Mental Health Care in the Federal Republic of Germany*

Summary of the report given by an Expert Commission to the parliament (Bundestag)

* The report includes a survey on the history and the present state of psychiatric, psychotherapeutic and psychosomatic care in the Federal Republic. Psychosomatic medicine and psychotherapy is recognized in the Federal Republic as a separate speciality with own university departments and its own place in the medical training syllabus. This speciality covers a large part of all psychoanalytic psychotherapy provided in the Federal Republic.

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A. Current provision of care for the mentally ill and mentally handicapped in the Federal Republic of Germany: facts and figures.

1 Critical assessment of the situation

— Care of the mentally ill and handicapped in the Federal Republic of Germany ** stands in urgent need of improvement. The situation is characterized by serious deficiencies in the provision of all forms of care: most notably, however, in the following services:

  a) complementary and ancillary (e. g. transitional facilities, such as homes and hostels, particularly for the chronically ill and handicapped; day centres);

  b) outpatient-services (e. g. neuropsychiatrists in office practice, especially in rural areas and small towns; outpatient clinics in hospitals and other institutions; counselling services);

  c) community-based in-patient services (e. g. psychiatric departments in general hospitals).

— Care of the mentally ill is to a great extent separated from the main body of medicine, with consequent disadvantage when compared with the care of the physically ill.

— There are shortages of qualified personnel in all services and professional groups, due primarily to inadequate educational and training facilities.

— The current provision of care is particularly inadequate for the following groups of patients:

  — mentally ill, mentally handicapped and maladjusted children and young persons,

  — persons suffering from drug dependence,

  — the chronic mentally ill, mentally sick old people and mentally retarded adults.

The critical state of German mental hospitals, most of which date from the 19th Century or the turn of the present century, has already been amply documented. With 98,757 beds, they carry the main burden of in-patient care, and about 60 per cent of their occupants are long-stay patients (chronic mentally ill or mentally handicapped). The hospitals are too large, the buildings are out-of-date and their geographical situation is often unfavourable.

The deficiencies in this sector of care stimulated the German Federal Government to appoint an Expert Commission. Although, in the meantime, the responsible authorities have spent large sums on crash-programmes for the reconstruction and modernization of mental hospitals, the Expert Commission emphasizes that the first step in reform must be provision of the basic human needs for all patients living in these hospitals.

2 Frequency of mental illnesses and handicaps. Introduction

Accurate figures for the numbers of mentally ill and handicapped persons in Germany cannot yet be given, because of the lack of adequate epidemiological research in this country. However, on the

** hereafter referred to as the FRG

basis of relevant studies in Denmark, Sweden, England and the FRG, as well as of surveys conducted at the instigation of the Expert Commission, at least the approximate order of size of the problem can be stated.

2.1 Extent of the problem

Mental illnesses and handicaps are not — as is still often assumed — a quantitatively negligible problem. On the contrary, a considerable segment of the population is affected: approximately every third citizen has at some time in his life suffered from a form of mental illness, or suffers from one currently. This means that in the FRG around 20 million persons are chronically, recurrently, or at least once in their lifetime directly affected by mental disorder in some form.

2.2 Consultations and treatment-episodes

Each year, about 70 % of the population consult a general practitioner. Of these, between 10 and 20 % present with mental illnesses, psychosocial crises or physical complaints related to psychological disturbance. This represents a total of 4 to 8 millions.

From 1.8 to 2.0 % of the population, or around 1 million persons, present each year with a more or less urgent need for psychiatric specialist treatment.

Neuropsychiatrists and psychotherapists in panel practice * are consulted each year for psychiatric disorders by 1 % of the population, or about 600,000 persons. The numbers admitted to psychiatric hospitals and departments during each year comprises 0.25 to 0.40 % of the population, or approximately 200,000 persons.

2.3 Number of persons attending for treatment, investigation or counselling for the first time each year in the FRG

About half the annual total of cases are new to psychiatric treatment. 1.0—1.2 % of the population (circ. 600,000 persons) make first contact with specialist treatment or counselling services because of mental illness or handicap during any one year.

If the results of a survey conducted in Mannheim in 1965 are extrapolated to the general population of the FRG — permissible only with some reservations — one arrives at the following rough estimates for the most important diagnoses.

Tab. 1

Diagnosis	%	Number of first illnesses annually in the GFR
Neuroses and personality disorders	*30.2*	ca. 205,000
Schizophrenia, manic-depressive and other psychoses	*17.6*	ca. 120,000
Dementing processes of old age	*13.8*	ca. 95,000
Mental retardation .	*13.2*	ca. 90,000
Alcoholism and other addictions .	*6.3*	ca. 43,000
Epileptic disorders .	*3.9*	ca. 27,000

The proportion with alcoholism or other addictions has increased since 1965, but no significant changes of frequency have been observed in other illness-groups.

2.4 Hospitalization and diagnoses

On the survey census day (30. May 1973) the 130 psychiatric hospitals in the FRG had a total of 98,757 beds, of which 94,197 were occupied. The patient-population comprised the following diagnostic groups (Tab. 2).

Tab. 2

Diagnosis	Percentage of the total patient-population in psychiatric hospitals
Mental disorders of old age, and other organic psychosyndromes	13,0
Schizophrenic psychoses	36,7
Affective (manic-depressive), paranoid, reactive and other psychoses	8,2
Neuroses, personality disorders and psychosomatic disorders ..	4,0
Drug addictions	9,6
Epileptic disorders	6,0
Mental retardation	18,5
Physical disease without psychiatric disorder (neurological and general medical) and miscellaneous	4,0

A steady increase in recent years in the number of admissions can be observed. The morbidity statistics of the "Landschaftsverband des Rheinlands" also show a trend which can be regarded as typical for other hospital authorities; namely steeply rising admission rates for all forms of drug dependency, in particular for alcoholism.

* Most of the medically-trained specialists in this field are doubly trained, in neurology and psychiatry, and treat neurological as well as psychiatric disorders.
The term 'panel practice' is used here in preference to 'private' or 'free' practice, since the great majority of patients are treated under government-regulated health insurance schemes.

Tab. 3

Distribution of admission diagnoses in the Rhineland mental hospitals *

	1960	1965	1970	1973
Organic psychosyndromes and mental disorders of old age	3,013	3,039	3,223	2,882
Schizophrenic psychoses	2,537	2,886	3,692	3,522
Affective (manic-depressive) psychoses	775	973	1,110	1,429
Psychopathy and abnormal reaction-states	1,133	1,288	1,707	2,087
Alcoholism	513	1,050	2,889	4,535
Drug dependency	165	241	635	1,095
Epileptic disorders	416	383	445	378
Mental retardation	901	897	923	804
Physical illness without mental disorder (neurological & general medical) and miscellaneous	232	177	347	497
Total	9,685	10,934	14,971	17,229

* Rhineland mental hospitals Bedburg-Hau, Bonn, Brauweiler (from 1969), Düren, Düsseldorf, Langenfeld and Viersen

3 Basic deficiencies in the care of the mentally ill and handicapped

3.1 The approaches to the psychiatric services

Beyond the ambit of specialist services exists a broad peripheral zone in which persons with psychiatric disorders of many kinds are encountered. Here, they may receive not only medical treatment and advice, but also non-medical counselling. The general practitioner occupies an important position in this field, since as family doctor he is frequently the first port of call for mentally ill and handicapped persons. This peripheral zone has great significance for mental health care, since the agencies which are active in it exercise a number of important functions, viz:

— preventive functions in the sense of early diagnosis;

— first aid and counselling facilities;

— referral to appropriate specialist treatment.

Here, the following serious deficiencies must be noted:

a) Non-professional counselling

Teachers, nursery-school teachers and play-group leaders, court and probation officers, and counsellors of various kinds inevitably encounter many mental disorders, psychosocial crises and severe emotional conflicts. They are required to carry out advisory functions, for which for the most part they are untrained or only inadequately trained. The consequence is that mental disorders often either go unrecognized or are dealt with in inappropriate ways. Repeatedly, one finds a dearth of information and of possibilities for cooperation with psychiatric and psychotherapeutic services or consultants.

b) Professional counselling

Professional counselling is provided by school psychological services, by assessment and advisory boards in industry, social insurance and public health departments, and above all by the social workers of both public and voluntary agencies. It is true that, in general, the recognition of mental disorders and handicaps is not a primary concern of these services. Nevertheless, they are very often confronted with such conditions. These services are important, in particular for prevention, because they can influence the conditions giving rise to faulty psychological development and to psychological crises.

When one considers, what would be required for improved counselling, early diagnosis and prevention, the following deficiencis are particularly marked:

— school psychological services exist only in inadequate numbers. Their organization and the qualifications of their staff are very uneven. Under these circumstances, they can function for the most part only as a kind of educational-psychological emergency service. No facilities exist for helping individual cases, for treatment of psychosocial conflicts or for advisory services to the schools themselves.

— Vocational guidance is often too biased in favour of the current requirements of the labour market. The special situations of young people and adults requiring guidance are insufficiently considered. The education and training of the vocational counsellors often does not provide them with the psychological and psychodynamic understanding required for preventive work or for intervention which may decisively influence future development, whether of healthy or of handicapped persons.

— In the counselling services and in the professional work of health, youth and social service departments, as well as of voluntary agencies and churches, opportunities for qualified advice and counselling in relation to mental disorders, mental illness and handicaps are severely limited by a shortage of established posts, lack of financial resources, case overloading, insufficient autonomy and bureaucratic red tape. Opportunities for special professional training are often absent. The systematic cooperation of these services with one another and with psychiatric agencies is almost universally unsatisfactory.

c) Advisory units with specialized tasks

Private, public, church and voluntary agencies provide a number of advisory or counselling units, whose functions relate to problems in life-planning, in marital and group relationships, and in child-upbringing and development. They are therefore directly concerned with mental disorders, illnesses, conflicts and crises. Despite staffing which varies widely both in quantity and in quality, they attempt to offer a range of facilities extending from information and advice to diagnosis and disposal, and beyond these to therapy.

The functioning of these services, which could fulfil — and, indeed, in part do fulfil — extensive tasks of care and management, is impaired by the following deficiencies:

— The total number of advisory units is too small. In addition, they are very unevenly distributed. Rural areas and small towns are at a particular disadvantage, as are working-class areas.

— Many advisory units are understaffed.

— Relatively few advisory units have qualified multi-disciplinary teams, which would allow them also to undertake therapy.

— Many advisory units are too narrowly limited in their activities to one area (for example, marital, sexual, or child guidance problems). Their activities, therefore, often cannot extend to cover complex problems of the family, the social reference group or the environment.

— The choice of clients is too restricted to the middle classes. The reason is to be found partly in the reluctant policy of the counsellors, most of whom do not regard themselves as being in a position to go out into the social field, but instead wait for the "demands" of the clients. Members of the lower social classes are thus scarcely reached.

— Especially inadequate are the provisions for social problem groups, which come least into contact with the counselling services.

— Modern techniques of family, group and social therapy still receive insufficient attention in the education and training of the counsellors.

d) The general medical practitioner

Between 10 and 20 % of all those who consult general practitioners during any one year suffer from some kind of psychiatric disorder or handicap. While the great majority of these patients do not require psychiatric specialist treatment, this estimate underlines the important filter-function of the general practitioner. Given the general level of training hitherto, he cannot adequately fulfil this function. The patient-load of the average general practice, moreover, does not permit the extended consultations required by many mentally ill patients.

In this context, it must be seen as a deficiency that general practitioners are often insufficiently skilled in those tasks required for care of the mentally ill and handicapped. They must be in a position:

— to recognize the psychological and social origins of symptoms of illness;

— to offer appropriate help to the mentally ill and handicapped more often than hitherto, as well as to provide access to social therapeutic and rehabilitation measures;

— on occasion to undertake a psychotherapeutic role themselves, at least within certain limits;

— to carry out treatment by means of psychotropic drugs, to the necessary extent.

3.2 Out-patient services

Compared with the efforts devoted to improving hospital in-patient care, developments of out-patient treatment facilities in the FRG have not been adequate to meet requirements. This failure has great significance, in particular, for care of the mentally ill and handicapped: such patients need out-patient treatment in particular forms and to a special extent, both because of the nature of their help-seeking behaviour and because of the heavy dependence of the clinical course of illness upon social factors.

The majority of all the mentally ill — estimated at 600,000 annually — is at present treated by neuropsychiatrists and psychotherapists in panel practice. In addition, the mentally ill receive treatment in the general practitioners' surgeries, in the university outpatient clinics and from the hospital senior neuropsychiatrists, who are authorized to provide out-patient treatment.

The separation of out-patient from in-patient care results in failure to meet the needs of a section of the mentally ill. It has been shown, namely, that those groups of the mentally ill, who are in need of pre-admission treatment or more specially of intensive aftercare, fall very easily between the meshes of the existing network of out-patient services. The consequences can be seen in recurrent illness-episodes, chronicity and relapses during rehabilitation. Many re-admissions to in-patient treatment could be avoided, if the out-patient care services were better developed and coordinated with those for in-patients.

Important tasks of out-patient care for the mentally ill and handicapped include crisis intervention (if possible around the clock), out-patient measures to

avoid unnecessary hospitalization and consultative treatment and care in relation to complementary services (half-way houses, hostels, boarding-out schemes etc.). These cannot be undertaken, or at least only inadequately, from the neuropsychiatric practices under existing conditions. It must, therefore, be characterized as a failure of care that such tasks, which represent an important supplement to the field of activity of practising psychiatrists, cannot yet be undertaken from the psychiatric hospitals and related institutions. This gap is all the more serious since the capacity of the practising psychiatrists to provide care is already limited by the relatively small number of practices, by their unequal distribution between urban and rural areas and also to some extent by deficiencies in postgraduate training.

In many parts of the FRG — in particular, in rural areas — facilities for psychotherapeutic care are so under-developed, that patients suffering from neurotic and psychosomatic illnesses can hardly hope to find suitable treatment. They must seek contact with far distant services, which, however, for the most part are already fully engaged with patients from their own catchment areas.

The general deficiency in outpatient facilities for the mentally ill is aggravated by widespread lack of special out-patient facilities for the following groups of patients:

— mentally disturbed, maladjusted and mentally handicapped children and young people;

— mentally ill old people;

— drug addicts;

— persons with neurotic and psychosomatic disorders;

— persons suffering from epilepsy.

Special attention must be paid, in reviewing outpatient services, to the following groups:

a) Neurospychiatrists in panel practice

On 31. 12. 74, a total of 1,041 neuropsychiatrists in panel practice were registered under health insurance schemes in the FRG. This means that a practising neuropsychiatrist in panel practice must provide specialist cover for 59,300 inhabitants on average. The generally accepted minimum provision of one neuropsychiatrist for 50,000 inhabitants has thus not yet been achieved. Also relevant here is the fact that a fairly large proportion of treated patients (circ. 1/4 to 1/3) are treated for neurological rather than psychiatric conditions. Moreover, the regional distribution of the practices is very uneven, rural areas being the most disadvantaged.

b) Psychotherapists

For the years 1973—74, a total of 1,263 specialists for adult psychotherapy (of whom 566 had recognized institute training) were ascertained to be practising in the FRG. About 50 % of medical psychotherapists are at the same time specialists in psychiatry, or in psychiatry and neurology; a considerable proportion are psychologists. To this total must be added 286 child psychotherapists. The marked concentration of psychotherapeutic specialists in the big cities results in gaps in provision in other areas.

Only in 11 places are there psychotherapeutic or psychosomatic out-patient clinics. Out-patient care is to a great extent undertaken by psychotherapists in panel and private practice. Altogether, in 1973, 8,453 cost-applications for psychotherapeutic treatment were approved by the health insurance panels.

3.3 In-patient services

In 1973 there were in the FRG 3,494 hospitals with a total of 707,460 beds and with 8,433,615 admissions during the year. According to the results of a census-survey conducted by the Expert Commission (31. May, 1973), the corresponding figures for psychiatric care were as follows:

— 241 hospitals,

— with 111,450 beds,

— and 225,676 annual admissions.

Psychiatric care, in other words, accounted for every 6th bed and every 37th hospital admission.

a) The mental hospitals

For the average citizen, it is self-evident that in the case of a physical illness he can attend a near municipal or voluntary general hospital. Should he be so unfortunate, however, as to suffer from a severe mental disorder, so that in-patient treatment is necessary, he must, as a rule, be sent to a relatively distant mental hospital.

The 130 mental hospitals of the FRG contain 98,757 beds. This means that on average 1.6 beds are available per 1,000 inhabitants. In 1972, 158,000 patients were admitted, of whom 84,300 were classed as first admissions. A third of these institutions have more than 1,000 beds and thus are well above the recommended upper limit of 600 beds. The buildings in most of the hospitals are obsolete. Two-thirds of the beds are situated in hospitals erected before 1925.

Despite considerable efforts by the responsible authorities to renovate and modernize these hospitals, the survey revealed the following deficiencies:

— the size of the mental hospitals and the resulting problems of structure and organization increase the risk of institutionalism.

— The unfavourable geographical situation of many mental hospitals renders more difficult their participation in community-based pre-admission care and aftercare.

— The catchment areas of the 66 mental hospitals with defined area responsibilities are too large. On average, the number of inhabitants in such a catchment area is 937,000. This average number of inhabitants varies from one region of Germany to another:

Tab. 4

Land	Mean No. of inhabitants per catchment area
Hamburg	1 766 000
Rheinland-Pfalz	1 230 000
Nordrhein-Westfalen	1 146 000
Saarland	1 119 000
Niedersachsen	1 031 000
Berlin (West)	1 031 000
Bayern	980 000
Schleswig-Holstein	855 000
Baden-Württemberg	832 000
Bremen	734 000
Hessen	503 000

— The mean duration of stay in the mental hospitals, because of the different composition of their patient population, is appreciably higher than in the university clinics or psychiatric departments of general hospitals. On the survey census day, 1973, the distribution of patients by duration of stay was as follows:

Up to three months	21 %
3—12 months	12 %
one to two years	8 %
two to five years	13 %
five to ten years	15 %
more than 10 years	31 %

This means that 59 % — approximately 60,000 patients — had been living for more than two years in a psychiatric hospital, and 31 % — approximately 30,000 — for more than ten years.

— 18,5 % — approximately 17,400 patients — in psychiatric hospitals on the census day were mentally retarded. It is not possible to provide the requisite remedial and educational facilities for these patients in the mental hospitals.

— There are, in the mental hospitals, still many dormitories with more than 10, or even more than 20 beds. Only half the rooms have only 1—3 beds.

The standard of medical care gives cause for concern. Only one quarter of the mental hospitals have a sufficient number of doctors. Altogether on the census day there were 1,651 doctors working in the mental hospitals. Each doctor, therefore, was responsible on average for 59,8 beds. 861 of the doctors were qualified psychiatric or neuropsychiatric specialists; 60 % of them were over 50 years old. As a consequence of this age distribution, an additional shortage must be expected in the coming years.

— The big institutions, in particular, suffer from a shortage of medical staff. The bigger the hospital, the less favourable its doctor-bed-ratio (Tab. 5).

Tab. 5

Size of mental hospital	No. of beds per doctor
less than 100 beds	27.2
100—500 beds	41.1
500—1000 beds	57.9
over 1000 beds	66.1

— On census day, only 195 psychologists were employed in the mental hospitals. Each psychologist must thus provide services for 506 beds on average. In view of the large number of psychologists who complete training, it is remarkable that such a small number are working in mental hospitals.

— With regard to nursing staff, the lack of qualifications is conspicuous. Of the 23,312 nursing personnel engaged in psychiatric inpatient units (4.2 beds per nurse)

  — only 42.2 % had had a state-recognized training;

  — only 6 % had had an additional psychiatric or social psychiatric training;

  — 17.0 % had had no nursing traning whatever;

  — 17.4 % had been trained as nursing assistants;

  — 16.8 % were currently undergoing training.

— The shortage of social workers is very grave. On census day there were only 183 social workers working in the mental hospitals. This corresponds to 540 beds for each social worker.

— Of the 542 occupational and work-therapists, only 26.4 % had completed an occupational-therapy training programmes. This reflects the dearth of training schools for occupational therapists. At present, there are only seven in the whole FRG.

b) Psychiatric departments in general hospitals

The provision of treatment for the mentally ill in specialist departments of general hospitals, comparable to that for the physically ill, represents an approach so far taken all too rarely, in the FRG There are in all only 44 such departments for psychiatry or neuropsychiatry, with a total of 3,164 beds. Most of these departments care for both neurological and psychiatric patients, and therefore are only partially available for the care of the mentally ill. Some 26,900 patients, of whom 13,800 are first admissions, are received into these units each year. The duration of stay in such departments — partly because of the different composition of their patient-clientele — is considerably shorter than

in the mental hospitals. 83 % of the patients had been in treatment less than 2 months on census day, and only 5 % for more than one year.

The regional distribution of the departments is very variable. For many areas this type of provision simply does not exist. 50 % of the psychiatry departments are to be found in Nordrhein-Westfalen. Their number is too small and their present structure inadequate for comprehensive care of the mentally ill.

c) University psychiatric clinics

Altogether, 23 university psychiatric clinics, with a total of 3.507 beds, participate in the care of the mentally ill. Their relative contribution to in-patient admission and to out-patient care is high. 87 % of the patients in such clinics on census day had been there for less than three months, compared with only 1 % longer than one year.

d) In-patient psychosomatic units

According to a questionnaire survey in 1974, there are in the FRG 40 psychosomatic hospitals or departments, providing altogether 2,253 beds. Of these, only 204 had been covered by the survey conducted by the Expert Commission. 1,773 beds are situated in 20 independent psychosomatic hospitals, and 480 are distributed among 20 psychosomatic units in other hospitals. Duration of treatment in such units is estimated at from 6 to 8 weeks on average.

Although the main focus on psychosomatic care lies in the out-patient sector, there exists a shortage of in-patient provision for defined groups of patients. The overall level of in-patient care is inadequate and very unevenly distributed between the regions.

3.4 Partial hospitalization

Facilities for partial hospitalization (day-hospitals and night-hospitals) are important in improving patients' chances of resettlement, as well as in avoiding or curtailing full hospitalization. Although their advantages have long been recognized, only a few day or night hospitals have been established so far in the FRG. This is due to two causes:

— underwriting of costs has not yet been satisfactorily resolved;

— the segregation of many large mental hospitals renders difficult the establishment of day and night hospitals, whose patients depend on a fairly short distance between hospital and home or workplace.

3.5 Special age-groups and patient-groups

a) Children and young persons

27 % of the population are children and young persons under 18 years. A number of investigations have shown that from 20 to 25 % of all school children manifest abnormalities of behaviour requiring some form of assessment. A study carried out for the Expert Commission reported that in one large city 31 % of all children starting school had behavioural abnormalities or impairments of performance:

— 16.3 % showed significant abnormality during the first school year;

— 6.0 % had school attendance deferred;

— 8.7 % were sent to some form of special school.

These figures indicate a considerable need both for advisory services and for out-patient and in-patient treatment services which — as the relevant investigation has also shown — is not nearly met.

In the out-patient field, the required multi-disciplinary care is at present provided, at least to some extent, by child guidance centres. The survey undertaken by the Expert Commission in 1973 covered 375 advisory centres for children, young people and parents in the FRG. Of these, 70 % were directed by clinical psychologists and 25 % by physicians. One third of these did not have the necessary minimum of staff drawn from all three specialties; 13 % were only branch offices from other centres. Each centre had a service population of 200,000 on average, instead of the 50,000 recommended in earlier guidelines from WHO. The total of 286 child psychotherapists is insufficient; it must also be considered unsatisfactory that the 11 centres with training facilities could report, all told, an average of only 32 training completions annually.

It seems that, with regard to in-patient treatment, child psychiatry is a relatively independent specialty. Incorporation into an integrated system of care does not yet exist, even in prospect. The deficiencies here are especially grave. In the Expert Commission survey, of the total No. of in-patient psychiatric units for children and young people only 17 were reported, with a total of 3,725 beds. Five of these units were in special departments, the remaining 12 were in hospitals of widely varying type and size. Conspicuous here is the shortage of specialists in child psychiatry. Compared with a long-term need for about 1,700, there are a present only 173 recognized specialists, of whom only 28 are in panel practice.

The deficiencies in provision of child psychiatric care are all the more serious in their consequences, in that preventive measures which could serve to avoid or reduce subsequent damage, notably through early diagnosis and treatment, are not forthcoming. Apart from single departments and out-patient clinics with corresponding activities, there are only three large, independent early diagnosis centres in the FRG.

b) Mentally ill old people

Although about 20 % of all hospitalized patients are over 65 years, and although mental disorders of late life, with 20 to 30 %, head the list of mental-hospital admission diagnoses, after drug dependency and schizophrenia, an adequate, comprehensive system of psychogeriatric care has still to be developed. Unresolved, above all, is the problem of cooperation and appropriate division of tasks between the hospital-based services and the agencies providing residential care for old people.

The sharp increase in elderly patients in recent years can be explained by changed living-conditions and an increased life-expectation. The proportion of people over 65 in the general population is increasing. Today, every eighth citizen in Germany is over 65 years old; by 1980 the proportion will have increased to 1 in 7. Field studies show that, on any given census day, 25—30 % of all those over the age of 65 suffer from mental disorders in the broadest sense. At a very approximate reckoning, however, only about 1 % require in-patient treatment. For about 14 %, out-patient diagnosis and treatment are required. The concept — still widely held, even among doctors — of psychiatric disorders in old age as an incurable form of deficit, and the therapeutic nihilism associated with this concept, have resulted in a very inadequate use of the treatment facilities now available.

Old people suffer particularly from the poor cooperation between clinical and social agencies. Thus, in one survey in Nordrhein-Westfalen, it was found that half the patients over 65 in mental hospitals no longer required psychiatric care, and could have been looked after just as well or better in residential homes, whereas on the other hand one-quarter of the residents of old people's homes and geriatric nursing homes were in need of psychiatric treatment which they could not receive there. This misplacement must be ascribed to the fact that, so far, no system for directing mentally disturbed old people to the various forms of treatment agency, according to their needs, has been established. The quantitative deficiencies in the field of psychogeriatrics (psychogeriatric wards, out-patient clinics, day centres, nursing homes and nursing personnel are all lacking) are exacerbated by qualitative deficiencies in cooperation between the services concerned, resulting in unnecessary detriment to the mentally sick old people. For them, the path to psychiatric care proves all too often to be a cul de sac.

c) Drug dependent patients

In recent years, abuse of alcohol and narcotic drugs has increased in the FRG to an alarming extent. Whereas in 1969 the number of alcoholics was assessed at about 600,000 today one must work on the basis of 1.2 to 1.8 million, or 2—3 % of the general population. The annual consumption of pure alcohol per head has increased from 3.2 liters in 1950 to 12.2 liters in 1973. Alcoholics and drug addicts comprise altogether about 30 % of admissions to psychiatric beds. The number of alcoholic confusional states admitted to psychiatric units has risen with the space of a few years by some 700 %. Younger men and women are increasingly at risk.

On the drug scene, the number of persons trying out drugs, or taking them occasionally, has actually diminished. The hardcore group of drug-dependent persons, however, has tended to increase. One must reckon here with about 10,000 young drug addicts and about 40,000 long-term narcotic users. Significant is the trend towards combined use of narcotics and alcohol, as well as the increasing consumption of 'hard' drugs, above all heroin. Against this background, the following deficiencies in care provision are alarming:

— the in-patient need is in no sense being met. The 31 special clinics (previously sanatoria), with 3,000 beds, and the 46 drug treatment wards in psychiatric hospitals, with 3,227 beds, are hopelessly overburdened; all the more so because of the poor pre-admission care: most patients first come into treatment only when they are already severely impaired.

— the general medicine departments, which as a rule provide the initial in-patient treatment during the early stages of illness, limit themselves to physical withdrawal and discharge the patients without having achieved any therapeutic influence on the continuing psychological dependence. This leads to relapses and to further deterioration.

— There are no special out-patient clinics for pre-admission care or aftercare. The situation in the out-patient field must be characterized as generally inadequate, despite the activities of many institutions and self-help groups.

— There is also a lack of day-care centres, which are important for stabilization following clinical treatment, and of halfway houses.

3.6 Social problem groups (risk-groups)

The social problem groups (socially disintegrated persons and families, poor families in temporary accomodation and slums, the homeless and those with no fixed abode, etc.) have been largely neglected up to now by medical, psychiatric, psychotherapeutic and education agencies. They represent a high-risk group for mental illness and handicap, behaviour disorders and personality disorders. In the nexus of social, economic and psychological problems to be found among them are included high proportions of alcoholism, broken homes, delinquency, antisocial conduct and mental illness.

It must be regarded as a deficiency that the problems of these high-risk groups are not being tackled with the necessary application of available knowledge, as well as with all available treatment and counselling resources of psychiatry, psychology, psychotherapy and special education.

3.7 Care of the mentally retarded

An integrated system of agencies cooperating in the care of the mentally retarded does not exist in the FRG. Precise data on the number of the retarded — and in particular on the number requiring special care — are lacking. It has been estimated that 6 per 1,000 inhabitants, or about 360,000 persons, are mentally retarded. Approximately one-tenth of the mentally retarded (0.55 per 1,000 or 34,000) are profoundly or multiply handicapped and, generally speaking, require long-term care in in-patient units. The present provision of in-patient care is quite inadequate. The institutions concerned are over-full.

A special problem is presented by the 17,500 mentally retarded accomodated in mental hospitals. These institutions cannot adequately provide the necessary programmes of special education and social training. The proportion of mentally retarded in the total of 94,200 patients in mental hospitals averages 18.5 % for the FRG. It is, however, very unevenly distributed among the individual states, as follows:

Nordrhein-Westfalen	25.1 %
Hessen	21.3 %
Schleswig-Holstein	21.2 %
Saarland	20.5 %
Rheinland-Pfalz	17.3 %
Niedersachsen	17.0 %
Bremen	13.5 %
Bayern	13.0 %
Berlin	11.9 %
Baden-Württemberg	9.6 %
Hamburg	5.4 %

In the Expert Commission survey, 93 homes and institutions were found to have more than 100 beds each. An additional No. of 36.000 mentally retarded and chronic mentally ill were living in these institutions.

Residential provision, differentiated for the various degrees of mental retardation, is so far being developed only on an experimental scale at a number of centres.

There are no special units for early case-finding and diagnosis, or for early treatment. In addition, there is a dearth of out-patient facilities for families which keep mentally retarded members at home or receive them back from institutions.

Encouraging is the rapid increase in recent years in the establishment of new sheltered workshops for the mentally handicapped. Here, however, it must be noted that the known 234 workshops, with in all 17,758 mentally retarded (1973 data), by no means fulfil the minimum need for one workshop place per 1,000 inhabitants (61,000 workshop places in the GFR as a whole). Around 60 % of those occupied in the workshops were under 25 years old.

3.8 Complementary and ancillary services

Complementary services such as residential homes, units for the most severely and the multiply-handicapped, various types of sheltered accommodation, day centres and patient clubs for the mentally ill and mentally handicapped who do not need hospital care, form an important part of the mental health care system as a whole. They reduce the pressure on clinical facilities, allow or promote resettlement and offer those persons who are not in need of hospital care, but who nevertheless require a sheltered environment, a wider range of possibilities.

In this sector of care, there is a lack of precise information on the number of facilities, as well as on the diagnostic distribution, age, background and rate of turnover of those who use them. However, all the indications are — as the preceding paragraphs have made plain — that the unfulfilled need here is extremely pressing, even though it cannot yet be precisely estimated. The lack of planning in this twilight zone, and the resulting gaps in service provision, severely impair the care of all groups of patients and handicapped persons.

The inadequate quality of care in some residential homes also calls for critical comment. Many homes, in which former — mostly elderly — patients of mental hospitals are being cared for, are inadequately equipped and do not have a sufficient number of qualified personnel.

3.9 Misplacement and coordination

The system of care for the mentally ill and mentally handicapped has grown up in an uncoordinated way. In-patient, out-patient and complementary services are provided by a large number of responsible authorities independently of one another, including national government, local government, charitable organizations and voluntary bodies. The mentally ill and mentally handicapped fall within the overlapping areas of responsibility of various administrations; namely, public health services, social services, youth and labour and employment departments. Neither the responsible authorities nor the administrations have up to now developed ways of coordination which would enable the special needs of this large group of the population to be substantially met. This lack of coordination is a central problem of the present provision of services.

An unhappy consequence of the confused overlapping of activities of almost all relevant services and administrations is large-scale misplacement. This was clearly demonstrated in a study of mentally disturbed old people in Nordrhein-Westfalen, which reported that 50 % of the over 65-year-old patients of mental hospitals were no longer in need of psychiatric treatment and could have been better cared for in residential homes. Also misplaced are most of the over 17,000 mentally retarded in the mental hospitals, the alcohol addicts on general medical wards, the chronic mentally ill in mental hospitals who do not need hospital facilities and the many patients with psychosomatic illnesses who are in general medical clinics. Misplacement is thus a general feature of the whole system of care, and demonstrates the existing shortcomings in planning and coordination more dramatically than any other phenomenon.

3.10 Professional education and training

Next in importance to the need for adequate *numbers* of mental health care personnel — the present situation is one of unfulfilled need, to an extent varying between the different professional groups — their *qualifications* are of crucial significance. These qualifications depend essentially on the nature and extent of the opportunities for professional education and training offered to those engaged in mental health care. The basic training of many groups involved in mental health care,

though not specializing in this field, has so far paid insufficient attention to the necessary skills. With the exception of medical postgraduate education, there is a widespread lack of facilities for professional training. Especially serious is the lack of systematic vocational training opportunities.

Existing educational and training courses are incomplete and lacking in balance. In many medical postgraduate courses, there is often a one-sided emphasis on the biological standpoint and a corresponding neglect of the psychological and social aspects of mental disorder and handicap, as well as of their responsiveness to environmental influences. Education and training are frequently too little related to practice. Much of the knowledge and many of the skills indispensible for the care of the mentally ill and handicapped can, however, be acquired only through daily contact with such patients, in conjunction with training programmes.

As regards psychotherapy, the present deficiencies in training lead to serious consequences for the provision of care. In the training curricula for all professional groups who have to master the medical, psychological, educational and social techniques required for prevention, counselling and therapy, the requisite foundation of psychological and social knowledge has so far received too little attention. In particular, opportunities are lacking for vocational training, since day-to-day contact with psychosocial conflicts could best be accomplished through training placements, with adequate facilities for supervision and exchange of experiences. Training courses in psychotherapy are only now being set up in some professions (e. g. in medicine) and in other fields are completely lacking. Moreover, there is a serious shortage of institutions for specialist training.

The existing shortages and omissions in education and training of those responsible for care of the mentally ill and handicapped are all the more serious, in that they cannot be made good or compensated for by any immediate measures, and are thus both enduring and far-reaching in their consequences.

B. Recommandations for a Reorganization of the Care of the Mentally Ill and Handicapped

1 Necessity and aims of the reform

The present deficiencies in care are grave. They call for a reorganization, designed to achieve the following objectives:

— that mental illnesses and handicaps should be subject to early recognition and intervention, so that serious impairments can be averted as far as possible;

— that where treatment is required, the need for hospital admission should be reduced by means of out-patient and related facilities;

— that the segregation of the mentally ill and handicapped from their normal social environment should be avoided;

— that psychiatric hospitals should be put in a position, in terms of personnel, buildings and administration, to offer real prospects of cure or relief for mental illness and handicap.

2 Principles and guidelines

2.1 Significance of social influences for prevention

The conditions in which mental illnesses arise and the circumstances leading to chronicity — above all in the areas of child rearing, of occupation and of living conditions — make it essential to explore such associations systematically, together with the problems and possibilities of prevention, and to communicate knowledge on these subjects to the affected persons, to institutions and to the responsible authorities.

2.2 Enlightening the public and educating professional groups

The education of the general public in mental health must be promoted more intensively. Professional groups whose members are frequently the first to be confronted with mental disturbances must be trained so that they can initiate prompt help.

2.3 Promotion of advisory services and self-help-groups

Preventive mental health care must be given priority to specialist treatment services. In order to explore to the full all possibilities for prevention, systematic promotion of social treatment, counselling and special education will be necessary as well as promotion of self-help groups for affected persons.

2.4 Consideration of all the mentally ill and handicapped, and those threatened with handicaps

Psychiatric and psychosomatic care must be comprehensively available to *all* who suffer from, or are threatened by, mental illness or handicap. This principle of comprehensive care provision implies that the needs of all affected groups of persons within a defined catchment area must be covered by every type of service.

2.5 Development of an equitable system of care

A comprehensive, equitable system of care must provide the following services for pre-admission care and aftercare, as well as for clinical treatment, within a defined care sector:

— counselling services;

— out-patient services (psychiatrists and psychotherapists in panel practice, out-patient services at hospitals and other institutions);

— in-patient services (psychiatric hospitals, psychiatric departments in general hospitals);

— partial hospitalization (day hospitals and night hospitals);

— complementary services (half-way houses, hostels, units for the severely- and multiply-handicapped, boarding-out schemes, day-centres, patient-clubs;

— rehabilitation services (workshops for the handicapped, sheltered places in industry, occupational training and rehabilitation centres).

2.6 Coordination and cooperation; planning; data collection

The planning of health care systems lies within the competence of the individual states (Länder). The coordination and cooperation of the various services must be guaranteed at local level. For the growth of rational planning, collection and analysis of all relevant data is indispensable.

The cooperation and coordination of all services is necessary in particular:

— to avoid misplacement of patients,

— to reduce double or multiple provision of care,

— to ensure continuity of treatment,

— to close gaps in the health care system by means of a continuing, flexible process of adjustment.

2.7 Community-based care

All services must be based on the local communities. In particular, day care, complementary and rehabilitation services can only function successfully if they are in proximity to workplaces, to residential areas, to social agencies and to administrative centres. Placement of the mentally ill and handicapped in institutions far removed from their areas of residence is only justifiable if they require special treatment and rehabilitation facilities, which have to be concentrated in regional centres.

In applying the principal of community-based health care, the different conditions in rural areas and in densely populated urban areas must be taken into consideration.

2.8 Restructuring of the big mental hospitals

The big mental hospitals must be reduced in size or divided up into manageable units (functional teams), because

— their unfavourable situation and the size of their admission areas make it difficult for them to participate in community care for their catchment population as a whole;

— the average duration of stay increases with the distance between place of residence and place of treatment, and the chances of resettlement diminish correspondingly;

— the risk of institutionalism grows with increasing duration of stay.

2.9 Separation of care for the mentally ill and the mentally retarded

The care of the mentally ill and the adult mentally retarded must be separated. The mentally retarded living in psychiatric hospitals are there, for the most part, only because there is no other sheltered residential accomodation for them. The mental hospital is fundamentally unsuitable for their treatment and care. Most mentally retarded patients need much more the type of institution which could offer:

— a sheltered residential situation with suitable facilities for recreation;

— facilities for remedial education, social therapy and rehabilitation;

— sheltered workshops;

— psychiatric and medical consulting services.

The development of an independent care system for the mentally retarded and handicapped is a matter of high priority. Neglect of these groups is no longer acceptable. The provision of complementary services (homes and hostels) for the handicapped should be a statutory obligation.

2.10 Collaboration of all participating professional groups

The need for multi-disciplinary cooperation in psychiatric and psychosomatic specialist services must be borne in mind in organizing the institutions. The character of mental illnesses — in particular, of those which run a chronic course — is more fundamentally affected by social and psychological factors than is the case with physical illnesses. The significance of such factors for the clinical picture, course and prognosis must therefore be taken into account in all diagnostic, therapeutic and rehabilitative measures. Medical, psychological, psychotherapeutic, social and remedial-educational aids must mutually reinforce one another. In the treatment of the mentally ill and handicapped, they form parts of an integrated whole. The contrasting of a "medical" with a "social" psychiatry must be regarded as divisive and harmful.

2.11 Equal status for the mentally ill and the physically ill

The mentally ill must be given equal status with the physically ill. All hitherto existing legal, financial and social disadvantages must be obviated.

2.12 The care of the mentally ill and handicapped as part of general health care

The in-patient care of the mentally ill and handicapped must become a basic part of medicine as a whole, through integration into the existing system of health care and sickness provision. This integration into the main body of medicine is an essential prerequisite for improvement of the care of the mentally ill and handicapped.

2.13 Promotion of education and training

All efforts towards reform must be accompanied by systematic education and training of the professional groups participating in mental health care. Improvement in the qualification of those active in the care of the mentally ill and handicapped is a fundamental requirement for the succes of reform.

2.14 Intensification and promotion of research

Prerequisite for improvement of the health-care structure and the treatment facilities is a systematic intensification and promotion of research in the fields of psychiatry and psychosomatic medicine.

3 The recommendations in detail

3.1 Counselling services

3.1.1 Specialist and non-specialist counselling in first contact and primary care services

Recommendations are listed below for the following professional groups:

a) For professional workers who have to deal frequently with mentally disturbed persons, or who are concerned with the conditions giving rise to, and with the consequences of mental disorders, namely:

   — teachers, nursery teachers, play-group leaders;

   —various professionals involved in the work of the courts;

   — priests and ministers of religion;

b) for workers in public institutions who have professional advisory duties, in particular:

   — school psychological services;

   — vocational guidance, investigation and referral sections of employment exchanges and social-security departments;

   — public health department staff;

c) above all, for social workers in youth and social-service departments, prison services, public health services, in industry and in voluntary organizations.

1. In education and training programmes increased attention should be given to knowledge from the fields of psychology (especially dynamic, learning — and social psychology), of psychotherapy and of psychiatry.
2. Establishment of permanent facilities for advice and supervision from psychiatric and psychotherapeutic agencies, from correspondingly qualified special advisory services, or from specialists appointed on a full-time, part-time or consultative basis.

In addition, the following are recommended:

3. Rapid build-up of school psychological services and training of teachers as school counsellors with competence in the management of psychosocial conflicts and crises.
4. Increase in the number of posts for remedial teachers in schools, residential homes and corrective centres.
5. Coordination of those public institutions which have counselling functions with psychiatric and psychotherapeutic agencies.

3.1.2 Counselling units with special functions

An important task of primary mental health care is undertaken by those counselling units, whether of privity, public, church or voluntary agencies, which in the course of their normal functioning deal extensively with mental disorders, conflicts and crises. This applies above all to units for family counselling, child guidance and marriage guidance, to youth advisory services and old people's advisory services and to various counselling services for alcoholics, drug addicts and those with sexual problems or suicidal tendencies. For this sector, the following recommendations are made:

1. Increased establishment of guidance or counselling units, with emphasis on:
   a) priority for hitherto neglected or inadequately served areas;
   b) staffing with qualified multi-disciplinary teams, thus enabling out-patient treatment to be provided in a community setting.
2. Combination of family counselling, child guidance and marital counselling by the establishment of new counselling centres, with a correspondingly differentiated staffing; integration of the existing guidance centres with these functions, on a collaborative basis.
3. Testing of the model of "psychosocial contact centres" as agencies designed to provide integrated, community-based counselling services for special fields. These should offer or negotiate help in acute conflict situations, as well as being active in preventive care.
4. Organization of counselling work for social problem groups in their interpersonal and living-situations.

5. Development of counselling services for university students.

6. Coordination of the counselling centres with psychiatric and psychotherapeutic agencies in the narrow sense.

7. Development of advisory and supervisory facilities for persons and institutions involved in general professional and non-professional counselling activities.

8. Examination and revision of educational and training courses and of opportunities for vocational training leading to qualification for work in the multi-disciplinary teams of the counselling centres.

3.2 Out-patient services

3.2.1 The neuropsychiatrist in panel practice

According to information from the Federal Association of Panel Doctors (Kassenärztliche Bundesvereinigung), on 31st December 1974 there were 1,041 neuropsychiatrists in panel practice. The greater part of psychiatric out-patient treatment is undertaken by these practitioners, if one judges in terms of numbers of patients.

Apart from an increase in the number of neuropsychiatric practices, at least to a ratio of about one practice for 50,000 inhabitants, all appropriate measures must be directed towards a better-balanced distribution of the practising neuropsychiatrists between densely populated zones, small towns and rural areas, in order to achieve an equitable level of care for the whole population.

Recommendations for the improvement of out-patient care by the practising neuropsychiatrists can be formulated as follows:

1. Postgraduate neuropsychiatric training must be intensified. Instruction in various psychotherapeutic methods must be included in the training, as well as practical experience in the field of outpatient care. This intensification of neuropsychiatric training should not, however, lead to an extension of the training period.

2. The flow of information and the cooperation between practising neuropsychiatrists, clinical institutions, social services and psychotherapeutic agencies, as well as with colleagues in other specialties, in particular general medical practitioners, must be promoted and improved.

3. Collaboration with social workers and related professionals should be made possible in neuropsychiatric practice, by means of appropriate regulations.

4. The cooperation between physicians, whether drawn from the same or from different specialties, should be increased by means of group practices or practice associations, with inclusion of clinical psychologists.

3.2.2 Out-patient services in psychiatric hospitals and other institutions

The separation between in-patient and out-patient treatment services at present found in the FRG is increasingly regarded as a serious limitation in the provision of community care for the mentally ill and handicapped. Under existing conditions, the two sectors of treatment do not form complementary parts of a total system within which the need for treatment services is being fully covered. As a consequence, a proportion of the mentally ill and handicapped suffers from a quantitative and qualitative inadequacy of care, especially of aftercare; or indeed receives no care at all.

The Expert Commission therefore considers it imperative that:

— the manifest gap in out-patient care for a section of the mentally ill should be filled by means of out-patient services supplied by the in-patient psychiatric units;

— out-patient services of this kind should take an active initiative in following up and seeking out patients in the community.

The out-patient service of the psychiatric hospitals should undertake, in particular, the following tasks:

1. aftercare and further measures for rehabilitation;

2. out-patient investigations and treatment to prevent relapses or to avert in-patient admission;

3. crisis intervention in densely-populated areas (24-hour-services) with the aim of providing therapeutic and advisory help on the spot for acute crises such as threatened suicide, states of acute excitement, etc.;

4. consultative treatment and advisory services for institutions which undertake care of the mentally ill and handicapped in any form (for example, old peoples' nursing homes, hostels, etc.).

The out-patient services in psychiatric hospitals, called for by the Expert Commission, should not be set up in competition with the panel doctors, but in order to supplement the system as a whole with an essential component of comprehensive care.

3.2.3 Special psychotherapeutic out-patient services

Out-patient psychotherapeutic treatment takes place in the office practice of specialist psychotherapists and in policlinics or out-patient clinics which are linked to special hospitals or psychosomatic departments in university hospitals, or to psychotherapeutic teaching institutes.

For the future development of this field of care, the following are recommended:

1. extension of the already existing psychotherapeutic policlinics and creation of new ones;

2. creation of out-patient clinics for children and young persons as part of psychosomatic departments, in children's hospitals and in training institutes for child psychotherapists.

It is also recommended that model out-patient mental health care services should be promoted on a regional basis in areas with outstanding deficiencies of provision. This model of care, which can be adapted in a flexible way to local conditions, and can be developed from various forms of existing services, could be allocated the following tasks:

— psychotherapeutic counselling, referral of the mentally disordered and mentally ill, treatment and prevention within restricted limits;

— cooperation with general practitioners, guidance centres, schools, kindergartens, social service departments, aftercare agencies, etc.;

— psychotherapeutic facilities for children and young persons, as well as for families.

3.3 In-patient services

3.3.1 Psychiatric hospitals and departments

The Expert Commission makes the following recommendations for the future structure of in-patient psychiatric hospital care:

1. The model for psychiatric in-patient care should be the psychiatric treatment centre, which can be implemented:
   — as a psychiatric department of a general hospital,
   — as a psychiatric hospital.

2. Appropriate psychiatric in-patient hospital units must be related to defined catchment areas. The extent of the care responsibilities allocated to a hospital unit must be in proportion to its size and to the functional capacity of its services.

3. Psychiatric departments and psychiatric hospitals must be so structured and planned in their functions, and must so cooperate with the diagnostic, therapeutic, counselling and supportive services of the catchment areas allocated to them, that a division between acute- and chronic-illness sectors, to the disadvantage of both categories of patients, can be avoided.

4. Psychiatric departments should be established wherever possible in general hospitals. The establishment of psychiatric departments in general hospitals can, however, be advanced in accordance with these aims only if the situation of psychiatric care in the catchment area as a whole is taken into consideration. The development of care should proceed in such a way, that the general hospital psychiatric department serves as an organic part of the total system of psychiatric care for a defined service area.

5. The bed capacity of the psychiatric department must depend upon the need and upon the distribution of treatment and rehabilitation facilities within the defined service area. As a general guideline, the Expert Commission recommends units of approximately 200 beds.

6. The necessary integration of general hospital psychiatric departments into the comprehensive care system of a service area must be effectively guaranteed.

7. Psychiatric hospitals can themselves, in order to meet local needs, set up and run psychiatric departments which are geographically separate but functionally linked to the parent institutions ("satellite-model").

8. The incorporation of general hospital psychiatric departments in the growth of comprehensive area-based care systems cannot always be realized. In those instances where no other possibility exists, the building of a psychiatric hospital must be accepted as necessary, although the resulting disadvantages for a close connection between psychiatry and general medicine must be clearly recognized. The total bed-capacity of such a medically and administratively independent hospital should not as a rule exceed 500 to 600 (subject to economic feasibility).

9. Non-specialized psychiatric hospitals should be so differentiated in function that they can care for all categories of mentally disordered in the required types of department and special unit, insofar as these do not have to be provided by specialized diagnostic, treatment or rehabilitation units serving regional populations.

10. In the establishment of psychiatric treatment centres, the principle should be observed that only those sub-specialties (departments) be created which have already achieved certain or undoubted independence within psychiatry. These comprise:
    — psychiatric care of children and young people,
    — psychogeriatric care,
    — care of drug-dependent patients,
    — care of the mentally-ill criminal offenders.

11. In order to ensure comprehensive care, it appears necessary to set up intensive care units in psychiatric hospitals.

12. Independent neurological departments with at least 40—60 beds should be set up in conjunction with a psychiatric treatment centre wherever the need in the service-area population is sufficient to make this clearly indicated.

13. It is desirable that the psychiatric treatment centres should establish psychotherapeutic departments. The principal activity of such departments should consist predominantly in out-patient and consultative services.

3.3.2 The therapeutic milieu in psychiatric hospital units

The provision of appropriate hospital units will not, in itself, suffice to meet the needs of mentally ill and handicapped patients during their hospital stay

or to exhaust the possibilities of modern psychiatric treatment. The Expert Commission regards the provision of an adequate standard for the fulfilment of humanitarian requirements as a basic condition. It must be taken for granted that each patient should have his personal possessions and personal clothing. Since the great majority of patients are not confined to bed, there must be an adequate provision of recreation and group rooms. Psychiatric wards should be open whenever possible. The patient should be free to move about inside the hospital and whenever possible outside as well, and to receive visitors. Psychiatric wards should be so arranged that they can accomodate patients of both sexes.

Of crucial significance in the treatment and rehabilitation of the mentally ill is replacement of a custodial atmosphere, which fosters passivity in the patients, by a therapeutic programme calling for active patient participation. This requires above all an adequate provision — within a planned programme of daily activities of group, occupational and work therapy — of facilities for sport and leisure, and of other activities promoting communication, which should be supplied on the ward or in central units provided for the purpose. In this way, the continuing cooperation of patients with one another and with the treatment staff, as well as the opportunity for joint participation in daily activities, can give a basic impetus to communication and social training.

The organization of a therapeutic milieu and an up-to-date therapeutic style are indispensible elements in psychiatric treatment. Careful investigations have shown that the number and the severity of those handicaps hitherto caused by the institution itself can be reduced through planned innovations of the kind indicated above.

To realize these aims, the various professional groups working in psychiatric institutions must cooperate more closely than hitherto, and must take part in regular group-discussions. The physician should thus be able to hand over some of his traditional functions to other staff members; for example, nurses and nursing sisters, social workers, psychologists, occupational therapists, etc. The patient himself, in such a system of mutual cooperation, will no longer be regarded merely as a passive object, but rather as a participant, who will be enabled — within his limits — to take an active and responsible part in the organisation of his own life.

3.3.3 Patient Advocates and Advisory Boards

1. It seems imperative to create the post of Patient's Advocate by means of appropriate legislation. The Patient's Advocate should have the function of an independent representative for all ill and handicapped persons in in-patient accomodation.

2. In addition, an independent Advisory Board (Board of Control) should be set up with responsibility for the psychiatric hospitals and institutions for the handicapped, as a further development of the so-called inspecting commissions already existing in a number of federal states, and along the lines of some foreign models. The Advisory Board should be answerable to the provincial state government. The Board of Control, in addition to its general supervisory functions in the hospitals, institutions for the handicapped and various special units, should also undertake advisory tasks.

3.3.4 In-patient psychosomatic units

Although the main emphasis in psychosomatic care is on out-patient treatment, psychosomatic departments and hospitals for defined patient groups are also required. Here the objective is the building up, in stages, of a differentiated in-patient psychosomatic care system, which can fulfil various tasks, according to the structure of the individual units. The in-patient psychosomatic units should as a rule be combined with out-patient clinics.
Priority should be given to the following individual recommendations:

1. incorporation of psychosomatic departments, with out-patient and consultative services, in psychiatric hospitals and general hospitals;

2. the extension of existing psychosomatic hospitals and creation of new, independent psychosomatic hospitals, as required.

The following are recommended, as further stages in long-term development:

3. the incorporation of psychosomatic departments in rehabilitation hospitals;

4. the incorporation of psychosomatic department in children's hospitals;

5. the establishment of psychosomatic departments in universities and training institutes;

6. the establishment of small psychosomatic clinics each with about 50 beds, as special clinics for special patient groups;

7. the establishment of independent psychosomatic hospitals for children and young people.

3.4 Partial hospitalization

Day hospitals and night hospitals, as important links in the treatment chain, represent essential components of the care system. They are a basic prerequisite for the graded rehabilitation of the mentally ill and handicapped. The Expert Commission therefore recommends that the building and development of such services should be put into effect or expedited, wherever possible.

3.4.1 Day hospitals

1. The day hospital is a unit for the treatment predominantly of acute or subacute mentally ill patients with sufficiently stable social backgrounds, who can therefore remain a limited time in care each day, but who spend the evening and night at home.

2. Day hospitals must have the same diagnostic and therapeutic facilities as psychiatric in-pa-

tient departments, and differ from the latter mainly through their smaller capacity and their part-time provision of care. They should be linked to independent psychiatric treatment centres, or to the psychiatric departments of general hospitals.

3. The need for day hospital provision depends to a varying extent on the structure and development of local in-patient, out-patient and complementary services. As a rule, each day hospital should be of a size to provide about 20 places.

4. The day hospital must be under medical direction. A medical practitioner must be available at all times when patients are present.

3.4.2 The night hospital

1. The night hospital is a part-time treatment facility, in which mentally ill persons who are working can reside and receive treatment for limited periods. The basic premise for admission to a night hospital is that the distance from his place of work is not too great for the patient to make the daily journey without undue strain.

2. The night hospital should be close to, and functionally connected with, a psychiatric in-patient hospital unit and a day hospital, so that prompt medical intervention and treatment is guaranteed during crises or physical illnesses which make the patient temporarily unfit for work.

3. It is considered that a night hospital should provide not more than 15 to 20 beds, thus ensuring a small group character and a family-like atmosphere.

4. The night hospital must be under medical direction.

3.5 Complementary services

The Expert Commission regards as imperative the construction and development of units for the care of those mentally ill and mentally handicapped persons who do not require hospital facilities. Such units should be referred to generally as complementary services because they complement the in-patient, out-patient and day-patient facilities.

How quickly, and to what extent, the burden on in-patient treatment units can be reduced, will depend upon the quantitative and qualitative growth and development of care by means of such complementary services; in particular, the restoration of psychiatric hospitals to their real function, the realisation of community-based care, and a medium- and long-term reduction of beds in *all* in-patient units.

3.5.1 Complementary services with full patient-care facilities

1. Complementary services with full patient-care facilities already exist in the form of homes and hostels, whose widely-differing functions derive on the one hand from the various forms of illness and handicap and the various therapeutic measures connected with them; on the other hand from the age-distribution of their inhabitants.

2. Depending upon its type, a home may serve either towards the complete social and occupational resettlement of the patients (half-way house), or, at least in the longer term, to enable the best possible rehabilitation of the patients in a sheltered environment (residential hostel).

3. After careful assessment, the total need for residential places is estimated at 2.24 beds per 1,000 inhabitants.

3.5.2 Other complementary services

Under the rubric "other complementary services", all types of units are comprised which offer a sheltered residential situation, part-time help (support and supervision) and a therapeutic structuring of leisure activities. Such services can be extremely variable, according to the type of patient-group and the particular functions concerned. In particular, the following types of service are concerned:

1. Supervised and unsupervised hostels.

   The units provide an essentially normal living situation for mentally ill and handicapped persons who are not yet adequately stabilized.

2. Boarding-out schemes.

   The boarding-out of mentally ill and handicapped persons in foster families under suitable conditions represents an important form of care.

3. Day centres.

   In many cases day centres, by relieving the burden on families, can obviate the need for institutional care.

4. Patient clubs.
   Patient clubs can serve towards activation and social support of the discharged patient, and towards their easier resettlement in the community.

3.6 Special rehabilitation services

The task of the special rehabilitation services consists in offering the chronic mentally ill and the mentally retarded the possibility of a graded rehabilitation into open industry. If this goal cannot be achieved by the patients concerned, such services can offer a sheltered workplace or the opportunity for learning or exercising appropriate skills.

3.6.1 Workshops for the handicapped

1. The Expert Commission attaches great importance to the provision, according to need, of a well-structured complex of workshops for the handicapped. They are, however, of the opinion that the underwriting and financing of work-

places, or opportunities for exercising appropriate skills in sheltered workshops, must be guaranteed for all disabled persons capable of rehabilitation, regardless of the commercial utility of the products (cf. section 52, Para 3 of the Federal Law on the Severely Disabled). A strict demarcation between those disabled persons who, according to the present statutory definition, can do commercially useful work and those who, although capable of rehabilitation, cannot do so, carries the risk that a further type of unrecognized workshop of inferior quality will be set up. This danger should be combated through a change in the legislation.

2. The Expert Commission considers that — contrary to the principles laid down by the Federal Minister for Employment and Social Affairs for the setting-up and authorization of workshops for the handicapped (Statement of 5th December 1974) — it is necessary, particularly in relation to the requirements of the mentally retarded who are capable of rehabilitation, that the affected services should be more comprehensively provided with staff.

3. The principle that all types of handicaps should be represented together within a workshop does not pay regard to the special needs of the mentally handicapped. The Expert Commission therefore recommends that, in workshops for the handicapped at any rate, separate programmes for the mentally retarded and handicapped should be offered. In densely populated areas, in which a correspondingly high demand for workshop places exists, it can in addition be sensible to plan for separate departments within the workshop for the handicapped, or indeed for separate workshops for the above-named groups of handicapped persons.

4. In the planning of workshops, one must reckon with an immediate need of one workshop place per 1,000 population for the mentally disabled (of which 0.8 per 1,000 should be for the mentally retarded and 0.2 per 1,000 for the chronic mentally ill and handicapped) and with an annual growth rate of about 0.1 per 1,000 in the following years. In the development phase of these workshops annual analyses will be required, in order to monitor accurately the need for places.

3.6.2 Sheltered workplaces

The Expert Commission recommends that provision of sheltered workplaces in open industry should be a statutory requirement. Sheltered workplaces should be made available to an increased extent by commercial firms. They can serve to test the work-capacity of the handicapped, and to permit a graded resettlement in working life. It seems logical, therefore, that workshops for the handicapped should have access to this type of sheltered workplace in nearby firms, in which the process of occupational resettlement can continue.

3.6.3 Centres for the handicapped

1. The Expert Commission recommends, wherever this seems appropriate, that those complementary services offering full patient-care facilities be combined together to form centres for the handicapped. Such centres should be independent units serving large area populations, and having the character of settlements. They should provide care and support for the mentally and multiply-handicapped who require long-term in-patient accomodation. Centres for the handicapped should contain between 200 and 400 beds.

2. The Expert Commission sees in the establishment of such centres a number of advantages. Here, experience with already existing similar institutions were considered:

   a) Centres for the handicapped offer the handicapped persons more space for activity. This will ensure greater safety for the most severally handicapped in particular, as well as greater possibilities for self-expression and self-realization.

   b) The corporate life of the most severally handicapped together with healthy staff in a small community group has a favourable influence on the treatment and rehabilitation of the affected persons.

   c) The staff can be offered better training provision and a better career-structure. This will make work with the severely and multiply-handicapped more attractive.

   d) Establishments of this order of size are economically feasible.

3.7 Services for special age-groups

3.7.1 Care of malajusted, disturbed and handicapped children and young persons

For improvement and restructuring of the care of maladjusted, disturbed and handicapped children and young persons, the Expert Commission recommends the following:

1. Services required for the care of maladjusted, disturbed and handicapped children and young persons should be combined together in linked systems, without regard to the divisions between various authorities and administrations. This should ensure an organisation based on need, and a direct cooperation between the various establishments. In order to allow the necessary differentiation of services, such a linked system should be planned in relation to every two standard care sectors.

2. In the realm of out-patient referral and treatment, care should be based above all on the existing child guidance units. These must accordingly be set up and developed, as a matter of urgency, as counselling units for children, parents and families, to such an extent that a

complete, multi-disciplinary team (psychologists, physicians, child-psychotherapists, social worker and special teacher) is available for every 50,000 inhabitants.

3. To be included in this linked system are the training units and day-care units for mentally retarded and handicapped children and young persons (special schools and kindergartens, day centres, diagnostic and assessment units, etc.).

4. For children and young persons for whom an out-patient mode of care is inadequate, because of the nature of the mental disturbance, the severity of handicap or the existing conditions in their social environment, a range of facilities for short-term residential care — homes, week-day homes, day hospitals or day centres — should be made available. Apart from the fact that these form part of the linked system as a whole, they could also be directly connected to one or more counselling units. In addition, homes will be needed for handicapped children and young persons, for whom in so far as their primary need is for special remedial education, long-term in-patient accomodation should be available in every standard care sector.

5. For young persons in conflict and crisis situations, with antisocial behaviour or with drug abuse, day centres (day clinics) residential homes and residential groups should be set up within the linked system of care and if possible, in connection with counselling units with a corresponding sphere of interest, in order as far as possible to avoid the need for other measures.

6. Central out-patient psychiatric services for children and young persons should support the other types of unit in the linked system, by providing direct access to special child psychiatric, neuropaediatric, medical and psychological diagnostic facilities, and should supplement them by means of short- and middle-term in-patient investigation and treatment, as well as through long-term special in-patient care.

   It is recommended that the centres for child psychiatry should comprise an out-patient clinic, a unit for in-patient diagnoses, short- and medium-term in-patient treatment, and a spatially separate unit for the long-term in-patient care of children and young persons with psychoses, multiple handicaps or brain damage. A centre of this type is envisaged for each linked system (two standard sectors). It can be set up as a fully autonomous special hospital, or — provided it is effectively independent and separate — in association with a general, psychiatric or paediatric hospital.

7. Regional units are required for a variety of special tasks (in-patient psychotherapy; care of mentally ill, epileptic and brain-damaged children and young persons requiring constant supervision). As far as possible they should be linked with centres for child psychiatry, so that special diagnostic and therapeutic facilities can be provided in common.

8. The provision of postgraduate education and training facilities must be extended, in particular for the following groups:

   specialists in child psychiatry;
   child psychotherapists;
   clinic psychologists specializing in child psychology.

3.7.2 Care of mentally ill old people

Whereas some other diagnostic categories have become less common, the proportion of psychoses of old age among admissions to mental hospitals in the FRG has increased appreciably. For better care of these patients, the Expert Commission recommends the following:

1. Independently functioning psychogeriatric units should be set up in the psychiatric treatment centres.

2. Because physical and mental disorders often co-exist in late life and the interlocking of psychiatric and general medical care is especially important for old people, psychogeriatric care units must also be created within the psychiatric departments of the general hospitals.

3. An important component of the psychogeriatric in-patient units should be so-called "assessment units". Such a unit consists of a ward in which the patients are admitted only temporarily in order to decide, on the basis of an early multi-professional diagnosis — to the extent that this cannot be done in an out-patient setting — which services and units are most appropriate to the patient's needs, and, where indicated, to initiate treatment.

4. Wherever possible, psychogeriatric day hospitals should be set up. Such units should permit basic diagnostic and therapeutic measures to be taken without the elderly patient having to be removed from his own accustomed environment. At the same time, temporary relief could be provided by this means for those families wihch themselves undertake the nursing and care of their sick elderly members.

5. The main emphasis in psychiatric care for elderly patients must be placed on out-patient provision. The setting up of psychogeriatric out-patient clinics is recommended, which together with the neuropsychiatrists in panel practice and in close cooperation with the social services — above all the old people's welfare services — should undertake tasks of counselling, treatment and prevention in each standard care sector.

6. Wherever possible, a psychogeriatric out-patient clinic should be combined with a day hospital and an "assessment unit", to form a

combined psychogeriatric centre. This centre would represent a combination of three specially important services for the care of the mentally sick elderly population.

7. Old people's welfare services comprise an essential component of the psychogeriatric care system. Here, the greatest importance attaches to old people's homes and old people's nursing homes. In future, the overloading of psychiatric hospitals with mentally sick old people should be avoided as far as possible by development and restructuring of the already existing old people's homes and by creation of new ones. Such measures will, however, require careful planning and implementation, since the situation of the mentally sick old people could be made appreciably worse by a strategy of compulsory discharge from the psychiatric hospitals and hasty transfer to unsuitable homes.

8. In order to coordinate better the work of the various authorities responsible for old people's welfare services, working groups should be set up in each standard sector by the authorities and institutions concerned. Between these working groups and the psychogeriatric units responsible for multi-professional diagnosis (out-patient clinic and assessment unit) binding agreements should be made on a voluntary basis, in order to permit appropriate placement of patients in the units best suited to their individual needs.

9. The improvement of psychogeriatric care will depend finally on the improvement of educational and training facilities for all occupational groups concerned with the care of old people. The introduction of a medical specialist for geriatrics is required.

10. Psychogeriatric departments should be set up in at least some university psychiatric departments, in order to improve undergraduate education and medical specialist training in psychogeriatrics; above all, however, to create more favourable conditions for psychogeriatric research.

3.8 Services for special patient groups

3.8.1 Drug dependent patients

In recent years, the numbers of alcoholics admitted to mental hospitals have multiplied. Alcoholism and drug dependency now comprise one of the largest admission categories, corresponding to about 30 % of all admissions to psychiatric hospitals. The number of alcoholic confusional states admitted to these institutions has increased within the past few years by about 700 %.

The danger of drug abuse and drug dependency has lost none of its urgency in the FRG in recent years. The numbers of persons experimenting with drugs or taking them occasionally appears to have diminished. On the other hand, the hard-core group of those who are already addicted or, because of persisting drug abuse, are in serious danger of addiction, appears to be increasing. This applies equally to the simultaneous abuse of several drugs. Also important in this connection is the growth of combined use of narcotics and alcohol.

The Expert Commission makes the following recommendations for an improved provision of care:

1. The main emphasis in treatment of alcohol and drug dependency rests today on out-patient care. In future care of the drug dependent, a community-based special out-patient clinic should play the leading role. This out-patient clinic should be in close contact with all those responsible for extramural services for the drug dependent — above all the physicians in panel practice — with public and private advisory centres, and with self-help organizations.

2. From the viewpoint of care for the drug dependent, an affiliation to psychiatric departments in general hospitals is especially desirable, since many cases of alcohol and drug dependence could be recognized earlier than hitherto, and could be brought under psychiatric treatment via the consulting service for general medical patients.

3. In-patient treatment of the drug dependent should be carried out in addiction clinics or special departments for addiction in the mental hospitals or psychiatric treatment centres. These should comprise units with a capacity of about 80 beds, for the most part open, though with sections that could be closed when necessary. The duration of stay in such in-patient treatment units cannot as a rule be laid down uniformly in advance for all patients.

4. Despite the successes which can be achieved today in treating drug addictions, one must still reckon with the probability that many alcoholics and drug addicts will be unwilling to accept long-term treatment and cannot be rehabilitated. Since the patients concerned are often those who exhibit a high degree of self-neglect and who suffer from serious physical or mental damage, their accomodation in closed units cannot always be avoided. In particular, closed nursing homes are necessary, together with some closed wards in psychiatric hospitals for a small number of the affected persons. The treatment of these long-term patients should if possible be part of the task of the same workers who are also responsible for the care of alcohol and drug-dependent patients in addiction clinics and special addiction departments.

3.8.2 Persons at risk for suicide

In the FRG, a total of 9,888 persons committed suicide in the year 1959. By 1971, the number had risen to 12,838. The suicide rate (number of suicides per 100,000 inhabitants) rose from 18.5 in 1951 to 21.0 in 1971.

The number of suicidal attempts is certainly much higher, although it can be only roughly estimated, According to such estimates, one must reckon with

at least 100,000 suicidal attempts each year in the FRG as a whole. The preventive measures essential for combating the problem of suicide risk are sadly lacking. This applies as much to primary prevention, early recognition and preventive care, as to the treatment and aftercare of suicidal patients, aimed at preventing recurrence.

3.8.3 Mentally ill offenders

Contrary to its original opinion, expressed in the Intermediate Report, the Expert Commission has adopted the viewpoint that the accomodation and treatment of mentally ill offenders in penal institutions does fall within the general sphere of competence of organized psychiatry. For the reorganization of this field, the Commission makes the following recommendations:

1. One section of the criminal mentally ill comprises a group of behaviorally disturbed patients, who are actually or potentially violent and therefore require special security measures. Under current conditions, the best solution would appear to be the institutional and administrative attachment of such units to individual psychiatric hospitals, to which whenever possible they should be adjacent. On the other hand, the building of security blocks within the hospital complex itself should in all cases be avoided.

2. Treatment facilities for the mentally ill offender must be greatly extended. Here, large-scale investments in personnel and buildings will be required. The penal authorities must therefore contribute more than hitherto to capital and running costs.

3. The care of mentally ill offenders has to be undertaken by personnel under difficult working conditions, heavy emotional burdens and special risks. The creation of a uniform system of supplementary payments for workers in such units is therefore necessary.

4. The Expert Commission warmly welcomes the planned development of social treatment institutions. However, it is to be feared that the construction of a sufficient number of such institutions will require many years and that until then mentally disturbed offenders, with a manifest need for treatment, will be thrown back increasingly on conditional discharge and accomodation in psychiatric hospitals, which are not equipped to cope with such a trend.

3.8.4 Epileptic patients

Some 5 % of the general population suffer at least once in the course of life from an epileptic fit; 0.5 to 0.6 per 1,000 suffer from chronic epilepsy. This means that for the FRG as a whole one must reckon with about 340,000 epileptics, including about 115,000 under 16 years.

The Expert Commission recommends an improvement of the care of epileptic patients by means of the following special services:

1. for every 1.2 million inhabitants, a special outpatient clinic for epileptic adults and children;

2. for every 7.5 million inhabitants, an in-patient department for treatment of epileptic adults and children;

3. four epilepsy centres for adults and four for children.

Epileptic patients in need of long-term or permanent psychiatric care should be dealt with as mentally ill, mentally retarded or multiply handicapped by the appropriate complementary services (in homes, centers for the handicapped, etc.).

3.8.5 Brain-damaged patients

According to available estimates, in the FRG each year about 10,000 persons suffer severe brain injuries, which they survive and which then present a need for rehabilitation. The Expert Commission makes the following recommendations for improvement in the care of such brain-damaged patients:

1. uniform provision of emergency treatment services, and increase in the number of neurosurgical departments;

2. establishment of rehabilitation departments, integrated within the hospitals (early rehabilitation);

3. creation of special units for brain-damaged patients, aimed at long-term rehabilitation and with facilities for occupational training and resettlement;

4. establishment of wards specially for patients with cerebral contusion, in every large clinic containing a neurosurgical department.

3.8.6 Patients of no fixed abode

The Federal Association for Homeless Persons (Bundesarbeitsgemeinschaft für Nicht-Seßhaftenhilfe) estimates the present number of homeless persons at about 70,000. The number of new cases has increased steadily in recent years. The average age of the homeless is about 45 years, 52 % being between 30 and 40 years old.

Although there is as yet no reliable information available about the causes of homelessness, an underlying complex of individual and social factors may be implicated which give rise to difficulties in forming and maintaining lasting personal relationships, as well as to irreparable loss of relationships. Mental illnesses and handicaps, frequently in association with alcoholism and delinquency, contribute largely to the occurrence of social isolation and social breakdown.

Currently, about 12,500 places are available for homeless persons in some 130 institutions, of which, however, about 30 % are in old people's homes and long-term homes for persons needing nursing care and supervision. In particular, the quantity and quality of local authority accomodation for the homeless is entirely inadequate, frequently still having the character of hostels in which the affected persons must care for their own needs.

Model experiments in out-patient and in-patient care should be undertaken, to establish reliable guidelines for the provision of therapeutic help for the homeless.

3.9 Care of the mentally retarded

Precise information on the number of mentally retarded — that is, of the children, young persons and adults, whose mental development has failed, temporarily or permanently, to reach the normal level for their age because of congenital or acquired disorders — is not yet available for the FRG. Taking into account the difficulties of ascertainment, a rate among the new-born up to 8 per 1,000 appears realistic. The Expert Commission believes that the following basic premises must be adopted in developing a system of care for the mentally retarded:

— living and environmental conditions for the mentally retarded should be so structured that they correspond, as far as possible, to the conditions for "normals". This applies also to relations between the sexes;

— the mentally retarded should, as far as possible, be given access to pre-school and school education, to occupational training, to the exercise of working skills and to normal leisure opportunities. This requires an avoidance of all tendencies towards segregation of the mentally retarded, as well as a readiness on the part of normal healthy persons to accept the retarded in their communities;

— the interests of the mentally retarded and their families must always be taken into consideration.

The Expert Commission makes the following recommendations for the improvement of care:

1. Care of the mentally retarded children and young persons is particularly closely related to the tasks of child psychiatry in the fields of prevention, early diagnosis and intervention, out-patient and in-patient diagnosis and therapy. In this age-group, therefore, care of the mentally retarded should be closely connected with psychiatric care.

2. Care of the adult mentally retarded, on the other hand, should in future no longer be provided in psychiatric treatment centres. Rather, for this age-group, special units are to be preferred in which, apart from the care of the severely and multiply-handicapped, social welfare, rehabilitation and sheltered work facilities should occupy a much more prominent position.

3. The Expert Commission recommends that the expansion of care for the mentally retarded should be energetically promoted in the following areas:

   — early screening and recognition;

   — special kindergartens (including early peripatetic work);

   — special groups in kindergartens;

   — special schools, special classes in the normal schools, facilities for home-tuition;

   — workshops for the retarded, occupational training places, special advancement courses, sheltered workplaces;

   — differentiated residential and leisure facilities;

   — advisory services;

   — crisis-intervention services;

   — units for special groups (e. g. the multiply-handicapped; the aging mentally retarded).

   In the main report, the distribution of units for the mentally retarded in a standard care sector or in a larger region is given together with corresponding estimates of need.

3.10 Combination of the necessary services in geographical areas

3.10.1 Standard care sectors *

The community-based cooperation of all persons and institutions concerned with the counselling, treatment, care and rehabilitation of the mentally ill, retarded and handicapped can only be guaranteed, if their many different tasks and activities can be related to defined geographical areas.

The Expert Commission therefore proposes that care sectors should be created, whose size should correspond to from 150,000 to 350,000 inhabitants and as a rule to 250,000 inhabitants. This type of geographical area should be designated a standard care sector.

The standard care sectors should, as far as possible, be defined so as to coincide with political or natural boundaries (for example, those of city wards, boroughs, counties, electoral districts, etc.), especially since in this way planning and coordination between local administrative bodies and local health authorities can be most effective.

The capacity and composition of the locally available psychiatric services of a standard care sector should ensure that all inhabitants, other than those who require special regionally-based facilities, can be provided with psychiatric care within the sector.

The facilities for counselling, treatment, care and rehabilitation in the standard care sector can be displayed schematically, as in the diagram (Fig. 1). For further details, in particular the functional coordination of the individual services with one another, the relevant chapters of the report should be consulted.

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* The term 'sector' is used here to refer to a geographical area with a population of about 250,000 (cf. 'sectorization' of psychiatric services).

Fig. 1

Mental Health Services in a Standard Care Sector

Primary medical care & social care agencies

General professional & non-professional counselling in the fields of:

— education
— pastoral work
— legal advice
— employment & social security
— social work

Counselling & guidance centres

General medical practitioners

"Psychosocial contact centres"

Medical specialists (non-psychiatric) in office practice

Extramural specialist services

Neuropsychiatrists in office practice

Medical & non-medical psychotherapists in office practice

Guidance / counselling centres for children, young persons & parents

Child psychotherapists in office practice

Mental health community centres (in under-serviced areas)

Hospital out-patient services	*Partial hospitalization*	*In-patient services*	*Complementary services*	*Special rehabilitation services*	*Services for the handicapped*
Out-patient clinics in psychiatric treatment centres	Day hospitals & night hospitals	Psychiatric departments in general hospitals	Halfway houses	Workshops for the handicapped	Centres for screening, early diagnosis & early treatment
Psychosomatic out-patient clinics	Day hospitals & night hospitals for special patient-groups	Psychosomatic departments in psychiatric & in general hospitals	Hostels & homes for special patient-groups	Sheltered workplaces in industry	Special kindergartens
Special out-patient clinics			Sheltered living-groups & dwelling houses		Special schools
			Boarding-out schemes		Special classes in the ordinary schools
			Day centres		Training, recreational & holiday centres
			Patients' clubs		
			Units for the profoundly & multiply handicapped		

COORDINATION — Mental Health Coordination Committee
Cooperation of responsible authorities
Mental Health Association — PLANNING

3.10.2 Regional care facilities

Administrative regions should be formed from a number of standard care sectors. At this level units and services must be provided which, because of their capacity and/or degree of specialization, have to be related to larger population units.

The following units must be based on such administrative regions:

— psychiatric hospitals (with 500 to 600 beds);

— independent psychosomatic hospitals;

— psychosomatic departments in large convalescent clinics, rehabilitation hospitals and children's hospitals (long-term planning);

— independent psychosomatic hospitals for children and young persons;

— psychosomatic out-patient clinics for children and young persons;

— in-patient and day-patient units for children and young persons, with special facilities for psychotherapy, remedial education and special education;

— departments for young persons in conflict situations, with antisocial behaviour etc.;

— in-patient and day-patient units for mentally retarded children and young persons;

— addiction clinics;

— special hospital departments for the drug-dependent;

— centres for child psychiatry;

— centres for the mentally handicapped;

— epileptic centres, hospital departments and out-patient clinics for epileptic patients;

— centres for high-risk children;

— special units for rehabilitation of the brain-damaged;

— units for mentally-ill offenders;

— industrial rehabilitation workshops;

— occupational training workshops.

In addition, the following should participate in provision of care:

— psychiatric university clinics;

— psychosomatic departments of university clinics and training institutes.

3.11 Coordination and planning

The Expert Commission is emphatically of the opinion that services for the mentally ill and handicapped as a whole, because of their necessarily close involvement with other medical disciplines and with non-medical services, especially in the social area, can only be improved to an optimum level, if they are effectively coordinated and their further development bound together by means of ongoing planning.

3.11.1 At the community level

1. At the level of the standard care sector, each service participating in care, treatment or counselling in this field should be represented on a mental health working group. The authorities responsible for institutions and services participating in the care of the mentally ill and handicapped should also, if they have not already done so, set up a committee with coordinative functions.

2. In order to ensure effective coordination and planning in the standard care sector, the Expert Commission recommends the establishment of a mental health committee by the county and city local authorities. All services, institutions, local government bodies and local administrations should be represented on the mental health committee. The secretarial and administrative work of this committee should as a rule be undertaken by the responsible health authorities of the participating counties and cities.

3.11.2 At provincial state level (the Länder)

1. The coordination and planning functions of the counties and cities must be united at provincial state level, especially as responsibility for planning rests with the Länder.

   It is therefore recommended that the so called "psychiatric offices", which already exist in some state ministries, should be expanded into departments for mental health care, or that corresponding departments should be newly established.

   Corresponding to these proposed reforms in the coordination of services for the counties and cities, the ministerial department should be integrated in the sections for health and social security, independent of any administrative demarcation, so that a close coordination with both these areas would be ensured.

2. The section for mental health care should have the standing of an advisory committee on the care of the mentally ill and handicapped.

3.11.3 At federal level

1. The Expert Commission recommends creation of an Institute by the 11 Federal Länder. This Institute should be set up on the basis of joint-user agreements between the Länder. Its task should consist essentially in the collection, processing, analysis and publication of data and information on the care of the mentally ill and handicapped in the GFR, in the development of survey methods and health statistics, and in the carrying out of special commissions from the Land governments and the Federal government.

2. The Expert Commission regards it as indispensable that at the Federal level, exactly as at the state provincial level, a department of the Ministry for Youth, Health and Family Affairs should be responsible for provision of health care for mentally ill and mentally retarded persons, including provision of nursing care.

3. The Federal Ministry for Youth, Health and Family Affairs should without delay set up a joint working party, whose main task should be to press for the recommendations set out by the Expert Commission, to work out ways of implementing these recommendations and to apply the planning concepts of the Expert Commission to innovations in the field of care.

3.12 Education and training

3.12.1 General viewpoints

The most important goals of all planning in the area of education and training are:

a) to increase the number of persons active in the care of the mentally ill and handicapped;

b) to improve the quality of training for all occupational groups.

The following steps should be taken to promote these aims:

1. Development of systematic training for as many occupations as possible. The various stages of the training courses should lead to higher qualifications equipping the holders to undertake more responsible duties.
2. Adjustment of training courses to meet the needs of practice, and with regard to subsequent coordination and integration in the various occupational fields.
3. Especially energetic promotion of specialist training, which should also be closely related to the needs of practice.
4. The harmonizing of different training courses, so that all those active in the care of the mentally ill and handicapped, despite different emphases in their practical work, should be basically in a position to assess the significance of biological, psychological and social factors in the incidence and treatment of mental illnesses and handicaps. In this connection, one must especially remember that, in many areas of the current care system, attention to psychological factors and to social aspects and consequences of mental illnesses are seriously deficient.
5. The creation of common interdisciplinary programmes in professional training which, however, should avoid any loss of the special interests of each professional group.
6. Increased attention, in professional training courses, to the modification of trainees' behaviour and attitudes towards the mentally sick and handicapped, by means of the techniques available for this purpose ("self-experience").
7. Improved education and training of professional groups, who are not trained basically for the care of the mentally ill and handicapped, but who in the course of their professional work regularly undertake some counselling and care functions.
8. The improved staffing and equipment of education and training centres.
9. Promotion of educational research, which should be combined with testing of the efficiency of different educational and training models.
10. Coordinated planning of training courses for the various professions at federal and state provincial level, as well as their adaptation to developments on the international scene.

3.12.2 Education and training of the various professional groups

In seeking to improve education and training of the various professional groups active in care of the mentally ill and handicapped, a number of different viewpoints must be taken into account.
The undergraduate, graduate and postgraduate education of medical personnel can be improved through the following:

1. increased consideration of out-patient care in both undergraduate and graduate training;
2. inclusion of psychiatric hospital experience in undergraduate and postgraduate education; this is in theory already a required part of postgraduate education, but in practice is not always achieved;
3. practical experience for all medical students in a psychiatric or psychosomatic treatment unit before or during their clinical training (nursing experience, clinical clerking or practical clinical duties in the third clinical study period);
4. creation and build-up in organization and personnel of training departments for medical psychology and medical sociology in all medical faculties and specialties;
5. implementation of the group training required by the approved medical curriculum;
6. an increase in the numbers of training places in all branches of the care of the mentally ill and handicapped;
7. systematic inclusion of aspects of care hitherto given little attention; increased emphasis on psychotherapy and psychosomatic medicine in the postgraduate training of neuropsychiatrists, psychiatrists and child psychiatrists;
8. regional organization and coordination of professional training;
9. special emphasis on promotion of postgraduate training for specialists in child psychiatry;
10. federal regulation of the training courses for the additional qualification "psychotherapy", which many general practitioners, as well as physicians in other specialties, should be encouraged to take;
11. introduction of a specialist physician and a recognized specialty in the field of psychotherapy and psychosomatics. In implementing this recommendation, however, the additional qualification "psychotherapy" must be regarded as a basic requirement so that its importance is not diminished and that, in further training courses for psychiatry and child psychiatry, the psychotherapeutic content and the qualifi-

cation in psychotherapy remain an integral part which will be broadened and extended;

12. intensification of graduate training facilities, both for physicians specializing in the care of the mentally ill and handicapped, and for physicians in other specialties, in order to make them familiar with important developments in the fields of psychiatry, psychotherapy and psychosomatic medicine.

For all other professions engaged in the care of the mentally ill and handicapped, application of principles corresponding to these detailed proposals for medical education is to be recommended. Here the first consideration must be development and elaboration of training measures corresponding to the structure already existing in medical undergraduate, graduate and postgraduate education. In particular, the following points should be considered:

Psychologists would be able to take over many tasks in the care of the mentally ill and handicapped if — as is urgently necessary — the subspecialty of clinical psychology is given recognition and a status introduced governing the required additional training for non-medical psychotherapists.

The improved education and training of all nursing groups should be energetically promoted, so that basic knowledge and skills as well as qualifications for work with the mentally ill and handicapped can be acquired. Training courses must be developed for trained nurses and nursing sisters, as well as for nursing assistants. For nursing sisters and nurses the Expert Commission recommends:

1. that in basic training psychiatry should be recognized as a main subject after internal medicine and surgery, and that "psychological medicine" should be recognized as a subject for specialist training.
2. that a special elective course should be made available in the third training year, leading to the acquisition of an additional qualification;
3. that specialist training leading to the title "nursing sister for psychiatry" or "psychiatric nurse" should be provided. This further training should primarily open the way to increased responsibility and to a decision-taking role for nursing staff engaged in institutional care. The duration of such a course should be fixed at not less than 1—1½ years;
4. to offer the possibility of acquiring a qualification "nursing sister or nurse for psychiatry, psychotherapy and psychosomatic medicine" by means of an additional year's training — making 2—2½ years all told.

The one-year training of the nursing assistant should be conducted in accordance with concepts which are practice-orientated and specific to psychiatry. A one-year occupational training course for "nursing assistant in psychiatry" should be developed.

Urgently required is a large-scale build-up of specialist training for nursing personnel, in which opportunities for acquiring increased understanding and self-awareness should be provided.

On the education and training of social workers, the Expert Commission recommends the following:

1. an intensification in the training syllabus of all subjects important in the care of the mentally ill and handicapped, together with increased possibilities for elective courses in psychiatry following on the basic studies. Here, a close integration of theoretical teaching and practical experience must be ensured;
2. a two-year vocational training for social workers, at least one training year should be completed outside psychiatric institutions. The aim of this training is an equipment for further duties in the care of the mentally ill and handicapped with a relative degree of autonomy.
3. Training possibilities, provided both at the regional and provincial level, by which regional courses can be organized in collaboration with other occupational groups.

The further training of social workers, social pedagogues and child psychotherapists has already been established. In the context of the urgently necessary development of child psychiatry, such training will become increasingly important.

In connection with the improvements already introduced into the training of occupiational therapists, special training facilities must be created or further developed for work therapists and in some instances also for occupational therapists, so that the growing tasks in the field of general, social and occupational rehabilitation can be undertaken by suitably qualified workers.

In order to remedy outstanding deficits in the field of residential care, the training programmes for remedial teachers, children's nurses and residential care workers must be energetically promoted. Efforts must be made to ensure that these professional and occupational groups, already established in the care of handicapped and retarded children and young persons, should also be trained to undertake corresponding responsibilities in the care of handicapped and especially of mentally retarded adults. The Expert Commission recommends that evaluative studies should be made to test how far the care of the mentally ill and handicapped could be improved through the creation of new occupational groups (for example, in work with the drug-addicted).

3.12.3 Special viewpoints in psychotherapy and psychosomatic medicine

In the curricula of training courses for members of every professional group which has to undertake preventive, counselling or therapeutic work, making use of medical, psychological and sociological methods, a basic psychological and social knowledge (basic concepts in economy, sociology, developmental psychology, conflict psychology, communication theory and family theory) is essential. In training courses, in which basic psychological

and sociological knowledge is already taken into consideration, increased emphasis must be placed on these subjects, while at the same time ensuring that the curricula are not overloaded. This recommendation holds for the specialties of education (teacher-training), social work, court work, school counselling, medicine, psychology and sociology.

For medical undergraduate education in particular, it is necessary to implement the training in psychotherapy and psychosomatic medicine, made statutory by the licensing regulation of 1970, but so far still largely unrealized, and to create in all German universities independent units for psychotherapy and psychosomatic medicine, which should be set up as teaching chairs with associated departments or clinics. At the same time, the necessary institutional conditions for training in medical psychology and medical sociology must be created.

Postgraduate education should be practice-orientated and accompanied by practical experience, which means that the realities of the psychological and social environment must be incorporated in training, in just the same way as clinical experience.

A medical specialty, together with a medical specialist qualification should be introduced in accordance with the importance of the field of psychotherapy and psychosomatic medicine. Analytical psychotherapy has grown in the past decades to an established specialty which, as can be seen from the current state of medical psychotherapeutic practice and the training requirements of the Institutes of the German Association for Psychotherapy, Psychosomatics and Deep Psychology, already aspires to the status of a medical specialty. Postgraduate training courses comparable to that for analytical psychotherapists are not yet available in other forms of psychotherapy, such as behaviour therapy and supportive therapy. If the question of officially-recognized qualifications is raised in relation to those other psychotherapeutic methods, they must fulfil comparable criteria in relation to basic clinical experience, as also to the extent and requirements of postgraduate training. The introduction of a medical specialist in the field of psychotherapy and psychosomatics will provide opportunity for further consideration and more precise definition of the conditions for conferring the additional title "psychotherapy".

In the postgraduate training courses in general medical practice, internal medicine, paediatrics, gynaecology, dermatology and urology, instruction on psychosocial factors and on techniques of intervention should be included in due proportion. The codification of an independent professional status for clinical psychologists is regarded as urgently necessary. Newly established training courses in psychotherapy for psychologists should correspond to the standards of the existing training courses.

The already-existing training course for child psychotherapists should be considerably extended.
In addition, the following are recommended:

- a special further training course for social workers and social pedagogues, to enable members of these professions to carry out counselling and social therapeutic tasks for the largely uncared-for socially disadvantaged classes of the population;
- further training courses for nursing sisters to enable them to carry out their special tasks and duties in psychotherapeutic and psychosomatic clinics;
- further training courses for social workers and others working in social institutions, counselling agencies, etc.

In the future planning of psychotherapeutic and psychosomatic care, the creation of training institutes is especially important, on the one hand to increase training capacity, on the other hand — and most notably — so that care facilities can be offered for the first time to inadequately-served regions. It is therefore recommended that such regions be given priority in the setting-up of training institutes through provision of adequate staff establishments and other necessary means. To meet the proper targets of care-provision, the setting up of a training institute in each region of one million inhabitants is recommended, whose scale of provision would make it possible to offer training courses, at any rate for psychotherapists and child psychotherapists.

It is urgently necessary to promote psychotherapeutic training for members of all mental health professions.

3.13 Legal problems in the care of the mentally ill and handicapped in the FRG

The Expert Commission has examined a series of various types of legal problems, which are basic to the care of the mentally ill and handicapped. Individual questions are concerned with the legislation controlling employment, social insurance, medical insurance, professional responsibility, civil liberties, reform of the laws on testamentary capacity, guardianship, trusteeship, statutory admission to hospitals and homes, censorship of letters, the diminished responsibility of mentally-ill old persons, voluntary sterilization, confidentiality of data and registration of the mentally ill.

The Expert Commission has made a series of recommendations on these various legal problems, which may be summarized as follows:

1. In all regulations governing social welfare and rehabilitation, mentally handicapped and mentally retarded persons should be awarded equal rights with the physically ill.
2. The central information service proposed in para 5 of the Federal Law on Rehabilitation should be set up without delay, since the existing multiplicity of services and facilities, especially for the mentally ill and handicapped, is confusing and obscure.
3. Limitations in the coverage provided by private sickness insurance, especially for psychotherapy, must be reduced.

4. The greatest possible use must be made of existing legal possibilities for improving outpatient care. The medical associations (Kassenärztliche Vereinigungen) should to this end grant contracts authorizing physicians and medical institutions to the necessary extent. Hospital authorities should support this development. The possibility of sessions in inpatient and day-patient units for physicians in panel practice should be further explored.

5. With regard to the necessary division of work between medical and non-medical personnel in treating the sick, the legislators must define clear areas of activity and responsibility for non-medical professions, for example psychologists.

6. A revision of the laws governing compulsory admission in the federal Länder is required. In particular, a generally stronger emphasis on the welfare aspects of admission — for example, by inclusion of preventive and follow-up supportive measures — should be taken into consideration.

7. The introduction of para 1631a, as intended in the draft "Act relating to parental responsibility" (Drucksache 7/2060) is unsuitable for the resolution of problems arising from the admission of minors at the instigation of their parents and should not be placed on the statutes.

8. A general reform of the guardianship laws is necessary in the interest of improvement of the care of the mentally ill and handicapped.

   What is needed is the development of a graded system of care, instead of or as a supplement to the existing guardianship system, with inclusion of welfare admissions, as well as replacement of testamentary incapacity by ascertainment of "need for care" and simultanoues appointment of a "care-giver" with definition of his area of responsibility.

9. In all the Länder, the legal position governing censorship of letters for compulsorily admitted patients should be stipulated if this has not already been done.

10. The existing schemes for rewarding work done by mentally ill and mentally retarded patients in the psychiatric hospitals should be replaced by real wages. New legislation must be passed to implement this recommendation, independently of the legal categorization of the patients' work. This legislation could constitute a "law relating to the minimum working conditions for therapeutic sheltered work".

11. In view of the various functions of different types of residential homes, minimal requirements for such homes must in each case be specified in terms of the standards for staffing, equipment and space. In homes which serve also for nursing care and treatment, a physician should participate in the administration. The unclear and dubious expression "nursing-care case" should be dropped from use.

12. The special problems of offences by old people must be given more attention than hitherto by the criminal authorities. It should be considered, whether or not for the first offence in late life the judge should be obliged to order an assessment of criminal responsibility in accordance with paras 20 and 21, and whether or not the judge is basically required in cases of diminished responsibility in old persons to proceed under the provisions for diminished responsibility under para 21, together with para 49, of the Federal Legal Constitution.

13. A statute should be introduced to permit the voluntary sterilization of mentally retarded persons who are capable of forming a decision, and for whom the operation is indicated in the best interests of their own welfare.

14. The laws and the draft laws for protection of confidential data from misuse should be examined with special regard to the need for confidentiality in treating the mentally ill and handicapped, with the help of psychiatric experts and under review of the federal and provincial state authorities responsible for mental health care. In this context, specific regulations governing confidentiality of data must be introduced to cover the special interests of the mentally ill and handicapped, in so far as these are not already covered by application of the general regulations of confidentiality.

15. Para 13 of the Federal Central Registration Law should be repealed without qualification.

3.14 Prevention

The Expert Commission has concerned itself in a number of its working groups with the extremely important problem of the prevention of mental illnesses and handicaps. Recommendations relating to early ascertainment, early intervention, prevention of relapses and chronicity are to be found above all in the sections dealing with primary medical and social care and with complementary and rehabilitation services, as well as with the care of special age-groups and patient-groups. The question of whether and how far the incidence of mental disorders and handicaps could be prevented in the first place is viewed in a separate chapter. In that section, possibilities are discussed as to how, on the one hand, the influence of risk factors — including those in the home and working environment — could be removed or mitigated, and on the other hand how the resistance of the individual to such factors could be increased. A large part of the recommendations on primary prevention are understandably based on measures focused on children at risk; increased facilities for guidance and special educational facilities for parents, kindergarten workers, educationists and teachers; consideration of mental hygiene promotion in the general educational sphere; development of differentiated vocational and professional guidance facilities. In addition, however, the promotion of community-based family advisory centres and crisis interven-

tion facilities is supported and the development of measures for the prevention of alcoholism and drug addiction are recommended. For the older age-groups are envisaged above all facilities for gradual retirement, various social activities in residential units for old people and their improved mental hygiene care.

3.15 Research

The Expert Commission makes the following proposals for the intensification and promotion of research in the field of psychiatry and psychosomatic medicine:

1. Stocktaking of the content of research.
2. Promotion of research departments in universities, or of research units in psychiatric hospitals and drug-addiction clinics, with clearly defined research programmes to be developed in stages.
3. Stronger promotion of research centres and units, which could provide training in research for younger scientists in the various specialties.
4. Provision of means for international cooperation and for exchange of scientists.
5. Release of scientific and clinical university teachers in special cases from part of their teaching duties; creation of clinical research chairs.
6. Modification of the regulations for appointment of assistants in research programmes. The requirements laid down in the university ordinances of several Federal Länder for temporary scientific assistants to undertake their own research is a questionable instrument for the promotion of scientific training. The temporary right to do one's own scientific work must — just as in the award of a research fellowship — remain dependent on the evidence of relevant research plans and their continuing execution, as well as of previous scientific achievement.
7. Introduction of an advisory procedure with ongoing supervision of projects in the context of the normal procedures of the German Research Association (Deutsche Forschungsgemeinschaft). Here, the special scientific competence and experience of the advisors themselves must be better guaranteed than has up to now been the case with the German Research Association (DFG).
8. Creation of posts with tenure for life, e. g. in clinics and institutes for specially skilled and established scientific workers in psychiatry and psychosomatic medicine without compulsion to pass through all stages of a university teaching career.
9. Integration of departments or working groups for clinical psychology and of the newly created departments or chairs of medical psychology and sociology in clinical psychiatric centres so as to ensure the necessary direct relation to clinical practice.
10. Creation of better conditions for the incorporation of research results in planning and innovation, e. g. through the seconding of experienced scientists as advisors to the ministries, on a time-limited basis.

3.16 Priorities

On the basis of analysis of the present situation and the recommendations for the reorganization of the care of the mentally ill, mentally handicapped and mentally retarded, the Expert Commission sets the following priorities for the first stage of implementation of reform:

1. Basic requirement
   Every reorganization of care must take as a basic premise the removal of grossly inhumane conditions. This basic requirement must also remain in view throughout implementation of the reforms.
2. Underlying principles
   In the course of implementation of the recommendations of the Expert Commission, the following underlying principles should be adhered to in all circumstances:
   — the principle of community-based care;
   — the principle of appropriate and comprehensive care for all the mentally ill and handicapped;
   — the principle of appropriate coordination of all services and agencies;
   — the principle of equality of care provision for the mentally ill and the physically ill.
3. The Expert Commission suggests the following list of individual priorities:
   a) development and extension of complementary services (residential care);
   b) development and extension of out-patient services;
   c) setting up of departments in the general hospitals;
   d) promotion of education and of vocational and specialist training;
   e) high-priority improvement of the care:
      — of psychologically-disturbed, maladjusted and retarded children and young persons,
      — of drug-dependent persons, especially alcoholics;
   f) development of model care sectors in both urban and rural areas.

Prof. Hippius as vice-president of the German Psychiatric Association (Deutsche Gesellschaft für Psychiatrie und Nervenheilkunde) recorded a dissenting vote to the Report of the Commission. Other names attached to this dissenting vote were those of Prof. Degkwitz, Dr. Dilling, Prof. Harbauer, Prof. Janz, Dr. Leonhard, Prof. Reimer, Dr. Sautter and Prof. von Zerssen.

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The report of the Expert Commission was communicated to the German Federal Parliament (Deutscher Bundestag) in the written statement of the Federal Minister of Youth, Health and Family Affairs on 25th November 1975 (3.4.1.2/474—5)

Excerpt from this written statement:

The Federal Government commissioned the preparation of the Report from an independent Expert Commission. In carrying out this task, the Expert Commission was free to act in accordance with its own knowledge and opinions. The inquiry cannot be regarded, either as a whole or in its particulars, as an official statement of the Federal Government.

Since the measures recommended in the Report are to a large extent matters for the Federal Länder, competent authorities and associations, because of their existing responsibilities, I shall communicate the Report to these various bodies.

Implementation of these recommendations — the immediate measures for solving the urgent problems revealed by the inquiry, as well as the longer-term measures — is dependent on the financial possibilities. In this connection I would refer you to the intermediate report of the Expert Commission (Drucksache 7/1124).

Since the costs of short-term, middle-term and long-term measures required at federal, provincial, community and institutional level will be considerable, it is necessary to point out at once that in view of the strained financial situation of the cost-bearing bodies additional means could not be raised immediately.