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Deinstitutionalization of psychiatric patients in central Europe

Abstract The central European countries Germany, Switzerland, Austria, and Luxemburg are confronted with a variety of individual problems concerning health care. After an analysis of problems which are shared by all the countries, these individual aspects are analyzed. In Germany there has been a rapid structural change of psychiatric care in the last 30 years. Although there was a broad movement to deinstitutionalize patients with chronic psychiatric disorders who need long-term care, there are still too many psychiatric beds in large psychiatric hospitals and still missing psychiatric departments in general hospitals in some areas. In Austria the process of deinstitutionalization has been delayed but a general survey of the health care system by the government led to an acceleration of this process in recent years. Due to historical reasons, the mental health care system in Switzerland is not easily comparable with the ones in the other two countries. Deinstitutionalization mainly means reduction of beds in the existing psychiatric hospitals rather than a structural change with a conversion to psychiatric departments in general hospitals. Luxemborg is a good example of the fact that economical factors are not the only aspects influencing development in psychiatric care. Psychiatric care is not community based, centralized, separated from medical care, and the supply system concerning complementary outpatients institutions is underrepresented. Thus, in all the countries the process of deinstitutionalization has still not come to a satisfying level. This is not only due to the economically difficult situation in the recent past. A change can only be expected when the opinions about modern principles of psychiatric care receive more weight in general society and with their political representatives.

Key words Deinstitutionalization · Mental health care · Long-term psychiatric care · Chronic schizophrenia

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Introduction

Regarding cultural, social, and economic characteristics, the central European countries of Germany, Switzerland, Austria, and Luxemburg show a considerable degree of diversity. Thus, each country is confronted with a variety of individual problems concerning health care. However, besides these differences, which are important for the interpretation and modification of the individual health care system, they have a number of aspects in common, which allow one to analyze historical developments as well as future directives. The main problems these countries share are

- an aging population,
- increasing population mobility,
- rising expectations concerning health and health care,
- socio-economic problems,
- cost containment,
- increasing pressure on health services,
- ensured high standard of health for the members of the European Community (Ludvigsen and Roberts 1996).

In addition to these social aspects, there are mainly four political principles influencing health care developments, i.e.,

- a mixture of corporatism and federalism in the political structure of the four countries,
- the consequent separation of social welfare and health care,
- the principle of equity in health care for all people, and
- increasing influence of data protection laws.

These social problems and political principles give rise to difficulties all countries have in steering health care and especially mental health care.

- Federalism causes uneven financial resources among the different federal states.
- Intensified economic competition leads to a restrictive societal attitude concerning care and rehabilitation of chronic mentally ill patients.

- The principle of equity in health care, ensured high standards, and the increasing capacity of modern medicine in combination with rising expectations are opposed by changing demographic parameters, the need for cost containment, and different financial potentials of the individual states.
- Relatively strict data protection laws cause a lack of scientific data. This makes it difficult to collect data of individuals along their way through different institutions. Especially in the complex network of institutions in modern psychiatry, this lack of person related data over a longer interval leads to a lack of steering data and makes reliable economical analyses difficult, if not impossible.
- There is considerable dissent about the meaning of the term deinstitutionalization. In Germany, for example, chronic mentally ill patients were moved from psychiatric state hospitals to rehabilitation hospitals in the black forest area which were initially built for patients suffering from tuberculosis. Thus, what may look like deinstitutionalization in fact constitutes a transinstitutionalization and does obviously not correspond with the ideas of the modern reform of psychiatric care.

Whether a system of mental health care is sufficient and fulfills international standards can be assessed by various criteria:

- Are there enough institutions (i.e., hospital beds, day care houses, rehabilitation services) for the treatment of psychiatric patients?
- Can these institutions be reached conveniently by the patients (community based)?
- Is the institution's (personal) equipment sufficient?
- Are the institutions the right ones (hospital versus outpatient services; sufficient network of mental health care)?

Whether something is sufficient is a question of defined standards and in the case of psychiatric care also mirrors general societal conditions. The characteristics of the organization of mental health care to a certain degree depend on the question of how mentally ill patients are tolerated in society. Thus, even such "objective" parameters as length of inpatient treatment are influenced by the attitudes of society (Angermeyer and Siara 1994a/b; Angermeyer and Matschinger 1995; Hoffmann-Richter et al. 1998).

The situation of psychiatric care in Germany

Since 1975 there has been a rapid change in mental health care in Germany. In 1971 the German government set up an Expert Commission to investigate the status of national psychiatric care. This included the analysis of the living and treatment conditions, respectively. Previously no real attention had been payed to the problems of patients with psychiatric disorders, whereas in other countries political and public interest for the conditions of mental health care had risen earlier, mainly due to an overcrowding in mental hospitals (Rössler et al. 1996). In Germany the Nazi regime had murdered between 90,000 and 130,000 mentally ill patients living in long-term care hospitals (Dörner 1985; Dörner 1986; Finzen 1996), leaving large mental hospitals in rural areas with fewer patients. Therefore, real interest in psychiatric care in Germany was delayed and did not rise before the late 1960s, when it was mainly driven by social political trends instead of institutional needs.

The main criticisms of the Expert Commission were (Deutscher Bundestag 1975):

- Almost all inpatients were treated in large state mental hospitals with an average number of 1,200 beds. In a first statement, the commission characterized those hospitals as "crude and inhumane" (Deutscher Bundestag 1973).
- Community-based psychiatric departments in general hospitals were underrepresented if not unknown.
- Outpatient treatment was insufficient.
- Psychiatry was separated from the general health care system.

This led to recommendations for reforms in accordance with internationally accepted standards of modern psychiatry.

In Germany, too, the federal political structure caused a very heterogenous development of psychiatric care. While national policy constitutes a framework for the general health care system, it is the different federal states' responsibility to practically realize and control health care measures. Different state laws and different orders by the governments of the 16 federal states (11 "old" states, i.e., West Germany and 5 "new" states, i.e., East Germany) created a variety of supply systems and led to an uncoordinated development of the system.

Secondly, the system of financing the costs of mental health care is extremely complex. Depending upon specific situations and phases of mental disorders (acute treatment, rehabilitation, sheltered accomodation, sheltered labor) treatment costs are to be financed by different institutions. Table 1 shows the main supporters of the costs of mental health care.

Special conditions exist for chronic mentally ill patients. For patients living in sheltered homes, social welfare covers approximately 85% of the total costs (Stroebel 1983). Before any money can be received from social welfare, the patients themselves are expected to cover treatment costs until they have reached a certain amount of poverty (DGPPN 1997).

Table 1 Financing institutions of the costs of mental health care in Germany (BMJFFG 1986)

Health insurance	21%
Disability funds/pension funds	11%
Federal bureau for labor	1%
Various financial supports	6%
Patients or relatives	18%
Social welfare	43%

In all federal states there are methodological problems in generating data on the mental health care system. While national health statistics are the most reliable measures in the assessment of its quality (Bremer ter Stege and Gittelmann 1987), these are not available in Germany. Data on patient care are gathered in different institutions, private or state-controlled, by different caregivers, in different settings. Overall nationwide statistics on mental health care are missing. A developing psychiatric case register for the city of Mannheim created between 1975 and 1980 with the intention to generate patient-focussed data was stopped by the legal authorities on the grounds of data protection laws (Rössler and Salize 1994).

In the assessment of the German mental health care system, it is furthermore essential to take into account the country's recent history. The nature and time schedules of reforms in eastern, formerly communistic federal states and those in western states need to be different.

Due to the methodological limitations, one has to be cautious in analyses of the deinstitutionalization process. The lack of nationwide, comparable statistics was already criticized by international experts years ago (Freemann et al. 1985), but with the unification of East and West Germany the problems in information gathering have even mounted. It will require great efforts by the authorities to reform the process of data aquisition in Germany until enough reliable information is collected to support the development of the mental health care system, especially in regard to the very needs of chronic mentally ill patients (Rössler and Salize 1996).

Characteristics of patients with chronic mental disorders

According to estimates of the Experts Commission, there are approximately 500,000 adults with chronic mental disorders living in West Germany (BMJFFG 1986; BMJFFG 1988). Based on this number and provided that the condition "chronic" is not influenced by the political system (although the label may well be differently interpreted), one may estimate that at least 650,000 chronic mentally ill patients are living in unified Germany, most of them suffering from chronic schizophrenia. Characteristically this diagnostic group has an early age at first episode and a high amount of lifetime disabilities. Both factors contribute to a substantial need for care over many years and not seldom decades. The direct and indirect costs for society are huge (Rössler et al. 1998). In the USA, estimates of the total treatment costs for schizophrenic patients reach from $34 billion (Rice and Miller 1994) to $65 billion per year (Wyatt et al. 1995). Because of differences in the disorder's prevalence, different care systems, and methodological difficulties in the operationalization of costs, data gathered in other countries are not easily transferable to Germany. Because of the above mentioned difficulties in creating case related data across variant care providers, there are only very a few studies on the costs of schizophrenia in Germany. Häfner et al. reported a mean of DM 15,574 of direct costs for one schizophrenic patient per year (Häfner et al. 1986). Salize and Rössler (1996) published data from a prospective, case related study and found a sum of DM 27,566 per patient per year for the direct costs in 1994/95. Given that indirect costs – although difficult to assess – exceed the direct costs by about 3:1 (Gunderson and Mosher 1975; Fischer and Barrelet 1987; Wyatt 1994), schizophrenia can be considered one of the most expensive psychiatric disorders. While there is no doubt that a humane society is obliged to cover the costs of schizophrenia, the way this money is used for the maximum benefit of patients in a time of limited financial resources requires considerable consideration. Along these lines, the Experts Commission recommended a process of deinstitutionalization paralleled by the construction of a system of complementary psychiatric institutions for outpatient care.

Indicators for the process of deinstitutionalization

Different indicators exist for assessing the process of deinstitutionalization. Most commonly the decrease of beds in psychiatric hospitals is used (Freemann et al. 1985; WHO 1991). Since 1970 there has been a steady decrease in the total number of psychiatric beds from 100,000 in 1982 to less than 60,000 in 1994. However, the data before and after 1990 are hardly comparable since the definition of "psychiatric hospitals" was revised by a new law in 1990 (Krankenhaus-Statistik-Verordnung, KHStatV), dismissing rehabilitation hospitals and health resorts from the statistics. On the other hand, the data on adult psychiatry after 1990 allow one to separately analyze beds in hospitals for the treatment of addicted patients and beds in departments for child and adolescent psychiatry (Rössler et al. 1996). From 1990 onwards, there are also data available for the new federal states (East Germany). According to the new law, only those hospitals are considered psychiatric hospitals which provide exclusively neurological and psychiatric services or constitute pure psychiatric institutions. Psychiatric departments in general hospitals received their own status (BMJFFG 1980–1989).

Another broadly accepted indicator for the status of deinstitutionalization is the number of beds per single psychiatric hospital (Freemann et al. 1985; WHO 1991). Table 2 shows the number of beds in so-called "Fach-

Table 2 Size of psychiatric hospitals ("Fachkrankenhäuser") in 1992 (Statistisches Bundesamt, 1994)

Type of psychiatric hospital (number of beds)	Number of hospitals of different size	Total beds per hospital-type
< 100	86	4,322
100– 200	30	4,329
200– 500	57	19,467
500–1.000	34	22,959
> 1.000	3	4,088

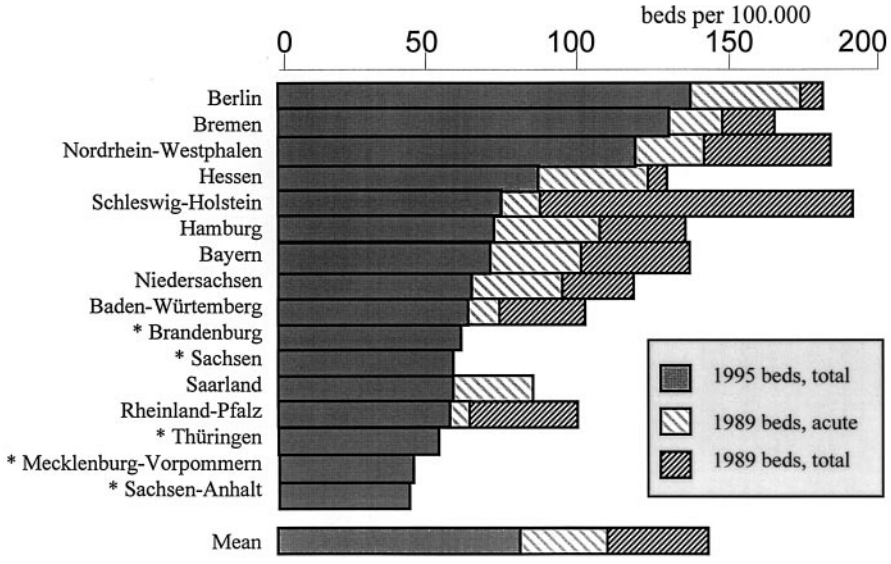

Fig. 1 Relative number of psychiatric beds per 1000 inhabitants in different German states – change from 1990 to 1995 (* = new states, i.e., former German Democratic Republic). Due to the political incongruency, data before 1990 are not mentioned for the new states because they are not comparable to the old states (West Germany). In Saarland 1989, the total number of beds equals the number of acute beds because the state's statistics only included acute psychiatric beds

krankenhäuser", i.e., specialized psychiatric hospitals according to the KHStatV.

There is a steady decrease in the overall number of beds in hospitals or departments treating mentally ill patients and a decrease in the mean number of beds in specialized psychiatric hospitals. Both results are an expression of the still ongoing process of deinstitutionalization.

Additional information to these absolute numbers can be provided by the relation of number of beds to the number of people living in the area of the distinct hospital. This relational data goes beyond the information one receives about the total resources of a health care system and gives an impression of the care patterns of a single hospital, a federal state or the country. Comparisons between hospitals and especially federal states or countries become more reliable when they are based on this relative indicator rather than on absolute numbers of beds. Figure 1 shows the change of this relational number from 1990 to 1994 in the different federal states of Germany.

Another difference between the absolute number of beds and the relational data concerns the mechanisms by which they may be influenced. To reduce the number of beds in a hospital may have various reasons: an order by the government responsible for mental health care; conceptual changes by experts working within the hospital; or economical decisions by the hospital's administration. Relational data are more likely to be used by politicians as a normative value to steer the situation of mental health care in a wider area.

Conclusions concerning the deinstitutionalization-process in Germany

Since the Expert Commission's report in the early 1970s, deinstitutionalization has been a major target of the reform of mental health care in Germany. The number of hospitals specialized in the treatment of psychiatric patients which are decentralized and situated in mainly rural areas has decreased. In the remaining hospitals of this kind, the number of beds (absolute and relative to the number of people living in the wider area) has significantly decreased. The impact of deinstitutionalization is also expressed by the markedly reduced mean length of stay of inpatients. A satisfactory degree of dismissals from psychiatric hospitals of mentally handicapped persons with no distinct psychiatric disorder has been reached. The living conditions of this group have become much more adequate in complementary institutions with improved pedagogic treatment regimes. The similar development for patients with chronic schizophrenia is still unsatisfactory. There are still too many patients with chronic psychiatric disorders living under conditions of inpatient care rather than individually supervised family-like care.

Along with the reduction of the size of large mental state hospitals, there has been a vivid and advanced development of psychiatric departments within general hospitals, which is still not finished. However, as the federal states are facing economical problems, there actually is the danger of stopping this process too early (Schwartz and Busse 1997). There is, furthermore, still a need for more day care institutions, especially those providing less sophisticated therapeutic programs (rather in the form of a structured day course and giving the chance for communication than distinct psychiatric therapeutic programs).

Reality of psychiatric care – especially in some of the German states – is still far from complying with the indicators (for example psychiatric beds per 1000 persons living in the community) recommended by the WHO or the German Society for Psychiatry and Psychotherapy (DGPPN). With the conceptual change from centralized care in big hospitals to decentralized care in a complex system of different caregiving institutions and doctors in private practices, the lack of reliable data on this complicated care system (i.e., patient-based data through different caregivers) will become more and more significant. A legislative change for this distinct problem seems to be ur-

gently needed. The Danish psychiatric register could well serve as an example in the development of such a person indentifiable data base (Munk-Jørgensen et al. 1993). The dangers of (necessarily) lowering data protection laws are controllable and only then it will be possible to detect and satisfy the needs of especially chronically ill psychiatric patients.

The situation of psychiatric care in Austria

The main targets of the Austrian move to reform the system of mental health care are very similar to those in Germany. In a careful analysis of the actual situation, the "Rechnungshof", a governmental institution, recommended to direct the reform as follows:

- a change from a centralized to a decentralized care system,
- an indicator of 0.3 to 0.5 beds per 1000 people living in the community,
- the treatment of chronic (long-term) patients in community based outpatients institutions,
- increased numbers of therapeutic staff while at the same time decreasing the number of nursing staff.

In its analyses, the Rechnungshof comes to the conclusion that the reform has still not reached a level sufficient when compared with these recommendations (Plepelits et al. 1998). Especially outpatient care does not fulfill the standards. Of the 318 specialists in psychiatry and/or neurology in private practice (with a total population of 7.62 Mio. this gives a rate of 0.04/1000 or 1 specialist/24,000), only 22% have a cooperation with health insurance companies, i.e., are involved in base care. According to the recommendations even the complementary care system (day care clinics, therapeutic accomodation, and others) is insufficiently developed. In Austria, too, it is difficult to rely on data about the health care system. This is mainly due to the nature of data collection and is especially true for outpatient care, where data are gathered and kept by different institutions or private providers or data are even missing altogether.

Table 3 shows the number of beds in the different psychiatric state hospitals. They range from 47 to 811 beds with a large variance between the different federal states.

These large hospitals also differ considerably in regard to the numbers of their long-term patients. Interestingly, in 5 of the 14 hospitals the number of long-term patients equals or even exceeds the number of acute patients, which indicates that the level of deinstitutionalization in Austria is still unsatisfactory. The total number of beds in these psychiatric hospitals yields an average indicator of 0.6 beds per 1000 inhabitants. In comparison with Germany, this number is lower, but still far behind the suggested 0.3. Table 4 shows a summary of the mean number of psychiatric patients per 1000 inhabitants for the different federal states of Austria from 1990 to 1994.

Table 3 Number of beds in different psychiatric state hospitals in Austria

	Total	Acute	Long-term	Others
PKH Baumgartner Höhe Wien	593	294	299	
PKH Ybbs	125	110	15	
AKH Wien	147	147		
KFJ Wien	47	43	4	
LNK Gugging	363	122	230	11
LNK Mauer	529	183	333	13
LNK Linz	686			
LNK Salzburg	443	179	84	180
PKH Hail	491	184	231	76
LKH Innsbruck	116	116		
LNKH Rankweil	281	209	72	
LSKH P/N Graz	811	392	390	29
LKH Graz	52	52		
ZSG Klagenfurt	182	164	18	
Austria total	4,916			
per 1,000 inhabitants	0.63			

Burgenland: patients treated in the states "Niederösterreich" or "Steiermark"

Table 4 Relative number of beds and admissions, mean costs per bed in 1990 and 1994, respectively, in the different Austrian states

	Mean number of patients per 1,000 inhabitants		Mean number of admissions per 1,000 inhabitants	Mean costs per bed		Change in %
	1990	1994	1994	1990	1994	
Wien	0.63	0.59	7.24	1,404,053	2,011,086	43.2
Niederösterreich	0.70	0.58		419,459	634,034	51.2
East			2.30			
West			3.35			
Oberösterreich	0.72	0.65	4.58	450,815	735,099	63.1
Salzburg	1.02	0.86	9.40	531,783	954,447	79.5
Tirol	1.32	0.89	6.21	429,450	847,715	97.4
Vorarlberg	1.08	1.05	6.23	697,184	969,595	39.1
Burgenland			1.74			
Steiermark	1.03	0.78	6.89	583,100	796,475	36.6
Kärnten	0.26	0.34	10.54	635,531	1,271,193	100.0
Total, Austria	0.80	0.67	5.95	643,991	1,013,730	57.4

While the numbers show decreases in nearly all states, they differ considerably from state to state. Even the admissions per year differ markedly, indicating that the frequency of using the health care system varies between the Austrian states and/or different standards of this health care system exist. The consequence of these differences are different costs per bed. Comparing the numbers for 1990 and 1994 also shows an increase of costs in all states and differences between them both in the absolute amounts as well as the relative change over the years.

The main points of criticism of the reform of mental health care in Austria are that

- there are still too many long-term patients living in large psychiatric hospitals,
- psychiatric care is not sufficiently community based,
- as a consequence psychiatric hospitals are too distant for patients living in secluded parts of the country,
- the complemantary care system is not sufficiently developed.

In view of recent governmental plans that affect psychiatric care in all of the states and incorporate most of the suggestions, the "Rechnungshof" study is concluded by an optimistic view into the future. Indeed, since this study has been published further efforts have been made in realizing these plans.

Mental health care in Switzerland

Swiss psychiatry differs from German or Austrian psychiatry mainly in the following respects:

- In Switzerland there are no intentions to establish psychiatric departments in general hospitals. The care of psychiatric inpatients is mainly in the hands of large hospitals predominantly situated in rural areas. Due to the country's relatively small size and its excellent infrastructure, nearly all patients are able to reach a psychiatric hospital within a time of 30 to 60 minutes. On the other hand, psychiatric care is often geographically separated from departments of somatic medicine, thereby, reinforcing a culture of nonmedical thinking in psychiatry.
- From the late 19th century, psychiatry in Switzerland began to develop away from neurology and strongly towards the newly emerging psychotherapeutic treatments, which became increasingly influential. This is important both for inpatient as well as outpatient care. Of the many psychiatrists working in private practice, only a few are treating acutely psychotic or chronical ill patients. Commonly patients with milder forms of psychiatric disorders are treated in private practice while patients with psychoses are referred to hospital linked ambulatories (social psychiatric services) (Ernst 1998).

These are main characteristics of the structure of the Swiss mental health care system, which however is also undergoing a process of deinstitutionalization mainly due to economical problems of financing the health care system. In this respect, it resembles all other countries.

According to the Association of Swiss Hospitals (VESKA 1994a and b), the rate of psychiatric beds per 1000 inhabitants has reached 1.4 in 1993 while the rate was 2.9 in 1970 (WHO 1971). This decrease indicates a process of deinstitutionalization in Switzerland. Yet the rate of 1.4 is still significantly higher when compared to Germany (0.9) or Austria (0.6). This is even more astonishing in the light of the favorable infrastructure of complementary outpatient psychiatric services and the density of psychiatrists and general practitioners in private practice. The reasons may lie both in a culture of hospitalized care for psychiatric patients (especially with chronic diseases), cultivated for nearly a century, and the isolation of psychiatric care from somatic medical disciplines. Even so there is an ongoing and continuing process of deinstitutionalization in Switzerland.

The situation of psychiatric care in Luxemburg

With its area of 2586 km^2, a maximal distance of 82 km north-south and 57 km east-west and a number of 380,000 inhabitants, Luxemburg is the smallest country of the European Community. Politically the country is divided in 3 districts and separated in 12 cantons. As one indicator of its economic power, the country's unemployment rate is very low. Other parameters of standards of living too contribute to the fact that Luxemburg has a leading position in Europe.

As in several other countries, general medical hospitals are to an considerable extent involved in psychiatric care. In these hospitals, psychiatric patients are treated by medical staff without special psychiatric qualification. In some of these hospitals patients are treated by their privately practicing psychiatrists which, however, limits these contacts to clinical visits in the frame of liaison psychiatric care.

For the core group of hospitalized psychiatric patients, there are 950 beds which yields a rate of 2.6 psychiatric beds per 1000 people. More than 80% of these beds are situated in the one big psychiatric hospital in Ettelbrück ("Hôpital Neuropsychiatrique de l'Etat", HNP). In a 1990 survey, a study group found that the length of stay for more than 40% of the patients in HNP exceeded 10 years and that the average duration of inpatient treatment for all patients who had been dismissed in 1990 was 6.5 month (Rössler et al. 1993). This indicates that a high percentage of chronical ill psychiatric patients, mainly schizophrenics, as well as mentally retarded patients were living in HNP. Only one third of the beds could be used for acute psychiatric care. On the other hand, there are psychiatric departments in 3 general hospitals. Nearly all patients in these departments were treated for acute psychiatric disorders, with a mean length of stay of 2 weeks.

These quantitative data are not so different from other countries in central Europe although they show a highly centralized system of psychiatric care. However, qualita-

tive analyses demonstrate major deficits in Luxemburg's psychiatric hospitals. In HNP as in the three small departments at general hospitals neither the architectonical nor the personal equipment fulfill modern criteria of pschiatric care. Large sleeping rooms with several beds with an open view from all sides could be found according to the research group's study.

On the ground of this situation the study group gave detailed recommendations (Rössler et al. 1993) to reform the system of psychiatric care in Luxemburg. The essential parts were

- New departements with approximately 55 psychiatric beds should be build in general hospitals and the existing ones should be adapted to modern standards.
- In HNP, the large central hospital, a department for acute psychiatric care should be seperated from a center for intensive rehabilitation which can serve as a center of competence for the whole country.
- Patients with chronic disorders (long-term care) as well as patients with mental retardation should be deinstitutionalized in several community based institutions.
- The number of day clinics should be increased and a supply network of social psychiatric services, ambulatories linked to the hospitals, and other complimentary services should be created.

In reaction to the recommendations, there have been some moderate changes so far. But the still existing deficits of the organization of psychiatric care in Luxemburg with its high economical standard shows that economical resources alone can not overcome old attitudes about care of psychiatric patients. Especially the changed views about treatment of chronically ill patients and mentally retarded patients (deinstitutionalization, community based care, family-like settings, differential network of outpatient services) are conceptional changes. Certainly money is important to realize new concepts but the main step is to convince the responsible people and, last but not least, a majority of the society that societal values which have received more and more weight in the second half of the 20th century must be also transfered to psychiatric care. A long-term stay for years and not seldom decades in a large hospital is in most cases not able to realize human values like maximal autonomy of the individual, the free will of a person if not in conflict with others, an accepted membership within a social group, maximal use of ones abilities to work, and compensation of deficits to garantee a maximal quality of life.

Has deinstitutionalization gone too far?

For the central European countries, there has been a process of deinstitutionalization since the early 1970s. Especially in Germany there has been a rapid structural change of psychiatric care in the last 30 years. Nevertheless, there are still too many psychiatric beds in big psychiatric hospitals and still missing psychiatric departments in gerneral hospitals in some areas. Even the complimentary psychiatric network is not fully developed in some parts of the country.

In Austria the process of deinstitutionalization has been delayed but the report of the "Rechnungshof" led to an acceleration of this process in recent years. The development is inhibited mainly by the lack of the complementary system of psychiatric care.

Due to historical reasons, the mental health care system in Switzerland is not easily comparable with the ones in the other two countries. Deinstitutionalization mainly means reduction of beds in the existing psychiatric hospitals rather than a structural change with a conversion to psychiatric departments in general hospitals.

Luxemborg is a good example for the fact that economical factors are not the only aspects influencing development in psychiatric care. In the smallest country in central Europe psychiatric care is centralized, not community based, seperated from medical care, and the supply system concerning complementary outpatients institutions is underrepresented. There are too few specialists of the different professions working in psychiatric hospitals. A change of this situation can only be expected when opinions about modern principles of psychiatric care receive more weight in the general society and their political representatives.

In Germany, Austria, Switzerland, and Luxemburg the answer to the question "has deinstitutionalizing gone too far?" clearly is "no!" In contrary there is – due to the difficult economical problems in health care – a serious danger of stopping the ongoing process too early. Investments have still to be made in building new psychiatric departments in general hospitals and in completion of the outpatients network of psychiatric care. Whether these investments can be done even in a time of restricted financial resources and a political philosophy of cost containment will decide about the ongoing development of general psychiatric care and especially care for the chronically mental ill.

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