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Foreign report

Mental health services in Germany

CHRISTINE M. TYRIE, Consultant Psychiatrist, Grimsby District General Hospital, Grimsby, South Humberside DN33 2BA

General hospital unit: Zentrum für Psychiatrie, Herten.

On a recent study trip I was able to examine approaches to health care, in particular, mental health services in what was West Germany. I visited a range of facilities and met a wide range of professional workers.

Health care is not the major political issue it now is in the UK. By and large health matters are administered at local (Lander) level although to avoid regional differences there is also federal legislation.

Ninety per cent of the population are insured under the state health insurance scheme. The average personal contribution to this scheme in 1987 was 12.6% of the basic pay. People may opt for supplementary private health insurance, and those whose income lies above the contribution assessment ceiling of the statutory scheme can obtain full insurance through a private fund; ironically this often works out cheaper. In 1985, 9.6% of the gross national product was spent on health. Health care is divided between hospitals and ambulatory (community) care. In 1986 there were 165,000 doctors, one per 370 of the population, as compared to one per 510 of the population in the United Kingdom, with 47% working in hospital. There is a huge nursing shortage with some 200,000 vacancies; this is because few stay in the profession after training due to their low status and low pay. Out of a total of 3,071 hospitals, 1,270 are special hospitals dealing with the chronically mentally ill. Some hospitals are administered by the Lander while others are private, either charitable or commercial concerns. Most large psychiatric institutions are a considerable distance from the nearest large conurbation.

In the early part of this century, Germany was at the forefront of psychiatric developments, but World War II had an enormous impact on the medical services in Germany and the post-war emphasis has been on industrial developments, improved productivity and increased standards of living for the physically and psychologically well. A federal enquiry in 1975 recommended bringing care closer to the local community; equal status for mentally and physically ill patients; providing need orientated and comprehensive care; and coordinating all care services.

As a result of this enquiry, catchment populations were recognised, institutions were downgraded but refurbished, psychiatric units were developed in general hospitals, and there was an increasing awareness of patients' rights. However, a follow-up enquiry in 1988 found that although standards of care had increased and a number of day hospitals opened, the development of community facilities had been impeded by a lack of cooperation among the agencies involved leading to inadequate support networks for chronic patients.

In all in-patient facilities there is a low nursing staff:patient ratio. The district general hospital unit at Zentrum für Psychiatrie in Herten serves 650,000 people, with 190 beds; staff included 120 nurses, but only 10% of these were trained. A full-time consultant and 15 junior doctors in training worked here, supported by six psychologists, six social workers and four occupational therapists. Most psychiatrists are neuropsychiatrists and approaches to treatment tend to be very organic; the low staff:patient ratio also militates against a more psychotherapeutic approach. Drug use in extensive but ECT is generally considered ideologically unacceptable. Seclusion facilities are rarely found but locked doors and actual physical restraint are widely used. Frequent progress reports on patients are required by the insurance schemes producing a huge administrative load.

There is no Mental Health Act in Germany and patients who require detaining are dealt with under common law, as is the appeal process. Legal detention in hospital has, to date, been synonymous with treatment. During my visit to Herten 30% of patients were involuntary.

There is no upper age limit for health care services. Theoretically all psychiatrically ill patients are treated together. As in the rest of Europe, the increasing number of elderly people is putting considerable strains on resources. Insurance schemes are reluctant to fund long term hospital admissions. There are a few private or charitable nursing homes and only ten special psychogeriatric day hospitals. Respite care facilities are, however, starting to be developed and there is a fund for special payments to families.

Postgraduate training in psychiatry consists of one year in neurology and three years in psychiatry, all hospital based. There is a postgraduate examination, but this is much less gruelling than the MRCPsych! Many doctors serve as an assistant psychiatrist, but it is possible to become a consultant immediately and/or set up in private practice. Psychiatric nurse training follows general training and involves a two year course consisting of 16 weeks theory and 40 weeks practical experience. Following training, a nurse must work for three years or pay back approximately 6,000 DM.

Out-patient services do not exist on discharge from hospital. It is up to the individual patient to seek the support of his private practitioner. Private practitioners can be very selective with regard to the patients they treat, and the homeless and those with personality disorders are poorly regarded. Re-admission rates to hospital run at 50–60% over the next year.

Psychiatric illness in the community is seen as a social problem. Rehabilitation is through work, the German philosophy being that personal identity is achieved through work. Patients unable to return to full employment are offered places in sheltered workshops such as the one I visited in Frankfurt which had a bicycle repair shop, machine tool shop, paper printing and fabric printing areas. These workshops are run by charities. The charities also offer a range of supported accommodation from hostels to sheltered flats. There are no community psychiatric nurses in Germany; their role is taken on by social workers employed by the charities. Charities obtain 80% of their funding from the social services budget.

Rehabilitation unit: Der Ludwig Steil Hof, Espelkamp.

Workshop: Eschenheimer Tor, Frankfurt

There are no clearly established monitoring or evaluation mechanisms within the German Health Service. The attitude is that "Künde ist Konig" (the user is king) and freedom of choice is a way of monitoring quality of service. The implications of this approach for the acutely disturbed mentally ill individual are only too obvious. Consumer led pressure groups do not exist and advocacy is regarded as being irrelevant for psychiatrically ill people.

Areas of clinical concern in Germany differ from those preoccupying British psychiatrists. There is currently a review of the forensic psychiatry service following the recent attempted murder of two leading politicians and there is grave concern over an increasing alcohol problem among women. Benzodiazepine dependence, which has become such an issue for us working in the United Kingdom in the last ten years, is not seen as a problem in Germany. This may well be because of the lack of out-patient services and follow-up, and the psychological consequences of sexual abuse are not seen as a major problem by German psychiatrists, who view sexual abuse in terms of Freudian fantasy. Although AIDS is

more frequent in Germany than the UK, the psychiatric implications as well as the wider health care implications of it are only starting to be considered.

Comment

Mental health services in Germany are well funded. Much of this is channelled into capital investment and many facilities are positively luxurious compared to parallel services in the United Kingdom. The number of doctors per head of population is significantly better than in the United Kingdom, but the fact that many of these doctors are hospital based clearly detracts from a community orientated approach. Treatment tends to be very organic with minimal use, or indeed opportunity for psychotherapy. The lack of out-patient services, either in the form of clinics or community based day centres, results in an approach to community care that is much less paternalistic than that seen in the United Kingdom. Federal agencies monitor the financial management of health services, but there is a lack of monitoring and evaluation of actual standards of care. Neither the consumer nor indeed the professions are organised in any way so as to have a voice in the ongoing management and development of the service. With the launching of an open European market in 1992, boundaries which have so clearly divided health care approaches in the European Community will come down. There are lessons that could be learnt on both sides of the Channel. The German style of devolved decision making is coming with the re-organisation of the NHS, but will the level of NHS funding ever reach the more generous level seen in Germany? Community based care is developing in Germany and with a considerably more liberal approach than that seen in the United Kingdom, but there are many, particularly chronically ill psychiatric patients, who might benefit from the sort of out-patient and community support services that we have developed in the United Kingdom.

Acknowledgement

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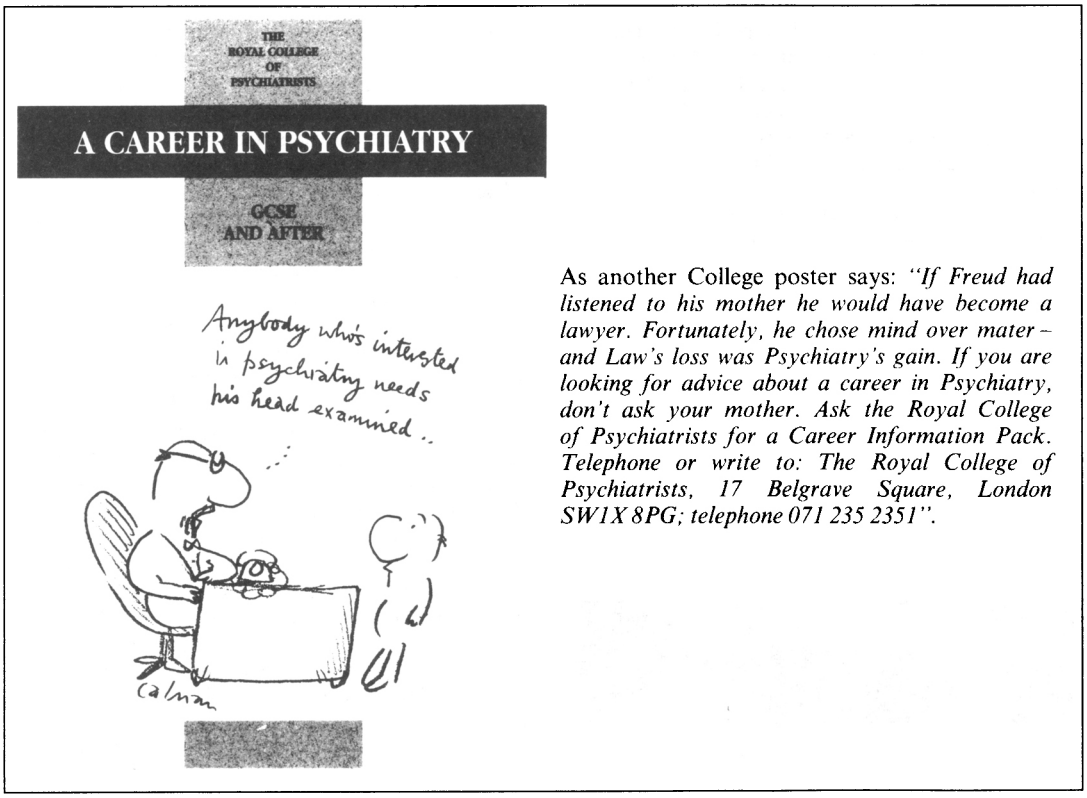

As another College poster says: *"If Freud had listened to his mother he would have become a lawyer. Fortunately, he chose mind over mater – and Law's loss was Psychiatry's gain. If you are looking for advice about a career in Psychiatry, don't ask your mother. Ask the Royal College of Psychiatrists for a Career Information Pack. Telephone or write to: The Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG; telephone 071 235 2351".*