Care about people with mental health problem across EU.

To describe quality of the services for people with mental health problems across the Europe we have first to agree about criteria according which we evaluate the services.

In the democratic part of the world there is basic general agreement shared criteria for evaluating a services for people with mental health is leading factor how much service allowed or support people with mental health problems/ include people with serious and long term mental health problems/ fulfill their basic human rights as.

- Respect of human dignity in all situations
- Right to decide about all aspect their life
- To live in normal conditions / in the community/

The service which is on a direction to fill human rights criteria has to be in general:

- Capable to support people with mental health problems as much as possible in as normal condition as possible. It is a service community based or community oriented.

- Clients centered. There has to be a system and procedures allowed clients has strong or dominant influence or voice in all processes of the care. All attitudes and decisions have to be on partner level. And there has to be legislation and mechanism which assure human rights are protected in all situations.

- Oriented on all need of the clients. Multidisciplinary and multi resort / social care, health care, housing, employment/ character have to be present.

Using this paradigm and result of lot of research we can be clearer what are main topics we have to observe and assessed to describe a quality of the services across EU:

- **National Policy**
  There have to be national policy reflecting human rights principles and have to be clear and enough strong system of its implementation.

- **Type of services**
  To evaluate if there is proper balance between hospitals based care and community based care. Number of beds/ in health and social sector/ and type of the hospital facilities.

- **Management structure**
  We have to evaluate if there is a management structure which allow all services are coordinated the way to achieve continuity of care. To assure care is primary delivered to clients in high need there have to be clear priority groups of clients and there have to be clear responsibilities of providers as catchment are responsibility or clients group’s responsibilities. To achieve there is effective use of resources there has to be some form of gate keeping between different levels of care / primary, secondary, tertiary care/

- **Quality Control**
To assure a good quality of care there have to be an independent system of monitoring and evaluation of the care. Inspection system. There have to be standards about a procedures and best practices. There have to be proper continual educational system for all professional in a field.

- **Financing**
  It is important to evaluate what percentage goes to mental health from all health and social care money. It is important to follow what percentage of all mental health money goes to which sector of care/ community based, hospital based/. There has to be a system of financing flexible enough to follow a client’s needs.

- **Involvement of the clients**
  In all above mentioned dimensions of the care there have to be mechanism which allowed a voice of clients has strong and adequate influence. And also needs of careers are met

Using these criteria we can say there are big differences across EU. But there are countries in EU where most of the criteria of proper and balanced care are more or less met. There is always space for improvement. Even if most of the clients are living in the community, there is always a question how much they are “integrated”. How much community is capable to integrate them?

Anyhow In lot of, mainly Western Europe countries have needed hospital care only or mostly in small psychiatric unit and most of the resources are in the community. Number of all beds per 100 000 inhabitant is les than 50. There is a management structure to assure comprehensive and continual care. There is a proper quality assurance system. The system has flexible financing. And there are lot of mechanism voice of clients is listened properly and careers has proper place in the system and proper support for their role.

On the other hand there are countries where most of the resources are in the hospitals sometime in extreme cases hospitals are only a resort for a care. There are still places where the hospital did not met basic human rights conditions of to be treated with dignity. Conditions where are more than 20 clients in one room. One toilet for 50 or more clients. There are countries with hospitals with more than 500 beds even more. In some countries there is more than 100 beds for 100 000 inhabitants. In such countries a care is fragmented, mostly only medically oriented. There is a poor quality assurance (INS) clued poor or none existed continual education. No in depended inspection. Rigid financing and most of the financing resources spend in hospitals. Clients / mainly named patients/are an “object” of care, very often based mostly on a control more then on support and cooperation.

To help us to understand such differences a probable to find and answer how to change it will be useful to have short excursion to a recent history of Europe.

In 19 century there was development of large psychiatric institutions. After the Second World War started a criticism of this arrangement of care especially from the aspect of human rights. But also there was criticism from medical point of view big asylum type institutions as such are not helping to stop a mental illness to be chronic “with all consequences” but they made a chronic course of mental
illness even worth. This "de-institutionalization movement" happened in countries with democratic development. In such countries alternatives were developed. Later national policies and process of a global transformation of old fission services started. Part of the process was also transformation of legislations. There was step by step improvement of the integration of clients to the decision process. Generally a transformation was about how, where and what to do differently to assure a human rights of the clients are protected. As a result of all this processes big institutions were closed down and replaced by community based and community oriented service.

After the second WW in eastern part of the Europe democratic development was interrupted by introducing totalitarian regimes. There were of coerce differences of intensity of oppression but there are some basic characteristics of all totalitarian regimes, principles they are based on.

- No respect to a human rights
- Control to every part of the life of every individual / paternalistic approach/
- Oppression of civic society
- Leaders know better than we what we need
- Stupid optimism

Because of the need of “stupid optimism” everything what compromise this optimism was put out of the public mind. No existential question. No social problems in socialistic countries, because it is ideal system how to organize society, there are no “social” problems. This is probable one of main reasons why totalitarian systems isolated people with handicap include people with mental illness out of the society. Institutions build in 19th century was somehow convenient to a totalitarian need of isolation of people "with problems”. Quality of care in mental health institution during a communist time in many case compare to a time when they were build up even decreased. Rehab principles were reduced and pure medical, controlling model were main “treating approach.

People with mental illness had very often even less rights then people with other handicap. For example in extreme not have a right to marry without permission. In some case admission to specialized institution was with a condition to put clients on a full guardianship. Director of an institution become their guardian. /This practice continue in many case until today/. The result was all their civic rights, anyhow limited already for every citizen, where taken away, which where.

Mental illness was seen as a condition which made person completely “not competent”. This attitude was a ground for political abuse of psychiatry. Who is against gorgeous socialistic or communistic system “is not competent” and must be mentally ill and has to be treated. Degree of political abuse of psychiatry was probable related to a level of previous experiences with democracy.

The was strong isolation from the rest of their world, blockaded of information include research, scientific literature and modern trends in all type of care especially mental health care.

Medical model in psychiatry with paternalistic features, neglecting of social and psychological factors was convenient to a general paternalistic approach in a totalitarian societies.
To compare developments on both parts of Europe we can see how In 80. In western countries there was already trend to reduce number of beds in big psychiatric hospitals. In lot of eastern countries the number of beds was still increasing in the same time.

Of course there were exceptions, a part of the world development influenced some of the countries but as general principles it was stagnation.

As a result of all mentioned characteristics development in eastern part of Europe did not follow a development in western- democratic part. Classical institutional model was “conserved” and in some aspect was more developed as oppressive system.

The discussion which started in old EU countries I 60-70 started in Eastern Europe in some version only after communist regime collapsed.

After 1990 there was in several countries enthusiasm to transform services. Main group who was motivated for the change were NGO, not known in the time of totalitarian regimes. New form of services, community based was developed mostly by NGO. Their financing was not structured. Become professional providers. Slowly the voice of users becomes stronger. On the other hand as more new service become visible as more the conflict between classical services and new service come up.

Entering process was some kind of stimulation. There was lot of support .For example Global initiative on Psychiatry, special development funds as MATRA, PHARE, activities of WHO, Monitoring and report as by CPT commissions, MDAC. But in only few countries process of reform become really national policy with a structure of its implementation.

It is interesting the process of entering EU was different in different countries. For example when Greeks was entering, one of clear condition was to change mental health services. There was scandal in mass media with horrible conditions in psychiatric hospital on an island of Leros and it probable influenced Greeks had to start to transform its services before entering EU. Although the conditions in some of the countries entering EU were not so much different as in Greeks there were no such condition. Rumania had condition to change services for children as a part of entering criteria. It was not a case of Bulgaria although the conditions were not so different.

After countries entered EU we can even see stagnation or regression characterized by following:

- Problem of financing of NGO. On the other hand classical institutions had a stable financing.
- Strengthening of influence of only medically- institutionally oriented groups or lobby groups/ supported by pharmaceutics companies/
- Interest to keep institutions for different “personal profit” reasons
- Syndrome of reaching the target “we are in”
- Many other “priorities then mental health
A principle of human rights was mentioned on the beginning as principle which followed can lead to a proper, well balanced care. But principles of human rights are not a primary invention of the Eastern Europe region. There are accepted but still like something from abroad, sometime as some tithing artificial. Of course the history of 50 years of neglecting of human rights play important role.

We can expect when Eastern part of Europe is integrated to EU a positive influence can be stronger than before. Paradoxically there is just now even more sensitivity and negative attitudes toward influence from old EU countries. Advice is often seen as criticism.

Hopefully it is not necessary all countries will repeated all mistakes made by countries already far away on the way of reforming a services. And hopefully reform process will not take 40 years as it was in many western EU countries.

- Investment to a young generation
- Support of exchange of good practices
- Standards of minimum quality of care / include independent inspection/
- To continue with message about human rights.
- Deliver a message institutions in general are not good solution.
- Emancipation of the non medical profession
- Emancipations of users and family members movements

Conclusion:

There is always lot of to do, also in the countries with proper balance of care and proper system of human rights protection. On the other hand there are countries where most of the resources are still in an old fission types of hospitals. In some countries there is very poor human rights protection. There is very poor dignity and we can still find places where people are treated worth than local animals.

It is difficult to talk about one Europe when differences are so big. It is difficult to be spokesman of human rights when in EU there are thousands human being locked in non acceptable conditions. For different reasons there are also thousand hundreds of kids, include a kids under age of three, in different kind of institution also very often in not acceptable condition

Transformation of mental health services is difficult process. There are financing conditions but what is a most important are proper attitudes and will to change of stake holders, professionals and other relevant groups. To change a mind takes generations. Hopefully this process can be speeded and positively influenced.