

26. **Parkes, C. M. & Brown, R. J.** Health after bereavement. *Psychosomatic medicine*, **24**: 449-461 (1969).
27. **Stein, Z. A. & Susser, M. W.** Widowhood and mental illness. *British journal of preventive and social medicine*, **23**: 106-119 (1969).
28. **Lowenthal, M. F.** Social isolation and mental illness in old age. *American sociological review*, **29**: 54-70 (1964).
29. **Lowenthal, M. F.** Antecedents of isolation and mental illness in old age. *Archive of general psychiatry*, **12**: 245-254 (1965).
30. **Townsend, P. & Tunstall, J.** Isolation, desolation and loneliness. In: Shanas, E. et al., ed. *Old people in three industrial societies*. London, Athlathon Press, 1968.
31. **Tunstall, J.** *Old and alone*. London, Routledge, 1966.
32. **Henderson, S. et al.** Social bonds in the epidemiology of neurosis: a preliminary communication. *British journal of psychiatry*, **132**: 463-466 (1978).
33. **Henderson, S. et al.** Social relationship, adversity and neurosis: a study of associations in general population sample. *British journal of psychiatry*, **136**: 574-583 (1980).
34. **Ødegaard, O.** Emigration and insanity. *Acta psychiatrica scandinavica*, Suppl. IV (1932).
35. **Malzberg, B.** Mental disease among native and foreign-born whites in the New York State. *American Journal of psychiatry*, **93**: 127-137 (1936).
36. **Dalgaard, O. S.** *Migration and functional psychoses in Oslo*. Oslo, Universitets Forlaget, 1967.
37. **Murphy, H. B. M.** Migration and the major mental disorders. A reappraisal. In: Zwingmann, C. A. & Pfister-Ammende, M., ed. *Uprooting and after . . .* Berlin, Springer, 1973, pp. 204-220.
38. **Ødegaard, O.** Norwegian emigration, re-emigration and internal migration. In: Zwingmann, C. A. & Pfister-Ammende, M., ed. *Uprooting and after . . .* Berlin, Springer, 1973, pp. 161-177.
39. *Social dimensions of mental health*. Geneva, World Health Organization, 1981.
40. **Fourastié, J.** *Le grand espoir du XXIème siècle*. Paris, Presses universitaires de France, 1949.
41. **Bell, D.** *Coming of post-industrial society*. New York, Basic, 1973.
42. **Shevky, E. & Bell, W.** *Social area analysis*. Stanford, CA, Stanford University Press, 1955.

341

4

## Mental health services models in Europe

D. Walsh

Formal systems of mental health care are a comparatively recent development since national commitments to the systematic provision of care for the mentally ill belong almost exclusively to the nineteenth century. It was only at the beginning of this period that it came to be recognized that the mentally ill constituted a separate category of needy and indigent persons. Up to this time, such provision as was made—and it was haphazard and varied from place to place—was part of the general provision for those incapable of looking after themselves and in need. Thus, the mentally ill were catered for jointly with the poor, the mentally retarded, the physically disabled and other destitute groups. In medieval times and long afterwards, this care was often provided by religious orders in monasteries or hospices. In this context, it is interesting to note that the inpatient institution providing care for the El Ferrol pilot study area, the Conjo Sanatorium, is a twelfth century Romanesque monastery, subsequently renovated and enlarged, which has catered exclusively for the mentally ill since the end of the nineteenth century.

In the eighteenth century, the mentally ill were to be found in many different places. Some were in institutions such as jails, some in hospices founded and administered either by ecclesiastical or lay organizations—for the most part voluntary—but many of the mentally ill were “at large”, either with their families or wandering the countryside. They were usually in an unsatisfactory condition, a prey to disease and early death. However, the eighteenth century saw the beginning of the identification of the mentally ill as a separate category of disabled persons. It was hardly surprising, therefore, that sporadic efforts to provide institutional care for the mentally ill should then have been made all over Europe. Initially, there tended to be a bias towards providing care for the mentally ill members of wealthy or noble families, who were either a serious embarrassment to their kinsfolk or an obstacle to the orderly inheritance of property and power. This need led to the development of the “private mad house” movement whereby homes, often of dubious quality, were set up and run for profit to cater for this class of person. However, not all institutions in the eighteenth century

were of this type. Some were established with genuine charitable intent, one such being Swift's Hospital in Dublin, established under the provisions of a bequest of the celebrated Dean Swift. This hospital was built in 1745 and still provides private care to those persons in the pilot study area of Dublin, which the hospital adjoins, who are willing and able to pay for it.

However, it was in the nineteenth century that a tradition was established in the care of the mentally ill which still marks and colours most of the mental health services of contemporary Europe. By the close of that century, the number of the institutionalized mentally ill had increased by a factor of three, or in some cases even more, as compared with its beginning. The reasons for this are unclear; the problem of whether the increase in mental illness was "real" or only "apparent" is still unsolved, and the disagreement continues. In other words, the evidence available to us today does not enable us definitely to say whether the increase in institutionalized mental illness over the period 1800-1900 was the consequence of an increase in the *incidence* of mental illness itself or whether it was due to *nosocomial* factors, the latter being those factors, other than an actual increase in the incidence and prevalence of the illness, that made it *seem* that illness had increased. These would include the greater visibility of the mentally ill because they were being brought together and placed in institutions. In addition, the more this was done, the greater would be the demand for further institutional places (more beds, more hospitals) though not necessarily from the mentally ill themselves. Thus, supply may have increased demand, and demand in turn ensured an increasing supply of beds and hospitals.

The nineteenth century approach to the mentally ill was essentially to institutionalize them and to provide the institutions necessary for this purpose, but the motives underlying this approach have been disputed. Some saw the hospital or asylum movement as springing from overt, genuine humanitarian concern for the mentally ill, combined with the increasing expectation that medicalization of care for those in institutions would lead to improvement and cure. Others, such as Foucault (1), looking back from the present century, see the growth of institutional care as an instrument of social control over a body of individuals who were a fiscal embarrassment to the orderly running of an increasingly bourgeois and industrial society.

Whatever the motivation, by 1900 the greatest proportion of Europe's mentally ill who received any form of professional care were resident in institutions specially designed, constructed and continually enlarged to contain them as the century wore on. Furthermore, this was the outward expression of a policy that was both clearly perceived and articulated, namely, that the best care and the greatest chances of cure lay within the asylums that had been so enduringly constructed. When the mental health services in the 21 pilot study areas are considered, it is important to realize that much of practice and even of policy is still coloured by, if not the practices of the nineteenth century, then certainly by the structures inherited from that time.

## Organization and financing

The organization and financing of mental health services in the 21 pilot study areas mirrors a diversity that reflects both national differences and sometimes also regional differences within a country, inasmuch as the financing and provision of services within a pilot study area may differ from those obtaining in the country as a whole. In some of the countries, as in the United Kingdom, the central government has a statutory obligation to provide mental health services, whereas in others, e.g. Spain (El Ferrol, Madrid) and Finland (Tampere) such services have to be provided by the local or municipal authority. In the two pilot study areas in the United Kingdom (Aberdeen and Nottingham), as in the country generally, services are provided entirely free to all through the National Health Service which is financed by central government. Thus, in Nottingham, "within the health service, psychiatric services are run as a single unit, administered and medically organized on a district basis" (2). Similar comprehensive services, available to all, are funded from central sources in the pilot study areas of Belgrade, Iasi, Oslo and Zagreb.

In none of the areas does an exclusively private system of care exist, but perhaps the greatest input from private services is in the Geneva pilot study area, where 44 psychiatrists practise privately, while substantial private components also exist in Athens and El Ferrol—both in countries where there is no national health service. Most common, however, is a combination of state-funded and private care. In some cases, private insurance is compulsory, as in Groningen, while in others, as in Dublin, private health insurance is not required by law, but for persons whose incomes exceed a certain limit and who are therefore financially responsible for their medical expenses, voluntary health insurance is almost universal because of the enormously high cost of medical care. In Brussels and Louvain, most of the health facilities are private services that are, however, financed by the government, the health insurance system covering almost the whole population. The Paris 13 pilot study area is an interesting example of a mental health care system that does not reflect the national situation: services are provided by the Mental Health Association of the 13th Arrondissement, which is a private association recognized as being of public utility. Since 1961, the services have been financed by annual grants, 60% being provided by social security organizations and 40% by public bodies, the state and the city of Paris. Most patients receive treatment free of charge whether or not they are covered by social security.

In many countries, such as the Netherlands, private care is underwritten by trade unions or professional organizations, to which sizeable proportions of the population belong. In one area at least (Tampere), a substantial contribution to the services is made by a voluntary organization—the Sopimusvuori Association—which works closely with the statutory services in providing day care facilities, sheltered workshops, rehabilitation homes, hostel accommodation and semi-private accommodation.

All in all, if the 21 pilot study areas are viewed as a whole, it would seem that institutional care is generally available to all who live in the pilot study areas. However, in certain cases, as in El Ferrol, because some patients live far away from the institution, their early admission to the hospital may be hindered or relatives deterred from visiting them once they have been admitted. To judge by the inventory of services and comments on them from the different areas, the same cannot be said of services outside the hospital. Many complain of a lack of outpatient services, day places, hostel accommodation and other facilities. The existence in a large number of pilot study areas of private facilities suggests that there exists or is believed to exist a superior kind of care for those who can afford to pay for it, but whether the reality matches the expectation is, of course, unclear and must remain so, since data from private sources for the patient census and cohort study were available from only one of the pilot study areas.

### Hospitals and catchment areas

Except in a few cases where asylums were placed in the centre of large cities, eighteenth and nineteenth century thinking led to the siting of hospitals either at the periphery of urban areas or, more commonly, remote from them so that the healing properties of pastoral quiet could exert their curative influences to the highest degree. This is reflected in the general relationship between catchment areas and their inpatient services in the pilot study areas. To take an extreme example, a hospital, half of which serves the El Ferrol pilot study area, is situated at Santiago de Compostela and the services are thus based "on a mental hospital far away from a capital and therefore removed from most of the area it serves" (3). Some parts of this catchment area are 160 km from the hospital and, in addition, transport services between it and the pilot study area are poor. On the other hand, many pilot study areas are served at least in part by university clinics that are usually either in the centre of a catchment area or in the heart of the cities or towns close by. This is the case in Groningen, Louvain, Oslo and Trieste. Although in one case (Nottingham) the mental hospital lies close to the city it serves and in Belgrade is in the city centre, the traditional situation whereby mental hospitals were built outside the city, in some cases in a ring around it, is reflected by the inpatient care available to Paris 7 and Paris 13 at Vaucluse and Soisy, respectively.

The nineteenth century origins of some of the hospitals providing the bulk of the institutional care for some pilot study areas are evident in their size. Thus, in three cases (El Ferrol, Mannheim and Mistelbach), the catchment area is served by a hospital having approximately 1000 beds. On the other hand, in one pilot study area, Dublin, inpatient needs are met almost completely by a converted tuberculosis sanatorium, built in the late 1950s and made redundant in the early 1960s by the decline in incidence of pulmonary tuberculosis.

In only a few cases, e.g. Dublin and Nottingham, does a single inpatient facility correspond precisely to its catchment area, i.e. the catchment area is served exclusively by the hospital, which in turn is exclusive to that area. In other instances, more complicated relationships exist between hospital and catchment area. Either the catchment area is served by many different inpatient institutions, as in Athens, where at least a dozen separate hospitals receive patients from the pilot study area, or the inpatient institution provides services for the pilot study area as part of a wider catchment responsibility, as in Brussels, Madrid and Zagreb. In the most common situation, some services are provided by a general hospital, and often by university and teaching units within that general hospital, but the greater part of inpatient care is still provided by the local mental hospital. This situation exists in, for example, Oslo and Trieste. In the case of Mannheim, a specialized research and teaching institute providing inpatient care exists in the centre of the city, but longer term care is provided by a traditional hospital outside the city.

In some cases, such as Geneva, the situation is quite complex, psychiatric care being provided by several different sources in the pilot study area. Various state and private institutions combine psychiatric care with other services, such as education, counselling and general health care, particularly with child services. In some areas, there may be separate adult psychiatric services for cases of different degrees of severity. For example, at Oslo, the Vinderen psychiatric clinic deals with neurotic and milder psychotic cases from the catchment area, but the more serious and disabling illnesses are treated in the traditional mental hospital at Gaustad.

In some pilot study areas, such as those of the United Kingdom, special accommodation has been provided since the nineteenth century for the mentally retarded, who are considered, both legislatively and in practice, to be different from the mentally ill and are therefore treated in separate institutions. In other areas, some at least of the mentally retarded are treated in mental hospitals, often as long-stay patients.

The size of the institutions providing inpatient care to the various pilot study areas varies enormously. Some of the more traditional mental hospitals have up to 1500 beds, whereas some of the units in general hospitals may have as few as ten. In general, though, bed numbers have been falling and patient/population ratios have fallen correspondingly. Iași is an exception, however, the bed/population ratio having actually increased from 1.5 per 1000 population in 1960 to 2.4 per 1000 population, i.e. almost double, in the late 1970s. In general, admission rates have increased substantially in most centres, although not in Aberdeen and Trieste.

### Decentralization and sectorization: Paris 13

The model of service provision in which psychiatric services are centred on the mental hospital and located almost exclusively within it,

however remote the hospital from the population it served, remained dominant throughout the first half of the twentieth century. It is true that outpatient psychiatric clinics existed at general hospitals or at health centres or polyclinics within cities or towns, and that even day places and hostel accommodation were available long before the Second World War. However, such services were isolated and few in number. For the most part, psychiatric services remained based on, and entirely located within, the traditional mental hospital.

In the 1950s, with the introduction of a much more effective range of drug treatments for psychiatric illness, it soon became clear that the large mental hospital, without any links with the community in terms either of structure or of staff, was an unsuitable vehicle for the delivery of modern mental health care. At the same time, doctors practising within mental hospitals had become increasingly dissatisfied with the resulting isolation from the rest of their medical colleagues. As a consequence, new policies were developed for the delivery of mental health care. These stressed the need to reduce the size of mental hospitals, the provision of community facilities for the mentally ill, the primary prevention of mental disorders, the need for a closer relationship between the psychiatric services and the general medical services, an improvement in the status of psychiatry as an academic subject—as exemplified by undergraduate and postgraduate teaching—and a greater interest in research. The objectives of these policies were to be achieved through increased emphasis on community care and on the provision of inpatient facilities for psychiatric care in general hospitals. All of these aspirations are reflected in developments in the delivery of mental health care in the pilot study areas, one of which (Paris 13) will be taken as an example, because in many ways it is a paradigm of what was later to become “sector psychiatry” and its example has been extremely influential.

In the late 1950s, a number of prominent French-speaking psychiatrists, among them Dr Philippe Paumelle, enunciated the principles governing the effective delivery of mental health care, including the following.

(1) *Continuity of care.* This ensures that persons and families receive care at all stages and at all levels of illness and are dealt with throughout by the same team—something that is not possible in the traditional mental hospital. The most effective way of ensuring continuity of care is by assigning teams and their associated structures, such as hospitals and clinics, to populations of manageable size. The services should be population-based, freely available to all, and easily accessible. In many ways, therefore, these services, in their working principles, foreshadowed the Alma-Ata Declaration as it relates to primary health care.

(2) *Coordination of care.* Psychiatric illness attacks and disables a variety of different human functions and age groups, so that disabilities and impairments exist in many functional areas. A multidisciplinary team is therefore necessary for their treatment, each member of the team

being aware of the skills of the others and knowing when it is appropriate to call upon and utilize them. Because of this multidisciplinary character, coordination of mental health care is essential.

(3) *Integration of care.* In any community, those who first come into contact with psychiatric illness are not the specialists of the psychiatric team but rather persons in key positions of responsibility in the community, such as teachers, the police, public health nurses, community nurses, social workers and general practitioners. The specialist psychiatric team must therefore integrate its efforts with those of the nonspecialists, as well as taking the lead in educating and counselling nonspecialists.

To put these principles to the test, the Association de Santé Mentale et de Lutte contre l'Alcoolisme for the 13th Arrondissement established a pilot scheme under which it provides, free of charge, psychiatric care for children, adults and the elderly. In 1973, the Association was linked to the teaching and research activities of the Pitié-Salpêtrière University Hospital Centre. The basic aim of the service was to provide continuity of treatment and unified therapy through the grouping of services and the location of health personnel in the area. The Association consists of two centres, one for adult psychiatry (the Centre Philippe Paumelle) and the other (the Centre Alfred Binet) for children. These are situated in the same building, which is in the heart of the 13th Arrondissement at the Place d'Italie.

The various services are grouped around each centre, and it is in these that the work of the medicosocial team responsible for parts of the area is carried out. For maximum efficiency, the 13th Arrondissement has been divided into sectors, each of which has a population of approximately 23 000, and each mental health centre has eight medicosocial teams, each of which is responsible for a sector. Broadly speaking, each team has on average 250 patients under treatment. Despite the logical division of the pilot study area into eight roughly equal sectors, differences have developed in recent years in the corresponding caseloads, as a consequence of changes in factors such as the proportion of immigrants and the elderly—both groups with a disproportionately high demand for services.

The adult services are based on the Centre Philippe Paumelle and almost 70% of first inpatient contacts are made through the centre, the remaining patients being directly admitted to the psychiatric hospital at Soisy, on the outskirts of Paris, some 30 km from the 13th Arrondissement. Other services, including a centre for psychotherapy and psychoanalysis and a day and night hospital (which deals with crises and emergencies), are also available in the 13th Arrondissement. An increasing number of first contacts with the service are made through the polyclinic, and it is calculated that in 1980, 10% of first contacts were made with this service, with a corresponding decrease to approximately 50% of first contacts at the Centre Philippe Paumelle. As an example of the high staff/patient ratios in the service, it may be mentioned that the psychotherapy centre has some 20 psychotherapists.

The Policlinique Psychiatrique (for emergency cases and day and inpatient hospitalization) was opened in 1976 and is expected to deal with emergencies occurring outside the working hours of the Centre Philippe Paumelle and to fill a gap, since the hospital for the 13th Arrondissement is located outside the area and is not easily accessible. The Policlinique has 35 beds and 25 day places. The inpatients are mainly long-standing psychotics, some new patients and other short-term patients presenting as emergencies, who may be kept in for periods ranging from one night to six weeks. The 13th Arrondissement also has a 45-place day hospital and a therapeutic workshop with an adjoining day hospital with another 40 places. In addition, a third day hospital with 20 places deals mainly with psychiatric patients with brain damage. A 27-place hostel deals in the main with long-standing psychotics, usually from the psychiatric hospital at Soisy. There is also a social club where, *inter alia*, evening classes are held.

The parent psychiatric hospital is the Hôpital L'Eau Vive at Soisy, which has 204 beds. Its main commitment is to patients from the 13th Arrondissement. The hospital operates on the principle of mixed wards, i.e. of wards that are mixed not only in terms of sex, but also in terms of nursing staff and types of illness. A nearby community hostel, the Foyer de Soisy, provides 23 places, and there is also a family adoption service for adult patients, serving mainly those suffering from chronic psychosis. A total of 23 patients have been placed and looked after by this service. Three large general hospitals in the 13th Arrondissement (the Pitié-Salpêtrière, Cochin and Kremlin-Bicêtre) have psychiatric departments. They accept patients who come for treatment voluntarily, but are neither equipped nor prepared to deal with involuntary patients or patients requiring long-term care. The Association does not collaborate with these departments, although a friendly relationship exists with them.

A number of psychiatrists are in private practice in the area and use the Association's services as required. The Association has a better relationship with them than with the general practitioners in the 13th Arrondissement.

It is estimated that the Association has up to 1% of the population of the 13th Arrondissement in care at any one time. Another 1% of the population will be receiving psychiatric care from the services outside the Arrondissement, so that we can say that 2% of the population of the 13th Arrondissement is in psychiatric care at any one time. Similar figures have emerged from psychiatric case registers in several industrialized countries.

The Centre Alfred Binet was founded in 1961 and is a mental health centre for children and adolescents in the 13th Arrondissement. It is served, in the same way as the Centre Philippe Paumelle, by eight medicosocial teams and provides an extensive range of medical, social, psychological, occupational and educational facilities for children thought to need them. It includes a 40-place day hospital, a 36-place intensive care unit, a 10-place small children's unit and an evening club

with 30 places. There is also a foster care service, which has placed 20 children with foster families.

It can therefore be seen that, based on the principles of a community-based service offering continuity of care and a coordinated multidisciplinary approach, services have been developed for small units or sectors, each with a population of approximately 23 000, and each having separate teams for adult and child psychiatry. This development had a marked influence on policy in mental health care, both in France and elsewhere, and provided the model for what is called the *psychiatrie de secteur*.

The basic principle underlying such sectorization is that population groups, and particularly urban populations, should be divided into units of manageable size, to which a given psychiatric team is then assigned. In many ways, there is nothing particularly unusual about this arrangement, since from the very beginning of the era of provision of psychiatric care—then almost exclusively institutional in character—the convention has been for care to be delivered at the local level. This meant that most asylums were built near the community they were intended to serve, although some were not. In addition, up to the middle of the nineteenth century, many of these communities were of manageable size. However, as populations and particularly urban populations increased in size, such communities became far too large, and, as a consequence, the mental health services became increasingly remote from them. It thus became apparent that a single centralized service, based on the mental hospital, was unsatisfactory and communities were subdivided into sectors of manageable size, to which specific teams were assigned. Such decentralization and sectorization is evident in the majority of the services provided in the pilot study areas. In terms of service organization, some pilot study areas themselves form individual sectors, some are part of a larger sector and some consist of a number of sectors. The actual population size of sectors varies from 49 000 in Groningen to 1 500 000 in Belgrade. The physical size of pilot study areas varies enormously, Tampere being 157 times larger than Oslo. Not surprisingly, Tampere is the most thinly populated (38 inhabitants per km<sup>2</sup>) while Nottingham is the most densely populated area (3242 inhabitants per km<sup>2</sup>).

It is also not surprising that centres in more densely populated areas have resorted to sectorization to a greater extent than those with a larger but more widely dispersed population. In Geneva there are three sectors, to which teams have been allocated in a rational manner, and this applies equally to child psychiatric services, which are particularly well developed in this pilot study area. Even when populations are concentrated—often in a central urban core surrounded by a more widely dispersed rural population—sectorization is possible as, for example, in the Aberdeen pilot study area, where the population of approximately 320 000, in part concentrated in the city but also in part scattered more thinly throughout the county of Aberdeenshire, has been divided into three distinct catchment areas.

Despite a general movement towards sectorization with the inpatient unit located at the centre of the catchment area, and therefore close to all sectors, as in Nottingham with its dense concentration of population and in Tampere even though the population is widely dispersed, there are still many exceptions. Neither in Athens, where patients from the catchment area are hospitalized in a large number of different hospitals, nor in Groningen where, despite its small population, the pilot study area sends patients to four mental hospitals (only one of which is located in the pilot study area itself) is there a direct one-to-one relationship between the inpatient facilities and the pilot study area.

### Community-based mental health services: Trieste

The dominant policy in psychiatry since the middle of the twentieth century is the reverse of that of the nineteenth century and holds that, as far as possible, patients should be cared for in the community, since this avoids the risk of institutionalization and assists in earlier and more complete rehabilitation.

The history of the community mental health movement has been well documented elsewhere and will not be reviewed here. In recent years, the WHO Regional Office for Europe has constantly had this topic in mind. A working group met in 1972 to discuss the development of comprehensive mental health services in the community (4), while other subjects subsequently considered by working groups have included psychiatry and primary medical care (5), the future of mental hospitals (6), constraints in mental health services development (7), and changing patterns in mental health care (8).

The outcome of these discussions can best be summed up by quoting part of the conclusions of the report of the Working Group on Changing Patterns of Mental Health Care (8), according to which:

The services should be community-based, i.e. they should provide facilities for a defined area population small enough to permit most patients to be treated within easy travelling distance of their homes. The services should be comprehensive, in the sense that they provide a range of facilities, differentiated to meet the needs of persons suffering from any form of mental illness or handicap to be found in the area population. Specialized forms of care which must be provided on a regional basis should be linked to the community-based services.

The various agencies and services engaged in mental health care for each area population should be so effectively coordinated that each part of the system can contribute to the care of individual patients, according to need, and that patients or their families do not suffer any disadvantage as a result of being transferred from one part of the system to another. This point applies equally to care given by medical and social agencies and nonmedical residential care.

Services of equal quality and standard should be available to all persons in the service population who stand in need of mental health care, irrespective of

financial or other considerations. In quality and availability, care for the mentally ill and mentally handicapped should be of a standard not lower than that provided for the physically ill.

This working group noted that at the time (1978), mental health care in many parts of the WHO European Region was in a state of transition from traditional custodial care towards comprehensive community mental health care. The situation can be illustrated by taking as an example the pilot study area of Trieste, in which the change from custodial care to community care has progressed most rapidly and gone furthest.

Legislation on the mentally ill in Italy in the late 1970s has brought about dramatic changes in the operation of that country's mental health services. Among the principal provisions of the new laws was one that laid down that no person could be admitted to a mental hospital who had not been hospitalized in one previously and that no person, whether previously hospitalized or not, could be counselled to enter such a hospital. These legislative changes were the sequel to innovations that were already occurring in several local mental health administrations in Italy and themselves date back to dissatisfaction with the established institutions.

The pilot study area consists of the city of Trieste and the six surrounding municipalities in the province of Trieste, with a total population of over 300 000. In the late 1960s and early 1970s, the pilot study area had residential facilities only, providing for a total of just under 3000 persons. Of these, 1300 were patients in the Trieste mental hospital, a great majority of whom were detained involuntarily. They tended to be poor and to be suffering from chronic psychosis. There were no community psychiatric facilities for such patients, who were also generally without health insurance, so that there were no alternatives to institutional care. Needless to say, the greater proportion of those in mental hospitals were long-stay patients, while those covered by health insurance were sent to clinics or sanatoria.

In the early 1970s the Trieste administration, well aware of the situation and anxious to change it, appointed the late Professor Bassaglia as director of the mental hospital. It also approved the recruitment of further professionals—doctors, nurses, social workers, etc.—and patients then began to be discharged. Many of those not discharged had their status changed from that of involuntary to voluntary patients, a great improvement in conditions in the hospital followed, and the development of community services began. The first step in this direction was the division of the catchment area into five sectors of about 60 000 persons each and, in keeping with this sectorization, the hospital was also divided into five corresponding divisions, each with its own team. Patients were allocated to these teams according to their area of residence. Each division of the Trieste hospital now began to admit patients, both male and female, whereas previously there had been only two admission wards for the entire hospital, one for males and one for females. Some long-stay patients, either with

chronic disabilities or hospitalized for largely social reasons, were "declassified", although they continued to reside on the premises. They were then legally no longer patients and were designated as "guests". Among other advantages, this allowed them to receive the social welfare allowances previously denied them.

While these changes were going on within the hospital, the move from hospital to community was given formal structure by the establishment of mental health centres. By 1977 five centres, one for each sector, had been opened and group homes were being provided for patients in increasing numbers. With the establishment of the centres all patients, whether new or otherwise, were dealt with by them, and admissions to the hospital divisions were discontinued. However, it was found that there were still some patients who, because of acute symptoms, needed hospitalization for short periods and, for these patients, an admission unit was provided that could be used by each of the five mental health teams. With the cooperation of the full-time staff at the unit, team members continue to care for those of their patients who are admitted to the unit. However, most of the day-to-day work with patients is carried out at the mental health centres. The old mental hospital in 1982 had about 200 residents, redesignated as "guests".

Other beds for psychiatric patients, many of them for alcoholics, are provided in the university hospital, but they tend to be few in number and are not the responsibility of the provincial mental health services. However, many psychiatric emergencies are seen at the casualty department of this general hospital. Those presenting in this way are examined and dealt with, according to the area in which they reside, by members of the appropriate sector team of the provincial service and not by the medical personnel of the hospital.

Thus, the pilot study area of Trieste has progressed further than any other area participating in this study in deinstitutionalizing and to some extent "depsychiatrizing" the formerly institutionalized and stigmatized psychiatric population. It has gone far to re-establish former inpatients of the mental hospital in the community and to prevent any further entry into this diminishing institution. The service, in addition to being community-based, is multidisciplinary and committed to continuity of care, and the efforts of the various team members appear to be highly integrated.

The question remains whether the provision of a service of this type is of greater benefit to the recipients and their families than the traditional custodial mental hospital care of the type that existed in Trieste before 1971. In 1978, at the request of the director of the Trieste hospital and mental health service, a WHO consultant visited the service to make "an assessment report on the organization of . . . services in the light of the recent change in mental health care policy and to write an appraisal". He felt that "in the absence of certain detailed information, it is not possible to make a full evaluation of the adequacy, effectiveness and efficiency of the service". However, he concluded that "the changes . . . are in line with major trends in European psychiatric practice" (9).

In summary, the services in the Trieste pilot study area are an example of the practical formalization of a definite policy, based on sociopolitical considerations, of deinstitutionalizing the mentally ill. Of all the pilot study areas covered by this study, Trieste provides the clearest example of both policy formulation and of the implementation of that policy in practice through programmes for discharging institutionalized patients, "declassifying" patients not immediately dischargeable, changing their status from involuntary to voluntary, and certain other changes within the hospital structure itself relating to the principle of sectorization. Outside the hospital, a programme of community alternatives to hospitalization on a sectoral basis has been resolutely pursued, aided by the setting up of a mental health centre in each of the five sectors, which can deal with most mental health problems on a community basis. For those problems requiring an overnight stay or a stay of several days, a unit has been provided on the old hospital site but physically and organizationally separate from it.

### Regional mental health services: Aberdeen

Perhaps the most common model emerging from an examination of the inventory of services provided by the pilot study areas is that of a catchment or pilot study area served by a number of different inpatient units, which may or may not be responsible for a particular catchment area or sector. This overall arrangement gives rise to what might be called regional mental health service, and an example of this type of service organization is provided by the Aberdeen pilot study area.

This is a geographically clearly delimited area, based on the city of Aberdeen, with its highly diversified population as a result of the recent growth of the offshore oil industry, and the surrounding rural areas of the country, which are separated from the rest of Scotland by mountains to the west and south and by the sea on the north and east. The inpatient psychiatric needs of the region were formerly served essentially by three psychiatric hospitals, together with a small clinic providing specialist services to a selected population among whom neurotic problems predominated. Originally providing care to a broad catchment area, these services have now been sectorized, inpatient units providing a full range of services to defined population areas. The community component of the services has increased considerably, and the inpatient/population ratio, which was as high as four per 1000 population in the late 1960s, has since fallen considerably. In common with many other regional mental health services where the population is served by a number of different centres, there is a range of specialized services, covering child psychiatry, alcoholism and neurotic disorders requiring psychotherapy. This model of the regional mental health service is possibly the most common one found in the pilot study areas and is exemplified not only by Aberdeen but also, for example, by Nottingham and Tampere.

### Combined public and private care

Although private psychiatric care is provided only to a minority of patients in the European Region, there are private care inputs in many of the pilot study areas. This leads to a mixture of care systems with varying degrees of communication and coordination between them.

The quantitative contribution of private care varies considerably and may or may not be known. In the Dublin pilot study area, for example, a psychiatric case register exists, to which the major private services cooperate by communicating data on patients treated by them and residing in the pilot study area. Approximately 10% of the patients in care, according to the definitions adopted for the purposes of the register, are looked after by the private services. In Mannheim, however, where there is some private input but where, because of data protection laws, there are restrictions on gathering information, no precise quantification of this input is possible. There is also some private input in El Ferrol, but most of all in the Athens pilot study area, where no fewer than 14 private hospitals, all situated outside the pilot study area, provide inpatient care to its residents. Collectively, these hospitals treat more patients from the pilot study area than the two public hospitals.

Thus, in certain pilot study areas, the private sector is quite considerable, but it is also heterogeneous. Some patients pay the entire costs of their treatment themselves, but the majority are probably covered by some private insurance scheme or even by a scheme associated with their occupation. Thus, some of the private patients in the Athens pilot study area are insured by the Merchant Seamen's Fund, and other similar occupational insurance schemes are in operation elsewhere.

### General hospital psychiatric units

Since many national plans for the development of mental health services have increasingly stressed the pivotal role of the general hospital psychiatric unit in the delivery of mental health care, it is to be expected that in many of the pilot study areas, general hospitals will make some contribution to such care. Somewhat surprisingly, though, this is of minor importance. Indeed, there are some pilot study areas, e.g. Dublin, Iași, Mistelbach and Zagreb, where neither beds nor services are provided by a general hospital. On the other hand, a sizeable contribution by general hospital units is found in Brussels, Groningen, Louvain and Randers.

Coordination between general hospital units and the public mental hospitals varies greatly. In some cases, the general hospital is responsible for a particular catchment area or sector. In others it is not, and a kind of selection procedure operates whereby newer patients with acute illnesses are more likely to be dealt with in the general hospital units, while those with greater disabilities and impairments tend to be admitted to the mental hospitals.

### Special units and units for special conditions

In a number of pilot study areas, patients with milder or more interesting conditions from the treatment and teaching point of view are seen in special units. This is the case in Aberdeen, Mannheim and Oslo. In addition, specialized units, e.g. for alcoholism, forensic psychiatry and child psychiatry, exist in many of the pilot study areas. In some instances, these units serve a much wider region than the pilot study area itself. They may even serve the country as a whole, as does the special neurosis unit in Oslo. In others, a specialized unit outside the study area shares its facilities, inpatient or otherwise, among the residents of that area and of other areas.

Services considered by some mental health administrations to be specialized are not so viewed by others and are provided by the sector team as part of the general services. In other areas, there is a high degree of specialization, e.g. psychotherapeutic facilities are available in Paris 13. In some areas, services that are supplied on a sectoral basis elsewhere are seen as a supra-sectoral or regional responsibility and are available only for selected cases. In others, such services may not be available at all, either in the sectors or regionally.

Some of the services in the pilot study areas provide teaching or are part of a university medical complex, as in Zagreb, where the psychiatric teaching hospital is not only part of the general health services (and has a wider regional responsibility as well) but is also an institute of the medical faculty.

Two examples of specialized services that appear to be fairly widely accepted and available are special services for children and for alcohol and drug abusers. At least two of the pilot study areas provide comprehensive separate services for children. These are coordinated, however, with the other services in the various sectors. In Groningen, the services of two sanatoria for alcohol and drug addicts are available to residents of the catchment area.

### Neuropsychiatric facilities

The tradition of dealing with psychiatric and neurological problems together persists in a few of the pilot study areas. Thus, in Belgrade, "neurology is still not completely separated from psychiatry... neuropsychiatrists employed in communes practise both neurology and psychiatry..." (10). However, new legislation in Yugoslavia provides for specialization in neurology, psychiatry and children's neuropsychiatry as separate fields, and these two specialties are already tending to become separated in inpatient settings. In Mannheim, psychiatric inpatient services exist in the neurological department of the university hospital and at the neurological department of the general hospital at Ludwigshafen.

### Other specialties

Special provision is made in some centres for various psychiatric subspecialties. Surprisingly, perhaps, the inventory of services in many pilot study areas does not mention any separate provision for psychogeriatrics or the care of the elderly mentally infirm. It therefore remains unclear to what extent such patients are dealt with by the psychiatric services or whether care is provided to them by geriatric services. In Tampere, however, separate psychogeriatric care is provided in a general hospital, which has a 37-bed unit for this purpose. In Louvain, on the other hand, geriatric services are not included among the psychiatric services, and it is not clear which service provides treatment to elderly patients with organic brain damage. In the Madrid area, although the relationship between the inpatient psychiatric services and the catchment area is somewhat poorly defined, there are separate geriatric units in the inpatient psychiatric hospital. In Dublin, no person over 65 years of age is admitted to the sector hospital without previous screening. If this shows that the problem is essentially an organic one, the patient will be referred to a geriatrician.

Special forensic psychiatric services are available in some of the pilot study areas, e.g. Groningen and Mannheim. These are usually shared with other catchment areas. Special services for juvenile offenders are also available in one or two pilot study areas.

As a further example of the kind of specialization that is occasionally available, it is worth mentioning that no fewer than three hospitals for psychosomatic diseases are included in the Mannheim inventory of services.

### Nursing homes

There is a long tradition in certain European countries of providing less intensive inpatient care for milder psychiatric cases whose acute symptoms have long since faded away and who merely need supervisory rather than nursing care. This system was most strongly developed in the Nordic countries. Although this practice has tended to die out, some care of this kind is still provided in the Tampere pilot study area and also in Randers. In this context, it is interesting to mention that the "boarding out" of psychiatric patients with families, as traditionally practised in Gheel in Belgium, is not mentioned as a service in any of the accounts from the 21 pilot study areas, except in Paris 13.

### Outpatient clinics and other services

One of the earliest initiatives in providing an alternative to inpatient hospital treatment in the psychiatric field was the opening of outpatient clinics. In a limited number of cases, this facility became available as long ago as before the First World War, but it is only since the end of

the Second World War that these clinics have become widespread. Their initial location tended to differ, depending on whether they were set up at mental or general hospitals, but what was common to virtually all of them was that they were hospital-based. More recently, and this is clearly reflected in the study areas, this service has tended to move from hospital to community. Thus, many contemporary outpatient clinics are free-standing, community-based and located conveniently close to patients' homes.

A further characteristic of this alternative form of care is that the range of services and the duration of patient contact have been extended far beyond a mere visit to a clinic. The word "polyclinic" also describes another characteristic of these clinics—that in many cases they are situated, and the clinical transaction takes place, in a building that also contains clinics in other medical specialties. In other cases, there is also an appreciable social input, as in the Mistelbach catchment area near Vienna where ambulatory care had previously been difficult to obtain for discharged inpatients. A psychosocial service has now been provided for patients discharged from the hospital at Klosterneuburg. This is provided by a full-time social worker and a part-time psychiatrist, who work from an office in Mistelbach but also make frequent home visits.

Services provided from an extra-hospital base in the community range from the simple, old-fashioned outpatient clinic where (in a building not shared by other medical specialties) patients simply make routine visits to the psychiatrist and then return home, and where no other psychiatric professional is available to provide care to the highly developed mental health centre providing the full range of psychiatric services, including day care. This type of centre functions as the linchpin of the psychiatric service, sometimes to the extent of largely replacing the psychiatric hospital, as at Trieste. This is perhaps the most significant development in the provision of psychiatric care to have occurred in the last ten years and holds great promise for the future. In some of the pilot study areas, such a centre is already functioning. In the majority, it is either in the process of being established or at least its establishment in the near future is under consideration.

At their most fully developed, such centres can provide beds and admit patients during acute stages of illness for short periods before discharging them to community care or in some cases transferring them to residential care. In addition, as well as providing overnight crisis facilities, some centres can provide emergency domiciliary services (11).

### A typical pilot study area

It is now worth trying to build up a composite picture of a contemporary European psychiatric service, as reflected in the inventories of services provided by the pilot study areas. It will be realized that this will not correspond precisely to any actual area, but may be

useful from the point of view of those wishing to assess the extent to which the philosophy of mental health care delivery as set out earlier, and to which all the pilot study areas would more or less subscribe, has been put into practice.

A typical pilot study area would have a population of approximately 300 000, the greater part of which would be concentrated in an urban centre (usually a medium-sized city) with a smaller proportion in the surrounding rural areas. In the past, the population of the pilot study area, and particularly the urban part, would have been much smaller and would have received psychiatric services from a large central mental hospital of 1000–2000 beds, situated on the periphery of the city.

With the passage of time, the increase in the population increased the strain on the mental hospital. It became overcrowded, and the number of patients increased both absolutely and relatively, so that 20 years ago it contained four patients per 1000 population. As a result, over the last decade or so, admission policies have become more stringent, patients have been discharged earlier after shorter stays, and some alternative forms of inpatient psychiatric care have become available in a nearby general hospital. As a consequence, patient numbers have been declining, particularly over the last decade. Because of the unwieldy nature of the mental hospital inpatient services and the increasing size of the hospital staff, who now include not only psychiatrists but also social workers, occupational therapists and psychologists, the need to rationalize professional responsibilities towards patients has become a pressing issue. A modified form of sectorization has therefore been, or will shortly be, introduced under which the catchment area has begun to be divided into population subgroups. So far, this process has led to the total population of 300 000 being divided up among five sectors, each having 60 000 inhabitants and each served by a team. An attempt is also being made to divide the psychiatric hospital in a corresponding manner into sections, for which each sector team will have exclusive responsibility. However, this change so far affects only the newer patients. The older long-stay inpatient population remains crowded together under poorish conditions and not assigned to any sector or team.

Quite recently, a new general hospital has been built. It is a university hospital and has a number of specialized services, some of which have a regional responsibility. Among these services is a psychiatric unit with approximately 40 beds. It does not serve any particular catchment area and its staff, who include the professor of psychiatry at the nearby university, do not have any commitment to the mental hospital or its services. It tends to deal predominantly with acute patients and with a large number of complicated neurotic cases, for whom it provides a psychotherapeutic service. However, there is a rumour that the Ministry of Health and the regional health authority are contemplating giving it a sectoral responsibility in order to reduce the load on the parent mental hospital and also because there is a trend both towards requiring such general hospital units to provide care for a specific population sector and towards establishing community services.

Although the psychiatric hospital has been providing outpatient services for over 20 years, it is only comparatively recently that any appreciable community services have been made available. Quite recently, a day centre was opened that, for the moment, can provide only limited accommodation: it has only 30 places for the five sector teams. However, further day centres are planned for the catchment area. Some will be purpose-built, but others will require the renting and conversion of existing residential property. Eventually, it is hoped that each team will have its own day centre. For the present, an increasing number of discharged patients are being brought every day, either by public or by hospital transport, to a day centre in the hospital grounds. As the number of patients thought suitable for such care is constantly increasing, this is not a satisfactory arrangement. There are difficulties in providing such a large number of patients with a mid-day meal and, in addition, the occupational and rehabilitation services of the hospital cannot really deal with such a mass of patients, now estimated to be 200, on the already large mental hospital site. For the future, therefore, the plan is to develop community-based day centres, so that the need for day patients to come to a hospital that is already too large can progressively be eliminated.

Five years ago, the accommodation for doctors in the hospital grounds became redundant as doctors no longer reside on the premises. It was therefore converted into a hostel for patients who are being rehabilitated or who, in some cases, have been discharged from the hospital and obtained jobs but have not been able to find accommodation for themselves. This hostel, with its 12 places, has now proved quite inadequate for the numbers requiring its services, and two houses in the city centre part of the catchment area have therefore been obtained, one by purchase and one by renting from the local authority, for discharged patients. When money becomes available, more such properties are to be acquired, and it is hoped that the hostel accommodation within the hospital grounds will become redundant.

The recruitment of professional staff has, overall, not been a problem, partly because the hospital is located in a relatively large city and partly because of the adjoining university psychiatric teaching unit, in conjunction with which a programme for training medical students and young doctors contemplating a career in psychiatry has been started. For similar reasons, other professionals have been reasonably readily available. However, there is a tendency for people to prefer to work in the university teaching hospital and for consultants to compete for the very limited number of posts available there in preference to those in the mental hospital. The development of community services has nevertheless encouraged professionals with initiative, drive and imagination to work in the sector psychiatric services. More nurses, particularly those with ambition, are competing for the nursing jobs based on the health centres, day centres and hostels. They also undertake a good deal of domiciliary psychiatric visiting.

For some time now, the sector teams have been trying to integrate their activities with those of the primary health care services. This has

not proved to be an easy task, but the team members have found that they have been most successful when their outpatient clinics have been based on health centres that are operated jointly by general practitioners, community physicians and community nurses. Professionals working in these clinics find that they are able to develop "outreach" services and to think in terms of prevention.

Overall, the development of this typical community-based, sectorized psychiatric service from a traditional isolated mental hospital has not been an easy task. One particular difficulty was that of ensuring that the regional and local health authorities achieve the correct balance between the different health priorities, so that the chronic problems, such as mental illness, mental handicap and geriatrics, receive a fair share of the available resources, equally with the high-technology acute medical services that the university hospital is vociferous in demanding.

Although services for the mentally retarded in the area are expanding, particularly for children, there is still a lack of inpatient accommodation for the chronic elderly mentally retarded, and such patients remain in the psychiatric hospital as a legacy of the old days. As far as possible, the five teams will not admit new cases of adult mental retardation to their inpatient beds other than on a short-term accommodation basis. By the same token, the geriatricians working in the catchment area—and there are only two of them—are based on the university teaching hospital. They perceive their role as that of acute medical clinicians dealing with the elderly, but have so far been unwilling to involve themselves in the wider aspects of geriatric care, such as the planning of services for the elderly sick. The psychiatric hospital, which formerly accepted new brain-damaged elderly patients unquestioningly, is now being much more restrictive in respect of its responsibility in this field. It is insisting on joint consultation with geriatricians, and the consultant in one of the sector teams has made it clear that he feels that all brain-damaged elderly patients should be dealt with by expanded geriatric services. As a consequence, he has virtually refused to allocate any of his psychiatric beds to such patients.

The treatment of patients with alcohol problems, of whom there are a very large number, is not handled in the same way by the five teams. Some of them provide specialized inpatient care in small "alcoholic units", using some of their hospital beds for this purpose. Others do not believe in this approach and do not intend to provide specialized facilities for these patients. All agree that people with drug problems should not be admitted to the hospital. Similarly, forensic problems are dealt with on a regional basis, while child psychiatric problems are covered by a small inpatient unit of six beds together with a large outpatient service at the university general hospital.

All the sector teams feel that a very small number of their patients will require special or intensive care for short periods because they are extremely disturbed and therefore dangerous, either to themselves or to others. There is a joint high-security locked unit for such patients within the mental hospital. This never contains more than 15 patients at any one time.

Since, depending on the surveys quoted, up to 40% of persons attending general practitioners are said to have a psychological component to their illness, it is legitimate to enquire what contribution the primary health care services make, in Europe, to caring for psychiatric illness. There is no set pattern in the pilot study areas; much depends on organizational and administrative arrangements. Thus, in some pilot study areas, general practitioners would appear to work single-handed, in others in group medical practices and, in a few instances, in a multidisciplinary health centre providing assessment and diagnostic facilities. In those cases where general practitioners are working in virtual isolation from the psychiatric services, early referral to specialist consultation is hampered. In such circumstances, patients are referred for psychiatric help less frequently and later in their illnesses than where a health centre arrangement exists.

In many cases, there are administrative difficulties about the integration of primary health care and specialist services. Sometimes, there appears to be competition between these two components of the health system for patients. This demarcation dispute is most evident in the issue of whether a discharged patient should be followed up by the specialist psychiatric services or the community-based health care elements.

One pilot study area, at least, has attempted to examine the extent of general practitioner involvement in aftercare. A cohort of 130 patients discharged from the psychiatric hospital of Klosterneuburg to the pilot study area of Mistelbach was followed up two years after discharge. Of these 130, 14 (10.8%) were found to have made no general practitioner contact since discharge. Fifty-six (43.1%) were found to have made less than one general practitioner contact per month, with the remaining 60 (46.2%) having contacted the general practitioner more than once per month since discharge.

## Comments and conclusions

It will be obvious that this account of the wide diversity of psychiatric services provided in Europe is written at third hand. The only way to get to know how a psychiatric service functions is to work in it for a period of time. Written descriptions, even visits, will not convey the nuances and subtleties of administration, organization and function that give each service its unique character. Similar structures can operate quite differently in different social and cultural settings, and such differences cannot adequately be reflected in written accounts.

Given these limitations as well as the obvious fact that there can be no blueprint for a psychiatric service that is universally applicable, and recognizing that patterns of care that are accepted internationally must be adapted to local circumstances, it is surprising that the 21 pilot study

areas all subscribe to many common basic policy and operational principles. All the pilot study area services are now either sectorized or are moving towards sectorization so as to ensure continuity of care. Most services make use of multidisciplinary teams and all services are becoming increasingly community-based through the reduction in the number of hospitalized patients and the provision of alternative community-based services, such as day centres, hostels and mental health centres.

Even though some services explicitly, and most services implicitly, declare their policy objective to be the integration of psychiatric services with those at the primary health care level, such as general practitioner services, the evidence from the inventory of services and the description of the way that these services operate all suggest that such integration has yet to be achieved. Although the trend towards caring for psychiatric patients in general hospitals rather than in mental hospitals is reflected by the availability of such facilities in the majority of the pilot study areas, both the inventory of services and the patient census indicate that somewhat less than 5% of all hospitalized patients in the pilot study area services are in general, as distinct from psychiatric, hospitals.

Finally, the need to supply a detailed description of the services provided in the 21 pilot study areas must undoubtedly have caused many team members in those areas objectively to assess the function as well as the structure of their own services, and at the same time helped to make them aware of developments elsewhere which, either directly or appropriately modified to suit local conditions, could improve the quality of the care that they offer to their patients.

## References

1. Foucault, M. *Madness and civilization*. London, Tavistock Publications, 1971.
2. Giel, R. & Hannibal, J. U. *Mental health services in pilot study areas*. Copenhagen, WHO Regional Office for Europe, 1980 (document ICP/MNH 007).
3. Palacios, R. *Social and demographic data, services inventory and in- and out-patient censuses for El Ferrol (141)*. Copenhagen, WHO Regional Office for Europe, 1981 (document ICP/MNH 007 (8)).
4. *The development of comprehensive mental health services in the community*: report on a Conference. Copenhagen, WHO Regional Office for Europe, 1973 (document EURO 5414 I).
5. *Psychiatry and primary medical care*: report on a Working Group. Copenhagen, WHO Regional Office for Europe, 1973 (document EURO 5427 I).
6. *The future of mental hospitals*: report on a Working Group. Copenhagen, WHO Regional Office for Europe, 1978 (document ICP/MNH 019 II).

7. *Constraints in mental health services development*: report on a Working Group. Copenhagen, WHO Regional Office for Europe, 1978 (document ICP/MNH 030 II).
8. *Changing patterns in mental health care*: report on a WHO Working Group. Copenhagen, WHO Regional Office for Europe, 1980 (EURO Reports and Studies, No. 25).
9. Bennett, D. H. *The changing pattern in mental health care in Trieste*. Copenhagen, WHO Regional Office for Europe, 1978 (document ICP/MNH 007 II).
10. Kalicanin, P. *Mental health service research, social and demographic data, services inventory, patient census and cohort study of the Belgrade area (171)*. Copenhagen, WHO Regional Office for Europe, 1982 (document ICP/MNH 007 (9)).