2000-01-01

Mental Health Care Policies and Services in Switzerland

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Abstract

This article summarises the recent development of Swiss mental health policies and services. The last three decades have been characterised by a strong emphasis on the socio psychiatric approach Bachmann, 1995; Ciompi, 1997, 1994,1987a, 1987b). The establishment of a decentralised, patient and community focused mental health care network, integrating different therapeutic methods under a uniform administration is the base concept of the emerging movement (Ernst, 1998;Bachmann, 1995,Ciompi, 1994, 1987b). Achievements and problems of mental health care provision are outlined. A more proactive role for mental health care professionals in policy is proposed to contribute to the solution of present injustices.

The situation in Switzerland can, however, be considered to correspond to that in a range of other countries. Since the Swiss mental health care system has been strongly influenced by international developments it might be seen to "portray" Europe on a small scale (Ciompi, 1994; 1987b). Not only in Europe but in all industrialised countries experts presently perceive difficulties in mental health care delivery in an astonishingly similar way (Ernst, 1998). Globally the similarity of mental health needs appears to be much greater than is the case for

physical health. The delivery of mental health care might thus be considered as a world-wide issue requiring an international response (Ernst, 1998).

Introduction

Switzerland, a country in central Europe with little over seven million inhabitants, is a federal state subdivided into twenty-six cantons (USTAT, 1997). There are four official national languages. The management of public health issues is mainly the responsibility of the individual cantons (Brunnschweiler, 1998;Diener, 1998;Ciompi, 1987a;Ciompi, 1987b). As a result of this division there are notable differences regarding the organisation and the quality of health care provision between the cantons; further there exists no federal centre for documentation and statistics in the health care field (Ciompi, 1987a; Ciompi, 1987b).

It is quite difficult to find credible general information on Swiss mental health policy and services. The author therefore surveyed experts in the field about existing comparative studies between the cantons; also librarians of several cantonal documentation centres proved to be a good source of information. A computer database on CD-ROM (Medline 1996-1998) was used to get access to relevant information. The result of these searches is summarised narratively.

Epidemiological data

At present there is no complete national epidemiological data on the morbidity of mental illness in the Swiss population. There is, however, some empirical work on a some of the cantons

e.g.Basel, Zürich. Ernst (1998) points out that the averages obtained in these studies correspond with reliable international data: thus around 25% of the adult population suffer, within a calendar year, a subjective and social relevant disturbance in mental health. Recent comparative global studies show this proportion of morbidity, as well as symptoms, and prognosis, to be uniform in all cultures and over time, despite significant differences between customs and degree of industrialisation (Ernst, 1998). An exception to this "principle of constancy" is the recent increase in substance abuse in Switzerland and other industrialised countries (Ernst, 1998). The number of persons making regular use of illicit drugs in Switzerland was recently estimated at 30'000 (Estermann et al.1996) (Cited by Ernst, 1998).

People with mental health disorders risk major destruction of their family and social relationships and hence insulation and discrimination within society. As a consequence mental health suffering remains misunderstood, hidden, and untreated in Switzerland (Ernst, 1998; 1990). With a view to the outlined peculiarity of mental health disturbances it is not astonishing that from the onset of public mental health care in Switzerland, treatments for mentally ill people differed and still differ from those for physically ill (Ernst, 1998). In the following sections past and more recent developments of Swiss mental health policy and services are summarised.

Development of Swiss mental health policy and services
In the eighteenth and nineteenth centuries special institutions for the mentally ill were established. In contrast to general public hospitals, mental health clinics were built distant from Swiss metropolitan areas "in the healthy countryside air" (Ernst, 1998). In these clinics patients did not recover but were often "banished" there for years in inhuman conditions (Ernst, 1998;Müller, 1997;Ernst, 1990).

The invention of neuroleptics in the middle of this century brought about a change in this unsatisfactory situation (Ernst, 1998;Müller, 1997;Ernst, 1990). The introduction of the new drugs caused a strong decrease in the average hospitalisation time. These drugs further allowed a major interaction of therapists and patients even during severe crisis (Ernst, 1998; Müller, 1997). The way towards a community focused, ambulatory mental health care provision and thus the abolition of the "monstrous" clinics seemed to be open (Ernst, 1998;Messerli-Rohrbach et al.1997; Ernst, 1990).

A strong social psychiatric movement in the sixties and seventies enhanced reform in this direction (Messerli-Rohrbach et al.1997). The extreme wings of social psychiatry at that time tended to be quite "anti-psychiatric" and anti-scientific (Ciompi, 1994). Under the slogan "liberty cures" the closure of psychiatric clinics was promoted as solution for mental illness (Ernst, 1998). More moderate circles had, however, a less radical view of what community focused care should be like. Their intention was, "to understand and treat psychiatric disturbances in close relation with their social environment". (Ciompi, 1994:p.7).

To achieve this, the foundation of new decentralised services was planned, in order to fill the gap between the traditional psychiatric clinic and the usual practice of private psychiatrists (Ciompi, 1994). A complementary network of small stationary,

ambulatorial, and halfway facilities should be created. The intention of these services was to specifically integrate the family-, work and housing spheres of a person with mental illness into therapy (Ciompi, 1994). A main objective was to reduce long hospitalisation periods far away from home, family, friends and work in order to enhance rehabilitation and hence reduce chronification and costs (Bachmann, 1995; Ernst, 1990). The socio psychiatric approach differs clearly from the individual psychodynamic and psychoanalytic one. The latter mainly tried to cure mental health problems by understanding and treating the subjective experiences of the single person; also it distinguished itself from biological psychiatry, which attempts to achieve the same through neurobiological elements of feeling and thinking (Ciompi, 1994). Despite these differences, less radical leaders of the social psychiatry campaign tried to avoid a dispersion of mental health care into the various ideologies: they recognised that only an integrative psycho-socio biological model could cope with the enormous complexity of mental illness (Ciompi, 1994).

Thus the establishment of a decentralised, patient and community focused mental health care network, integrating different therapeutic approaches, is the base concept of the emerging Swiss socio psychiatric movement. In order to enhance co-ordination, continuity and efficiency of such a complex multidisciplinary union of services, forms of organisation other than the traditional institution were required (Ciompi, 1987b). The French model of sectorization was adopted in which all mental health services in a geographically clearly defined area and population came under a uniform administration (Ernst, 1998; Bachmann, 1995;Ciompi, 1994).

What has been achieved?
The last three decades of mental health care in Switzerland have been characterised by a strong emphasis on the socio psychiatric approach (Bachmann, 1995; Ciompi, 1997,1994,1987a, 1987b). In a majority of the cantons a wide range of innovative, decentralised mental health care facilities and therapeutic-rehabilitative methods have been developed (Ciompi, 1997;Bachmann, 1995;Ciompi, 1994;Ernst, 1990;Ciompi, 1987b).

About half of all cantons have introduced sectorization (Bachmann, 1995;Ciompi, 1987a, 1987b). In several cantons this process is at present in progress (see Diener, 1998; Hell, 1998;Ciompi, 1997). According to Ciompi (1987a) and Ernst (1998) various factors have enhanced sectorization and the therapeutic pluralism of the present mental health care system: the federal structure of the country favours the introduction of uniform administration for geographically clearly defined areas and populations. Further, the coexistence of various methods and systems was facilitated by the lack of "artificial barriers" between psychiatry and psychotherapy. Also the linguistic and cultural pluralism of Switzerland facilitated the exchange of ideas with neighbouring countries. Last but not least the whole process was aided by the advantageous economic situation of the country.

The Swiss mental health care system and its services have made significant steps forward during the last decades. In fact the innovative organisational and ideological changes have had noteworthy positive effects on the patient population. Increasingly mentally ill persons can now be treated outside the

traditional psychiatric clinics thanks to the new local socio-psychiatric facilities (Ernst, 1998;Ciompi, 1987b).

The autonomy and quality of life of many persons with mental health problems and of their families have thus notably improved (Ernst, 1998;Ciompi, 1987b). There is empirical evidence of the positive effect which the community focused approach can have especially regarding social rehabilitation chances and dereliction prophylaxis in the long-term mentally ill (Heitiger and Saameli, 1995;Goldberg, 1991,Cited by Ernst, 1998),). Some evaluation studies showed that the treatment of mental health disturbances in socio-psychiatric services could be less expensive than the one in the traditional psychiatric clinics (Ciompi, 1997,1994, 1987b).

The role of the clinics has changed because of these developments. They now concentrate on short, intensive therapy of acute mental illness (Ciompi, 1994). As a consequence, a massive reduction of beds in the traditional psychiatric hospitals has taken place in a majority of the cantons (Ernst, 1998;Ciompi, 1994,1987b). The concept of building big insulated institutions has been abolished, most psychiatric clinics have reduced in size, and while staffing levels have increased (Ciompi, 1994,1987b).

However, whilst these developments have been positive there are still a number of problems within the Swiss mental health system. Ciompi (1994) has pointed out that a number of the newly founded services have not integrated the social environment into therapy, but nevertheless call themselves socio psychiatric, just by being decentralised from the traditional psychiatric clinics. The multiplication and diversification of

mental health facilities can create new problems such as the co-ordination of care, and liaison with authorities and organisations which has become more complex and difficult to survey (Ciompi, 1987a). A true network, promoting the continuity of care has, therefore, only been rarely realised (Diener, 1998; Ciompi, 1987a). The mental health care provision for the elderly or for adolescents and children, for example, can be considered as sufficiently developed only in four and three cantons respectively (Hämmerle, 1998;Bachmann, 1995). Wide variations do exist between the regions. There are still cantons without any or very few community focused services (Bachmann, 1995;Ciompi, 1987a, 1987b). This is especially so in the more rural cantons (Ciompi, 1987b).

Many expectations of the early socio psychiatric movement were exaggerated. Despite the implementation of socio psychiatric principles the chronification of psychoses, for example, has not been reduced significantly (Ernst, 1998;Ciompi, 1987b). Related to this fact is the observed paradox that with the introduction of socio-psychiatric networks the rate of persons in need of hospitalisation can increase (Ernst, 1998). Ernst (1998) highlights that this does not mean that a new demand has been created. He sees the high estimate of untreated suffering in the population as a possible explanation for this phenomenon. Thanks to a well managed, decentralised service network numerous previously unnoticed indications for hospitalisation are now picked up by services. As a consequence, more acute beds are needed. The size and organisation of community mental health services has tended to allow only the stationary treatment of a small number of acute cases and put pressure on services (Ernst, 1998). The result is that the reduction in beds in psychiatric clinics began to stagnate around 1980 (Ciompi,

1987b). Furthermore, the discovery of additional cases means increasing costs: although in single cases treatment decentralised socio psychiatric facilities has proved to be less expensive overall costs have increased (Ernst, 1998).

In times where there is a chronic financial under funding in public services (Walt, 1994) the covering of additional cost cannot be expected. Social expenses are under pressure also in industrialised countries: in Switzerland issues such as dismantling of the social state welfare system, economy measures and privatisation are increasingly discussed (Ernst, 1998; Diener, 1998; Hell, 1998;Hämmerle, 1998;Bachmann, 1995). Health care costs hence were and are cut. Between 1995 and 1998 the state has reduced its contribution to cover public health costs from 28% to 25% (BFS, 1998).

As outlined above the introduction of socio psychiatric services has not lead to major reduction in beds for acute treatment in psychiatric clinics. The bigger public psychiatric institutions are obliged by law to admit acute cases and they have had to cope first with the financial constraints (Ernst, 1998). In order to reduce financial pressure long-term mentally ill persons are increasingly in danger of being discriminated against, especially the elderly mentally ill, who are often placed in old peoples' homes, where they are not counted in mental health statistics. As a consequence they live with a less adequate provision of care than that offered in the clinics (Ernst, 1998,1990;Ciompi, 1987b). Ernst (1998) considers this tendency of neglecting long-term mentally ill as the main problem at present of mental health care in Switzerland.

According to experts in the field a more proactive role for mental health care professionals in policy might contribute towards the solution of present injustices. Firstly, they may directly inform the responsible authorities and the press about occurring inequities (Ernst, 1998; Müller, 1997;Ernst, 1990;Ciompi, 1987b). Secondly, they have the opportunity to inform and educate patients and their families and hence empower them to express their needs and become politically active (Ernst, 1998). In the Zürich canton, for example, it took two decades of constant pressure from psychiatrists on the responsible authorities before conditions in the psychiatric state hospital were improved (Ernst, 1990). In 1995, again in Zürich, a group of parents of mentally ill people had a major influence on the formulation of a legislation regarding the right of appeal for hospitalised patients (Ernst, 1998). A creative role for mental health care professionals in policy thus represents a powerful resource to improve the future quality of mental health care provision across the country.

Conclusion
This article summarised the development of Swiss mental health policies and services over the last three decades. Achievements and problems of mental health care provision have been outlined. The Swiss reality can be considered to correspond to one in a range of other countries. Since the Swiss mental health care system has been strongly influenced by international tendencies it might be seen to "portray" Europe on a small scale (Ciompi, 1994,1987a). In this context it is of interest to mention that, not only in Europe, but in all industrialised countries experts presently perceive difficulties in mental health care delivery in a notably similar way (Ernst, 1998). According to

Ernst (1998), in less industrialised countries the range of problems tends to be at least quantitatively similar as in industrialised ones. Globally, the similarity of mental health needs appears to be much greater than is the case for physical health; the delivery of mental health care might thus be considered as a world-wide issue requiring an international response (Ernst, 1998).

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