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Editorial

Reform of Mental Health Care in Europe

Progress and Change in the Last Decade

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It is now almost 10 years since the World Health Organization (WHO) published its last review of mental health care in Europe. The authors (Freeman *et al*, 1985) expressed cautious optimism about steady, although slow, reform, and the reintegration of people with mental health problems into the wider community. The WHO's next review is due soon; it is likely that there will be less optimism. Are we in a temporary blip in an inevitable movement towards non-institutional treatment and social care supporting ordinary lives? Or are the forces of reaction gathering to exploit the fears of a badly informed populace to recreate the old institutions in new forms?

The context of reform

The review period encompasses a time of social upheaval. In the West, there has been high unemployment and financial retrenchment. In Central and Eastern Europe we have seen the collapse of the centralised command economies, the displacement of refugees, and civil war. The impact upon the mental health of the populations is apparent, for example in the rising suicide rates in eastern Europe and the collapse of inadequate state systems of mental health care to be replaced, as yet, with nothing at all. Politicians and health workers are looking to the West to find answers in our "mixed economy of care". It is a good moment for us to ask ourselves what they will find.

In Western Europe our preoccupation with how we pay for services in a time of recession and financial uncertainty could be seen as an argument about economic priorities within a broad agreement about what we should be trying to achieve. But is this the case? The effect of changes in social relations on attitudes and human relationships is nowhere more critical than at the margins of normality, where shifting and sometimes contradictory definitions of what is acceptable are a problem for providers and users of mental health services.

The growth of the user movement

Implicit in the movement towards community care has been a shift in power between mental health workers and their clients. This has been interactive, always in the direction of more control for the user. The impetus for these changes has come largely from independent groups and non-government organisations whose members are linked by a personal investment in promoting the well-being and dignity of the service user. In most countries of northwest Europe, national mental health associations ensure an independent voice in the construction of mental health care legislation and provision. Some associations, once perceived as radical, are so well established that users sometimes feel them to be too close to government and the medical profession. Hence the rise of more radical user groups.

In Central and Eastern Europe, and some southern European countries like Greece, independent mental health associations, or any kind of independent sector, are rare. This makes it difficult to ensure that new legislation achieves a reasonable balance between the rights and needs of the patient and the protection of the public. Even in a relatively well developed system such as in the UK, when something goes wrong, care and control quickly becomes synonymous, creating a legislative panic in which reform is revealed as fragile.

Another effect of a poorly developed independent sector is that there is no halfway house between the private (for profit) sector and public bureaucracy, which generally discourages innovation and empowerment.

Changing perceptions of mental 'illness'

There has also been a subtle shift away from the focus on an illness model of mental problems towards a model of functional disability. The doctor or psychiatrist becomes only one expert among many others in the management of a disability. The concept of disability management is about enabling someone to lead a normal life, and this requires a multidisciplinary approach which will deal with areas in which medical professionals have no claim to expertise – housing, employment, social and political activity. The medical profession is not necessarily in a leadership role, but rather one of a number of professional groups who provide timely specialised intervention. This shift is different from that

envisaged in the radical critique of psychiatry in the 1960s, which came from within the profession, leaving authority with the (radical) psychiatrist. Current critiques of mental health care are marginalising psychiatry and forcing a painful rethink about the nature and extent of the medical role.

Economic and social integration

This shift is dramatically illustrated in the priority now accorded to work and employment. Users of services and mental health workers are no longer seeing work as a part of therapy, but rather as an essential step away from the culture of dependency towards economic integration and full civil rights.

One result of this has been the steady growth of social enterprises and cooperatives designed to create waged employment for people disabled by poor mental health. In Germany and Italy flourishing self-help cooperatives and 'social firms' providing economic integration and independence are testimony to this shift in attitudes. These businesses operate commercially with disabled and non-disabled staff working together on equal terms and sharing in management. The skills required for the firm to survive are vocational and commercial, with the mental health workers providing background support and expertise. Some firms are also able to support their members in other areas of their lives, such as housing.

The importation into Europe of the clubhouse model from the USA is a related development, in that it combines the concept of the self-help group with a well defined programme leading towards employment. There are now clubhouses in several European countries, notably the UK and the Netherlands, which have a long tradition of independent initiatives working within a regional health care framework.

Defining mental health problems as a form of disability also enables these social firms and employment training schemes to be eligible for financial support from the European Union. Italy, Ireland and Germany in particular are making good use of this opportunity. In the UK, perhaps unsurprisingly, England and Wales have lagged behind Scotland and Northern Ireland in making use of the European dimension, while Greece, uniquely among the countries of the Union, has received through Regulation 815 a substantial investment from the European Social Fund for the reform of its public mental health services.

Learning from the experience of others in Europe

Organisational changes in the delivery of services have happened with little involvement or awareness of the public at large. The desirability of local services designed to meet different needs and integrated with the general health care system is understood and accepted among health and social care professionals in northwest Europe. But still respectable British newspapers confuse mental health problems with learning disabilities and respond to acts of violence by mentally disordered offenders with sweeping, ill-informed generalisations about schizophrenia. One way forward is to regard the reform of mental health services as a European rather than a national issue, and work for change together with our colleagues in the Union, especially in the area of educating the public and changing attitudes.

It is acknowledged that the UK led the way towards non-custodial care and treatment in the 1950s, but others have now caught up or surpassed the UK in the organisation of local ambulatory services. The Netherlands with its system of RIAGGs (regional institutions for ambulatory mental healthcare), is particularly well developed, as are France and Scandinavia. The picture in Italy is more mixed, but despite all the debate about the Italian experience there is little doubt that the quality and organisation of mental health services in some areas in the north are the equal of any in the world. The south of Italy is another matter, and in countries such as Greece and Portugal the process of differentiation and the regionalisation of services has scarcely begun. In these countries there is the opportunity for more 'developed' partners in the European Union to provide expertise and also to receive creative ideas from the task of reform. The deinstitutionalisation of the appalling institutions of Leros and the creation of mobile services in the mountains of northern and western Greece, where none have existed before, demands both skills and ingenuity. Here solutions have been developed which will contribute to the development of mental health care in similar areas throughout the world.

Progress or a new location for the dispossessed?

There are elements of progress, in that no country in the European Union will admit to a mental health care strategy based on the continuation of the large mental institution, in which people are isolated from their families and the world in general for the rest of their lives. This is not to say that all European countries have a mental health care strategy, nor that there are no longer appalling institutions within the European Union; but the drift towards differentiation of need and the provision of community-based services is inexorable, and the rights of the mental patient are gradually becoming enshrined in the legal systems of most countries.

However, provision is patchy. Even in the best systems there are signs that all is not well, and that too many people are receiving inadequate care. The problems in the former communist countries and in some of the southern countries are more acute but not different in kind from those in the northern countries.

In 1985 the WHO noted that people with chronic mental health problems in need of continuing care posed the greatest difficulties for planners and mental health specialists. Now it is clear that this group, who were supposed to benefit most from the closure of the institutions, have in many cases fared worst. This is partly but not entirely due to underfunding. In both the UK and the Netherlands, where multidisciplinary care and support is relatively well developed, it has proved difficult to organise and coordinate teams in such a way as to ensure that people do not 'fall through the net'. Attention quickly becomes fixed on the needs of those who are most obviously getting into difficulties, at the expense of routine but essential support for daily life. Recent moves towards coordination have been partially successful, but in both countries concerns have remained that the skills of the professionals are becoming thinly spread, and those involved in the early warning systems – care workers, families, employers – often find the system too complex to feel confident about negotiating a prompt response.

'Sectorisation' does not answer all the problems either: the smaller the area of population, the less the number of people with extraordinary needs, and hence the difficulty of financing appropriate specialist facilities. Without such facilities, however, a few people can overwhelm the primary care and generalist support structures. There must be a balance between local services and supradistrict facilities which can enable the local services to care for the majority.

Community care is not a cheap option: it involves expanding the definition of health care far beyond what it has been before. Ordinary housing, vocational training, supported employment, social care and counselling and all the other myriad supports for managing a psychiatric disability, are costly, and cut across the responsibilities of many local and national government departments. Aside from the difficulty of moving finance from one sector to another, no government department in any country will take on new spending responsibilities if this can be avoided. Where will the money come from? This is a matter which can only be resolved through political will, and this in turn involves the most problematic area – the attitudes of the general public. Everywhere in Europe people are happy to see mental patients getting a better deal – until it involves them living next door. Recent work by the Glasgow Media Group (Philo *et al*, 1993) has shown that people are more influenced by media coverage of mental health issues than by their own experience. A media which is obsessed with crime and violence and is only too willing to link these to mental illness is hugely damaging to reform and the rights of the mentally ill. Only concerted and continuous efforts at public education supported by the European Union and member governments, and involving user groups, mental health associations and professionals, can hope to turn or at least check the tide of fear and hostility towards real integration.

Lessons from the edge

A psychiatrist from a former communist country has described (unpublished) the effect on members of his profession of the breakdown of the monolithic state. The transition from a system where professional judgement was largely unnecessary because all treatment was set down by the state and patients were never asked about anything because they were not regarded as fully human, has left many younger doctors deskilled, unable to find a role, and desperate for help. And yet – he complained – the West still persists in working through the vestiges of the old medical establishments rather than seeking out those who are struggling to create a new order, more in tune with modern thinking. Perhaps the truth is that our problems are not so different, and that the chill wind of upheaval blowing through our own economic and social institutions is making those of us working on the margins of normality huddle together in familiar surroundings rather than reach out to colleagues who may, in extremity, find new answers with us.

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