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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	Psychiatrists	Psychologists	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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Requests for reprints of the Rwanda article to Morton O. Wagenfeld

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CHALLENGES AND PROSPECTS**

A Special Issue of the
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(Volume XVI, Number 4; December 1989)

Special Editor
ROBERT G. NEWBY

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Recent Work on African-American Studies
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SPECIAL ISSUE: <i>The Truly Disadvantaged</i> ; Challenges and Prospects (Special Editor: ROBERT G. NEWBY).	XVI	4	Dec	1989
Old Folks' Homes for Blacks During the Progressive Era IRIS CARLETON-LaNEY	XVI	3	Sept	1989
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Predictors of Job Satisfaction Among Three Racial/Ethnic Groups of Professional Female Human Service Workers R. L. McNEELY	XIV	4	Dec	1987
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