The Impact of the WHO on the German Mental Health Policy

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Bibliography
1. **Institutional Relationships between Germany and the WHO**

In our case study we explored the impact of WHO organizations and of main WHO documents like the Mental Health Action Plan for Europe (WHO EUR/04/5047810/7) on the national mental health policy in Germany. For this aim we carried out document analysis and conducted interviews with policy actors in the field of mental health. The interview partners are listed in the attachment.

Mental health policy – or partly: Psychiatry Policy is in Germany split between many actors. To understand the relationships between Germany and the WHO we first have to identify the responsibilities for mental health policy in Germany.

1.1 **Responsible Actors for the Framing of the Mental Health Policy in Germany**

Who are the key actors to structure mental health policy in Germany? As it will be shown, this question is not an easy one to answer, because all three levels of German policymaking are involved in the regulation of mental health: the federal state (Bund), the particular state (Länder; the English translation of the particular state level is not unambiguous, therefore we will keep the German term) and the community level in form of governmental districts and communities. This overlapping of responsibilities is derived from an in-between status of the topics mental health between the health care system in general, which is the responsibility of the federal state (Bund) and in-patient-care, which is the responsibility of the state (Länder) and the movement of the last years towards a community-psychiatry, which involves the communities. As our interviewees reported, this mixture of competencies leaves the question of the last competencies open. On the (Bundes-)state-level, no binding guide-lines can be issued, as the psychiatry-planning lies in the power of the (Länder)-states. The Länder develop so-called Länder-Psychiatry-Plans which, however, are not legally binding:

„And the Länder are watching what the subordinate regional corporations are doing, they themselves do nothing and they actually don’t want to do anything there. So this 3rd Bavarian Psychiatry-Plan came into being, which is more like a wish-list for christmas formulated in subjunctive - we would like, we wish and so on.‖ (I1: 215-219). The actual responsibilty for psychiatrical politics is always handed down level by level. As will

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1. Due to the question of anonymity, we will use numbers instead of the names of the interviewees; the second number shows the lines out of the cited interview.
be shown farther below, there is - in the perception of the actors involved - no uniform Psychiatry- or Mental Health Policy in Germany, and neither does there exist a possibility to create such a general and binding uniformity:

“Well, because there is no psychiatrical policy in that sense, at all. Neither is there a Mental Health Policy, which is why it’s so difficult. It is in no way detectable that something of that kind exists. To the contrary, it is all a meshwork made of all kinds of things, of arrangements. What are we doing now? And what now? - Somewhat like that. So, you won’t find anybody in Germany, in contrast to England or the USA, where you can identify centres, which are making downright Psychiatry-Politics. Something like that does not exist in Germany.” (I15: 108-115)

Out of the variety of actors involved, following central actors have a substantial impact on the co-organization of the German psychiatrical politicies:

- The Ministry of Health (Bund-level)
- Aktionsbündnis Seelische Gesundheit (League for Mental Health)
- Aktion Psychisch Kranke (Alliance for the Mentally Ill)
- Deutsche Gesellschaft für Psychiatrie und Psychotherapie (German Association for Psychiatry and Psychotherapy)
- Deutsche Gesellschaft für Sozialpsychiatrie (German Association for Social Psychiatry)
- Arbeitsgemeinschaft der obersten Landesgesundheitsbehörden AG Psychiatrie (Consortium of the highest Länder-Health-Agencies AG Psychiatry)
- Ministries of the Länder
- Governmental districts
- Communities

2 The Ministry of Health professionally and financially supports associations and expert panels whose aim it is to take part in the organization of psychiatrical politics in Germany.

3 The DGSP acted during the so called Psychiatry-Enquete in 1975 for the implementation of the aims and ideas of social psychiatry like small scale community care, integration of psychiatric patients in the society or de-stigmatization, while the DGPPN stands for a more traditional, more biologically explained psychiatric treatment. This bisection of associations is sustained till today and shows in a way the bisection of psychiatric ‘believes’ and frameworks.
1.2 Cooperation between the WHO and Germany

Institutional cooperation between Germany and the WHO are the following:

- The so called «National Counterpart» for Mental Health is nominated by the German government to cooperate with the WHO. It is the department 314 for Psychiatry, Neurology and Pediatrics at the Federal Ministry for Health.

- The German «National Collaboration Centers» for Mental Health are:
  - University of Munich, Department of Psychiatry, Chef Prof. Möller
  - Central Institute of Mental Health Mannheim (CIMH), Prof. Meyer-Lindenberg and Dr. Salize

Beside the institutionalised cooperation several German individual experts have active contacts to the WHO and take part in WHO working groups:

- Prof. Resch Universitätsklinik Heudelberg, Kinder u. Jugendpsychiater
- Prof. Remschmidt; Direktor em. der Klinik für Kinder- und Jugendpsychiatrie der Universität Marburg
- Prof. von Cranach WHO AG Stigma und Diskriminierung
- Prof. Cramer Hochschule München Master Mental Health

2. Contribution to the Production of the Helsinki Declaration and the Mental Health Action Plan

During the preparations for the WHO conference in Helsinki, the member-states were involved in various ways, as has been reported by actors participating at that time and by the WHO. Prior to the Helsinki-conference, the Network Mental Health had been founded by the WHO, consisting of representatives from every European state. The experts appointed by their respective governments were to build up the contact and exchange between the WHO and their states. Therefore, it was crucial to find people who owned the trust of their governments as well as that of the professional community. These experts were called the «National Counterparts», of which there existed 52 for the area of Mental Health. They met twice a year to prepare the Helsinki-conference. There were specific work-groups for the larger topics like stigma or violence in psychiatry. During the preparation-phase, the national governments had to issue reports concerning
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The present psychiatric situation in their country. WHO-experts conducted the observations and assessments of the situation in their respective country.

As prominent actors of WHO-Europe reported back then, the preparation-phase was an important means to raise awareness for the subject of Mental Health in Europe as well as to heighten the willingness for cooperation of the countries involved:

“So, this was a process that had been supported and also demanded by governments in Europe from the very beginning and to an ever-increasing degree. So there were no motivational problems during the preparation and implementation.” (I18: 118-121)

Looking back, motivation is considered as having been high from the perspective of the WHO. Yet, not all national actors share this view. To the contrary, the experts involved in the preparation and presented Germany during the Helsinki-conference unanimously criticise the low motivation on Germany’s part, beginning with the absence of the Minister of Health and her substitution through the secretary of state during the conference, which has been perceived by the experts as a sign of low interest in the cause:

„And the next day the discussion of the ressort-ministers took place. We all sat in the back and in the front there sat the 52 ministers or their substitutes and commented on the issue, every country, on how important it is to them to develop psychiatry-policy? And it is all of them, yes, I have made ticks everywhere. And I think, only two countries - Andorra and Germany, Germany was represented by secretary of state Theo Schröder because Ms.Minister couldn´t come. They have, when they where given the floor, they didn´t say anything, they didn´t have a statement. I found that totally disappointing, and I tried to tell that the secretary of state during lunch. And he said, that we had all this already, it had all been realized, and he didn´t need to be the 100th person to comment on that matter, yes.” (I21: 56-66)

When asked specifically, the WHO-actor involved back then can confirmed the partially lower engagement:

„On the other hand I have to say that especially the western-european countries behaved a little distanced in that matter. And those who were really interested also were the countries with the greatest problems, i.e. the eastern-european countries, which had these periods of transformation and restructuring, which had to go through all this social stress.” (I18: 321-326) In his perception, the social pressure had been particularly great in Eastern Europe so that these governments had to take on the psychological problems in their countries: the massive transformation processes of the 90s had caused huge tensions and conflicts, which found an expression also in a low general and mental health standard of the population. High violence-, suicide- and depression-rates increased pressure on the eastern-European governments to an amount that made it impossible to
ignore mental health problems in the population. This acute pressure had not been existent in Western Europe in the late 90ies. In Germany this happened a few decades earlier: the social turbulences of the 68s forced the nation to face the situation in its psychiatries and begin to work on the consequences of Nazi-Germany manifested in its mentally ill. Numerous media reports sensitised the public and raised attention for the sometimes inhumane circumstances in psychiatries. As a result, the federal government founded an expert-commission in the German Parliament in the summer of 1971, which entered the historical records as «Psychiatry-Enquete» (Sachverständigenkommission 1975). The expert-commission issued their interim report in 1973, in which it demanded instant measures for the rectification of the partially degrading and inhumane situations in psychiatric institutions. As will be shown later, this report initiated a number of reforms that are still being demanded nowadays by the WHO (e.g. communal psychiatry, integration etc.). German politics seem to be content with the reforms achieved at that time and frequently reject further initiatives with the comment, that “we already have all this, it has all been realized already” (I5: 442).

3. Impact and Reception of the Helsinki Declaration and Action Plan

The WHO-actors who were involved back then perceive the involvement of the member-states in the preparation of the Helsinki-conference as a facilitating factor for the following implementation of the declaration. The intensive preparation phase was to secure the later acceptance of the demands: „Well, what am I supposed to say, after we took this participatory approach, where actual national experts were asked and totally included in this work, there was no detectable motaviational lack in the different governments to implement the recommendations of the conference.“ (I18: 112-116) Yet, on closer inquiry, he admits: „I have to say the agenda was sometimes a little neglected.” (I18: 203) The active preparation did not suffice to guarantee implementation. Special constellations, like the presence of particularly invested actors on national or international terrain, can sometimes help to put the topic of Mental Health back on the map: “It is a little up and down.” (I18: 210) On the other hand, the topic Mental Health is to a high degree endangered by economic-financial fluctuations: “And fact is that, when money is short, then naturally the area Mental Health is one of the first to be cut down, where activities are getting limited.” (I18: 321-322) The potential saliency of the topic Mental Health – be it nationally, be it internationally – is subject to strong structural fluctuations and depends on the state´s and the Länder´s finances as well as on individual preferences of the leading personalities.

We could not identify concrete policy changes in Germany directly or indirectly caused by the Declaration or the Action Plan. To the contrary, leading experts repeatedly
complained in this context about the impossibility of doing exactly that, as there seems to exist no overall psychiatry or Mental Health policy in Germany:

„Any kind of Mental Health policy is absent. Whatever that might be. Umm - what´ s missing is a kind of - of umm - direction, at least concerning the area of provisioning, so the area of direct help. That is missing at all. Everybody is working for himself there. And you wont find any actors who can make any statements that are heard and perceived by others in this federal structure of Germany. So I suppose the doctors in Haar⁴ wont even know that there is anything like a competence of the European Union for health policy. That is totally unknown to them. They would say, it´s our competence.“ (I21: 312-319)

As one of our interviewees, a medical director of the largest clinic for psychiatry in Bavaria has put it:

“There exists no so called mental health policy in Germany. Not even a psychiatry policy. This field is just caught between two stools, between the Bund and the Länder... So in Bavaria, there are some ‘Guidelines’ for Psychiatry, but no consistent policy.” (I8: 98-101)

In the experts´ opinion, which is supported by our document analysis, the WHO and the Action Plan has no direct influence on psychiatry politics in Germany: „That has found next to no resonance in Germany, as the WHO isn´t present in Germany at all. In most countries where they go there´s a WHO-delegate and people know... and here there is an absolute disinterest and ignorance about what the WHO is doing. Even students of medicine don´ t know what the WHO is. And the same is showing when you visit the WHO in Geneva. I find the country the least represented among the members of the WHO in Geneva is Germany.“ (I2: 347-353) As a cause for the little impact of the WHO on Germany experts identify the federal structure of Germany, that renders an unambiguous competency for the organization of a Mental Health policy in Germany impossible, in addition to the reforms that took place in the 80s on the initiative of the «psychiatry Enquete», which make the present situation seem «satisfactory» and «not requiring further alterations».

Furthermore, there has to be made a distinction concerning on which level we are looking for effects of the WHO Action Plan or other similar papers, e.g. the EU Greenbook. On the level of policy-makers, the structural conditions explained above inhibit the potential impact of the papers. Apart from that, however, there is yet another level to be taken into consideration: the level of everyday practice by doctors or hospital-directors, that are referred to as ´street-level´-policy makers in our project. After all, all efforts and declarations of the WHO or the EU would find their most immediate impact on the single patient in their direct implementation by doctors or hospital-directors. Do they know the

⁴ One of the greatest psychiatric clinics in Bavaria, with over 1000 beds.
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work of the WHO or the EU? Do they apply their guide-lines? Although we obviously cannot make any global statements on that matter, we can convey an impression on this question. A leading person of one of the largest psychiatric research institutes in Germany tells us, that even he himself, formerly involved in the WHO, does not know the EU Greenbook:

„Well, I am - I -- am, you have noticed it already, critical towards the -- effects of such things. The Greenbook, I haven´t occupied myself with that. But in a way I have been active in the WHO in a consulting manner for a longer period of time. I do think that things like that get recognized. They go under in everyday business.“ (I7: 101-105) As all the experts interviewed confirmed without exception, active doctors, professors or students of medicine, but even directors of prominent scientific institutes cannot afford to invest time in the papers issued by the WHO additionally to their everyday tasks. Analogue, another psychiatrist expressed the relevance of then WHO in his everyday work as: «I tell you a little sadly, equal to nothing. I think that the topic is much to young to concern the professional basis apart maybe from diffuse worries. Much prejudice and fear come into play when it´s also about safety of your job etc., and in how far oneself can still determine the supply. Apart from that, I don´t notice much about that with my colleagues or in other institutions. It´s mainly unknown to them, too.” (I9: 265-271)

In this context, a frequent point for criticism is the absence of official obligatory trainings for further education of the doctors on this subject. In order to close this gap and to inform psychiatrists and other concerned professions about the international situation, the German Association for Social Psychiatry dedicated its yearly conference to that topic in 2007. It was their aim to inform about the Greenbook and other European efforts and to work against possible fears:

„...so, the EU issued this Greenbook, now, what does this mean? Often this was coupled to that service-guideline, about which everyone was worried, oh my gosh. If these projects in the Health area now all have to be advertised all over Europe and everybody can bid, then these frequently quoted `Polish low-pay workers´ will come and will offer supervised single accommodation. And our expensive German social workers will have the disadvantage. That was the fear.“ (I9: 211-217)

The topic of the annual conference directs our attention to an interesting aspect: present diffuse fears that emerge in the context of supra-national activities. On the one hand, it is about the potential influence by the EU on national politics – as we will see, the federal government officially rejects this – and, on the other hand, existential fears about impending loss of jobs and influence. The fear is that through international efforts jobs in Germany could be lost as low-pay work-force from eastern Europe moves up.
Not only the immediate policy-level, but also the discourse-level have to be differentiated from the ones named above. It is evident that certain studies, or better: statements derivable from the same, play a vital role in the discourses. In this sense, the statement that 27% of all EU-citizens suffer at least once in their life-time from mental disorders frequently shows up in the discourse. The number «27» is considered a self-explanatory indicator confirming the status that Mental Health should have in policy-making. Similarly, studies or single data delivered by the WHO are being used as arguments – often by NGO´s – to stress the importance of their cause, e.g. during negotiations with the government for the financing of a new project.

„When you file a motion nowadays and you say, we need a, whatever, a work project, an accommodation project, a counselling service, that´s were it is in. And there is also, you know, I know it because in all areas, not only in the daytime-structuring- but also in the living- and counselling-area, the gerontology-area is pretty salient right now, and there the WHO is quoted again when in the end a concept or an institution is planned to be requested for a district. (I9: 298-304)

The governmental side also leans in their arguments on ´evidences´ delivered by the WHO:

„That actually is my job, at that gateway between the executive and politics – making that evidence based. That is exaggerated, that is simply not possible in every area. But we want as good as possible a scientific foundation. And that is why we ourselves have a little budget for research-endeavours, where we can prepare and support our own things. Therefore, we are working very closely together with numerous scientific institutions and scientists as single persons. And we naturally base our judgement on statements by relevant institutions and expert-boards. And the WHO is a substantial part of this.” (I16: 87-94)

The federal government´s official position on supranational efforts finds its most recent expression in the government´s statement on the EU-Greenbook (BMG 2006). The Greenbook´s history and the failed attempt to turn it into a whitebook show that many national states are defending themselves against the interference of the EU or other supranational organisations in their national politics. It becomes immediately evident from the federal government´s statement on the Greenbook that Germany wants to prevent any interference with its national Health policy. Although the federal government in principle welcomes any efforts to raise the awareness for the topic of Mental Health, already the second paragraph refers to the competency of the national states to structure their Health politics and the EU´s role as merely consulting: „There should be no predefinition for the implementation of new – and in certain MS only with disproportional high costs researchable – indicators resulting from consultations on a «European
strategy», which eventually enable the Commission to exact an influence on national politics exceeding its competencies in the Health area as they have been defined in EU constitution law. “(BMG 2006: 1) Even the implementation of new research methods is rejected with reference to «disproportional high costs». Of course, the German federal government agrees with the EU on the point that the mental health of the population is vital not only for the thriving of the single individual, but also for the realisation of the EU´s strategic goals, e.g. long-term prosperity, solidarity and social equity.

The federal government´s statement on the Greenbook refers to the Action Plan ratified in Helsinki in 2005, which lays out a far-reaching frame for effective action and intermediate goals that the member states should move towards in the coming 5 to 10 years". (BMG 2006: 2). As the Action Plan already directs the strategies for the next 10 years, no other compulsory measures on the EU´s part would be necessary. In addition, the statement emphasises that Germany has de-institutionalised the greatest part of its psychiatric provision since the so called «Psychiatry Enquete» in 1975.

In spite of the reservations and the stress on sovereignty in health-policy matters, the federal government approves the common activities promoting the exchange of knowledge and experience in the areas of Prevention and Health Advancement, Quality of Life, Social Integration and the Fight against Stigmatisation. The «gateway between science and politics», whose institutionalisation is suggested in the Greenbook, is looked upon critically by the federal government, however: „Institutional integration, composition, competencies and financing of such an institution are to be analyzed critically with a focus on the maintenance of lean structures and the avoidance of disproportionate bureaucratisation." (BMG 2006: 6) Also, the federal government perceives the competencies and tasks of such an institution as unclear and fears competency-conflicts. It would have to be checked beforehand what weight the scientific `input´ should have. The «additional bureaucratisation, e.g through the establishment of a standardised reporting system is being rejected “ (BMG 2006: 7)

4. Analytic Discussion

The topic Psychiatry is in Germany historically a difficult subject. At the beginning of the 20th century, already before the actual Nazi-period, there were considerations in the spirit of eugenics on how one could allocate the resources in the Health system to those who were really `worth´ it. Some physicians, lawyers or anthropologists like Alfred Hoche, Karl Binding or Fritz Lenz called the mentally or chronically ill «ballast-existences», that weren´t considered worthy of procreating or even living. This thought was pursued and expanded by science and politics alike and hand-in-hand. Already in 1934, one of the earliest Nazi-laws, which had to a great part been drafted by the physician and psychiatrist Ernst Rüdin, department chief of the Research Institute for
Psychiatry, and Eugen Fischer, director of the University of Berlin, ordered compulsory sterilisation of the mentally ill. (Kühl 1997).

This negative influence of science and its cooperation with the evil is still a lasting memory in the German mind and leads to reservation when it comes to the co-operation of science and politics: «Well, the influence of science on Health politics is documented pretty well in this historic examples, I think. And this support exists, back then in a negative way. It doesn´t exist anymore in a good way, at least to that extent, as politics don´t have long-term goals anymore." (I11: 178-182)

It was not until the movement of 1968 that the atrocities by the Nazis against mentally ill people were brought to public discussion. By 1970, the German Physicians´ Conference (Deutscher Ärztetag) worked for the first time in his history on the psychiatric provisioning of the population. At the beginning of the 1970s, the Alliance for the Mentally Ill (Aktion Psychisch Kranke) and the German Association for Social Psychiatry (Deutsche Gesellschaft für Sozialpsychiatrie) were founded as an expression of the heightened awareness for the psychiatric situation. In 1971, the expert-commission “psychiatry enquete” of about 200 members was constituted at the Bundestag, whose leadership was transferred to the Alliance for the Mentally Ill. In their interim-report of 1973 and the final report from 1975, the commission pointed out several shortages in the provisioning and demanded the rectification of the sometimes undignified situations in the larger psychiatric institutions. The commission demanded following substantial reformations of the psychiatric provision in Germany: restructuring of the larger psychiatric hospitals, the integration of psychiatric departments into other hospitals, the development of close-to-home provisioning, the assistance to counselling services and support groups, the equivalence of somatic and mental illness, and the support of education and further training (Deutscher Bundestag 1975). This short list shows the affinities to the principles of the WHO action plan.

Around the 30th anniversary of the «Psychiatry Enquete», elements of the federal government as well as other organisations, e.g. the German Association for Psychiatry and Psychotherapy (Deutsche Gesellschaft für Psychiatrie und Psychotherapie), conducted researches and issued reports on the developments during the past 25 years (Arbeitsgruppe Psychiatrie der Obersten Landesgesundheitsbehörden 2003, 2007, Stellungnahme der Deutschen Gesellschaft für Psychiatrie, Psychotherapie und Nervenheilkunde 2008). As will be shown later, most reports come to the conclusion that on the whole the demands of the Enquete from 1975 have been fulfilled. This is supposedly the reason for Germany´s reservation against an engagement in new reforms.

On the other hand, the expression `Mental Health´ does not seem to be very common in Germany, yet. In the documents analysed the expression is rarely used and most
interviews began with the counter-question about what exactly we might mean by Mental Health:

“I don’t know what you want to say by Mental Health? It’s only a non-translatable expression. It’s a working-title like in -- yes, in the American slang, one would say, Mental Health would be some umbrella term for all kinds of things, psychiatry, social work in Mental Health, nursing in Mental Health, and so on. In the British use of the word it tends more toward the meaning of social- and community-psychiatry. And in the German it’s -- many believe, I think, they believe that is psychiatry. So, the term is used quite diversely.” (I5: 37-44) As the quotation shows, even the notion of ‘mental health’ rose concerns in the interviews. One of the first questions – not from our side, but from the interviewees – was: “What do you exactly mean by ‘mental health’?” It seems that it would be more correct to speak about psychiatry-policy than about mental health in Germany. “There is none. There is no Mental Health policy in the sense of a master plan that could help us, a psychiatric - a kind of early diagnosis.” (I7: 328-333)

The interview-partners mainly understand the difference between `Mental Health` and `Psychiatry` as an emphasis on positive concepts of health – and in this sense prevention – instead of negative ideas of illness: “The WHO has taken a sharp turn away from Psychiatry-concepts and towards Mental Health-concepts since the end of the 90s. That is connected to Dr. Saraceno taking up the direction of the psychiatric department in Geneva. And Mental Health is something completely different from Psychiatry, it has totally different aspects, that is prevention, for example, the overall health of the population, not just the treatment of diseases, which is the psychiatric way. And Saraceno is from Italy. Italy is one of the leading countries in the Psychiatry-reform, with all the problems they had. Because, in the 70s, there was this huge Psychiatry-reform in Europe, which you could call `from Psychiatry to Mental Health´. Dr. Saraceno imported this thought into the WHO back then, and he succeeded with it.” (I13: 167-177) In the following part, we will concentrate on some substantial points in the Mental Health Action Plan and will investigate the status of their realisation in Germany. We have seen in the analysis above, that there have been no major changes in psychiatry policy due to the Mental Health Action plan. But now let us take a look to the contents of the Action Plan: are its ideas realised in Germany?

4.1. **Key Ideas of the Mental Health Action Plan:**

**De-Institutionalisation, Community Based Treatment**

The intended all-encompassing close-to-home provision and their networking with other suppliers was an explicit goal of the federal psychiatry policy in the last 25 years – to this result comes the Inventory on the Developments in Psychiatry in the last 25 Years (Bestandsaufnahme zu den Entwicklungen der Psychiatrie in den letzten 25 Jahren) of
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The Consortium of the highest Länder-Health-Agencies AG Psychiatry (Arbeitsgruppe Psychiatrie 2003). The «Psychiatrie-Enquete» of 1975 (Deutscher Bundestag 1975) pointed out that geographically manageable Provision-areas of 150'000 to 350'000 inhabitants are to be defined as a foundation of psychiatric provisioning oriented towards close-to-home service. The inventory of 2003 confirms that in all Länders this request has been met and the provision-areas have been defined in according size (Arbeitsgruppe Psychiatrie 2003). Also in the sense of the requests issued, the number of beds in psychiatric hospitals has been reduced by about 50% since the 80s (Arbeitsgruppe Psychiatrie 2003). While in 1980 in the old Länder there were 839 local inhabitants per bed in a psychiatrical hospital, by the year 2000 it was an average of 1304 in all of the Länder. (s. Arbeitsgruppe Psychiatrie 2003: 25). Yet, the number of vacancies in day-clinics increased from about 2600 in 1990 to 8400 in 2000. Apart from walk-in clinics at psychiatric hospitals and since the year 2000 also in general hospitals with psychiatric departments, the close-to-home provisioning is coordinated by the so-called socialpsychiatric services (Sozialpsychiatrischer Dienst). These services provide advice in a pro-active manner for people concerned and their relatives, initiate psychiatric support and care for the chronically ill.

Walk-in clinics, social psychiatric services, day-clinics, day-structuring offers and supervised accommodation are not financed by the health insurers, but by local and supra-local providers of social welfare and partially even through voluntary contributions by the communities and the Länder. When the money is short, these structures are especially at risk from budget cuts. Unfortunately, it could not be achieved to include the health insurance companies in the close-to-home provisioning and to make them re-invest back into the provisioning of mentally ill persons at least some of the profit they made through cutting down the bed-number and the length of stays in the larger institutions.

The psychiatric clinic in Haar, a suburb of Munich, is one of the largest Clinics on this area nation-wide. Exactly these institutions were to be reduced and replaced with walk-in clinics and the integration into general hospitals. Although the number of beds has been reduced by more than half, it is still at about 1200. In the interviews with the responsible doctors in Haar, they described the little impact of the WHO´s ideas and seemed to be in favour a more or less traditional kind of Psychiatry. Although the visitor to Haar does not notice at first glance, as the gigantic area with its vast number of buildings persists unchanged, many reform ideas do have reached Haar and change is taking place. The situation is described by the respective ministry as follows:

„In the middle of the 80s, I worked as an intern at the district-hospital Haar, as it was called back then. It was still a hospital with 2800 beds, 2800 beds. I believe, nowadays they are down to 1100 and the number is falling. In this respect, Psychiatry has changed enormously. This is an enormous achievement. We have far more psychiatric units at
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general hospitals now. This promotes acceptance. And I believe, this is a just and important way, which has to be pursued further on." (I14: 265-271)

The so called Atrium-House in Haar is one of the projects where the attempt is made to break open the petrified structures of a great psychiatric institution: „And where one can, how should I put it, home-like, in a cosy atmosphere, one can try to treat these episodes of illness without having to institutionalise these people right away. A psychiatrist has been employed not long ago in order to help Haar with the process of reducing bed-numbers and de-centralisation and then to build up team-psychiatry, too, and also to organize the close-to-home provision. So you can see, things are moving, even in Haar. And I mean, you´re right, Haar is one of the big - also negative examples for a gigantic institution. And - well, at least one does try." (I13: 107-113)

4.2. Prevention and the Concept of Mental Well-Being instead of Illness

Unfortunately, the concept of prevention in the area of mental health seems to play a subordinate role in Germany. Both, the Ministry of Health of the Bund (Bundesministerium für Gesundheit) and of the Land Bavaria (Bayrisches Staatsministerium für Umwelt und Gesundheit) are sponsoring projects that focus on children and the youth to strengthen their personal competencies and to thus prevent mental problems. However, what is missing is a larger, nation-wide campaign on the topic of prevention or a long-term strategy – a lack even recognised by the Ministry of Health. The so called «Prevention-Law» could have contributed to close this gap, though it would have obligated the health insurances and the retirement insurances to finance disease prevention. Sadly, the coalition parties could until this day not come to an agreement, although the «Prevention-Law» is fixed in the coalition contract.

A the former WHO-officer told us, prevention measures are the first to be cut short massively in times of economic fluctuations, as we are facing on a global scale at the moment. This is exactly the misconception – to take potential long-term losses into account to achieve short-term savings – that the WHO is trying to counter: He told us that the WHO „...tries to spread the message that in the end no state can afford not to invest in its population´s mental health. There was always the tendency to say, okay, we don´t have enough money. And first of all we have to support the immediate treatment of diseases, and so forth. And as long as we can´t do this, we have no money to support the promotion of mental health. And this, of course, is a misconception." (I13: 221-226)

Indeed, in the discourses the financial arguments are the most compelling. As the quotation also shows, the financial efforts are – depending on the aim of the argumentation – brought up as a negative or a positive factor. Alternatively, it serves to prove the necessity of saving or the necessity to invest. In the following quotation, the
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fraction of the gross national product used up annually for the treatment of mental diseases serving as an argument in favour of expanding prevention measures:

„And then they came with their accountant-statistics by Wittchen – this compendium, a very conventional approach. But these 3 to 4% of the Gross National Product were always central. And that worked – that argument. And the rest was, well, it wasn´t that important how the rest was justified. And of course you can, if you – they did realize that, if you expand provision now - - and here in Munich it is, well, Munich is totally over-supplied, so that won’t work, just to expand the services. That would work like a vacuum-cleaner, it would just suck even more patients to Munich. So, prevention is the only thing that´s left. But, excuse me, what is prevention? Or what is the promotion of health? These are just metaphors, you - pheew -...“ (I4: 117-126)

Just as the expression Mental Health has not yet entered into common German language, neither has the positively defined concept of Mental-Well-Being. Evidently, a lot has changed in the traditional understanding of psychiatry, especially since the «Psychiatry-Enquete», but our interview-partners as well as the documents we analyzed start out at the assumption of mental diseases and possible ways of their treatment, instead of a concept of general Mental-Well-Being. Our last quotation by one of the founders of the degree programme „Mental Health´ at the Munich College elucidates the problems connected with a positive definition of Mental Health. The negative definition – absence of illness – is comparably easy to deliver; but a positive concept of Mental-Well-Being is for the policy-maker not easy to realise, except if understood as prevention. What does seem possible is mostly a mixed array of programmes and projects, which approximate in their variety that of the terminology mental health (s. Chapter 4.6).

4.3. De-Stigmatisation

The German Association for Psychiatry and Psychotherapy (Deutsche Gesellschaft für Psychiatrie und Psychotherapie) states in their report from 2008 that it has not been achieved up to this day to abolish the stigmatization of the mentally ill in Germany (Stellungnahme DGPPN 2008). Although there have been numerous initiatives and campaigns against this form of stigmatization, which have been mostly initialised by NGO´s, as also the report by the WHO asserted (WHO Mental Health 2008). Here, BASTA in Bavaria and Open The Doors in Düsseldorf are named as especially successful programmes, whose results have been scientifically evaluated. Nation-wide publicly financed anti-stigma campaigns are still missing. Ministries of the Bund, public organizations and ministries of the Länder are sponsoring a multitude of campaigns. An important legal change (Sozialgesetzbuch IX) has been made to obligate employers to internal rehabilitation of their members, even in the cases of mental illness.
As a cause for the stigmatization of mentally ill, most of our interview-partners see a lack of information and the fears stemming therefrom and from eventual peculiar behaviour in public: „These fears are simply fear and ignorance that this is just the surface. It it has gotten better in the last 10 years, but prejudice is still there. – Very strong ones.” (I22: 276-278). The solution to the problem of prejudice and stigma is often hoped for in information and education – as, when the population knows that mentally ill people are no danger to them even if they behave peculiarly, then the prejudice will decrease. Especially in this context, the people interviewed deemed the tendencies of the media very dangerous to excuse the acts of delinquents with their alleged mental illness, as that has the suspicion fall back on the non-violent majority of mentally ill people: „For example, sexual harassers or something like that, well, the media say that they are mentally ill. And that the people who are actually mentally ill are suffering from this, are practically being stigmatized, because there are people, who - uhhm - who are in my opinion – less mentally ill, but just have know socially adapted behaviour.” (I21: 137-140) In this context, many committed people complain about their efforts being made useless by the yellow press. The time- and cost-intensive anti-stigma programmes and campaigns seem to reach far less people than an outrageous scandal in a yellow press article, that puts delinquents and the mentally ill on the same level: „Then I really ask myself, why am I working at educating the public, trying hard to give society a realistic impression of the mentally ill, if a single person can destroy this with one article and make mentally ill people look bad to the public. And I am sure that many people attach great importance to just one such article, because they more likely read it – than anything else published on this topic.” (I22: 312-318)

An effect of the stigmatization – apart from disadvantages on the job-market or exclusion from social life – is a dread to openly admit to mental problems, as long as one can hide them: „That is a problem of stigmatization. People almost brag their allergies. That is almost chic. But there are the greatest reservations to say that maybe one is depressive or has some other mental disorder.” (I 17: 104-107)

### 4.4. Social Integration

By the paragraph against discrimination of disabled persons in the constitution (Benachteiligungsverbot behinderter Menschen im Grundgesetz; Artikel 3) and the law for equalization of disabled and non-disabled people (Behindertengleichstellungsgesetz von 2002) derived from it, there is a guarantee for participation, equal rights and autonomy also for mentally ill people. Also the aspect of equalisation supports the abolishment of psychiatric ‘bed-warehouses’ with several hundreds to thousands beds and situated remote from familiar surroundings, friends and family, as here there can not be spoken of autonomous living in familiar surroundings.
Integration was also supposed to mean integration in the first segment of the job-market. For this reason, in 2004 employers were obligated to care for early intervention and rehabilitation in the sense of an internal integration management (Abs. 2 Sozialgesetzbuch IX). The DGPPN, however, identifies deficits in this respect (Stellungnahme DGPPN 2008, Arbeitsgemeinschaft der Obersten Landesgesundheitsbehörden 2007). „The principle of rehabilitation instead of retirement is definitely not realised with the mentally ill. The great number of invalidity pensioners because of mental disorders is hinting at this problem.“ (Stellungnahme DGPPN: S. 5) Therapy and rehabilitation should be organized according to every-day life to allow the affected to re-engage in normal every-day routines as quickly as possible and to sustain or to re-establish their ability to work. Life-oriented walk-in services are preferable to stationary-institutional solutions.

4.5. User-Movement, Information

The «Psychiatry Enquete» of 1975 (Sachverständigenkommission 1975) demanded a stronger inclusion of organizations of people affected (of ‘users’ of psychiatry) and of their relatives in the psychiatric care and provisional system. Such organizations can do valuable work by informing of the public, and thus the abolishment of stigmatization, as well as by collaboration with the committees organizing Psychiatry in Germany. The Consortium of the highest Länder-Health-Agencies AG Psychiatry (Arbeitsgruppe Psychiatrie der obersten Landesgesundheitsbehörden) finds that organizations of people affected with mental illness as well as those of their relatives have firmly established among the national suppliers since the 1990s (Arbeitsgruppe Psychiatrie 2003). An indicator of that was the fact that in practically all Länders associations have been founded by people directly affected by mental illness as well as by their relatives, which are financially supported by the Länders and are represented in the Länder´s psychiatry committees.

The lingo of the caring services – e.g. nurses or social workers – reflects a change in the attitude towards mentally ill people and the spreading of the user-movement. They deliberately speak of ‘clients’ who receive a service, not of patients. The latter expression they often explicitly reject during the interviews: „To me, they are no patients anymore, because they are just released. And they are not acutely ill at the moment. And the word - customers, that is - that´s a little to superficial for my taste. Because a customer comes around, buys something and leaves again. Umm, while a client, I think, is someone who is accompanied for a longer time or cared for and who gets more of a service - so, not a good, but a service.“ (I14: 78-84) Rejecting the expression ‘patient’ means also a rejection of the strongly negative approach to mental illness. In this sense, not a possible deficit of the mentally ‘ill´ is emphasised, but their simply being different. It is stressed that even somebody hearing voices or acting strangely in public does not
have to be ill and can lead a normal life - although he or she might need help with doing that.

The organizations of people affected or those of their relatives are contributing in the planning of Psychiatry as well as in informing of the public and thus the reduction of prejudice against the mentally ill. Not only the campaigns and programmes that are launched by these organisations play an important role, but also their function as multiplicators – because a dedicated member has no little impact on his or her personal surroundings, where it spreads: „Information and Research. The more we understand, the more we can spread this knowledge, the more we can inform and make sure through education that this knowledge is understood, there more it will become common-sense, I believe. So, I think this has shown in all areas in history, one always has to try and provide knowledge. Knowledge prevents prejudice. Knowledge also prevents taboos and, hopefully soon, it also prevents stigmatization of mental illnesses.“ (I12: 136-242)

Some of the people interviewed do not see the connection between information and de-stigmatization as being that linear. They express their scepticism, if education can actually end prejudice – as prejudices are by definition unfounded, predefined value-statements that defy every attempt of deconstruction. So educational campaigns serve also to salve one´s conscience with the thought to have done something: “Education is helping like antibiotics are helping with a viral infection, the flu. Of course, they do not help, but it´s soothing the nerves.“ (I18: 321-324) Also those who are a little less sceptic towards attempts of education do not consider the lack of information as the general cause for stigmatization of mentally ill people, because there is enough information out there to make up one´s own mind about mental illness. It is more about disinterest in education, respectively the greater interest in scandalous headlines than in rational-educational information: „I am actually not sure, if people really want to know that? Maybe they don´t want to read about it. My impression is they are more interested in the negative, these headlines, this - oh, something´s happened and so on. I don´t know, there are enough offers to get this information.“ (I19: 154-158)

### 4.6. Projects

Mental Health Policy, in the sense of Education, Prevention and the emphasis on Mental Health instead of disease is in principle organized in project-form, as no over-regional nation-wide competency exists. Projects are therefor launched by all kinds of actors on all levels of social life. The federal government, too, has to resort to the bidding, organisation and (co-)financing of projects, if it wants to perform as policy-maker. On the one hand, this part of Mental Health-policy seems fragmented and, thus, barely organized, on the other hand, it is exactly in that way that grass-roots movements originating from the basis can be supported. The policy-makers emphasise these
advantages and stress that a structuring of the projects `from above´ would not be possible at all: „You always have to see, you can´t decree health, can´t make it top-down. You have to chose a bottom-up approach. You need the acceptance, that´s why you have to adopt and support various approaches that are existing. And that is why there´s such a colourful variety of the most different projects.” (I18: 218-222)

Examples for larger and/or important initiatives, programmes and projects:

- „Gesundheitsziele.de“ initiated by the Federal Ministry of Health
- German Network for Mental Health
- Open the Doors, BASTA
- Tiger Kids,
- ALF
- «Mit mir nicht»
- Kompetenznetz Depression

Summarizingly, it can be said about German Mental Health Policy that with the «Psychiatry Enquete» a major reform movement was initiated, which already back then

5 www.gesundheitsziele.de, one of the main Health-Goals in Germany is dedicated to the topic of depression («Depression – verhindern, erkennen, behandeln»).
6 http://www.gnmh.de/home.html, a wider-reaching initiative for Mental Health, supported by the Federal Ministry of Health.
7 http://openthedoors.de/de/, a nation-wide initiative for the de-stigmatization of the mentally ill.
8 http://www.stmug.bayern.de/suche/index.htm?q=tiger%20kids; although the project basically serves the interest of physical education and nutrition of kindergarteners, it was also named by the Bavarian Ministry of Health as an example for mental prevention.
9 ALF is a project to communicate common life-skills to school-children. http://www.ift.de/index.php?id=208&0=
10 http://www.stmuk.bayern.de/imperia/md/content/pdf/umwelt-gesundheit/mitmirnicht_06.pdf, project for the prevention of addiction and violence and for the strengthening of the personalities of school-children.
was trying to establish many ideas still present in the WHO today: „What the WHO said 20, 30 years ago, that this is somehow brought into reality sometime soon... Yes, just this holistic thing, you know. The human being isn´t - -a small part, but consists of many parts. Man is not just a part of his sum, it´s a whole individual. And the WHO said already back then in their guide-lines, respect human beings, appreciate their abilities, their dignity is untouchable. All these things were spread already 20 years ago and, thank god, have gotten through, finally.” (I11: 190-197). Unfortunately, many policy-making actors seem a little too content with the results of the reforms initiated back in the days. This can fortunately, if only partially, be counteracted by a devoted NGO-movement.
Attachment

List of interviewees

Interviews have been conducted in the following institutions – altogether 25:

- Bundesministerium für Gesundheit – German Ministry for Health
- Bayerisches Staatsministerium für Umwelt und Gesundheit – Bavarian Ministry for Environment and Health
- Thüringer Ministerium für Soziales, Familie und Gesundheit – Thuringian Ministry for Social Affairs, Family and Health
- WHO Europe
- Aktionsbündnis Seelische Gesundheit – League for Mental Health
- Aktion Psychisch Kranke – Alliance for the Mentally Ill
- Deutsche Gesellschaft für Psychiatrie und Psychotherapie – German Association for Psychiatry and Psychotherapy
- Deutsche Gesellschaft für Sozialpsychiatrie – German Association for Social Psychiatry
- Psychotherapeutenkammer Bayern – Chamber for Psychotherapy
- Zentralinstitut für Seelische Gesundheit – Central Institute for Mental Health
- Bündnis gegen Depression – Alliance against Depression
- Max-Planck-Institut für Psychiatrie – Max Planck Institute for Psychiatry
- Hochschule München – Munich College, Department for Mental Health
- Isar-Amper Kliniken – Clinic for Psychiatry München-Ost
- BASTA – Open the Doors
- Bezirkskrankenhaus Günzburg – Regional Hospital of Günzburg
- Ariadne Hilfverein für seelisch Kranke – Supporting Association for the Mentally Ill
- Münchner Psychiatrieerfahrene – Munich User of Psychiatry
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