Original article

# Dubious justifiability of involuntary hospitalization: A cross-cultural, system-dynamic analysis *1

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## Abstract

This study presents critical factors to avoid human rights infringements in psychiatric care and to promote the wellbeing of Persons with Mental Disorders (PWMD). We performed cross-cultural, system-dynamic analysis of mental health systems of South Korea, Japan and South Africa, in terms of legislation, resource and outcomes and historical development. Our system-dynamic analysis derived two prerequisite factors for overcoming human right infringements in psychiatric care: (1) increasing resource allocation for community care instead of hospital-based care; (2) establishment of the recognition of that the justifiability of involuntary hospitalization is inherently dubious supported by journalism as well as reformation of mental health law.

## Key words

human rights, involuntary hospitalization, mental health act, system-dynamic analysis, journalism

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## 1. Introduction

Both Japan and South Korea are known for their long duration of hospitalizations for Persons with Mental Disorders (PWMD)[1~4]. Japan, in particular, is notorious for its long hospitalization (average length of hospital stays: 300days, OECD 2012[5]). The rate of involuntary hospitalizations is especially high in Korea (74% in Korea, WHO 2014[6]), more than 40% in both of Japan and South Africa. See Table 1).

On September 26, 2016, the Korean Constitutional Court pronounced that the procedures of involuntary hospitalization as defined in the Korean Mental Health Act were inconsistent with the Constitutional principle of minimizing infringements of human rights which made Korean government to reduce involuntary hospitalization[7]. Meanwhile, in Japan on July 26, 2016, 19 handicapped people were killed in a facility by a previous employee of this facility who was discharged 5 months ago from 2 weeks of involuntary hospitalization[8] which resulted in the revised draft of tighten management scheme of PWMDs by Japanese government.

On the other hand, in South Africa in 2017, it was reported that rapid deinstitutionalization caused more than 94 deaths of patients between March 23 and December 19 in 2016 in Gauteng Province, being transferred to 27 non-governmental organizations (NGOs) operated under invalid licenses[9].

In reaction to these situations mentioned above, we tried to present critical factors that could be instituted to avoid human rights infringements in psychiatric care and to promote the wellbeing of PWMD.

We performed cross-cultural, system-dynamic analysis[10] of mental health systems of South Korea, Japan and South Africa, in terms of legislation, resource and outcomes and historical development.

## 2. Three different mental health systems

The mental health systems of South Korea, Japan, and South Africa are widely different. Thus, we first compared mental health systems of these three countries in light of their legal systems, resources and outcomes, and historical development. Secondly, we reviewed the influence of various factors to mental health systems by means of the human ecological system-based framework.

### 2.1 Problem spaces of mental health system in the context: Legal system, resource and outcome, and historical background of mental health systems

Table 2 shows a summary of the legal system of mental health of South Korea[11, 12], Japan[13, 14] and South Africa[15]. Table 1 shows resources and outcomes of mental health of these three countries. Followingly in the next section 2.2, we review how these actual situations have been historically developed in the three countries.

A common process of development of legal systems is a shift from the public security model to the health care model, and now the social welfare model, seeking for compatibility with international human rights conventions: All human being are born free and equal in dignity and rights[16]; having the right of self-determination by nature. Therefore, all persons have the right to receive the best available mental health care, having the right to live and work, as far as possible, in the community, and any treatment should be based on informed consent, except in the cases where the capacity to consent is

**Table 1 Comparison of mental health resource and outcome among South Korea, Japan and South Africa, based on WHO reports**

| | South Korea | Japan | South Africa |
|---|---|---|---|
| Total population | 49,512,023 | 126,999,807 | 53,139,528 |
| *2011* | *48,500,717* | *126,995,411* | *50,492,408* |
| Total health expenditure per person (USD 2013) | 1,880 | 3,966 | 593 |
| Recent Mental Health Policy | 2014 | 2014 | 2013 |
| Estimated mental health spending per capita (USD) | 44.81 | 153.7 | Not applicable |
| Total staff for mental health impatient care | 16,490 | 136,075 | Not reported |
| Total staff for mental health outpatient care | 2,717 | 12,622 | Not reported |
| Psychiatrist/100,000 | 5.1 | 20.1 | 0.4 |
| *2011* | *5.12* | *10.1* | *0.27* |
| Mental health outpatient facility, total(/100,000) | 1,353 | 5,739 | Not reported |
| *2011 outpatient facility, total* | *1,138(2.35)* | *2,936(2.31)* | *3,460(6.85)* |
| Mental health day treatment facility, total (/100,000) | 79 | 3,242 | Not reported |
| *2011-day treatment facility, total* | *55(0.11)* | *1,337(1.05)* | *80(0.16)* |
| Mental hospitals, total(/100,000) | 1,314 | 1,071 | 63 |
| *2011 mental hospitals, total* | *1,232(2.54)* | *1,072(0.84)* | *62(0.12)* |
| Psychiatric units in general hospitals (/100,000) | 265 | 582 | 37 |
| *2011 psychiatric beds in general hospitals* | *20,004(41.24)* | *92,857(73.12)* | *1,362(0.16)* |
| Residential care facilities (/100,000) | 197 | 1,422 | 37 |
| *2011 Community residential facilities* | *127(0.26)* | *1,992(1.57)* | *63(0.12)* |
| Mental hospital beds/annual admissions (/100,000) | 113.1/Not reported | 200.3/199.5 | 22.7/ Not reported |
| *2011 Beds in mental hospitals* | *72,378(149.23)* | *259,580(204.4)* | *9,846(19.5)* |
| General hospital psychiatric unit beds/annual admissions | 54.5/Not reported | 69.2/98.0 | Not reported |
| Residential care beds/annual admissions | 4.7/Not reported | 15.3/11.6 | Not reported |
| Total number of inpatients | 65,976 | 302,156 | |
| Admissions that are involuntary | 74% | Not reported (More than 40% report in Japanese) | 43% in 3 provinces |
| Discharged inpatients followed up within one month | 68% | Not reported | |
| Treated cases of severe mental disorder | 646,458 | Not reported | |
| Inpatients staying less than 1 year/1-5 years/more than 5 years | 63%/29%/8% | 35%/29%/36% | Not reported |

*Italic*: Data of 2011, shown compared to data of 2014.
Source: World Health Organization (WHO). Mental Health Atlas-2014 country profiles (Republic of Korea, Japan, South Africa) [cited 2017 May 1]. Available from: http://www.who.int/mental_health/evidence/atlas/profiles-2014/en/
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**Table 2　Comparative Law of involuntary hospitalization/care for mentally ill patients: South Korea, Japan and South Africa**

| | South Korea | Japan | South Africa |
|---|---|---|---|
| **Description on human rights in the Acts** | Clearly described in the “fundamental ideas”, in terms of: respect for dignity and value of human being; rights to receive optimum medical treatment, protection, necessary education; no discrimination; voluntary hospitalization; unrestricted environment and freely exchange opinions with others for hospitalized persons. | None<br>(Limited descriptions in another Act on Support for People with Disabilities) | Clearly described in Preamble quoting Constitution to prohibit unfair discrimination of people;<br>Chapter III defines rights and duties relating to mental health care users with items of “respect, human dignity and privacy”; “consent to care, treatment and rehabilitation and admission to health establishment”; “unfair discrimination”; “exploitation and abuse”; “determinations concerning mental health status”; “disclosure of information”; “limitation on intimate adult relationship”; “right to representation”; “discharge reports”; “knowledge of rights”<br>- Chapter VII defines obligations of authorities to provide services for mentally ill prisoners. |
| **Judgment of involuntary hospitalization/care** | Consents of 2 guardians and 1 psychiatrist (Since the time of implementation of the revised Act, diagnosis of 2 psychiatrists, one of which is not affiliated to the hospital comes to be needed.) | Consent of 1 family member or legal guardian and diagnosis from 1 “designated mental health doctors” (governmentally certified psychiatrists on involuntary hospitalization) (“hospitalization for medical protection”) | |
| **Judgment of involuntary hospitalization/care, in case at risk of harm himself/herself or others** | Mental health specialist may request a head of regional government (autonomous Gu and Si/Gun/Gu, if there is consensus from 2 or more psychiatrists, may request hospitalization of the relevant person. | Diagnoses by 2 “designated mental health doctors”, ordered by a prefectural governor, being noticed by a citizen or police force.<br>(“administrative hospitalization”) | Application is made by defined family, relatives etc.<br>A person must be examined by 2 mental health care practitioners |
| **Board review** | 5-10 members composed of (1) psychiatrist, (2) lawyer, (3) mental health specialists (4) Family members of a mentally ill person, (5) person having expertise and experience in mental health following defined items. | Notification of involuntary hospitalizations are reviewed by a board composed of (a) a learned authority of psychiatric care (designated psychiatrist); (b) learned authority of mental health or welfare; (c) learned authority of law. | A Review Board, appointed by the Executive Council of province, consisting of (a) mental health care practitioner; (b) magistrate, an attorney or an advocate admitted in terms of the law of the Republic; and (c) member of the community concerned. |
| **Commitment of Court or police in the decision process (or notification process)** | In some serious cases, a person may be admitted in an emergency hospital, with the consent of a doctor and a police officer | None (Police shall notify to the prefectural governor when they find a person with risk of harming oneself or others.) | In some serious cases, the Court decision is additionally needed. |
| **Standards to evaluate capacity, diagnosis, and risk of harm** | None<br>(Police force has its own practical guideline) | “Hospitalization for medical protection”: Admission to the psychiatric wards either to treat diseases or to secure the patients’ mind and body are refused by the patients of concern due to their insight less to their own diseases<br>“Administrative hospitalization”: risk of harm to self or others due to psychiatric disorders, | Defined in the legislation |
| **Requirements for social integration** | Description about rehabilitation | None | Description about rehabilitation |

Source: References No. 7～11.

insufficient, or if domestic legislation so provides, having regard to the patient's own safety or the safety of others, under defined conditions, including the determination of qualified mental health practitioner [17, 18]; all of which should be in accordance with the 10 principles of the World Health Organization (WHO) [19].

Especially, South African legislation had been established directly based on the Constitution to prohibit unfair discrimination [20], as described in the preamble of the Act. With regard to resource and outcome (Table 1), South Africa is resource limited, while, South Korea is of intermediate or satisfactory status and Japan seems to be over-resourced. Japan is much more resourced not only in terms of hospitalizations but also out-patient/day care facilities, however, its de-institutionalization activities have been on sluggish stagnation.

Here, we analysed more in depth the overall summary of the three countries.

### 2.2 Historical Perspective on Comparative Law: South Korea, Japan and South Africa

#### 2.2.1 South Korea

The Korean Constitution was instituted in 1948. It has been amended 9 times through several generations of autocratic Presidents. The Declaration of Democratization was adopted in its most recent revision in 1987. The aim of the latter was peaceful success of Seoul Olympic in 1988. Until 1970, psychiatric disorders had not been well recognized since individuals with these disorders had been taken care of by their families and relatives in rural areas [21]. The rapid economic growth and nuclearization of families since the 1970's led to increasing numbers of psychiatric patients being hospitalized in unauthorized facilities and without governmental action [22]. In 1983 certain human right infringements at an unauthorized facility was publicized by media and broadcast on national television channels leading to the government, which resulted in 1984 establishing a plan for mental health improvement. However, this plan was intended to increase mental institutions to "secure society" because South Korea was preparing for the Olympic. Many homeless and poor people were hospitalized into mental institutions to secure and "clean" the cities. At that time, several cases of deaths of patients were reported, and sometimes parents were involuntary hospitalized which resulted in divestiture of property by their own children. There was also an increase in the numbers of psychiatric hospitals and psychiatrists during this period.

In 1995, the Mental Health Act was passed in South Korea. It has been revised 6 times to improve and protect the rights of people with mental disorders and to rectify the tendency of long hospitalization. The legislation has mandated that mental health policies are issued every five-years from 1998 [23]. Although the Act has been revised to strengthen human right protection, some citizen's groups have criticized this legal system and filed several lawsuits claiming that the Act was unconstitutional which eventually came to unsuccessful. The activities of the Korean Alliance of Mental Illness (KAMI), a citizen's group collaborating with lawyers, are most prominent. The pre-existing 'Mental Health Act' was superseded by 'the Mental Health Promotion and Welfare Service Support Act' in 2016, which went into effect in May 2017. Despite it defining the conditions and procedures of involuntary hospitalization in a more democratic way than previously, the Korean Constitutional Court in September 2016 ruled that the procedures of involuntary hospitalization as defined in the pre-existing 'Mental Health Act' were not consistent with the constitutional principle by common assent of nine judicators [7]. The

Constitutional Court decision reflects a maturation of the Korean society to accept such people in their community.

Notwithstanding social efforts such as ‘the reform vision’, deinstitutionalization has been difficult to implement with the number of long-stay psychiatric beds being maintained, or in certain facilities, even being increased. The lack of progress with regard to changes may derive from wrong and insufficient resource allocation coupled with strong public prejudices.

#### 2.2.2 Japan [24]

The Japanese Democratic Constitution was promulgated in 1947 while Japan was still under occupation of United States (US) after the defeat of Japanese imperialism. This Constitution remains unchanged until now. The laws for private captivity and psychiatric hospitals were established in 1900 and 1919, respectively. In 1964, the US ambassador Edwin O. Reischauer was stabbed by a 19-year-old schizophrenic person. The blood transfusion for his emergency treatment caused him hepatitis. The impact of this event was the revision of Japanese mental health law to strengthen involuntary hospitalization of a person at risk of serious harm to himself/herself or to others, accompanied by the rapid increase of public and private mental hospitals.

The 1950 Mental Hygienic Law was revised in 1987 to the Mental Health Act and then revised again in 1999 to the Act for Mental Health and Welfare of Persons with Mental Disabilities. In mid-1980s, there were revelations of violence by some private hospital workers resulting in deaths of patients at psychiatric wards. The Japanese Mental Health Act was therefore revised to establish a system of “designated mental health doctors” authorized for the decision of involuntary hospitalization, to prevent arbitrary decisions of hospitalization by unauthorized psychiatrists. However, this system increased indiscriminate involuntary hospitalizations. Psychiatrists could obtain this license by means of submitting 8 case reports of their experience with involuntary hospitalization. Recently in 2015 and 2016, it was revealed that many of these case reports were “fake” reports (copy and paste of the same cases) [25]. Accordingly, the Japanese Ministry of Health and Welfare revoked more than 100 qualifications.

The Mental Health Act in Japan was revised several times along with its mental health policies to improve human rights protection and the social integration of PWMD. However, violence to the patients by their workers at some psychiatric hospitals have been repeatedly reported. Japan has been continuously criticized by prestigious international organizations for its involuntary and long hospitalization along with physical restraint; as well as polypharmacy of psychiatric drugs. In 2013, a suit on the unconstitutionality of involuntary commitment was dismissed.

In July 2016, 19 handicapped people were killed and 26 were injured in a facility by a previous employee of the facility who, in February 2016, had in a letter to the Congress Chairman confessed his plan of this massacre based on his belief of eugenics [8]. This was brought to the attention of the police. Moreover, a few days later he confessed these beliefs at the facility then voluntarily terminated his job. Again, this was brought to the attention of the police, then the mayor ordered that two “designated mental health doctors” must assess the individual for involuntary hospitalization. He was then hospitalized involuntarily. After two weeks, he was discharged. This was then followed by the July massacre. A Governmental committee was set up to discuss this tragedy and issued a report in early December stressing the necessity of continuous “support” (actually “monitoring”) to those

who are discharged from involuntary hospitalization. Eventually, revision of Mental Health Act to strengthen such "support" was proposed in May 2017 but it has not passed yet.

Coincidentally in May 17, 2017, a young New Zealand man, teaching English language in Japan, suddenly died after being restrained to bed for 10 days in a psychiatric ward [26]. He was then suffered from bipolar disorder and admitted to a psychiatric hospital with manic episode. Cause of death is alleged due to deep vein thrombosis or adverse effect of sedative by the bereaved family, quoting from the doctor's explanation though the autopsy was inconclusive. This caused international voice to review the use of physical restraints in Japanese psychiatric treatment, where average time of physical restraint is 96 days, comparing several to tens of hours in other countries.

#### 2.2.3 South Africa

Democracy was established in South Africa in 1994 and its Constitution implemented in 1996, thereby overcoming the notorious apartheid era since 1948. Of note, the latter had, followed colonialism and segregation since the 17th century [27]. The first hospital for mentally deranged persons was established in 1711, being followed by the prison colony on Robben Island in 1846. From the latter half of 20th century "political criminals" who struggled for freedom of black people were imprisoned in Robben Island, and the mental hospital was converted into a hospital for chronically ill patients [28, 29]. Some other "lunatic asylums" were established in the first half of the 20th century. These were regulated by the 1916 Mental Disorders Act, and thereafter by the Mental Health Act in 1973. Private hospitals made profit from the government according to the number of patients. These hospitals have used the labor of these patients for building and repairing their facilities [30]. Especially in the era of apartheid, discrimination against black patients and political abuse of psychiatry were strongly criticized through the international investigations by the America Psychiatric Association and A Special Committee on the Political Abuse of Psychiatry of the Royal College of Psychiatrists in 1983 [31].

Soon after transition to democracy, the, Mental Health Policy was issued in 1997 [32], and the current day Mental Health Care Act was passed in 2002, followed by the renewed national policy and plan for 2013 to 2020 [33]. Recognizing the negative legacy of apartheid and its "vicious circle" of poverty and mental illness, this policy endorsed a long-term vision of integrating mental health into community-based, primary health care programs, according to the World Health Organization (WHO)'s recommendations [34, 35]. With South Africa's strong intention of implementing the United Nation (UN)'s Covenants on human rights [36〜38] into their Constitution and the Mental Health Care Act, the aim was to change discriminatory attitudes toward mental disability and to develop advocacy strategies according to the WHO guidelines [39]. However, even now several serious problems remain such as wide discrepancies of resource among provinces; heavy reliance on psychiatric hospitals; rapid de-institutionalization without enough development of community-based services resulting in high numbers of homeless mentally ill. In 2017, the Health Ombud reported that rapid deinstitutionalization under the "Gauteng Mental Health Marathon Project (GMMP)", with misinterpretation of 2013-2020 policy, caused more than 94 deaths of patients between March 23 and December 19 in 2016 in Gauteng Province, being transferred to 27 non-governmental organizations (NGOs) operated under invalid licensed. This tragedy highlighted the problem of "dual-royalty" conflicts of health professionals follow-

ing state policy, taking precedence over their responsibility of protecting rights and welfare of their patients [9].

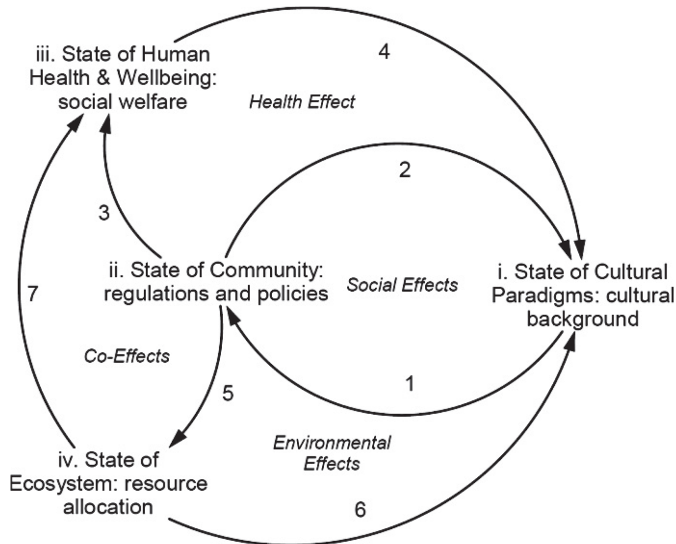
## 3. Subsystems about mental health

Based on the above review, here we analyse ecological system of these three countries. In Fig. 1, a Cultural Adaptation Template (CAT) [10] is translated to apply more specifically to variables relevant to mental health system in South Korea, Japan and South Africa. There are some candidate variables for applying specific analysis as below (Table 3) [40].

### 3.1 State of Cultural Paradigms: cultural background

In South Korea, Confucianism philosophy promotes people of authority to act with benevolence for the favour of vulnerable people, as well as extended family system have given support to PWMD. Japanese culture is in majority mixture of religions of Shinto (belief in Japanese gods) and Buddhism along with Confucianism philosophy. In South Africa, along with the majority of Africans with traditional culture and beliefs, Westernized culture had been established since the era of colonialism in 17th century; then they experienced recent dramatic democratization overcoming apartheid in mid-1990s, which contributed to revision of democratic mental health act and new mental health policy. This strong awareness of human right is common in South Korea, overcoming political suppression in 1980s. Also, Christianity shared in 80% of South African and 40% of South Korean may contribute to humanitarian attitude toward PWMD, which are not shared in majority of Japanese. Japan has not historically experienced civil revolution, as their democratization was direct result of defeat of World War II where ancient

**Fig. 1 The CAT translated to a current mental health problem space diagram**




In fact, variables about State of Community are not limited just 'mental health act'. Enforcement ordinances, enforcement regulations, authoritative interpretations and government policies should be considered all together.

Abbreviations: CAT, Cultural Adaptation Template

**Table 3 Some variables about social integration and deinstitutionalization in South Korea, Japan and South Africa: Commonalities and variabilities**

Acronyms of country names in parentheses are inserted when the item is specific to one or two of the countries.

| A. Variables for promoting social integration and deinstitutionalization | B. Variables for impeding social integration and deinstitutionalization |
|---|---|
| **i. State of Cultural Paradigm: cultural background (3.1)** | |
| **(Cultural background)**<br>• High level of familial support and kin relationship for the cases<br>• Traditional strong brotherhood<br>• Strong community spirit in general<br>**(Religious and ethical background)**<br>• Healthy spirits and ethics with benevolence/beneficence in Confucianism (K), Buddhism (J), African indigenous (SA), and Christianity (SA, K)<br>**(Background of modern society)**<br>• Social awakening among intellectuals and social requirement for political correctness<br>**(Recent historical background in terms of human right)**<br>• Strong human right awareness overcoming political suppression until 1880s (K) or apartheid until mid-1990s (SA). | **(Cultural background)**<br>• Remnants of feudalistic classism<br>• Faulty collectivism between groups<br>• Firm social prejudice toward mental illnesses<br>**(Impact of modernization)**<br>• Poor neighbor support in urban areas<br>• Secularism and materialism in modern society<br>• journalism to sensationalize the aberrant behavior of PWMD (K)<br>• Ostrich policy of journalism never provide ethical analysis on conflicting issues in mental health situation concerning (J)<br>**(Recent historical background in terms of human right)**<br>• Lack of human right awareness because of historical lack of civil revolution (J) |
| **ii. State of Community: regulations and policies (3.2)** | |
| **(Regulations and policies)**<br>• Strengthened human right protection in recent mental health acts and policies (SA, K, J)<br>• Mental Health Act in SA (2002)<br>• "Law Related to Mental Health and Welfare of the Person with Mental Disorder" in 1999 and "Act on Support for People with Disabilities" in 2005 (J)<br>• Mental Health Policy Framework and Strategic Plan 2013-2010 (SA)<br>• Enactment of the Mental Health Promotion and Welfare Service Support Act in Korea (2016)<br>**(Constitutional judgment)**<br>• The judgment of ***unconstitutionality*** of preexisting Mental Health Act in Korea (2016) | **(Actual difficulties in implementation of legislations and policies)**<br>• Prevalent involuntary treatment (K, J, SA)<br>• Inadequate enforcement of guardianship and custody in law for PWMD (K, J)<br>• Mental health policy insufficient for de-institutionalization (K, J)<br>• Lack of social agreement about patient autonomy vs paternalism in the revised or newly enacted laws (K, J)<br>• Wong application of governmental policy causing harmful rapid deinstitutionalization (SA)<br>**(Constitutional judgment)**<br>• The Judgement of ***constitutionality*** of preexisting Mental Health Act in Japan (2013) (J) |
| **iii. State of Human Health and Wellbeing: social welfare (3.3)** | |
| • Appropriate level of social security (K, J)<br>• Legal obligation of employment of PWMD | **(Actual difficulties to facilitate employment of PWMD)**<br>• Low employment rate of PWMD<br>• inactive back-to-work from sick leave<br>**(Poverty problem)**<br>• Social determinants such as poverty, unemployment, violence, substance abuse, low education, lack of basic amenities, etc. (SA)<br>**(Wealthy problem)**<br>• Poverty business induced by generous social welfare (J) |
| **iv. State of Ecosystem: resource allocation (3.4)** | |
| **(Number of psychiatrists)**<br>• An acceptable number of psychiatrists (K)<br>**(Education)**<br>• Well-educated psychiatrists with global standard of U.S. (K) or U.K (SA)<br>**(Financial resources)**<br>• Relatively intact control of government, by means of public insurance system (K, J)<br>• Low cost of treatment<br>• Favorable funding for mental health services (K, J)<br>• Primary care and essential drug-oriented healthcare policy, which is inevitable because of limited resources (SA) | **(Prevalence)**<br>• High suicide rates (K, J)<br>• Steeply rising the prevalence of mental disorders (K, J)<br>**(Number of psychiatrists and staff)**<br>• Excess (J) or insufficient (SA) number of psychiatrists<br>• Insufficient number of mental health nurses and clinical psychologists (K, SA)<br>**(Education)**<br>• Limited globalization in education of psychiatrists (J)<br>**(Facility resources)**<br>• Insufficient social rehabilitation services<br>• High number of Mental Hospitals (K, J)<br>• Unacceptable level of some facilities<br>• Sufficient number of outpatient/day treatment facilities not resulting in de-institutionalization because of excess number of hospitals (J)<br>**(Financial resource)**<br>• Long economic slump in Korea (K); poverty and political corruption (SA)<br>• Although there are sufficient mental health professionals, integration of mental health service in community-based primary care system has not been enough<br>**(Inappropriate resource allocation)**<br>• Unsound (J, K) or limited (SA) financial allocation<br>• Mental health resources centralized in and near big cities and in large institutions<br>• Squander of medical expense (J) |

Abbreviations: K, Republic of Korea; J, Japan; SA, Republic of South Africa

regime of Imperial system was kept.

### 3.2 State of Community: regulations and policies

Within the above-mentioned cultural paradigms and historical contexts, each of South Korea, Japan and South Africa has established, developed and improved mental health legislations and mental health governmental policies.

South Korean Constitutional Court stated [7] that the Act is insufficient to minimize human right infringement to deprive freedom of body and does not provide explicit standard to evaluate what is the mental disability which needs hospitalization. Meanwhile, Japanese Court denied the claim of unconstitutionality of the pre-existing Mental Health Act.

On the other hand, South African mental health legislation is positively evaluated in terms of minimization of such human right infringement [41]. Their legislation defines not only about the consent of related people and diagnosis of psychiatrist but also how decision-making capacity and risk to harm him/herself or others are defined in the legislations [41]. This is the point exactly the Korean Constitutional Court criticized pre-existing Act.

South African Constitution, established overcoming apartheid, leads the Mental Health legislation with solid human right protection. However, because of "selectively interpreted, misrepresented" implementation of 2013-2020 mental health policy, rapid deinstitutionalization of mentally-ill patients caused tragedy of great deal of deaths of these people. This was condemned by the Health Ombud that certain officials and certain NGOs violated the Constitution and Mental Health Act and the Mental Health Care Act.

### 3.3 State of Human Health and Wellbeing: social welfare

Social welfare, as the foundation of wellbeing of PWMD, is well-established in Korea and Japan, meanwhile in South Africa, poverty-related mental ill-health is regarded as in a vicious cycle, and social determinants such as poverty, unemployment, violence, substance abuse, low education, lack of basic amenities etc. has been serious unresolved problems [33]. Each of the three countries has legislative provision for employment of people of mental disorders, integration of these people into the society has not been enough.

In contrast, in Japan, its well-established social security is sometimes criticized that it discourages the willingness to become economically independent of people in poverty. What is even worse, it caused unethical "poverty business", aiming to exploit from the poverty people, e.g., some mental clinic provided cheap residence to PWMD to rip off their welfare payment [42].

### 3.4 State of Ecosystem: resource allocation

While the laws and policies have been developed, prevalence of involuntary hospitalization is still now high rate in these countries (Table 1), and policy for de-institutionalization has not yet worked well. In both of South Korea and Japan, insufficient social services, too many mental hospitals, inadequate allocation of financial and human resources, and urban concentration of facilities, along with high suicide rates and steeply rising prevalence of mental disorders, have been impeding variables [1].

In South Korea, the retrenched government budget due to long economic slump is another threat in the community [2]. Among the total amount of health resource, only 2.6% has been used for mental

health sectors [1]. Furthermore, much of financial resources are spent in mental hospitals, not for community centres. In South Korea, 90% of psychiatric hospital beds are private and in Japan, it is 83% [43]. In Japan, squander of medical expense causes stagnation of de-institutionalization and "comfortable" hospital environment has been reason of justification of long-term hospitalization. Japan is relatively high-income country and can afford to consume substantial money of public healthcare insurance for long term hospitalization and irrational prescription of multiple dosing regimen.

In South Africa, although dramatic democratization in the late 1990th, recent political corruption has expanded the gap between wealth and poverty. Their mental health services still have been labour under the legacy of colonial mental health system, reliance on mental hospitals (WHO-AIMS). In the case of Gauteng Province (GMMP), the Health Ombud's report [44] stated that "newly-established NGOs were mysteriously and poorly selected, poorly prepared, "not ready", their staff was not trained, not qualified"; "patients were transferred to faraway places from their homes and communities, bringing additional financial burden and stress on the family".

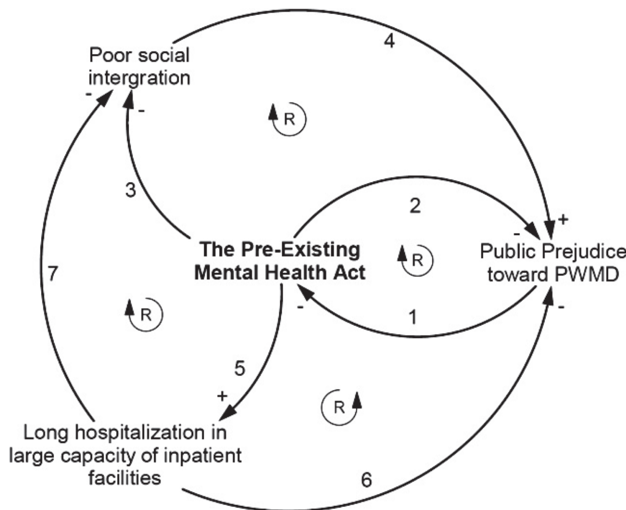
## 4. System-of-Interest for social integration of PWMD

### 4.1 System-of- Interest under the pre-existing mental health act

The mental health problem space described in Fig. 1 can be applied to two specific system-of-interest (SSoI) under the pre-existing mental health act in Fig. 2, and the revised Mental Health Act in Fig. 3.

Seen in Fig. 2, all causal loop diagrams have effects of vicious cycles. The details of each links have been stated in Table 4. This means poor social

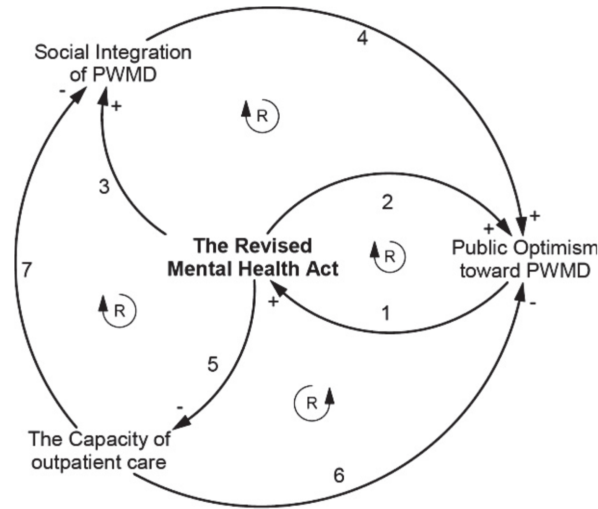
**Fig. 2 Social integration under the *pre-existing* mental health act: *vicious cycles***




The diagram is a system-of-interest diagram that focused on the public perception toward the Persons with Mental Disorder (PWMD) and the number of inpatient beds. The 4 CLD show some bandwagon effects: social effect (L1-L2), health effect (L1-L3-L4), environmental effect (L1-L5-L6) and co-effects (L1-L5-L7-L4)

Abbreviations: PWMD, Persons with Mental Disorder; CLD, Causal Loop Diagrams; L, Loop

**Fig. 3　Social integration under the *revised* Mental Health Act: *virtuous cycles***




The diagram is a system-of-interest diagram that focused on the public perception toward the PWMD and the number of inpatient beds. The 4 CLD show some bandwagon effects like Figure 2.
Abbreviations: PWMD, Persons with Mental Disorder; CLD, Causal Loop Diagrams

integration and long hospitalization is an inevitable consequence under the current system in Japan and South Korea. This bandwagon effect of the system makes public prejudice worse. In this condition, it is hard to expect the shifting of the cultural paradigm about mental disorders.

### 4.2 SSoI under the revised Mental Health Act

Unlike Fig. 2, Fig. 3 illustrates what changes will be expected in the subsystems, after an enactment of the new, innovative Mental Health Act, along with the establishments of revolutionary

**Table 4　Influence links in the System-of-Interest under the *pre-existing* mental health act**

| Link | Actions/ processes/ mechanisms represented in Fig. 2 | Polarity |
|---|---|---|
| 1 | Public prejudice (irrational belief) toward predictability of psychiatry on PWMD to harm him/herself or others leads to justifiability of pre-existing mental health act in Korea and Japan. | - |
| 2 | Coercive measures for dealing with PWMD affect public perception in a negative way. Stigma towards mental disorders tend to be justified by the official and conventional laws and institution. | - |
| 3 | Involuntary commitment-oriented policy is one of the biggest barriers for social rehabilitation. | - |
| 4 | Public indifference toward PWMD and insufficient outpatient treatment could cause failure of social integration which increase the prejudice against PWMD. | + |
| 5 | The original concept of mental health act induces the health care marketplace to expand the psychiatric beds. As a result, inpatient beds per 1,000 people are 2.9 and 1.31 in Japan and Korea in 2012, respectively. Economic incentives may add up this trend. The rates of inpatients staying longer than 1 year are more than 65% in Japan, 37% in Korea, not reported in South Africa in 2014. | + |
| 6 | Increased psychiatric beds affect the public perception toward PWMD negatively, like ‘They ought to be in hospital, and separated from society.’ | - |
| 7 | Institutionalization of PWMD hinders social rehabilitation directly. They lost opportunities to engage with other people, and lack of social relationship lead to poor social skills subsequently. | - |

Abbreviations: PWMD, Persons with Mental Disorders

**Table 5 Influence links in the System-of-Interest under the *revised* Mental Health Act**

| Link | Actions/ processes/ mechanisms represented in Fig. 3 | Polarity |
|---|---|---|
| 1 | A constructive change of the cultural paradigm with healthy skepticism about psychiatric disorders is a powerful foundation of revolution of the care principle of Mental Health Act. | + |
| 2 | Deinstitutionalization oriented Mental Health Act promotes changes from social isolation toward social inclusion of PWMD of the public. | + |
| 3 | Clarification about involuntary hospitalization as "unconstitutional" and basically human right infringement induce the re-socialization of PWMD spontaneously. Such proactive arrangement of legal regulation provokes the social change with knowledgeable public-driven outpatient care and social inclusion of PWMD. | + |
| 4 | With the proper intervention for behavioral problems of PWMD along with personalized support toward employment will facilitate mutual interaction with PWMD and the open attitude of the public about mental disorders. | + |
| 5 | According to the revised Mental Health Act, huge capacity for hospitalization is no longer required. Redistribution of medical resources should be viewed in association with the increased demand for outpatient care. | - |
| 6 | Decrease or even abolishment of big mental hospital like asylum as it is defined to be unjustifiable by law is closely linked up with decrease of prejudice and stigmatization that "they ought to be in hospital and separated from society". | - |
| 7 | Decreased number of mental hospitals and increased capacity of outpatient care promotes social integration of PWMD, automatically | - |

Abbreviations: PWMD, Persons with Mental Disorders

policies.

Seen in Fig. 3, all causal loop diagrams have effects of positive reinforcements. The details of each links are shown in Table 5. This means the change of social institution such as new innovative laws or enlightened policies can trigger profound changes on all subsystem about mental health.

## 5. Economic interests of stakeholders and sensationalism in media

From the above analysis, we hypothesized as driving force triggers two significant rate-limiting factors for hindering healthy feedbacks of the system. The first is economic motivation of mental facilities, which mostly impact on ecosystem (B1 in Fig. 4); the second is the issue of journalism which should mostly impact on cultural paradigm and public perception (B2 in Fig. 4). These two causal loops, B1 and B2, may block the virtuous circle for deinstitutionalization and social integration for PWMD by "lock-in effects". However, if we well recognize these two feedback loops and control successfully, two desirable reinforcing feedback loops will start (R1 and R2 in Fig. 4).

For R1, obvious solution is to switch financial resource allocation from hospital to community-based facility. However, the process would take long time because strong economic incentives of mental facilities is big obstacle, as typically shown in Japan. Meanwhile, poorly implemented deinstitutionalization plan is typically shown in South Africa. These two contrasting examples would clarify critical points to consider.

The secondary factor of the obstacle, the issue of journalism, varies in the three countries.

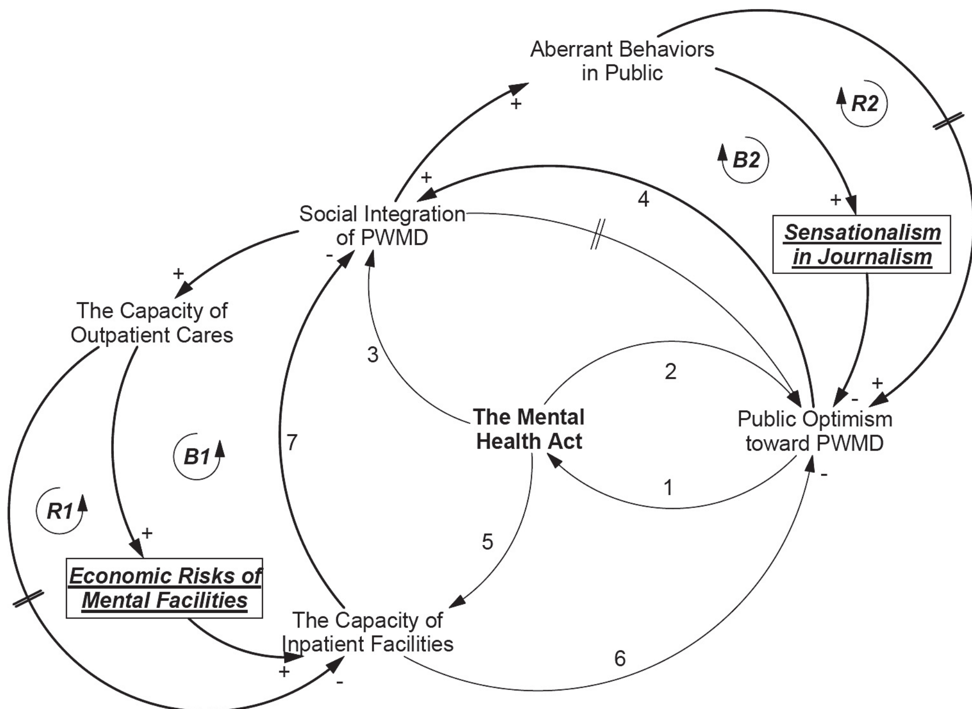
In Korea, the unhealthy commercialism of the press tends to sensationalize the aberrant behaviour of PWMD. Clinically, violent behaviour or homicides by PWMD are extremely rare. Nevertheless, exaggerated and repetitive reports make people to be scared at mental illnesses. Imprudent social networking service (SNS) usage patterns may play roles to increase the prejudices

(B2 in Fig. 4). Actually, the Constitutional decision about unjustifiability of involuntary hospitalization legislation have made meaningful changes of the attitude of journalism.

In Japan after the event of slaughter of 19 disabled people, media promote to show the lives of such disabled people and tend to avoid strengthening involuntary hospitalization of a person at risk of harming others. However, some critics argue that the institutionalization of the disabled itself indicates the public indifference of human right. Ostrich policy of Japanese journalism never provide ethical analysis of essential conflict of values between protection of vulnerable people and fundamental human right of freedom. We believe this should be one of the main causes of inability of shifting from hospital-based to community based psychiatric care.

In South Africa, the situation of journalism is completely different form both of South Korea and Japan. In South Africa, there is a strong cultural framework to avoid discrimination, fostered from their modern history to overcome apartheid. We can find much of media advocacy to achieve human rights. However, actual limitation of resource and gap between rich and poor are crucial, unresolved problem. Also, the moral lesson of Gauteng Province (GMMP) revealed that regard-

**Fig. 4 SSoI merged with the CLD of two external drivers**




This diagram summarizes the ‘lock-in effects’ by two major external drivers, i.e., economic motivations of mental faculties and yellow journalism about mental disorders. According to the CAT, economic incentives related to the management of mental health facilities may be included in the ecosystem, and sensationalism in the news media may be included in the community. However, they would do better to be regarded as external factors for clarification, under the new situation of enactment of the revised mental health act. Only if the two major external drivers are under control, healthy positive feedback will be expected. (B means negative feedback loop, and R means reinforcing feedback, respectively.)

Abbreviations: SSoI, Specific System of Interests; CLD, Causal Loop Diagrams; CAT, Cultural Adaptation Template

less of the ideal Constitution and mental health legislation, their misinterpretation and inadequate resource allocation will inevitably originate human-made disaster.

## 6. Conclusion: For the human rights of PWMD

As described above, it is never easy to achieve deinstitutionalization of PWMD. Drastic decision making of a nation to shift the limited resource from hospital-based toward community-based care would prerequisite. Healthy journalism would be a key factor to overcome deep-routed economic motivation of private hospitals to keep patients inside the walls. Journalism is much cultural issue and various in each culture. However, fundamental bill of human rights is common in the world. Therefore, cultural advocate and enlightenment by journalism based on solid belief and recognition that justifiability of involuntary hospitalization is inherently dubious would support future direction of reformation. Positive future does not come cheap. By our vigorous system analyses about ecology of mental health spheres with South Korea, Japan, and South Africa, mental healthcare can be reformed constructively and drastically.

### Conflict of interests

We declare no conflict of interest in the form of financial support or relationship.

### Author Contributions

In this study, HP conceived the conception and design of this research. HP, TS, AD and CK acquired the data. TS and CK integrate and analysed the data in the whole. HP, TS and AD drafted the manuscript and figures. All authors contributed to and have approved the final manuscript.

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