Constraints in Mental Health Services Development

Report on a Working Group

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Note

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This report is also issued in French and Russian.

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1. INTRODUCTION

The Working Group on Constraints in Mental Health Services Development was attended by 21 experts from 16 countries in Europe and from the United States of America, and by 2 staff members of the WHO Regional Office for Europe. The participants included clinical psychologists, psychiatric clinicians, administrators working in hospitals and mental health services, academic psychiatric staff with primary responsibilities for teaching and research, senior medical and administrative staff working in regional and national departments of mental health, and psychiatric nurses working both in the field and in administration. (A list of the participants is given in Annex II.) Also present were a number of observers from the local psychiatric services based in and around Cork, and from the Department of Psychiatry in the University of Cork.

The Working Group was welcomed by Mr D. Whelan, Assistant Secretary, Department of Health, Dublin, who, speaking on behalf of the Tánaiste (the Deputy Premier) and Minister of Health of the Republic of Ireland, noted that the World Health Organization Regional Office had, since its foundation, been especially concerned with the development of comprehensive mental health services based in the communities which they served. It had therefore become imperative to achieve greater coordination between those community mental health services and the systems of general public health, social security and education, and to improve collaboration with volunteers and other interested nonstatutory agencies in those areas. Although a start had been made in such developments in most European countries, the process had been completed in none. However, each government in the Region was concerned that there should be a logical programme for the development of comprehensive community mental health services and it followed that the constraints upon the fulfilment of that programme should be identified and understood.

Dr A.E. Baert, Regional Officer for Mental Health, in an opening address on behalf of Dr Leo A. Kaprio, Director, WHO Regional Office for Europe, noted that the primary objective of the Regional Office's long-term mental health programme, which had been approved by the Regional Committee in 1970, was to bring about the integration of psychiatric care with other types of treatment in general hospitals, with social care provided in the community, and with primary medical care in clinics, in the offices of family practitioners, and in the homes of patients.

Dr Baert recalled that the Working Group on the Future of Mental Health Hospitals, Mannheim, 2–5 November 1976,[a] had concluded that

[a] **WHO Regional Office for Europe.** *The future of mental hospitals:* Report on a Working Group. Copenhagen (document ICP/MNH 019 II) (in preparation)

psychiatric units and mental hospitals should no longer be situated remotely from the communities they served, and that all new and existing general hospitals should include psychiatric departments which could provide for the people in their catchment areas a range of services including, *inter alia*, out-patient care, inpatient and day-hospital treatment, and crisis intervention. That Working Group had also considered that mental health services should cooperate closely with primary care and general medical services, and with the social agencies in their catchment areas.

Inpatient care in such a system would be but one of a range of therapeutic options, so that proper preliminary assessment of the illness and of the patient's needs would be essential in determining which other parts of the treatment system would, initially, be most likely to bring about relief of symptoms and be most helpful to the patient and his family. There should, thereafter, be free movement of the patient between the various parts of the psychiatric service as determined by the changing needs of the patient and his family, and by the response of the illness to treatment.

The type of care selected should always be the least restrictive of liberty, and that least likely to produce dependence, and yet it should be the vehicle likely to achieve the most effective therapeutic results.

Staff in long-stay psychiatric hospitals ran the risk of professional isolation and of becoming socially insensitive, and that could lead to poor staff morale. To counter that they should be given responsibilities outside the hospital, e.g., in clinics, and outside the health service as a whole, in community work or with social or other caring agencies.

Dr Baert reminded the Working Group that the long-term objective of the Regional Office's mental health programme had been clearly stated and approved by health authorities, administrations and professions alike; it was to secure the establishment of comprehensive community mental health services. However, the means by which that would be achieved were less clear and there were many factors impeding progress towards that objective. The Regional Director had therefore given the Working Group the task of identifying those constraints which were preventing the development of comprehensive community mental health services, and of making proposals for overcoming them.

The participants elected Dr D. Walsh as their Chairman and appointed Dr H.C. Fowlie as their Rapporteur. Dr A.E. Baert acted as Secretary to the Working Group.

In order that the Working Group could move expeditiously to its main task of making recommendations, it was assumed that there was agreement on conceptual matters such as the parameters of psychiatric illness, the range of proper concern of mental health services, and the desirability of implementing the WHO objective of universal comprehensive community mental health services. The participants then presented in summary form the previously circulated papers describing the situation in their respective countries

regarding mental health services development. Some or all of the following topics were examined to determine the extent to which they acted as constraints in the development of comprehensive community mental health services in each country: lack of adequate information about the size and nature of mental health problems and the resources available to cope with them; lack of national mental health policies; unavailability and inaccessibility of services; inadequate staffing; lack of financial resources; outdated and inappropriate legislation; lay and professional bias against the mentally ill; resistance to change and inadequacy of research.

2. REVIEW OF COUNTRY POSITION PAPERS

To have reproduced these papers in their entirety would have been repetitious, and even to abridge them would have meant an undesirably long report. What seem to have been the main points have been taken from each, but no single paper was comprehensive and the authors' indulgence is craved if this selection from, and rigorous compression of, their ideas does their efforts less than justice.

Algeria. Psychiatric services are poorly developed in Algeria. The most important constraints are not only lack of finance or material resources, but also a failure to adopt the ideas and morality implicit in community mental health care. There is little evidence of political or social will to divert resources from making good other pressing deficiencies, such as transport, sanitation, and emergency medical services, in the social and industrial infrastructure of the country. There is much professional resistance to change and the allocation of resources also gives preferential treatment to maintaining the *status quo* in its dependence on large remote mental hospitals. Sectorization and the multidisciplinary nature of services are as yet barely accepted, even as desirable objectives, and do not exist in practice to any great extent.

Belgium. Political, economic and administrative planners sometimes have difficulty in relating to and understanding the clinical psychiatric viewpoint and the mental health needs of the community. Although a national plan exists for mental health systems, its flexible local application is very difficult to achieve. There is a good network of extramural services but they are too selective in the kinds of patients treated, and often they duplicate themselves. Inpatient mental hospitals are remote and understaffed, especially with nurses. The public prefer to give voluntary support and to contribute financially to nonpsychiatric provisions, and there is still much fear and apprehension even in the face of the widespread adoption of a social model,

as opposed to a medical model, of psychiatric illness and problems. This is manifested also in the refusal by different agencies and subspecialties to work together. The law on compulsory admission is outdated and it is feared that new laws recently promulgated will result in excessive concern with procedural and judicial matters. Research was insufficiently funded, especially long-term research into the delivery and quality of care.

France. While it is recognized that there are other important constraints operating, great stress is laid on the fundamental nature of attitudinal constraints. There is still considerable public fear of mental illness and the mentally ill, and even psychiatric services in the community are prejudiced against and reject severely disordered psychotic or psychopathic cases. Families, too, have reservations about types of treatment which make them responsible for much of the care required, and at the same time blame them for the illness; and some families still reject their sick members. The refusal of some psychiatrists to intervene unless the patient seeks treatment voluntarily is perplexing to the community and arouses anxiety and anger in some cases; perhaps unintentionally, these attitudes have created a challenge to the medical role and privileges of the psychiatrist.

Federal Republic of Germany. The concept of community care was challenged because the concept itself and the stated desirability of it were assumed to be somewhat theoretical, or even ideological in part, and not sufficiently based on scientific data or field studies. Special emphasis was laid on the observation that poor results from countries where comprehensive mental health services had been already introduced were not always sufficiently considered in planning new services. In the Federal Republic of Germany, the *Länder* possessed coordinated plans for developing community mental health care, but there was still, inevitably, reliance on large institutions. There were as yet few general hospital, day care or outpatient psychiatric units. The problem of devolution of services to gain proximity to the patients' environment was described and compared with the centralizing pressures of fragmented specialization. In the Federal Republic of Germany, one of the major constraints seems to be not only the lack of adequately trained staff, but the scarcity of suitable persons motivated for training in this type of demanding work. As most responsibilities regarding health matters are with the *Land* governments, a variety of approaches to the improvement of psychiatric services results. One of the obvious disadvantages of this structure is sometimes health, social and other legislation which is on occasion contradictory. Research is too much orientated towards the needs and skills of university departments, and does not adequately reflect the reality of services and the needs of whole populations.

Greece. The country is very far from having comprehensive community mental health services. There are no general hospital psychiatric beds, few

day hospital or other community provisions, and the mental hospitals and associated outpatient clinics are mostly located around the two major cities, as are the vast majority of practising psychiatrists, so that considerable parts of the country have no specialist services at all. Furthermore, the law of 1862 is outdated and repressive, so that hospital treatment can only be had by patients admitted on a compulsory basis. Psychiatric services are seriously underfinanced. Public prejudice and rejection, even of former mental patients who have recovered, continue to be serious and major impediments to the introduction of community services.

Hungary. There are good information services, a flexible legal framework, and a progressive national mental health policy, but the latter has not yet been fully implemented, for there are serious staff shortages and professional training is inadequate, and indeed, in the case of social workers, almost nonexistent. There are great urban/rural disparities favouring the cities, and there is only limited experimentation with "open-door" institutions and extramural services. Prejudice is still considerable and its effects are rationalized as being due to lack of money. It is perhaps as a result of this that mental health is given a low priority in the country's total health budget.

Ireland. There is a lack of information which accompanies, or perhaps contributes to, poor planning and a failure to establish priorities within the mental health field. Professional staff seem unwilling to accept and to use data from information systems, and there is a lack of finance for adequate development of community mental health care.

Italy. There are virtually no reliable data on which planning assumptions can be made. There are very few professional staff so the emphasis is on institutional care and chemotherapy. There is great disparity between the north and the impoverished south of the country in the distribution of resources, and a national health scheme has only recently been introduced. Though out-of-date, the current legislation is not thought to be a significant impediment to developing a community mental health service, and it is thought that prejudice and bias have much reduced in the past decade.

Netherlands. As in most other countries, the constraints when viewed in terms of mental health care are much greater than when viewed in terms of mental illness. Social and behavioural data are available, but their relevance is questioned and their applicability in doubt; mental illness statistics relate to inpatient mental hospital care only. Very little service-orientated research is conducted other than in a single case-register study. Not enough is known of how resources which are, on the whole, well tabulated are used. Mental hospitals are very unevenly distributed and they, like the extramural services, are quite separately organized and financed.

Extramural and general hospital services are highly selective and may exclude some groups of patients altogether. There is an overall shortage and uneven distribution of staff which may be aggravated by the role-blurring and democracy of teamwork. Mental health services are underfinanced and replacement of outdated mental hospitals is not accorded sufficient priority. Public prejudice is still expressed, not least in the reluctance of central and local government to employ former patients. Some of the professional resistance to change is due to the indefinite nature of proposals for change.

Norway. The size of the areas covered and the lack of staff, combined with a history of *ad hoc* development of services, have resulted in a gap between the real needs of the population and the ability of services to meet these. The aims now are to reduce distress, to provide a service for neglected at-risk groups, and to improve coordination, staff training, and the operation of information systems which will result in better evaluation of the service provided.

Poland. A mental health policy has recently been introduced which emphasizes primary prevention and the role of the primary care team, and there will shortly be new and more flexible mental health legislation. There remains, however, undue reliance in practice on large institutions which are badly placed for the districts they serve. The outpatient clinic network, though extensive, concentrates on the follow-up of patients discharged from these institutions and on the compulsory treatment of alcoholism, so that there is a general neglect of the neuroses and milder states of psychotic illness. Prejudice and fear is marked in the public, and in the medical administration there is a narrow, restrictive attitude which perhaps causes, and certainly adds to, the difficulties stemming from the low priority given to mental health in national budgeting. Staff are too few and are biologically, rather than psychosocially, orientated.

Portugal. The position prior to 1974 was that psychiatric services had been poorly developed and were almost exclusively centred on mental hospitals or on the private sector. Since then, the psychiatric services have begun to change against a background of massive political, local governmental and social changes resulting from democratization and decentralization. Services are poorly staffed and very unevenly distributed, but recently legislation has amalgamated aspects of social and health care in beneficial ways. There is resistance to change by established staff, but it seems imperative to change from the former heavy reliance on services in the coastal area, and especially in Lisbon. It is as yet too early to report on the effect which these multidimensional political and social changes may have on the possible redistribution and reorganization of mental health services.

Romania. There is a national plan for independent regions and sectors, with an emphasis on community psychiatry, and progress is being made in

implementing it, but it is impeded by the uneven distribution and the remoteness of some existing resources. Furthermore, rapid industrialization and urbanization in some areas demand new medical services, in the provision of which psychiatry has been given a low priority, so that people are again remote from the psychiatric services which they have to use. New ideas in hospital architecture and building cost limits mean that in some cases new buildings do not readily permit the adoption of modern and comprehensive psychiatric therapies. The extension of new extramural services is prevented by staff shortages and a lack of suitable premises. There is poor coordination, especially of the social work input, within mental health teams. Although public attitudes have improved very considerably, there is still apprehension and prejudice, and the former psychiatric patient has difficulty in gaining acceptance and employment in the community. This means that psychiatrists are making "euphemistic" administrative diagnoses which would ultimately make the interpretation of national data extremely difficult.

Sweden. Services are still based on traditional institutions and provide a circumscribed somatic approach which ignores the multidisciplinary nature of the problems presented. Although comprehensive sectorized services were officially recommended in 1974, as yet only one such service exists. Lack of money is not a serious impediment, but financial allocations favour the continued dependence on, and predominance of, large institutions whose directors determine these allocations and the therapeutic policies of their services. Differences in psychiatric ideologies, causing confusion and misunderstanding, have delayed development. There are too few psychiatrists and psychotherapy is a relatively neglected area in training. Legislation is a significant impediment to multidisciplinary teamwork.

Turkey. There is little movement towards comprehensive mental health care; there are no catchment areas and little possibility of postdischarge follow-up from institutional care. There is no modern legislation in the mental health field and no system of social security. There is substantial public fear of mental illness and psychiatric treatment, considerable prejudice against the mentally ill, and, especially in the rural parts of the country, there is unwelcome competition between religious bodies and psychiatry as to which is the proper caring agency for the mentally ill.

United Kingdom. Services in some areas remain remote and inaccessible, and there are very substantial shortages of all specialized staff except nurses. Lack of finance has been a severe constraint, but there is a declared governmental policy designed to lessen this. Prejudice among the public and a traditionally reactionary professional attitude, which generates resistance to change, are seen as important constraints.

United States of America. The constraints here include the lack of finance, which is attributed to the political naivety of mental health workers,

preferential insurance schemes, and a fiscal emphasis on illness rather than health care. Such money as is available for mental health – some 1% of the gross national product, or some 14% of all health care finance – is directed more to maintaining institutional care than to developing community care. Staff resistance to change and anxiety about role-blurring, together with changing role definitions, are potent constraints on the evolution of community mental health care, as is poor administration by care professionals as opposed to professional administrators.

During the Working Group's discussion of the country position papers, it became evident that a clarification of the concept of comprehensive community mental health care was necessary (see section 3). The Group considered it best to deal with the various constraints under six separate headings, in relation to attitudes (section 4), information (section 5), manpower (section 6), material resources (section 7), coordination (section 8) and administration and policy (section 9).

3. THE CONCEPT OF COMPREHENSIVE COMMUNITY MENTAL HEALTH CARE

Early in its deliberations the Working Group had to make explicit different preconceptions about the meaning of comprehensive community mental health care. In particular, the concepts of comprehensiveness and of community orientation had to be explored, and in this respect a potentially confusing divergence of opinion became apparent.

On the one hand, community mental health care could be taken to mean a system of service to the community based on the behavioural and sociological sciences, which was designed to assist not only individuals and their families but also discrete groups within society to overcome the stresses occasioned by living in the psychological climate and material condition in which they found themselves. Proponents of this viewpoint saw the assistance given as positive mental health, and as the *raison d'être* of community mental health programmes. This view of the community orientation of the mental health team was prevalent mainly in the North American continent, where comprehensiveness which encompassed a team's responsibility for the full range of mental health and mental illness care, up to and including long-term institutional care, did not seem to play any great part in the concept of community mental health care.

A second view of comprehensive community mental health care was of a movement designed to shift the emphasis of an illness-orientated service

from a restrictive institutional base to a liberalizing noninstitutional, extramural and domestic field of operation. This viewpoint seemed to be more prevalent in Europe.

The Working Group recognized that these differences of opinion existed and that different emphases would exist in mental health services in different countries and in different parts of the same country. However, the Group thought it important to emphasize the comprehensive nature of a community mental health service. Thus, a comprehensive community mental health service was not based solely in the community, for the community-based elements of it would be only a part of the total range of services and facilities which ought to be available to a community. The need to develop one or several parts of that totality would depend largely on the social pressures within the society to be served, and on the perceived and recognized needs of the community.

In the ensuing discussion of constraints on the development of comprehensive community mental health services and how they might be overcome, the Working Group took an all-embracing view of the topic and concerned itself always with a degree of comprehensiveness which would encompass the mental health problems of the community as well as the mental illness problems of individuals and families in whatever geographical or architectural setting was best suited to the effective resolution of those problems.

4. CONSTRAINTS RELATING TO ATTITUDES

The Working Group realized that the most universally operative constraint impeding the further development, or the introduction, of comprehensive community mental health services was the persisting apprehension and prejudice which the presence of mental illness evoked in most people and which determined the stigma which was still attached to mental illness and to the mentally ill in many countries of the world.

Miss M.R. Mamelet (France), introducing this topic for discussion, suggested that this fear and stigma arose out of two fundamental points. Firstly, a person who was severely ill mentally ran the risk of a degree of restriction or loss of liberty which was unique and, in some situations, very difficult to reverse. This, when combined with the loss of self-determination which the illness itself was believed to cause, meant that the average person, who believed to a greater or lesser extent that he could logically control his own life, was afraid of losing this control over his own destiny in the way that the mentally ill person appeared to do. This feeling of fear and apprehension then became centred on mentally ill persons and was then

expressed by individuals, or by society as a whole, in attitudes of rejection and hostility. This aspect of bias had been aggravated by the occasional, but persisting, abuse of their restrictive power by individual psychiatrists. Although rare in most countries, these cases of abuse of authority attracted considerable adverse publicity and did much to perpetuate the antipathy felt towards psychiatry.

Secondly, Miss Mamelet believed it had been naive to proclaim that in every case mental illness and the mentally ill person were qualitatively the same as physical illness and the somatically ill patient. They were not, and psychiatrists had to bear much of the blame themselves if, now, they were hoist with their own petard in their efforts to destigmatize mental illness. The mentally ill did, in a minority of cases, behave in bizarre ways which evoked annoyance and disquiet as well as compassion, and paradoxically the increasing informality of treatment, and the greater likelihood of the patient remaining in the community, had directed attention to the truth of this rather than to the fact, which had been one of the mainsprings of community care for the mentally ill, that the great majority of psychiatric patients were behaviourally normal.

Psychiatry as a discipline had first separated itself from neurology, and in more recent years there had been a distinct trend to take psychiatry out of the field of medicine altogether. Thus some people talked of residents rather than inpatients, of clients rather than patients, and of problems rather than symptoms. Behaviour which hitherto had been confined to institutions – "out of sight, out of mind" – and to which mental hospital staff had perhaps become inured, was now public, and as such it was disquietening and sometimes literally threatening. This trend towards a normative view of psychiatric illness had been compounded too by a trend towards therapeutic passivity by some psychiatrists who believed in self-determination by their patients and in nonintervention to an extent that, even though legally entitled to do so, they would not, for reasons of conscience, and even at the expense of life itself, deprive anyone of liberty. Such had been the case in the widespread reluctance to intervene in self-destructive behaviours, of which severe alcoholism was one, which from a commonsense point of view were seen by the public to be illnesses which were so damaging to all concerned that they called for some kind of compulsory preventive detention.

It should not be forgotten that compulsory legislation was designed to protect the sick as much as to protect the public, and that asylums were conceived of as havens of refuge from the outside world rather than as prisons separating patients from people in the community. The psychiatrist had been put, or had put himself, in a difficult position. Unlike other doctors whose responsibility began and ended with their patients, the psychiatrist found himself with duties and loyalties to his patient which sometimes conflicted with those which he held towards society. He possessed powers

over the liberty of individuals which people feared he would exercise over them when they were in his care, but which they none the less wished him to exercise in respect of others who had been placed in his care. Furthermore, it did not make the integration of the sick person with his family and the community easier when widely proclaimed but ill-understood etiological theories seemed to blame the family and the community for the illness itself. Small wonder that the reaction of the community and his family to the mentally ill person continued to be an amalgam of apprehension and repugnance, rejection, and even revenge overlaid with compassion and concern.

However much this appraisal of people's attitudes was disputed, it would remain an unpalatable truth until such time as the family and the community were given the skills and resources and the opportunity to make restitution and to expiate the guilt they would continue to feel if, indeed, they were held to be responsible for the misfortunes of mentally ill persons.

Fortunately, however, although mental illness was still feared, there was also abundant evidence of compassion and concern for mentally ill people. There was also in the public mind a willingness to adopt the concept of care in the community provided it was a part, but not the only part, of a range of resources for assisting such people to regain health or to adjust as well as possible to continuing disability. And so the element of comprehensiveness, meaning a range of facilities which, separately and in conjunction, would meet all the needs of all patients in a community, was as important as, and perhaps from the public's point of view even more important than, the concept of basing some or most of these services within the community itself.

The Working Group felt that these constraints of attitude, arising as they did out of fear and ignorance, could only be removed if the public and other professions were made more aware of the truth and reality of mental illness and of the treatment of it. It was important, therefore, not to "oversell" either the patient or the therapy, for great damage had been done in the past by unrealistic optimism in this regard. Psychiatrists must be willing to place their work and methods under scrutiny, and they must be rigorously honest in their public accounts of, and claims for, the mentally ill so that there was a greater awareness of facts. This would mean encouraging the public to visit facilities even more than they did; it would mean a greater involvement of the mental health team in public education, in community life and in public relations, and it would mean involving the public in the policy-making and management of mental health services.

In addition to countering the present negative aspects of public misinformation by these and other means, it would be necessary to point to more positive aspects of health education. Thus, the relative rarity of loss of liberty and of physical restraint, the rarity of irrationality and loss of control, the relatively high recovery rates, and the frequency of complete recovery should be demonstrated and declaimed – but without overemphasis. Persisting mythologies had to be swept away so that mental illness could

be dedramatized and shown for the most part to be almost unremarkable. The shortness of stay of most people admitted to inpatient psychiatric care needed emphasis, as did the misnomer of calling some mental hospitals long-stay institutions, for the duration of stay of all but a small handful of persons admitted to these hospitals was probably shorter than that of many people admitted to so-called acute facilities.

Psychiatrists would have to take care, however, not to "guild the lily", lest public confidence was deceived. Certainly so far as therapy was concerned, it was imperative that psychiatrists showed caution in their optimism, restraint in their claims, and honest humility in their admission of mistakes and failure.

If community psychiatric services were to claim comprehensiveness, then the organization of services and the relative responsibilities of associated health and other agencies had to be such that no person in need of care or treatment was denied it. Psychiatrists should admit that selective rejection of some problem behaviours and some patients had occurred in the past, and having admitted that, they had to ensure that it did not continue. A mental health team needed a clear remit to its responsibilities, and where that did not cover all eventualities then the coordinative machinery had to encourage different teams in a comprehensive service to become positively selective and specialized. Above all, a comprehensive mental health service should not leave the families of patients/clients feeling that they had been abandoned or ignored in their desire to find help, and frustrated in their attempts to do so.

The comprehensive community mental health service would have an important educational role which it would the more readily initiate because it was close to, and identified with, the population of a particular catchment area. With assistance from health education professionals and with better use of the communications media, it would be able to reach out to the public, to primary care physicians and to other medical specialists, as well as to other caring agencies, such as police forces, social work departments, the churches and educational authorities.

The Working Group felt it important for those charged with responsibility for mental health services to consider mental health as well as mental illness, and to realize in that regard that children and the parents of young people should have greater opportunities within educational curricula to deal with the healthy development of personality as well as of intellect. They needed opportunities to discuss and to be made aware of self-damaging behaviour and self-destructive life-styles, and it was necessary to promote in them greater understanding of such vital aspects of mature living as their feelings, their relationships, their emotional wellbeing, and the potentially liberalizing and liberating use of leisure. It seemed probable that this would diminish prejudice and stigma as well as having some effect in preventing mental ill-health.

Members of the Working Group made frequent reference to the role of, and the use of, the mass media – press, television and radio – in informing and changing public attitudes, and there was general agreement that the media had not been exploited to the full in promoting mental health. It was recognized that some journalists were more interested in sensationalism than in objective information; that attitude could be countered by greater skill on the part of psychiatrists who took part in interviews and programmes, and by a greater willingness to take initiatives in public education. There was value in teaching students of journalism about mental health and illness, and although many, if not most, psychiatrists would claim that one of their skills was to facilitate communication, it was also of value to recognize that journalists had skills in mass communication which could usefully be learned by psychiatrists who undertook the essential tasks of public education. That was especially true for the member of the comprehensive community mental health team who acted as press liaison officer or principal public spokesman, and it was an important aspect of public relationships that some one person within the comprehensive community mental health team should be widely known to do so.

5. CONSTRAINTS RELATING TO INFORMATION

Mr J.U. Hannibal, Technical Officer for Mental Health, WHO Regional Office for Europe, led the discussion on the ways in which lack of information could and did act as an impediment to the progress which could be achieved, and as a constraint on the type of development which would be desirable in community mental health services.

Regional Office studies indicated that no country had a complete range of relevant, centrally available, nationally based information which was readily accessible to external parties who had a legitimate interest in mental health or related data. Furthermore, such information as was available in each country was rarely comparable with that available in other countries, so that international comparison was at best unreliable, and at worst impossible. Disappointingly, preliminary indications from current local and regional studies being carried out in Europe under the aegis of the Regional Office indicated that the information collected, even at those local and regional levels, was not readily available and was neither comprehensive nor comparable. In many areas there was a manifest reluctance on the part of related social and other health agencies to cooperate in the development of new schemes of data collection, and even in the release of currently available data. For instance, whereas the importance of sociodemographic factors in the genesis and expression of maladaptive behaviour and morbid

symptomatology was recognized, sociodemographic data such as unemployment rates, crime rates, details regarding housing conditions, family structure and standards of educational provision were often not available to those who were concerned in health service planning. In the particular instance of mental health services planning, when such information was available to planners, it seemed that it was only rarely taken into account by them, although it was admitted that variations in those factors could, for instance, very significantly influence one or more aspects of a mental health service programme to be introduced in a particular area.

Mr Hannibal, himself a sociologist, believed that the manifest deficiencies in that respect could be remedied only by developing refined national information systems out of, and eventually in place of, the existing schemes of data collection which were rudimentary in most countries. If that were done there would be in the future not only a bank of raw data for analysis, but also an ongoing and cumulative system for comparative evaluation which could be used in monitoring morbidity and in planning treatments and service developments.

Turning to another aspect of ignorance, the speaker directed attention to the social responsibilities of mental health care professionals who, in his view, had a duty to educate the public and other professionals about the nature of overt mental illness and of the psychological problems which could arise from social breakdown, or which were related to, or accompanied, somatic illness. Lack of this type of information had a bearing on the prejudice to which the mentally ill were exposed.

In the general discussion it became clear to the participants that two kinds of ignorance were impeding progress in developing comprehensive community mental health services. On the one hand, there was the ignorance which public and professional groups in medicine and in disciplines related to mental health displayed about the nature of psychiatric illness and psychological problems which, together, comprised mental health. As well as being the cause of failure to detect illness, that ignorance was expressed in stigma and prejudice, and lay at the centre of the attitudinal constraints already discussed.

Those same people, the public and health or other professionals, also impeded progress by their lack of knowledge about the nature and availability of existing services, and about the potential for developing those services in ways which would serve the community more effectively. Physicians did not know enough about available psychiatric services; psychiatrists did not known enough about the range of available voluntary agencies; few, other than those directly involved in social work, and sometimes not even they, knew or understood the complexities of social legislation and the rights accorded by it to members of the public in need. The public, for its part, could not hope to comprehend the complex interrelationships between different caring systems and so, often bewildered and not knowing whom to approach, might end by seeking help from none.

The second type of ignorance, on the one hand, concerned the lack of factual epidemiological data. Members of the Working Group questioned the appropriateness of much of the information currently gathered in their respective countries, and doubted its reliability. They were aware of the considerable investment of labour and effort involved in the collection of data for current national information systems, but expressed scepticism about the extent to which the data were actually used in central or regional planning. Most of the information obtained was irrelevant to the sectorized operations of a community mental health team. It was felt that that might be the result of *ad hoc* enquiries having assumed a permanence because of a reluctance to stop data collection systems once they had been started, and because there was rarely any internal, intrinsic monitoring of the value of particular kinds of data within a system, or any set time limit for review of the usefulness of any data collecting system itself.

It was felt that too often data were collected because they were easy to collect rather than because they were useful or readily understood. An example was furnished by the generally available statistics relating to hospital beds. Most psychiatric practitioners knew that the term "beds" was capable of many definitions, including available and empty beds, occupied beds, available but not usable beds, staffed beds, unstaffed beds, short-stay beds, long-stay beds, psychogeriatric beds, adolescent and obervation beds, and so on. Bed frames were easily counted, but merely to report that X beds were available per 1000 population in a particular region gave at best little useful information about, and at worst a misleading picture of, the resources available to the community within a psychiatric service.

The late Dr A.R. May had reported[a] in 1976 "What is becoming clear, however, is the need to question the validity of an overall ratio of 'beds per 1000' as an indicator of adequate service..... In the light of present..... lack of information about the function and distribution of existing resources, it is impossible to decide the optimum number of beds per unit of population". The Working Group went further than this: it rejected the usefulness of overall bed ratios.

Whereas central planners seemed to promote data systems concerned with census dates and treatment episodes, and so with development programmes based on administrative prevalence, the "clinician" was more interested in cohort studies or case registers which told him something about the condition or conditions he was called upon to treat and the outcome of treatment for the individual patient or client.

Local records in which the subject could not be identified were of value only for prevalence purposes, and, because such records were not action-orientated, the health professional often saw little return for the work input

[a] **World Health Organization.** *Mental health services in Europe.* Geneva, 1976 (WHO Offset Publication No. 23)

connected with data collection. As a result, the accuracy of the input often deteriorated, and reporting rates drifted down so that the reliability of any prevalence study was questionable. However, when local records allowed subject identification and therefore could be action-orientated, as for instance in immunity records or some treatment programmes, the interest of practitioners rose because they could experience a tangible clinical purpose and profit from their efforts. The social cost of that advantage was the anxiety generated about confidentiality within systems, especially linked systems, in any one of which the subject could be identified. In such linked systems it was relatively easy for someone with a legitimate interest in one aspect of a person's life to obtain not only information immediately relevant to that interest and which had on an earlier occasion been volunteered by the subject, but also information peripheral to, or even unconnected with, that interest which the subject would not in a face-to-face interview have chosen to reveal. For instance, where an immunization programme was linked with mental health data it would be theoretically possible for a health visitor, concerned to maintain the immunity status of a child, to learn that the mother had had a therapeutic termination of pregnancy before marriage, and that the father was alcoholic. There was a fear that such systems would be assessed not only by individual health professionals concerned clinically with the subject, but by government departments which might use the information in some punitive, or at least penalizing, way. No easy solution to the problem emerged in the Group's brief discussion of it.

The Working Group recognized that there had been several earlier World Health Organization publications on the topic, and so merely summarized the types of information which were desirable. Data systems should be evolved from random population sampling and the research that that could facilitate. The system should be concerned with cohort or case register studies, with census studies, with illness episode studies, and socioeconomic data were essential. In addition, there should be more information about the nature of the material and manpower resources available to combat the problem of mental ill-health, and the value of financial data collection by way of cost/benefit analysis and fiscal returns should be explored further.

As to the setting up of information collecting systems, it seemed to the Working Group essential that the purpose, as well as the parameters, of any system be defined and agreed with the collectors of the raw data in the clinical field before it was introduced; and also that it should be clearly recognized that because their respective interests were different, the relative feedback of information would be different for planners, clinicians and the public. The input/output time cycle for information systems should be relatively short, so that sceptics could not say that the information was only of historical interest and had no contemporary relevance. It had to be recognized also that skills in interpreting statistical data, to say nothing of interest in doing that work, were relatively scarce among clinicians; it was desirable,

therefore, that any feedback should be accompanied by some descriptive interpretation and analysis which had historical prospective and predictive value. Only thus would the output from data systems be seen to be credible, relevant and reliable so that its use would become increasingly important and frequent in policy making, programme planning, clinical management, health education and primary prevention.

In summary, the Working Group saw ignorance as central to unhealthy attitudes. Good planning and the logical development of community mental health services necessarily proceeded from accurate knowledge of prevalence and natural history, but there was a tension, as yet unresolved, between the confidentiality and the ready availability of data in any national information system.

6. CONSTRAINTS RELATING TO MANPOWER

Dr Feldman (USA), introducing the topic of manpower limitations as a constraint on the development of community mental health services, challenged the Working Group, and psychiatry in general, by doubting the adequacy and appropriateness of existing psychiatric training at both undergraduate and postgraduate levels for fitting a clinician to work in community mental health; and also by questioning the assumption that those appointed to implement programmes of community mental health would have the necessary managerial skills.

Certainly in the United States – and he had no reason to think it would be otherwise in Europe – Dr Feldman believed that psychiatric training and community mental health services were like ships that passed in the night with only the briefest awareness of each other's presence and without communication. In a rapidly changing and developing social situation there had been little or no coordination between service needs on the one hand and academic programmes and syllabuses on the other. Postgraduate psychiatric training was still substantially committed to one of two approaches: either, as in the United States, to an in-depth analytical approach to the individual patient and his problems or, as in Europe, to a predominantly organic approach to the patient and his illness. Much of the work of a community mental health service, however, was of a different order and most staff working in such services felt that their professional training had been inadequate, in that they had not acquired sufficient knowledge of sociological theory and practice, or skills in brief psychotherapy, group and family psychotherapy, crisis intervention and the treatment of immigrant ethnic or minority groups, all of which had been shown to be essential to the type of community mental health service developing in the United States and in

some European countries. There was now a substantial but complex body of knowledge, especially in the area of social and behavioural sciences, which was relatively ignored in psychiatric training.

Furthermore, in addition to those deficits in initial professional training, there had been only very slight development of continuing professional education, so that the experienced clinician continued in his accustomed way without undergoing the necessary adaptation to the changing needs of the society which he was serving.

The kinds of problems presented by patients/clients in some community mental health services did not readily fall into psychiatric diagnostic categories, nor even make for obvious allocation of tasks between different disciplines, and for those reasons employment in a community mental health service, which of necessity had to be in a multidisciplinary team setting, had universally generated role-blurring and promoted an egalitarianism leading to interdisciplinary rivalry and intradisciplinary anxiety. Such feelings very often "got in the way" in a treatment situation, so that attention had to be diverted from the patient/client and his problem to the therapeutic team and its problems. Staff who had not worked in those settings in their training were unlikely to encourage the development of a methodology with which they would be unfamiliar and which they could recognize as likely to be anxiety-provoking for themselves.

Because the psychiatrist working in the kind of community mental health projects commonly found in the United States infrequently used somatic-medical skills, people there were questioning whether medicine should be the core discipline, and also whether the nature of the problems presenting in, as well as the skills and initial and further training necessary for, work in high-quality community mental health care did not call for the emergence of a "fifth profession".

Dr Feldman also pointed to deficiencies in the quantity and appropriate distribution of the variety of professions required in a community mental health service, and to the relatively poor manpower planning forecasts. He thought that those poor predictions were aggravated by the failure of coordination between training agencies and those responsible for the future planning of services.

Mental health administration was a neglected area in the training of psychiatrists, many of whom in senior positions, found themselves responsible for administration. Manpower management, budget organization, decision-making and the skills and techniques necessary to influence political decisions, which ultimately determined budgeting for mental health, were some of the topics for which an administrator required knowledge and skill. Though it was fashionable, meanwhile, to deplore the possession of power and influence, and to deride the value of and need for leadership, it was also necessary to recognize that power and leadership were enduring characteristics and that an awareness of how to use power properly and to acquire

leadership qualities were vitally important to senior administration and therefore an intrinsic part of administrative psychiatry.

In the discussion concern was expressed that the role-blurring and core training referred to by Dr Feldman might increase the existing insecurity within some professional groups in mental health, and aggravate what was perceived as a diminishing quality of personnel in that field.

The Working Group was, however, agreed that if psychiatry was to be practised in a community setting with a comprehensive service, then the psychiatric component of the curriculum of all the disciplines involved would have to change radically. When drawing up programmes of instruction and clinical experience, teaching departments, it was felt, should be influenced to a greater extent than at present seemed to be the case by full-time clinicians working in community settings, so that there was among teachers a greater awareness of the universal multidimensionality of the problems presented by people who were in need of help, or who were clearly ill. Clinical teachers would have to pass on new knowledge and skills in social and liaison psychiatry, and for all, but especially for senior staff, there was an urgent need for training in mental health administration and in health education techniques.

The teaching departments of different disciplines should cooperate to a greater extent in core training and, in higher or specialist education, there was value in rotational experimental secondment to the various branches of a community comprehensive mental health service. The value of that type of teaching and experience lay as much in the personal contacts established across disciplinary boundaries and in the increased awareness of the job content and of the skills of other professions as in the acquisition of factual knowledge outside the student's discrete discipline.

It was felt that if the content and quality of teaching was improved, job satisfaction and job status would be improved also, and that that would increase recruitment. There would in turn be an increase in professionalism and expertise, but, paradoxically, in the face of that very specialization it was important to reduce the stresses in multidisciplinary treatment groups created by demarcation disputes about the distribution of tasks among the different disciplines. It had to be recognized that some tasks would be carried out best by a particular person in a team because of some attribute of his or her personality, while other tasks would devolve squarely on one or other discipline. Although working in a specialized field, staff would have to come to accept, without anxiety or sense of threat to their professional status, that every member of a mental health team had a generalist role as well as a specialist one.

For reasons of economy of finance as well as of skills, it would also be necessary in everyday practice to encourage and promote those effective treatments which maximized the use of the least labour-intensive methodologies, and the training of staff in all disciplines should reflect that aim by concentrating upon those methodologies.

7. CONSTRAINTS RELATING TO MATERIAL RESOURCES

The Working Group thought it particularly appropriate that a representative from a developing country should introduce discussion on this topic, and this was done by Dr M.A. Bakiri (Algeria). Dr Bakiri saw the basic constraints of material resources to be their inadequacies of quality and quantity and their inappropriateness and maldistribution. The very presence of buildings was in some instances a constraint on the development of services, for the buildings represented an investment, not only of capital funds, but of personal life-style and aspirations for the staff working in them. Those investments were threatened when proposals were made for alternatives to institutional care which would move the focus of importance and interest in psychiatric care away from such institutions, and it should not cause surprise that established institutional staff resisted that. Indeed, sometimes staff could be seen resorting to defensive inertia to counter that threat. It was yet another aspect of the ubiquitous attitudinal constraints on the development of comprehensive community mental health services.

Dr Bakiri was also concerned to place psychiatric development in perspective with the many other material and social developments which were pressing urgencies in any developing country, for it was against the background of these that mental health had to compete vigorously for limited resources within restricted national budgets. He was also concerned as to how the relative importance of developments within medicine itself should be established, and could see that some advances, in the fields of communicable diseases and public health, for instance, were imperative, whereas in others – and the psychiatric field might be held by some to be one of these – advance could be regarded only as desirable. He felt that, irrespective of the level of socioeconomic progress of a country, the establishment of psychiatric services must always be relevant to and necessary for any community, for good mental health was a prerequisite of good social and economic functioning and progress. It was self-evident, however, that the system of care appropriate to one culture, or to a particular level of socioeconomic development, would not necessarily be appropriate to another. For instance, there was perhaps a danger in adopting for developing countries the solutions of industrialized countries.

More attention should be directed to the most effective use of existing resources and to the development of new, cost-effective, resources. Although staff increases were a burden on revenue resources rather than on capital resources, which were concerned with material advances, in situations where there was a choice in the matter, staff development was probably more important than the provision of new, high-cost material resources. However, that should not be allowed to give rise to the belief that the psychiatric

patient and psychiatry, or mental health, should be accorded, or would be content with, second-rate living and working conditions.

The allocation of capital resources was ultimately a matter of political choice, and, in the field of mental health, it was largely determined by subjective value judgements. The professions involved in mental health care therefore needed to concern themselves with public attitudes and with the way in which the concept of social concern was developed and gained expression, for it was only by the expression of such concern that influence could be brought to bear on political decision-makers so that budget allocations favoured the mentally ill, or at least did not, as so often happened, operate to their disadvantage.

In the discussion which followed the Working Group saw two levels at which constraints imposed by material limitations could be overcome. The first was the manipulation of tangible resources, and the second the steps which might be taken to increase budgetary allocations.

Therapeutic manpower was seen as a first priority in the development of a community-based comprehensive mental health service, and although such services should work predominantly in extramural facilities which either kept the treatment in or carried it into the community, the existing institution-based services for chronic patients could not be neglected. However rapid or extensive the development of community services, the institution-based services were likely to remain, albeit in reduced form, for many years.

There was a need to examine the possible benefits to be gained from reallocating existing resources before new material resources were planned and built, for it would frequently be more economic to upgrade and convert existing buildings than to build new premises. The milieu of established premises was often more domestic and more conducive to group and community psychiatry than the prevailing "sterile", "clinical" architecture of many modern hospital buildings. Where new buildings were provided, however, the architectural features and operational policies should be such as to minimize the emergence of a "total-institutional" milieu and they should encourage functional flexibility. Such new buildings should also be of limited life-span lest their permanence created for furture generations the same problems as were now being experienced in relation to buildings that dated from the middle and late nineteenth century.

Capital allocation was also required for material resources which would encourage and develop the economic contribution of the patient, whether in partially or fully self-supporting productive life. It was important, therefore, to provide not only residential facilities but also industrial therapy units and sheltered workshops which would facilitate this. Their funding required careful coordination, for often different government departments were responsible for the provision of vocational and rehabilitative resources.

The Working Group believed that more financial assistance should be made available on a pump-priming basis to encourage voluntary or

nonstatutory agencies to assist in the care of the mentally ill. Pump-priming by a statutory authority which allowed a voluntary agency to initiate a service as a pilot project could result in ultimate responsibility being assumed either by the voluntary agency or by the authority itself. Improved budgetary control and analysis would be of benefit in making more effective use of such financial resources as were available, but, instead of leading to the more effective use of existing financial allocations, improved budgetary control might lead to a reduced allocation. The proceeds of economy or savings should always be made available, if not wholly, at least in substantial part, to permit new development by the staff or service which effects the saving in the first place.

When it came to consider the relative priority which different countries and societies would give to psychiatric development, the Working Group found itself grappling with difficult philosophical problems. It did not seem that there was any self-evident place for psychiatry in the hierarchy of socio-economic priorities adopted by different social groups. Furthermore, it seemed that at a certain level of socioeconomic development, management by objectives was not possible in the psychiatric field, for there was no cultural pressure to set objectives. Management was then merely a response to some event which threatened such social stability as there was. In that kind of situation it was only as other deficiencies within a society were met -- e.g., the creation of road and transport systems, power services, industry, water services, emergency medical services – that social awareness developed and that needs were particularized so that modern psychiatric services became a priority. Nevertheless, it had to be made apparent to communities that psychiatric illness itself was extremely costly when measured in terms of loss of productivity and usefulness to the community, and that, therefore, planning for future services should be by objectives set to minimize that social cost rather than by expedient responses to crisis and urgency. It was clear that that aspect of the allocation of material resources resulted from the attitudes of the community in general and the political decision-makers in particular, and it was a further reason for the Working Group attributing major significance in the constraints on the development of psychiatric services to lack of information and to the prejudiced attitudes of the public.

8. CONSTRAINTS RELATING TO COORDINATION

Coordination was described by one participant as the most sought after, but the most elusive, operational component in comprehensive mental health care systems in all countries.

Dr van Londen (Netherlands), in introducing this topic for consideration, discussed firstly, coordination within and between health care agencies and, secondly, coordination between these agencies and nonhealth agencies.

Within the health care system itself there seemed to be three distinct but interrelated areas in which a mental health service had to operate. It was clear that there was an area of overt mental health care which would range through institutional long-term care, short-term care either on a crisis intervention or a brief treatment basis, extramural care in outpatient clinics or alternatives to hospital care, and a variable area of private psychiatry. Those various components comprised the resources of the team which would be responsible for the mental health care of a sector of the community, and it was important that they should be coordinated so that, at the time and in the way most appropriate to his needs, a patient could make use of the part or parts of the total service which were most likely to be accompanied by therapeutic benefit.

The second area of health care, which emerged in discussion as possibly the most important, was that of primary health care. The family practitioners probably undertook the bulk of psychiatric medical practice, but there was concern about the relatively low level of psychiatric expertise among general medical or family practitioners, and about the pressures upon such practitioners which prevented those who might from paying more attention to the dynamic and psychological aspects of their patients' problems and illnesses. It was certain that much psychiatric morbidity went undetected and also that there was poor coordination, and little effective joint therapeutic work or cooperation, between primary health care and specialist mental health services.

Thirdly, within health care itself, there was little coordination between somatic and psychological medicine. The psychological component which accompanied much, if not all, somatic illness treated in institutions, in extramural services and in the private sector, was very largely unrecognized, or, if recognized, went untreated; and there, too, there was a need for improved cooperation.

In addition to those deficiencies of coordination which were intrinsic to clinical medicine in health care systems, it was also apparent that administrative coordination was required between different levels within the hierarchy of health departments. Where a therapeutic programme was multidimensional, and where, as was almost universally the case in mental health care, it was therefore dependent on the resources of a variety of specialties and agencies, close and rational coordination was required not only in the planning and execution of a treatment programme itself, but also between the operational policies of different departments. Furthermore, the forward planning proposals for those disciplines and departments had to be coordinated, taking cognizance of their interdependence and of the complementary but competing nature of their claims on resources.

In the ensuing discussion two further aspects of the problem of coordination were elaborated. It was pointed out that the functional unity of the clinical mental health team required substantial coordination of different professional disciplines in regard to their manpower policies and their agreed delegation of powers. In particular, it seemed important that, within an agreed but broadly formulated operational policy, substantial therapeutic autonomy should be devolved to the individual members of a mental health care team, for "restrictive practices" adopted by, or imposed upon, one or more members of a therapeutic team could substantially impede, if not vitiate, a global therapeutic plan.

It was also pointed out that lack of coordination ultimately penalized patients, and concern was expressed at the extent to which, in poorly coordinated mental health care systems, patients could be buffeted between a multiplicity of agencies in a kind of "Brownian movement" which effectively prevented any kind of rational multidisciplinary treatment programme or operational policy. Where, as a result of poor coordination, there was a poor hand-over mechanism between agencies, with no procedure for reporting back on action taken by the recipient agency, patients/clients could even become lost in passage between one agency and another so that they dropped out of a treatment or caring programme completely.

In this general discussion the Working Group quickly found itself in a semantic entanglement. The similarities of, and differences between consultation, coordination, cooperation and integration were explored, it being perceived in this exploration that there was a parallel between, on the one hand, the gradual changes in a movement from specialism to generalism and, on the other, the different gradations of interplay involved in consultation, coordination, cooperation and integration. A major problem which emerged was the difficulty of determining who was responsible for what in a totally integrated situation in which role definitions were lost, or at least blurred, and in which specialism seemed to be discounted in favour of a generic viewpoint and intervention.

In seeking to suggest ways in which coordination could be enhanced, the Working Group felt that devolution of decision-making and of responsibility was of substantial importance in all the agencies concerned with mental health care. Too often reorganization resulted in centripetal concentration of authority which, in turn, produced administrative and therapeutic frustration and impotence. Given the policy of sectorizing psychiatric care, it was important that sectors, and the numbers of personnel within them, should be small enough to permit reasonable span of control and yet large enough to attract posts of sufficient authority, and staff of sufficient seniority and experience, so that the sector team could command attention and earn respect in its operational decisions as well as in its therapeutic interventions. Where the span of control was too large, coordination would inevitably suffer, and where it was too small there would be no truly coordinative function.

It was thought that coordination would be assisted if senior staff were appointed jointly between agencies so that they had responsibilities in more than one area of the caring system. Similarly, within the health services appointments should be made not to institutions but to sectorized mental health teams, so that by the same token the persons appointed were given responsibilities for the totality of the mental health system and not merely for one part of it. This did not imply, of course, that a psychiatrist, for instance, would necessarily work clinically in all, or even most parts of the system, but that, in his administrative and planning role – and it was felt that all senior staff had such a role – he would have some corporate responsibility for the whole as well as a particular clinical responsibility for his part of it.

The creation of comprehensive community mental health teams was seen to be fundamental to good coordination. The staff working in those teams could most readily give support to primary care practitioners in their offices and in health centres, give domiciliary consultation and crisis intervention in patients' homes, work in outpatient clinics, act as liaison between psychiatry and somatic medicine, and use a multidisciplinary approach to intake and assessment. Unlike institutional staff who, in the main, were apart from the community, the community mental health team would have a physical presence within the community itself and so would be more able to incorporate voluntary workers into its therapeutic programmes, and to liaise with voluntary agencies in their work.

It would also be possible, indeed desirable, for the team in its planning of services to coopt a member of some organization representing patients or a representative of the community being served by the team, for it was likely that important feedback on the public's awareness and acceptance of the service would be received in that way.

The Working Group believed that coordination became more difficult to achieve the further one moved away from direct responsibility for the patient. The clinical team had the greatest chance of achieving coordination, perhaps because its members were able, consciously or otherwise, to make use to the dynamics of their own group in resolving problems. Coordination between major agencies at regional level in policy planning was the most difficult to achieve, possibly because of the size of the group, the relative infrequency of interaction and the intangibility and conceptual nature of the problems they were called upon to remedy. It seemed necessary, therefore, to establish programme planning groups for mental health, and subgroups for particular aspects of mental health, such as the care of alcoholics, adolescents and the mentally-infirm aged. However, such groups should be relatively small, they should be given a specific remit and they should work to a set time-table which was shorter rather than longer so that a sense of urgency and purpose was received and conveyed. Subgroups should disband once they had reported. Any relevant central government, local government or

voluntary agency would be represented on these planning bodies to ensure not only that there was coordination and rationalization within the particular programme for a subspecialty, but that the development plans of the agencies took account of the proposals for that subspecialty.

Although much was known about the dynamics of relationships within organizations themselves, very little research had been done, and therefore very little was known, about the dynamics of the relationships between, as opposed to within, organizations and agencies. It was perhaps for that reason that reorganizations which only effected changes in organizational structure very rarely modified the corporate behaviour of agencies, or even the individual behaviour of members of them, and that in turn was perhaps the reason why it was difficult to achieve effective coordination between authorities, agencies and organizations.

9. CONSTRAINTS RELATING TO ADMINISTRATION AND POLICY

In introducing this topic for discussion, Dr Dabrowski (Poland) gave an account of the recent introduction of legislative proposals and administrative arrangements on mental health protection and on psychiatric care as two distinct fields in Poland, from which he drew examples of the constraints facing many countries and the possible solutions open to them.

It was helpful to consider four separate but interrelated topics: the legal requirements of any mental health legislation; the ministerial programme, i.e., the national policy which would be promulgated within the legal framework enacted; the executive regulations which would be designed to implement that policy; and the associated legislative and executive programmes in related spheres, such as social security, employment or housing.

It seemed clear that there was still, in many countries, a substantially restrictive and anachronistic legislation. Legislation should not prevent anyone from receiving psychiatric treatment who freely sought it, and should be such that psychiatric treatment was obtainable on the same basis as any other kind of medical treatment or social care. However, society, through its legislation, had a duty to protect itself and its members, and it was in that sphere that real conflict arose between the necessity to ensure public and private safety on the one hand, and to ensure that mental health legislation did not encroach upon or remove any human liberty or rights on the other hand. That dilemma could only be resolved by wide public debate of the moral and ethical issues involved. Such public debate would inform and, it was hoped, determine governmental policy, and that was yet another example of the importance of correct factual information relating to mental

health, and of the absence of bias and prejudice in the attitude of both public and government. It was important that political expediency or electoral opportunism should not be permitted to determine or disrupt long-term planning in the field of mental health for, the end result being intimately associated with public attitudes, it could only be achieved by a process of slow but progressive change.

In the brief discussion which followed, the Working Group again stressed the need to ensure that the public and their representatives in government were less prejudiced against the psychiatrically ill, more aware of the extent and nature of psychiatric illness and mental health problems, and more determined to correct anomalies and make good deficiencies where these existed in psychiatric services. There was an urgent need for the public to be concerned about the ethics of restriction of liberty, and about the immorality of the poor living standards and the erosion of human dignity which were, in too many instances, still associated with mental health care. Similarly, mental health care professionals should themselves become more responsive to the changing expectations of the public in those matters, and be willing to engage in self-examination and mutual constructive criticism, possibly by the creation of quite overt ethical and standard review procedures, not only for research purposes, although that was paramount, but also in relation to the everyday practice of psychiatry. Psychiatry as a discipline should not lull itself into a false sense of security by believing that abuses would occur only in institutions, for in community care itself some practices, both in their observance and in their breach, could transgress acceptable moral and ethical standards even though they took place apparently under full public scrutiny.

For the various legislative and executive governmental programmes to be compatible, it was necessary to ensure cross-representation on departmental steering groups, and also desirable that those departmental groups should have advice from the periphery on the need for flexibility in interpreting executive regulations and operational plans designed to secure national policy. It seemed important that policies should determine objectives rather than prescribe the methodology by which attainment of those objectives was to be sought.

Most European countries lack a clearly stated national mental health policy, and among those who have one there are difficulties in its implementation. A major difficulty in providing effective mental health services has to do with the inability of most mental health professionals to administer these services properly. On the other hand there is frequently a dissonance between expressed programme goals and availability of resources. Most mental health administrators are insufficiently familiar with the planning, budgeting and programme-using techniques needed in central administration.

Different examples of failure in mental health administrations and management were mentioned, including the construction of "mental beds"

which later became superfluous; planning at national level which was countered by contradictory execution at local level; insufficient coordination between mental health and social care services; requirements of the staff which were in conflict with the demands of the public, etc.

Owing to shortage of time, the Working Group did not find it possible to explore in any depth or in a systematic way the constraints presented by administrative mechanisms in mental health care. Indeed, although they were mentioned they were hardly discussed at all, and it may be interesting to reflect on why that was so. The majority of psychiatrists, and nurses, become administrators because professional advancement is linked to the assumption of an administrative responsibility, and they usually do so therefore without benefit of administrative training. Clinical expertise is thus rewarded by reducing clinical work with which they are familiar, and sometimes even by abandoning it altogether, and by assuming a new and often unfamiliar role. The new work gets done by nous, by goodwill, sometimes by experience, but rarely by virtue of the application of known principles and practice. Because "the administration" is slow to respond, does not seem to comprehend the minutiae of the clinical situation, or frankly rejects a proposition, it is said to be inefficient. And yet there are principles of business management, rules of administration and even a vocabulary and language which clinicians on the whole refuse to recognize or with which they do not familiarize themselves. Until these mutually dependent groups – administrators and clinicians – agree to recognize and respect each other's expertise and can talk in mutually agreed terms there will always be mistrust and mistakes which, together, are the administrative constraints to development. With the emergence of professional democracy in health services, any member of staff may be called upon to assume an administrative role and so all should obtain some understanding and knowledge of administration in their training.

10. CONCLUSIONS

At the end of its discussions it seemed clear to the Working Group that its remit had been a very extensive one, and that, as with so many meetings of that kind, more questions had been asked, and more problems had been reformulated than had been answered or solved. It had hardly been possible to explore in any depth any of the major topics which had been discussed, and the Working Group was therefore very hesitant about making recommendations and very tentative in its formulation of them.

Nevertheless, the Working Group considered that it had been valuable to undertake its examination of the constraints to the development of community mental health services, for it allowed firstly, reaffirmation of a

widespread belief in the reality of the concept of comprehensive community mental health care and secondly, demonstration of its viability in some areas. It was patently obvious, however, that in some areas a start had not yet been made to the implementation of such services, and that in most other areas there was a very substantial failure to develop them universally.

Perhaps the most important understanding to emerge from the Working Group's deliberations was that, whereas lack of material resources and financial backing, together with insufficiency of specialist staff, seemed to loom largest in the position papers written by representatives prior to the meeting, it appeared during the discussion that the greatest impediment to progress lay in the minds of men rather than in their pockets or purses. Bias, prejudice, fear and ignorance seemed to be the root cause of inertia and resistance which the public, mental health care professionals, national policy and programme planners and governments alike displayed, and it was those attitudes which determined the relatively low levels of capital and revenue funding and of recruitment which superficially appeared to be the impediments to progress. It seemed that psychiatry as a discipline had been unduly optimistic about the public's level of tolerance, understanding and enlightenment, and there was a danger that by moving too far ahead of public opinion there would, in fact, be a reaction against the psychiatric patient and against the development of community-based services.

While some of the attitudinal changes which would be necessary were a matter of morality, ethics and value judgments, it was also a fact that some of them would stem from better information. In that connexion, it seemed clear that no country was doing sufficient either to collect information or to ensure that appropriate information was available to the public, to mental health professionals, to policy and programme planners and to legislators.

Another important constraint was the lack of manpower and particularly of auxiliary medical staff. These numerical difficulties were exacerbated when existing staff, as often was the case, did not have the skills required for new psychiatric techniques, and had not participated in adequate continuing professional education. The lack of experienced administrative staff, whether lay or medical, who could assume a leadership role was also a significant constraint on service development.

It also became apparent in the Working Group's discussions that in many instances existing resources were not being used to their full potential, in that they were not being adapted and modified to meet what appeared to be the changing demands of the communities which they served. In addition, new resources were often less than adequate or were inappropriate for the tasks which were expected of the community mental health services, and furthermore it was often the case that when new resources were being made available they were not being developed in ways which were likely to reduce dependence on "total-institutional" care or in ways which would encourage the development of extramural services. In summary, the Working

Group was clearly persuaded that the full potential of existing resources, and the allocation of adequate new resources which would lead to the universal development of effective comprehensive community mental health care, was not being realized in a satisfactory way in any of the participants' countries.

Ineffective coordination and administration of those resources prevented the delivery of comprehensive community mental health care. Such deficiencies were often overcome by the leadership of charismatic personalitites but they existed in spite of goodwill and good intent, and might be due to the lack of knowledge about institutional dynamics and the lack of training in administrative techniques which was so widespread.

Lastly, it appeared also that in some countries there was a lack of political will to assign to the mentally ill and to programmes for mental health care a greater priority in the distribution of national resources. It seemed probable that this lack of determination stemmed from the antipathetic attitudes already described, and that the difficulties thus created were compounded by an all too frequent and prevalent inconsistency of political purpose and direction which resulted in intermittent implementation and ineffective and inefficient planning of services.

11. RECOMMENDATIONS

(1) Inertia, bias and prejudice within the community should be reduced by better understanding of mental health and illness, and this will require greatly enhanced professional intervention in the fields of public relations and press, radio and television communications.

(2) The ignorance about mental illness and mental health on the part of the public in general, of influential bodies and individuals, and especially of local and national legislators and administrators, should be reduced by their being given more factual information about psychiatric illness and mental health problems, and about the nature, aim and potential of community mental health services.

(3) Professional staff in mental hospitals and in community mental health teams require greatly enhanced continuing professional education and training which takes account of the advances of knowledge and changes in clinical practice associated with community mental health.

(4) Education authorities should make a greater effort to inculcate in adolescents and young adults the basic preventive health principles related to mental wellbeing.

(5) Deficiencies of staff should be reduced by giving priority to revenue funding for staff development rather than to capital funding for new buildings, except where provision of the latter is imperative.

(6) Making good staff deficiencies is dependent on recruitment, which in turn is influenced by the public image of mental health as a discipline; it will therefore call for a radical reappraisal of training programmes and role definitions.

(7) The lack of material resources should be overcome in the least costly yet most effective way, often by the modification or redesignation of existing resources instead of, or prior to, the allocation of entirely new buildings or premises.

(8) Poor coordination should be eradicated by improved administrative training and research; by the greater involvement of peripheral practitioners or field workers from all agencies concerned in the planning of agreed local programmes for which they will ultimately be responsible, and by the setting of national and regional objectives by appropriate departments working in conjunction with each other.

(9) Restrictive mental health legislation should be liberalized so that it is consistent with generally accepted human rights. Staff in the mental health field should develop ethical criteria and standards review procedures. Mental health legislation should be regularly reviewed and should be compatible with other social legislation.

Annex I

AGENDA

1. Previous activities of the Regional Office relating to the development of comprehensive community mental health services

2. Constraints in the development of comprehensive community mental health services:

   (a) lack of adequate information about the size and nature of mental health problems and the resources available to cope with them

   (b) lack of a national mental health policy

   (c) unavailability and inaccessibility of services

   (d) inadequacy of staffing

   (e) lack of financial resources

   (f) outdated and inappropriate legislation

   (g) lay and professional bias against the mentally ill

   (h) resistance to change

   (i) inadequacy of research

3. Proposals for overcoming the constraints

4. Conclusions and recommendations

Annex II

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[a] Participation expenses not paid by WHO

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[a] Participation expenses not paid by WHO