



**WESTERN  
MICHIGAN**  
UNIVERSITY

The Journal of Sociology & Social Welfare

---

Volume 18

Issue 2 June - Special Issue on Mental Health  
Services: An International Perspective

Article 2

---

June 1991

## Mental Health Services: An International Perspective

Thomas R. Holmes

*Western Michigan University*

Merl C. Hokenstad

*Case Western Reserve University*

Follow this and additional works at: <https://scholarworks.wmich.edu/jssw>



Part of the Clinical and Medical Social Work Commons, and the Social Work Commons

---

### Recommended Citation

Holmes, Thomas R. and Hokenstad, Merl C. (1991) "Mental Health Services: An International Perspective,"  
*The Journal of Sociology & Social Welfare*: Vol. 18 : Iss. 2 , Article 2.

Available at: <https://scholarworks.wmich.edu/jssw/vol18/iss2/2>

This Article is brought to you by the Western Michigan  
University School of Social Work. For more information,  
please contact [wmu-scholarworks@wmich.edu](mailto:wmu-scholarworks@wmich.edu).



# Mental Health Services: An International Perspective

THOMAS R. HOLMES

Western Michigan University  
School of Social Work

MERL C. HOKENSTAD

Case Western Reserve University  
Mandel School of Applied Social Sciences

*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.

### References

- Baasher T., El-Hakim A, Galal A. et al. (1979). Rural psychiatry: the Fayoum experiment, *Egypt Journal of Psychiatry*, 2, 77-87.
- Beigel, A. (1983). The WHO Collaborative Study on Strategies for Extending Mental Health Care, III: Evaluative Design and Illustrative Results. *American Journal of Psychiatry*, 140, 11.
- Chikara, F. B. (1990) *Mental health services in Zimbabwe*. Unpublished manuscript, Department of Psychiatry, School of Medicine, University of Zimbabwe.
- Eisenberg, C. (1980) Portrait of a Central American Slum, *World Health Forum*, 1, (1 and 2).
- Farley, G. K. (1988). An American perspective on day-treatment programs for children in Norway, *International Journal of Partial Hospitalization*, 5(1), 109-111.
- Freeman, H., Fryers, T., & Henderson, J. (1985). *Mental health services in Europe: 10 Years on*. Copenhagen: World Health Organization Regional Office for Europe.
- Harding, T. W., Busnello, E. d'Arrigo, Climent, C. E. (1983) The WHO Collaborative Study on Strategies for Extending Mental Health Care, III:

- Evaluative Design and Illustrative Results. *American Journal of Psychiatry*, 140, 11.
- Higgins, J. (1981). *States of Welfare: A Comparative analysis of social policy*. NY: St. Martins Press.
- May, A.R. (1976) *Mental health services in Europe*. (WHO Offset Publication No. 23) Geneva: World Health Organization.
- Mechanic, D., and Rochefort, D. A. (1990). Deinstitutionalization: An appraisal of reform. *Annual Review of Sociology*, 16, 301–327.
- Murthy, R. S., & Wig, N. N. (1983) The WHO Collaborative Study on Strategies for Extending Mental Health Care, III: Evaluative Design and Illustrative Results. *American Journal of Psychiatry*, 140, 11.
- Polcin, D. L. (1990) Ethical issues in the deinstitutionalization of clients with mental disorders. *Journal of Mental Health Counseling*, 12 (4), 446–457.
- Wig, N.N. (1989). The future of psychiatry in developing countries — the need for national programmes of mental health. *NIMHANS JOURNAL* (National Institute of Mental Health and Neurosciences (NIMHANS) in India, 7(1), January, 01–11.
- Sartorius, N. (1987). Mental health policies and programs for the twenty-first century: a personal view. *Integrative Psychiatry*, 5, 151–158.
- Sartorius, N. (1988). Mental Health in Primary Health Care. *International Journal of Mental Health*, 17 (3), 5–12.
- Sartorius, N. (1988). Opening Address. *International Journal of Mental Health*, 17 (2), 5–7.
- World Health Organization Expert Committee on Mental Health. (1975) *Organization of mental health services in developing countries*. (World Health Organization Technical Report Series No. 564) Geneva: World Health Organization.

