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DEPARTMENT OF PUBLIC WELFARE

June 30, 1967

TO: Mr. Morris Hursh, Commissioner

FROM: David J. Vail, M. D.
Medical Director

SUBJECT: Summary and impressions of mental health programs in Britain, France, Denmark and the Netherlands; June, 1967 (International Seminars tour)

I call your attention to the series of five previous reports from the different countries visited, and the supplemental article from the London Sunday Times of June 4, 1967.

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Disclaimer

Before proceeding to make the comments which follow, in which I attempt to summarize and evaluate overall impressions of programs in Europe which I visited in the mental health study tour of June, 1967, I should point out the hazards of this undertaking. First, there is the problem of trying to extrapolate from a small, fleeting experience a total gestalt of something that is bound to be big and complex; the old fable about the blind men and the elephant comes to mind. A specific, if narrow, example of this problem is the difficulty in attempting to make a judgment about mental health programs in "France" when in fact one has only seen pieces of the program in the Department of the Seine.

Added to this general problem of trying to induce from small samples are specific effects that produce distortions: the ever-present language problem, for example, or the effects of fatigue or the state of one's digestion. Another kind of distortion is what might be called the "interest filter," that is, the set or system of prejudices imposed by one's particular interest. Mine happens to be administration and program organization. This in turn leads me to look first at those factors in a given situation and judge accordingly in a fashion more or less fair than the circumstances may warrant; thus the treatment program in a given place might be substantively superb, but if the administration were faulty I would be inclined to give it a poorer rating than it might deserve. From this point of view, for example, I conclude that programs in Britain are vastly overrated, for in

my value system an operation that is as sloppy and loose as is the British in the overall cannot be seen in a very positive light. Likewise I cannot get too enthusiastic over a program whose success depends on selection of "suitable" cases when as a public administrator I am acutely conscious of the public need to do something about "unsuitable" cases. I am sure this "interest filter" will operate in all cases; I would venture to say that other reports by the participants of this trip -- members of other professions with interests and backgrounds different from mine -- will differ considerably at certain points, especially where value judgments operate.

Finally, there is the distortion brought about by "visitorship" -- the peculiar psychology that operates in some mysterious fashion to produce at times a game of cat and mouse,where the group visitors may quickly become inquisitorial rather than merely interested, and the host may be seen as producing a snow job rather than an exposition. In this context one may judge too harshly when the host is cold or suave, and too leniently when he is warm and candid. In other words, one may often judge <u>programs</u> on the basis of impressions of <u>individuals</u>; this is not necessarily completely invalid, but it is not necessarily valid either.

One must bear all these distortion factors in mind in reading what follows, which is, when all is said and done, an attempt to form a whole out of bits and pieces.

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The following summary is arranged under these headings:

1. Law
2. Organization of programs; medical practice
3. Community mental health movement
4. Continuity of care
5. Breadth of programs; inclusiveness
6. Treatment
7. Professional status, functions, and training
8. Conclusions

#3

1. Law

The most modern law is that of Britain, enacted in 1959 to take effect in 1961. Compared to this, and to the laws of most U. S. states, the basic Netherlands law of 1884 and French law of 1838 are ancient indeed. I have no information about mental health laws in Denmark, though I would venture that the most recent codification was around 1955.

2. Organization of programs; medical practice

The foregoing reports together with other material, probably cover reasonaly well the aspects of program organization for general inquiry. In summary one might comment that there appears to be no single ideal way of organizing mental health-mental retardation programs. Rather, these must be carried out in the framework of law, tradition, and commitments existing in the given community.

Patterns of medical care and practice vary from country to country in Europe, but one is continually impressed with the totally different concept of medical practice/coverage in Europe generally as against the U.S. In Europe medical care is to all intents and purposes free to the consumer (who is, on the other hand, handsomely taxed). Further, in the medical profession itself there appears to be a feeling about public vs. private practice quite different from what we see here. That is, one gets the distinct impression that public practice in Europe is the first choice of most physicians, and private practice a career undertaken after the physician's reputation has been secured. In direct contrast to the values here in the U.S., the young European psychiatrist tends to apologize about private practice he may be doing, dismissing it as something undertaken for purely monetary purposes that he will be quit of as soon as possible. The overall effect of this value system cannot be overestimated, for it has profound implications for the distribution of medical care in the population; and means that U.S. and European systems of general medical and health care and mental health programs can be compared no more easily than can U.S. and European "football" (which are different games).

One must recall also that the general background of social security and social welfare programs is quite different in Europe as compared to the U.S. Witness that the first nation-wide introduction of social legislation occurred here in 1935 under the dire exigencies of the Depression, whereas far-reaching social legislation was introduced in Denmark in the 1870's and within a decade later in Germany by the militarist Bismarck.

A final special touch on the therapeutic aspects of social welfare is the following quote from Dr. Arie Querido, spark plug of the Amsterdam program in the 1930's. This may overstate the case for medical supervision of social programs, but it does give a "feel" of medical responsibility that can be extended beyond the confines of Amsterdam and is certainly different from accustomed patterns in the U.S. The excerpt follows (emphasis supplied).

> "In the first place, the service can be described as a buffer mechanism between the patient and society in which you can adjust the social pressure to the needs of the patient. That is more or less the principle. You have patients you must free from all social pressure, and you have to send them to the hospital; and you have patients who can stand just so much, and you have to adjust the social conditions of these patients so they get only that much pressure and no more. Therefore, you may give the patient certain material aids. You may give him money. You may give him clothes. You may give him a job. That never has the same meaning as the giving by, let me say, the Bureau of Public Assistance. It is not a dole. Nor is it a bribe. It is, indeed, a medicine. You have to handle it as such. You have to insist very much that it is the psychiatrist who determines the material aid, always with the needs and the medical facts of the patient in the background.
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> "The situation you have with the patient is not a therapeutic situation in the orthodox sense, but is an authoritative one. You more or less represent the good, the giving, the permissive aspect of society toward the patient. Therefore, it follows that you can deal with such patients for whom this situation is acceptable and of therapeutic value."
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> Dr. A. Querido, "Early Diagnosis and Treatment Services." Elements of a Community Mental Health Program, Proceedings of a Round Table at 1955 Annual Conference, Milbank Memorial Fund, 40 Wall Street, New York 5, New York.

3. Community mental health movement

It appears that European countries have awakened to the spirit of the "community mental health movement" during the past 10 years just as we have done in the U.S., as epitomized in President Kennedy's 1963

mental health message to Congress and the subsequent legislation. However, there are many ramifications and differentiations of the "community mental health" idea. In Europe it appears that the psychotic person has the first call on available services and the neurotic person does what he can; here it seems to be the other way around, a fact that the progenitors and promoters of "community mental health" in the U.S. have not really acknowledged. Another basic point of interest is the community base of mental health operations. I question the extent to which this really exists in the European countries I have seen, with the exception of the Netherlands. One must differentiate a situation, as in Britain, where the hospital conducts certain programs in the community it serves from a situation where the control function really resides in the community. This is a distinction that is often overlooked.

4. Continuity of care

Here again there is much variance and value confusion, and a variety of circumstances in which comparisons can simply not be made. One must differentiate between continuity of care and continuity of responsibility. The two accompany each other fairly well, so it seems, in France, where the hospital psychiatrists follow the patients in and out of the hospital. But in Britain the situation breaks down, for where the hospital medical staff follows patients the local authorities may be completely by-passed. In this frame of reference Denmark is the most conservative of the countries visited. Continuity in the Netherlands, in contrast, is more truly continuity of responsibility, for the care portion may be handled in a variety of facilities; however, during all this time the local authorities still maintain control over the case.

5. Breadth of programs; inclusiveness

Here one is dealing with the vaguest of impressions, in reference especially to mental retardation and alcoholism. There appears to be great variety in the various countries in this regard, not far removed from the variances found from state to state in the U.S. In Denmark, for instance, mental retardation programs are sponsored under an entirely different state ministry from the mental health and mental hospital programs. In France and in the Netherlands alcoholism is dealt with as a sub-type of mental illness, rather than a special issue as we tend to find here. It is very hard to form clear impressions, much less make value judgments.

6. Treatment

Here one forms a wide variety of impressions, and it is difficult to differentiate national trends from purely personal differences of individual practitioners.

I put treatment into four broad categories for purposes of description here: somatic, verbal, motoric, and social.

(a) Somatic

Drugs and EST are more or less standard: EST is still used a fair amount in Britain while almost considered obsolete in the Netherlands. I was quite surprised to find insulin still in use, both subcoma (Denmark) and coma (France). Sleep therapy is used more than here (we had a hint in one place that this might bear some relationship to methods of financial reimbursement to private-practicing psychiatrists).

(b) Verbal

Individual and group psychotherapy vary. For example, one finds little use of either as we understand the terms in Britain; and relatively more of both in France and the Netherlands. The Therapeutic Community method, under the criteria of Maxwell Jones, is found betimes, but one must be wary of how this term is used. At one hospital, for instance, the female service was said to have three separate therapeutic communities going while the male service had none. At another hospital I was shown a section that was said to be a "therapeutic community" but I could find nothing which on the face of it could be either identified as a community nor described as therapeutic.

(c) Motoric

Here I group those therapies that have some relationship to body functions and movements and to activity. One sees a great deal of both in European treatment facilities. Under the heading of body functions and movements one finds emphasis on physiotherapy as we understand it, but more significantly also on body-building, calisthenics, muscular expression of the self (as in expressive dancing), and on what I call for want of a better term "body image therapy" -- the deliberate attempt to bring one's perceived-from-within and perceived-by-others selves into realistic approximation. I was surprised to find hydrotherapy still in use in France, complete with sophisticated rationale.

In the activity category one would classify the wide variety of occupational therapies and especially industrial therapy, where this term is used in the European sense to denote organized programs of contracts and/or sales outlets with industry or private markets, utilizing assembly-line techniques geared to individual skills. One of the hazards of this kind of tour is the perpetual exposure to O.T. and industrial workshops, to the point where in final cynical moments of fatigue and ennui one may wonder what else is really going on in the way of a treatment program.

(d) Social

Here I lump together a variety of activities well known in the U.S., but possibly developed a little more in the countries we visited, such as social clubs for former patients, self-government enterprises, publications, etc. At Les Murets Hospital outside of Paris, for example, I was impressed by the Association Sportive et Culturelle d'Entr'Aide des Murets (Sport and cultural mutual benefit association of Les Murets), supported in part by local authority subsidies, in part by income from sales of various products, and in part from membership subscriptions by patients and staff. (At this place one source of income for the Association was the sale of eggs from a hen-yard which a psychiatric technician had set up behind one of the wards.) The funds of the Association go for special items that regular government appropriations will not provide.

7. Professional status, functions, and training

It appears to me that the structure of mental health professions in Europe is more simplistic and less differentiated than here, as I had observed previously. Psychiatry and neurology are not as distinct as here; in fact we were told in France that psychiatry is an "unofficial" branch of "neuro-psychiatry." Psychologists are not as plentiful and tend to be confined to testing. The various rehabilitation therapy professions do not seem to be developed as we know them. Social work seems to be developing as a profession, though not in a way that would satisfy the A.C.S.W. (In the Netherlands the home visits and other casework contacts are made by nurses who have had some special additional training in social work.) Nursing seems to follow the lines of what we call here "diploma schools," with differentiation between general and psychiatric nursing diplomas permitted, and an option by

spending additional time in training (to a total of 4-4½ years) to qualify both as general and psychiatric nurses. One must recall that most persons who receive formal professional training go directly from high school into their specialty training.

As to the power structure, I would say that the physicians and nurses are pretty much in charge. There are invariably more physicians available -- and well trained ones -- than one will find in public mental health facilities and programs in the U.S.; so also in the nursing staff.

8. Conclusions

Sorting out an experience of this kind, though enjoyable, is strange, for one tries with only partial success to relate observations to more familiar situations; ultimately conclusions may be metaphysical, even mystical, in nature, or at least poetic -- though not necessarily the less valid for that (as when the Czeck writer Capek once described Denmark as "a thin piece of bread thickly spread with butter").

One is envious and ashamed of seeing the wide variety of social welfare programs available to the people of western Europe, and the proliferation and ready accessibility of medical and hospital care for the entire populations. More specifically and narrowly in the mental health field, however -- leaving aside mental retardation as a special problem with different dimensions -- the comparisons are not all that disparate and in fact the balance may tip in the opposite direction. In Minnesota, for example, there is very broad coverage of services for neurotics and other persons, including children, with mild disorders through the combination of private and public auspices, and increasingly adequate programs for the apparently diminishing group with severe disorders. Already Minnesota, if one leaves out the V.A. beds, has a mental hospital bed capacity well below the 1.8 beds/1,000 population figure scheduled for Britain for 1975. How does one judge these matters? By incidence and prevalence rates of mental hospitalizations? Suicide and homicide rates? Alcohol consumption? Economic distress? It is very baffling.

In Minnesota, as elsewhere in America, the curse of bad distribution of physicians may produce side benefits in the form of forcing us to create adequate information and control systems, and to find ways of delegating portions of responsibility that have been traditionally viewed as medical in nature.

Suffice it to say that "East, west, home's best" and that here in Minnesota we have nothing to be ashamed of. If we can really implement

the area-development concept and the public responsibility and control functions of the county welfare department, so that we can be confident of having a community-based program, there is in my opinion no reason why we cannot then legitimately claim to have the finest mental health program in the world.

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cc - Medical Services Division Staff

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