of the quality of mental health services. The European Report (WHO, 1985, p. 59–64). showed that countries such as Belgium, Sweden and Iceland have high ratios of psychiatrists of 9.6 to 12/100,000 population. This would be a range of 96 to 120 per million as a point of comparison with Zimbabwe's one per million. The mean number of psychiatrists on the 22 European countries which could be compared in the study was 6.7/100,000 in 1982. This was up from 5.6/100,000 in 1972. Thus there is tremendous availability of psychiatric services in much of Europe as compared to other areas of the world.

Interestingly, however, the European Regional Report (WHO, 1985) made the point that just as the number of beds per thousand population may not be the best indicator of quality psychiatric services, so may the number of psychiatrists not always be an indicator of optimal psychiatric care. The Report drew these conclusions:

The most significant change indicated by the data available is the very considerable increase in most countries in the number of psychiatrists. Many countries now have very high ratios to population. In the absence of other comparable developments in trained staff and flexible, community-based, integrated services, this has several dangers. Psychiatrists take a high proportion of the limited mental health budget, yet often pay little attention to chronically sick or disabled patients, long-stay institutional residents or the elderly mentally infirm who constitute the great bulk of psychiatric need. Neither do they necessarily involve themselves in service development work. Indeed, if trained in traditional patterns of work, they may represent a great force of inertia in traditional patterns of care, and therefore a constraint on the development of comprehensive, community-based services. (WHO, 1985, pp. 71)

The European WHO Report indicates that one of the most critical personnel needs in industrialized countries is for community mental health training of personnel who will help carry out treatment as it moves from institutional to community care, often utilizing multi-disciplinary teams including psychiatrists, nurses, psychologists, social workers and other auxiliary personnel (WHO, 1985, pp. 87-90). It is also true in developing countries that training needs are in the area of psychosocial community interventions.

In Europe psychologists have been less central in providing mental health services than psychiatrists and their role has been largely in testing and assessment of patients. In recent years they have been assuming a greater role in providing treatment services as well. The WHO (1985) study showed an increase in the ratio of psychologists to psychiatrists. Whereas in 1972 there were one third as many psychologists as psychiatrists in the

reporting European Countries, in 1982 there were two thirds as many psychologists as psychiatrists. In comparison, the United States has a ratio of 1.14 psychologists employed in the public mental health system for each psychiatrist (NIMH, 1987). Many more psychologists are employed in the private sector.

There are twice as many social workers employed in mental health organizations as there are psychiatrists in the United States. This is very different than many European countries where social workers were counted as part of the auxiliary staff in the study by WHO and were not even listed as a special category. Social workers do have a central function in mental health services in some countries in Europe, but roles of social workers vary greatly from country to country as does the extent and nature of professional training and the type of certification or licensing. It has therefore been very difficult to collect data on social workers. (WHO, 1985, pp. 70–71).

Psychiatric nurses play a central role in mental health care. Their levels of staffing have remained stable in Europe on the average, but there has been some fluctuation by individual countries. The ratio of nurses varies from one per psychiatrist in countries such as Czechoslovakia, Greece, Spain and Turkey to over 20 per psychiatrist in France, Ireland, Malta, and the United Kingdom (WHO, 1985). In the United States the ratio of nurses to psychiatrists employed in mental health services is three to one (NIMH, 1987). Part of the variance has to do with the roles nurses take in service provision and the way they are credentialed. Another factor is the level of other auxiliary staff including social workers, occupational therapists etc. The data on these groups is so variable in the European countries studied that the data provide little meaningful information.

One of the keys to making those transformations appears to be the retraining of mental health professionals to provide effective the community based services.

(4) What is the role of community intervention in prevention and mental health promotion?

In the developing countries the provision of basic health care services are important to the prevention of many neurological disorders. A recent publication by WHO indicated that 50%

of neurological disorders are preventable by currently known methods (WHO, 1988). The link between primary health care and mental health services provides an important means not only for the provision of mental health services but for the prevention of mental health problems. Mental health planners in developing countries see key components in the promotion of mental health as (a) improving the overall functioning of the health care system, (b) supporting overall socioeconomic development, and (c) enhancing and improving the quality of life in general (Wig, 1989, pp. 6).

Community interventions have been shown to be quite effective in improving both overall health care conditions and the mental health of communities. Innovative programs in community psychiatry have had significant impacts on improving overall functioning of the community in the slums of developing countries. In Honduras, Central America, mental health techniques were combined with community organization methods to create a sense of community through organized cooperative activities and self-help endeavors (Eisenberg, 1980). These programs improved the overall health of the community as well as their mental health services. In Egypt mental health services were integrated into a health care center that was part of a Mosque in an attempt to intervene at the community level (Baasher T. El-Hakim A, Galal A, et al., 1979). In the article on Mexico the reader will find a variety of self-help projects described which have had considerable success in improving both physical and mental health in poor communities. Similar methods are being undertaken in other developing countries. In addition it is important to remember that historically many of the interventions of traditional healers were often important components to the health functioning of families and the community. It is a common practice of shamans, for example, to involve other family and community members in the cure of an individual's illness.

The European Regional Office of WHO has consistently promoted the principles of comprehensive community-oriented mental health services. The meaning of community mental health in Europe and the United States refers largely to efforts to provide treatment in the community to people formerly cared

for in hospitals. In the United States the community mental health model began in the 1960s and continues, with ever more emphasis placed on non-institutional solutions. This trend has been accelerated in some areas because of the perceived cost saving of noninstitutional alternatives in a time of fiscal austerity. This has often lead to releasing people from institutions without adequate community services to support them. Some claim that deinstitutionalization has been a failure, particularly in larger cities where many former patients have ended up on the streets.

In Europe one of the most fundamental changes in services in the last decade has been the move towards sectorized community services where multi-disciplinary teams provide diverse community based services to a defined geographic region. In Vienna, Austria for example the city was divided into eight sectors with 400,000 people in each sector. Four psychiatrists and four social workers were assigned to each sector and at least one third of their time was to be spent improving services to the area rather than individual personal care (WHO, 1985, pp. 79). In Sweden local mental health teams have been established for population groups between 25,000 and 35,000. The teams consist of a psychiatrist, a psychologist, a nurse, a social worker with responsibility for both inpatient and community based care. Variations on these models are found throughout Europe.

(5) How available and accessible are mental health services?

What is the availability of services to different locations and socioeconomic groups in various regions of the world? In highly developed countries of Europe with national health care systems, mental health services are widely available to much of the population. In the United States there is less equal distribution of services because of the lack of a national health care program. G.K. Farley compared the impact of these differences on psychiatric services to children by comparing services in the United States with those in Norway and found service in the United States limited by the lack of a national health care program (Farley, 1988).

The process of deinstitutionalization, has raised new issues of access to services. As public hospital services become

increasingly difficult to access in the United States because of the emphasis on deinstitutionalization, the poor often find themselves without any effective treatment alternatives. Mechanic and Rochefort (1990), in their comprehensive analysis of deinstitutionalization in the United States, point out the incomplete development and inadequate performance of supportive services which were supposed to provide for those released from or diverted from hospitals. They emphasize the "severely mentally ill are multiply disadvantaged by poverty, disability, lack of housing and employment opportunities, and persistent social stigma," and that any solution must be a comprehensive one addressing all the entitlement structures if it is to be effective (Mechanic and Rochefort, 1990, p. 324). The recognition of the interconnectedness between good mental health care and the availability of general health care and social service is often lacking in mental health care planning.

In many developing countries much of the psychiatric resources remain focused on a small number of chronically mentally ill in institutions and modern Western style psychiatric services are channeled to only a small number of people largely through the private health sector (Wig, 1989). These services are usually available only to the wealthy in the larger cities, while for the poor or rural population other systems have been developed. Clearly the nature and availability of services in a developing country such as Zimbabwe with 10 psychiatrists for a population of 10 million, will be considerably different from countries like those in Scandinavia where they have generally 10 psychiatrists per 100,000.

A highly successful method of making mental health services available to the majority of the population in developing countries has been the integration of mental health service with the primary health care network. In 1975 the World Health Organization recommended that developing countries add mental health services to the current primary health care infrastructure in order to maximize their use of the limited number of trained health care personnel (WHO, 1975). With the support of WHO, a series of projects was developed in several regions of the world to implement this concept. This included the development of a national mental health care plan, the training of health care

personnel, and the integration of mental health services into primary health care centers. WHO reports on the progress of these projects as of 1987 for the south east Asian and Mediterranean regions. It shows considerable progress has been made in India, Nepal, Pakistan, and Egypt in developing a national mental health plan, training primary health care workers to provide mental health services and in beginning to offer mental health services at primary health care centers in some regions of these countries. Other countries have adopted national mental health program plans and have begun training primary health care workers (Wig, 1990). Similar progress has been made in other regions of the world. WHO sponsored a study of the effectiveness of training primary health care workers in mental health tasks in Columbia, India, Sudan and the Philippines. The results showed that in most countries skills in such areas as accurate diagnosis of mental disorders were dramatically increased (Harding, Busnell, Climent, Diop, El-Hakim, Geil, Ibrahim, Ladrido-Ignacio, Wig, 1983). The training methodology developed in these WHO projects has been shown to be very effective in giving general health care workers the knowledge to make key health care management decisions (Murthy, R.S. and Wig, N.N. (1983) In fact these training materials and methods were of such good quality and universal utility that they could be adapted for use in highly industrialized countries as well (Beigel, 1983).

### Summary

This review provides a useful orientation to some of the key trends and issues facing mental health around the world. Not only are mental health problems a global concern, but service delivery directions also have an international dimension. Trends such as the use of primary health structures as a vehicle for the provision of mental health services are apparent throughout the world. Issues such as the availability, accessibility and effectiveness of community based care are concerns for developing as well as developed countries. The organization and division of service provision responsibilities among provider disciplines, although impacting countries differentially, also are of international interest. These and other trends and issues such as deinstitutionalization and decentralization which are discussed



in the W.H.O. reports and other cited literature deserve further investigation and analysis within an international perspective.

The articles which follow address a number of these and other trends and issues as they are evidenced in seven nations. The article for each of the countries included in this edition of the *Journal of Sociology and Social Welfare* examines current issues and future trends in mental health, within the cultural context of that country. Introductory material also includes relevant demographic data. Each article then provides an overview of the current mental health services delivery system. Institutional care and community based care both are examined with attention to the services provided, the patterns of staffing and the treatment methodologies utilized. This overview provides a foundation for an examination of issues in financing, delivery and staffing of services. In each case the article concludes with a discussion of future trends.

These articles singly and in sum should increase both interest and understanding about mental health services in the countries addressed. If so, this special issue will have helped to promote an international perspective on mental health.

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# The Development of Mental Health Services in Sub-Saharan Africa: The Case of Rwanda\*

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*This paper considers several aspects of the evolution, organization and current status of the mental health system of Rwanda. The centerpiece of the Rwandan mental health system is the neuropsychiatric hospital in Ndera. Resource constraints preclude development of an extensive system of specialty mental health care. The World Health Organization has proposed that mental health services can best be delivered in developing countries through decentralization and integration with primary health care services. The accomplishments and problems encountered in implementing this model in Rwanda are described and, based on this experience, some recommendations are offered for other developing countries.*

\*This paper is adapted from, Gatarayiha, Froduald, MD *Evolution of Psychiatric Care in Rwanda*. Unpublished specialist thesis. Brussels: Department of Psychiatry, Faculty of Medicine, Free University of Brussels, 1989. Requests for reprints to: Morton O. Wagenfeld, PhD, Sociology Department, Western Michigan University, Kalamazoo, MI 49007.

This paper considers several aspects of the organization of the mental health system of Rwanda. Very little data are available in English on this nation. Some recent articles that describe its health and mental health problems are: Baro (1990), and Blanc (1984). The World Health Organization publishes reports on mental health in Africa (WHO, 1977). Any mental health system is a reflection of historic developments, economic conditions and societal values, and needs to be understood in that context. As background, then, we consider some of these factors.

Rwanda is a small, landlocked country with an area of 10,169 square miles, of which 7,229 square miles are usable. It is located in the heart of Africa with Zaire to the west, Burundi to the south, Uganda to the north, and Tanzania to the east. It enjoys a mild climate, with an average temperature of 64°F. Rwanda's soil is generally good for agriculture. However, its value is lessened by erosion, small parcelling, and lack of refertilization by farmers.

Economically, the country is one of the most disadvantaged: a charter member of the "Fourth World". According to World Bank statistics, it ranks as the world's 17th poorest country, with a per capita Gross Domestic Product of \$180 per year (Blanc, 1984).

The Rwandan people live in communities that are dispersed over many hills, some of which are not easily accessible. More than 90% of the people live in rural areas. The leading export is coffee, which accounted for nearly 75% of revenue. Other agriculture products and minerals account for the balance of exports.

The land is divided into family farms, which are becoming smaller and smaller because of the increase in population. The reduction of cultivable land and means of production has brought about serious economic problems and malnutrition.

Data from the Agency for International Development (cited in Blanc, 1984) indicates that Rwanda's health indices parallel its economic condition. In 1970, infant mortality was reported as 133/1000 live births and life expectancy at birth is 46 years. In 1978, the leading causes of death for hospitalized patients were: measles, perinatal mortality, gastroenteritis, pneumonia, maternal mortality, other respiratory infections, helminthic infections,

and gastritis. For our purposes, it is important to note the high morbidity and mortality from alcoholism and its complications. The reported statistics fail to show this clearly, since many of the problems are subsumed under the label of gastritis.

Finally, Rwanda is one of the African countries where the incidence of AIDS is reaching alarming proportions and this will particularly test the mental health services. Mental patients are at risk for the disorder, while AIDS may also be a factor in the incidence of mental and neurological disorders (Baro, 1990).

In light of these needs, the annual per capita expenditure for health of \$2.00 is grossly inadequate. There is a severe shortage of health personnel and facilities. There are 5,010 persons/nurses, 54,870 physicians, and 670 hospital beds.

Three ethnic groups make up the Rwandan population. The Hutu represent 89.9% of the people, the Tutsi, 9.8% and the Twa, 0.4%. The predominant religion is Catholic. The level of education has continued to improve. The proportion of students in school has increased from 45.6% in 1978 to 67.4% in 1982.

Conflict between folk (traditional) and scientific (Western) views of the etiology and treatment of mental disorder exists in both developing and industrialized nations. In the latter, the primacy of the scientific model is such that accommodation to, or integration of folk systems is generally not a major concern, except in isolated areas. In a developing nation such as Rwanda, however, the traditional system is quite strong and needs to be a part of the overall system of mental health care.

An extended discussion of the various Rwandan belief systems about mental disorder is outside the scope of this paper. Briefly, in traditional Rwandan culture, an illness is not simply the result of the malfunctioning of an organ. Nor is it injury to an organ from an outside physical cause. It is essentially a break in the harmony of one's life, attributed to either a physical problem created by a magical power, or an intangible force such as God, local spirits, or ancestral spirits. In Rwanda therapeutic rituals are often addressed to *Ryangombe*, a divinity who is the source of peace, love and fertility.

In Western terms, traditional medical practitioners employ a holistic approach, treating the patient's symptoms, as well as looking for causes in the physical and spiritual worlds. Unlike

the Western mechanistic model, no distinction is made between somatic and the psychic factors.

The Rwandan people believe in a superior creator and in ancestral spirits who protect their descendants. In exchange, they must honor the ancestral spirits and fulfill ritual obligations to them. Such obligations must be in the form of community or individual offerings. Evil spirits of the deceased are sources of unhappiness, suffering, failure, and everything bad. Every sickness is the result of ill-omened influences from an enemy or from the spirit of a dead ancestor who is jealous or who wants revenge.

The Rwandan people are convinced that, apart from the spirits, other individuals with whom they live intimately, could inflict disasters upon them and their families. The victims may suspect sorcerers, who are able to work at a distance and who can also get a hold of and use items such as the victim's hair, nails, clothing, etc.

In traditional conception, mental disorder is perceived as the field that confronts transcendental powers or the transcendental part of man. It is the field of invisible battles and forces. It is the spirit world. To enter this world, much preparation and experience are necessary. Dealing with spiritual forces, whether good or bad, brings a possibly fatal shock to the unprepared person.

Mental illness is a sign of the alliance with the spirits, and of the continuation in offspring and groups. The mental patient carries a message of prestige. At the same time, he strengthens the social and familial bond. The cure encourages symbolic circulation. The explanation of mental illness is both social and moral. The evil is caused by another human, ancestor, or spirit. So, the delirium and hallucinations represent an oracle, a message. Above all, when a hallucination uncovers the world of the ancestral spirits, its value as a message is no longer doubted. The psychotic person becomes equal to a fortune teller, and his message is the message of the perspicacious oracle.

Since the explanation of the abnormal condition has to do with the supernatural powers of men and spirits, the traditional society does not consider the mental patient, *per se*, to be a marginal being who should be locked away. The society simply

insists that the person conform to certain rules in the community. As long as he does not disturb family peace or law and order, he may converse with himself. If a patient commits brutal acts, starts a fire or attacks the community, he may be tied up in a room to prevent him from running away or harming himself and others.

## The Evolution of Mental Health Services in Rwanda

### *Pre-Independence*

The Rwandan mental health system is a mixture of both Western and non-Western elements. Psychiatry as a science or branch of Western medicine is fairly new in Africa. In the French-speaking regions of the continent, the first mental hospitals were constructed in the 20-year period from 1940-1960. Like the U.S. before World War II, mental patients who were deemed dangerous or who were abandoned and rejected by their families were often incarcerated without any psychiatric care. This is still a fairly common occurrence in many African states.

Given the fact that, according to traditional African belief, mental illness is caused by curses, the evil eye, violations of a taboo, the schemes of evil genies, sorcery, etc., Rwandans find it hard to believe that modern psychiatry, with its different etiologic models, would have much to offer them.

Western medical services were introduced in Rwanda in the 1930s, coterminously with the period of a missionary expansion. The services that were available were very limited, due to lack of equipment and personnel, and were less accessible to the rural population, which makes up the majority of the population.

Rwanda was originally part of German East Africa (along with Tanzania and Burundi). After WW I, it came under Belgian tutelage as Rwanda-Burundi. Before the country's independence, a psychiatric service in Bujumbura (in what was later Burundi), took care of some Rwandan mental patients. When both countries achieved independence in 1959, the patients were sent back to Rwanda. No structure had been planned to receive them, except for the prisons for those who were considered dangerous. The others were abandoned, left to themselves to lead a life of wandering about the hills.



*After Independence*

To deal with the influx of patients, planning for the construction of a psychiatric institution in Ndera, in the center of the country, began in 1963. The Rwandan government agreed to furnish the land and personnel, and would insure the maintenance of the hospital. The government requested the collaboration of the Brothers of Charity, a Catholic religious order highly regarded in Rwanda for their educational activities, as well as for their wide experience in psychiatry in Belgium. The Brothers responded by creating *ASBL CARAES*, a charitable organization to provide financial support for their activities in developing countries. In addition, the Belgian Ministry of Cooperation contributed to the construction of the hospital.

The hospital opened in 1972, with a capacity of 120 beds. Its first mission was to empty the prisons of psychiatric patients who had been housed there since the independence of Burundi, and to limit itself to serious cases. The Ndera Center rapidly expanded in the face of a growing number of patients. In 1980, after eight years of operation, there were 1,762 hospitalizations and almost 10,000 consultations annually. These cases, mainly acute, were evidence of the extent of psychiatric morbidity in the country. This rapid increase in caseload exceeded the capacity of the available manpower. In addition, the location of the hospital in the center of the country forced patients to travel long distances for treatment. Along with the barrier of distance, there were also difficulties linked to the state of indigence and with the widespread lack of familiarity with the modern medical system. Some patients only came back to the hospital in the event of a relapse. Others were obligated to fall back on traditional treatments.

Because of a lack of adequate resources, it was not possible to create sufficient aftercare and transitional services for patients who experienced difficulties in being reintegrated into society. Some had no family to receive them, while others needed protective housing and long-term care. To do this, a building with 47 beds was constructed next to the hospital. Patients here are helped by a small auxiliary staff. These patients are more or less independent and keep themselves busy with productive activities which are adapted to their conditions.

Another element of the mental health system is the psychiatric section in the Central Prison in Kigali, which houses about 100 patients: 80 percent male. For the most part, these are legal cases and chronic patients who, for lack of space at the hospital, remain in the prison. The patients are visited three times a week by a socio-medical team who, in addition to treating the patients, also discuss the possibility of leaving or transferring from the prison. It is hoped that, in the future, these patients will be transferred to a new residence in the vicinity of the hospital.

### *Creation of Psychiatric Dispensaries*

The rapid increase in patient load at Ndera, along with a chronic resource deficit and the long distances made it clear that the hospital would be unable to respond to all of the country's mental health needs. Distance is important for two reasons: remoteness from services and estrangement from family. To help ease the problem, the creation of psychiatric dispensaries was proposed in two areas: one in the north and one in the south. In 1979, as part of the WHO demonstration program discussed below, a dispensary with 10 beds was created in Butare, in the southern part of the country. At this time, the dispensary for the northern region is still in the planning stage.

The dispensaries were designed essentially to insure outpatient consultations, but were also equipped to hospitalize a few acute care patients whose treatments would last only one or two weeks. The hospital was also confronted with the presence of chronic patients.

### *Integration of Health and Mental Health Services*

While the establishment of the Ndera hospital and the regional psychiatric dispensary were important steps in providing mental health services, they were insufficient to deal with the level of psychiatric morbidity.

It is evident that developing countries do not have the fiscal or personnel resources to provide an extensive specialty mental health system. In addition, the provision of general health services are seen as having a higher priority.

In 1974, the World Health Organization (WHO) suggested that mental health services in developing countries could best be delivered through decentralization and by integrating them with primary health care. In 1975, WHO proposed a demonstration program for developing strategies to provide mental health services in developing nations. These services would be provided by general health personnel. These personnel could not treat all categories of mental disorder. Of necessity, their scope of practice needed to be defined in a limited fashion.

In 1977, the demonstration was undertaken in six African nations: Botswana, Lesotho, Rwanda, Swaziland, Tanzania, and Zambia. A plan of action was developed for each country. In Rwanda, three guiding principles were articulated (a) creation of a network of decentralized mental health services that would be accessible to the entire population; (b) integration of mental health services into the framework of general health; and (c) promotion of prevention.

These principles provided the basis for developing a more formal plan of action. As noted earlier, these principles required a program that would be part of the local health system and also part of a total public health plan.

As noted above, the dispensary in Butare was initiated as a further step in the decentralization of mental health services. In spite of poverty and a lack of resources, the dispensary proved that it was possible to treat patients with a wide range of psychiatric problems and to enable some chronic patients to lead useful lives with their families. Sensitization of the population through the mass media (radio, newspapers) about mental health problems was an important element of the demonstration project.

To obtain an integration and active participation of the population in programs of mental health care, it was necessary to enlist the support of the entire health system—local leaders, civil servants, religious leaders, educators, etc.

#### *Project Coordination*

The Rwandan government established a national group for mental health. The group consisted of senior civil servants from

the ministries of education, public health, social affairs, foreign affairs and international cooperation, justice, public works, interior, as well as defense. The group assigned functions for each ministry and developed a plan for interagency cooperation. The secretariat of the national group consisted of the coordinator of WHO programs for Rwanda, the deputy Director General of the Ministry of Public health, and the psychiatrist responsible for implementing the mental health program.

In order to initiate the program, the government of Rwanda requested international help, particularly from France and Belgium. A team from the Catholic University of Leuven's University Psychiatric Center/St. Camillus, under the direction of one of the authors (FB), played a central role in the development and execution of the project, as well as providing all of the research and scientific support.

To begin to integrate mental health with general health care, 12 pilot centers were chosen. This selection took into consideration regional conditions, demographic distribution of the population, local needs, state of existing health centers, and possibilities of sensitization of the population.

Since the needs to be covered concerned the whole of the country, four zones, corresponding to four cardinal points, were chosen to be developed and later to serve as experimental points for the sociomedical units of each region: north, south, east, and west. The 12 pilot centers were supposed to ensure the mental health activities in 107 of 143 of the country's communes.

The intervention phase began in September, 1980. A mobile team from Ndera, including a doctor, medical assistant, nurse, and a social worker made visits once a month to five pilot centers. These mobile teams worked with the center staff. The team's purpose was to evaluate the state of the patients, to prescribe necessary treatments and, if necessary, to transfer patients to the hospital. In addition to these secondary and tertiary interventions, the team engaged in primary prevention by working with families and public authorities to modify pathogenic psychosocial factors. After one year, the number of patients followed at the five pilot centers was 117. At the present time, the hospital is required to arrange quarterly visits in each pilot center and to entrust the health care representatives with

the responsibility of starting up and supervising psychotropic medication regimens.

It could be said that the beginnings were rather quiet. The introduction of this program raised criticism in the medical community. Tasks considered appropriate only for specialists were to be assigned to inexperienced and — presumably — incompetent employees.

The initial resistance was also linked to an inability to understand the operation of such a system, which could disrupt the regular organization of health services by bringing about an overload of work. The lack of interest and negative attitudes regarding mental health progressively evolved. With time, this initial reticence gave way to an acceptance of the idea of incorporating mental health care.

In 1981, seven rural health agents participated in a month-long training course at Ndera devoted to the promotion of mental health and psychiatric treatment. One of the requirements of the course was that the seven had to involve themselves further in the activities of mental health in their own work zones in collaboration with the mobile teams. In the last 10 years, about 150 agents have been trained.

The educational program is centered on characteristic diseases which are described in terms of behavior, and which can be recognized by nondoctors through defining how diseases can be detected, diagnosed, and treated.

Based on the experience of the Ndera Hospital, the education program dealt with ten priority problems — each illustrated by locally-made video tapes: agitation, with or without aggressiveness; withdrawal syndrome, with or without muteness; patients with very bizarre behavior; patients with vague, recurring complaints; behavioral problems due to confinement; infections, surgical intervention, and car accidents; attempted suicides; mental problems as a complication of epilepsy; anxiety and depression; acute mental confusion and insanity; and, anti-social behavior, delinquency, and drug and alcohol abuse.

The hospital in Ndera, as the national reference center, was a determining factor in the organization and coordination of the project as well as the education of needed employees. In this sense, the hospital has grown, not in physical size, but rather

in the infrastructure of polyclinical cares, hospital treatments, lodging facilities, and the possibilities of education, evaluation and retraining.

At the educational level, it has been agreed that instruction in mental health should be integrated into the programs of study in national schools which educate physicians, paramedical personnel, and social workers.

### *Current State*

Currently, 15 health centers have psychiatric consultation services. Up until 1986, the last year for which data are available, more than 6000 patients had been regularly followed up in the outlying areas by rural personnel, accompanied by mobile teams. The treatment is generally prescribed by the doctor and administered by a nurse or other health care representative.

A measure of the program's success is that the opening of the pilot centers greatly reduced the flow of patients to the Ndera Hospital. This is all the more striking, inasmuch as it concerns patients who, for the most part, must follow a treatment plan developed at the hospital. Moreover, those patients who do require hospitalization can be selected in advance by the doctor. This enables a relative stability in the number of patients cared for in the psychiatric department of the hospital.

As the program progressed, local communities became active participants. As a matter of fact, community pressure resulted in the creation of three new pilot centers which had not been part of the original complement.

As Baro (1990) has noted, there is no shortage of problems. For example, it is difficult to obtain supplies of psychotropic drugs. Inadequate training leads to mistakes in treatment. Overcrowding at Ndera results in early discharge of patients, unmet needs and overwork for the staff. Mental health consultation needs to be available in all of the general hospitals, with a few beds set aside for acute cases of serious psychosis.

### *The Role of Traditional Medicine*

As noted earlier, a large part of mental health care is provided by traditional, or folk, healers. The causes of mental

disorder are explained at the time by the patient's personal problems and the cultural representations of the disease linked to beliefs such as witchcraft, misfortune, or evil spirits. This system of interpretation, associated with the power of family ties, accounts for a large portion of the population to acknowledge the illness and to facilitate its treatment in the wake of cultural demonstrations organized for the protection of the whole community. Particularly in rural areas, traditional conceptions of illness and the unity of the group encourage the integration of a person with mental illness.

What helps to insure the persistence of the traditional systems is their adaptability to cultural context and their unquestioned effectiveness. It is not easy to go from a system of traditional representations of illness to understanding the psychopathological processes of Western medicine. An additional difficulty in integrating the two therapeutic systems is that this effort is taking place in a context of social change and cultural instability. The importance of integrating the two systems is underscored by the fact that many of these cultural changes result in social disorganization that can contribute to the increasing incidence of psychiatric difficulties.

To encourage the promotion of traditional medicine, the Rwandan government created an association of healers who met in two dispensaries. In the future, it is anticipated that this program will be extended to mental health.

### Some Reflections on the Program:

#### *Accomplishments*

One of the cardinal principles enunciated by WHO is that essential basic health care services be available to and accepted by all. The experience in Rwanda demonstrates that mental health services can be provided at the community level by incorporating them into ambulatory general health care and delivering it with multifunction staff — what we have termed "polyvalent" medical personnel. Judging from the number of cases seen in the centers and a decline in the number of patient admissions to Ndera, this mode of service delivery has appeared to be effective and full of promise. By being delivered at the local level,

these services are close to the unserved communities. Access to the programs is easy and administrative formalities are relatively relaxed. In this situation, services are more likely to be accepted by the population. In fact, it is possible to help mental patients and their families without having to invest more than their resources allow and without having to resort to methods which are considered unacceptable to them.

The integration of health and mental health services also allows for diffusion of knowledge about mental disorder to a broader audience of primary care medical and paramedical personnel. It facilitated early diagnosis, treatment, and follow-up care.

When a patient is cared for in a health center, the treatment can begin immediately, hospitalization is frequently avoided, the possibility of preventive detention in a prison is averted, and the family can stay in contact with the patient — something that is not possible when the patient is sent long distances from this home. These centers also take responsibility for after care. Every patient who leaves the neuropsychiatric section of the Ndera Hospital receives a letter of introduction to a dispensary or health center in order to allow regular supervision.

### *Problems and Limitations*

While one can judge the program an overall success, the success is not unqualified. Given the realities of resource constraints, the emphasis on decentralization and integration has had repercussions in other areas. The central role played by the Ndera Hospital in staffing the mobile teams and in providing training for the health workers in the pilot centers has presented an enormous financial, administrative and personnel burden, and placed existing programs at risk. This diffusion of effort has made it difficult to set goals and analyze already completed projects.

During the planning of the project, emphasis was placed on patient care and facilities construction. The education of personnel was neglected. These problems are having an impact on the quality of patient care.

One can speculate on how well the brief training given to the health workers and the lack of an infrastructure in the pilot cen-



ters will relate to the continued ability of the centers to maintain the mental health services. The health workers are a heterogeneous group; ideas about mental illness are not assimilated well by all. The lack of education of the polyvalent workers is also reflected in reported errors in the handling of psychoactive medications and preparing the patient for hospitalization. In this situation, some health workers tend to relegate psychiatric care to a minor position, thus helping to perpetuate its lag behind general medical care.

These problems notwithstanding, the rapid increase in the number of cases of mental disorder seen in the primary care centers is encouraging and is an index of the dedication and good will of the Ndera Hospital staff.

### *Recommendations*

Reflecting on the experience of developing mental health services in Rwanda enables us to offer some recommendations for other Third World countries.

(a) Initially, a higher priority needs to be accorded to mental health activities. This would be facilitated by the central government developing a national policy on mental health and creating a division of mental health in the Ministry of Public Health.

(b) Along with this, there is a need for a broader educational program to enable primary care health workers to carry out mental health activities. We need to make more room for mental health in health care in general, and we need to sensitize health staff to the problems of mental health. A place to begin would be by defining the tasks that each of the different positions of health personnel must complete, and then work out the methods of education needed for each position. The government and the institutions concerned will have to make sure that all of the education programs contain clearly-worded pedagogical objectives, and that the evaluation of these programs are carried out in step with the objectives.

(c) Recognizing that folk healers are an important source of mental health care, mechanisms of collaboration with them need to be explored. Collaboration with the healers could lead to more effective preventive measures, improved methods of

patient care, particularly in encouraging them to pursue prescribed regimens.

(d) A continuous evaluation program is important because it allows access to information on the volume and intensity of psychiatric programs, cost, and effectiveness of services, and current needs. It could also serve to monitor the evolution of the activities and could help considerably in establishing new services.

(e) Mental health activities could be extended by establishing psychiatric beds in general hospitals for acute psychosis cases and by creating active consultation services. The example of Ndera shows us that a primary care physician is able to take care of most psychiatric syndromes if he is assisted by a specialist. Thus, the mental health teams, working out of the rural or prefectorial hospitals, could maintain the activities developed in the pilot centers.

(f) In general, the tasks of mental health rely on more than just a policy. There is a need for cooperation and coordination, more at the level of planning than at execution, between mental health, public health, and social services.

### A Final Note

Economists are fond of noting that wants are infinite, while resources are always finite. Even industrialized countries, such as the U.S. and Belgium, which spend considerable sums for health services, have come to realize that unrestricted access to health care for all is a financial impossibility: some limits, priorities, or constraints need to be imposed. The limitations in a poor, developing nation like Rwanda are severe. Proportionately less resources are available for health care. The small amount that is available is likely to be allocated to the prevention and treatment of infectious diseases, infant mortality and malnutrition, with the result that mental health care is accorded a relatively low priority.

The overall effectiveness and utility of the WHO strategy of decentralization and integration as a means of extending the scope of mental health services delivery must be viewed in the context of these severe resource constraints and priorities.

This paper has considered some of the accomplishments and problems of this program. Based on this experience, we have been able to suggest some guidelines for other developing countries.

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# MENTAL HEALTH SERVICES IN INDIA

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*India has a population of over 800 million of which about 20 million are suffering from a mental illness. In terms of numbers of patients alone, mental health planners are presented with quite a challenge. How the challenge is being met is the topic of this article. Governmental efforts need to be augmented by voluntary agencies and private practitioners for optimal mental health care. Despite deficiencies, India is a pace setter for many developing countries. It has the political will to initiate needed changes. Aftercare services for the mentally ill should be a top future priority.*

India is the second most populated country in the world with a population of over 800 million people. The predominant religion is Hinduism, although Islam, Christianity, Sikhism, Buddhism and Jainism are also widely practised. The country is primarily dependent on an agrarian economy and 70% of the people live in villages. Over the last few decades, however, this agrarian society has been moving toward urbanization and industrialization.

The vast subcontinent of India is divided into 32 States and Union territories. Among these are 7 large States with a population of over 50 million each, including Tamilnadu in the South with 58 million, and Uttar Pradesh in the North with 133 million. In 1981, as part of an administrative decentralisation process, the States were divided into 361 districts, each having a population of 1 to 2 million. These districts are further divided into smaller units called block samithis and village panchayats (see map in the Appendix).

## History of Mental Health Services

Indian culture, one of the most ancient in the world, exerted considerable influence over the Far East for centuries. Medicine occupied an important place among the physical sciences in

ancient India. The traditional system of medicine, Ayurveda, dates back to the 6th century B.C. Ayurveda (Ayur-life, Veda-knowledge) means the science of the knowledge and prolongation of life. According to Charaka, life is divided into 4 kinds — Sukha (happy), Dukha (unhappy), Hita (good) and Ahita (bad) and the objective of Ayurveda is to teach what is conducive to a healthy and long life (Venkoba, 1978). Ayurveda is subdivided into 8 specialties one of which is Bhuta Vidya which deals with psychiatry. Ayurveda recognised the importance of mental diseases when it classified the human maladies into 3 categories — exogenous, endogenous, and psychic. The doctrine of Tridosha (3 humors described as Vata, Pitta, and Kapha) plays a pivotal role in the consideration of etiology, pathology, diagnosis, and Ayurvedic therapeutics.

The Siddha system of medicine was indigenous to the old culture of the Tamils, who live in South India, and is still practiced by people of Tamil origin. The Unani and Graeco — Arab medicine was developed during the Arab civilization and is practised widely in the Indo-Pak subcontinent. It is interesting to note that traditional systems of medicine form a vital force in the delivery of health care in India. This comprises 70% of overall health care. The other 30% is provided by qualified physicians and general practitioners (Taylor, 1976).

Religious and superstitious beliefs exercised a strong influence in the daily lives of the people. Those who acted strangely by the standards of the day were thought to be afflicted with devils and demons. The remedies for such afflictions were in the form of ceremonies, rituals punishments, and sacrifices. Certain shrines, for instance, attained fame for the treatment of various mental disorders and continue to be popular today.

The advent of British rule in India, brought with it the early mental hospitals which primarily reflected the needs and demands of the European patients in India during that period. They were built with a view to protecting the community rather than caring for the insane (Sharma, 1984). However, marked changes were brought about by the Indian Lunacy Act of 1912 by which lunatic asylums were brought under central supervision. Even more significant was the recognition of specialists in psychiatry, who were appointed full-time officers. After India

attained Independence in 1947 the emphasis of the Government was more on the creation of psychiatric departments in general hospitals (GH) rather than mental hospitals. G.H. psychiatric care meant shorter hospitalization and a better involvement of the family members. The shift in emphasis from that of the mental hospital base to the general hospital setting, brought about a definite change in the care of the mentally ill.

The effect of stigma, as well as the large number of untreated mentally ill in the community, brought to the fore the importance of community intervention in the comprehensive care of the mentally ill. Keeping in mind the urgency of formulating a policy on mental health to improve the current mental health delivery system, the Government has drawn up the national mental health program (NMHP, 1982). This program aims at integrating mental health with primary care at a reasonable cost and also promotes healthy psychosocial development. The role of the voluntary sector, in this regard, assumes special significance.

### Sociocultural Correlates of Mental Health

A knowledge of the health care system that operates in India demands a certain understanding of the cultural practices and beliefs intrinsic to the Indian psyche. Indian culture tends to foster dependence right from birth akin to oriental cultures (Neki, 1976). The aged and the infirm are not abandoned but looked after by their families. However, the social change caused by exposure to Western norms and practices is bringing in an era of industrialization and modernization, which is having its impact on the Indian structure.

The concept of setting up homes for the care of sick people has not yet gathered momentum and the family continues to bear the brunt of caregiving. However, migration and the large number of women entering the work force because of economic necessity are likely to reduce the number of family caregivers. The conflict faced by the family is obvious, and does not augur well for the family's continued mental health.

Epidemiological studies estimate that 20 per 1000 of the population are affected by a severe mental illness (NMHP, 1982). Severe mental illness thus constitutes a major problem with around 16 million people suffering from these illnesses. Mental

retardation is estimated at 0.5–1.0% of all children. Alcohol and drug dependence rates, though still low as compared to the West, reveal a disturbing rising trend, particularly in the urban setting.

Psychiatric problems of the elderly especially in the large urban areas are assuming importance due to the weakening of the traditional family structure and social support systems. It is estimated that by 2000 A.D. persons aged 65 and over in India will total 53 million, which is 5.6% of the population (UN, 1986). The risk of dementia has also been found to be high in this population. It is interesting to note that life expectancy at birth has gone up from 38.7 years in 1955 to 55.4 years in 1985. Improved delivery of health care has undoubtedly contributed to a better quality of life. It is therefore ironic to note that India, while reaping the benefits of modernization, is also struggling to cope with its adverse effects.

### Current Mental Health Delivery System

Mental health care is largely provided by the government. It is grossly inadequate considering that there are 20 million people needing care and facilities have only 25,000 beds. Such a lack of public facilities has encouraged the growth of a large number of private nursing homes. As the government sector has severe financial constraints on account of other health priorities, the voluntary sector has initiated a few mental health care programs.

Psychiatric care is not covered by insurance or social security. However, most government centres provide care free of cost not only for inpatients and outpatients, but also for specialised services. Notable among these are programs for mental retardation, drug addiction, suicide prevention and psychogeriatric care. The three major providers of mental health care are institutions, aftercare services, and general hospital and community services.

### *Institutional Care*

Forty one mental hospitals with 20,000 beds offer institutional care for the severely mentally ill. Most states have at least

one such institution. Initially planned for long term custodial care, these centres provide special clinics and outpatient care. The ratio of mental hospital beds is .025 per 1000 population in India, which contrasts significantly with the United Kingdom which has between 2.9–3.0 beds per 1000. The availability of most beds gets blocked by long-stay patients and much of the mental health budget is spent on maintaining the infrastructure. Health planners therefore discourage further mushrooming of such centres.

### *Aftercare Options*

Few organised services exist for the rehabilitation of the mentally ill in India. The centrally supported institutes, such as National Institute of Mental Health & Neurosciences (NIMHANS), Bangalore and Central Institute of Psychiatry (CIP), Ranchi, have well organised industrial, occupational and recreational services. Apart from government agencies, a few voluntary organisations provide aftercare facilities for the mentally ill. The Schizophrenia Research Foundation (SCARF) established in Madras is a pioneering effort in this direction. Other institutions of a similar kind are Sanjeevini in Delhi and Abhaya in Trivandrum. These primarily deal with severe mental illness in contrast to those involved with addiction, alcohol and suicide prevention, and mental retardation.

The unfortunate fact is that most of these largely urban based agencies are poorly funded and are not able to fully address themselves to the issues involved in the rehabilitation of the mentally ill. Halfway homes, sheltered workshops, daycare centres, and child psychiatry units exist, though conglomerated in urban areas. As a result, rural areas suffer considerable neglect as they have large numbers of people in need of mental health care.

All welfare schemes of the disabled are coordinated by the Central and State Ministries of Social Welfare and Health. The physically disabled and the mentally retarded have been given high priority by the government and policies have been framed for long-term support to provide vocational rehabilitation and employment. Mental illness, however, has not been classified as a handicap. As a result, the mentally ill are not eligible for



welfare benefits. The absence of adequate care and benefits for the mentally ill is fast becoming a cause for much concern.

### *General Hospital Psychiatric Units*

The establishment of General Hospital Psychiatric units has led to a qualitative change in overall psychiatric care. Around 5,000 beds are available. These are largely in teaching hospitals attached to the 67 medical colleges. Efforts have been made to start such units in the remaining medical colleges. Both major and minor psychiatric morbidity is dealt with in these settings and their establishment has led to a larger clientele seeking help.

### *Outpatient and Emergency Services*

Much of the minor psychiatric morbidity is contained by the Medical and Casualty Clinics of the hospitals in towns and districts. Cases unmanageable by several practitioners, indigenous therapists, faith healers, teachers, and key informants are referred to such treatment units. Patients with psychoses, dementia, mental retardation, drug and alcohol problems, neuropsychiatric disorders, and psychosomatic illnesses are provided care. The emergency services treat acutely excited patients. Often clients in a subacute delirious state or postfebrile confusion are referred to these centres. Attempted suicide forms a large category of referrals needing resuscitation and crisis intervention.

### *Staffing Patterns*

*Within state differences.* The staff in an institution or a general hospital psychiatric unit is comprised of psychiatrists, clinical psychologists, social workers, nurses, and trained attendants. The number varies according to the size, capacity and roles of the treatment setting. For example, the Tezpur Mental Hospital in Assam, has only 1 psychiatrist and no other mental health professionals to look after 1000 inpatients. In contrast, the Mental Hospital in Madras, Tamilnadu State has 28 psychiatrists, 24 social workers and 4 clinical psychologists and 200 ward attendants to cater to 1800 inpatients and outpatient and special clinics.

*Centre-state differences.* A similar disparity exists between centrally sponsored institutions such as National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore, Central Institute of Psychiatry (CIP), Ranchi, and state hospitals. While the central organizations are well funded and staffed, the others are inadequately supported. Latest estimates on all mental health services place the number of psychiatrists in India around 2,000, clinical psychologists around 600, and social workers around 1,000.

*City-district differences.* The Districts which have a population of 2 or more million have the administrative capability and the infrastructural support to cater to clients from a large number of towns and villages. However a few districts have psychiatric units functioning with one psychiatrist and no other members of the mental health team. Efforts have been made to strengthen the District or Block level hospital psychiatric units from which outreach programs can be extended into the community. No psychiatric staff are available beyond the district setting.

*District-primary health center differences.* The Primary Health Center (PHCs), with its subhealth centres are the most peripheral health posts catering to a few villages. Recently a few PHCs have been upgraded to form the Community Health Centres (CHC) to look after 100,000 people. Each PHC looks after 30,000 people and has a staff of 2 doctors, 1 pharmacist and 1 auxiliary nurse supervisor. The Subhealth Centre (SHC) looks after 5,000 people in a group of villages called collectively the 'Panchayat'. The SHC has a Multipurpose Health Worker (MPW) who is a person with school education and an 18 month midwifery in service training.

No mental health care is available beyond the districts, and it is in the villages that most Indians live.

### *Treatment Modalities*

Facilities for Electro-Convulsive therapy (ECT) and pharmacotherapy exist on a pattern similar to western countries. The dosage requirement of neuroleptics is, however, much lower. ECT is known to provide quick results with judicious use.

Among the psychosocial therapies, family therapy has been found to be most relevant and useful in India. Behaviour

therapy is beneficial particularly in neuroses and psychosomatic disorders. Psychoanalytic therapy has not taken root in India, due to concepts alien to the culture, the high cost factor, and reluctance on the part of clients and families to seek this mode of treatment. Yoga as an adjunct to these therapies has enhanced mental health and contributed to a reduction of psychosocial stress thereby improving the general adaptations of the individual.

### *Yoga Therapy*

The word Yoga derived from the sanskrit word Yuj is used to connote the "Yoking of all the powers of the body, mind and soul to God" and facilitates a person practising it to function at the peak of his potential and harmony in his everyday transactions. Patanjali, one of the foremost exponents of Yoga, defined it as Chitta Vritti Nirodha. Chitta is the mind constantly bridled with thoughts, emotions and ideas, all of which cause a turmoil or whirlpool (Vritti) within it. Nirodha signifies control or restraint. The essential purpose of Yoga is therefore to control the mind, maintaining it in a state of tranquility and peace. To many Indians, Yoga is a way of life and not merely a form of treatment.

Consisting as it does of 8 steps, it encompasses physical, mental and social behaviour. Yama and Niyama are comprised of abstentions of the mind; Asanas, the adoption of right posture; Pranayama the right breathing, the Dhyana, meditation. Yoga and meditation as a form of psychotherapy have been stressed by several workers. Its utility in anxiety states, depression, and other forms of neurotic and psychosomatic disorders has been established. It has also been used for treatment of insomnia, to increase productivity in industry, and learning abilities in children.

Psychotherapy and group therapy are mostly supportive and didactic in nature. This is effective and pragmatic considering that in a day, 2 or 3 psychiatrists/social workers have to manage an out-patient clinic. For instance, a general hospital psychiatric setting, such as the one in Madras, manages 100 continuing and 15-29 new clients every day. They are managed by a staff of 2 or 3 psychiatrists/social workers.

### *Community Services*

Services for the community have been initiated by both the government and voluntary sector, particularly after the national mental health program (NMHP) was drawn up in 1981. The main objective of NMHP is to provide basic mental health care at the grassroots level, apart from ensuring availability and accessibility of services to the most vulnerable and underprivileged sections. The specific approaches involve diffusing mental health skills to the peripheral health service system, territorial distribution of resources, and integration of mental health care with general health services. Pilot studies linking mental health with community development have been initiated by NIMHANS in Bangalore through district mental health training programs in Bellary in Karnataka state. Similar tasks have been taken up in Goa, West Bengal and Rajasthan.

Voluntary agencies such as SCARF, Madras, have implemented community based rehabilitation as part of NMHP in the district of Chinglepet in Tamilnadu. The guidelines offered to the ministry suggest that service programs be located in the community. Vocational-rehabilitation, public education programs, and training of health workers to identify disability and provide care have been found to be beneficial.

### **Current Issues and Future Trends**

#### *Funding and Relationship to the Health Care System*

The oft repeated statements of the government justifying poor funding for mental health is changing after a Charter for Health Development has been agreed upon with the World Health Organization. Mental health is expected to form a part of the overall health development program. There is the likelihood of a reordering of priorities in the 8th Five Year Plan (1990–1995). However India will not be in a position to spend 5% of the Gross National Product (GNP) on Health, as suggested by the Health for all by 2000 agenda. The percentage of GNP currently available for health is around 2%. Only a small proportion of this amount is available for mental health — and that is taken by large institutions and mental hospitals.

The 7th Five Year Plan of India (1985–1990) has allotted 10 million rupees for NMHP and the amount would be raised three times during the 8th Five Year Plan. It is expected that there would be a shift from curative to preventive, urban to rural and privileged to less privileged groups. Although NMHP is a major movement, the basic flaws are variations between urban and rural facilities, distorted priorities, and neglect of the governmental sector.

### *Privatization*

Privatization of psychiatric care in organised settings has not taken root in India, as has been the case in the U.S. The majority of the patients consult private psychiatrists for a fee and are at times admitted to nursing homes which are not strictly psychiatric units. With a change in the Mental Health Act of India more nursing homes are likely to function.

A few institutions in cities offer custodial care to the mentally handicapped. But this is done without governmental support. The laws pertaining to mental illness continue to be restrictive. Most industries and organised sectors prefer not to have psychiatric units, but recently some public and private sector undertakings are beginning to provide psychiatric care.

These enterprises have actually taken up provision of mental health care for their employees and families. Large organizations like Tata steel, Indian Airlines, Port Trusts and others, provide for reimbursement of medical expenses of their employees. To some privatization means poor service provided at high cost. The Government however, does not link with private, profit-making agencies. Exploitation, corruption, and competition for profits are some of the factors that restrict the growth of private nursing homes.

While the cost of psychiatric care has increased, no provision exists in the insurance industry to provide benefits. Persons with a psychiatric breakdown cannot claim insurance if labelled psychiatric, and often take refuge in a medical diagnosis covered by insurance policies.

Privatization has also brought about growth in health care through support from international agencies such as United States Aid for International Development (USAID), Canadian

International Development Agency (CIDA), Swedish International Development Agency (SIDA), Norwegian Aid for Development (NORAD), Danish International Development Agency (DANIDA) and others. These are some of the leading health promotion agencies that offer financial support for priorities set up by the government of India. Unfortunately, none of the agencies has taken up programs in mental health, because they are of low priority. Recently some support has emerged for mentally handicapped children.

### *Issues of Service Delivery*

*Deinstitutionalisation.* Unlike the West, deinstitutionalisation has not been a major problem in India. It is noninstitutionalisation which is of grave concern. As indicated earlier, several million people need hospitalisation but facilities are not available. Hence these patients are kept in the backyards of homes, or cared for by the local people. Family support is fairly adequate or at least it seems so for want of other options. But such a situation will not last long, as the caregivers are under extreme duress and family structure too is changing from a joint to a nuclear type. Despite the fairly integrated family set up, a large number of chronic mentally ill remain without homes, treatment or community supports.

Efforts are being made to offer shelter through outreach programs and community homes (both traditional and permanent). Cooperative enterprises between a social service agency (e.g., SCARF) and a church or temple affiliated organisation are also being planned in some parts of the country. A range of settings needs to be established to provide hostels, halfway homes, fostercare and partial hospitalization.

*Homelessness.* A homeless individual, according to the Alcoholism, Drug Abuse and Mental Health Administration (ADAMHA), is one who lacks shelter, resources and community ties (ADAMHA 1983). The increasing problem of homelessness among the CMI in the U.S. is due to deficits in service delivery, rapid discharge of mental hospital patients, and lack of alternative strategies in providing shelter (Bachrach, 1987). The homeless, mentally ill also constitute a major problem in India. It is not clear as to what proportion of the homeless in India are

mentally ill. Millions of normal but socially handicapped people sleep in the open air and in the streets for want of shelter. A vast proportion live in subhuman conditions in huts, tenements and slums. Therefore, the mentally ill among them have not drawn the attention of planners of mental health workers.

A detailed study is required to differentiate the mentally ill and the socially disadvantaged within the category of homelessness. While in the West, the cause of homelessness is mainly due to deinstitutionalisation, the problem in India is one of noninstitutionalisation. The ministries of Housing and urban Development, Health and Social Welfare need to assess the extent of problem and make provisions for their shelter.

### Future Trends

#### *Integrating Mental Health in Primary Care*

The most effective way mental health care can reach the vast numbers living in the villages is by providing mental health training in the PHC setting. This has been started by several governmental and nongovernmental agencies and it is expected that high priority will be given by the health planners through the NMHP. The district hospital should be a nodal point for the referral of more acute mentally ill. In some states such as Kerala, Tamilnadu, and Maharashtra, a full fledged psychiatric service is available in most districts and this is an encouraging trend. Social workers, public health nurses and trained multi-purpose health workers are able to actively supplement psychiatric services in the community by helping in detection of mental illnesses and distribution of basic drugs.

#### *Mental Health in Medical Curriculum*

The current medical curriculum has meager provisions for the teaching and training of psychiatry to undergraduate students. This is indeed a glaring lapse in that much of the mental health care is provided by general practitioners and primary care physicians rather than by the psychiatrists. Recommendations to incorporate behavioural aspects of the illness in the

curriculum have been submitted to the Indian Medical Council and it is hoped that psychiatry will soon be recognised as a definite branch of study for undergraduates.

### *Social Security and Insurance Schemes*

Social security and insurance schemes which are the norm in the West have not really caught on in India. Although there are insurance schemes which cover various medical disorders, a psychiatric illness is not one of them. A psychiatric diagnosis is enough to bar an individual from any benefit, be it monetary or employment. While the physically disabled and handicapped receive a measure of welfare benefits, only recently have there been a few job reservations for those with mental retardation. This is a major change brought about by the Welfare Ministry and there is a possibility that disability caused by chronic mental illnesses will soon be recognised as a handicap. It is hoped that certain concessions will be given to the families of the mentally ill in availing treatment at low cost. This trend promises much hope to the families who are burdened by the strain of providing care to those afflicted with disorders such as schizophrenia and dementia.

### *Aftercare Services*

Although medical intervention and provision of acute care is well planned out, the need for rehabilitation and aftercare of the mentally ill, is, as yet, inadequate. Aftercare services in the form of sheltered workshops, cooperative enterprises and halfway homes would go a long way in enhancing the quality of mental health care in India. Several psychosocial rehabilitation models appropriate to both the urban and rural communities need to be planned, which would further augment mental health care in the community.

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Figure 1

*Distribution of state mental hospitals, central institutions, and voluntary organizations in India.*



#### Legend

- State Mental Hospitals
- ▲ Central Institutions
- ★ Voluntary Organizations



# Mental Health Services in Mexico\*

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*The history of mental health services in Mexico is traced from the time of the Spanish conquest to modern times. The present structure of mental health services is outlined as it relates to the overall social services and health care system in Mexico. Inpatient, aftercare, partial hospitalization, and outpatient service are outlined and described. Levels of service and distribution of facilities and staff by region are given. Methods of intervention are described from traditional healers, to highly specialized modern psychiatry, to innovative community self-management programs. Key issues in the future are financial resources, distribution of services and staff, and ways to optimally use human resources.*

Mexico had a population of over 79 million people in 1986. While the birth rate has declined from 44/1000 in 1970 to 27.3 in 1986 the population is still very young. Thirty-nine percent of the population is under the age of 15. The social class distribution is 55% in the subproletariat, which includes peasants and poor people in urban centers, 25% in the proletarian class, 18% in the middle class, and 2% in the privileged class (Lenero, 1982).

Epidemiological studies reveal that the incidence and prevalence of psychiatric illnesses do not differ substantially from those in other countries. Ten out of every 1000 people suffer some kind of psychosis and 12 out of 1000 are afflicted with some type of mental retardation (Calderón & Cabildo, 1970). The population in hospitals is composed of those suffering from developmental disorders, cerebral damage early or

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late in life, and psychotic disorders, primarily schizophrenia. The outpatient population consists of several types of neuroses and somatoform disorders (De La Fuente, 1989). The incidence of epilepsy is 18/1000. The more prevalent childhood pathological conditions are: attention deficit disorders with hyperactivity, developmental and conduct disorders (Escotto, 1983; Zimmerman, Baez, & Vargas, 1981b).

Substance abuse has been on the increase in Mexico. The rate of alcohol consumption in the population over 15 years old, expressed in terms of pure ethanol, increased from 4.7 liters per person per year in 1974 to 5.4 liters in 1984 (Soberón, Kumate & Laguna, 1989a). A recent survey showed that 4.3% of the population, between 12 and 65 years of age consumed one or more drugs and that active consumers make up 0.8% of the population. The highest percentage of active drug users was found in young males between the ages of 12 and 34. In this age group 7.9% have used drugs at least once and 1.7% are active users. Specific drugs dependency percentages in the population at large are: Marihuana 2.5%, tranquilizers 1.71% solvents 0.65%, cocaine 0.28%, and heroin 0.09% (Medina-More, Tapia & Sepúlveda, 1989).

Mexico has had epidemiological patterns similar to those identified with developing countries, but in recent years those patterns prevalent in developed nations are also occurring. Mexico had a death rate in 1983 of 554/100,000 inhabitants. It has significant environmental health problems ranging from the lack of proper sewage disposal to pollution by toxic waste. The national and international economic crisis of recent years has worsened adding to the stress on individuals, families, and the health care system. For example between the years of 1981 and 1986 the purchasing power of minimum wages dropped 37% (Anuario Estadístico, 1986).

Mexico, as most of the world, is faced with difficult challenges and situation creating a high level of stress contributing to the appearance of dysfunctional behaviors such as anxiety disorders, depression, and psychological factors affecting the physical condition. These stressors may be as concrete as malnutrition, famine, drought, or high rates of mortality, and social factors such as crowding, lack of education, unemployment,

underemployment, and migration from rural areas to urban areas. These conditions foster aggressiveness, alcoholism, delinquency, drug addition, and prostitution. All of these factors affect the social and functional unity of the family.

### History of Mental Health Services in Mexico

The prehispanic cultures of Mexico considered that certain phenomena, which today we classify as psychopathology, were caused by divine influences. Treatment services were therefore focused on calming down the ire of the Gods. Special priests intervened with religious procedures to re-establish lost equilibrium (Somolinos 1976). Descriptions of pre-Columbian medical practices can be found in the following documents from the sixteenth century: *Codice Badiano* (De La Cruz, 1964), *Historia General de las Cosas de la Nueva Espana* (Sahagún, 1569–1582) and the *Codice Mendoza* (1938). Additional sources are to be found in the works of protomedic Francisco Hernández (1946) and Morley (1961), where we find a description of psychopathology in the Mayan culture. In the works of Lopez-Austin (1971) and Martinez Cortes (1965) descriptions of psychopathology in the Nahuatl culture can be found.

Shortly after the Spanish conquest in 1566, the first psychiatric hospital of America was established. The friars of the Hipolito Order were entrusted with the care of older and mentally afflicted people. In 1602 the Juaninos Order took on the responsibility of caring for the destitute, many of whom were mentally ill. The Hospital of San Hipolito and another founded by Jose Sayago in 1690 dedicated to the care of demented women, remained active until 1910 when they were replaced by the "Manicomio General De La Castaneda (Insane Asylum of the "Castenneda"). This new hospital was built with all the latest technology available at that time, with a capacity of 1000. The facility soon became filled beyond capacity, however, and in the later part of its existence services deteriorated as it served over 3000 patients. Several other provincial psychiatric hospitals had been started in the 1800s as well as a few general hospitals with psychiatric units (Calderón, 1970).

In 1946 a psychiatric division of the Mexican Institute of Social Security (IMSS) was established. This period saw the

introduction of many new ideas. For the first time psychoanalytic teachings became important for many psychiatrists. Other developments included a rural hospital in 1944 with agricultural activities for the rehabilitation of the mentally ill and occupational and recreational therapy. In 1948 the first private general hospital (Hospita Espanol) began to offer psychiatric services and in 1954 the Universidad Iberoamericana established the first center for psychological service for a university community. This center became part of a training program for licensed psychologists teaching the methods of Carl Rogers (Lartigue, 1976). In 1955 the Faculty of Medicine of the National University of Mexico organized a Department of Medical Psychology, Psychiatry and Mental Health which provided services to students (De La Fuente, Díaz & Fouilloux, 1987).

Other developments of this period include the creation of the National System for the Family's Integral Development (DIF) in 1977, which grew out of the early Institute for the Protection of Infants, which had been founded in 1961. This period also saw the opening of 12 regional psychiatric hospitals and the closing of the deteriorated "Castenada" facility in 1965 (Calderón, 1970).

### Present Structure of Mental Health Services

The right to receive mental health services was raised to the institutional level in 1983 as an amendment to Article IV of the Constitution. The resulting General Health Protection Law (1984) created a national health care system designed to harmonize programs developed at the federal level with those developed by the states. Out of this initiative the Department of Public Health (Secretaria de Salud, SSA) developed a national health program which included thirteen top national priorities. The seven related to mental health are: medical attention, environmental health, social assistance, general health education, infant-maternal care, and programs against addiction. The importance and complexity of the alcoholism and addiction problems were considered so great that a National Council Against Alcoholism and a National Council Against Addiction were created (Soberón Kumate & Laguna, 1989a).

*Overview of Mental Health Services*

Mental health services are classified under three important headings in Mexico: (a) medical attention, (b) social assistance, and (c) social solidarity. Social solidarity refers to programs of joint responsibility, involving the people in marginal communities without health care services who work together with the government in order to generate needed services. The most important institutions providing medical services are: a special program of the Secretariat of Health and Public Assistance (SSA), a division of the Mexican Institute of Social Security (IMSS), the Institute of Social Security for State Employees (ISSSTE), The Federal District Department's medical services (DDF), the Army, the Navy, the Mexican Petroleum Corporation (PEMEX), and the Collective Transportation System. Social Assistance is carried out by a department of the Integral System for Family Development (DIF), the National Institute for Senior Citizens (INSEN), and the Juvenile Integration Centers (CIJ). Social solidarity services are provided through the IMSS-COPLAMAR program (Coordination for the Marginal Groups Plan).

The IMSS has a general plan for the provision of psychiatric and mental health services.

- (a) Preventive psychiatry. This consists of public health promotion services whose primary goals are to foster the self-help abilities of individuals, families and communities. Education materials are designed to provide information on the prevention of mental illness and knowledge about when professional services are needed and where they might receive mental health services.
- (b) Primary psychiatric treatment. This service is largely provided by family doctors properly qualified for this purpose. They diagnose and treat mild and moderate cases. In general family medicine clinics or in outpatient clinics of general hospitals, referrals are made to special psychiatric services when required.
- (c) Medical psychiatric referral network. This service connects psychiatric patients who have other illnesses to the specific medical services required and vice versa.



- (d) Short term psychiatric hospitalizations. This service is focused on remedial and rehabilitation interventions and is intended for patients who need only temporary hospitalization.
- (e) Services to the chronically mentally ill. This service cares for patients who require long-term hospitalization or custodial care. Special attention is given to after-care and prevention services and includes day, night and weekend partial hospitalization facilities, as well as preventive services to support the family and optimal use of community resources (Soberón, Kumate, & Laguna, 1989c)

### Psychiatric Hospitals

The World Health Organization has recommended a minimum of one psychiatric bed for each 10,000 inhabitants. In 1980, the Federal District and neighboring states' ratio was, one bed for every 5,453 inhabitants and in 1986 one bed for every 8,881 inhabitants. During the same period, the country's southeast had one bed for every 20,876 inhabitants, and the Zacatecas, San Luis Potosi, and Aguascalientes had one bed for every 55,315 residents (Soberón, Kumatu, & Laguna, 1989b). Under the SSA there are now 17 registered psychiatric hospitals in Mexico; three in the Federal District of Mexico City, five in the State of Mexico, and one each in the following states: Durango, Guanajuato, Hidalgo, Michoacan, Nuevo Leon, Oaxaca, Puebla, Sonora and Tabasco (Anuario Estadístico, 1986).

The Valley of Mexico (the Federal District and State of Mexico) contains almost half of the psychiatric hospitals under the Department of Health (SSA) and 63.1% of the psychiatric beds of the entire country (see Table 1). It also has 70.6% of the doctors and 76.4% of the paramedics. Of the 385 medical doctors, 147 are psychiatrists, 49.3% them work in the Federal District and 10.9% work in the State of Mexico. (Soberón et al., 1989b). Of the 25 psychologists working for the Department of Health, 15 work in the Federal District (Census of Human Resources, 1988).

Table 1

*Inventory of Beds, Medical Consultants Offices (MCO) and Human Resources of the Psychiatric Hospitals of the Department of Health in 1986*

Localities	Units	Beds	MCO	Human Resources				
				Total	Med	Paramed	Sick	Other
DF	3	1278	80	1076	157	54	400	465
Durango	1	110	4	84	7	2	27	48
Guanajuato	1	177	7	93	6	52	9	26
Midalgo	1	600	3	245	11	18	64	152
Mexico State	5	2054	59	1374	125	54	480	664
Michoacan	1	72	3	72	10	7	27	28
Nuevo Leon	1	120	5	130	12	10	74	34
Oaxaca	1	160	5	89	7	6	28	48
Puebla	1	474	13	236	20	9	95	112
Sonora	1	112	6	110	9	16	43	42
Tabasco	1	120	5	192	21	10	40	121
TOTAL	17	5277	190	3701	385	1368	1740	

*Note.* From *Anuario Estadístico*, 1986, pp. 329–345.

A number of other psychiatric hospitals and units work in coordination with the Department of Health, some of these are operated by the Mexican Institute of Social Security. The Mexican Institute of Psychiatry and the National Institute of Neurology and Neurosurgery as well has the hospitals connected with ISSTE, the Army, the Navy, PEMEX, and the Collective Transportation System, all have psychiatric units and can supplement the service to other government facilities and private hospitals.

### *Methods of Treatment*

The main treatment approach in the psychiatric hospitals under the Department of Health is pharmacological with parallel assistance in behavioral, occupational, and recreational therapy based on a behavioral contingency management system

using a token economy. It is also common, however, for electroconvulsive therapy and insulin shock to be used as treatment.

The Juan N. Navarro Hospital provides special services for children and adolescents. In addition to pharmacotherapy and psychotherapy, treatments include special education, therapy of mothers, group psychotherapy, speech therapy and recreational therapy (Macias & Verduzco, 1984).

In the hospitals under the Mexican Institute of Social Security, multi-modal therapies are used. Whether or not psychopharmacology is used, various techniques of behavior modification are applied. A variety of occupational therapy methods are used including recreation, cultural activities and other work activities. In these institutes group treatment is preferred over individual treatment and the family is provided with information and family therapy if it is needed.

In private hospitals psychotherapy is provided in addition to psychopharmacological treatment. Psychotherapy is available to individuals, groups and families. There are three therapeutic communities with a psychoanalytic orientation in Mexico, one is private and two are in government institutions.

Around 1971, some members of the Mexican Psychoanalytic Association (APM) established the first therapeutic community in the country, the "Mexico City Psychiatric Institute" which remained operative for five years. At a later date, 1978, the second therapeutic community was established by a psychoanalyst under the name of "Instituto Mendao". This institute provided services mainly for the upper class, and a with a strong emphasis on research activities (A. Mendizabal 1983; M. Mendizabal, 1985, 1989). There is a third existing community which has been active since 1986 called the "Psychiatric Regional Hospital" which is run by the IMSS system in the state of Nuevo Leon.

The "Mendao Therapeutic Community" trained the mental health professionals who later worked in the "Michocan Therapeutic Community" which is a public facility under the State Government; this hospital no longer works solely according to the psychodynamic model with which it started.

Although these facilities can cover a very small number of patients in relation to demand, they are the first therapeutic

communities with a more integral approach, where psychodynamic, family, social and occupational aspects are employed in order to return the patients to their communities with a better chance for success.

### *Aftercare Services*

The Federal District Department of Health provides four general hospitals, two specialized and three psychiatric hospitals. There are 118 general hospitals at the state level: 96 offering outpatient psychiatric consultation services and 5 providing beds for temporary hospitalization (De la Fuente, 1989). The other governmental institutions mentioned also offer services in their general, regional and specialized hospitals.

The Mexican Foundation for the Rehabilitation of Persons with Mental Disorders (which is affiliated with the Richmond Fellowship) provides some of the most outstanding work reintegrating patients back into their community. This is a private organization established in 1978, providing rehabilitation services in the "Jose Sayago National Hospital". This facility also runs a day care center and two half-way centers where mental health technicians are also trained. The Iberoamerican University and the Psychiatric Hospital of Orizaba's Voluntary Association, joined with this foundation in 1981 to establish a special rehabilitation program of the mentally ill with a special emphasis on conduct disorders. This program developed capable expert teams by integrating its own methodology with ecological, legal, familial, organizational, and social approaches. Unfortunately the State political climate failed to nurture this project further (Lartigue 1981; Lartigue and Blanco 1982).

### Outpatient Mental Health Services

The Department of Health provides health care services through 1751 health centers and 351 community health centers and 108 of these centers provide outpatient mental health services. A survey of the 28 center providing mental health services in the Valley of Mexico determined that 96% of the centers had departments of clinical psychology, 71% had departments of psychiatry and social work, and 46% provided educational

services. The greatest number of patients, 51%, were in the 6 to 12 age range (Zimmerman, Morales, Buendia, & Saad, 1981a). The mental health of children and adolescents is a high priority for the Department of Health.

The Mexican Institute of Social Security provides mental health services as part of its social security program. It makes available a team made up of one psychiatrist and one psychologist for every 150,000 insured members. Workers and employees are registered as members by law, paying a monthly quota in proportion to income, and the cost is shared with the employer and the government. In addition each general hospital counts on a minimum of one psychiatrist and one psychologist for each 372,500 insured persons. There are 65 psychiatric service units in such hospitals which can provide temporary hospitalization if needed (IMSS Instructivos 1987a, 1987b).

The National System for the Integral Development of the Family (DIF) has the mission of serving the least favored sectors of the population, like abandoned minors, the dispossessed, the elderly and the needy handicapped. It has under its charge 13 programs related to mental health, such as those concerned with social and family integration, services to preschool age children, fostering community development and social readaptation of juvenile delinquents and prevention of child abuse. The DIF has over 10,000 persons working directly in the community or in its 148 special units which include: 24 Rehabilitation and Special Education Centers, 23 Centers for Community Development, 22 Family Centers, 18 Centers of child Development, 13 Centers of Social and Urban Welfare, 7 Vacation Centers, 8 Rehabilitation Centers, 5 Mobile Units, two Temporary Shelters, a Community Health Service and the DIF National Institute for Mental Health, as well as other services such as foundling homes, shelters, and cultural and recreation centers (Soberón, Kumate, & Laguna, 1989d).

The National Institute of Mental Health (integrated in the DIF services) is the institution charged with designing, developing, and evaluating research programs in the mental health field focusing on four areas: psychiatry, neurology, pediatrics, and institutional support services. In psychiatry the project is directed toward mental health disorders of the underprivileged,

addiction, social maladjustment, community disasters, family and mental health epidemiological studies. The National Institute also offers external medical consultation to children and young people with learning difficulties, psychomotor retardation and convulsive disorders. The National Institute of Senior Citizens (Instituto Nacional de la Seneotud, INSEN) provides psychological and psychometric evaluation services, occupational therapy workshops, day-time residences and shelters (Soberón et al., 1989d).

There is a wide range of other institutions providing specialized services and doing advanced research, for example the National Institute of Nutritional Research, the Children's Hospital Federico Gomez, The National Institute of Neurology, the Mexican Institute of Psychiatry. Outpatient mental health services are also provided by the hospitals and health care systems serving special groups such as the Army, Navy, PEMEX, and Collective Transportation System.

Services are also available for mentally retarded people. The Center of Personal and Social Training (CAPIS) evaluates and trains this clientele for work placement in supervised settings. Individual and group treatment is provided for community functioning and the development of survival and work skills (Zacarias, 1983).

In 1973 a special program was started called IMSS-COPLAMAR (Coordination for the Marginal Groups Plan). It was developed with the purpose of providing social services to deeply deprived and isolated communities in rural and urban areas of the country. The program functions in 19 states and its infrastructure is comprised of 51 rural hospitals, 2,264 rural medical units, and 104 auxiliary medical units. It offers services to 10 million people who represent 64% of the deprived rural population.

The COPLAMAR program starts with the organization of the community and concludes with the achievement of self-managing health care. This program is targeted at problems resulting from poverty and underdevelopment. It functions with voluntary social workers that give support to families and the community, in order to develop self-help capacities. The alcoholism program is an example: in 1986, 22,730 cases of

alcoholism were detected, 5,437 were integrated into existing Alcoholics Anonymous Groups, and 807 new self-help groups were formed, making a total of 1974 operating groups (Soberón et al., 1989c).

### *Outpatient Service Methods*

In a study of the 28 health centers providing mental health services, it was found that 10 used the diagnostic classification system of the World Health Organization, four used a plan set up by the "Group for the Advancement of Psychiatry", two used a system of behavioral change classifications, and one applied the DSM-III. Six centers did not use any classification system and two did not specify. The treatment methods used by the health center were as follows: 67% relied on psychopharmacology, 48% on psychodynamic therapy, 44% behavior management methods, and 12% used other kinds of therapy. Only 36% of the centers in question gave treatments in the patient's environment, services such as orientation to the community and community prevention (Zimmerman, Baez, & Vargas, 1981b).

The Juvenile Integration Centers (CIJ) were merged into the Department of Health in 1982, in the social assistance subsector with the purpose of preventing drug addiction and to provide treatment and rehabilitation services. A primary goal of this program is to reintegrate the drug addict into the family and social nucleus. The principal method used is brief psychotherapy offered on an outpatient basis. In some cases the patient is hospitalized in detoxification clinics. Currently there are 39 local Centers, two hospitalization units and a service-by-phone operating 24 hours a day in the Federal District (Soberón et al., 1989d).

Information on the number of private mental health professionals is not available, though it is estimated that 20% of the total number of psychiatric hospital beds available are private. The methods used by psychotherapists, psychiatrists, and psychoanalysts are diverse. They include pharmacological treatments and psychotherapies ranging from classical psychoanalysis to expressive and supportive therapies with a psychoanalytic orientation. Other methods include: behavior therapy,

rational emotive therapy, biofeedback, body therapies, transactional analysis, gestalt therapy, transpersonal therapies, and bioenergetics. The treatment can be individual, couple, family, or group, and are usually moderate or long-term in duration.

"Folk medicine" has received little attention in the medical literature of Mexico, though it is an important recourse to people when facing suffering and disease. From the time of ancient Mexican history, there have been tribal leaders regarded as having outstanding intuition, intelligence, and overseer capacity. In the times of the Toltecs, these men of knowledge founded their lineages in order to transmit their particular way of creating a reality, from one generation to the next. These lineages survived the conquest and still exist today. They are scattered in the countryside and in the cities where they form very complex subcultures. These leaders are called "Chamancas", and are still advisors for the people that search for their guidance and relief. They consider themselves as defenders of the weak and the needy, informing of old traditions and representing a deep root in the pre-Hispanic culture. Their rituals, willpower, and optimism are used for healing the sick, forecasting the future, giving advice and relieving anxiety. (Grinberg, 1987)

### Current Issues and Future Perspectives

#### *Financial Resources*

Health care expenditures amounted to 8% of the federal government's budget in 1986. Of the funds available to the Department of Health (SSA), 14.4% was allocated for preventive care, 39.8% to curative care, and 26.7% to administrative expenses. Thus, administrative costs consumed twice the amount used for preventive health care. The budget available to the Institutos Nacionales de Salud (National Health Institutes) was 12.02% of the total health care expenditures (Anuario Estadístico 1986).

In the last few years both the total national budget and the specific budget for the Health Sector have been severely reduced due to the Mexican foreign debt problem. The financial resources available have provided for a 87% population coverage. Forty-nine percent of this fund has gone to the population covered by the social security system and 33% has been used



by those who are not covered but still depend on governmental health services. An additional 5% goes to private health care. Ten million Mexican citizens remain without permanent health care (Soberón et al., 1989a).

### *Mental Health Distribution and Staffing*

Mental Health services are still being concentrated in the Valley of Mexico even though the government has attempted to geographically decentralize the service system. The centralization of services has had a detrimental affect on the rest of the country.

The process of deinstitutionalization of psychiatric patients is a long term task and is far from completion. Ignorance, irrational fears and prejudices about mental illness are serious obstacles in the way of accomplishing this objective. Furthermore, the lack of a service infrastructure does not facilitate the organization of a mental health system which could help integrate psychiatric patients back into community and family life. Also needed are employment services able to train these former patients for productive and creative tasks.

Staff limitations also are a serious problem for the delivery of mental health services in Mexico. The country has only a total of 1,108 psychiatrists. This results in 1.5 specialists for every 100,000 persons; a number far from the 5 per 100,000 recommended by the World Health Organization. While the number of psychologists exceeds 10,000, very few work in psychiatric hospitals or health centers. Only 250 social workers are adequately trained in the field of mental health, and there are only 30 rehabilitation technicians in the entire country able to care for the mentally ill.

It is true that Mexico is a country still in a developing stage and therefore limited in available economic and technological resources. On the other hand, it has the experience of an enormous human potential even though it is not as yet aware of its capabilities. The society's developmental power was demonstrated through the acts of civil responsibility, principally in Mexico City, in the months following the 1986 earthquake. These acts were not only expressive of a solidarity from a fraternal point of view, they were effective from the perspective of the results

attained and their usefulness in the prevention of psychopathological disorders.

The adequate structuring of this creative potential is needed along with indispensable changes in the socio-political system that would make such structuring possible. This would provide a foundation for the improvement of mental health services in a country marked by many contrasts and cultural diversity.

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# Mental Health Services in Egypt

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*This paper begins with a historical perspective on mental health care from ancient Egypt to modern times. Current mental health services are described including epidemiological information, the structure of services, and methods of service delivery. Contrasts are made between urban and rural community care systems. The changing demographics of institutional care are analyzed in detail and future plans for psychiatric services are discussed. The recent development of comprehensive interdisciplinary model of service and the founding of a training center for this model is described.*

Mental hospitals have been providing care and treatment for the mentally ill for the last two centuries. With improved physical methods of treatment and a liberal social climate, treatment of the mentally ill has shifted toward community based services. The provision of mental health services in psychiatric units in general hospitals also emerged as an alternative for treatment of the acutely mentally ill.

It has been envisaged, somewhat over-enthusiastically, that mental hospitals would be eventually phased out and replaced by community based psychiatric services with general hospitals as centers for short-term treatment. Although rapid return to the community is beneficial to many patients, rigid adherence to this policy is neither wise nor clinically effective.

## History of Mental Health Services in Egypt

In Egypt three thousand years ago, Imhotep, minister of King Zoser, the builder of the Sakkara pyramid, was a well known physician who treated mental patients in general hospitals. This fact was discovered in the "Sleeping Temple" in Sakkara, south of Cairo (Okasha, 1978; Ghalioungui, 1963).

The first mental hospital in the world was built in Baghdad, Iraq in 705. This was followed by hospitals in Cairo (800

AD), Damascus (1270 AD), and Aleppo in Syria. At that time, mental patients were being burned, condemned and punished in Europe.

It is interesting to give a brief account of the 14th Century Kalawoun Hospital in Cairo. It had separate sections for surgery, ophthalmology, and medical and mental illnesses. Generous contributions by the wealthy of Cairo allowed a high standard of medical care and provided for patients during convalescence until they were gainfully occupied (Baashar, 1975). Two features are striking: the care of mental patients in a general hospital and the involvement of the community in the welfare of the patients, foreshadowed modern trends by six centuries.

In the beginning of the 19th century during the French occupation of Egypt, the director of medical services in the Egyptian Armed Forces, a French physician named Claude, approached the Egyptian ruler regarding the appalling state of mental patients in Cairo. At that time, all medical hospitals were under military auspices so mental patients in Cairo were transferred to a military hospital in the middle of the City (Al Azbakia). After a few years, they were transferred to an independent building not far away in Bolaque. In 1880, a great fire demolished one of the palaces of the prince except for a two-story building. This was painted yellow and became the first mental hospital in Cairo in the year 1883. It was called the Yellow Palace (El Saray El Safra). At that time it was situated in Abbassia a remote desert suburb of Cairo. Now it is in the middle of an expanded, overcrowded city and there are plans for the hospital's demolition. In 1912, another state mental hospital was built in Khanka. It occupied about 300 acres including a large plantation and was situated several kilometers north of Cairo. In 1967 a third mental hospital was established in Alexandria (Al Mamoura) and in 1979 another was founded in Helwan, a suburb south of Cairo.

Starting from 1949, outpatient facilities have been extended by central hospitals in almost all governorates of Egypt. There are thirteen medical schools in Egypt and each has a psychiatric unit with inpatient and outpatient psychiatric services. The largest mental hospital, Abbassia, is more than 100 years old and Khanka is about 80 years old. They are facing great difficulties regarding care, finances, treatment, and rehabilitation

while accommodating about 5,000 patients. The new policy of deinstitutionalization and provision of community care may reduce the number of hospitalized psychiatric patients but will not solve the problem (Okasha, 1988).

### Community Mental Health

In spite of the rapid social changes in Egypt, the majority, especially in rural areas, belong to the extended family hierarchy. It is disgraceful and shameful to care for an elderly demented away from family surroundings. The parents of retarded or hyperkinetic children feel a primary responsibility towards their children rather than having them looked after in an institution.

In rural areas, community care is implemented naturally without the need of health caretakers. Egyptians have a special tolerance to mental disorders and have the ability to assimilate chronic mental patients even to a sacred degree. These patients and those with mild mental retardation or borderline intelligence are rehabilitated daily by cultivating and planting the countryside along with and under supervision of family members.

Community care in the form of extending health services to hostels, day centres, rehabilitation centres, health visitors is only available in big cities. A good example in applying community care is in the prevention of drug abuse. There has been an increase in the abuse of heroin and other narcotics since the early 1980s. Mass media orientation, legislative acts, antinarcotic squad seizure of traffickers, initiation of centres all over Egypt and deployment of social workers, religious people, and politicians to orientate the masses about the hazards of drug abuse, have triggered an interest in psychiatry and mental disorders.

A lot of epidemiological work has initiated a radical change in mental health policy and programs. Although community care started in the sixties, active participation of the community exploded with the increase of drug abuse among youth.

The priorities for community health care services in Egypt are not for mental health, but rather for bilharziasis (schistosomiasis), birth control, infectious diseases in children, and recently, smoking and illicit drug abuse. The programs which are available for community care in big cities take the form of



outpatient clinics, hostels for elderly, institutions for the mentally retarded, centres for drug abuse, school and university mental health.

The new national health program will focus on decentralization of mental health care and community care in different governorates. Emphasis is made on recruiting mental health teams, especially psychiatric nurses, psychiatric social workers, occupational therapists, and clinical psychologists.

### Current Mental Health Services

The population of Egypt now is 56,000,000. There are about 100,000 doctors, one for each 560 citizens. There are about 500 psychiatrists which means one for each 200,000 citizens. There are about 7500 psychiatric beds, one bed for every 7000 citizens. The number of psychiatric beds in Egypt is less than 10% of the total hospital beds.

There are three mental hospitals in Cairo accommodating approximately 5600 patients, one in Alexandria, one in Dakahlia, one in Asyout. Psychiatric beds are also available in general and private hospitals.

Table 1

*Number of Beds in Psychiatric Hospitals*

<i>Cairo</i>	
Abbassia	2500
Khanka	2500
Helwan	600
<i>Alexandria</i>	
Mamoura	650
<i>Dakahlia</i>	
Harbit	50
<i>Asyout</i>	
In general hospitals	250
In private hospitals	800
TOTAL	7500

Egypt is divided into 24 governorates, 19 with psychiatric clinics and outpatient units and 5 with no psychiatric services, namely Matrouh, Red Sea, New Valley, and North and South Sinae.

In Egypt, there are about 250 clinical psychologists but hundreds of general psychologists are working in fields unrelated to the mental health services. There are many social workers practising in all psychiatric facilities, but unfortunately they are general social workers who have minimal graduate training in psychiatric social work. There was an attempt to educate psychiatric social workers at the Institute of Social Services in Cairo in 1960. It lasted only for two years due to a shortage of students.

There are four High Institutes of Nursing equivalent to medical schools and they graduate highly qualified psychiatric nurses. Unfortunately, the majority leave the country to work in the petrodollar Arabian Gulf States with their incomparable salaries. The majority of nurses working in mental health facilities are general nurses with minimal psychiatric training. Nursing Schools graduate psychiatric nurses but in insufficient numbers to cover psychiatric services.

Traditional and religious healers play a major role in primary psychiatric care in Egypt. They deal with minor neurotic, psychosomatic, and transitory psychotic states using religious and group psychotherapies, suggestion, and devices such as emulets and incantations (Okasha, 1966). In one study (Okasha, 1968), it was estimated that 60% of outpatients at the university clinic in Cairo serving low socioeconomic classes have been to traditional healers before coming to the psychiatrist. The after-care services in Egypt are still limited. This is due to the poor orientation of the masses to the need for follow-up care after initial improvement.

### Deinstitutionalization

Dehospitalization or deinstitutionalization can be achieved in several ways: (a) preventing or postponing admission to mental hospitals and referring to intensive nonresidential care or extramural hospitals (b); admitting to psychiatric wards in general hospitals; (c) shortening the hospital stay; (d) discharging long-stay patients to nonresidential care; and, (e) separating different

types of psychiatric units, i.e., units for mental retardation, dementia, addiction.

In order to evaluate the deinstitutionalization policy, the following questions are important to answer.

(a) Reducing the size of mental hospitals is often considered an important goal of deinstitutionalization. Have the size of hospitals been reduced in Egypt? If the number of inpatients is accepted as the indicator of the size of an institution, then indeed there is a slight decrease in the size for the largest mental hospitals in Egypt.

(b) Do mental hospitals show a reduction in inpatients and inpatient days? There has been a gradual decrease in the inpatient population of general mental hospitals accompanied by a decline in the annual inpatient days. We do not know which sections of the general mental hospitals were less utilized: the units for medium or long-stay patients, or the units for subspecialties such as psychogeriatrics and the mentally retarded patients. It seems that turnover occurs among those who stay less than one year.

(c) Has there been a decline in the length of stay of patients in mental hospitals? One possible explanation for the decrease in the annual number of inpatient days could be found in fewer admissions to and shorter stays in mental hospitals. Indeed the duration of treatment in mental hospitals has become shorter. About 30% of patients admitted to mental hospitals between 1980 and 1988 had been discharged within 6 to 12 months, a decrease from earlier decades. The trend in the 1980s was towards an increase in the percentage of stays from 1 to 5 years, but a decrease in long term hospitalization of more than 5 years (see Table 2).

d) Are psychiatric wards in general hospitals having an influence in reducing or preventing admission to mental hospitals? There are no signs that the psychiatric wards in general hospitals are helping to prevent more admissions to mental hospitals. Still the psychiatric wards in general hospitals do have a central function in the short-stay treatment of psychiatric patients.

Table 2

*The Percentage of Inpatients According to Their Length of Stay in the Hospital from 1980 to 1988*

Year	Less than 6 months	6-12 months	1-5 years	6-10 years	10-20 years	20 years
1980	23.9	5.9	30.8	12.5	14.3	12.6
1981	24.3	5.8	31.2	12.3	14.4	12.0
1982	24.1	6.9	30.9	12.4	14.2	11.5
1983	22.3	6.8	35.7	12.1	10.3	12.6
1984	22.8	7.1	32.0	11.6	14.1	12.4
1985	23.2	6.9	35.4	11.8	11.2	11.5
1986	22.7	6.5	36.1	11.7	11.6	11.4
1987	23.1	7.1	35.3	11.4	11.7	11.4
1988	23.5	6.7	36.0	11.0	11.4	11.3

The task of psychiatric wards in general hospitals and mental hospitals is to serve patients who are severely disturbed. Many patients and their families prefer to contact psychiatric wards of general hospitals for the clinical treatment of a first episode because of a shorter travelling distance and less stigmatization. There are some differences in the population of these two types of institutions. In general, patients in the psychiatric wards are young females with more years of schooling. There are also significant differences in respect to psychiatric diagnosis. The mental hospitals having 79% of their patients with a diagnosis in the schizophrenic spectrum, where as with the psychiatric wards 25% are diagnosed with schizophrenia. In the psychiatric wards 54% percent are affective disorders or anxiety disorders (see Table 3).

e) Is the expression "revolving door psychiatry" correct in view of admission and discharge rates? The characteristics of patients admitted to mental hospitals also have changed. There are more young, married and divorced patients with affective disorders, anxiety disorders, substance abuse, and personality disorders. There has been a change in the age distribution with an increase in the 20 to 40 years of age category and a decrease in the 45 to 64 years of age category. The proportion of the elderly patients admitted has remained relatively

constant. This reflects the admission and discharge policy of mental hospitals.

Table 3

*Diagnosis by Type of Hospital*

	State MH %	General MH %	Private MH%
Schizophrenic spectrum	79	25	43
Major affective disorders:			
Depression	5	28	17
Mania	4	13	12
Anorexia Nervosa	1	3	2
Anxiety disorders	—	13	—
Mental subnormality	2	—	—
Organic mental disorders	1	—	—
Substance abuse	7	3	12
Conversion dissociative disorders	1	6	4
Borderline personality disorders	—	2	2
Complication of psychotropics	—	3	2

Readmission figures document the results of admission and discharge of patients during symptomatic change. Patients are discharged with encapsulated delusions, cognitive deficits, and social handicaps. In different studies, it has been found that discharged schizophrenics have residual dysfunctions as follows: 15% delusions and hallucinations, 30% negative symptoms (adaptive behavioral or attitude problems), and 70% neurotic symptoms especially depression. Research also shows that 60% of chronic inpatients have cognitive impairment as measured by organicity batteries (Okasha, 1988). Following this line of argument, the admitted, long-stay schizophrenic patients of the 1950s have become the most evident "revolving door" patients of the 1980s.

f) Is the number of new and old long-stay patients decreasing? In the 1970s, many patients stayed continuously longer than two years in the hospital and 40% stayed more than ten years. Now the picture has changed. Many inpatients who were in the

hospitals for ten years or more have left. Also, some have died and many who were mentally retarded have been transferred to more suitable institutions.

The number of long-stay patients is constantly decreasing but this group still dominates the picture in the mental hospital days of stay. Many of the younger chronic patients have been released. At the end of 1980, about a third of the long-stay males and half of the long-stay females were 60 years or older. Previously these proportions were remarkably smaller.

Differences of long-stay and short-stay patients were studied at one of the largest mental hospitals in Cairo (Okasha, 1988). The study showed demographic and socioeconomic data distinguishing short-term and long-term patients (see Table 4). Married patients were found more often among those with short-term hospitalization (53%), than among those with long-stay hospitalizations (26%). Long-term patients were significantly less educated and younger on admission. They recorded a significantly higher prevalence of disturbed home atmosphere and family history of psychiatric disorder. They tended to be of low socioeconomic status and they were more likely to be unemployed. The vast majority of both groups were admitted involuntary but patients with short-term hospitalization showed a significantly higher rate of voluntary admission. Also they

Table 4

*Psychodemographic Data*

	Short Stay	Long Stay
Social Status	more married	more single
Employment	more employed	more unemployed
Education	more educated	more illiterate
Family atmosphere	more stable	more disturbed
Family history of psychiatric disorder	rare	more common
Voluntary admission	more frequent	less frequent
Previous admissions	frequent	rare
More visits/month	common	less frequent

had a significantly fewer number of previous psychiatric admissions.

The Okasha (1988) study also revealed differences in length of stay as affected by diagnosis (see Table 5). Patients of short-term hospitalization were more frequently diagnosed as paranoid (39%), disorganized (35%), and catatonic (12%). The patients with long-term hospitalization were labelled residual (29%) and undifferentiated subtypes (13%) according to DSM-III criteria.

Table 5

*Diagnosis by Length of Stay*

DSM-III	Short Stay	Long Stay
Disorganized	35	24
Catatonic	12	8
Paranoid	39	26
Undifferentiated	8	13
Residual	6	29
TOTAL	100	100

In a recent study comparing emergency and urgent admissions in state hospitals, general hospitals and private hospitals in Egypt, differences were found in the male/female distribution and also in the diagnostic pattern.

In all types of hospitals, schizophrenic spectrum showed the highest incidence. The major affective disorders and the anxiety disorders showed more admissions in the general hospitals, while substance abuse was evident in more of the private hospital admissions.

From these studies we can see that the necessity for the presence of mental hospitals is established. There is no doubt that a number of our patients will need a long-stay hospitalization. There are some characteristics in the psychodemographic data and in the subtypes and diagnostic categories of the psychiatric disorders that are associated with a prolonged stay in hospitals.

It would seem that this revolving door policy in psychiatry is not very successful because patients are discharged while they are still symptomatic so they drift onto the streets until they

commit some petty crime and then they are readmitted only to be discharged again onto the streets. We always speak about extramural services and community care but from my experience, whether in developed countries or developing ones, the community is not yet prepared to assimilate ex-mental patients or patients with residual symptoms.

It is well known that after an episode of schizophrenia, (sometimes an affective disorder) not less than 30% to 40% will be functioning at a lower level than prior to the episode. The more relapses they have, the more likelihood of handicap and incapacity. Thus, in more rapidly releasing patients from institutional care, we are putting a burden on families and the community services for people who are handicapped. We are asking the patients to resocialize themselves knowing that many of them have actual structural and morphological changes in their brains.

It is likely that mental hospitals will persist and will outlive their obituaries but with a lesser capacity and wider distribution throughout different parts of the country. They will accommodate patients because the community is unable to provide adequate services for them. They will be in need of not only medical treatment, but also rehabilitation and work therapy. This can be provided by psychiatric social workers, clinical psychologists and auxiliary psychiatric medical staff while short-term and emergency cases will require the experience of the medical profession, specifically the psychiatrists.

#### Future Trends

The future policy of psychiatric services in Egypt is to build medium-stay hospitals of 600 beds which will serve three neighboring governorates and short-stay hospitals of one hundred beds. At the time, there will be psychiatric wards in all general hospitals accommodating between 10 to 20 patients. The recommended ratio of psychiatry beds to medical beds is 1:10. The encouragement of intensive psychiatric outpatient treatment in all general hospitals is proposed. It is hoped that the era of deinstitutionalization and extramuralization will be put into perspective and we should be well aware of the burden the community is asked to tolerate.



The mental health program for the next ten years will provide a long-stay hospital of 150 to 200 beds in every governorate with outpatient day centre and short-stay beds for acute cases. It is envisaged that outpatient services should include an intensive role of the psychiatric social worker and the clinical psychologists, psychiatric health visitors and active participation of the psychiatric nurses.

The Egyptian program will focus on recruiting more personnel for the psychiatric team, namely, clinical psychologists, psychiatric social workers, occupational therapists, mental health visitors, and psychiatric nurses from the high institute of nursing and nursing schools. The training of these people is being given as much or more priority as is the training of psychiatrists.

In the summer of 1990 a model psychiatric centre, based on the psychiatric team concept, was opened at Ain Shams University as a prototype for other governorates in Egypt. The centre was initiated by charities and later financed by the government. It serves one hundred inpatients including sections for substance abuse, child psychiatry and geriatric psychiatry. The emphasis is outpatient services where one hundred patients can be examined daily. The involvement of psychiatric social workers, psychiatric nurses, and clinical psychologists with the psychiatrists in giving a comprehensive services to the patients will be an example for other centres. It has a liaisons with the high institute of nursing, nursing schools, faculties of social welfare, and psychology departments of universities to train their graduates in the multidisciplinary approach to psychiatric disorders. This centre emphasizes the fact that any psychiatric disorder is a psycho-socio-biological entity and unless the patient is approached in the history taking, aetiology and management with these three dimensions taken in consideration, the approach will be faulty.

The media coverage given to this model program has initiated a widespread tendency for pioneers to start projects or centres based mainly on charities. In developing countries, the state cannot afford by itself to finance mental health programs and give them the same priority as other health problems.

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# Mental health Policy and Programs in Israel: Trends and Problems of a Developing System\*

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*Israel has an ancient history blended together with a relatively brief independent identity. An introductory section provides a backdrop for understanding mental health policies and programs in the context of the cultural and historical background of Israel's people. The second section portrays the nature of the mental health delivery system. The final section focuses on three interrelated issues: the limited development of community mental health services, the dominance of the mental hospital in the provision of mental health services, and the medicalization of mental health services.*

Israel mental health policy and services reflect the country and the people they serve. Although Israel gained its independence only forty years ago, it is a state of people with an ancient history. Understanding the current problems and continuing issues of the country's mental health services cannot be done without taking into account the political and social conditions of the country as well as the historical and cultural background of its people.

There are about 7000 patients hospitalized in 38 psychiatric inpatient facilities in the country. More than 11,000 admissions per year have been reported by these facilities. Mentally ill people occupy more than one-fourth of the total number of inpatient beds in the country (Central Bureau of Statistics, 1989; Israel Ministry of Finance, 1989). An estimated 650,000 psychiatric patient care contacts take place each year in about 60

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outpatient mental health services (Mental Health Services, 1986; Siegel et al., 1989; Ministry of Health, 1989). There are about 90 other mental health services in the community, such as day care units, social clubs, sheltered housing and rehabilitation services (Popper & Rahav, 1984; Ministry of Health, 1989). Mental health services are allocated a substantial part of the state's health budget. Although mental health services have not been at the top priority list of public agenda, these services and the condition of the mentally ill have drawn public attention. The disability and vulnerability of the mentally ill and the quality of services provided for them have been, from time to time, a cause for public concern.

The purpose of this paper is to describe the mental health policies and programs of Israel and to analyze the major issues they face in light of the current problems of the country, its history and the cultural background of its people. Some of the problems of the mental health service delivery system stem from organizational and financial difficulties, while others reflect deeply embedded structural factors.

The paper has three major parts: I. Introduction, II. Israel Mental Health Delivery System, and III. Current Issues and Continuing Problems. The Introduction includes a short description of the country and its people, and a brief history of mental health policies and services. The second part which focuses on describing the mental health service delivery system starts with a discussion of epidemiological data revealing recent trends in mental health services. It follows with analyses of institutional care, community services and psychiatric rehabilitation programs. This part is concluded by a section on budgetary and personnel issues and touches upon disability and income maintenance legislation and programs pertinent to mentally ill persons. Finally, in the third part of this paper, three interrelated issues of the mental health system will be addressed: the limited development of community mental health services, the dominance of the mental hospital in the provision and administration of mental health services in the country, and the medicalization of mental health services.

## I. Introduction

### *The Country*

Israel is a small country located at the eastern end of the Mediterranean Sea. It was founded in 1948 as a homeland for Jews from all parts of the world. Israel is small, about the size of the state of New Jersey. Its current population is about 4.5 million people, 82% of whom are Jews and 18% are mostly Arabs. The Jews, many of whom emigrated to the country after its establishment, represent heterogeneous ethnic groups. The population is younger than those of Western European countries and the United States. Thirty percent are under 17 and 8.8% over 65. The majority of the population, about 90%, are city dwellers. Israel is a democratic republic with a parliament-cabinet form of government.

By most economic and social indicators, Israel may be considered a relatively developed or developing country. The literacy rate is about 95%. It has a relatively high standard of living, with a per capita income level categorized as high, and similar to those in such countries as Spain, Singapore and Ireland (per capita GNP for 1990 is \$8615.). The country has a mixed economy, largely based on services and manufacturing industries.

Israel may also be characterized as a welfare state. It has quite an advanced system of social welfare insurance and services. The National Insurance Institute (NII) provides a broad range of benefits. These include old age and survivors' pensions, maternity benefits, family allowances, industrial injury benefits, unemployment compensation and disability benefits. The government also offers relief grants and an array of welfare and health services.

By most indicators used worldwide, Israel has well-developed health insurance and medical services. Ninety-six percent of the population is enrolled in one of several comprehensive health insurance plans, providing hospitalization and a wide range of other medical services. National expenditures on health constitute 7.4% of Israel's GNP. This proportion is higher than those for countries such as Denmark, England, and Japan. Health conditions in Israel are generally good. Life expectancy — 77.0 years for women and 73.6 years for men — is among the highest in the world, while infant mortality is among the

lowest. The ratio of physicians to population (1:340) and the number of specialists compare favorably with the most developed countries. The proportion of general hospital beds is 2.8 per 1000 of general population.

This introduction cannot be complete without mentioning two factors that shape the attitudes of the people in the country. Both are related to the very existence of Jews and the state of Israel. The common memory of the Holocaust, and the fact that since its establishment, Israel has been in a state of conflict with the Arab world, have a major effect on social and political life in Israel. The constant threat to the existence of the country and its people, intensified through several wars, has taken a toll on the social and emotional life of the people in Israel and created an enormous economic burden.

### *Brief History of Mental Health Services*

*Early developments.* Although the formal history of mental health services in Israel can only start from the time the state was established, the beginning of mental health services goes back more than 50 additional years. The first institution designated specifically for mentally disordered persons was established in 1895. Two compassionate women founded the "Ezrat-Nashim" shelter in Jerusalem. Medical care, when available, was provided by general practitioners. It was not until 1921, that a trained psychiatrist practiced in the country (Dagan, 1988; Hailprin, 1937).

At the time of independence, there were 1200 psychiatric beds in Israel. Only 200 of these beds were provided by the government. There were two government mental hospitals, two public<sup>2</sup> mental hospitals and two inpatient psychiatric units in general hospitals. About two-thirds of the psychiatric beds were provided by private, for profit hospitals. The rate of psychiatric beds for the country was 1.32 beds per 1000 persons in the general population (Miller, 1977).

Mental health services were considered a low priority among the organized Jewish community prior to the establishment of the state. The General Sick Fund (Kupat Holim), the medical insurance and health care program of the major labor union (similar to HMO in the U.S.), which covered about 80%

of the population, resisted for a long time to include mental illness under its coverage (Brill, 1974). This fact, as well as the circumstances associated with the war of independence and the waves of immigrants that came into the country immediately after its establishment, explain the inadequate level of mental health services in the early years of Israel's history.

Mental health services were far from being able to respond adequately to the new circumstances which resulted from hundreds of thousands of immigrants that poured into the new country. It seems that a disproportionate number of mentally ill arrived in the country with many other immigrant groups (Aviram & Shnit, 1981). In addition, mental health needs among the survivors of the Holocaust were believed to be enormous. Attitudes regarding mentally ill persons, which in the prestate era were rather intolerant (Hailprin, 1937; Aviram & Shnit, 1981), changed. The general public, as well as the government, were sensitive to the needs of, and felt a moral commitment to provide services to, the concentration camp survivors (Ramon, 1981).

The major efforts of the mental health services of the new state during their first decade were to provide more psychiatric beds in response to the increased demand for inpatient care. The government used old army camps, an ancient Ottoman castle and jail, or deserted Arab villages, and also built new facilities in an effort to meet the demand for institutional beds. The General Sick Fund of the General Federation of Labor opened its second mental hospital in 1949. In one decade the number of beds increased by more than 2.5 times. In 1958 the number of psychiatric beds in Israel was 4335. The rate of beds was 2.2 per 1000 population, an increase of about 70% over the rate that existed when the state was founded. Until 1963 the increase in the number of psychiatric beds was proportionately higher than the general increase in the population (Chesler-Gampel, 1970). This achievement is indeed impressive, especially in view of the tremendous increase of the general population of the country during this period.

During the first half of the 1950s another process that shaped the mental health services for years to come was taking place. This was the legislation of the Mental Health Act, which in 1955



replaced the antiquated and inadequate Ottoman law that was in effect since the 19th century. Although at the time mental health services in Israel already represented different types of treatment and care, the Legislature chose to enact a law which related exclusively to inpatient hospitalization. The orientation of the law was based on the medical model, providing physicians with broad discretionary power regarding mental hospitalization and commitment (Aviram & Shnit, 1981; Bazak, 1972, 1979; Shnit, 1982).

*Consolidation of the structure of mental health services.* During the 1960s, new mental health services were added, and the system was consolidated. The major increase in ambulatory mental health services occurred during the second half of the 1960s and the beginning of the 1970s. Between 1965 and 1977 the number of outpatient service units increased by 70%, from 37 to 63 units. The increase during the following decade was only 10% (Popper & Rahav, 1984).

The structure of mental health services as it exists today was already in place in the early sixties. Mental health services included special psychiatric hospitals, inpatient psychiatric units in general hospitals, outpatient clinics, child guidance clinics, day hospitals, transitional facilities, institutions for long term care, and some rehabilitation services.

During the 1970s several community mental health centers were established, a few drug rehabilitation services were opened, and mental health hotlines began operating (Miller, 1977; Aviram & Shnit, 1981). The additions of the 1980s were primarily in the after care services — social clubs (Moss & Davidson, 1980; Naftally, 1986), sheltered homes (Hammerman, 1984), and rehabilitation services (Moss & Davidson, 1984; Levy & Davidson, 1988).

Inpatient services have mainly been provided by governmental hospitals or by private (for profit) hospitals, paid for by the government. The General Sick Fund's share in the provision of ambulatory mental health services was larger than its share in the provision of inpatient psychiatric services (Popper & Rahav, 1984; Kupat Holim, 1980, 1983). However, while the government was hardly involved in the provision of ambulatory general medical services in the country (those services were

provided mainly by the Sick Fund), a substantial proportion of ambulatory mental health services was provided directly by the government.

*Reorganization plans and policy changes.* During the 1970s two major policy changes were undertaken. In 1972 a plan for the reorganization of mental health services was announced by the government (Ministry of Finance, 1973). In its basic approach this "Reorganization Plan" was similar to the American model of the Community Mental Health Centers program. It called for the delivery of comprehensive mental health services in a geographically defined community (Tramer, 1972; Falik, 1978).

In 1977 the Government reached an agreement with the General Sick Fund regarding the provision of psychiatric services in the country. The guiding principle of this agreement, which became effective in 1978, was that psychiatric services should be provided on a regional basis, according to medical needs, and be free of charge. The Sick Fund was required to provide psychiatric services in the regions under its responsibility to all applicants, regardless of their insurance coverage, and in return, the Government assumed the costs of providing mental health services to members of the Sick Fund, as well as to anyone else, free of charge. It was an ambitious plan that attempted, among other things, to promote the Reorganization Plan and improve the delivery of mental health services in the country (Aviram & Shnit, 1981).

Following this agreement, the General Sick Fund amended its insurance coverage policy and eliminated coverage for psychiatric services for its member as of 1978 (Kupat Holim, 1986). Although there were no immediate practical consequences, this policy change represented a major retrenchment of the Sick Fund from its previously accepted responsibility toward the insured population, and created problems that surfaced later. Recently, in 1989, the Government changed its policy of providing psychiatric services free of charge, and has been attempting to collect fees for psychiatric services.

Until recently the Mental Health Services central administration was a separate branch of the Ministry of Health. Its independent status was never established by law and was rather an administrative arrangement. At the end of 1989, the Ministry

of Health announced its intention to change this organizational structure, and incorporate Mental Health Services, including its inpatient and outpatient services, into the Hospitalization Service Branch of the Ministry. At the time of the writing of this paper, the process of this administrative change has not been completed.

## II. Israel Mental Health Service System

*Changing Trends in Mental Health Services.* The major efforts of mental health services during the first 15 years of the new state, until about the midsixties, were to increase the number of psychiatric beds and to organize the psychiatric inpatient services. This is not to say that professionals and policy makers were unaware of other needs, or that they completely neglected the development of other forms of mental health services.

During the 1960s, as immigration into the country decreased and economic conditions improved, attention shifted to ambulatory services. The number of outpatient clinics almost doubled, and the number of visits in them quadrupled between the years 1965 and 1977 (Rahav & Popper, 1984). Day care programs<sup>3</sup>, not available until the late sixties, became available. The number of day care unit beds tripled during the seventies, and in 1985 exceeded 1000 (Central Bureau of Statistics, 1978; 1989).

After-care services, rehabilitation, and community care programs for long term mentally ill patients have been recognized needs, as well as being among the declared goals of mental health services for quite some time (Tramer, 1972; Miller, 1977). However, not until the 1980s could one observe some action in this arena. During this period social clubs and rehabilitation services were developed, and increased attention was given to the establishment of sheltered housing for mentally ill persons in the community.

There has been a noticeable decline in inpatient hospitalizations during the last decade. Epidemiological data reveal that this trend is reflected in all the usual indicators of inpatient services — the number of beds, resident population, and admissions. The trend is manifested in both absolute numbers and rates per populations (Popper & Horowitz, 1989; 1990). The number of patients in mental institutions in Israel continued to

Table 1

*Inpatients and Day Patients in Psychiatric Care Facilities in Israel: Numbers and Rates of Resident Patients and Admissions in Selected Years: 1948–1988<sup>1</sup>*

	1948	1958	1970 <sup>2</sup>	1978	1988
absolute numbers					
<i>End of year</i>					
Inpatients	1197	4188	8038	8925	7036
Day Patients	—	—	303	896	1220
<i>During the year</i>					
Admissions for Inpatient Care					
Total	n/a	4619	10577	12995	11035
First Admissions <sup>3</sup>	2593	n/a	4853	2933	
Readmissions <sup>4</sup>	n/a	2026	n/a	8139	8102
rates per 1000 population					
<i>End of year</i>					
Inpatients	1.3	2.1	2.7	2.4	1.6
Day Patients	—	—	0.1	0.3	0.2
<i>During the year</i>					
Admissions					
Total	n/a	2.3	3.6	3.5	2.5
First Admissions	n/a	1.3	n/a	1.3	0.7
Readmissions	n/a	1.0	n/a	2.2	1.8

<sup>1</sup> Source: (Data is based on the Psychiatric Case Register reports.) Central Bureau of Statistics (1989) for 1958, 1970, 1988; Chesler-Gampel (1970) for 1948; Popper & Horowitz (1989) for 1978.

<sup>2</sup>From 1970 numbers do not include mentally retarded.

<sup>3</sup>Some figures are based on estimates.

<sup>4</sup>Some figures are based on estimates.

climb and peaked in 1978, with close to 9000 resident patients. By the end of 1988, the number dropped roughly 20% (7000). There is a similar trend of decline in the number of psychiatric beds. The trend of decline was a modest one at the beginning of the period, accelerating to an average of 4% decline per year

during the later part of the period. The decline in the rates of patients per 1000 of the population is even more impressive. The highest rate of inpatients per population was measured in the second half of the sixties. After 1970, the rate, which was about 2.7 per 1000 of the population, started to decline. The trend of decline accelerated during the last decade reaching about 30%, to 1.6 per 1000 in 1988 (Popper & Horowitz, 1989; Central Bureau of Statistics, 1989). The decline in the number of resident patients in institutions was for the short stay and the long stay patients as well. Between 1975 and 1988, the number of patients who were hospitalized one year or less declined by 19%. The rate of decline for this period for the longer stay patient was only 5.6%. During this period the proportion of the long stay patients in Israel mental institutions increased from 63% to 66.5% (Popper and Horowitz, 1990).

The number of admissions fluctuated during the second half of the 1970s and early 1980s averaging about 13,000 per year. It started to decline after 1981, dropping by about 15% between 1981 and 1988. The rates of admissions declined by 36% between 1973 to 1988, from 3.9 to 2.5 per 1000 of the population. An even higher rate of decline has been reported in regard to first admissions (Popper & Horowitz, 1989). Between 1975 and 1988, first admissions to mental hospitals declined by 50%, from 1.4 per 1000 of the population in 1975 to 0.7 in 1988.

The decline in inpatient hospitalizations is indeed impressive. Although the rate of decline is not so high as in the U.S., it is similar to the rates in other countries (Goldman, 1983), such as Britain, where deinstitutionalization trends were present during the last 25 years (Brown, 1985). In assessing this trend, Popper and Horowitz (1989; 1990), pointed out the increase in the number of day care unit patients, and the development of alternative care facilities in the community during about the same period. They attributed the changes to a configuration of factors — demographic, social, and clinical as well.

### *Institutional Care*

*Facilities.* Psychiatric institutional treatment and care are mainly provided by two types of facilities: special psychiatric hospitals and psychiatric inpatient units in general hospitals.

There is considerable variability within these facilities by the type of care, patient characteristics, costs, staff, ownership, and level of care. At the end of 1987, there were 38 psychiatric inpatient facilities in the country (Table 2). Almost half of the beds were in government special psychiatric hospitals. The second largest provider were private (for profit) psychiatric facilities. About 40% of the beds were in these hospitals (Table 3). Since the government pays for most of the patients in private hospitals as well as regulates these hospitals (Halevi, 1984; Ministry of Finance, 1989), one could say that about 90% of the psychiatric beds in the country are government beds.

Table 2

*Psychiatric Inpatient Facilities by Type and Ownership. 1975, 1980, 1987<sup>1</sup>*

	1975	1980	1987
<i>Special Psychiatric Hospitals</i>			
Government <sup>2</sup>	12	15	12
Private (for profit)	22	21	12
General Sick Fund	3	3	3
Other Not-for-Profit	3	3	2
<i>Psychiatric Units in General Hospitals</i>			
Government	3	4	5
General Sick Fund	1	1	3
Other Not-for-Profit	1	1	1
Total	45	50	38

<sup>1</sup>Source: Popper & Horowitz (1989); Mental Health Services (1989).

<sup>2</sup>Includes a forensic unit in a prison.

In 1980, there were 50 psychiatric inpatient facilities in the country. During an eight year period this number declined by one fourth (Table 2). The major decline occurred in the number of private hospitals. The total number of beds in private psychiatric hospitals diminished during this period by about 25%. This figure accounts for about 75% of the total decline in the number of psychiatric beds in the country. At the end of 1988,

there were 7362 psychiatric inpatient beds in Israel. (Table 3; Central Bureau of Statistics, 1989).

Table 3

*Number and Proportion of Psychiatric Beds in Israel by Type and Ownership, Selected Years 1975–1987<sup>1</sup>*

	1975	1977	1983	1987
<i>Special Psychiatric Facility</i>				
Government				
#	3593	3796	3881	3513
% <sup>2</sup>	44.1	42.9	46.5	47.2
Private				
#	3644	4094	3571	3080
%	44.7	46.3	42.8	41.4
General Sick Fund				
#	498	516	481	451
%	6.1	5.8	5.8	6.1
Other Not-for-Profit				
#	250	248	192	143
%	3.0	2.6	2.3	1.9
<i>In General Hospitals</i>				
Psychiatric Units <sup>3</sup>				
#	168	210	221	257
%	2.1	2.4	2.6	3.4
Total				
#	8153	8846	8346	7444
%	100.0	100.0	100.0	100.0

<sup>1</sup>Source: Popper & Horowitz (1988)

<sup>2</sup>Percentages are for columns

<sup>3</sup>Includes units in governmental, General Sick Fund and other public, not-for-profit hospitals.

The public (other than government) sector provides about 8% of the beds in special psychiatric facilities (Table 3). These beds are provided by not-for-profit organizations, of which the largest is the General Sick Fund. Considering that this health

Table 4

*Admissions to Psychiatric Facilities in Israel by Type, 1988<sup>1</sup>*

Type of Facility	Admission <sup>2</sup>	Beds <sup>3</sup>	Number of Admissions Per Bed
<b>Government Special</b>			
Psychiatric Hospitals			
#	6566	3513	1.87
%	55.9	47.2	
<b>Private Special</b>			
Psychiatric Hospitals			
#	470	3080	0.15
%	4.0	41.4	
<b>Sick Fund Special</b>			
Psychiatric Hospitals			
#	2507	451	5.56
%	21.3	6.1	
<b>Other Nonprofit Special</b>			
Psychiatric Hospitals			
#	235	143	1.64
%	2.0	1.9	
<b>Psychiatric Units in</b>			
<b>General Hospitals</b>			
#	1978	257	7.70
%	16.8	3.4	
<b>Total</b>			
#	11,756	7,444	1.58
%	100	100	

<sup>1</sup>Source: Mental Health Services (1989); Popper & Horowitz (1989)<sup>2</sup>Includes admissions to day care in psychiatric hospitals (about 1/2% of total admissions).<sup>3</sup>Figures for end of 1987.

organization covers about 70% of the population and provides 31% of general hospital beds in the country, the number and the



7% proportion of psychiatric beds provided by the Sick Fund, is relatively small (Ministry of Finance, 1989). Also, the proportion (3.4%) of psychiatric beds provided by general hospitals is rather small (Tables 2; 3).

*Acute and long term care facilities.* Psychiatric units in general hospitals and the Sick Fund hospitals provide mostly acute psychiatric inpatient services. About 40% of the admissions to inpatient psychiatric services in Israel during 1988 occurred in these facilities, which comprise only about 10% of the psychiatric beds in the country. Although also government hospitals were a major provider of acute psychiatric care, the large proportion of long stay patients in these hospitals (Popper and Horowitz, 1990), resulted in a lower rate of the number of admissions per bed in comparison with the general hospitals and the Sick Fund facilities (Table 4). Only 4% of inpatient care occurs in general hospitals. This proportion is lower than in other countries (Siegel et al., 1990).

Private psychiatric hospitals mainly provide long term care. Although 41% of the psychiatric beds in the country are in these hospitals, their proportionate share of the total yearly psychiatric admissions in the country was only 4% in 1988. A recent Ministry of Health Policy decision discouraged new admission to private hospitals. Ninety percent of the patients in these hospitals are hospitalized for periods longer than a year (Popper and Horowitz, 1990). These institutions are similar to nursing homes. They provide shelter and maintenance, with relatively little medical, social, or rehabilitative services. Staffing ratio per patient and cost of care are much lower than in other hospitals. The government sets up the fee schedules (which varies according to the type of population cared for), and regulates these institutions (Halevi, 1984). The quality of care in some of these institutions caused public concern, from time to time, and has been considered by some a disgrace (Neumann, 1982).

*Admissions and resident patients.* As already mentioned, there were about 11,000 admissions in psychiatric facilities in Israel during 1988. The rate of admission per 1000 population was 2.5. The number of resident patients at the end of 1988 was 7035 and the rate was 1.6 per 1000 population (Table 1). The majority of the admissions (73.4%) were readmissions. About 55% of all

admissions are males. Admissions by age and gender shows interesting differences. About 70% of male admissions are for the age groups of 18–44. The proportion of first admissions of these age groups among women is about 50%. Children (up to 17 years old) constitute 8.4% of first admissions. About one fourth of all admissions are between the ages of 18–24 (Popper and Horowitz, 1989; Mental Health Services, 1989).

*Mental commitments.* The majority of the admissions to Israel hospitals are voluntary. According to 1988 data, about 13% were admitted as civil commitments, and 4.5% were committed under the criminal code (Popper, 1989). Civil commitment is defined by the Israeli law within the realm of medicine, authorizing specially appointed district psychiatrists to issue commitment orders. Based on earlier data, the proportion of involuntary hospitalization may be higher, at about 24% of all admissions (Aviram & Shnit, 1984), which is more compatible with other countries (National Institute of Mental Health, 1987).

*Diagnostic categories and chronicity.* Schizophrenia is the major diagnostic category of persons admitted to institutions in Israel; 55% were so classified. Affective disorders are the second largest category, constituting 14% of all admissions. The proportion of this category among women is twice as high as for males (19.2% and 9.5% respectively) (Mental Health Services, 1989). Only 2.6 of the patients did not have any of the psychotic diagnoses (Siegel, 1990).

There is no accurate information regarding the proportion of chronically mentally ill persons in the country. Data on the length of stay of patients in mental hospitals reveal that 68.7% were hospitalized by the end of 1988 for more than a year. Almost 50% of all patients were hospitalized for 5 years or longer. The largest proportion of long stay patients was in the private hospitals (89.4%). The proportion of this category of patients in the government and the Sick Fund hospitals was lower (60.4% and 16.2% respectively) (Popper & Horowitz, 1990). These figures reflect the function of these hospitals and policies of their governing boards.

*Length of hospitalization.* Total numbers of hospitalization days for mental illnesses for 1988 was 537.8 per 1000 of the general population. Psychiatric hospitalization constituted 27%

of all hospitalization days in the country. Excluding hospitalization days for chronic illnesses and rehabilitation, hospitalization in psychiatric facilities was 40% of total hospitalization days.

The average duration of stay for those released during 1988 from psychiatric inpatient facilities was 224 days (compared to 5.1 days for those discharged from general hospitals) (Central Bureau of Statistics, 1989). The increase in the average length of stay for those discharged from mental hospitals in recent years, compared with 15 and 20 years ago, coupled with the declining numbers of residents and admissions in mental hospitals, indicate that recently a relatively larger number of long term patients have been discharged from mental hospitals than in previous years.

The average length of stay of 184.2 days for all patients in mental hospitals in 1987 was about the same as in the past (Ministry of Health, 1986). The average bed occupancy rates have been declining during the 1980s. This may indicate an improvement of hospitalization conditions. While during the 1960s and 1970s the occupancy rates were about 100%, for 1988 it dropped to 86.1%, becoming similar to the bed occupancy rate of medical beds (Central Bureau of Statistics, 1989).

*Treatment modalities.* The knowledge which is available and the high quality of training of mental health professionals provide mental institutions with access to high standards of treatment methodologies. Institutions use a variety of approaches to treatment and care. Specific information on the exact types of treatment methodologies and their differential use among institutions is not available, nor is there information on the distribution of professionals employed in the institutions by type of training and level of education. However, a review of the minimum requirements for those who wish to be hired, as well as the teaching material used for educating the professionals (e.g. Elizur, Tyano, Munetz, & Neumann, 1987) allow the conclusion that the level of training is high by any western standards, and that mental health services use a variety of mental health treatment modes such as psychodynamic, biological, psychosocial and so on. Although Israeli mental health professionals were initially heavily influenced by the Central European psychiatric tradition of the 1930s, and the psychodynamic tradition is still

quite influential, other approaches seem to be expanding. There is a need for more specific and accurate information on this subject matter. Additional information regarding mental health personnel is discussed in the section related to staff.

### *Mental Health Services in the Community*

The decline in the number and the rates of mental hospitalizations in Israel during the last decade has been attributed by some to the development of mental health services in the community (Popper & Rahav, 1984; Popper & Horowitz, 1989, 1990). Indeed the addition of outpatient clinics, day care units, community mental health centers, and some after care and rehabilitation services has changed the nature of mental health services in Israel. However, there is a need for studies assessing the direct influence of the community mental health services on the reduction of the resident population in inpatient care, and the exact contribution of the development of mental health services in the community to mental health services in general.

Based on a 1986 survey of psychiatric care utilization (Siegel et al., 1990), 68% of the care delivered in the week of the survey was in community facilities. During this week, 14,952 patient care contacts occurred in mental health facilities in the community. Since the survey was restricted to mental health facilities and since many patients receive care from other social and rehabilitation services such as the National Insurance local social service departments, as well as from private mental health practitioners, one may conclude that the number of care contacts of mental patients is substantially larger.

The bulk of the nonresidential community services were provided by outpatient clinics, which represented 80.8% of the patient care contacts during the week of the survey. Day care units provided 9.6% and social clubs 4.5%. The proportion of consultation was 5.2% of patient care contacts. About one half of the patients receiving care in community facilities had psychotic diagnoses, major affective or organic diagnoses, or were recipients of disability insurance. The others were rated as less dependent (Siegel et al., 1990).

*Day care units.* There were 1200 patients receiving care in 28 day care units at the end of 1988. These units were budgeted

Table 5

*Outpatient and other Community Mental Health Facilities by Type and Affiliation, 1989<sup>1</sup>*

	Gov- ernment	Sick Fund	Public (other)	Total
<i>Day Care Units</i>				
Total	18	8	2	28
At inpatient psychiatric facility	15	5	1	21
In the community	3	3	1	7
<i>Ambulatory Units</i>				
Total	39 <sup>2</sup>	19 <sup>3</sup>	4	62
At inpatient psychiatric facility	14	10	1	25
In the community	22 <sup>4</sup>	7	3	32
Followup outpatient unit (at psychiatric facility)	3	2	—	5
<i>Occupational Rehabilitation Units</i>				
Total	7			7
At inpatient psychiatric facility	3	-	-	3
In the community	4	-	-	4
<i>Drug Treatment &amp; Consultation</i>				
Total	6	1	10	17
Outpatient	4	1	10 <sup>5</sup>	15
Day treatment	2	-		2
<i>Consultation<sup>6</sup></i>				
Total		1	2	3
<i>Social Clubs</i>				
Total			33	33
<i>Hotline</i>				
Total			8	8
<i>Consultation for Students</i>				
Total			5	5

*Sheltered Residential  
Programs in  
Community<sup>7</sup>*

Total	8	-	4	12
				<hr/> 182

<sup>1</sup>Source: Ministry of Health, Mental Health Services, Information and Evaluation Department. (1989). *List of Psychiatric Services in Israel*. Jerusalem: Ministry of Health.

<sup>2</sup>in addition, 6 clinics branches

<sup>3</sup>In addition, 2 clinics branches

<sup>4</sup>Most units are administratively connected to psychiatric inpatient facilities.

<sup>5</sup>Consultation services "Al- Sam"

<sup>6</sup>Not including psychiatric consultation services in general hospitals.

<sup>7</sup>Total for 1989, 177 residences; 285 residents. Sources: Report of the Committee on Sheltered Residence for Mentally Ill (1989); & Hammerman (1984).

by number of approved beds. The total number of beds were 938 (Table 5; Central Bureau of Statistics, 1989). Seventy five percent of the day care units were either in, or administered by inpatient facilities. About two thirds of the units were run by the government. Day care services were developed in the late sixties and early seventies. In 1970 there were 300 patients in these services in the country. The number peaked by 1987 and surpassed 1300, and later slightly declined.

Day care is mainly provided by the government and the Sick Fund facilities. The proportion of day patients per inpatients was higher in the Sick Fund facilities than in the government ones (454 and 290 per 1000 population, respectively, for 1987). The 1986 survey revealed that 80% of the day patients were adults, 11% were aged, 6% adolescents and 3% children (Ministry of Finance, 1989).

Since the classification of day care unit beds is not clear and the reporting system on day care patients has not been accurate, it is hard to judge how much of the increase in the reported day care is a reflection of a more reliable reporting system, and how much of it reflects a real growth. No doubt

that much more attention is currently given to this mode of treatment by practitioners and policy makers alike. There has been an impressive change in the proportion of day care patients compared with the total number of inpatients, from 10% in 1980 to 15% in 1988. However, this change is mainly a result of the decline in the number of inpatients during this period. Furthermore, the increase in the number of day care unit beds since 1980 consists only 10% of the number of inpatient beds which were closed since that time. Nor was there a significant change in the number of day care units in the country during the last decade (Ministry of Finance, 1987). Also, the rates of day care beds per population have remained about the same. While the rate of inpatient beds declined by about 27% between the years 1980 and 1988 (from 2.2 to 1.6 per 1000 population), the day care unit bed rate of 0.2 per 1000 of the population remained constant throughout the whole period (Central Bureau of Statistics, 1989).

*Outpatient mental health services.* Outpatient mental health services are provided by about 60 facilities. Approximately one half of these facilities are located in the community while the rest are in, or attached to, inpatient facilities. The number of the Sick Fund facilities are about 30% of the total number of outpatient mental health facilities in the country (Table 5). Until recently, outpatient services were provided free of charge. A new policy instituted a small fee for service. Decisions regarding the treatment and its duration are within the discretion of each clinic (Mental Health Services, 1984).

Information regarding the number and characteristics of patients receiving outpatient mental health services is less comprehensive than those about inpatients. According to the 1986 survey, there were 13,779 persons receiving ambulatory care in the community during the week of the survey (Ministry of Finance, 1989). Based on 1982 figures, it was estimated that there were about 36,200 new admissions to all outpatient psychiatric services in the country (Popper & Rahav, 1984). The number of contacts in outpatient services increased from 144,000 contacts during 1965 to 555,300 contacts during 1977 (Mental Health Services, 1984), and was estimated to reach about 700,000 in 1986 (Mental Health Services, 1990).

Community mental health centers (CMHC) were one of the central components of the 1972 Reorganization Plan of the Israeli Mental Health Services (Tramer, 1975). The first CMHCs, intended to serve as models for the rest of the country, were established in Ashkelon and Jaffa. Although other mental health outpatient clinics bear the title of CMHC or provide some of the services envisioned by the Plan, the concepts of CMHC program are far from being implemented in full. The 1978 agreement between the government Mental Health Services and the Sick Fund was reached in order to assure the delivery of comprehensive mental health services on a regional basis throughout the country. However, so far, no systematic assessment of the changes and their effect has been done.

Data on personnel in outpatient facilities is limited. Data from the 1986 mental health survey reveal that the total number of the equivalent of full time positions employed in public mental health services in the community was 714 (Mental Health Services, 1986). Since this number included also those employed in day care units and rehabilitation units administered by community mental health agencies, we can estimate that the number of positions in outpatient units was about 650. Research on personnel utilization in these type of mental health services has not yet been initiated in any substantial form and the information is only sketchy. Data on the Sick Fund mental health outpatient services, serving about 45% of the country's population, shows that at the beginning of 1985 the total number of positions was 233. Thirty two percent were psychiatrists, 21% psychologists, 16% social workers, 7% occupational therapists, 4% nurses, and 20% administration and maintenance (Kupat Holim, 1985).

A recent study of mental health outpatient services in Jerusalem illuminates some of the questions regarding characteristics of outpatients and types of services provided for them. About 40% of all patients who had attended the adult outpatient clinics in Jerusalem during a five week period in 1986 were in regular contact with the clinics for at least one year. Two thirds of those (or 27% of all patients) were diagnosed with one of the major psychiatric disorders, and either had previous mental hospitalization or received disability insurance or both. More than 90% of those diagnosed with major psychiatric disorders



received psychotropic medication. The mode of treatment for the majority of these patients were non-psychodynamic. About 75% of them received treatment such as drug follow-up, supportive treatment, social clubs etc. (Lerner, Wittman, Zilber, & Barasch in press).

*Emergency mental health services.* Emergency mental health services on a 24-hour-a-day, 7-day-a-week basis are mainly provided by inpatient mental health facilities and by emergency rooms of general hospitals. Recently, the Sick Fund psychiatric hospitals and some of the government hospitals have developed special admission units with emergency holding facilities that provide intensive care on a short term basis. In addition, an emotional first aid hotline service is provided by a public organization (Eran) in eight locations in the country. Some outpatient community mental health services provide emergency services, however these are limited to regular working hours. There is rather limited information on these type of services.

Most of the general hospitals in the country have psychiatric consultation services. These services are available also in emergencies. Indeed, many of the mental health emergencies are first seen in the emergency rooms of general hospitals. A study of psychiatric referrals to a general hospital emergency room suggested that a combination of poor understanding of the general practitioner or the family doctor of when to refer urgently, efforts by these physicians to bypass clinic waiting lists, and lack of alternative community facilities might have accounted for the finding (Vigiser, Apter, Aviram, & Maoz, 1984).

*Rehabilitation services.* Increased interest of policy makers and some program administrators in mental health rehabilitation during the last decade resulted in several new policies and programs. However, in spite of some interesting and successful individual programs in this area, the scope of this service and the budgetary allocations for mental health rehabilitation services fall short of the needs. Rehabilitation has yet to assume its appropriate place on the mental health services priority list of policy makers in Israel (Levy & Davidson, 1988). Prior to the last decade the few rehabilitation programs were more or less a result of individual interest (e.g. Spivak, 1977) and not an outcome of a concerted policy effort.

Policies and programs in the area of psychiatric rehabilitation are within the domain of three governmental agencies: (a) Rehabilitation Services of the Ministry of Social Welfare, (b) national Insurance Institute, and (c) Mental Health Services of Ministry of Health.

Former mental patients are considered within the target population of the Rehabilitation Services of the Ministry of Social Welfare. The number of ex-mental patients among the clients of the rehabilitation centers administered by the Ministry of Welfare throughout the country is rather small. Two factors may account for this situation: Scarce resources and concerns about the potential negative effect of mentally ill clients on the programs and their public image.

As a result of the General Disability Law of 1974, the National Insurance Institute (NII) assumed a central role in rehabilitation programs for the mentally ill. This agency administers disability benefits programs, including income maintenance payments and rehabilitation services. The NII did not develop special rehabilitation services for the psychiatrically disabled persons and focuses on the occupational aspect of rehabilitation. The Ministry of Defense provides similar rehabilitation services to disabled veterans.

Mental Health Services views psychiatric rehabilitation as part of its domain. The interest and activities of the National Health Services in this area have increased during the last 10–15 years. Policy makers at the Mental Health Services believe that the special problems of mentally ill persons require that the Mental Health Services have the central role in the development and administration of rehabilitation services for mentally ill people whether they are located in the hospital or the community. An indication of the increased interest of Mental Health Services in rehabilitation services is the fact that since 1978, 10% of the disability benefits that the mental hospital receives for its patients from the NII is allocated for rehabilitation services.

Psychiatric rehabilitation services focus on the development of skills in three areas needed for successful community living — employment, social life, and housing. In the following sections, each of the services in these areas will be more specifically discussed.

*Occupational rehabilitation.* Occupational rehabilitation services have been considered relatively better developed than the other types of rehabilitation services (Levy & Davidson, 1988). There are two types of psychiatric rehabilitation services: (a) Transitional rehabilitation and training agencies, and (b) Sheltered workshops. While the first type emphasizes the education and training aspect of rehabilitation and integrates their programs with treatment services, the second type focuses on the provision of stable and sheltered work place for disabled mentally ill people.

In 1989 there were seven transitional rehabilitation services in Israel, providing services to about 300 persons. Four of these were provided in the community, while three were part of hospitals (Table 5; Popper & Horowitz, 1989). In addition, several sheltered workshops have been developed during the last several years as a result of special efforts of the government Mental Health Services, in cooperation with the NII and the Ministry of Social Welfare. There are seven such workshops in the country with a total number of about 200 clients.

*Psychological rehabilitation.* Although psychosocial aspects of rehabilitation are included in some of the transitional occupational rehabilitation services, the emphasis in those services is on the world of work. Psychosocial rehabilitation services geared to the training and education of former mental patient in and for community living are rather limited in their development in Israel (Spivak, 1977; Moss & Davidson, 1984).

Many new social clubs for mentally ill persons which have developed during the last decade function as psychosocial rehabilitation in addition to their purpose of providing leisure time activities for mentally ill people in the community. The development of these clubs is a result of efforts undertaken by "Enosh", a voluntary organization established by families of mentally ill persons in the late 1970s. In general, the established mental health service agencies have been supporting these efforts. Currently there are 33 such clubs in the country (Table 5; Naftally, 1986). The 1986 mental health survey revealed that 667 community service contacts during one week occurred in social clubs. This number represented 4.5% of patients in treatment by non-residential mental health services (Siegel et al., 1990).

*Sheltered residences.* Although early efforts in the development of sheltered care residences in the community started in Israel about thirty years ago, major efforts in this area have occurred during the late 1970s and 1980s (Hammerman, 1984; Levy & Davidson, 1988). A recent report indicated that there are 177 sheltered apartments for mentally ill persons located in the community. During the six year period, from 1983 to 1989, the number of residents in these facilities more than doubled. In 1989, 285 residents lived in these facilities. In addition there were about fifty residents in 3 hostels operated by mental hospitals and located in the community (Report of the Committee on Sheltered . . . , 1989).

Sources of financial support for these facilities varies a great deal. Some are budgeted in total by mental hospitals, others are supported by public voluntary organizations, while still others are paid for in full or in part by the residents. Disabled and dependent people are entitled to up to 95% of their rents (up to a certain level). Rental payments are provided to eligible individuals by the Ministry of Housing. In view of this fact, it is rather surprising that the number of mentally ill persons in sheltered facilities is not larger. Residents in some of the facilities which have been operated by hospitals continue to receive other services from the hospitals. Hospitals receive 50% of the Disability NII benefits for those residents living in sheltered residences under the direct supervision of the hospital.

### *Mental Health Service Expenditures, Budgets and Personnel*

*Expenditures for mental health services.* Mental health services were allocated 12.7% of the total budget of the Ministry of Health for 1989. This amount was the equivalent of about 90 million dollars. There are no comparative figures for the budgets for mental health services provided by other sectors. Based on the fact that government expenditures for hospitalization in government hospitals and private hospitals are about 80% of all national expenditures on mental hospitalizations, a rough estimate for total expenditures for mental hospitalization would put the yearly figure between 100 to 115 million dollars.

Mental health services are the second largest item of direct costs (not conditional on income from outside resources) in

the budget of the Ministry of Health. The government directly operates 60% of mental hospitalization in the country and has been financially responsible for about 80% of these services. This proportion is quite different from the government proportion of the operation and financing of all medical expenditures. In the 1987/88 budget year, the government was responsible for the operation of 21.5% of total health service expenditures. It was financially responsible for 50% of these expenditures (Central Bureau of Statistics, 1989).

*Distribution of budget between inpatient and outpatient services.* Inpatient services take 90.4% of the budget. Calculating only direct services, excluding central administration and central services, inpatient services take up an even larger portion of the budget (93.5%). Community services are allocated about 5.3% of the total budget. More than 25% of these services are provided and administered by hospitals. Hospitals may provide additional community services, though these do not appear as a separate item in their budgets.

The high proportion of 90% or more allocated to inpatient mental health services is in sharp contrast to the distribution between inpatient and ambulatory care in the general medical services budget and expenditures. Expenditures for ambulatory medical services and preventive medicine is proportionally about the same as those for general hospital care (about 32% each) (Central Bureau of Statistics, 1989). The uneven distribution of the mental health budget has always been the case (Halevi, 1984; Aviram, 1983).

*Staff.* In May 1986 6247 full-time equivalent positions were employed in all mental health services in Israel. About 10% were physicians, 29% nurses 8.3% psychologists, 5.4% social workers, 5.3% occupational therapists, and 42% nonprofessional, including orderlies, nursing aides, maintenance personnel and administrative personnel (Mental Health Services, 1990). About 50% (3160 in 1988) of the mental health personnel were employed directly by the Ministry of Health. Only about 9% of all the people employed by Mental Health Services of the Ministry of Health were in community mental health facilities.

Training professionals for community mental health services have encountered difficulties (Aviram, 1977). It seems that pro-

professionals prefer the more traditional inpatient and outpatient mental health services and consider them as a relatively desirable place for employment (Aviram & Katan, 1988). The prestige, however of psychiatry among physicians in Israel is rather low. Neumann (1982) asserted that a very small percentage (much smaller than in the United States) of graduates of medical schools in Israel chose psychiatry as their specialty, and that most of the psychiatrists in Israel are immigrants from Europe or the Americas.

Several changes have taken place in the number and the distribution of mental health personnel during the last decade. Data on mental health manpower in governmental services reveal that since 1979 the number of physicians increased by about 50%, the number of nurses and other professional personnel increased by 10%, while the number of maintenance and administrative staff remained the same (Ministry of Finance, 1979; 1989). If the numbers of professionals employed in mental health services, and their ratio to non-professionals is an indication of the quality of the services, then we must conclude that there has been an improvement in the mental health care services during the last ten years. In view of the fact that during the same period the numbers of resident patients in the government mental hospitals declined by 7%, the changes in the number and the distribution of the professional and non-professional staff is even more impressive.

However, the major part of the increase in the number of personnel occurred in inpatient services (Table 6). If indeed money would have followed the patients to the community, the 21% decline in the numbers of resident patients in all mental hospitals between the years 1978 and 1988 should have resulted in drastic changes in budgetary and personnel allocations for community mental health services. Instead of the present 5% or 6% budgetary allocation for, and 9% personnel positions in community services, the figure would be close to 25% and expenditures for community services more than four times higher the current level.

Table 6

*Changes in Inpatients, Budgetary Allocations, and Manpower in Israel Mental Health Services, 1979-1988/89<sup>1</sup>*

	1979	1988/89	Change
Inpatients			
Resident patients			
Numbers	8,774	7,036	(-) 20%
Rates <sup>2</sup>	2.3	1.6	(-) 30%
Admissions			
Numbers	12,958	11,035	(-) 15%
Rates <sup>3</sup>	3.4	2.5	(-) 26%
Budgetary allocations			
Percentage of Mental Health services of total Ministry of Health budget	13.6	12.7	(-) 8%
Percentage of community mental health of Mental Health Services budget <sup>4</sup>	5.0	5.3	(+) 6%
Percentage of "conditional expenditures" of mental health budget <sup>5</sup>	1.0	28.0	
Manpower			
Ministry of Health — Total	19,176	19,823	(+) 647 (+) 3.4%
Mental Health Services — Total	3,040	3,160	(+) 120 (+) 3.9%
Psychiatric hospitals	2,763	2,853	(+) 93 3.4%
Community mental health	277.5	285.5	(+) 1 (+) 0.4%
Percentage of mental health services of total Ministry of Health Manpower	15.9	15.9	N.C.
Percentage of community mental health of total mental health services manpower	9.1	8.9	(-) 2.2%

<sup>1</sup> Sources:

- a. Inpatients (1979; 1988): Popper Horowitz (1989); Mental Health Services (1989).
- b. Budgets and manpower (1979; 1989): Ministry of Finance (1979; 1989)

<sup>2</sup>Rates per 1000 of the general population

<sup>3</sup>Rates per 1000 of the general population

<sup>4</sup>Including also drug abuse treatment and community mental health services administered by hospitals

<sup>5</sup>Expenditures are conditioned on income from outside sources such as Disability Benefits or patients' payments.

*Disability insurance and income maintenance programs.* The Disability Law, implemented in 1974, had a paramount effect on services for the mentally ill and continued to affect the system for years to come. Discussing this law and its effect is beyond the scope of this paper. Briefly, the major effect of law on the mental health service system is three fold: (a) It provided income maintenance benefits to disabled mentally ill persons. (b) It established rehabilitation services within the National Insurance Institute, financed them with a portion of insurers' contributions, and offered rehabilitation services to mentally ill people who meet eligibility criteria. (c) It established, and continuously financed the Fund for the Development of Services for the Disabled, which has become one of the major funding sources for innovative programs in mental health rehabilitation.

### III. Current Issues and Continuing Problems

Recent epidemiological data suggest that deinstitutionalization has been taking place in Israel. After a long period of stagnation, trends of mental hospitalization indicate, by all acceptable measures, that the change is real and substantial. Although this development could be attributed to a configuration of social, economic, and clinical trends, one should not minimize the contribution of the concerted policy efforts undertaken since 1972 to reduce mental hospitalizations and to increase and improve community services.

The Israeli mental health service system faces three interrelated problems: (a) Limited development of community mental



health services. (b) Dominance of the mental hospital in the provision and administration of mental health services in the country. (c) Medicalization of mental health services. These problems reflect, on the one hand, current organizational and financial issues, and on the other deeply embedded cultural factors and traditional belief systems.

### *Limited Development of Community Mental Health Services*

Israel mental health policy, announced in 1972, and enhanced by a 1978 agreement between the Government and the General Sick Fund, called for drastic changes in the service delivery system. Based on the objectives of this policy and the experience gained in other countries, one would expect changes in the three most critical elements of the mental health system: patients, manpower, and financial resources. If indeed this policy had been implemented as stated, there would have been an observable change in the flow of these critical resources.

The significant decline in the number and rates of inpatient hospitalizations has not been accompanied by an equivalent increase in the resources provided for community services. Although, as has been noted, there were some positive changes in the provision of mental health service in the community, data indicate that those developments lag far behind what might be considered as justified and necessary.

Although there have been major declines in the numbers and rates of resident patients and admissions in mental institutions during the last two decades, the allocation of funds and personnel for, and within mental health services, has not been substantially changed (Tables 1, 6). The 1989 Ministry of Health budget for mental health services allocated 5.3% for community mental health services, while the proportion for inpatient services was over 90%. Even if one adds the allocations for community services through trust funds and foundations of which the government is a part, the total proportion of community mental health services of the budget would not change by more than 1%. This small proportionate allocation for community services has remained about the same during the 1970s and the 1980s (Halevi, 1984; Aviram, 1983).

The slow pace of development of community mental health services was previously pointed out (Israel State Comptroller, 1980; Aviram, 1983). Although there has been an increased attention toward, and some important additions to community mental health services, budget allocation for, and personnel deployment in community mental health services indicate that the general trend has remained about the same. Considering the changes in hospitalization trends and the knowledge about needs for community care and rehabilitation services, there is still much to be desired in terms of community mental health services in Israel.

#### *Dominance of the Mental Hospital in Inpatient Services*

The mental hospital has been occupying a central and dominant position in the mental health service system in Israel. Inpatient services consume and control over 90% of the budget. They pay salaries at higher levels than community services, and attract able personnel. The fact that many of the innovative community care projects have been initiated and administered by mental hospitals, is perhaps another indication of the central position of hospitals in the mental health services in Israel.

Due to the mental health law and regulations, as well as the structure of services, inpatient psychiatric services have a great deal of control over the flow of patients to and from mental hospitals (Aviram & Shnit, 1984; Aviram, 1983). Many of the community mental health services are provided by mental hospitals. Some are actually located on the grounds of mental hospitals. Others, even though located in the community, are administered by the hospital, and the mental hospital has control over their budget. For example, 75% of the day care units are located in inpatient facilities. In recent years many independent community mental health services were administratively attached, or put under the umbrella of mental hospitals. This trend is both a consequence and an indication of the supremacy of mental hospitals in the system.

This situation is not conducive to the development of community services, and is in contradiction to the knowledge regarding community care and rehabilitation programs for former mental patients. One must remember that the *raison d'être*

of the hospital is inpatient services, and community services have lower priority. Furthermore, attachment of community programs to mental hospitals may enhance dependency inclinations in patients and slow community adjustments of clients. The stigma, unfortunately still attached to mental hospitalization, might also have a negative effect on the rehabilitation efforts.

### *Medicalization of Mental Health Services*

Strong currents to further enhance the medical orientation of the mental health service system in Israel have recently been shaping the system. These trends have been influenced by ideological and theoretical convictions as well as by administrative considerations and professional-political interests. The recent decision of the Ministry of Health to change the organizational status of Mental Health Services from an independent branch to a section within the Ministry of Health Hospitalization Services (Milner, 1989) is a result of these trends and an indication of future directions.

Supporters of the administrative structural change have based their arguments on professional/theoretical reasons, as well as on administrative effectiveness and efficiency considerations. They claim that the medical model should guide the structure of mental health services and the treatment and services provided for mentally ill people. They argue that mental illness is a medical problem and within the domain of the medical profession. Recent research findings regarding the biological nature and etiology of the major mental illness — the argument continues — enhances these claims. Other professions, important as they are, are ancillary services. They emphasize that psychiatry is not different from any other medical specialty and does not need any special arrangements for the regulation of its practice or for the population and services within its domain. Following this logic, a special administrative branch for mental health services is not needed, nor is there a need for special laws regarding the mentally ill and mental health services.

From the administrative perspective, supporters of the changes believe that incorporating mental health services into Hospitalization Services, the dominant and strongest branch of

the Ministry of Health, would strengthen the internal organizational status of mental health services, and improve their chances to get a larger portion of the budgetary allocation.

Those who object to the changes contest some of the arguments and claim that, given the present needs of the mentally ill, level of knowledge, and type and array of services needed for them, the change in the administrative arrangements and the principles of the service delivery structure, are not justified or, at least, premature. Some believe that the changes have also been driven by professional — political and sectorial interests. Some professionals, being critical of the changes and the new administrative structure the mental health delivery system, have been arguing that these new trends represent a regression. They believe that these recent policy changes would hinder many positive developments that have happened, and would adversely affect the public mental health system in Israel.

Medicalization of the services for the mentally ill is not unique to Israel. Indeed, the recent changes in orientation have been similar to trends in other countries (Aviram, 1990). In Israel, where the deinstitutionalization movement has been a rather late arrival, and where the development of community care programs has been slow and far behind the needs, the effects of the intensive medicalization trends of the system might be quite negative. One of the problems resulting from the medicalization trends, is that the model of service is mainly acute and does not deal appropriately with chronic conditions. The medical model and the practice of curative medicine, the dominant approach used in other branches of the Israeli health services system, does not fit well with the needs and the service delivery system required for a large segment of the mentally ill population whose problems demand a life-long medical and social care system.

The expectation that mental health services would fair better within the administratively strong section of Inpatient Services than remaining a weak, independent branch in the Ministry of Health is questionable and could be proven unrealistic. In a situation in which the Government has continuously put pressure on the health care system to reduce its expenditures, mental health services is a rather weak competitor over the scarce

resources. The decline in the proportion of mental health services of the total budget of the Ministry of Health, and the tremendous increase in the proportion of budgeted expenditure conditioned on external sources of income in the budget of mental health services, are cases in point (Table 6; Halevi, 1984). Not having a separate and independent mental health service administration, around which a professional and public constituency may identify and can be organized, would politically weaken the service. Furthermore, it may increase the fragmentation of the mental health services in a time that persistent and coordinated efforts are necessary in order to respond adequately to the diverse and complex needs of the mentally ill.

Changes and improvements in social programs are usually not a result of a linear progression, but rather represent cycles with ups and downs. It seems that Israel mental health services is currently at a cross-road. Specific policy decisions may determine whether progress continues, or whether mental health services are entering a period of stagnation or even reversal of its previous positive achievements.

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### Notes

1 Data for this section are based on the following sources: Israel Central Bureau of Statistics (1989), Israel Government Year Book (1989), Israel Ministry of Finance (1989), Encyclopedia Judaica (1972), Bank of America (1990), and Napzeger (1990).

2 In Israel the term public mental hospital denotes nongovernment, non-for-profit mental hospital.

3 The term which is synonymously used in Israel is Day Care Unit (used henceforth).

# Mental Health Services in Hong Kong: History, Modern Development, and Issues\*

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*This paper provides a comprehensive account of the history, current mental health services, and related-issues in Hong Kong. Psychiatric services provided by the Government such as inpatient, outpatient, and day-patient treatments are highlighted. Community mental health services rendered by the voluntary sector such as the counseling and casework, care in half-way houses, and psychiatric nursing are also discussed. Recent statistical information provides a detailed picture of psychiatric institutions and characteristics of patients. Mental health issues typical of developed countries are discussed.*

Hong Kong is one of the most densely populated places in the world. With its land area of only 1,071 square kilometers and six million people, the overall population density per square kilometer is 5,330 (Hong Kong Government, 1989). Recent indigenous epidemiological research indicates that living in Hong Kong is very stressful and the mental health problems of the population are alarming (Lee, 1985; Mak & Shek, 1987; Millar, 1979; Wong, Lau, & Wong, 1984; Shek & Mak, 1987). Hence, mental health services play an important role in the well-being of people in Hong Kong.

## History of Mental Health Services

In old Hong Kong Chinese society, mental patients were considered a disgrace to the family. Relatives would tolerate the burden of looking after a mentally disturbed member and would try to keep the patient inside the family (Lo, 1981). The

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first mental hospital built in 1925 provided only custodial care. The discharge of recovered patients was a great problem at that time because their families were reluctant to bring them home for fear of social stigma. The number of patients in the mental hospital rose from 308 in 1925 to 679 in 1940. The number declined during the war period from 1942 to 1945 (Lo, 1981). In 1949, a qualified Chinese psychiatrist was appointed as the first medical superintendent of the mental hospital. He started the systematic development of mental health services for the rapidly growing population of Hong Kong (Singer, 1971).

### Mental Health Institutional Services

Generally speaking, mental health institutional services for the mentally ill include treatment in psychiatric hospitals, day hospitals, and outpatient psychiatric clinics. The following sections highlight the provision of mental health services by the Medical and Health Department of the government in Hong Kong.

### Psychiatric Hospitals

Psychiatric hospitals were built to meet the needs of mental patients whose conditions required hospitalization. The first psychiatric hospital—Castle Peak Hospital—was opened in 1961. Currently, there are three psychiatric hospitals with 3,445 beds, and there are 624 beds in the psychiatric units of general hospitals (Medical & Health Department, 1988). In Hong Kong, the need for psychiatric hospital beds is estimated on the basis of 1 bed per 1,000 population. However, the number of hospital beds is far behind the planned provision.

To minimize the adverse effects of a large institution, subspecialties are created with different wards assigned to the large psychiatric hospitals for children, adolescents, geriatrics, neurotics, and neuropsychiatric cases (Goffman, 1962). Moreover, in parallel with the world trend of operating smaller psychiatric units within general hospitals on the regional or district basis, an additional 2,238 beds are to be established in general hospitals in the 1990s (Medical & Health Department, 1988).

### Hospitals and Clinics

The first psychiatric unit that provided a comprehensive range of inpatient, outpatient, and day-patient services in a general hospital was the Kowloon Hospital Psychiatric Unit built in 1971. Subsequently, other outpatient psychiatric clinics and day hospitals also were established. The outpatient psychiatric clinics provide a wide range of assessment, treatment, counseling and after-care services on a regional basis. The day hospitals provide occupational, therapy and social and recreational services for patients with less severe mental conditions for whom hospitalization is unnecessary.

### Day Hospitals

Gradually, more and more psychiatric patients are treated in the community (Goldman, 1982). Some mental patients attend day hospitals for treatment and return home to spend the evening with their families. This approach is consistent with the modern view that whenever possible patients should be treated outside psychiatric hospitals (Goffman, 1962; Schulberg, 1977). Most treatment methods employed in psychiatric hospitals are available in day hospitals. The locations of day hospitals are easily accessible to the public. Every day hospital can serve about 50 clients and is located in districts with populations of about 500,000. At present, there are ten day hospitals and 14 outpatient psychiatric clinics in operation throughout Hong Kong.

In 1987, there were 6,295 admissions to psychiatric hospitals, 751 to regional day hospitals and 238,332 visits at psychiatric outpatient clinics. Clinical psychologists working for the Hong Kong Government Mental Health Services conducted 10,227 interviews, which included psychological assessment and therapeutic functions (Medical and Health Department, 1988).

### Psychiatric Inpatient and Outpatient Statistics

The relative stability of admission figures to government psychiatric hospitals reflect the limit imposed by bed spaces and resources in hospitals. The slight decrease in admission figures (about 2%) in the three year period might be due to the effect of public attention to the crowded state of psychiatric hospitals.

Table 1

*Number of Admissions to Government Psychiatric Hospitals and Attendances at Outpatient Psychiatric Clinics (from 1985–1987)*

Year	Midyear population	Government psychiatric hospital			Outpatient psychiatric clinic		
		New	Readmission	Total	New	Revisits	Total
1985	5,422,800	3137	3298	6435	5823	206,564	212,387
1986	5,532,600	3027	3372	6399	5594	218,687	224,281
1987	5,613,400	2865	3430	6295	5918	232,314	238,232

The increase in the number of psychiatric outpatients is gradual and steady each year. This is in line with population growth, an increase in public awareness, as well as an increase in outpatient services.

Table 2

*Distribution of Psychiatric Inpatients by Age in 1983*

Age	Treated & Discharged	Remaining in Hospital
	%	%
0-14	1.0	0.8
15-24	23.0	15.4
25-34	31.9	18.1
35-44	15.5	20.1
45-54	12.9	15.9
55-64	7.6	9.6
65 & over	6.2	8.8
unknown	1.9	1.3
Total	100.0	100.0

In 1983, a survey involving two groups of psychiatric inpatients was conducted by Mental Health Services of the Hong Kong Government. Included were 6,276 treated and discharged patients, and 3,576 who remained in hospital at the end of the year. Over half of those treated and discharged were in the age group of 15 to 34, while of those remaining in hospital, about

one half, were from 25 to 54 years of age (Table 2). The chronicity of some mental illnesses, notably schizophrenia, increases with age; and patients of this category often experience more frequent and/or prolonged hospitalization.

Table 3

*Distribution of Psychiatric Inpatients by Diagnosis in 1983*

Diagnosis	First admitted	Readmitted	Total in-patient
	%	%	%
Schizophrenia	53.6	61.7	58.0
Paranoid-states	5.0	2.5	3.6
Affective psychoses	6.5	9.4	8.1
Neurotic disorders	10.1	4.4	7.0
Others	24.8	22.0	23.2
Total	100.0	100.0	100.0

Schizophrenia was the most common diagnosis among the first admitted, readmitted, and the overall inpatient population. Readmission rates for both schizophrenia and affective psychoses are higher than their respective first admission rates. This reflects the greater potential for those experiencing one of these illnesses to suffer a relapse. Patients with neuroses were less frequently readmitted and they only accounted for 7% of the hospital population.

There are many more psychotic patients than neurotic patients requiring in-patient treatment which is comparable to other developed countries. Moreover, psychotic inpatients usually require much longer hospital stay than neurotics.

### Professional Personnel and Treatment Approaches

The mental health services adopt a multidisciplinary team approach in the treatment and rehabilitation of the mentally ill. There are three basic approaches to psychiatric treatment in Hong Kong. The first is the biological approach which emphasizes physical methods of treatment, such as the use of drugs. The second is the psychological approach which stresses treatment by psychological methods. The third is the social approach

Table 4

*Distribution of Psychiatric Inpatients and Outpatients by Major Diagnostic Categories in 1983*

Diagnosis	New psychiatric		Psychiatric inpatients			
	No.	%	Treated &		Remaining in	
			No.	%	No.	%
Psychosis	1,297	30.3	4,770	76.0	2,975	83.2
Neurosis	2,204	51.5	948	15.1	229	6.4
Others	779	18.2	308	4.9	308	8.6
Unknown	0	0.0	250	4.0	64	1.8
Total	4,280	100.0	6,276	100.0	3,576	100.0

which seeks to treat mental illness by social means, such as manipulation of the environment (Singer, 1981). Examples of treatment methods include drugs, electroconvulsive therapy, psychotherapy, behavioral therapy, occupational therapy, and physiotherapy.

All patients referred by other agencies are assessed and treated by medical officers under the supervision of consulting psychiatrists working within the framework of the Mental Health Ordinance of Hong Kong. For the care and treatment of patients, different professionals are involved. Clinical psychologists offer a wide range of services in both individual and group settings. Referrals from medical officers are accepted for diagnostic investigation, counseling, and rehabilitation. Medical social workers assist patients and their families with social or familial problems associated with the illness. Through team collaboration, utilization of community resources and liaison with outside agencies, they contribute to the social rehabilitation of patients and the patients' reintegration into the community.

Occupational therapists apply planned programs in pre-vocational training, self-care training, and other therapeutic activities to help patients overcome psychological and behavioral dysfunctions in order to facilitate their recovery and to prepare them for future work, social and home settlement. Physiotherapists help to treat patients with a physical or neurotic complaints, thus aiding their overall recovery. Maintenance and

progressive exercise programs are held, which aim at helping to improve the patients' general condition. The role of the community psychiatric nurses is to perform their nursing duty in noninstitutional settings and to follow-up on the ex-mentally ill and their families. They also provide educational services to the public on mental hygiene.

### Community Mental Health Services

The ultimate goal in the rehabilitation of the mentally ill is for them to reintegrate into and live as normal members of the community (Wing, 1968). A variety of services are provided to facilitate reintegration. The following sections describe the community mental health services launched by the voluntary mental health agencies in collaboration with the government departments in Hong Kong.

#### Counseling, Casework, and Preventive Services

Many voluntary counseling/family service centers, with staffs of social workers, counselors, and clinical psychologists, provide individual, group and family counseling for normal as well as ex-mental patients. In a recent study on voluntary mental health services, Mak and Lai (1989) found that all of the surveyed agencies launched community mental health education activities such as exhibitions, seminars, talks and courses. Moreover, most of them produced publication and mass media education on mental health. Their productions included newsletters, radio and television programs at the primary prevention level. Most of the agencies provided mental health services at the secondary as well as the tertiary levels of prevention (Caplan, 1964). At present, there are about twenty voluntary social service agencies actively promoting community mental health programs in Hong Kong.

#### Half-way Houses

Half-way houses provide temporary shelter for recovered mental patients after their discharge from the psychiatric hospital. They provide a suitable environment to assist individual growth and development of the recovered patients. Under the



guidance of social workers and mental health personnel, half-way house residents offer mutual support to each other and prepare themselves to return home or learn to live independently (Budson, 1979; Raush & Raush, 1968).

By the early 1990s, 30 half-way houses with 1,200 places will be established. Many of these half-way houses will be in public housing estates, offering an integrated form of community environment with which many recovered mental patients are familiar so as to facilitate adjustment and integration.

### Community Psychiatric Nursing Services

The Community Psychiatric Nursing Service was established in 1982 to provide continuity in aftercare treatment programs for discharged mental patients, to assist them in social readjustment and to educate the patients and their families in mental health. Community psychiatric nurses visit the homes of mental patients, and advise them and their relatives on medication and on matters related to rehabilitation and treatment of their conditions, thus assisting in the prevention of relapse. Many mental patients who would otherwise require hospitalization can be taken care of in their homes with the services rendered by community psychiatric nurses. The service is regionally based and jointly operated by the voluntary agencies and the Medical and Health Department. There are now seven such centers.

### Sheltered Workshops, Vocational Training and Employment

The sheltered workshops serve either those ex-mental patients who cannot enter into open employment because of limited capacity, or help other discharged patients to develop work habits before attempting open employment (Anthony, 1977). The sheltered workers engage mainly in industrial assembly work and the workshops are capable of accepting orders of simple contract jobs. One agricultural workshop serving discharged patients is engaged in the production of vegetables, flowers and the rearing of pigs and pigeons. The sheltered workers normally receive wages in accordance with their individual productivity level. A daily incentive payment is also paid for attending the sheltered workshop.

The voluntary mental health agencies and the Technical Education and Industrial Training Department offer vocational training courses to the recovered mental patients. As for open employment, the Selective Placement Service of the Labor Department and some voluntary agencies help ex-mental patients find employment.

### Social Clubs

Voluntary agencies run social clubs for ex-mental patients to prepare them socially and psychologically to integrate into the community. Social and recreational services are also provided to the chronically mentally ill patients who are not able to utilize the normal community facilities.

### Compassionate Rehousing

The Compassionate Rehousing Plan offers special assistance in providing accommodation to those recovered mental patients whose family environment is not suitable for their mental conditions but who do not need to be kept in institutions. Under this plan, several recovered mental patients who cannot return to their families for one reason or another may jointly apply for a housing unit. This enables them to live in a home-like setting, sharing with each other and offering mutual assistance (Soni, Soni, & Freeman, 1978).

### Social Security and Financial Assistance

Those discharged mental patients who are in financial difficulty may apply to the Social Security Units of Social Welfare Department for public assistance. Some may be eligible for disability allowance based on the appropriate medical recommendations. A number of trust funds are also available to help cover special expenses such as removal of accommodation and purchase of furniture.

### Current Mental Health Issues

Prominent mental health services issues include public attitudes towards ex-mental patients, personnel and burnout, accommodation for ex-mental patients, and resources constraint.

### Public Attitude Toward Ex-mental Patients

The attitude of the public towards ex-mental patients influences the successful rehabilitation and community integration of the discharged patients. The public usually holds a biased attitude towards mental patients based on fear of their unpredictability and alleged dangerousness. The public's biased attitude towards ex-mental patients can be seen in the recent public opposition by some residents towards the location of half-way houses in their housing estates. Community education is seen as a means of alleviating public prejudice. Such community education, an essential component for community mental health care, requires the joint efforts of government, professionals, community members and a well-informed and cooperative media. Moreover, it has to be carried out on a long-term basis.

### Personnel and Burnout

The further development of mental health services as well as the provision of existing services will demand considerable personnel, particularly psychiatrists, clinical psychologists, nurses, occupational therapists, physiotherapists, and social workers. In a recent study on problems encountered by voluntary mental health agencies, Mak and Lai (1989) found that 56% of the surveyed agencies reported staff shortages, and 22% indicated heavy workload or burnout phenomena among professional workers. While the first phenomenon might be explained by the inadequate resources in training professionals, the recent massive emigration of professionals has made the issue more acute. The second phenomenon might be due to the vicious effects of staff shortages, overwork, and the demanding nature of mental health work (Lamb, 1977; Pines & Maslach, 1978). Until there are improvements in work conditions, increases in training facilities with more resources allocated to recruitment of high caliber professionals, the quality of mental health services will be greatly affected.

### Accommodation for Ex-mental Patients

In Hong Kong, crowding in psychiatric hospitals is always a problem in that occupancy rates often exceed capacity. A

source revealed that some patients were found to be staying in hospital unnecessarily because of insufficient aftercare facilities (Medical & Health Department, 1989). If aftercare services and accommodation facilities are increased, quite a substantial number of patients in psychiatric hospitals can be discharged. Until more long-term care homes, half-way houses and sheltered workshops are established, the crowding will continue to be a problem in psychiatric hospitals (Budson, 1979; Pepper, Kirshner & Ryglewicz, 1981; Soni, Soni, & Freeman, 1978).

### Resource Constraints

The development and provision of services for the mentally ill will require funds, physical facilities, as well as staff. Mak and Lai (1989) found that 56% of the voluntary mental health agencies reported a financial deficit, 11% identified a scarcity of training resources, and 11% indicated insufficient office space. Resource constraints hampered the provision and development of mental health services.

In summary, the development of the mental health services are mandatory to the well-being of the people in Hong Kong. In spite of the strenuous efforts by voluntary mental health agencies and government departments in the last four decades to establish the present mental health services, several barriers to continued development of the services exist. These include the financial constraint, emigration of professionals, lack of accommodation for ex-mental patients, and negative public attitudes towards ex-mental patients. It is hoped that various mental health professionals, the government, and the voluntary agencies will develop innovative, inexpensive, and integrated mental health services in Hong Kong in the near future.

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# Mental Health Services in Japan

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*Modern Japanese mental health services have their beginning with the conclusion of World War II. The system of services has since changed at all levels. New laws affording fundamental rights to mental patients were initiated in 1950, but reforms are in process even today that continue down the path toward more enlightened and specialized care. Demographic data are presented including the number of patients and their characteristics, and the number and kinds of service providers. An outline of the administration of mental health services is provided with special emphasis on institutional care. Future trends are highlighted.*

## Brief History of Mental Health Services in Japan

In Japan two pieces of legislation concerned the mentally ill prior to World War II. The Confinement and Protection for Lunatics Act of 1900 provided procedures to confine mentally ill patients in their own homes. The Mental Hospital Act of 1919 laid down administrative procedures for compulsory detention in an asylum. These two statutes were designed specifically to permit relatives or local authorities to exert their protective powers for safeguarding the public. The rights of the patients themselves were considered to be of secondary importance.

After the Second World War, under the Constitution newly promulgated in 1946, fundamental human rights of the Japanese people were afforded maximum respect. But unfortunately, the Mental Hygiene law of 1950 was not in harmony with the philosophy and principles of the Constitution. This law decreed that psychiatric patients be institutionalized in psychiatric hospitals. Private custody was prohibited ostensibly so that the mentally ill could receive adequate medical treatment. This law included the principle of compulsory admission by administrative order under the standard of "dangerous to self and others".



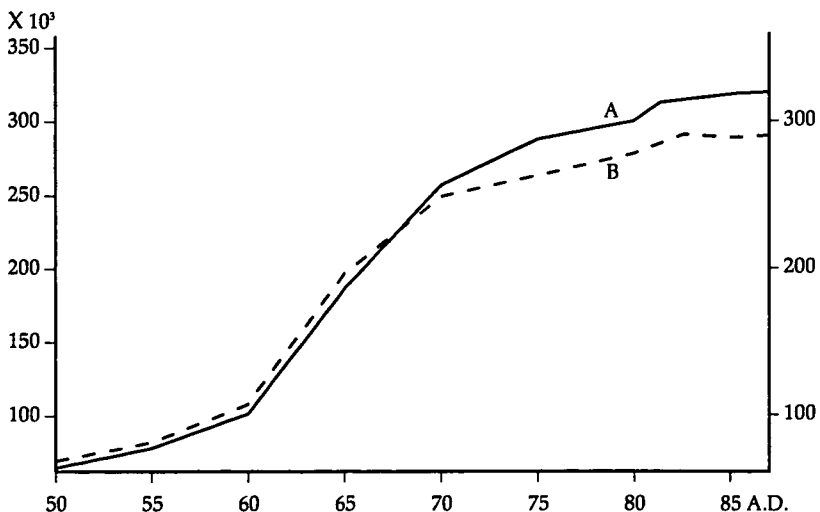
This involuntary admission system essentially transferred the right to make a decision regarding hospital admission from the patient to someone else. Therefore, as of 1987, over 90% of the population in mental hospitals in Japan consisted of involuntary patients.

Psychiatric care in Japan has emphasized hospitalization over other options. In 1950, the number of beds occupied by mentally ill people decreased to 2 per 10,000 general population. But, since 1951 Japan has undergone a rapid industrial development which has resulted in a rise in the utilization of inpatient facilities. By 1988 the total number of psychiatric beds reached a peak of 28 per 10,000 general population and the number of beds totaled 351,358.

In 1960 a plan was put forth (the Income Doubling Plan) which requested an increase in psychiatric beds to cope with the increasing number of patients who were involuntarily hospitalized by the governor and whose expenses were completely subsidized by the government. The government's response was

Figure 1.

- (A) The net number of inpatients in mental hospitals in Japan: 1950-1989  
 (B) The number of inpatients per 10,000 population.



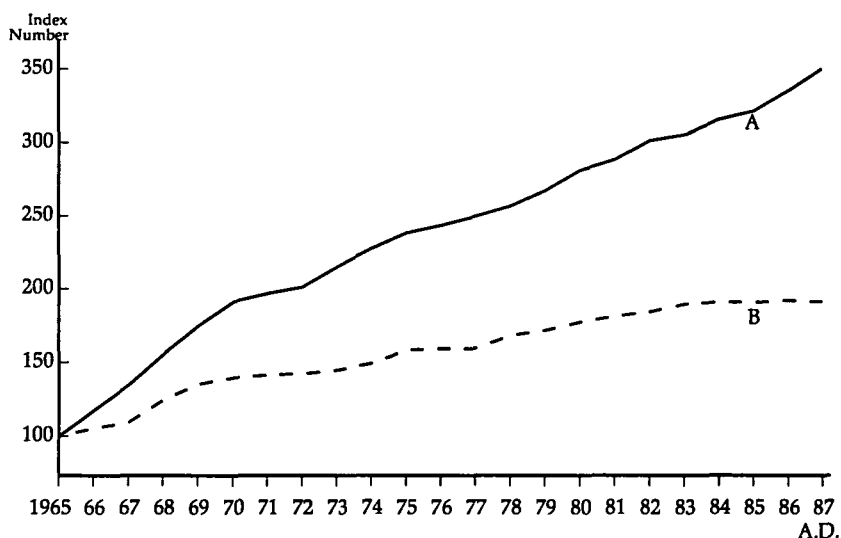
to restrict the number of public hospital beds and subsidize private hospital beds. This policy, not surprisingly, increased the number of private psychiatric beds which is a characteristic of present day Japanese mental health care. Of the total number of beds in psychiatric facilities, 88.5% are in the private sector (most of them are incorporated and nonprofit).

In 1965, the Mental Hygiene Law was partially revised in order to encourage outpatient services and other mental health services at the community level. The revised law provided that each prefecture (although smaller geographically, a prefecture is a local governmental unit roughly equivalent to state level governmental units in the U.S.) establish a Prefectural Mental Health Center and public financial assistance for outpatient psychiatric services.

Figure 2.

(A) The total number of outpatients in Japan: 1965-1989

(B) The total number of outpatients



A comprehensive plan or budget has yet to be set forth by the government for community psychiatric care. Though a system of outpatient care has been developed, the percentage of outpatient care expenses relative to total psychiatric care expenses has remained static since 1965. This means that the basic

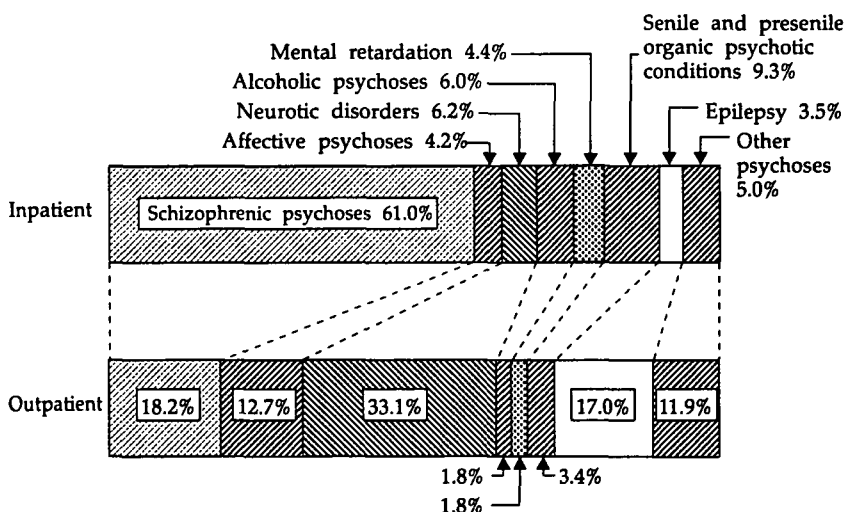
pattern of psychiatric care delivery has not changed in the last twenty-five years. The primary means of treatment for the mentally ill in Japan remains the psychiatric hospital.

### Demographic Data Relevant to Mental Health

The total number of long term patients is increasing every year. Currently more than 50% of inpatients have been in the hospital for more than five years. The average age of hospitalized patients has increased every year and reached a current peak of between 45 and 55 years. The patients over 65 years old accounted for 19.6% of all psychiatric patients in 1988. As shown in Figure 3, schizophrenic psychoses are the most frequent primary diagnoses of the mental disorders for admission and outpatient care. Most of the social rehabilitation programs for patients with these psychoses work toward normalization.

Although not shown in Figure 3, alcohol dependence is 20 times more frequent in males than in females. Consultation service, information dissemination, and voluntary support

Figure 3. Distribution of clinical diagnosis



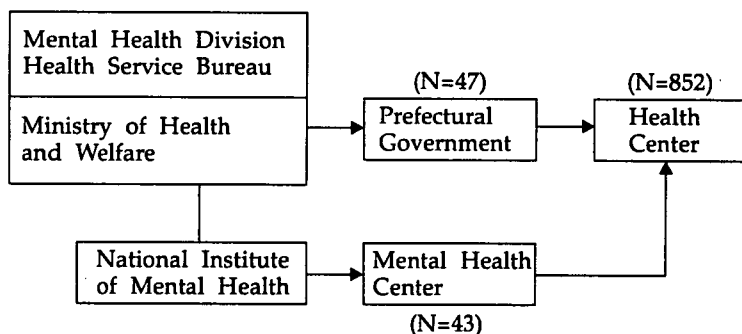
Source: stat. M.H.W. 1987

programs in the community for alcoholics and their families are arranged for these disorders.

### Outline of Mental Health Administration

Mental Health Law is within the jurisdiction of the Mental Health Division of the Health Service Bureau of the Ministry of Health and Welfare. In each Prefectural Government, the Department of Public Health is in charge of mental health services, and most prefectures have mental health centers. Mental health centers have responsibility for promoting public mental health services and disseminating information at the prefectural level by carrying out consultation, training, education, and research. In local districts, consultations and other mental health activities are carried out chiefly by mental health counselors or public health nurses who belong to health centers. The relation between these departments and institutions is shown in Fig. 4.

Figure 4. The relationship between departments and institutions



### Institutional Care

As of June 1988, the statistics concerning institutional care were as follows: number of inpatients -341,962; psychiatric beds per 10,000 population -28.4; number of involuntary admissions by the Prefectural Governor -21,803; mean length of stay in days -513.8; 18.3% of the psychiatric hospitals are public and 11.7% of the beds are public. For more institutional statistics, see Table 1. Japan has no special hospital security unit for mentally

disordered offenders and refractory patients. Most of them are hospitalized in the public and private mental hospitals.

Table 1

*Table of Psychiatric Hospitals and Beds in Japan\**

	Hospitals	Beds
Total	1,641	351,358
Private psychiatric hospitals	1,341 (81.8%)	310,868 (88.5%)
incorporated (nonprofit)	977	249,256
private	364	61,612
Governmental psychiatric hospitals	249 (15.1%)	34,457 (9.8%)
national	91	9,276
local government	158	25,181
Another psychiatric hospitals (Established by Red Cross etc.)	51 (3.1%)	6,033 (1.7%)

\*(Ministry of Health and Welfare)

JUNE 30, 1988

### *Staffing Patterns*

As of June 1987, there were 8,725 psychiatrists (almost half of them are part-time), 37,087 nurses, 36,402 assistant nurses, and 20,342 nurse aides. The exact number of allied health staff working in psychiatric hospitals is not known. It is estimated that there are 500 occupational therapists, 830 psychiatric social workers, and 600 clinical psychologists. Among them, only occupational therapists have national regulation.

### *Community Care*

Community care programs have gradually developed since 1970, but they have not been an important factor in the treatment of psychiatric patients. Community care programs include: (a) day services (monthly or weekly) at public health centers, (b) day-care services in private or public hospitals, (c) aid system for the employers of ex-mental patients, (d) approximately 400

small scale sheltered workshops, and (e) community residence programs. Japan has only 125 approved day-care programs (50% of them are private). The aid system for employers is the only system for vocational rehabilitation for mental patients. While (a) and (c) are the programs of Japanese government, (d) and (e) are either run by patients' family associations or voluntary mental health personnel.

Japan has 43 prefectural community mental health centers and 852 public health centers. The activities of community mental health services of these public health centers are not well coordinated with psychiatric hospitals in the community.

According to the fact-finding survey of mental health conducted by Ministry of Health and Welfare in 1983, more than 30% of hospitalized patients could leave the hospitals immediately, if there were enough social support systems in the community. Sixty percent of the families of patients said that they could not afford to look after relatives who were discharged from the hospital.

### *Community Mental Health Services*

Community Mental Health services in Japan are shown in Figures 5 and 6. One thousand four hundred and twenty five outpatient facilities and clinics take care of 700,000 patients and deliver medical services including case management and counseling for recovering patients. Forty three Prefectural Mental Health Centers and 852 Health Centers are in coordination to deliver public mental health services including counseling, day care programs, information dissemination, and other services.

Day Care Centers are day treatment facilities which provide medical therapy and social activities for several hours during the day. Nonresidential Social Rehabilitation Facilities deliver occupational and recreational activities and family support. However, Japan does not have enough social support systems in the community to accept many hospitalized patients.

### *Current Issues*

After some improprieties with inpatients in Utsunomiya Hospital were reported in 1984, many protest that mentally ill

Figure 5. Overview of mental health services (June, 1988)

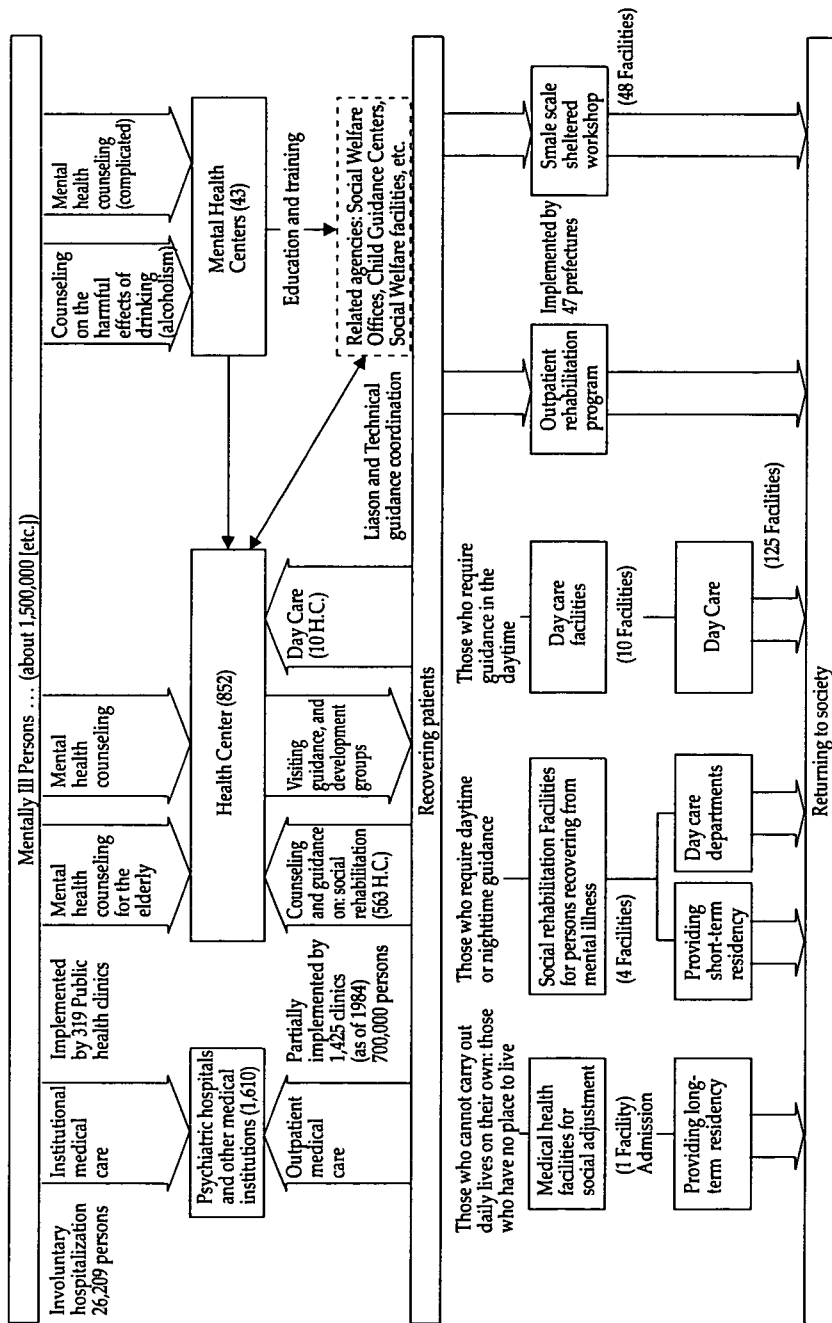
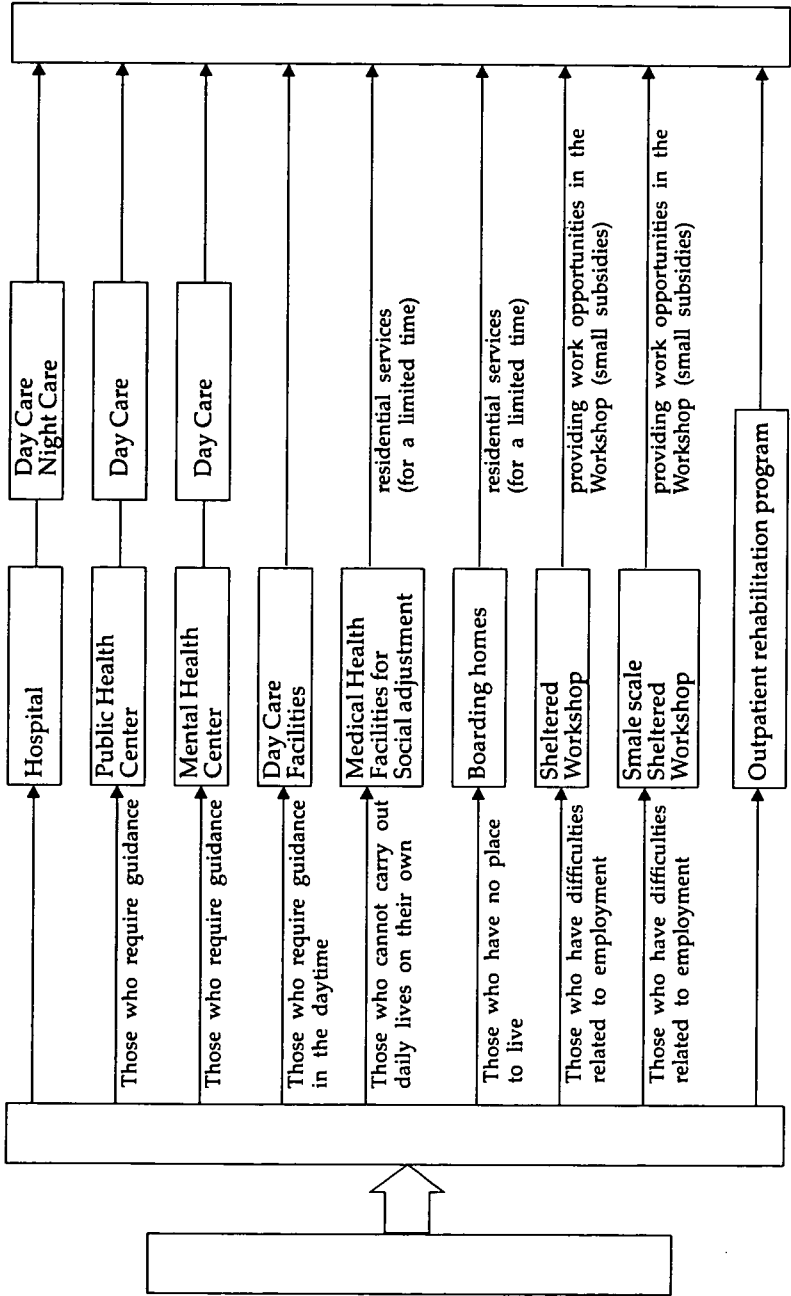


Figure 6. Scheme of mental health services (1989)





persons in Japan were subjected to violations of human rights. These protests were made domestically and internationally, and the government of Japan declared an amendment to the Mental Hygiene Law in August 1985. After two years of investigations and discussion, the newly revised Mental Health Law was legislated in 1987, and it has been in operation since July 1988.

In the course of the investigations, there were confrontations between psychiatrists and jurists in reference to the best way to assure patients' rights. The basic concept in amending the Mental Health Law was the protection of the human rights of the patients, changing conditions of admission, changing standards for designated physicians, and the promotion of social rehabilitation for mentally disordered persons.

The main points of the amendment for the protection of patients' right are:

(a) in case of admission to a mental hospital, the superintendent of a mental hospital shall endeavor to admit the mentally disordered person on his/her consent (Voluntary Admission); (b) to guarantee all patients' rights to appeal to the Prefectural Governor for discharge or to report inappropriateness of treatment; (c) to establish The Psychiatric Review Board to review the necessity of involuntary hospitalization and the propriety of treatment; (d) to prohibit restrictions on actions, such as correspondence, telephone calls and visitors; and, (e) to give the notice of patients' rights in writing at admission. Such rights include: (a) particular restrictions on actions, such as the use of seclusion room for over 12 hours or physical restraint by suitable apparatus, should be decided only by a designated physician; (b) the director of the psychiatric hospital must inform the patient of these rights at admission; (c) as to admission for medical care and custody and involuntary admission by the Prefectural Governor, the director is required to give a regular report to the governor; and, these reports and the appeals of patients concerning discharge or better treatment may be reviewed by the newly established Psychiatric Review Board.

The principle reform concerning type of admission is the introduction of the voluntary admission. If the superintendent of a mental hospital decides to admit a mentally disordered person, it shall be done by voluntary consent if possible and

the patient should be informed of his/her rights. If a voluntarily admitted person requests discharge, the superintendent shall do so unless a physician deems it necessary to continue that admission for medical care and custody. In this case, the superintendent may refrain from discharging that person for a period of not longer than 72 hours. This voluntary admission option was not provided in the original Mental Hygiene Law, although Japan had another type of voluntary admission (so-called "free" admission, 5-10% of total admissions) which was not included in the original law.

A person who has been deemed mentally disordered by the superintendent of a mental hospital, as a result of an examination by a physician, and thus in need of admission, can be admitted involuntarily, when a person responsible for his custody consents to the admission. Previously, this consent admission had priority at the admission, even if a patient agreed to the admission. More than 80% of inpatients were admitted with the consent admission. Thus, it is misleading to say that

Table 2

*The Transfer Between Admission Types in the Two Years after the Enforcement of The New Mental Health Law, July 1, 1988. (The Findings of Private Mental Hospitals, 842,. J.P.M.H. June 30, 1990)\**

Type of Admission June 1988		June 1990 New Admissions as of June 1990	
A. Voluntary Admission	not legislated -0-	51.5%	63.8%
B. Involuntary Admission	consent by guardian inv. & vol. admission 82.4%	admission for medical care and custody (involuntary) 41.5%	28.0%
C. Involuntary Admission by Governor	5.7%	4.0%	1.5%
D. Free or General Admission not Included in MHL	free admission 11.9%	general admission 3.0%	6.7%

\*Emergency admission and temporary admission are very few.

more than 90% of inpatients were involuntary admissions. Six months after the enforcement of the new law, 34% of new admissions were voluntary which shows that many inpatients had previously been misclassified.

#### *Involuntary admission by the Prefectural Governor*

A person may be involuntarily admitted only when the results of medical examinations made by two physicians, designated by a Prefectural Governor, have agreed that the examined person has been deemed liable to injure himself or others because of a mental disorder.

#### *Emergency admission*

A mental hospital may admit a person for a period of not longer than 72 hours, without the consent of the mentally disordered person, after the superintendent has concluded as a result of a medical examination that the person in question is mentally disordered, and there would be extreme interference with his medical care and custody unless he is admitted to the hospital without delay.

#### *Qualifications for the Designated Physician of Mental Health*

The Designated Physician of Mental Health is defined by Article 18 of the mental health law. Psychiatrists are required to practice for more than five years, and prove their experiences with eight case reports for registration. Designated Physicians are responsible for daily activities and decisions on all admissions and discharges except for voluntary ones. The restrictions on action specified by the Minister of Health and Welfare should be judged by Designated Physician. So, treatment in psychiatric hospitals cannot be executed without a Designated Physician. In 1988, there were 7,000 Designated Physicians.

The psychiatric rehabilitation system in Japan is underdeveloped compared with psychiatric rehabilitation facilities in other developed countries. Many chronic psychiatric patients hesitate to leave the hospital and live in the community because of the lower cost of admission and lack of rehabilitation facilities.

Concerning rehabilitation, the new law set forth a policy which had been neglected since the amendment in 1965. Psychiatric rehabilitation was included in the purpose of the law stated in Articles 1 and 2, which prescribes that the completion and increase of rehabilitation facilities is a duty of the national and local governments. The law requires that information about government standards concerning patients' rights should be made more easily available to the patients. Ninety percent of all hospitals believe the new law should be amended again, because too much paperwork is required and the psychiatric rehabilitation policy lacks an adequate social support system and financial support. Many Japanese psychiatrists are working diligently on a compromise between psychiatric practices and patients' rights.

### Challenges for the Future

The elongation of mean life expectancy represents a human triumph, but at the same time, the explosion in the absolute number and relative proportion of an elder population increases the number of patients with dementia. It is considered likely that these changes in demography also affect the operation of the social security system. The Ministry of Health and Welfare established a Task Panel for the Demented Elderly in 1986, and the Panel emphasized in its recent report in 1987, that the following policies should be implemented immediately:

To enforce health promotion activities which are intended to prevent geriatric diseases, so as to reduce the incidence of cerebrovascular diseases, the most frequent cause of dementia in Japan.

To improve the availability and accessibility of home care and institutional care.

To establish needed services, staff must be attracted, retained and trained, and a network for a continuous care system must be formed.

Mental disorders in childhood or adolescence accompanying social and behavioral symptoms are of great interest lately, although the number of institutions or health personnel that are specialized in these fields is lacking. Policy improvement regarding these disorders cannot be overemphasized.

The Mental Health Law says: The National, Prefectural and Local Governments shall endeavor to enable mentally disordered, etc., to adapt themselves to the social life, by expanding and improving the facilities needed for medical care, social rehabilitation and other welfare purposes and education . . . . Today, no remarkable change can be found in the social rehabilitation of mentally disordered persons. A request should be made for more subsidies and legal support to promote the rehabilitation and community care of the mentally ill people in Japan.

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# A Cross-Cultural Perspective on Selected Mental Health Systems

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*The information provided from authors around the world on their respective mental health systems is analyzed and compared. Several key dimensions are utilized, including the relationship of mental health services to other services, institutional care, community care, staffing, prevention and mental health promotion services, and accessibility. Resources and governmental priorities are identified as being essential to the provision of effective services. It is clear that the general trends identified by the experts for mental health in both developing and developed countries are by no means universal in applicability.*

This edition of the *Journal of Sociology and Social Welfare* has brought together a distinguished group of authors from around the world to present a picture of mental health systems in selected countries. Using a common format, the information supplied provides the reader with a rare opportunity to compare the state of mental health services in countries from various parts of the world.

This special issue has purposely included both developed and developing countries. In considering the mental health systems of developing countries, some experts believe that there is a problem with models of mental health being too deeply rooted in Western European and North American culture (Wig, 1989). It may well be the case that methods of service delivery which are perfectly suitable to the culture and social problems of the United States may have limited application to mental health problems in developing countries.

Many of the problems highlighted in the preceding articles have also been mentioned elsewhere in discussions of general mental health trends (Sartorius, 1987). These include neuropsychiatric disorders of the elderly, alcohol and drug dependence, and the psychosocial problems accompanying newer diseases and problems such as HIV. Sartorius goes on to point out that "Mental health and functioning are held in low esteem by most people in most countries of the world" (p. 152). This low priority in the hierarchy of values is a matter of grave concern because it becomes operationalized in the competition for scarce financial and human resources within each country. Medicalization of services is another trend echoed in some of the papers in this issue.

Holmes and Hokenstad identified several key dimensions in their introductory article: the relationship of mental health to other services, institutional and community care, staffing, prevention and accessibility of services. By organizing the paper in this manner, it is hoped that the reader might be assisted in comparing the analyses provided by the authors from the represented countries. Countries will be mentioned in alphabetical order whenever possible in the discussion of each dimension.

#### Relationship of Mental Health Services to other Health and Social Services

Holmes and Hokenstad note that the integration of mental health services into the health care network is a trend in developing countries as well as in Europe. With limited resources, the choice to integrate is logically superior to that of pursuing the construction of an extensive and independent specialty mental health system. This principle gets at least qualified support from Egypt where the suggestion is made for psychiatric wards in all general hospitals. In Hong Kong, additional beds are projected in general hospitals as well.

In India, we read that mental health care is integrated with primary care especially in the countryside, but to some extent in the urban areas as well. In Rwanda, to the extent that traditional healers comprise the most common form of primary health care, mental health services are in the primary stream of services. In

fact, this is a theme common to all of the developing countries included in this special issue.

In contrast, integration into the health care system is mentioned as a policy problem in Israel. It is the medicalization of mental health, which includes apparently successful attempts to absorb Mental Health Services into the Ministry of Health. This trend is paralleled in the United States, where a recent recurring proposal is to fold the National Institute of Mental Health into the National Institutes of Health.

### The Status of Institutional Care and the Centralization vs Decentralization of Services

It has been noted that mental hospitals have been with us for almost as long as history has been recorded. Even before the first mental institution in the world was built Egyptian physicians were treating mental patients in general hospitals three thousand years ago. This shows that at least one of the recently published guidelines for treating mental patients in general hospitals as a way to increase the availability of mental health services is not exactly new (WHO, 1975). This idea would undoubtedly increase the availability of mental health services to the general populations of developing countries even if there are good arguments to be made against the medicalization of mental health services (see Aviram, this issue).

Mental hospitals as institutions serving the mentally ill are an important component of any analysis of a mental health system. Whether the country in question is very old, such as Egypt or India, or very new, such as the country of Israel, a discussion of the country's response to mental illness must include the role of the mental hospital. In a developing country such as India, the question is not how long have mental hospitals been around, and what has become of them, but rather, how few of them exist in comparison to need.

There was much activity in the field of mental institutions beginning in the 1940s. In 1949 a qualified Chinese psychiatrist was the first medical superintendent of a mental hospital in Hong Kong. In Israel, a country established, in 1948, their first mental health priority was to expand psychiatric beds and this was apparently accomplished mainly by increasing the number



of mental hospitals. Of course, as Aviram explains, the beginning of the mental health system was made much earlier than 1948.

Japan's modern mental health legislation began with the Mental Hygiene law of 1950, a law which required that psychiatric patients be placed in mental hospitals. And finally, Rwanda's first mental institutions were built beginning in the 1940s. So mental institutions played an increasingly important role in modern mental health care in many countries all over the world following the conclusion of World War II.

Holmes and Hokenstad make the point that decentralization and deinstitutionalization are the trend in both Europe and the United States. Okasha provides ample evidence that this is the direction in Egypt. He notes that deinstitutionalization is a goal, that mental hospitals in Egypt are getting smaller, and that patients are, on the average, staying for shorter periods of time.

In Hong Kong, Mak reports that psychiatric hospitals are still overcrowded, but that the expansion of psychiatric beds will occur in smaller sized wards in general hospitals rather than in large psychiatric facilities. In India, where the need is so great as to dwarf the service system, there is an introduction of psychiatric units in general hospitals. But Rajkumar points out that there are essentially no mental health services available in the villages where most Indians reside.

Aviram tells us that in Israel there have been dramatic declines in the utilization of mental institutions which occurred simultaneously with increases in the use of alternative service options such as day care services. In Japan, there seems to be an exception to the general trend. Asai reports that the delivery of mental health services has not changed there for decades. The psychiatric hospital is still the main avenue of care, with an increase in the number of inpatients rather than the decrease reported elsewhere. In Mexico, the attempt to decentralize has so far not been successful. Attempts to deinstitutionalize have been hampered by a combination of factors in Mexico, and so is proceeding slowly. In Rwanda, the problem is more a matter of building a mental health system, rather than reorganizing it. The specific information about the mental health systems reported here show both support for the general trends described

by Holmes and Hokenstad, and the need for caution not to overgeneralize. Every country has special historical, cultural, geographic, and demographic conditions that need to be considered.

### The Status of Community-based Mental Health Services

If the direction of mental health services in many countries is away from institutional care, then what are the opportunities for outpatient care? In Egypt, according to Okasha, the community is not ready to provide for people on an outpatient basis. In Hong Kong it is said that community care is the goal. That goal is being pursued by a variety of agencies providing community mental health programs there. In addition, the stigma of mental illness is still an obstacle.

India also has a problem with stigma, in addition to the large numbers of untreated mentally ill persons. Community care in India means care in the community by the patient's family, rather by some outside agent. In Israel much of the care provided to the mentally ill is community care by professionals. There are many outpatient facilities in Israel, and the comprehensive system of care there is similar to other developed countries in Western Europe and North America. However, there is no clear pattern that can be discerned on the basis of developed vs. developing countries. Japan, Mexico, and Rwanda are examples of this point. Japan, the epitome of high technological and economic development, reportedly has relatively few outpatient services. Mexico, in contrast, is characterized by Lartique and Vives as a developing country, yet has a relatively sophisticated and complex outpatient services system. Rwanda has a primitive mental health system by Western standards, yet has a rich and effective network of traditional healers in place.

### Staffing

The adequacy of mental health professionals in any given country is relative to the total population of that country. The following table will give the reader a comparison of the professional staff available for mental health services in the countries included in this volume.

Table 1

*Approximate Population, and Mental Health Staffing Totals for Selected Countries, Based on Data From 1986 to 1990*

Country	Psychi- atrists	Psych- ologists	Social Workers	Nurses	Total Population
Egypt	250	250	N.A.	N.A.	52,000,000
Hong Kong	Not Avail.	N.A.	N.A.	N.A.	N.A.
India	2,000	600	1,000	N.A.	800,000,000
Israel	624*	518	337	1,864	4,500,000
Japan	8,725**	600	830	37,087	123,700,000
Mexico	1,108	10,000+***	250	N.A.	79,000,000
Rwanda	N.A.	N.A.	N.A.	N.A.	N.A.

\*Physicians working in mental health

\*\*Almost half of them are part-time

\*\*\*Very few work in psychiatric hospitals or health centers

Numbers are not available on the traditional healers. Their importance in a country like Egypt is underscored by the Okasha study (1968) showing "that about 60% of the out-patients at the university clinic in Cairo serving the low socio-economic classes have been to traditional healers before presenting to the psychiatrist." Lartique and Vives remind us that there are thousands of herb merchants, healers, shamans and the like providing services to the people of Mexico. And of course, as Gathayara, et al. inform us, a large part of mental health care in Rwanda is provided by traditional healers.

### Accessibility of Mental Health Services

In Egypt it is said that of the 24 governmental subdivisions, roughly equivalent to "states", five of the 24 have no psychiatric clinics nor in-patient units. In India, with an estimated 20 million people needing care and 25,000 beds, the issue of accessibility pales. Availability precedes accessibility. First the services have to be brought into existence, then the issue of deployment becomes relevant.

### Resources, Priorities and Notable Factors

There are other common themes in the papers comprising this special issue. For example, There would seem to be a dichotomous relationship between modern mental health treatment and traditional healing practices. Perhaps with the exception of Rwanda, there is a competitive tone to the discussions of traditional healers and one senses the parenthetical manner with which some authors treat the topic. To be fair, this could reflect only a lack of familiarity with the subject.

On the one hand this is perfectly understandable and reasonable. The two systems (scientific and religious/magical) do have contrary premises and beliefs upon which they base their practices. On the other hand, the holistic health movement in the United States, and elsewhere is attempting to study the possibility of gleaning the best and most successful attributes of all systems of healing with the ultimate goal of integrating them. Perhaps these articles demonstrate the strong divisions that must first be overcome prior to any such integration on the part of some mental health scholars.

There are significant statistics describing the size and composition, location and concentrations of the various populations of the countries represented here that bear repeating. Mexico, with thirty-nine percent of its population under the age of fifteen is going to have very different mental health concerns than a country like the United States with an aging population. And a country like India where seventy percent of the people live in rural villages is going to contrast dramatically with countries like Hong Kong and Israel where almost all of the population is urban in location and orientation. Size of the country is also an important issue of note. India has 800 million inhabitants, more than ten times the size of Hong Kong or Israel, and more than three times the size of the U.S.

While all services of modern mental health care seem to have originated with the mental hospital, there have been a wide range of services and styles of treatment over time and from place to place. Psychiatric care in Japan has always stressed hospitalization, according to Asai. In Egypt, the priority for community care is not in the realm of mental health, but in the areas of birth control, infectious diseases in children and

recently smoking, and illicit drug abuse. In Mexico there are a wide range of services, from prevention to services for the chronically mentally ill. Methods of treatment range from pharmacology, psychodynamic therapy, and behavior management.

In Hong Kong, the problems of mental illness are treated with organic interventions, including psychopharmacology, psychological methods, and the social approach, which means manipulating the environment. In Rwanda, the plan to provide mental health services includes decentralizing, integrating into with general health care provision, and stressing prevention. In India, the major source of treatment is the mental hospital, with some small attempt to establish general hospital psychiatric units. However, in India, the major problem continues to be a demand for service utilization that far exceeds the supply of available staff and facilities to provide that service. Israel, by contrast, is described as having a highly developed system with a broad array of services, even though some of those services have just been initiated in the last decade.

### Conclusion

One of the most common threads running through the articles included in this issue is the inadequacy of resources and the low priority assigned to mental health services compared to other needs. Here, we are reminded of the political process of assigning priorities. In Mexico, where the total budget of the country has been severely limited because of a large and growing foreign debt, funds for the mental health sector are severely affected. Ninety percent of the mental health budget of Israel is devoted to inpatient services, although the most activity and growth has been in other service sectors. In Rwanda there is reported to be a lack of resources and staffing. In India, the numbers can be overwhelming and then numbing to contemplate. Just imagine twenty million persons suffering from mental illness and just 25,000 beds catering to this demand.

The World Health Organization recommends a focus on prevention, integration of mental health services into the general health services, and decentralization. If resources are limited, as they are in almost every country, then prevention services have an uphill battle in the race for a share. When inpatient

care absorbs so much of the budget, there can be little left over for prevention. Also, if the government assigns priority to other non-mental health needs as is the case in Egypt, there is not likely to be much money provided. Two big obstacles to be overcome when it comes to decentralization is the uneven distribution of resources, and the difficulty of finding competent, trained staff willing to go to remote areas. If prevention and decentralization are to occur, then more emphasis must be put on community mental health services.

As Hokenstad and Holmes explain in the introductory article, there is a continuing need to aid developing countries so that they can avoid the pitfalls that the United States and European countries have experienced. Is this something that can be reasonably accomplished? Only time will tell. One thing is certain. We in the United States can learn much from other countries, whether they are developing or developed. And everyone can benefit from a continuing dialogue.

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