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THE SPECTRUM OF MENTAL DISORDERS : HOW MUCH OF THIS SPECTRUM SHOULD BE THE RESPONSIBILITY OF THE MENTAL HEALTH SERVICE
(The spectrum of Mental Health Problems and the Extent of responsibility of mental health services)

by

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Genesis of the Question

The question of the extent of responsibility of the mental health services (out of the total spectrum of mental health problems) has been occasioned by many reasons. Experience in the United States with community psychiatry is perhaps one of the prime reasons why this question is being raised today with such vigour. Community psychiatry necessitates social action, which however, is not the sole concern of mental health services but also of social welfare services, educational services, legal, administrative and political agencies and so on. Mental Health Services, therefore, have been required to define the limits of their own specific field of concern. The mental health professional has always had a triple role - of a somatotherapist, psychotherapist and sociotherapist - one or another of those taking precedence over the others depending upon the professional's training orientation and the specific setting in which he is required to work. In the practice of community psychiatry more and more psychiatrists have beeen drawn to the social field and fewer and fewer left to look after psychiatric hospitals

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(where still the bulk of psychiatric patients are to be found) - hence the lament that "psychiatrists are least found where they are most needed".

A psychiatrist as a member of the community mental health services, often finds himself '... in an undefined role, catering to undefined needs of an undefined clientele' and so is prone to ask himself: ' Am I still a psychiatrist, still a physician, or have I become an inadequately trained social scientist or some kind of a revolutionary?' (Lavitt & Rubenstein, 1971).

Where it was not considered feasible for the same person to perform all the three roles, health teams consisting of a psychiatrist, a psychologist and a psychiatric social worker came into being. However, this soon led not only to status struggle within the team but also to the demand for proper role definition for the whole team as well as for each of its individual constituents.

The team approach, however, is an expensive endeavour. An acute shortage of mental health manpower was felt even in such countries as the US where the ratio of mental health specialists to the population is amongst the highest in the world and where the most favourable balance of brain-drains. A solution of this problem has been sought through the production of ancillaries called psychiatric aids, psychiatric technicians, attendents, or mental health workers etc. The new set up has necessitated a new redistribution and redefinition of roles.

It has, therefore, become important for the various reasons outlined above to define the extent of the clinical responsibility of the mental health services.

While this question has universal validity - in so far as it can be raised anywhere in the world without loss of relevance - no single universally valid answer can be given to it. The answer, necessarily, has to be given in the context of local conditions relating to the characteristics of the existing mental health service and its manpower, features of the population to be served and its expectancies, and the existence and degree of development of other public services having an interface relation with the mental health service.

Characteristics of the Population:

Populations vary from country to country in regard to social, cultural and technological development and organization. Some of these factors have greater relevance to mental health than others.

Material affluence determines a country's capacity to muster resources for its mental health service - and in this regard there are wide international and inter-regional differences - even within the underdeveloped world. For instance, per capita income varies from US $ 35 in Indo-Pak to US $ 85 in Malaysia in the South East Asia Region. However, the upper limit of this region constitutes the lower limit in Latin American countries (Haiti having per capita income of US $ 84) and the higher limit reaches over ten times that (US $ 915 in Venezuela) (UN, 1969).

Another factor worth considering is that per capita income correlates poorly with the expenditure that states make on health care. The USA, for example, spends 1.2% of GNP on health, India, 0.6% and Sri Lanka, 2.8%. While mental health is a high priority in the US draining a sizeable fraction of the health exchequer, it ranks hardly anywhere among the health priorities in India.

Literacy modifies community expectancies. Not only does one find contrasts between the modes of thinking, levels of sophistication and patterns of mental morbidity of the literate and the non-literate communities, but also between the demands these respective kinds of populations can make in regard to social action. Literacy also bears relevance to the distinctive modes of their social perception of mental morbidity as well as their ability to socially contain certain forms of mental illness in contradistinction to others - factors which would directly infringe upon the spectrum of clinical responsibility of the mental health services.

Other factors include the degree and rate of urbanization and population migrations, the degree and rate of technological development and industrialization. The age-structure of the population and the rate of change of this structure also determine to a degree what kind of demands would be made from the mental health services and this in turn will determine the scope of responsibilities of these services. For example, where longevity is high, geriatric psychiatry will figure high among the responsibility of mental health services. Employment facilities also affect this pattern in a way. Where hordes of able-bodied, able-minded individuals are waiting in cues for employment, rehabilitation programmes for the mentally sick become matters of low or no priority, but where a country has short-fall of manpower as against its employment opportunities, rehabilitation naturally assumes high priority.

Demands and expectancies of urban populations from mental health services are different from those of rural populations, and wherever attempts have been made to reach the rural populations the scope of mental health services had to be adjusted to the new demands and expectancies.

Predominant social problems of a community also to some degree influence the role spectrum of the mental health services. To illustrate: "the endemic manifestations of violence in Latin America can hardly be surpassed by those in any other part of the world" (Leon, 1972). For the population between 15 and 44, there, homicide is the first cause of death with rates of 61 and 47 respectively (WHO, 1967). Opiates are a great pest in Thailand (Aroon, 1971) alcohol in East Africa (German, 1972), and venereal diseases in Jamaica, which top the list of physical pathologies in psychiatric hospital patients (Burke, 1972). As a result of such factors, while certain psychiatric disorders will figure predominantly in the responsibilities of the mental health services in one country, it might be almost absent from that of another.

Characteristics of Existing Mental Health Services

The organizational pattern of the existing mental health services in a community determines for them the scope of their clinical responsibility. For example, the existence of 'Asylums', Half-way Houses, Day Care Hospitals, Child Guidance Clinics, Walk-in Clinics, Suicide Prevention Services, Deaddiction Units, Telephonic Services and the like are a variety of commitments to certain segments, smaller or larger, of the spectrum of mental health problems. Each kind of service caters to a particular kind of clientele and the overall spectrum of clinical conditions being looked after by the mental health services, thus, depends upon the spectrum of such services. These services, once instituted, generate their own need, and establish a negotiated order within themselves and within the administrative and economic structure of the communities so that their existence becomes self-perpetuating.

At times, some of the available services demand greater inputs compared with their outputs. Some of these services even throw up certain syndromes as 'artifacts'. Munchanssen's syndrome is one such example. Another one is, what I call ' pseudoparasuicide'. Such syndromes which are by-products of the services themselves, then, become a part of the spectrum of their clinical responsibility.

Another important factor that impinges upon this spectrum is the existence of a competing system of medical (and mental health) care and the spectrum of conditions that it specifically draws to itself. In countries where mental health services are relatively inaccessible, the population has to fall back upon the more readily available popular substitutes. These may be of the nature of Shamanism, witchcraft, exorcism, astrological remedies or religious ceremonies. These, in turn, reinforce magico-mystical notions and foster mistrust and rejection of the professional mental health services even when they may be available. Further, they tend to draw to themselves certain special kinds of syndromes - such, for example, as 'possession syndromes', 'seizures', and 'religious manias'. Among certain populations, the folk-healers are even more adept in dealing with such syndromes than the practitioners of 'scientific medicine'. Prince (9) has observed this in Nigeria, Torrey (1972) derives his 'basal components of psychotherapy' from more universal observations of this kind.

In India, in spite of Health Centres having been lavishly established in the rural areas, 'only about 25-30 per cent of all patients go to visit them', the rest either patronize Ayurveda or Unanai or some other brand of folk medicine. They also tend to introduce their own peculiar 'artifacts'

by popularizing their 'theories' as folk belief (Neki, 1971). The 'Dhat Sydrome' found in India appears to be the outcome of Ayurvedic theories about the genesis of semen and its place in human health preservation. Such syndromes, though artifacts of competing systems of medicare, often become the responsibility of the mental health services.

To sum up, the characteristics of the mental health service and other existing systems of medicare that compete with it in any given community determine to an appreciable extent the spectrum of conditions that would come under the care of the mental health services.

Factors Relating to Personnel Resources:

What kind of mental health personnel a community has, their number, their distribution, and their predominant scientific orientation determine what kind of clinical burdens they are likely to shoulder.

If a community has no specially trained mental health personnel (and to be sure, there are still a number of countries altogether without such personnel) it has perforce to fall back upon its general medicare and public health services to cater for mental health needs. The same applies to countries where mental health personnel are few and far between. "It is in these countries observes Lin (1969) that the general practitioner has to shoulder much of the mental health responsibility - yet, there is little indication so far that this is being realized by the proper quarters. That is what makes the picture grim".

Whereas the number of psychiatrists in most developing countries is very low, it differs from region to region. In most African countries, it is, perhaps, the lowest. The total number of psychiatrists in Black Africa is but a few hundred. In twenty Latin American countries, by

contrast, there are over three thousand psychiatrists (average 1.52 per 100 000 population) (Leon, 1972) while in five countries of South East Asia, the number of psychiatrists is on the average about 0.1 per 100 000 population (Neki, 1973). Compare these figures with those obtained in the better developed countries Figures per 100 000 population even a decade age stood for the USA, at 7 25, for Switzerland at 4 72, England and Wales at 2.02, USSR at 2 55, and Japan at 2.5 (WHO, 1962)

Where the number of psychiatrists is small, patient load is proportionately great. The most pressing demand upon them is made by psychotics who constitute a bulk of their clientele Their approach becomes predominantly somatotherapeutic, and their orientation biological. An analytically trained psychiatrist becomes a misfit in such a system. He is more prone to set up private practice for the benefit of the 'Westernized urban elite'.

Wherever there are psychologists, psychoanalysts, psychiatric social workers and psychiatric nurses (in addition to psychiatrists), they have also to make their own niche in the mental health services, and these services, then have to adapt to the specific professional proclivities of such personnel.

While in most places, these categories of personnel have functioned side by side, and in collaboration with psychiatrists, in some places, they have functioned apart from him, especially if he were altogether absent from the scene I am aware, a psychiatric nurse virtually remained in charge of an asylum in Nigeria for a number of years until a trained psychiatrist became available

The distribution of personnel also makes a great difference In some places, most psychiatrists are engaged in manning psychiatric hospitals.

In India about 40% of the psychiatrists are found to man mental hospitals, an equivalent proportion is engaged in teaching in medical colleges and very few are in private practice. In Latin America, on the other hand, over one third of the psychiatrists are exclusively in private practice and about a quarter appear to be engaged in part time practice (Leon, 1972). The predominant orientation of psychiatrists in these countries is dynamic - analytic, while that of the ones in India is eclectic. It appears, wherever the ethos of American psychiatry has had its influence, dynamic approach became the dominant orientation and private practice the principal professional commitment.

The Syndromes:

There are only few syndromes, which are indisputably the responsibility of the mental health service. These mainly include the functional psychoses. Even some psychoses in many developing countries are caused or accompanied by somatic illnesses of various kinds. These may include malnutrition, chronic infections like syphilis, tuberculosis or leprosy, acute infections and communicable diseases with their sequellae, helminthic infestations, and climate calamities e.g. heat stroke and dehydration. A psychiatrist, therefore, has to keep up with his internal medicine in looking after these patients.

Organic brain conditions generally go to neurological services unless they show a frank psychotic breakdown or become behaviourally unmanageable.

Psychoneuroses and psychosomatic conditions, even in countries with most well developed mental health services, are being looked after predominantly by the general physicians. In the UK, for instance, 95% of psychoneurotics are being looked after by the general practitioners. It is not that the psychiatrist is unwilling to treat them. The predominantly somatic

symptomatology of most of the neurotic conditions necessitates a physician to be consulted almost invariably in the first instant. Where, the number of psychiatrists is small, there is greater reason for psychoneuroses to remain the ongoing responsibility of the general practitioner almost entirely.

In the field of mental deficiency, the educable defective will be the responsibility of the educational services. However, there are cases of severer subnormality which will require institutional care and/or treatment such as, for instance, those caused by metabolic and endocrine causes, or those that can be ameliorated by surgical intervention. However, only about 15% of retarded children are affected to such a degree that they must be considered ineducable. Thus, the main responsibility in this field would rest with the educational services, mental health services providing consultancy arrangements and care of a limited number of retardates that require professional care.

Areas such as delinquency and psychopathy, drug addiction and alcoholism with widespread social pathology as their substratum, call for social action far beyond the limited scope of the mental health services. Clinical responsibility of mental health services in these areas can be but limited - only looking after those showing or tending to show psychotic breakdowns. Preventive services unless strengthened by appropriate and widespread social measures and administrative and political reform usually prove to be sterile. In many cases, they raise public expectancies without commensurate resources being available and so only thwart effort and enthusiasm of workers. Mental health services should, however, provide consultancy expertise to planners of relevant social action. Personality counselling can be considered a luxury - and may be left, as it always is left, to a private arrangement between those who have the resources to purchase it and those who have the expertise to sell it.

Conclusion:

To conclude, one may say, that no universal prescription can be given regarding the extent of clinical responsibility of the mental health services in any given community. It will be determined by a horde of factors, the more important ones of which have been discussed above.

In most developing countries mental health services are still rudimentary. This is a happy situation in so far as they have not yet been bound down into the strait jackets of already established institutions and service patterns many of which are of questionable utility. It is important, therefore, for the planners of mental health services in those countries to weigh the projected mental health needs of their communities against the manpower and other resources likely to be available and to predetermine what would be the spectrum of responsibilities of the mental health services in their judgement. In this, it would also be necessary to determine the relative responsibility of mental health services in areas where they have interface interaction with other services such as the educational, social welfare, public health, legal and administrative agencies.

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