Questions d'économie de la Santé

n°180 - October 2012



# The Evolution of Psychiatric Care Systems in Germany, England, France and Italy: Similarities and Differences

Magali Coldefy (Irdes)

**The treatment of mental illness, affecting one in four Europeans, became a health policy priority under the impetus of the World Health Organisation Mental Health Plan for Europe elaborated in 2005. This plan promoted a more effective balance between inpatient hospital care and outpatient care through the development of community mental healthcare services. Since the 1970's, the majority of European countries have shifted away from institutionalised care in large mental hospitals to the integration of patients in their living environment through the provision of home and community care services.**

**After outlining the differences in the speed and scale of deinstitutionalisation of mental health care in Germany, England, France and Italy, we examine the current delivery and structure of mental health services in the same four countries.**

**Other than the difficulty of obtaining high quality data that are comparable across countries, the first elements of comparison reveal that the pace, scale and completeness of deinstitutionalisation has been uneven. They also point to the fact that France is lagging behind in the integration of psychiatric care in general hospitals and also in the development of mental health facilities and support services for persons treated outside the hospital context.**

The treatment of mental illness constitutes a major challenge for European countries in that one in four individuals experience some form of mental disorder during their lifetimes. Mental illness represents the second major cause of morbidity after cardiovascular disease. It accounts for 20% of disability adjusted life years and is responsible for 35 to 45% of work absenteeism (OMS Europe, 2006). Despite the extent of this burden on countries, health budgets allocated to mental health represent on average only 5.8% of total health expenditures. Since 2005, with the launch of the World Health Organisation (WHO) action plan promoting mental health in Europe, the treatment of mental illness has become a health policy priority in Europe and throughout the world. It has now been recognised that a more balanced approach towards ambulatory and hospital care is needed and that community-based care improves the quality of life of the majority of patients (Thornicroft, Tansella, 2004).

The majority of European countries have thus moved away from a mental health care system characterised by the segregation and social exclusion of patients in 19th century asylums to a new model of care promoting the social integration of patients through the provision of communi-

ty-based mental health care services. In the four countries concerned, the psychiatric deinstitutionalisation process that occurred in the 1970's was initiated by the same set of factors: the development of new treatment techniques, notably pharmacological, a change in attitude towards mental illness and the claim that locating care facilities closer to patients' living environments provided a more effective and less stigmatising treatment experience. The main challenge was to achieve the right balance between hospital care and community-based care and at the same time 'despecifiying' psychiatry to make of it a medical discipline like any other.

This general trend should not, however, mask inter-country differences either with respect to the reduction in the number of psychiatric beds and psychiatric hospitals or the importance and nature of community-based services (OCDE, 2008).

If Germany, England, France and Italy experienced the process of deinstitutionalisation of psychiatric care in the second half of the 20th century, the speed and methods by which it was implemented varied, notably due to differences in social and political contexts. Furthermore, health budgets allocated to mental health vary according to country: 14% of health expenditures in England, 11% in France, 11% in Germany and 5% in Italy (OMS, 2008) [table 1]. After having outlined the history of the deinstitutionalisation process and mental health care policy in each of the four countries, we will then examine the current delivery and structure of mental health care in the same four countries.

## A variable deinstitutionalisation process according to country

During the first half of the 20th century, the mental health care delivery model was fairly similar in each of the four countries. Hospitalisation in large, specialised institutions was the only form of care for individuals suffering from mental illness. Regarded as an indicator of the quality of care, and as pharmacological treatments were not yet available, the provision of care in specialised institutions was considered a sign of progress in comparison with the previous model which interned the mentally ill with prisoners and the poor. Very rapidly, however, the problem of overcrowding in these institutions led to the neglect of their initial therapeutic goals (Shorter, 2007). Alternative forms of care then emerged in the different countries such as therapeutic foster homes, post-cure or mental hygiene centres but the genuine reform of mental health systems was not undertaken until the 1970's.

### Different implementation timeframes

The deinstitutionalisation process initiated in the 1970's followed a different timeline in the four countries concerned, beginning much earlier in France and England. In these two countries, the first reforms were undertaken between the two World Wars, notably in England with the development of the first free outpatient services (Mental treatment Act de 1930), and shortly afterwards in France with the introduction of services for the treatment of mental prophylaxis (circular issued by Rucart in 1937): 'The duty of physicians, of psychiatrists (…) is to go out and meet the population' (Bonnafé, 1975). These reforms marked the birth of care delivered 'outside the walls' of the mental institution. It was not until the second half of the 20th century, however, that a deinstitutionalisation policy, or rather de-hospitalisation policy in France, was instituted in these two countries. The development of neuroleptics in the 1950's created the opportunity to practice follow-up care outside the hospital, from which emerged the idea that mental health care could be provided by other means than hospitalisation.

In Germany and Italy, reforms were introduced much later for different reasons. In Italy, where psychiatric care was regulated by the Giolitti Law of 1904 (equivalent to the French Law of 1838 on the care of lunatics) until the end of the 1960's, reforms in all medical domains, including mental health, lagged seriously behind other European countries. In Germany, the effects of the Second World War contributed to retarding the reform process. The crimes perpetrated against the mentally ill during this period stirred up controversies and criticisms to such a point that fixing long-term mental health objectives using a conciliatory approach were impossible (Demailly, 2011). The shift towards community-based care began in the mid 1970's, a period of both political and social reform.

In France, on the contrary, the Second World War accelerated the mental health reform process. The abnormally high death rate among patients hospitalised in psychiatric institutions during the conflict (Lafont, 1987; von Bueltzingsloewen, 2007) revealed the dysfunctions of institutionalised psychiatric care (patients' deplorable living conditions, stigmatisation and social exclusion) and contributed to raise awareness regarding the need for a radical change in the mental healthcare delivery system (Coldefy, 2011). The government circular of 1960 instituting the sectorisation of psychiatric services was the result of strong collaboration between decision-makers and a minority of psychiatrists. In view of the limited awareness of disalienating practices among the majority of French psychiatrists,

T1

**Contextual data**

| | | Germany | England | France | Italy |
|---|---|---|---|---|---|
| Population in 2010* | | 81,757,000 | 61,792,000 | 62,787,000 | 60,483,000 |
| Standardised mortality rate per 100,000 inhabitants* | by suicide | 10,0 | 6,5 | 15,2 | 5,4 |
| | related to alcohol abuse | 51.4 | 49.7 | 66.0 | 40.1 |
| Percentage of GDP allocated to health* | | 11.6% | 9.6% | 11.9% | 9.5% |
| Percentage of health expenditures allocated to mental health** | | 11% | 14% | 11% | 5% |

**Sources**: * OCDE 2010 ; ** OMS 2010.

**Data downloads:** www.irdes.fr/Donnees/Qes180_EvolutionDispositifsSoinsPsychiatriques.xls

the text was considered revolutionary (George and Tourne, 1994). French sectorisation policy advocated the organisation of public hospital services across a geographical network of sectors, the 'psychiatric sector'. The sector became the basic unit for the provision of public sector psychiatric care, delivered and coordinated by multidisciplinary teams. It was to provide a comprehensive range of care and services covering all mental health care needs in a given geo-demographic neighbourhood: prevention, care, post-cure and rehabilitation.

In Germany, this type of reform was not undertaken until the 1970's following the Care Quality Commission report on mental health (Salize *et al.*, 2007). This Commission denounced the 'miserable and inhumane conditions' in numerous psychiatric hospitals marked by inadequate care provision due to understaffing, the virtual absence of psychiatric services in general hospitals and within the community, and a segregated healthcare system in which mental health care was provided by a system separated from the general health system (Deutscher Bundestag, 1975). The Commission recommended a fundamental change of approach and notably, the restructuring of the majority of psychiatric hospitals (Demailly, 2011).

In England, the creation of a National Health System (NHS) in 1948 and a favourable social and political climate will lead to the progressive closure of the old psychiatric hospitals. Contrary to France where the 1960 circular instituting sectorisation demonstrated a strong collaboration between decision-makers and psychiatrists, reforms in England were more the result of reactions to emerging trends or broader political initiatives in the health and social domains (Glover, 2007). Thus, in the 1950's, based on the observation that the number of long-stay patients suffering from schizophrenia or chronic disease was tending to decrease (Tooth, Brooke, 1961), the government progressively aimed at the closure of large psychiatric hospitals. It began with the Hospital Plan for England and Wales in 1962 planning the closure of half the psychiatric beds by 1975. Secondly, in 1971 a government paper proposed the complete abolition of the psychiatric hospital system and the transferral of all services to the general hospital (Killaspy, 2006).

In Italy, the reform movement took place a little later. Until the 1968 Mariotti Law introducing voluntary internment, admission into a psychiatric hospital was by compulsory commitment only and was entered in an individual's criminal records. This relationship with the law and the inhumane treatment of patients hospitalised in Italian psychiatric hospitals was denounced by several authors (de Girolamo, 1989). Chapireau (2008) evokes a 'psychiatric prison' in which surveillance and repression prevails over health and humanitarian aims (Maj, 1985). The 1968 Mariotti Law opened the way for the development of outpatient care and the opening of centres for mental hygiene (Chapireau, 2008). The slowness of reform and lack of progress in Italy gave rise to a militant movement, Psychiatria Democratica, led by Franco Basaglia. It denounced the systematic violation of human rights in Italian psychiatric hospitals, demanded the radical transformation of mental health care, and finally resulted in Law 180 of 1978, prohibiting all new admissions into psychiatric hospitals.

## From the reduction in hospital beds to the closure of psychiatric hospitals according to country

In England, as in Italy, the deinstitutionalisation process led to the closure of large scale psychiatric hospitals, contrary to France and Germany where services were simply downsized or restructured. Although Italy was slower in initiating reform, it proved to be the most radical. Voted in 1978, Law 180, prohibiting all new admissions to a psychiatric hospital, completely modified the structure of mental health care with international repercussions. The complete restructuring of Italian psychiatry led to the progressive closure of all psychiatric hospitals (Chapireau, 2008). In parallel, it developed a range of non-hospital residential facilities counting a total of 17,000 beds in 2006. The total number of acute care and residential care beds has dropped by 68% since the 1978 reform (de Girolamo *et al.*, 2007). In England, 112 psychiatric hospitals out of 126 have been closed. The total number of pychiatric beds has dropped from 140,000 to 25,000. As in Italy, more or less medicalised supported accommodation has been developed outside the hospital proposing 41,330 places (of which 21,280 with a high level of nursing staff) (Glover, 2007) [Tables 2 and 3].

In France, the sectorisation of psychiatric services was not a pronouncement against full-time hospitalisation, but one in favour of developing alternative care facilities (George and Tourne, 1994) that, combined with hospital care, would create a coordinated and comprehensive network of mental health care services. Still considered necessary, hospital services were therefore not abolished, but the focal point of psychiatric care was shifted from the hospital to the sector (Duchêne, 1957). Full-time hospitalisation in France was thus drastically reduced: today, 68% of patients are monitored by ambulatory services whereas full-time hospitalisation only concerns 11% of patients. In parallel, the number of full-time hospital beds has been reduced by half dropping from 120,000 to 55,000 (Coldefy, 2011). Full-time, non-hospital residential facilities have also been developed, but to a lesser extent than in England and Italy (fewer than 7,000 beds in alternative health facilities). To these, however, can be added 6,151 authorised places in medicalised nursing homes and specialised care centres for persons with severe mental disabilities.

In Germany, as in France, deinstitutionalisation consisted more in restructuring

## Context

This article is issued from a paper presented at the annual conference of the World Psychiatric Association in 2009 on the theme: "Mental health in Europe: Problems, perspectives and solutions. An overview of mental health care in four major European countries". It takes up certain discussion items presented by Giovanni de Girolamo (Health Care Research Agency, Emilia-Romagna Region, Bologna, Italy), Gyles Glover (Wolfston Research Institute, University of Durham, England), Hans Joachim Salize (Central Institute of Mental Health Mannheim, Germany) and Magali Coldefy (Irdes, France).

**T2** **Psychiatric bed capacity in public or private hospitals in Germany, England, France and Italy**

| | | Germany | England | France | Italy |
|---|---|---|---|---|---|
| Total number of adult psychiatric beds | | 54,088 | 54,340[1] | 55,141 | 10,083 |
| Density per 100,000 inhabitants | | 66 | 88 | 88 | 17 |
| Percentage of psychiatric beds | in general hospitals | 40% | - | 33% | 40% |
| | the for-profit private sector and PSPH | 8% | 53% | 35% | 54% |

[1] +10,600 Long-stay beds.

**Sources:** according to Salize *et al.*, 2007 (Allemagne) / Boyle, 2011 (Angleterre) / de Girolamo, 2007 (Italie) / SAE 2010 (France).

**Data downloads:** www.irdes.fr/Donnees/Qes180_EvolutionDispositifsSoinsPsychiatriques.xls

than closing psychiatric hospitals Few were closed, but the majority were downsized and oriented towards the provision of regionalised acute care in parallel with the development of psychiatric services in general hospitals. Germany counted 54,000 beds in 2007, against 117,000 in West Germany alone in 1970. A large percentage of psychiatric beds were reallocated to sheltered accommodation for persons suffering from psychiatric disorders, the equivalent of French medical-social structures. In total, 63,000 places are currently available in sheltered accommodation (of which 36,000 with permanent medical staff).

## Unequal integration of psychiatric services in the general hospital

In these countries the integrative therapeutic approach for individuals suffering from mental disorders was essentially achieved by integrating psychiatric services in general hospitals and developing community-based care facilities as in England with the 1959 Mental Health Act abolishing the distinction between psychiatric and general hospitals[1] and encouraging the development of community based care. The National Health Service (NHS) Hospital Plan of 1962 presents hospital-based psychiatric care as a 'component of general hospital services' (Minister of Health, 1962) and a report published in 1965, Better Services for the Mentally Ill, describes the appropriate structures for comprehensive mental health care based in the community (Secretary of State for Health and Social Security, 1975). The economic recession that followed, however, halted the reform process. Mental health policy was given renewed impetus at the end of the 1980's with the growing number of homeless in the streets of major cities, many of whom suffered from serious mental illness.

In Germany, the development of psychiatric care in general hospitals began in the mid 1970's. Of the 54,000 psychiatric beds available in Germany in 2007, 40% were in general hospitals. One of the specificities of Germany is the large number of beds dedicated to the treatment of psychosomatic disorders with 3,000 based in hospitals and 15,000 in rehabilitation centres. Originally intended for patients suffering from somatoform disorders with a high psychosomatic component or psychological co-morbidity, these beds are currently reserved for patients suffering from mild psychological disorders such as anxio-depressive syndrome (Berger, 2005; Salize *et al.*, 2007).

In Italy, the 1978 reform instituted the establishment of small, acute care psychiatric units in general hospitals with a maximum of 15 beds in each unit. It severely restricted procedures for compulsory admissions and established the creation of new community mental health services to provide psychiatric care to geographically defined areas. In 2000, Italy counted 10,083 psychiatric beds of which over half were in private-for-profit establishments.

In France, the integration of psychiatric services in the general hospital began in the 1980's together with consultation-liaison psychiatry providing an interface with medical services. The aim was to fight against the stigmatisation of mental illness and the individuals experiencing psychological suffering, but also mental health professionals and health-care structures (Coldefy, 2011). In 2010, however, two thirds of psychiatric beds in France were still based in specialised psychiatric hospitals.

**T3** **The provision of outpatient care services in Germany, England, France and Italy**

| | Germany | England | France | Italy |
|---|---|---|---|---|
| Number of community-based centres for mental health | 523 | 762 | 2,018 CMP[c] | 707 |
| Other outpatient services | 586[a] | 689[b] | 94 teams MPP[d] | 1,107 |
| Number of places in day or night hospitals | 8,539 | - | 18,922 | 942 |
| Number of psychosomatic beds | 3,183 | - | - | - |
| Number of day centres, CATTP | - | - | 1,138 | 481 |
| Places in rehabilitation services | 39,663 | - | - | - |
| Places in crisis centres | - | - | 370 | 98 |
| Number of places in non-hospital accommodation | 63,427 | 41,330 | 11,619[e] | 17,343 |

[a] social-psychiatric services.

[b] 335 crisis resolution teams, 220 assertive outreach teams, 50 early intervention teams, 52 rehabilitation teams et 32 homeless mental health teams.

[c] medico-psychological centres. [d] mobile psychiatry-precariousness teams.

[e] 2,793 places in therapeutic foster families, 1,056 places in therapeutic flats, 1,619 places in post-cure centres, 6,150 places in medicalised reception centres and specialised reception centres.

**Sources:** according to Salize *et al.*, 2007 (Allemagne) / Glover, 2007 (Angleterre) / de Girolamo, 2007 (Italie) / SAE 2010 (France).

**Télécharger les données :** www.irdes.fr/Donnees/Qes180_EvolutionDispositifsSoinsPsychiatriques.xls

[1] In France, the 1970 reform transformed the psychiatric hospital into a specialised hospital and the Law of July 31st 1991 regarding the reform of hospitals, abolishes the notion of the specialised hospital.

## Different healthcare structures with a common aim of improving patient care outside the hospital

In the four countries studied, the deinstitutionalisation process is being pursued through actions aimed at improving patient care outside the hospital. With this aim in mind, a series of initiatives were taken in England during the 1990's, favoured by a change in government in 1997 and considerable increases in health sector financing: in 1995, an update of mental health legislation introduced the monitoring of patient follow-up care outside the hospital. In 1998, the National Service Framework for Mental Health (NSF-MH) addressing the mental health needs of adults aged from 18 to 65 years old, set out detailed national standards, service models and objectives. Local Implementation Teams (LITs) associating local representatives, public and private care providers, and patient/family representatives were charged with its implementation. In 2003, England counted 174 LITs, each covering a median population of 230,000 habitants. The National Service Framework was further reinforced in 2000 with the NHS Plan favouring the recruitment and training of mental health personnel. Community Mental Health Teams (CMHT), 762 in 2008 but on the decrease since 2005 with the development of specialised teams, are made up of one or several doctors, nurses, social workers, psychologists, occupational therapists etc. Patients are referred to them directly by general practitioners. The bulk of their work consists in individual consultations, and occasionally home visits. In addition to the CMHTs, three other teams constitute local mental health services: the Crisis Resolution Service charged with preventing hospitalisations through the provision of intensive home care (270 in 2008 available 24/7); the Assertive Outreach Teams, teams specialised in dealing with particularly difficult or desocialised patients or those not adhering to treatment (248 in 2008), and teams charged with the early identification and prevention of psychotic disorders (151 in 2008). Teams specialised in rehabilitation (52 in 2008) or the care of the homeless (32 teams in 2008) have also been created (Glover, 2007). It was within this framework that the 'care programme' approach emerged, setting out a clinical practice framework recommending care quality standards to minimise potential risks facing mentally ill individuals living in the community (Jones, 2002). Among the key care quality standards, one concerns primary care and the access to specialised services: identification and assessment of needs by a professional in the primary care sector, orientation toward effective treatment, including referral to a specialist, and continuity of care; the other concerns the care of severe disorders based on a coordinated care programme established between the user, the family, the main carer and the general practitioner. This programme includes crisis prevention, risk reduction and discharge preparation in the case of hospitalisation, and an annual assessment of the care programme and carer needs (Boyle, 2011).

In Germany, the deinstitutionalisation process was slowed by the restructuring of East Germany's mental health system in 1990. Reforms had nevertheless been undertaken from the 1960's with the opening of psychiatric units in general hospitals and the small-scale development of community-based services. Mental healthcare, however, remained dominated by the psychiatric hospital and, more especially, the lack of resources due to the weakness of the East German economy (Salize *et al.*, 2007). As a result, an East-West divide in Germany persists in the provision of community-based care. Numerous hospitals (general and psychiatric) thus supervise ambulatory psychiatric services (Institutsambulanz), particularly for patients suffering from serious disorders and patients requiring multidisciplinary care. In 2002, Germany counted 304 ambulatory care services. This was completed by the creation of 219 similar services (Ermächtigungsambulanz), whose aim is to treat patients with specific problems that are addressed by office-based psychiatrists. Home care is also delivered by teams comprising nursing staff, social workers and other professionals (such as ergotherapists) in addition to psychiatrists. These teams notably deal with prevention and carry out home visits (Salize *et al.*, 2007).

The second type of ambulatory care in Germany, the social-psychiatric services (Sozial-psychiatrische Dienste) address individuals suffering from chronic mental illness. Complementary to hospital and ambulatory services, they also include long-term rehabilitative care. In the majority of Länder, they are directed by psychiatrists and integrate social workers and/or psychiatric nurses. They deliver a broad range of care including prevention activities and day care. In 2000, Germany counted 586 social-psychiatric services (Arbeitsgruppe Psychiatrie 2003) [Salize *et al.*, 2007]. Despite these advances, access to rehabilitative care and the social integration of mental health patients is still considered insufficient (Busse and Riesberg, 2004).

Mental health planning in Italy was made difficult by its political instability and economic problems and no plan was adopted before 1994 (Burti, 1997). In addition, Law 180 was essentially an indicative rather than a prescriptive law to which no budget was specifically allocated and which gave no indications regarding mental healthcare service requirements or professional training needs (de Girolamo *et al.*, 2007). The national situation is highly disparate (de Girolamo, 1989; Piccinelli *et al.*, 2002; Tognoni and Saraceno, 1989). To reduce inequalities, the Ministry of Health launched multi-year plans (1994-1996 and 1998-2000), recommending the elaboration of a network of services in each local health unit, better professional training and the setting of quality standards, and the creation of mental health departments, administrative organisms grouping together several local health units responsible for mental health services in a geographic area of around 150,000 inhabitants (Burti, 1997). A national network of 211 mental health departments now deliver ambulatory and hospital care and also residential care facilities in geographically defined zones that generally correspond to somatic healthcare units. 707 community mental health centres, equivalent to French medico-psychological centres (CMP), deliver the major part of ambulatory and out-patient care via a network of over a thousand out-patient facilities. They propose individual consultations, organise day-care activities and provide

home care. Contacts with other social and healthcare agencies that can intervene in emergencies are established for patients suffering from severe disorders. In the majority of regions, centres are open twelve hours a day and five or six days a week. The majority integrate a multidisciplinary team composed of psychiatrists, psychologists, social workers, nurses and educators (de Girolamo *et al.*, 2007).

In France, alternative healthcare structures established as closely as possible to patients' living areas have been developed as well as social and medical-social structures. As in Italy, the medical-psychological centre (CMP) is the central pivot in ambulatory care supply. The CMP is the reception and care coordination unit. Healthcare teams and all out-patient care activities are coordinated with hospital units in terms of prevention, diagnosis, care and interventions in the home or other residential substitutes such as medical-social centres, prisons etc. In 2010, Italy counted 2,000 CMP (Annual Health Establishment Statistics (SAE)). Certain CMP are also habilitated to deal with psychiatric emergencies (Coldefy *et al.*, 2009). In parallel to these core structures, a whole range of ambulatory and part-time services have been developed to enable patients to live with their illness. In 2010, France counted around 19,000 part-time hospitalisation places and 1,000 therapeutic activity centres and therapeutic workshops. More recently, teams specialised in certain forms of care have been created. These include 100 mobile psychiatry-precariousness teams and teams specialised in the psychiatric care of adolescents and the aged.

## Insufficient development of alternatives to the hospital and significant regional disparities in the four countries

In France, if a specific policy has been implemented with the aim of achieving a better balance between hospital and community-based care, the development of alternatives to full-time hospital care remains insufficient. Even if alternative community-based facilities and social and medico-social services have been established, considerable regional disparities in the provision of care and the organisation of care, that has often remained hospital-centred, are still observed.

These disparities not only concern facilities and human resources, but also the degree to which sectorisation policy has been completed (a 1 to 13 gap in terms of beds and places in adult psychiatry). Furthermore, the French psychiatric system is heavily compartmentalised between health professionals (general practitioners, psychiatrists and psychologists) and modes of practice (private and hospital), but also between the health system and the social services (Coldefy, 2011). The priority aim of the latest Psychiatry and Mental Health Plan (2011-2015) is to 'prevent and reduce the interruption of care to improve living with a mental illness' requiring the psychiatric sector to 'shift from a totalist approach to a global approach'.

Disparities in the provision of care are apparent in each of the countries studied in specific ways and at differing degrees. The case of Italy is specific in that it presents significant regional variations, notably due to decentralisation, including financial. If the development of community-based services has been significant in several regions and have improved access to mental health care services for numerous patients, certain regions have remained very poorly equipped, notably in the south. Girolamo *et al.* (2002) observe an inverse relationship between residential accommodation structures and community-based outpatient services suggesting that regions invest differently. Some regions have thus privileged the transfer of patients into long-stay residential accommodation or private establishments rather than develop community-based outpatient care. In more general terms, and despite national directives, the development of community-based outpatient care services has been slow and variable. A better integration and closer collaboration between the different services appears more and more necessary in the mental health sector and several initiatives have been taken (notably the development of Community Mental Health Pacts' [Lo Scalzo *et al.*, 2009].

In Germany, where mental healthcare organisation is closest to that of France, there is considerable regional variation in terms of psychiatric bed capacity at national level, varying from 5.3 psychiatric beds per 10,000 inhabitants in the Land de Saarland to 10.6 in the Land of Bremen. As in many other countries, there are wide disparities between urban and rural areas both in terms of bed capacity and the provision of mental health services in general (Salize *et al.*, 2007). As the health system is organised at Länder level, there exist both regional disparities and variable healthcare production in different health sectors. Hospital bed capacity is fixed by the Länder, whereas local authorities organise and oversee the range of generally independent community mental health services, including professional services and sheltered accommodation. This division is one of the key factors in the German health system: the large gap between hospital and ambulatory care, two distinct sectors that are separately financed and managed by different teams (Salize *et al.*, 2007). This situation also has consequences on available data as there are no official national data but a collection of heterogeneous data from different sources.

In England, regional disparities in the distribution of NHS beds between Strategic Health Authorities (SHA) are also significant: from 0.8 beds per 100,000 inhabitants in the South-East SHA to 8 for London, with a national average of 1.6 (Boyle, 2011). The government has allocated a massive budget to the development of community-based care over the last two decades. The hospital admission rate is relatively low overall with 300 admissions per year per 100,000 inhabitants compared to Germany (1,240), France (1,000) and even Italy (800) [Roelandt, 2010]. This situation can be explained, among other things, by an efficient coordination between mobile teams and community social services enabling

patients to remain in their family environment. In England, hospitalisation is the exception rather than the rule, which is not the case in the other three countries (even in Italy for very short stays) [Roelandt, 2010].

* * *

This first analysis of the evolution of mental healthcare systems in Germany, England, France and Italy provides an insight into the current differences in the organisation of care. The social and political contexts, the implementation time frames, therapeutic orientations and the degree to which the deinstitutionalisation process has been completed differ from one country to the next. Compared to our European neighbours, France has been relatively slow in integrating psychiatric services into the general hospital but also, and more especially, in the development of supported accommodation and services for individuals suffering from psychiatric disorders in their everyday lives. Mental health care in France was for a long time managed essentially by the psychiatric sector, often with a 'totalising' view of its mission. A more global approach to mental health care in coordination with the social sector and other actors in the health and social domains (office-based medicine, private health establishments, and medico-social and social support services) remain insufficiently developed. The involvement of users and their families in the therapeutic project, notably through the concept of empowerment or self-responsibility as in the British example, remains embryonic in France. Conceived in terms of health, French mental health care does not sufficiently take into account the different dimensions of everyday life (notably accommodation and access to employment and training) whereas they strongly contribute to an individual's quality of life or the social integration of individuals confronted with mental illness (Greacen, Jouet, 2012).

Cultural differences as well as healthcare financing in its different components (ambulatory, hospital, sanitary, social) seem to play an important role in the organisation of care and the development of community-based outpatient services and supportive social and medico-social structures and services.

Furthermore, in the four countries studied here, the public sector operates alongside a private sector, whether for-profit or not, in variable proportions: somewhat low in Germany and France (8 and 35%), whereas the private sector provides the majority of mental healthcare services in England and in Italy where it represents almost half the total number of psychiatric beds (de Girolamo, 2007; Boyle, 2011). In both these countries, the transferral of a large proportion of patients into private establishments can be debated, notably in terms of quality and continuity of care by the original psychiatric teams. The place of the private sector in the provision of psychiatric care is poorly documented and would merit further development. In more general terms, this synthesis needs to be pursued and enriched by research on the quality of services delivered to the population in each of these countries and on the improvement of the quality of life of patients suffering from mental illness. ♦

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10, rue Vauvenargues 75018 Paris • Tél.: 01 53 93 43 02 • Fax: 01 53 93 43 07 • www.irdes.fr • Email: publications@irdes.fr •
**Director of the publication**: Yann Bourgueil • **Technical senior editor**: Anne Evans • **Associate editor**: Anna Marek • **Reviewers**: Zeynep Or, Sylvain Pichetti •
**Translator**: Véronique Dandeker • **Copy editing**: Anna Marek • **Layout assistant**: Damien Le Torrec • **Diffusion by subscription**: €60 per annum •
**Price of number**: €6 • **ISSN**: 1283-4769.