Caring for mentally ill people

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Despite legislation to harmonise mental health practice throughout Europe and convergence in systems of training there remains an extraordinary diversity in psychiatric practice in Europe. Approaches to tackling substance misuse vary among nations; statistics on psychiatric morbidity are affected by different approaches to diagnosis and treatment of psychiatric disorders; attitudes towards mental illness show definite international differences. Everywhere, though, mental health care for patients with psychotic illnesses is a "cinderella service," and there is a general move towards care falling increasingly on the family and the community.

Legislation is fostering harmonisation of mental health practice throughout Europe (box 1). Countries like Britain are forcing their system of training into the Procrustean beds of "Euro-training" and "Euro-certification," and the past decades have seen an explosion of European psychiatric associations and European mental illness programmes (box 2). It is becoming increasingly clear, however, that there is an extraordinary diversity in psychiatric practice in Europe. We will discuss some of these contrasts in the light of the heterogeneity of the European sociocultural environment, differences in attitudes toward mentally ill people, and the miscellany of training programmes for mental health workers in Europe.

Schisms in European psychiatry

The lack of reliable markers for psychiatric diagnoses has contributed to the continued use of "nationalistic" diagnostic categories such as the Scandinavian "reactive psychosis" and the French "bouffée délirante." Even a diagnosis of "schizophrenia" can refer to quite different concepts, resulting in striking disparities in national incidences of the disorder.¹

Modified electric shock treatment for depressive states has fallen into disrepute in countries like the Netherlands and Germany, whereas in Britain, Denmark, France, and Bulgaria it continues to be widely used.^{2,3} Psychoanalytical theory (revolving around "unconscious" conflicts) is popular among

Box 2—Mental illness programmes in Europe

WHO/EURO: strategies for reducing suicidal behaviour: multicentre study on parasuicide and collaboration in developing preventive programmes on suicide

WHO/EURO: the development of model approaches to stress management in the community to assist high risk groups such as migrants and displaced persons

EC Handicapped People in the European Community Living Independently in an Open Society (HELIOS): organised cooperation in the field of vocational rehabilitation on behalf of disabled people. Established in 1975

EC-BIOMED I, European Collaborative Study on Affective Disorders: interaction between genetic and psychological vulnerability factors

EC-BIOMED I: European Collaborative Study on Risk Factors for Dementing Disease

Council of Europe, "Pompidou Group": multicity study of drug misuse

European Science Foundation, Molecular Neurobiology of Mental Illness: a network of centres throughout Europe for the coordination of the mapping of the human genome for linkage to schizophrenia and affective disorder

BIOMED I (1990-1994) is the EC Medical and Health research programme with a budget of more than 130 million ecu.

mental health workers in many countries, such as France, Germany, and Switzerland, whereas more scientific biological and behavioural principles are favoured in, for example, the United Kingdom.¹ There are international differences in the indications and perceived therapeutic properties of drugs such as antipsychotic agents¹ and a curious north-south divide in the annual per capita exposure to benzodiazepine tranquillisers is apparent (fig 1). The German practice to treat relatively mild neurotic disorders on an inpatient basis in costly "psychosomatic" clinics contrasts with efforts elsewhere to treat these conditions in the community.

Variation in national approaches to tackling substance misuse has been discussed by Farrell and Strang,⁴ and the contrasts in alcohol consumption in European countries (fig 2) are thought to be related to variations in national alcohol taxation policies,⁵ and different levels of awareness of the risks of alcohol. The European health and behaviour survey showed that subjects from Hungary, Poland, and Portugal were significantly less well informed about the risks of alcohol than those from Germany, England, Ireland, and Spain.⁶ However, high scores for risk awareness were recorded in nations with high alcohol consumption, throwing doubt on the effectiveness of media campaigns to reduce harm related to alcohol.

The involvement of mental health workers in drug dependency services varies widely across Europe depending on how addiction is conceptualised. European countries seem to be divided as to whether drug addiction is a disease, a criminal behaviour, or a

Box 1—Harmonisation of psychiatric practice in Europe: initiatives and effects

1950 European Convention of Human Rights: rights for psychiatric patients; scrutiny of national mental health legislations

1953 European Convention on Social and Medical Assistance: right of treatment of foreign nationals (including psychiatric detention)

1957 Treaty of Rome (amended as Single European Act, 1961): right of settlement of professionals, necessitating harmonisation of specialist training

1961 United Nations convention: theoretical uniformity in legislation on illicit drugs

1993 Free internal market and public health chapter (129) in Maastricht Treaty: may lead to changes in the epidemiology of problems related to substance misuse

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BMJ 1994;309:1218-21

FIG 1—Per capita exposure to benzodiazepine tranquilisers (source: *Pharmacological Reviews*, June 1992)

lifestyle. In Spain and the Netherlands, possession of illicit drugs with a view to use is not an offence, or action is never brought; in Finland, Britain, and Ireland long prison sentences may be imposed.⁷ However, with the advent of a high prevalence of HIV among injecting drug users, especially in southern Europe, some countries have adopted a more pragmatic "harm reduction" model, aiming to preserve life and physical health rather than insisting on abstinence as the only option. For example, in the United Kingdom around 15 000 drug substitution points now exist for methadone maintenance programmes, whereas there are only 50 in France. In Norway, Sweden, and Finland methadone maintenance is even rarer, and compulsory treatment is more common; in Russia compulsory treatment remains the only option.^{8,9}

The European environment

The pluralistic approach to the diagnosis and treatment of psychiatric disorders impedes comparative epidemiological research into true differences in psychiatric morbidity between nations.¹⁰ Such research might yield clues as to the aetiology and prevention of psychiatric disorders. For example,

FIG 2—Annual alcohol consumption per inhabitant (source: *Dranken (distillers)*, Schiedam, 1985)

trends in suicide rates (fig 3) may be linked to variation between countries in unemployment,¹¹ religious beliefs and social integration,¹² or, particularly in eastern Europe, forced social changes.¹³ These are pressing issues, as suicide rates in Europe are on the increase in the younger age groups¹⁴; Rihmer and colleagues recently suggested that the very high rate of suicide in Hungary is related to unrecognised depressive illness.¹⁵

In eastern Europe under communist rule, remarked Newmann, "the deteriorating psychosocial circumstances pushed the majority of the population into a . . . somatic disorder approaching disease as defined in ICD9."¹⁶ Post-communism may be no less detrimental. The unexpected and sudden transition from life in a rigidly controlled world to one of competition and the need to find a new identity seems to have created unfavourable conditions for mental health.¹⁷

FIG 3—Death by suicide and self inflicted injury in European countries (source: *WHO/Health for All indicators*, 1991)

The newly established eastern Europe or Balkan supply route for illicit drugs, together with the changing social situation, has led to a considerable increase in problems related to alcohol and drug misuse.^{4,18}

The highly heterogeneous nature of psychiatric morbidity associated with adverse migration and displacement in Europe needs to be recognised.¹⁹ A survey of Turkish workers conducted in the Netherlands suggested that neurotic illnesses associated with worries about family at home are common.²⁰ In the United Kingdom and in the Netherlands, high rates of schizophrenia have been reported in Afro-Caribbean migrants.^{21,21a} Workers in Germany and Denmark found considerable differences in the mode of presentation between immigrants from different backgrounds.^{22,23}

Community care and attitudes towards psychiatric patients

The historical segregation of psychiatry from the rest of medicine, Mangel has argued, has made mental health care for patients with psychotic illnesses a "cinderella service" everywhere.²⁴ Several publications have attempted to provide an overview of how various European countries have tried to remedy this situation.^{25,26} There has been a generalised movement of

Box 3—European mental health service programmes

WHO/EURO (1976, 1985, 1994): mental health services in Europe: data on trends and developments in mental health policies, legislation, financing, utilisation, training, and organisation in countries throughout Europe

WHO/EURO (1992): establishment of a European data-bank on evaluative studies on community based mental health care

Commission of the European Communities (CEC): concerted action programme on the delivery of mental health services, through coordinated field studies, designed to evaluate the advantages and disadvantages of care in the hospital and in the community

The EC social fund and the State of Greece: the transition to community care in Greece

deinstitutionalisation (reduction of the number of patients treated within the walls of the psychiatric hospitals), particularly in the United Kingdom and Italy. In Italy the notorious Law 180 of 1978 legislated for the "gradual closure" (prohibition of first admissions after December 1979, and of readmissions after December 1980) of the psychiatric hospitals, to be replaced by small wards in general hospitals and a network of community mental health centres. The law was passed quickly, without prior evaluation, and the Italian psychiatric services were hardly well prepared for such a radical initiative.

OBSTACLES TO COMMUNITY CARE

There is little to suggest that the development of extramural facilities (community care) in Europe has kept pace with the rundown of mental hospitals; systematic studies such as the WHO pilot areas study found scarce evidence of care in the community.²⁷ Uncertainty remains, not only about the fate of a substantial cohort of discharged psychiatric patients²⁸ and their relatives (C Samele, unpublished data) but also whether the alternative innovations really are superior to mental hospitals. In Italy, Law 180 has survived, but not without considerable problems, especially in terms of increased burdens to families. Successful implementation, in the spirit of the law, has been limited to small and medium sized towns, especially in the north.²⁹

Only one European study, published recently, has tried to investigate prospectively whether long stay patients actually benefit from community placement.³⁰ Several European projects have now been initiated, aimed at stimulating this type of mental health service research, and the transfer of information from the research community to decision makers and managers at all levels in Europe (box 3). In many countries, however, specific obstacles continue to impede transition of services—for example, in Britain there is

an illogical distinction between health and social systems, and in Germany the separation between public inpatient and private outpatient treatment gives rise to high readmission rates and inadequate continuity of care for patients with psychosis,³¹ and overprovision of services for middle to high income neurotic patients.³²

Attitudes towards mental illness are important now that care increasingly falls on the family and the community. A European study of attitudes towards mental illness in Sweden, Britain, Italy, and Greece showed definite international differences, the northern countries being most tolerant. Patients' movements are also more established and active in northern Europe.³⁴ All this may be misleading, however, as support by the extended family is probably much more developed in southern Europe.

The legal framework

"National" attitudes may also be reflected in, for example, quality of mental health legislation and, perhaps more importantly, the degree to which correct implementation is enforced. Most European countries, especially those within the European Union, have now shed or amended their nineteenth century mental health acts. In countries like the Netherlands and England, legislative changes were partly the result of proceedings by individuals against the state under the European Convention of Human Rights. However, new is not necessarily better. France's 1990 act is in many respects similar to its 1838 act and 1968 amendment; in Ireland the 1981 act has still not been implemented, whereas in Spain to date no specific mental health act exists. In England and France involuntary admission is in practice a largely clinical decision, whereas in Austria, the Netherlands, and parts of Germany the decision is ultimately made by a judge or judge's representative. This is an important difference, as in the latter three countries a legal appeal procedure is "built in," which in the Netherlands has been reported to result in quashing of involuntary admissions (requested by the clinician) in almost 60% of cases within on average five days of detention.³⁵ Follow up studies are needed to establish whether this results in increased risk of clinical deterioration or even suicide in patients released against clinical advice.

FORENSIC PSYCHIATRY

Britain is the only European country in which forensic psychiatry is a recognised specialty. British attempts to create more beds in medium secure units for mentally abnormal offenders contrast sharply with the situation in countries like Switzerland and Denmark, where virtually no such beds are available.

In the Netherlands, France, Belgium, Portugal, and the United Kingdom diminished responsibility may be considered for any mental disorder (including personality disorder), but the use of this psychiatric defence is much more restricted in countries such as Denmark and Italy, and the notion of diminished responsibility has been given up completely in Sweden.

In the Netherlands the legislator has, largely in response to strong calls from patients' groups, moved to a position where psychiatrists who "assist psychiatric patients with suicide" are not necessarily prosecuted.³⁶ Undoubtedly this is the starkest illustration of the extent to which attitudes and legal responses to mental illness diverge in Europe.

Psychiatric training in some European countries*

	Duration (years)	Examination	Structured programme	Logbook	Subspecialties†	Neurology	Psychotherapy
Portugal	4	Exit	Yes	Yes	No	Yes	No
Netherlands	4-5	No	Yes	Yes	No	Yes‡	Yes§
Belgium	5	No	Yes	Yes	No	No	Yes
Denmark	5-5	No	Yes	Yes	No	Yes	Yes
Spain	4	Entrance	Yes	Yes	No	Yes	No
France	4	Entrance	Yes	Yes	No	No	No
UK/Ireland	7¶	Midway	No	No	Yes	No	No

*Greece and Germany are not included as they are currently revising their programmes.

†EC certificate issued after four years, including one year senior registrar training.

‡Those who wish to enter public practice or enter academic psychiatry have to pass an examination organised by the hospital authorities.

§Child psychiatry not included.

¶Currently specified as a "minimum" amount of somatic pathology.

§Includes personal therapy.

Training issues

The duration and content of training differ greatly across Europe (table). Duration varies from four to seven years among nations, but these figures are

misleading as completion of training confers different rights in different countries.³⁷

In most training schemes the trainee is more of a postgraduate student under continuous assessment, rather than an apprentice with extensive service commitments who has to pass a cross sectional exit examination, as in Britain. The introduction of more continental-style training programmes in Britain, as outlined in the Calman report,³⁸ may result in a reduction in service provision by trainees and lead to a situation where "privileged" (yet badly paid) training posts may exist alongside "service" posts for juniors not in training, as is the case in the Netherlands, Germany, Spain, and France. As a result, these countries have a vast grey circuit of unqualified practitioners with long experience but no qualifications, and most face shortages of qualified psychiatrists.³⁹

Psychiatrists are encountering increasing competition from psychotherapists who are not medically qualified. In Germany, this gave rise to a momentous crisis in which the existence of psychiatry was at stake. Henceforth, German psychiatrists are to be extensively trained as psychotherapists and obtain a dual qualification,³⁹ as has been customary in the Netherlands for some time. It is not clear how European Union legislation affects such dual registrations as the title of psychotherapist is protected only in Austria, Italy, the Netherlands, and Sweden.

LACK OF HARMONISATION

The United Kingdom now recognises five adult subspecialties; in continental Europe not so many divisions are made. For example, child psychiatry is not recognised in some countries (Belgium, Spain, Portugal), is a special interest in the Netherlands, and is seen by others as a separate subspecialty (Britain, Italy, Germany, Greece). The Mono-Specialist Section for Psychiatry of the European Union of Mono-Specialists has recently set up, at the request of the European Commission, a European Board in Psychiatry to make recommendations for the training of psychiatrists in Europe. In a separate initiative, psychiatric trainees in 1992 set up the European Trainees Forum. The European disparity concerning adult specialties (forensic, old age, psychotherapy, learning disability, general) will be an issue, as the European certificates of specialist training apply only to the generic discipline (apart from child psychiatry).

The situation with regard to nursing has been reviewed by Stallknecht.⁴⁰ Considerable disagreement remains about the requirements for psychiatric nurses, and this has delayed European harmonisation of mental health nursing. Some countries (Denmark, Italy, Germany) do not have specialist training at all, but in others (Luxembourg, Belgium, France, Ireland, the Netherlands, and the United Kingdom) a specific qualification is required, obtained either as part of the general training or afterwards. In practice, psychiatric nurses who wish to migrate will now have to apply for recognition under European Commission general directive 89/48, and in the United Kingdom each case will be considered separately on its merits.

Conclusion

Mental health professionals have to respond to the needs dictated by the local environment and are required to take into account existing attitudes towards mentally ill people. It is therefore only natural that a certain degree of diversity in training and practice exists between countries. It is also plain, however, that "noise" from peripheral historical and political events interferes with bringing together psychiatric expertise in Europe—and this would hold considerable potential

for finding solutions to major mental health problems. The European challenge is to exploit the diversity and to overcome the parochial.

We thank Dr P Woodruff, Karyna Gilvarry, Professor R Murray, Professor N de Smit, Dr M Farrell, Dr P Griffith, Dr S Gupta, Professor M Bourgois, Professor M Berger, Dr G Kirov, Dr M Ingborg, Professor W Vandereycken, Dr K Luss, the Royal College of Psychiatrists, WHO-Euro, and Bibliothèque Henri Ey for information and advice.

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