

### Background:

I will use this space to outline some approaches to mental illness and its health care: this consists of the understanding of community care and what it replaced, the various paradigms of mental illness (such as the medical model of schizophrenia) including normalisation (interacting with patients in a way which is as culturally normal as possible) and how "the mentally ill" were treated when the perception of them was different from what is normal in our culture. I will describe some of the groups who fight for rights of consumers and their approach to mental illness and finally look at the background of some of the mental health care in the three countries which I will later compare.

The critiques of social policy are controversial. Three writers should be discussed when looking at the debate. Erving Goffman's "Asylums" published first in 1961 underlines the similarities in all total institutions of Western society. He singles these out as a category of institutions because they are "encompassing to a degree discontinuously greater... Their encompassing or total character is symbolized by the barrier to social intercourse with the outside and to departure that is often built right into the physical plant, such as locked doors..." (Goffman p15 1991) In his introduction he compares prisons and mental institutions: "providing we appreciate that what is prison-like about prisons is found in institutions whose members have broken no laws" (p11 Goffman reprinted 1991). His approach is that mental institutions are abnormal, he describes the staff-patient relationship, patients "take on somewhat the same characteristics as inanimate objects" (p73 Goffman 1991) and believes that the mental patient has been "deserted by society" (p136 Goffman 1991). According to Kathleen Jones a view like this attacking asylums has encouraged in the English speaking world the closure of provision for the mentally ill (see Kathleen Jones, Chapter 10 "The ideologies of destruction" 1993). This argument is strengthened by the media backlash with spectacular cases recently like Benjamin Silcock's climbing into a lion enclosure at London zoo and the murder by Christopher Clunis resulting in the creation of the Zito trust. How successful has Goffman been in changing perceptions of the institutions where mentally ill people reside? This raises the question of the relevance of Goffman under the "community care" arrangements. Is community care the result of Goffman's work? It is difficult to trace answers to these questions (and Erving Goffman did not want to attach himself to any particular move-



ment). I argue that although Goffman is still relevant to institutional life for those with severe mental illness, for the majority there is now a life outside "total institutions" (see Goffman's "introduction" in 1991), which is a harder to analyse because of such a large number of variables.

Michel Foucault has used historical analysis to show us the role of madness in our society. "Madness and Civilization" (Foucault 1961) reminds us that madness was set apart from life by an act of will and by delegating our responsibilities for it to science (or the psychiatrist), we have broken our common language between "madness and non-madness and reason and non-reason" (Foucault "Preface" 1995) leaving silence in the place of communication. "I have not tried to write the history of that language, but rather the archaeology of that silence" (Foucault "Preface" 1995). What are the effects of public "silence" on the former patients in the community. If mentally ill people in the myriad of contacts with the public are expected to conform, or pretend to be well to survive in the community, what is this impact on them? This kind of effect will contrast with their dealings with professionals such as psychiatrists who tend to see mental illness in terms of a medical model (having something wrong with them). On the one hand with a section of the community they are culturally normal, on the other believed to be impaired. As with any community, consumers wish to identify with their peers, with care in the community this means some are going to reject psychiatric classification and live a double life in the community-identification as a deviant and trauma could well be the result, according to my own experience. Foucault outlines the dangers of the medical model itself with its scientific labelling, objectification due to professional attitudes (see "On being sane in insane places" (D.L. Rosenhan 1973) when healthy students disguised as patients in various American asylums find such processes equally discomforting) and Foucault suggests the use of science itself: all this creates in my opinion rebellion or forced conformity.

Thomas Szasz also criticised mental health professionals. But "The myth of mental illness" and "Law, Liberty and Psychiatry" written in the early 1960s have a different aim. Mental illness according to Szasz is simply problems which can be resolved if the individual is given autonomy. It seems that Szasz is saying if only the individual could stand on his own two feet, mental illness would go away. There is no role for the present state of psychiatry.



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"Much of what passes for "medical ethics" is a set of paternalistic rules the net effect of which is the persistent infantilization and domination of the patient by the physician" (Szasz "The Myth of Mental Illness" 1961). In "Law, Liberty and Psychiatry" (Thomas Szasz 1963) he argues against the extension of state power, believing compulsory detention of mentally ill individuals was against the American Declaration of Rights. Thus it is not so much the mentally ill person's fault, but society and medical professionals are to blame. These are similar targets as have been written above, but for different reasons.

The medical model as it is called, to some extent understands the problems of the mentally ill as coming from their illness with a mental cause. Recently with schizophrenia this is seen in terms of heredity with a gene rather than social origin. Nevertheless the individual's environment is seen as affecting the course of the illness. (Braginsky p38-43 1969 "The Search for a new paradigm") The problem with this "label" of schizophrenia in my opinion is that it covers such a wide range of different characteristics from withdrawn to violent to suicidal, with some suffering from problems with thought processes and some not. It can be stigmatising for the individual with this label. "Mind" a mental health charity particularly focused on "users" of mental health services argues that so many different classifications of mental illness share similar features such as depression (although large differences also exist), that words like schizophrenia mean almost nothing (see "Not on your own" "The Mind guide to mental health" by Sally Burningham 1989") To some extent any acknowledgement of mental illness creates stigma in society, and so professionals may ask how they are to convince people to treat their illness, if they cannot at least give it a name. This essay is about treatment of these kinds of illnesses.

The controversy surrounding the nature of mental illness is important, for the individual and the state. The individual mentally ill person has this very label to contend with, he must decide how to handle this slide in social status and stigma. Moreover he must choose (if given the choice) between different drug treatments, and whether to trust in psychotherapy or medication. For the state a mentally ill person if seen as a defect, is a drain on resources from the state, family and friends. "Approximately one in a hundred people worldwide will suffer from schizophrenia at some point in their lives. There are approximately 250,000 people suffering from the illness in the UK at any one time." (NSF Annual Review p4, 1994/5). Ap-



proximately one billion was spent on schizophrenia by the state in 1992/3 (NSF p4 1994/5). Moreover the ages of 18-25 for men, and for women a year or two later, are the most common for developing schizophrenia (NSF p3 "One in Ten" 1995). A drain on the male and female labour force. There are also high suicide rates for this age group: about 40% for men, about 30% for women (NSF p6 1995). It is easier to give that individual psychotropic medication, than change that person's lifestyle. For example a housewife may be suffering depression from being in the house all day with young children. If given drug therapy that person can continue with her tasks-caring for her husband and her children.

My model of mental illness is this "social paradigm." It is the reaction to mental illness from people outside the individual (which can make him an "outsider" or "insider") which decides his or her fate. This perspective is similar to feminist and black perspectives. This means mental illness is irrelevant, whether caused by inside or outside forces. It is the reaction to that being which will determine his or her fate. Someone with a so-called physical illness is treated very differently from someone with "mental" illness. Disability is accepted with the former, not with the latter! I am not suggesting the consumer is fully fit, but the intensity of this person's illness is out of proportion to the reaction. It is the unknown which makes an individual discriminate, and not knowing what mental illness is leaves the onlooker little choice unless symptoms are under drug control - a social sanction which also affects the consumer. These illnesses are complex, giving someone without experience of them a difficult task: both intelligence and environment interact as part of the illness, memory and physical reactions also. The whole person is involved with "mental illness," and the cause seems less important other than as a justification or weapon for the doctor-patient relationship, at least not important while there is no cure. This might change with gene therapy, but social therapy has been inconclusive and can be dangerous for schizophrenia, (the illness upon which the experience for this model is based). The importance of the values with which we treat mental illness is therefore paramount. What determines such values is also important: what role does mental illness fulfill for the mentally healthy? The role of the state, and voluntary groups in society in detail is beyond the scope of this essay, although it will be touched on in everything which is touched on subsequently.

Mental Health Law does not cover this or many of the areas of implementation of services.



However the analysis of "community care" which follows should not be thought of as occurring only in the 1990s, such a concept has been traced back to the 1959 Mental Health Act and before. But I see the real question of community care is not when did it begin, but has it yet arrived? Sir Louis Blom Cooper QC (past chairman of the Mental Health Act Commission and involved in Public Inquiries into homicides committed by people with a diagnosis of mental illness) said as much at a conference I attended to called "Community Care: Rhetoric or Reality" (7/7/96). As he said, referring to present legislation (1959 and 1983 Mental Health Acts and 1990 Community Care Act), "legislation says little or almost nothing about care and treatment outside hospital." He also made clear that community care is essentially about closing down hospitals and discharging patients into the community creating a "new class of homeless and rootless" (same speech). Furthermore he pointed out that the Community Care Act requires "Hospital" treatment at which both treatment and residence must be the same, and focuses on doctors. There is no provision for community mental health centres as seen in the United States. The same speaker also advocated forced treatment in the community, which seems a move away from improving patient care (because of the compulsive element) if this is the central approach for moving from the large asylums.

Community care is the subject of this paper, but a key question is what community care? Does it exist? Andrew May LL.B (Deputy Chief Constable of Dorset Police) described the experiences of the mentally ill as "a life of diversion from what we take for granted" (7/7/96). The activity of community care seems to involve councils, administrators and policemen (who decide whether people are taken from the street to hospital, prison or simply left there), but few decisions are taken by doctors, carers or former patients. It is the latter group which this paper will focus on. Andrew May at the same conference interestingly said that about 15,000 adults a year are interviewed but not believed to be mentally ill (he estimated 10,000 were mentally ill out of a total 140,000 interviews). He also wondered whether the police might "resort to CS spray" (Andrew May 7/7/96) through misunderstanding about the mental state of the person. Through examples like this a human rights approach appears to take in the best interests of the patient. In my comparative analysis I will have to assess whether this is in fact the case, or whether the nature of care in the community in contrast to the verification of a closed ward makes abuse of rights too difficult to detect. Tribunals reviewing the various Sections keeping people in hospital under compulsion, under the 1983 Mental Health



Act (amending the 1959 Act) made (to some) logical sense, as the whole process took place in hospital. Forced drug taking "in the community" or at least outside hospitals as advocated by Sir Louis Blom Cooper would in my opinion create a nightmarish number of practical problems, -not least how to bring the people in. This would break fundamental human rights, creating a divisive consciousness among consumers as I have found in my own experience of wards at Friern Barnet, where compulsion in the past caused much resentment. Without patients on hand assessment outside hospital would be near to impossible. Would we then have to go back to prison-like "hospitalization?" Community care must take in the wishes of the patient.

The pressure group "Mind" (National Association for Mental Health) has this critique as their central approach. Consumers are elected to a decision-making board which is the centre of a charity with regional affiliates. MIND is against the medical model of mental illnesses taking a normalisation approach, but not trying to value the patient according to measurable abilities. MIND takes the consumer as more than a normal member of society, as he or she is discriminated against by professionals and the wider public. The problem with this approach (mentioned by Ramon 1991 as an implicit part of normalisation) is that it sets predetermined values on what is normal and what is not. Often discriminating against the minority by setting out what is well and unwell. It is argued it is better to recognise illness when it occurs (sometimes MIND takes a less medical outlook).

Two other charities SANE (Schizophrenia: A National Emergency) and NSF (the National Schizophrenia Fellowship) have a different critique to MIND arguing that labels are necessary (for example schizophrenia) and that some professionals' view of the deviancy of mental illness at least recognises the difficulties that carers and professionals have to endure. NSF was originally a carers' organisation and SANE was started by professionals as opposed to users. An example of a users group is "Survivors Speak Out" which sees consumers as victims and tries to make psychiatric hospitals more consumer friendly (meeting the needs that the mentally ill see as important). The onset of community care entails the need for community supervision for consumers. Developments such as user run self-help groups have appeared locally (NSF has called its Hove group "Voices" which I have attended). However none of the charities not even MIND take the rhetoric of a partnership between state and vol-



untary groups very responsibly in my opinion. Local charities' support workers lack professional training (which is better than very little training at all, as I found working for a local hospital visiting service and visiting a local self-help group) and plans are not comprehensive. In the Lewes, Brighton and Hove area which some local branches of the charities cover, there is little coordination between the groups, or between groups and state health services. My own experience of this does not mean that there is no cover for mentally ill people from charities, but it could be more comprehensive, meaning that not all those using psychiatric services were included, and what services there were lacked expertise.

Critiques of the law come from these charities. Larry Gostin an American "activist" in this area worked for Mind and helped formulate the 1983 Mental Health Act which amended the 1959 Act. It set up a system of tribunals to appeal against 28 day and 6 monthly compulsory detentions (section 2 and section 3 of the 1983 Mental Health Act), with a three person panel of a lay, psychiatrist and social worker. The consumer appealing against this hospital detention had the option of representation through a solicitor. This complex process resembled more the American desire for justice through the courts, reflecting Gostin's human rights background. MIND's focus on the user was matched by the NSF's focus on the family and carer. At this time (Summer 1996) there is pressure from this latter group, on MPs, to codify the carers' role in the detention process. I have heard one activist from the NSF suggest that detention in the home would improve on the current situation of users wandering the streets before they can be picked up, and either "sectioned" or given the medicine they need. Voluntary detention is of course an alternative way of staying in hospital, and has come under fire from both liberal and conservative elements. MIND claims that voluntary patients lack rights as forced detention mainly concerns the 1983 MHA leaving little protection for them. On the other hand professionals argue that voluntary patients can leave when they want thereby putting themselves in danger in the "community," defending the restrictions.

The professional critique, at least from psychiatrists, questions why people were ever put into the community. There is no single perspective from this group, but what approach there is, aims to defend their position of influence over what happens to the mentally ill. Nevertheless despite this, psychiatrists have been slow to move into the community in Britain (unlike some notable exceptions in Italy like Franco Basaglia). There appear to be three reasons why



community care happened (Kathleen Jones 1993). One has been previously mentioned, namely the critique of people like Goffman and Foucault which provided an excuse and a certain legitimacy to governments to empty asylums, although only silence followed questions of what was to happen afterwards to those needing long term care. The second reason for emptying asylums was also politically expedient, to save money. Although community care was recognised from the 1970s as requiring serious financing, the old asylums were in an increasing state of disrepair. Keeping them going would require money which would always be accompanied by bad publicity. That same amount of money, it was believed, could follow a patient into the community. The final reason for community care was the New Right ideology of the free market. "Quasi-markets" were the new catch phrase of the 1980s, the old "statist" approach of central funding would be replaced by giving the patient choices about which care best suited his or her needs. Although the patient did not actually make the choice, carers (in this case not parents but mental health professionals in partnership such as social workers and psychiatrists) would have more options: charity, private residential and new health services provided by regional authorities. When community care arrived the new approach did not offer much to the patient, because these were not patient centred reforms. Psychiatrists were on the whole against them, although other professionals such as nurses, social workers and occupational therapists were more in favour. The Griffiths Report in 1986 criticised the state of community care, arguing against use of private residential homes as an all in one institution for the elderly mentally ill. Griffiths criticised the lack of coordination between the health and social work professions and demanded accountability with a "Minister of Community Care." A White Paper called "Care in the Community" followed, but the law when it arrived, as already mentioned, offered little in the way of services for the mentally ill, being more about the closure of large institutions. This does not mean that there is no care in the community in Britain, but it is ad hoc, consisting of local initiatives by local councils.

In Italy since the late 1970s there has been a radical critique from a number of sources which has criticised institutionalisation (the psychological and social effects of being kept in locked wards run by the medical profession), and the labelling of mental illness, and developed an alternative therapy and way of life for those ill people they have the resources to reach. This trend of normalisation (as culturally normal a life as possible) has spread from North Ameri-



ca internationally, and since reforms in Poland against Communism and its system of health care, has been practised there too (later I will discuss the 1994 Polish Mental Health Protection Act). The history of East European mental health - similar to Russian mental health although an improvement - is worse than in Western Europe. It was a way of containing political prisoners in some institutions, and even where mental illness was the primary focus, such care was inadequate. Perhaps some aspects of the care in Poland reflected something of a "Latin Rim" state (Esping-Andersen 1990 spells out some characteristics of these), in that families often bore the brunt of the burden leaving the state to take an impersonal role in total institutions where there was little chance of appeal.

Normalisation is the final approach we will look at, as it is the architect of all that has gone on before. Wolf Wolfensberger in "The Principle of Normalization in Human Services" (1972), wrote for a North American audience that this principle was intended for people seen as mentally retarded, but could be used as much for architecture as for mental illness! It is seen in expressions such as consumer or user meaning mentally ill person. Wolfensberger's definition was as follows: "Utilization of means which are as culturally normative as possible, in order to establish and/or maintain personal behaviours and characteristics which are as culturally normative as possible" (Wolfensberger p28 1972). He sees normalization as an ideology, but a good ideology rather than a bad one, opposed to deviancy. These ideologies are being referred to by Wolfensberger in the context of "human management models," meaning the ideology of those with great power over those in their charge. In my opinion the relevance of this is that patients cannot just "take it or leave it" from their psychiatrists. If they are on strong drugs they need constant help to find the right drug and level at which to take it. The ideology of the psychiatrist is therefore relevant, how relevant can be determined by looking at a harmful ideology, that of the deviant. According to Wolfensberger the patient does not have to be intentionally deviant, but can be treated as deviant much as you can be labelled Schizophrenic or stigmatised. To understand the significance of this patient interaction with the psychiatrist, it helps to realise that "the interaction between patient and clinician is incidental to the treatment and there is no exploration of it" (Harold Bourne p248 in *Psychiatry in Transition* 1988). The patient can therefore easily be seen as deviant. But not if, according to Wolfensberger, normalisation is the ideology of the psychiatrist. This can render harmless the medical model, especially when the psychiatrist from the outset is trying to



make the patient feel normal, when normalisation is an ideology. No longer is the patient given a "sick role," and the relationship should be one of equality. The obvious problem with this application to mental illness, is that the state of the user could be temporary. But I believe that this is due to an illness of the brain which is abnormal, during which the person must be treated with equality. The question is does a concept like normalisation bring this equality about?

Critiques are not the only influence on mental health services, for there exist differences between countries due to the different characteristics of welfare states. The latter for the majority, determine the services they receive, although there are innovative movements which do not fit this generalisation (for example the pioneering work of Franco Basaglia in Italy). We will look first at some of these national differences.



## Chapter One: National Models

To say that mental health policy exactly follows the social policy of a "welfare regime" is problematic. Especially when that welfare regime takes the models supplied by Esping-Andersen in "The Three Worlds of Welfare Capitalism" (1990), which make a number of general statements concerning the whole of social policy. But these models are useful in differentiating between states. Bob Deacon attempts to stretch Esping-Andersen's classifications to parts of "The New Eastern Europe" (Bob Deacon 1992). This chapter attempts to tell us whether national models help the understanding of the "mental patient" in the 1990s.

Esping-Andersen used the following criteria for distinguishing between welfare regimes: firstly the degree of decommodification, in other words to what extent workers were no longer commodities, for example the Marxist analysis of workers in the capitalist process of production as commodities. Decommodification involves the provision of services and benefits available on the basis of citizenship entitlement (not position in the market). As Esping-Andersen puts the definition (Esping-Andersen p37 1990): it is not "complete eradication of labor as a commodity...rather the concept refers the degree to which individuals, or families, can uphold a socially acceptable standard of living independently of market participation."

Secondly Esping-Andersen looks at the distributional impact, how services and benefits contribute to inequalities, social stratification and egalitarian directions. Finally he sees to what extent pension entitlements were dependent on state systems, occupational systems or market systems. (Bob Deacon p18 1992)

These variables look useful: entitlement to services, inequality and the elderly are all issues in mental health. However it is only when we look at the models created by these variables and compare them to the experience of mental health systems in our three countries, that we will know how useful Esping-Andersen's work is. We can ask what the models tell us not of the more general question of social policy, but of mental health policy. Or is the latter just a part of the former? In other words is there just one distinct model or two for each country? An important question for this paper is how consumer friendly is this categorization. Do the variables create a model which reflects the user experience of mental health in each of these countries?



There exist three types of welfare-state regime: "liberal," "corporatist," and "social democratic." The liberal welfare state consists of means-tested assistance with benefits for low income state dependants (usually working class). There is a work-ethic and benefits are low and associated with stigma. The state encourages the market to subsidise private welfare schemes. This kind of state minimises decommmodification and social rights. Examples of countries are United States, Canada and Australia (others have included the United Kingdom with some of these countries).

If we look briefly (more detail on individual systems later) at mental health work in some of these countries, for instance in America and Britain, our liberal model with these variables is useful: benefits are low, although in Britain higher than for the rest of the unemployed, stigma is attached, the state encourages the market with "quasi-markets" for delivery of mental health services in Britain. There is hardship for the working class with lower recovery rates from mental illness. There is poverty and social exclusion for those with mental illness, although there are decommmodification effects at least in Britain with a free health service. Work is no longer required from the mentally ill, although lack of work is a more important problem now.

A second model clusters Austria, France, Germany and Italy according to Esping-Andersen (1990 p27). Regarding Italy, one of the countries in our study, described by some (Leibfried in Jones 1993) as one of the "Latin Rim," we might expect mental health care to be under-resourced, commodified and dependent on family carers, as the welfare state is said to have a smaller role than in some more northern states (for example Scandinavia). This is not entirely the position of mental health in Italy, nor is it a complete picture of Esping-Andersen's welfare regime. The latter describes corporatism fitted to a "post-industrial" class structure where social rights were never under review, although attached to class and status. Markets are marginal, but the state does not redistribute wealth from one class to another, due to status differences included in its redistributive programme. Unlike our Latin Rim hypothesis, commodification was never preeminent. But the church is important and hence so is family life, with benefits encouraging motherhood, and with families having to look after their own. Mental health care since laws were passed in the late in the 1970s has been innovative especially in certain projects, although more generally the mental health system is under-re-



sourced. Esping-Andersen's view of social rights in this cluster of states and the "subsidiarity" of care to the family rather than the state, fits Italy. Although the user experience of some good care is not explained by the Esping-Andersen model.

This Italian radical fringe is surprising, and arises out of the political ideology of representatives in local government in the late 1970s. It involves decentralisation and a lack of dependence on the state by these groups. A lack of national scale which characterises it, is a problem faced by community care in all three of the states in this paper. Why is reform only local? Maybe poor resources is one answer due to the lack of interest of government political elites in community care. It is not easy to win votes through the provision of mental health care. But also this distaste may come from the unpredictability of public reaction to violent incidents by mentally ill people "in the community." Moreover a lack of national scale as in small projects creates less blame if something goes wrong, and costs less.

In this paper I will not look at Scandinavian states which fit the third of Esping-Andersen's models: the social democratic regime. The reason being that the mental health system of these states does not diverge as radically from Britain, as does Britain from Italy and Poland, in my opinion. Scandinavian states despite caring for the helpless by encouraging work by women and men, and catering for all classes with a universal system of benefits designed to satisfy both middle and working class, the social democratic type of welfare state is no more user-friendly than Britain.

Two questions occur to us at this point: are the mentally ill a new class-the underclass? Even if there is an underclass, some of Esping-Andersen's "measurements" of an individual's relationship with the state in his variables, such as decommodification, are still relevant.

Secondly is this underclass represented by any model for comparative analysis? My new model will try to have this perspective, but I will not dismiss Esping-Andersen: equality, class, citizenship and benefits are important subjects for differentiating between states-and also important for mentally ill people.

Deacon (1992) uses Esping-Andersen's criteria to discuss Eastern Europe. How appropriate are these variables for our purposes? Bob Deacon (p5 1992) gives us an example of the problem of Western interpretations of former "Eastern European" policies. In the past, policies



such as child care grants, guarantee of work for mothers and fathers, liberal abortion legislation, subsidized housing and benefit levels seemed progressive, and if tried in the West might have been seen as a social democratic regulation of market capitalism, but to East European citizens they were perceived as a way of forcing work out of citizens for the benefit of privileged party members. Interpretation of the changing face of the new Eastern Europe makes analysis difficult, also there is a need to look at past as well as present if our analysis is to be precise. For example the mental health framework in Poland makes no sense if we just look at the recent (1990) Polish legislation on mental health. Such a perspective takes no account of Poland's long history under state socialism which has changed the fabric of society. Are user perspectives the same in Eastern Europe? It may also be difficult with the lack of data to answer Esping-Andersen's distributional questions. Moreover what are our value preferences when using these Esping-Andersen variables? How do we rate decommodification in the East European analysis? Is it good or bad? Citizens may not prefer to be decommidified and unemployed. Entitlements due to citizenship may not be welcome when accompanied by the Communist state system. Similarly with the desire for equality; the class system would need a longer analysis because of claims of former East European states about the importance of the proletariat.

A look at the ways of analysing mental health systems, which we have just done, has brought us to the conclusion that I need to look at new variables and need to set out the values we hold. To do this I will now embark on a new framework of variables using a consumer perspective. Esping-Andersen's variables concerned consumer perspectives-but did not come from the consumer! More importantly they "summarised" the whole of social policy. I want to create variables for mental health alone.



## **Chapter Two: A new framework**

Firstly I will try and outline what I mean by consumer perspective, the basis of my new framework. This basis for users' of mental health services must involve what they want. Experience of mental illness has shown that it can confuse, there is also no cure for it so consumer's wishes for a cure cannot be granted. Nevertheless users can make choices from the beginning of their illness, if the technical questions concerning drugs are understood. In other words with care the mentally ill person is no different from the rest of the population (here I am talking about schizophrenia). This care might take a lot of patience, hence the need for professionals such as Community Psychiatric Nurses and Psychiatrists. But mentally ill people can be given choices about where they live, which drugs and at what levels they take, in other words essential principles such as freedom, homes, adequate means and health care choices can be given. In some cases patients must take drugs to live in the community, but if the alternative is presented as hospital care, and choice over the drug and at what appropriate level is given, there can be compromise. This is what I call the consumer perspective: giving the consumer choice over both his body and his quality of life and entitlements in society. Mental illness exists and incapacitates, but not in the way hitherto understood by society. From experience among the severely mentally ill and having schizophrenia myself, I know the choices I was not allowed to make. Although capabilities of present society should also be understood, I will not demand more than I reasonably think can be granted. I emphasise that this conception of society and the mentally ill is "social democratic," not Marxist. In other words the conception understands illness and choices as capable of improvement. I realise this and so try and put in other interpretations where the social democratic model seems to fail.

For too long professionals have decided too much about every aspect of users' needs, where and when they are treated, what treatment consists of and every other aspect of their lives day and night including relationships and recreation (see Goffman 1961). More needs to be done to change this than just putting patients into the community. When these needs are hard to ascertain, user's families and friends should be consulted. But as the House of Commons Select Committee declared about users' views of the Community Care Act (1990): it is difficult to get hold of such views. Can surveys tell us the user perspective? Even if they can we want more: from the data we need issues which will stand as points of comparison between the



different states. With these we can build models of mental health care for Poland, Italy and Britain with the same variables. We might well ask at this point why we want these models. Is comparison an end to itself? The user perspective should allow us to compare reality in the three countries with the aim of showing where policy can be improved, not just because some countries have what others do not, but a user model compiled from three countries will have sufficient breadth to show us just how far back we are in trying through mental health policy to answer user needs.

"Consumer" perspectives on deinstitutionalisation have been examined (Griffith EEH et al "Hospital or Community Living" 1996). I quote from the survey of eight studies with 415 clients with severe disabilities and histories of extended periods of hospitalisation, living in various communities in the United States, Canada and the United Kingdom. Asked directly whether they preferred hospital or community, 98% stated a clear preference for the community. Reasons for this result included the following, that the community offered freedom, choice, mobility, autonomy, privacy and safety, proximity to family and friends and town of origin. Disadvantages included that the community can be stark, lonely and largely devoid of meaningful activity or human contact. Others were inadequate housing, poverty and unemployment, daily structure, lack of assistance with daily living skills and social rejection, isolation, unavailability, inaccessability and poor quality of health care. Hospitalization included disadvantages such as stigma, rejection, loss of freedom, loss of autonomy, privacy, loss of dignity and little access to family and friends in extended inpatient stays. Advantages of hospital were provision of basic needs, shelter and food, health care and structured social and recreational activities. If consumers were given a simple choice between hospital or community, community living would win. If the factors were weighted, personal costs of long term hospitalization, loss of freedom and dignity, disruption of natural activities and supports, outweighed potential or actual clinical benefits. Finally the article adds that stakeholders do not just include consumers. (Although the latter is the focus of our paper and the survey.) Other stakeholders might include family, friends and certain professionals and even the criminal justice system.

From the viewpoint of the user I will set out some guidelines for comparison (variables). When patients declare that they do not want their activities disrupted, "natural" activities as



the survey puts it, what do they mean? We are given clues by the survey's mention elsewhere of friends, social activities, employment, recreation and structure. It depends of course on the patients asked since not all responses are the same. For example class, race and gender will make a difference. I intend to interpret some of this survey on client views, because the data lacks amplification and does not report the actual responses of the users. I at least have experience of mental illness and long stays (six months) in secure psychiatric institutions, finding community care or lack of it perplexing after being made to say so long in psychiatric hospitals or asylums. However it is worth mentioning that I have a possible value bias: I am white, male and see myself as middle class or possibly like other former patients see myself in a class of my own. Another problem is that the data of the survey includes Britain, but not Italy and Poland, an important problem which I can only attempt to rectify by writing about the context of their mental health systems and by studying East European history and present state of mental health reforms in Poland, and doing the same kind of research in Italy. My experience makes Britain not such a problem. The difference in these systems which make them interesting, also makes them difficult to study. Moreover the recent history of Eastern Europe makes finding data on the changes, and on the past, quite difficult.

The first step is to create the variables:

***Freedom** for the user: including privacy from the opposite gender, dignity, freedom to make any type of relationship desired, choice about treatments, mobility, autonomy (including no labelling).*

***Meaningful activity:** including the chance to look for and take paid employment, structure to an otherwise empty day and recreation.*

***Home and shelter** no explanation necessary.*

***Adequate means:** to keep from poverty and to have basic needs as recognised by the dominant culture.*

***Health care:** short stays in hospital (which the WHO report also stipulates), access to quali-*



*ty health care, assistance to daily living if necessary, direct choice over the form of health care (such as drugs and solitary confinement).*

*Discrimination or stigma attached to illness, no racism, sexism with representation of cultural and sexual orientation-such as black and female support, no abuse of dignity by staff or public.*

*Safety no explanation necessary*

*Proximity family and friends. Including community.*

*Continuity of natural activities, no breaking off of contacts, work or other expectations.*

*Infringement of rights of others in order not to be put through the criminal justice process (prisons').*

#### Values:

The variables above are an attempt at normalisation and as such they are biased. They are also a personal attempt to create, with the help of some academic surveys already discussed (Griffith EEH 1996), a list of what are essentially rights. How far will they operate as variables? I believe they can operate as the variables with which we look at mental health systems, and even small mental health projects within those systems, but it is important to understand which values we are promoting, before we begin the comparison. For example the first freedom variable or principle entails a view of mental illness. I myself within a general hospital "mental ward" have had a relationship with a woman voted on by staff. Involved in this was a view of schizophrenia as a deviant illness, while at the time I had no less awareness of daily life as I have now. In the past I was told countless times by my consultant that I had no understanding of my illness: stigma which would show up on the discrimination or stigma principle. In other words I do not believe in the medical model of schizophrenia. Nevertheless I am not going to embark on a further study of mental illness (see background), because the health care principle such as assistance to daily living if necessary, and access to



quality health care, encompasses mental illness. Part of the reason for this sweeping assumption, which does not even mention the "personal-humanistic" tradition (Harold Bourne p248 1988), summarised by Harold Bourne as focusing on exploring a person's interaction with others, is that I do not believe in the usefulness of therapies like psychoanalysis for Schizophrenia. But neither do I believe totally (as should have become clear) in the medical-impersonal tradition. Their pharmacological treatments (drugs) seemed to have some beneficial effects on me, but also side effects. Giving such problematic drug treatments without counselling (which is common) is extremely dangerous, and has cost one man his life whose suicide note I read. Evidently hospital treatment needs urgent reform, but even for those who still reside in institutions in England, it is in community care that most dangers lie. Having looked at some of the problems of my experience of asylum care, I will now turn to care in the community and my values here.

Is community care better than asylum care? Goffman explains what I have experienced as some of the pitfalls of asylum care in the background to this essay. Is community care any better? We do not have to look at individual experiences to answer this question, I can extend Goffmans' ideas into the community. For example in England we can imagine with the scarest of evidence (see survey above for evidence) that residential care in the community can have similar problems to an asylum: neither activities nor structure, hostile staff frequently unqualified (I am not talking here of therapeutic communities) seeing the patient as a deviant, no advice over drugs which are given in outpatient clinics far away from home, the break-up of relationships, no safety and - another of our principles - a danger to the rights of others! I will compare mental health care in the different countries, but first place this within each country's contemporary history.



### Chapter Three: Different mental health care systems

#### Poland

In this chapter I will introduce the mental health systems of the three countries. I will use data on the history of psychiatry in Russia and the Eastern bloc during the Cold War, the Polish Mental Health Protection Act (1994), the work of the Hamlet Trust encouraging self-help activity, journals looking at Central and Eastern Europe as a whole and as a background Bob Deacon's "The New Eastern Europe" on the Polish welfare state. The intention of this section is to introduce and explain Polish mental health as a whole, in order that I can later compare elements of the system with the other countries: Italy and Britain.

There were two types of hospital in Russia and spin-offs from them in central and east European states. One hospital was run by medical personnel for the mentally ill, the other for political dissidents where counselling and drug treatment were prescribed as a form of "resocialisation" or indoctrination, and torture. In eastern bloc states like Poland community care consisted of families caring for the mentally ill with society not accepting that mental illness was a problem, and giving little help. There existed in all east bloc states asylums on the Russian model, although to a lesser extent.

Since the 1980s Polish authorities have rapidly come to accept the problems within their mental health system. Civil Society, for example the Solidarity trade union and the Catholic Church, have the potential in the mental health field to introduce normalisation, as the Mental Health Protection Act (August 19 1994) put it: "mental health protection" shall consist of "comprehensive and generally available health care and assistance" and the "social approach" of "understanding, tolerance and kindness, and the counteraction of discrimination." Implementation of this Act is at an early stage. In January 1995 the Act came into force, requiring local authorities to create community care centres with Non-Governmental Organisations (NGO) helping. One NGO, the Hamlet Trust, has a user group from England helping organise self-help in Poland, one instance of this help is the "Brotherhood of Hearts" near Krakow. I will quote from one of their reports to get the flavour of the group as well as an impression of the state of Polish mental health: "There is a huge hospital near Krakow. It is quite old and methods of treatment as well as the attitude of the staff towards the patients are far from sat-



isfactory. Many people who were once treated there say it was sheer horror. Quite often they felt degraded especially by the assisting staff. They needed someone to speak for their rights." Although this report could have come from England 10 years before, I need to rely on such material because there is a scarcity of published work on the Polish mental health system. The Hamlet Trust also reports that Mental Health Awareness Days have now become a regular feature of the Summer calendar in Krakow, such events will increase public awareness. The NGO work will spread ideas and good practices from Western Europe.

### Italy

Information about Italy is less hard to get and consists of books, journals and extracts of law. Key books include a comparison between Italian and British mental health systems, "Psychiatry in Transition" edited by Shulamit Ramon with Maria Grazia Giannihedda, and Kathleen Jones' chapter on Italy. (Previously this author has been used by me concerning the history of the British mental health system. I also have the text of law 180 (1978) from a French (my translation) report on mental health legislation in Europe (1990), given to me by the Hamlet Trust. Journal articles were collected with the use of BIDS ISI and PSYCH.LIT computer information systems.

The background and understanding of Italian psychiatric reform needs less introduction, as this country had a similar psychiatric system to Britain before the 1970s. Nevertheless there may be confusion on the nature and extent of reform, because both optimistic and pessimistic reports have been made about them. An example of the former is "Psychiatry in Transition," (Ramon et al 1988) an example of the latter Kathleen Jones' "Experience in Mental Health" Chapter 3. Early small scale reforms were made with revolutionary fervour lead by Professor Franco Basaglia. This developed into a movement which by the late 1970s had influence in Parliament. In 1978 Law 180 was passed that declared that no new patients were to be admitted to (the traditional) mental hospitals. 15 bed units were to be set up in the psychiatric hospitals with patient stays for 48 hours. However it soon became clear that reforms needed local leaders to bring about change, Basaglia himself was to die two years after the Law 180. Today there exists pockets of reform in places like Trieste, where what I will term revolutionary change does take place. The community has been brought into the old asylums and patients where possible have been freed into the community. But there is a lack of statistics



on mental health more nationwide! As in Britain, putting patients into the community means, in the 1990s, losing track of them. Either they are homeless, alone in accomodation or they are in the South of Italy still in terrible conditions. Kathleen Jones cites reports of patients in dormitories with no recreation and kept much longer than Law 180 would have us believe. Therefore there is less funding in the "Latin Rim" welfare state for the mentally ill nationwide, than would be found in Britain. Nevertheless the reform movement (Psichiatria Democratica) has introduced many impressive innovations.

### Britain

Sources for British material include the King's Fund, a mental health resource centre with its own library for research, NSF and MIND material as well as journals and books. Noteworthy among these are "Community Care" magazine which comes out weekly, journals from the British library and authors such as Shulamit Ramon, Larry Gostin, and Kathleen Jones.

The media has taken increasing interest in mental health issues, for example documentaries by Jonathon Miller about asylum care or current affairs programmes about care in the community. The outline of the history of mental health care is in the public domain - Victorian asylums were built for laudable motives, but soon overcrowded. What is not so clear are the conditions in some hospitals in the 1980s. Mental Health care in Britain is decided in outline by parliament, but day to day running is the work of local authorities. It is only with the onset of care in the community gathering pace in the 1980s that these authorities have implemented their care with coordinated teams. Previously mental health provision was divided between social workers and the medical lobby. Another problem has been the resources open to local authorities. They have been "rate capped" in the past, with Community care money only available from central government after agreement with various agencies.

Legislation until the Community Care Act (1990) consisted of the 1957 Mental Health Care Act amended by the 1983 Mental Health Act. These dealt with the rules governing hospitalization. Seen by some as a rights based approach, in practice it was unusual to be released without the psychiatrist's consent (see Larry Gostin 1977). The Community Care Act closed the large asylums, which were replaced by General Hospital Care, not much better than the asylums in care, depending on the local authority. (My own experience has been of general



hospitals in North West London and Brighton.) But with community care there was inadequate provision and resources for care in the community (Simon Goodwin 1993). As in Italy, this consisted of residential homes, and many moved into lonely accommodation. There were few hostels or therapeutic communities for consumers (Means and Smith 1994). The latter care consisted to some extent of re-education (Brackx and Grimshaw 1988), for example my experience of the Richmond Fellowship after a visit to one of their homes is of a controlled and repressive regime, depending on who you happen to have as your co-residents! There is a lack of information on what actually happens to those who leave hospital. By its nature care in the community loses track of residents and although some studies have been done (Professor Leff at the conference "Community Care, Rhetoric or Reality"), there is an increasing worry that the mentally ill are ending up on the streets of big cities. My own eye witness accounts testify to this and "The Big Issue," a magazine for the homeless, runs regular features on mental illness. What is apparent is that for the long term mentally ill, there is a lack of reforming enthusiasm in Britain. We lack a Franco Basaglia (although groups like "Survivors Speak Out!" do exist) and instead are "fed" media reports on the violence of the mentally ill, without being given the horrendous suicide rate of mentally ill people. The latter are more likely to kill themselves than harm anyone else. Of the 250,000 people estimated to have schizophrenia in the UK today, twenty-five thousand will take their own life (NSF "One in Ten" p2 October 1995). A publicised social movement comprising consumers and friends, might give us more identity.



#### Chapter Four: Comparison of mental health systems.

Using the variables above, there will be a bias against the very different conditions in Eastern Europe, nevertheless although our model appears to be social democratic, presupposing that principles such as freedom can be brought about, we will try to lessen this social democratic bias in all three countries by discussing in the same section, what other models might make of our data, and the social democratic variables.

*Freedom:* In Poland my interpretation of freedom is strictly limited, unlike in Italy the reform movement (Solidarity and the Catholic church) is not primarily concerned with mental health. It is hardly surprising that civil society has not yet taken on the mental health crisis. This is due to the economic constraints caused by trying to switch to a market economy, the legitimacy crisis with the return of Communist leaders and the recent history of Communism when the mentally ill were seen as "dangerous classes." Outside influences in Poland in the form of NGOs will brighten future prospects spreading ideas much as normalisation came from North America to Britain and then Italy. But in Britain and Italy reform movements aside, democracy has not brought the end of the asylum (or general hospital), despite the sustained attack on the medical model of illness by normalisation. People are still constrained in Italy, Britain and Poland, but in Italy and Britain the majority of users are no longer controlled in the relationships they make, the treatments they have and where they reside, as they used to be under asylum care. This conclusion does not take account of the minority who are still constrained in the two Western countries.

*Meaningful activity:* Western economies are all facing high levels of unemployment so there is not much chance of ill people finding employment. High spending decommodified welfare states do spend some money on day activities for the mentally ill but these can be very stigmatising. In Poland with the limiting of admissions with the Mental Health Protection Act and the partnership between voluntary groups and the state, users (are they yet consumers?) can find help with day activities from some NGOs. The former Communists probably did not even want such people to have jobs, seeing them as a possible danger to society. However with the state no longer owning the means of production, the state must seek legitimacy. In a post-communist society it is difficult to see what form these ideological foundations will



take. Does Poland need to employ the mentally ill?

*Home and Shelter:* The mentally ill are on the streets in all three welfare states. Esping-Andersen (1990) demonstrates the different priorities of different welfare states. Bob Deacon predicts for Poland a Conservative Corporatist welfare state with authoritarian tendencies. This does not bode well for the homeless with the state possibly pulling out of the housing market. But even with well established democratic states there is a homeless problem. In liberal welfare states (Britain and later possibly Poland) the severity of capitalism is seen as legitimating for governments, not boding well for the mentally ill.

*Adequate means:* the standard of living required and whether this needs to be comparable to that of the dominant culture or above the poverty line is a much debated point. Users would obviously prefer to have incomes comparable to other members of society. The legacy of Communism may encourage Polish civil society to give the mentally ill adequate or culturally acceptable standards of living, but this is not apparent at the moment. Everyone had shelter and food, it was claimed under Communism. Research needs to be done to see if these expectations remain. This is not the case with Western societies where the mentally ill are marginalised because their standard of living is so low.

*Health Care:* governments need the legitimacy of efficient and acceptable health care. But not until Post-Fordist expectations did mental health come up to the standards of the rest of health care. These standards have not risen that much however, and there is still little choice in Britain of treatment (perhaps because of inertia!) unlike in Italy where a "pro-choice" movement began in the 1970s. The mentally ill are the excluded minority with less money spent per patient bed than in the rest of the health area. The exclusion happens whatever the degree of decommodification, although the latter does help consumers. But this is not enough to bring them within culturally normal levels of income within each society. For Poland, legitimacy, elites and the post-communist economy and state are important conceptions from my Habermas, Offe perspective. Health care is increasingly in Poland becoming a demand, - mental health care should follow. Commodification is present in Poland's rapidly developing economy. Do Polish users have less expectations than in the West? To what extent this is the case should not be exaggerated because conceptions of rights were kept alive by people such as Adam Mischnik and Solidarity. Moreover some principles are basic and were kept



alive even by eastern bloc regimes.

*No discrimination or stigma:* There are a number of groups in civil society in the West - Feminists, Antiracists and groups against discrimination such as "Survivors Speak Out!" We have not really developed this theme before, instead concentrating on models of mental health care. Feminists were initially hostile to community care because it would be women who would bear the burden of it, as is the case in Italy where in the South the family is the main unit of care. Black representatives might also complain of discrimination in the community. The issue of discrimination goes to the centre of mental illness for blacks and non-blacks. But their excluded position within society, creates special problems of normalisation with white professionals. Communism was proud of its record on some of these issues, southern Italy has no tolerance of them, while in Britain different institutional groups have squabbled over the issues. These problems are at the heart of our social democratic model, and a test as to whether it accommodates them.

*Safety:* Suicide rates are high in Italy and Britain, and rising in Poland. The "mentally ill" are more vulnerable from other illnesses when they are homeless, as well as open to other abuses living day and night on the street. Problems multiply once on the street: drugs, crime, illnesses, alcoholism, diet, violence, unemployability and so on. But suicide is not just a homeless problem, lack of choice in health services as well as lack of normalisation can lead to it. I have come across an instance of this in asylum care, when lack of time by staff and lack of choice in drug treatment, lead to a regime which offered only one conclusion to a co-resident: pain from continued arthritis over some time and increased intolerance of heavy doses of drugs lead to this result, according to the suicide note.

*Proximity family and friends:* Family are the main carers in Poland and Italy. In Poland because of the attitude of the welfare state, in Italy due to its weakness. Public attitudes must also play a part. Polish attitudes to mental illness were negative, a legacy of the Communist era, but there has been reform in Poland by NGOs which is based on generating positive attitudes to consumers. Britain has influential charities which represent family and friends of the mentally ill, for example the National Schizophrenia Fellowship.

*Continuity:* continuity of work is utopian in Poland, but a basic demand from users in Britain



and Italy (Northern Italy). Users do not want asylum in the community if in our society it is associated with stigma and incapacity to work.

*Protection of rights of others:* the criminal justice process is used for the "criminal" mentally ill in all three countries, but these are simply users who create a public order problem. There are frequent cases in the British papers of mentally ill persons not in secure psychiatric hospitals, but in prisons. As mentioned earlier it is up to prosecuting authorities and the Police to decide who goes to hospital. As Andrew May said in the conference "Community Care, Rhetoric or Reality," about 15,000 people are for example, initially misdiagnosed by Police each year. The Police have no compulsory training in the mental illness area.



## Chapter Five: Analysis of our results.

Firstly with reference to a structure conception: users are being controlled by forces unaccountable to them. Central government is one influence. In Britain and Italy central government took the decision and tried to shift the problems of implementation to the regions. In Poland in spite of new mental health laws the government is paralysed, a fate consumers must accept. Other structural influences are professions consisting mainly of inertia, an important force, which prevents people like Franco Basaglia from extending reform even when it is law, or in Britain prevents social workers from reforming medical care. Structure can also leave consumers as little better than commodities in society. But the state is only one part of the structure conception, the other being the voluntary sector which is still small in Poland with NGOs, but not so in Italy and Britain. It is this "diversity" of structure without a state controlling all resources, that is the main conclusion from my consumer friendly model.

The second conception is ideas. Normalisation is the foundation of my "principles" (see chapter two), and Italy and Britain both show its influence with the rise of user movements. Foreign NGOs are also showing the influence of these ideas in Poland. Since the 1980s in most of Europe and in the three countries I examine, the Right is gaining influence. In Britain the Right is also increasing its grip on power with quasi-markets, in Italy with the backlash against *Psichiatria Democratica*. In Poland the influence of the Right can be seen by a liberal conception of the role of competition. The Right has affected the user creating out of control quasi-markets in the form of community care in Britain where professionals have choices, but the consumer can only choose by moving to a new area out of the local authority control. In Italy the consequence is the lack of extended reform along the lines of Trieste, especially in the South. The harsh climate for mental health is the result in Poland.

The third conception is pluralism as an influence on mental health. The reliance on cost, academics and government to explain community care in Britain shows a social democratic (model) understanding of society. A Marxist perspective would emphasize the relationship of domination. Reformers have failed to turn the tide of liberalism in Italy, *Psichiatria Democratica* has failed. In Poland where there is no longer a bed and a job for everyone, is this more to do with reformers or structural inadequacy of Communist economies? Politics in Poland are at the moment paralysed with the victory of Communists and economic change.



So where are these groups which can change society, and mental health care? The problems of mental illness do not tell us why community care has now come about. This is clearer in Poland where changes in the state since 1989 can be seen to play a larger part in changing mental health practice, while not having anything to do with mental illness (For example the Mental Health Protection Act). In Italy or Britain, the contrasts are less apparent. Pluralist forces or psychological approaches are seen as more important. But they do not explain recent events in Western Europe, such as the quickening pace of Community Care.

The final conception that influences the way we see mental health is Post-Fordism. Like de-commodification, this concept describes a change in economic processes which have influenced the way society is structured. Examples of these forces are quality not quantity in manpower recruitment. New political parties without class based support, such as the Greens, emphasise that post-materialism (quality of life issues over materialism) may have arrived. These values encourage trends such as normalisation and it may not be the case that Poland is long excluded from such trends, leaping a stage of development. For mental health in Poland Post-Fordism means new issues: freedom, choice, meaning, dignity, attitude and environment. Quasi-markets in Britain seem part of this trend, so does NGO work in Poland. The ten or so principles above also represent this change, because they deal with quality of life or post-materialist issues, such as found in manifestos in Western Europe. In Italy it has been argued that the work of Basaglia was made easier by the local success of Communist parties, supporting mental health issues as a way of attacking central government. However the Post-Fordist thesis appears to account for more recent changes in Britain of declining leftwing parties caused by production and labour socialisation changes, ushering in the advent of specialisation and the end of mass workers represented by powerful trade unions. Maybe economic reform in Poland, when successful, will also have a dynamic effect.



### Conclusion:

What it is to be a "mental patient" is a difficult question with Europe changing so fast. Polish mental health may take on Western attributes, themselves a product of North America and Western Europe. The unification of the European Union may quicken this process in terms of unity, although at the moment it looks unlikely to take a direct policy role for Britain and Italy, Poland not being in the EU as yet. Nevertheless indirect influences could be substantial from unity: the spread of ideas, the coming together of the structure of economies with Post-Fordism having a diversifying effect, resulting in changes in government and civil society. What is clear is there will be no "one model" to describe mental health care in a diversifying European country, although a comparative perspective may become easier as Europe comes closer together.

This paper has tried to stress these changes in terms of the user. Not through psychological variables, but using a social paradigm. This social outlook does, I believe, have a psychological dimension: normalisation can effect mental illness. However rights are enough reason to look at consumers in this way.

I have looked at states not orientating themselves to user demands. Comparative analysis of Poland, Italy and Britain has demonstrated the individual states' diversity (within each society, not comparatively between the countries), with state structures consisting of not an overall plan, but private and public initiatives. Decentralisation does not depend on government but increasingly on "self-government agencies" and on "voluntary associations" (Article 1.1 and 1.2 Polish Mental Health Protection Act 1994). *Psichiatria Italia* has only attempted radical but small scale change in centres like Trieste. Finally my experience of Brighton is as an overworked and under resourced health service not attempting to provide care for all users in the community, with inexperienced charity care. This seems to fit in with government intentions of competition for user care, but these quasi-markets tend to offer the choices to the General Practitioner rather than the consumer.

Are there differences between mental health in these three countries? Esping-Andersen shows that different labels could describe the state policy of the three countries, while my own comparisons show the similarities between the three states, as regards those in control



of services. Looking at the consumer perspective: in Britain national differences are most influential with a high spending and decommidified welfare state, but not in Italy especially with the large independent input (such as Franco Basaglia). In Poland because of the state's confused policy position, diversity is the most important factor for the consumer, because it gives him or her some choice.

My own eleven point framework for comparison describes the impact of structures, these latter when compared are diverse and my model best brings out the nature of these structures in different states. The key variable of who controls services brings out different criteria from Esping-Andersen: with my model Britain, Italy and Poland all seem diversified in their dealings with mental health needs. Where the decommidification description fails - not taking account of the regional difference in southern Italy, the mixed sources of care in Britain and the nature of the state's relationship with the individual in a Poland of transition - a diversity model looks at these differences. However decommidification demonstrates other consumer needs, for example the consumer's relationship with the state in terms of benefits and housing, how much the consumer receives. The degree of diversification, describes how mental health care is received. Diversity points to the similarity of the states in mental health care despite the radical differences I expected before using my variables, while decommidification differentiates. Diversity deals not so much in terms of approach and values (for example normalisation) as in types of agencies.

Values are in the area of ideologies, the latter are influenced by diversification and as has been said with normalisation, affect the consumer. The relationship between ideology and delivery of services (which is what diversification is about), includes many issues: for example an injection can be a cure or an assault, benefits can help poverty or on medical advice prevent the recipient from finding work. A rights charter filled in by consumers would answer some of these questions. But individuals are not just affected by acts, but by attitudes and these ideologies like normalisation are very important. A nurse's attitude when giving out pills can mean the difference between degradation and generosity from the consumer's point of view, which he or she will sense in a variety of ways. These acts or attitudes are not just held by state workers, but by charity workers, police, housing managers and cleaning staff. In other words the whole community. In diversified community care the consumer will be af-



fectured by these forces. In Britain we can imagine the effect of media, public and voluntary and state officials, having a combined influence on a consumer. In Italy we must imagine a more "Latin Rim" or mediterranean society-especially with the difference between North and South. In Poland we may understand the disgrace he feels at being mentally ill, but not the economic position of having no job or status in a market economy out of control, such as in the Poland of transition today.

This diversity of care does not seem to be moving in the direction of the user, as I have defined their needs in the ten or so principles above. Is this the future for the consumer? To discover an answer I will have to review the present. Comparing the different countries we see the development of a Post-Fordist society: increasing homelessness in all three countries, employment for only the adaptable increasingly in Poland, Italy and Britain. The poverty of those without such abilities creating what looks like an underclass of the mentally ill. There is increasing stigma because psychiatrists as a professional group, do little to combat this sick role. Suicide is increasing and prisons are used for the mentally ill. These are the impacts diverse care has on the consumer, leading to falling through the social security net, and resultant homelessness and suicide. The dispersed consumers are difficult to find. The work ethic of Northern European countries is a further source of stigma for the unemployed mentally ill.

The underclass idea is reinforced by looking at the lack of power of the user: groups such as charities allow little democratic control, and it is hard for the user to influence them as I have found with Mind and the NSF in Britain. The influence of Franco Basaglia in Italy, NGOs in Poland (despite user groups the Hamlet Trust is run by a millionaire who sits on the central controlling board) look little different. The cost of mental health, as perceived by government elites with reports of rising levels of mental illness in a Post-Fordist society, makes it difficult for interest groups to obtain higher funding. There is also an ideological problem, where state care is seen as "socialist" and quasi-markets seen as following liberal market ideas.

What will quasi-markets bring? If continued in Poland: authoritarianism because they are not accountable. In Britain and Italy these ideas will bring subordination of consumers to une-



lected authorities. Polarisation of professions (such as psychiatric and nursing) will be caused by changing work practices due to the new competitive environment. There will be suffering due to outdated public opinion's effect on the consumer. The outlook for consumers in what is a changing political climate in these three countries is pessimistic - how can consumers, their families and friends attack a right-wing political climate, if in mental health it is undemocratic? Democracy and the protection of the state are out of fashion, polarisation of medical services and charity care, rather than community care, back in.



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