Joint Action on Mental Health and Well-being

TOWARDS COMMUNITY-BASED AND SOCIALLY INCLUSIVE MENTAL HEALTH CARE

Situation analysis and recommendations for action

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EXECUTIVE SUMMARY

Community-based mental health care is a well-recognized approach to addressing effectively and efficiently the challenges associated with the burden of mental disorders and promotion of mental health in the population. A strategy to shift away from a traditional model of care based on large psychiatric institutions to more community-based services is therefore essential.

There are today many reasons why the development of community-based mental health services is central to improving mental health systems. Community care contributes to improved access to services, enables people with mental disorders to maintain family relationships, friendships, and employment while receiving treatment, so facilitating early treatment and psychosocial rehabilitation[1].

Community mental health care is associated with continuity of care, greater user satisfaction, increased adherence to treatment, better protection of human rights, and prevention of stigmatisation[2].

Community mental health care aids the establishment of a structured collaboration with primary health care services, which plays an important role in the identification and treatment of people with mental disorders. These collaborative models of care are particularly effective in the treatment of people with mental and physical co-morbidities[3,4].

Under the framework of the EU Joint Action on Mental Health and Wellbeing, key stakeholders from participating countries (Austria, Bulgaria, Estonia, Hungary, Ireland, Italy, Portugal, Spain and UK) worked together with representatives of relevant European mental health organisations to develop a framework for action on community-based and socially inclusive approaches to mental health. Their work gave a special emphasis to the transition from institutional to community-based care for people with severe mental disorders, and was part of a commonly endorsed action framework on mental health and wellbeing in Europe.

The specific objectives of the workgroup were: 1-analysing the situation of community-based and socially-inclusive approaches to mental health in participating countries, as well as in EU countries at large; 2- mapping the scientific evidence, best practices and the available technical resources relevant for the implementation of community-based and socially-inclusive approaches to mental health in Europe; 3- developing recommendations for action at EU-level and in Member States for this work package; 4- supporting the engagement and commitment of Member States and other stakeholders in effective action to develop community-based and socially-inclusive approaches to mental health in Europe.

The methods used included a literature review, the analysis of existing data on a selected set of indicators related with the transition to community-based care in EU, the analysis of original and more extensive data related to this process collected in the nine countries participating in the workgroup with the support of a questionnaire specifically developed for this purpose, a SWOT analysis (to evaluate achievements, barriers and challenges in MS) in six participating countries, and the selection and description of good practices.

What is the situation in Europe?

Across Europe, much effort has been made over recent decades to shift away from institutional to community-based mental health care. However, despite all these efforts, much more has still to be done if we want to provide accessible, effective and social inclusive mental health care to all people with severe mental disorders in Europe. The key findings of this project show that:

Deinstitutionalisation and the development of community-based care is accepted by more than half of EU countries as a major goal of their mental health policies.

Many countries have developed or initiated some type of mental health reform in the last few decades.

Most countries have undergone important transformations in psychiatric hospitals but for a number of countries these hospitals continue to play a central role in mental health systems and consume the vast majority of resources allocated to mental health care.

The reduction of beds in mental hospitals/psychiatric hospitals, and the transfer of patients to community services and residential facilities have played a key role in deinstitutionalisation, followed by the veto of new admissions.

The involvement of different stakeholders in the planning of deinstitutionalisation has gradually increased in the last 15 years.

Despite many significant advances in the development of community care across Europe, community-based services networks have only partially been developed in most countries, with many not introducing timely transfers from traditional services to community-based systems of mental health care.

Beds in community-based facilities, including general hospitals, have become an important part of the mental health systems in most of the EU countries.

Although in a less systematic way, residential facilities in the community have also increased significantly across many EU countries.

Few EU countries offer home treatment and community-based rehabilitation.

Primary mental health care also remains very limited in many countries, particularly in relation to severe mental disorders.

According to stakeholders perception, the highest levels of achievement were found in the development of inpatient beds in general hospitals, followed by the development of outpatient services in general hospitals and in the community, day care services and community mental health centres. By contrast, the services that were perceived to be less well developed include primary mental health care, followed by the development of outreach or mobile mental health teams, E-Health and self-help and other users groups in psychosocial rehabilitation, perceived achievements were highest in residential alternatives in the community, while vocational and supported employment initiatives were considered of low achievement or non-existent.

The largest perceived barriers to transferring to community based care included low political priority, and insufficient and inadequate funding, followed by the lack of consensus among stakeholders and cooperation between health and social sectors.

Facilitating factors considered to have the highest impact included strong government support, participation of users and families, and NGOs.

What are the major policy recommendations?

According to the situation analysis presented in this Report the process of deinstitutionalisation and the development of community-based care have been adopted as major mental health policy goals for more than half of EU countries.

Significant advances across Europe have been made in the transition from institutional to community-based care for people with long-term mental disorders. However, progress has been very uneven across countries and for many there is still much to be done to create community-based mental health service networks and to provide good quality and socially inclusive care.

Therefore, the Joint Action for Mental Health and Wellbeing recommends that Member States develop and implement policies and services to address existing insufficiencies and gaps in European mental health care systems, to promote community-based care and the social inclusion of people with long-term mental disorders. To achieve this, 12 integrated strategic areas, each one including a group of actions, are recommended.

Recommended strategic areas

1. Developing concerted plans to generate political commitment for mental health system development;
2. Developing/updating mental health policies and legislation;
3. Integrating mental health in primary health care;
4. Shifting the locus of specialized mental health care towards community-based services;
5. Establishing or increasing the number of psychiatric units in general hospitals;
6. Promoting a coordinated transition towards community-based care, to ensure the improvement of quality of care and the protection of human rights across all parts of the system;
7. Ensuring that community psychosocial supports are available for people with severe mental disorders;
8. Developing community-based services and programmes for specific populations;
9. Improving the use and effectiveness of mechanisms to monitor the implementation of mental health reform;
10. Ensuring resources are used effectively to address needs and develop community-based services;
11. Promoting cross-sector cooperation;
12. Promoting the use of relevant EU instruments.

Main recommended actions:

- Map the key decision makers who can play a significant role in the process of change, and collect information about the organisations that should be approached and invited to become partners in strategies to generate political commitment;
- Monitor the implementation of mental health policy across the EU;
- Encourage and promote the revision and updating of mental health policy, based on human rights and the available evidence, in countries where this is needed;
- Promote the revision and updating of mental health legislation, taking into account the principles of recovery and the recommendations from CRPD;
- Promote research and dissemination of collaborative and stepped-care models between primary care and specialist mental health care;
- Promote co-ordination of care and effective follow-up of discharged patients in order to ensure continuity of care;
- Increase knowledge and understanding of mental health disorders among relevant general hospital personnel in an attempt to reduce stigma, discrimination, or misconceptions regarding people with mental disorders;
- Develop and establish a community mental health team in each catchment area;
- Promote the active involvement of users and carers in the delivery, planning and reorganization of services;
- Develop facilities and programmes that have so far been underdeveloped in many EU countries, such as integrated programmes with case management, outreach or mobile mental health teams, E-Health, self-help and users and carer groups;
- Develop structured cooperation between mental health services, social services and employment services, to ensure that community-based residential facilities, vocational programmes, and other psychosocial rehabilitation interventions are available;
- Develop the capacity of mental health leaders to mobilise and steer the implementation of mental health policies;
- Develop and improve information systems to collect and aggregate data and promote the use of existing data to monitor the impact of policies and services focused on the transition from mental hospitals/psychiatric hospitals to community-based care;
- Develop efficient mechanisms for funding mental health care that are commensurate to the needs of the population; including incentives that promote the development of community-based care;
- Maximise the use of relevant EU financial programmes, especially EU Structural and Investment Funds to support the deinstitutionalisation and social inclusion of people with long-term mental disorders.

More detailed description of the recommendations can be found in chapter VIII - Key Findings and Policy Recommendations.

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I. INTRODUCTION

Reforming mental health systems across Europe to ensure the provision of long-term socially inclusive mental health care for people with severe mental disorders has been an important major challenge over the past few last decades. The impact of severe mental disorders on the individual, their family and wider society is huge and transfering from traditional mental hospitals/psychiatric hospitals to community-based care is essential for delivering high quality care to this group. The transition towards community-based mental health care is a complex process with many significant barriers to overcome.

Under the framework of the EU Joint Action on Mental Health and Wellbeing, key stakeholders from participating countries (Austria, Bulgaria, Estonia, Hungary, Ireland, Italy, Portugal, Spain and UK) have been brought together. These stakeholders have worked with representatives of relevant European mental health organizations to develop a framework for action on community-based and socially inclusive approaches to mental health. Their work includes a special emphasis on the transition from institutional to community care for people with severe mental disorders; and forms part of a commonly endorsed action framework on mental health and well-being in Europe.

The specific objectives of the workgroup includes: 1-analyzing the situation of community-based and socially-inclusive approaches to mental health in participating countries; 2- mapping the scientific evidence, best practices and the available technical resources relevant for the implementation of community-based and socially-inclusive approaches to mental health in Europe; 3- developing recommendations for action at EU-level and in Member States for this work package; 4- supporting the engagement and commitment of Member States and other stakeholders in effective action to develop community-based and socially-inclusive approaches to mental health in Europe.

This Report presents the results of the work carried out to meet these objectives and the methods used. The situation analysis of the transition from institutional care to community-based care in Europe is described and discussed, followed by a review of best practices and the available technical resources relevant for the implementation of community-based and socially inclusive approaches to mental health in Europe. The conclusion outlines policy and service recommendations for action that can complete the transition from mental hospitals/psychiatric hospitals to community-based care for people with severe mental disorders in Europe.

II. METHODS

The progress made across EU Member States in the transition from hospital-based to community-based care for people with severe mental disorders was evaluated with the collaboration of national and European working groups that included relevant experts, policy makers and other stakeholders. These working groups drew on the available knowledge and resources from other European mental health projects (including toolkits, guidelines and databases) to identify the key elements to be taken into consideration when seeking to improve the effectiveness and sustainability of future initiatives.

To address the project's objectives the following were conducted:

1 - A review of the literature;

2 - Analysis of existing data on selected indicators relating to the transition towards community-based care in the EU;

3 - Analysis of extensive original data collected from the nine Working Group (WP5) participating countries (Austria, Bulgaria, Estonia, Hungary, Ireland, Italy, Portugal, Spain, UK), using a questionnaire specifically designed to assess the transition process (Transition from hospital-based care into community-based care Assessment Questionnaire);

4 - A SWOT analysis for six participating countries; and

5 - Identification and description of good practice examples of the transition process across the 9 WP5 participanting countries.

1 - LITERATURE REVIEW

The literature review focused on the transition from institutional to community-based mental health care to identify the context, approaches and facilitators for achieving successful transfer. The review took stock of some of the key challenges in moving from institutional to community alternatives and how these may be overcome. The main objective was to describe successful transitions to community mental health care and how this was carried out and evaluated. Factors that promote social inclusion were also explored. A further aim was to help formulate policy recommendations to stimulate the shift towards community-based mental health care.

Three questions set the parameters of the review:

1 - What examples of successful transitions from institutional to community care can be described from the existing literature?

2 - What are the main challenges to moving from institutional to community-based mental health care?

3 - How can these be overcome?

4 - What is the evidence of effective or best practice in relation to community based and social inclusive care?

The search for relevant literature was conducted by applying some of the techniques used for a systematic review. Both published (academic) and unpublished (grey) literature such as policy briefings or reports were included if applicable. An Information Specialist developed the search strategy using a series of search terms to identify the published literature. Full searches were conducted using seven bibliographic databases. Table II. 1 lists the databases searched, search dates and the number of results produced:

Table II. 1.

DATABASE SEARCHED	DATE SEARCHED	NUMBER OF RESULTS
CENTRAL (Issue 3 of 12, March 2014) on The Cochrane Library	10/4/2014	660
MEDLINE (OVID, 1946 to April Week 1 2014)	10/4/2014	4801
EMBASE (OVID, 1980 to 2014 Week 14)	10/4/2014	5806
PsycINFO (OVID, 1806 to April Week 2 2014)	11/4/2014	6218
Conference Proceedings Citation Index – Science on Web of Science (Thomson Reuters, to 9/4/2014)	13/4/2014	2398
ERIC (http://eric.ed.gov/?, 1966 to present)	13/4/2014	79
CINAHL Plus with Full Text (EBSCO, 1937 to 11/4/2014)	11/4/2014	1874
TOTAL		**21757**
AFTER DE-DUPLICATION		**16798**

To capture details of the build-up towards the process of deinstitutionalisation and the development of community care, literature published from 1975 to April 2014 was included. Given this broad scope, the literature search yielded some 17.000 reference titles. The specific inclusion criteria were articles or reports published in English; based on European countries, with some relevant examples included from the international literature; descriptions and evaluations of the transition from institutional to community-based care; the development of and descriptions/the evidence base for models of community-based services; and social inclusion. A two-stage filtering process was used to narrow down the number of reference titles to be included in the review; the initial stage excluded titles based on

abstracts only and the second on the full text. Key papers were crossed referenced for other relevant articles not identified by database searches. Grey literature was identified by members of the research team, experts involved in the Joint Action and others in the field. A total of 101 reference titles were selected for the literature review.

2 - ANALYSIS OF SELECTED EXISTING DATA FROM EU COUNTRIES

Analysis of selected existing data from EU countries was carried out using a set of indicators listed in Table II. 2. This provides information on the transition process across EU countries and drawn from a number of sources: the WHO Mental Health Atlas 2005 and 2011 (WHO, 2005; WHO, 2011), the WHO 2008 Baseline assessment (WHO, 2008) and the EuroPoPP report (Samele et al., 2013).

Table II. 2. Indicators of the transition process in EU countries

	2005	2008	2011/12
Governance	----------	----------	Atlas 2011
Beds Mental Hospitals	EuroPopp Table 5.4	EURO Table 6.1	EuroPopp Table 5.4
Beds General Hospitals	EuroPopp Table 5.5	EURO Table 6.1	EuroPopp Table 5.5
Beds forensic units	----------	EURO Table 6.19	----------
Day care facilities	----------	----------	Atlas 2011
Out patient visits	----------	EURO Table 6.4	Atlas 2011
Residential facilities	----------	EURO (beds/100,000) Tables 6.17 e 6.18	Atlas 2011 (places/100,000)
Rehabilitation facilities	----------	EURO Table 6.15	
Admissions to inpatient units	----------	EURO Table 6.3	Atlas 2011
Median days in inpatient (MH; GH; Comm)	----------	EURO Table 6.2	
Hospital admissions and LOS for schizophrenia	----------	----------	EuroPopp Table 5.6
Home treatment	----------	EURO Table 6.10	----------
Formal collaboration with other sectors	----------	EURO Table 9.5	
Participation of users	----------	EURO Table 10.2	----------
Funding	----------	----------	EuroPopp Table 5.9

3 - ANALYSIS OF TRANSITION IN PARTICIPATING COUNTRIES

A questionnaire to assess the transition from institutions to community-based care in the 9 WP5 participanting countries was developed in collaboration with relevant scientific experts.

Questionnaire development

A first draft of the questionnaire was developed, based on previous work and tools to assess the transition process. This initial questionnaire and several relevant reference reports were presented and discussed at the first meeting held in April 2013. The questionnaire was subsequently revised and reviewed to include contributions from partners and members of the scientific committee until a final version was agreed.

The questionnaire focused on the key dimensions for assessing the transition process during three different time periods: prior to 1998, between 1998 to 2008 and 2008 to 2012. These time periods were selected because of the available information on transition, using the Baseline Assessment Questionnaire, for all European countries published in 2008 in "Policies and practices for mental health in Europe - Meeting the Challenges" (WHO, 2008).

The collection of new data was, however focused on 1998 and 2012 and there were two main reasons for this. Repeating this exercise for 2012, using selected questions from the Baseline Assessment Questionnaire (2008), closely aligned with the purpose of this assessment, meant that important and more recent information on the evolution of transition over the last four years could be obtained. Also, issues related to 1998 would help provide an accurate understanding of the evolution that took place in the previous 10 years.

The questionnaire included not only key questions from the 2008 Baseline Assessment, but also those from several other questionnaires that assessed different aspects of the process of deinstitutionalization and the development of community mental health care in Europe. These were: the DECLOC Report (2007); Mapping Exclusion; Institutional and community-based services in the mental health field in Europe Report (Mental Health Europe and Open Society, 2012); Shifting care from hospital to the community in Europe: Economic challenges and opportunities (MHEEN Group, 2008); OECD Project "Mental Health Systems in OECD Countries (OECD, 2014); WHO – AIMS (2009), Mental Health ATLAS 2011 (WHO,2011); and Innovation in Deinstitutionalization: QWHO expert survey. Geneva, World Health Organization.

The Questionnaire was divided into three sections:

Section I covers issues concerning the implementation of policies and plans to promote the transition process, including relevant developments taking place before and after 1998.

This section contains 34 questions aggregated into three groups:

- Mental health service reforms – 3 questions.

- Closure, downsizing and quality improvement of psychiatric hospitals - 15 questions.

- Development of community care - 16 questions.

Section II includes questions directly related to the purpose of this assessment and the collection of new data for developments between 2008 to 2012. This section covers six areas:

- Policy and Legislation overview – 6 questions.

- Mental health services – 10 questions.

- Mental health funding – 4 questions.

- Human rights – 5 questions.

- Social inclusion – 2 questions

- Empowerment of users and carers – 4 questions

This section comprises 31 questions from the WHO Baseline Assessment (2008).

Section III includes questions on the achievements, barriers and facilitating factors during the process of transition. A five-point Likert-Scale is used to assess the perceived impact of any barriers, facilitators and several areas of achievement. Forty questions are distributed across these areas:

a) Achievements (26 questions) including:

- Legislation, policy and plans.

- Advocacy and public education.

- Integration of mental health care into primary health care.

- Outpatient clinics.
- Community mental health care.
- Inpatient treatment in general hospitals.
- Closure/restructuring of mental hospitals and asylums.
- Residential care in the community.
- Employment, vocational and occupational rehabilitation.

b) Barriers (10 questions) including:

- Political issues.
- Financial/management.
- Leadership.
- Stakeholders.
- Human resources.
- Inter-sectorial cooperation.
- Integration of mental health into primary health care.

c) Facilitating factors (14 questions) including:

- Political issues.
- Legislative measures.
- Users/families participation.
- Health reforms.
- Research.
- Human rights perspective.
- International cooperation.
- NGOs and their involvement.
- Mental health professionals.
- Recovery perspective.

At the end of this section, additional 'open text' information was requested to allow participants to describe more fully the achievements, barriers and facilitators.

A glossary was also included at the beginning of the questionnaire so that proximal interpretations could be made for various concepts included in the questionnaire.

Data collection

Representatives of the participating countries were asked to collect information for Sections I and II. Information for Section III was collected in collaboration with members of the national networks created within participating countries, including mental health leaders, professionals, users, families and other relevant stakeholders.

Data collection took place during 2014. Completed questionnaires were submitted by e-mail and checked for any inconsistencies or missing data. Any found were then clarified with participants via e-mail and/or tele-conference.

Data Analysis

Raw data from all questionnaires were extracted and transferred into Excel and re-checked to ensure the correct information was received and inputted. All data analyses were performed using SPSS (Statistical Package for the Social Sciences), version 19. This package was used to carry out descriptive statistics (e.g. frequencies and cross-tabulations) on mainly categorical data.

4 – SWOT ANALYSIS

Data analysis of the completed questionnaires complemented the SWOT analysis of the transition process. Six participating countries completed this task, through a group exercise of each national network. Examples of good practice that may be replicated across Europe were also identified and described for all participating countries.

5 – GOOD PRACTICE EXAMPLES ON THE TRANSITION FROM INSTITUTIONAL TO COMMUNITY CARE

A template for good practices reporting was used for standardised data collection, based on the 'WHO Guide for Documenting and Sharing "Best Practices" in Health Programmes' (WHO 2008). The groups of each national network made the selection of the good practices examples presented in Annex 2 .

III. LITERATURE REVIEW

Historical background to the transition from institutional to community MH services

The development of large asylums around the end of 1800s was closely linked to the origins of modern psychiatry. Investment into asylums emerged out of a movement of social welfare to care for the 'feeble' (Fakhoury and Priebe, 2007). Previously, people with mental illness were ridiculed by the public and kept in dire conditions. The introduction of 'moral treatment' was one of the most important asylum reforms at the time. In 1792, Philippe Pinel as chief physician of La Bicetre in Paris, improved the conditions and practices of asylums, allowing patients to move freely and treated humanely. There was also an emphasis on selecting and supervising suitable attendants who were able to facilitate psychological work, particularly the employment of ex-patients as they were thought less likely to adopt inhumane practices (Gerard, 1997). Similar practices were also introduced in other parts of Europe. In England, William Tuke also emphasised the importance of treating the mentally ill with respect and compassion and opened the York Retreat in 1796. In Italy, Vincenzo Chiarugi managed to institute humanitarian reforms where chains were outlawed as a means of restraining the mentally ill between 1785-1788 in one asylum, and a more humane regime introduced in the newly renovated St. Bonifacio Hospital in 1788 (Mora, 1959).

Asylums were built to accommodate and provide basic care in locations away from the rapid urbanisation of new towns during the industrial revolution, thought to increase mental illness. Locating the mentally ill in remote areas also had the benefit of making the mentally ill less visible, whose behaviour may have been perceived as bizarre and odd in a society with strict moral codes.

Initially designed to provide good living conditions many asylums became seriously overcrowded by the beginning of the 20th century. The combination of increased admissions and a lack of funding during times of war or economic hardship meant patients starved to death and living conditions become notoriously poor (Fakhoury and Priebe, 2007).

The historical context to the transition from institutions to community-based services differs widely between countries in Europe. The transition in some countries started with the development of a 'movement' that questions the official status quo in psychiatry. The pressure to bring about psychiatric reform often coincides within a wider context of political and social change and a growing public awareness of marginalised groups.

Successful closures of mental hospitals/psychiatric hospitals

A number of commentators have charted the process of deinstitutionalisation in Europe and internationally (Fakhoury and Priebe, 2002). The reasons for initiating this process are varied but there is a broad consensus on the need to shift away from large mental hospitals/psychiatric hospitals to comprehensive community-based mental health care (Caldas de Almeida and Killaspy, 2011). The reasons include better accessibility to services; greater service user satisfaction and increased met needs; protection of human rights; better clinical, social and vocational outcomes (see Caldas de Almeida and Killaspy, 2011 for an overview of the literature).

Much of the literature provides a descriptive analysis of the closure of psychiatric hospitals using indicators such as the decline in the number of psychiatric beds overtime, a large reduction in the mean length of stay and a rise in the use of psychiatric outpatient services.

Case example – Italy

Italy was one of the first European countries to start the process of closing its mental hospitals. The enactment of Law 180 in 1978 set in motion a radical programme of deinstitutionalisation. Franco Basaglia was the lead proponent of this reform and it is worth recounting how this took place. Basaglia's work began in 1961 and over the course of two decades he details how he and his co-workers closed asylums and developed community alternatives (Babini, 2014). His work and reflections while trying to close two asylums in Gorizia and Parma and actually closing the Trieste hospital (Northern Italy) provide valuable insights into the process of deinstitutionalisation and the challenges he and his associates had to confront before patients could be discharged to the community.

The process happened in three stages as Schepher-Hughes and Lovell (1986) describe[1]. Basaglia was critically aware of how the asylum met patients' basic physical needs of food, safety and shelter; but that it suppressed autonomy, liberty and love. At this time he described the asylum as:

> *An enormous shell filled with bodies that cannot experience themselves and who sit there, waiting for someone to seize them and make them live as they see fit, that is as schizophrenics, manic-depressives, hysterics, finally transformed into things (Schepher-Hughes and Lovell, 1987).*

For Basaglia, other approaches used in Europe, such as the 'open door policy', served only to reemphasise the extent to which patients were institutionalised. Patients were encouraged to physically dismantle or destroy hospital barriers – doors, bars and window gratings and old furniture. Wards were opened up and paid work was created for patients either in farming, in the kitchen, or from maintaining the grounds. This was important for enabling patients to feel they had more in common with the outside world at least in terms of paid work. This later led to the development of work cooperatives as a non-exploitative alternative to sheltered work.

The next stage in the process saw the creation of 'assembleas' or meetings which replaced formal arrangements between doctors, nurses and patients. These were not therapeutic communities and patients were free to attend or not. Assembleas were not controlled spaces and were very often chaotic as patients expressed their anger or hostility in the struggle against the institution. Common sense and lay opinions established the criteria for the most appropriate times of discharge for each patient. Any errors of judgement regarding a particular discharge become a shared responsibility if a crisis arose. Assembleas was one of several methods used for deinstitutionalised practices across the country. Others included consciousness raising in the community, spontaneous meetings with visiting family members, discussions with people from the local community and within formal political arenas.

Approaching the community was an important part of the process. The aim was to work alongside organisations particularly those related to the labour market – unions, factory owners and managers of small firms. This was to persuade these organisations to employ a 'new class of social marginal' – a person who had no work experience or someone who had lost their skills because of long-term institutionalisation. Basaglia recognised the importance of families of patients and in approaching them found that they were either ill-prepared or reluctant to take back relatives who had been difficult in the past.

A new form of mental health worker was central to Basaglia's community alternative. This person was not to be located within a community mental health centre or at a day hospital, but within the hub of the ex-patient's life, both public and private. The community mental health worker was to take the side of the ex-patient and their family.

At the third stage, a key focus for Basaglia and his colleagues after downsizing two mental hospitals/psychiatric hospitals was to combine the closure of a hospital with the preparation of community alternatives for ex-patients. This 'total amalgamation' began in 1971 when Basaglia became Director of the psychiatric hospital in Trieste. The province's administrator was willing to accept a radical transformation of the asylum. In first tackling the asylum and later the community, patients were able

1 Stage one was the destruction of the mental hospital. Stage two focused on community praxis. The third stage was the combined dismantling of the hospital and the development of community based mental health centres.

to develop a new sense of personal and social identity, challenge popular stereo-types about the asylum and misconceptions of mental illness. Basaglia devised a new legal status for patients too frail or elderly or difficult to relocate into the community who then became guests, where their civil liberties were restored and they were free to come and go as they wished. Wards in the asylum were converted into autonomous housing or apartments for those remaining there. The community was encouraged to visit the asylum and often shows, plays or film festivals took place within the old asylum.

With the help of the Provincial administrator and the labour unions, Basaglia and his colleagues were able to open six community mental health centres. This work was carried out in the mid-1970s within a context of chronic unemployment and housing shortages, which meant a lack of financial resources for ex-patients. Advocating on behalf of ex-patients to secure higher entitlements and widen opportunities in the community was an important endeavour. This work represented another important change where additional costs associated with the transition from hospital to community based mental health care were mostly concerned with the amount of social benefits paid to ex-patients, rather than higher costs of medication or staff increases (Donnelly, 1992).

These stages used by Basaglia and his co-workers are not intended to be a description of a technique but to encourage stakeholders to continually raise questions about ‘what is the real problem’ and ‘whose needs are being served- whose are being neglected?’ (Schepher-Hughes and Lovell, 1987).

LEGISLATING DEINSTITUTIONALISATION

Basaglia and his wife, Franca Ongaro-Basaglia, founded Psichiatria Democratica which aimed to bring together many of the models and achievements of the previous pilots of deinstitutionalisation (Schepher-Hughes and Lovell, 1986). Supported by other political parties and a social climate of change, Law 180 featured both a radical and gradual phasing out of mental hospitals by prohibiting further admissions to them (Mosher, 1982; Ramon, 1984). After December 1980 admission to these hospitals became unlawful. Law 180 did not apply to forensic psychiatric hospitals.

Law 180 was quickly assimilated into the newly formed National Health Service (Law 833) and in administrative terms this led to the development of Local Health Units to organise health services.

OUTCOMES OF ITALIAN PSYCHIATRIC REFORM

Over the past three decades since Law 180 a number of research studies and national surveys have attempted to evaluate the impact and implementation of the reform. There was a steep fall in the number of discharges from both public and private mental hospitals, which commenced prior to the reform. In the early 1970s there were around 75,000 patients living in mental hospitals, and by 1977 this reduced to 58,000, and then 38,000 in 1981 (a rate of 67.6 per 100,000 population) (Morosini, et al, 1985).

Responsibility for implementing the reform was given to the 21 regional governments (Ferrannini et al, 2014). Each differ widely (e.g. culturally, politically, geographically) and for this reason implementation of the reform was highly uneven (Burti et al, 1996). General hospital psychiatric wards were the only public units permitted to admit psychiatric inpatients under Law 180. Prior to Law 180 these were relatively rare, but by 1984, around 236 units were in operation with approximately 3,100 beds (De Salvia and Barbato, 1993). The total number of psychiatric inpatient beds in General hospital psychiatric units was 6,380 (1.28 per 10,000 inhabitants) in 2009; and down from 6,780 beds in 2007 (Di Fiandra et al, 2013).

A few longitudinal studies have examined the social and clinical outcomes of patients treated in the community some years after the psychiatric reform. Favourable outcomes were found for people with schizophrenia in six Italian cities (Trieste, Verona, Arezzo, Naples, Cetraro and Cagliari), where the use of social and/or vocational skill training was predictive of improved outcomes, but not number of days as a psychiatric inpatient (Kemali and Maj, 1988). Studies of the impact of comprehensive community based mental health services, such as those in South Verona, show important positive outcomes where

patients were found to have few 'needs for care' (Lesage, et al, 1991); and when compared to people treated in other outpatient settings had the greatest number of met needs (Mosher and Burti, 1989). A seven-year follow-up study comparing public hospital inpatients with schizophrenia and those based in the community found improved symptomatology for half those in community settings; and for hospital patients symptoms were either unchanged or had deteriorated (Mignolli et al, 1991).

IMPACT ON THE FAMILY

After the Italian reform between 55% to 70% of patients discharged from mental hospital returned to their families (Casacchia and Roncone, 2014; Gallio et al, 1991 cited in Burti and Benson, 1996; Rampazzo and Turci, 1988). Interviews with 267 family caregivers of patients with a major mental illness, randomly recruited from the Trieste psychiatric case register, found many had change jobs or had retired to look after their family member. Over half (57%) reported a negative impact on family life, tiredness (49%), and reduced family income (29%) (Gallio et al, 1991). Over 80%, of families in the same study, however, were very satisfied with the care provided by local community mental health services. Other studies also note problems in caregiving often associated with patients' antisocial behaviour (Roncone et al, 1992 cited in Burti and Benson, 1996); poor self-care and unemployment (Gallio et al, 1991). Relatives' caring for those with long-term mental illness in Naples, were found to experience poor social relationships with others, depression and deteriorating physical health (Veltro et al, 1993). Similar findings were also found for 40 relatives caring for family members with schizophrenia, affective psychosis or depressive neurosis in South Verona where the main negative effects for carers were psychological problems (67%) and reduced leisure activities (57%) (Samele and Manning, 2000). Interestingly, more positive findings included high levels of social contact among virtually all relatives in the study and the reduced levels of burden in relatives whose family member with mental illness was employed (Samele and Manning, 2000).

CURRENT SITUATION

In a special supplement on Italian community mental health services Fioritti and Ammadeo (2014) provide an overview of current practice, noting how the system tries to balance a humanistic approach to psychiatry with the use of scientific evidence. Lora et al (2014) describe the current situation for three regions. This highlights some of the stark differences between regions in the models and implementation of community mental healthcare; reflective of Italy's history and autonomous regions. A particular issue for one region, Campania, concerns the inadequate number of psychiatric beds available to manage service users with acute, post-acute and chronic mental illness. The current provision of psychiatric beds in general hospitals is 0.26 per 10,000 population and lower than the national average. The rising demand for psychiatric beds and long-term care has resorted to the use of private clinics to provide both intensive and residential treatment. A common situation for many regions is the stabilisation or reduction in resources for mental healthcare and the high demand for these services.

Very recently, further landmark changes were made in Italy with the decision to close forensic mental hospitals; replacing these with small facilities for discharged offenders with mental illness, together with diversion schemes to general community mental health care (Peloso et al., 2014).

Case example – England

In England, the gradual process of psychiatric hospital closures began with a combination of events - the establishment of the National Health Service in 1948 and a growing awareness that keeping patients in hospital long after they had recovered from their acute stage of mental illness infringed their human rights. By 1959, the Mental Health Act set out for the first time procedures for compulsory admission to psychiatric hospital, making the distinction between voluntary and involuntary commitment clearer (Killaspy, 2006a).

The post-war era also brought optimism and hope and with it three major developments in the care of psychiatric patients – the open door policy; the introduction of antipsychotic and antidepressant medication in the 1950s; and a drive to locate care in the community (Jones, 1972). Research studies on psychiatric disorder at the time show the importance of living conditions and its impact on behaviour and symptoms rather than the accepted view that these were inherent characteristics of the disease itself (Wing and Brown, 1970).

In the UK and across Europe the impetus to discharge people from asylums existed prior to the development of new psychotropic drugs, and although these served an important role in the transition to community based care, they only had a modest impact on mental hospital discharge rates (Boardman, 2005).

Influential movements emerging during the 1960s and 1970s provided a radical view on the need for deinstitutionalisation. Hoffman's work, (1968) highlights the poor standards of care and quality of life in asylums; Rosenhan (1978) revealed the dangers of psychiatric hospitals; and the anti-psychiatry movement criticised the use of diagnostic categories and the role of society and the family in causing mental illness (Szasz, 1961; Laing and Esterson, 1964).

By 1971, government policy made its first clear statement emphasising the importance of non-hospital based facilities and the gradual closure of large mental hospitals (DHSS, 1971). The main policy objectives of the White Paper entitled Better Services for the Mentally Ill (DHSS, 1975) suggested guidelines to relocate specialist services in local settings, the expansion of local authority residential, day care and social work support and the establishment of organisational links between day and residential services, specialist and primary care services and local authorities and planners. At this time, 130 mental hospitals/psychiatric hospitals operated in England and Wales and by 2000, more than 90 had been closed (Leff et al, 2000).

The Team for the Assessment of Psychiatric Services (TAPS) established in 1985 provided one of the few detailed evaluations of the national policy focusing on the planned closure of two of six large psychiatric hospitals in North London and their replacement with community based services. The decision taken in 1983 by the regional health authority (North East Thames Health Authority) to close these hospitals was based on the relatively high costs of patient care and a large backlog of repairs (Leff et al. 1996).

After a 10-year reprovision programme one of the hospitals, Friern Hospital, closed in March 1993 on schedule. By contrast, financial constraints delayed the closure of the second hospital, Claybury, until January 1997. Mental hospitals/psychiatric hospitals patients discharged to the community were followed up extensively.

A one-year follow-up of 737 patients discharged from Friern and a proportion from Claybury revealed very little change in psychiatric symptoms and social behaviour (Leff et al, 1996). Almost half of the discharged patients had been in hospital for more than 20 years; and 78% were moved to staffed homes in the community. Patients appreciated their less restrictive environments and 80% wished to remain in their community homes. Social friendships increased but contacts with relatives decreased significantly. Twenty-four deaths were recorded, two of which were suicides. The number of suicides were not significantly higher than that of the general population. Seven patients were lost to follow-up, presumed to have become homeless and two received a prison sentence (Leff et al, 1996).

At five year follow-up, 18.8% (126 of the 670 mental hospitals/psychiatric hospitals patients discharged) had died and 12 were untraceable (Leff and Trieman, 2000). Data were thus available for 523 (or 97%) of the discharged patients who were assessed at three time points (baseline, one year and five years). There were no significant changes in symptoms over time and about 40% of patients assessed, using the Present State Examination, experienced active delusions and/or hallucinations during the follow-up period. Similar findings were also found for social outcomes, in which community skills had improved significantly by one-year follow-up and maintained by five years. Domestic skills increased significantly at one year, but then decreased at five years. Social networks and the numbers of friends made in the first year were maintained over the five years; while the number of confidants had increased at each of follow-up.

Case Example – Spain

In Spain, a movement challenging the existing psychiatric structures emerged in the 1970s. During this time the dominant form of mental health care was provided by institutions and run mainly by Provincial councils, religious orders or the private sector. As Spain re-established its democracy in the 1980s following the Franco dictatorship, the process of psychiatric reform began (Baca et al, 2010). There was growing public awareness that the long-stay population were the most marginalised and that institutions severely hindered patients' autonomy and social skills (Poveda et al, 1987). By 1985, a new model of mental health care was presented by the Ministry of Public Health in a landmark Report from the Ministerial Commission on Psychiatric Reform, specifying that psychiatric care must become an integral part of the general system of healthcare; segregation of patients in psychiatric hospitals must be eliminated; psychiatric hospitalisation should be reduced and community alternatives created; and the civil rights of patients must be guaranteed when restricting their freedom during involuntary admissions to hospital. The decentralisation of health services was also pursued in which 17 autonomous communities could take responsibility for delivering healthcare.

Both the psychiatric reform and the passing of the 1986 General Health Act were pivotal to the development of modern mental healthcare in Spain (Bobes et al, 2012). The main objective was to transfer the provision of mental health care from mental hospitals/psychiatric hospitals to the community. This change led to the development of new out and inpatient facilities including mental health centres, day hospitals and rehabilitation units offering intermediate community mental health care, psychiatric wards located in general hospital and improved coordination with primary care and social services (Bobes et al, 2012).

Vázquez Barquero (1999) used theoretical publications and evaluation studies on the organisation of psychiatric care in Spain, legislative measures, reports, protocols and annual reports to assess the process of transition in Spain. The number of mental hospitals decreased from 121 in 1973 to 87 in 1994. Over the same period the number of psychiatric beds in these hospitals fell by 27,121, from 43,000 to 15,879. The creation of psychiatric units in general hospitals began around 1991 where 88 were in place with 2,107 beds, increasing to 105 with 2,401 beds in 1995. The transition was also characterised by the increase in short-stay hospital admissions to these units and a decline in those to psychiatric hospitals.

Salvador-Carulla et al. (2010) examined the organisation, provision and financing of mental healthcare in Spain following recent psychiatric reforms using the existing literature, reports and empirical data from regional and national health plans, also drawing on an iterative discussion with an expert panel on the features of Spanish mental health services. The focus on the process of deinstitutionalisation has been successful for the most part. The transition to and the development of community based alternatives, however, has been relatively slower. Great heterogeneity between autonomous communities was found, whereby the lack of earmarked budgets and an imbalance in mental healthcare and the lack of monitoring information of the reform process have generated new challenges to address – including better harmonisation and integration between health and social care and to prevent widening geographical disparities.

Creation of community based services

Developing community-based mental health care requires a series of coordinated actions that need to be pursued over a long period of time (Tansella et al, 2006).

Community based alternatives to asylums were first developed in the 1920s and 1930s. It was only by the 1950s, as patient numbers continued to increase and unacceptable standards of care in asylums came to the fore, that community alternatives were considered more seriously by professionals and the public (Fakhoury and Priebe, 2007). In England, the passing of the 1930 Mental Treatment Act extended the voluntary admission procedure to asylums and encouraged asylums to establish an outpatient department to assess patients' fitness for voluntary admission (Killaspy, 2006a).

In some European countries the process of deinstitutionalisation ran alongside the development of community based mental health services. In England, for example, as dates were set for hospital closures debates began to intensify over what range of community services and support should be provided for those being discharged to the community. The lack of provision was a concern and so too was the appropriateness of community placement for the most disabled people needing high support. Clifford et al. (1991) present findings from surveys of five psychiatric hospitals due for closure and involved in the planning for community care. Using the Community Placement Questionnaire (Clifford, 1989) and a standardised staff completion schedule designed for service planning, information was collected on 1,308 patients. These psychiatric hospitals contained a predominantly elderly and severely disabled population, many having spent over five years in hospital. Even those considered 'new long stay' (people with a hospital stay of less than five years and under the age of 65 years) were not found to be too dissimilar from those with a stay of between five to ten years. In conclusion, Clifford et al, (1991) state:

The majority of long-stay patients currently in hospital are severely disabled but could manage to live in the community with support. There is thus little long-term justification for keeping large mental hospitals/psychiatric hospitals, assuming that provision is made in the community.

The transfer of staff from institutions to community-based services also proved successful according to a longitudinal study by Carpenter et al (2000). Most staff from one mental hospitals/psychiatric hospitals following their transition to community based alternatives considered this to be better for patients. There were relatively low levels of reported stress and job satisfaction was high.

In England, outpatient clinics became an integral part of psychiatric service provision and a key resource for assessment and follow-up as community mental health care provision developed. Other community based alternatives were also being developed for people with mental illness, including supported housing, day services and community-based mental health nurses and social workers. Underpinning this development were government policies, such as 'Better Services for the Mentally Ill, and 'Care in the Community' (DHSS, 1975; 1981).

New community mental health services were later introduced following the National Framework for Mental Health (DoH, 1999) to provide specialist provision such as early intervention, crisis resolution or home treatment teams and assertive outreach treatment (Killaspy, 2006a). The evidence for these specialist community services is reviewed in the section on 'models of community mental health care' below.

Precise descriptions of the development of community-based mental health services and the timing of their introduction across European countries is limited. In Sweden, there was a major lack of information about the distribution of hospital and community resources following psychiatric reform (Malm et al. 2002). Although the process of deinsitutionalisation commenced in the 1970s, major health reforms took place in the mid-1990s. The main objective of this reform in 1995, with the passage of several Health and Social Care Acts, was the social integration and improved quality of life for people with mental illness, equal to that of the general population (Hansson and Steffansson, 2001). The government commissioned the National Board of Health and Welfare to follow-up and evaluate the impact of the psychiatric reform over a period of four years. It found that around 70% of people with mental illness

lived in their own homes, but the boundaries between the state and municipalities in terms of rehabilitation programmes for them were unclear.

Following this reform, community mental health care lagged behind deinstitutionalisation in Sweden. Most people with major psychiatric disorders are seen by primary healthcare providers (Munk-Jörgensen et al., 1997). However, the build-up of community mental health services accounted for the continued reduction in the utilisation and length of stay in inpatient care. This was particularly so after the reform, in which the proportion of long-stay patients reduced by half between 1994-1997 (Silfverhielm and Kamis-Gould, 2000).

Health and social are highly decentralised in Sweden which has led to considerable variations in the organisation of mental health care (Sjöström, 2013). There is often overlap between mental health services provided by general psychiatric hospitals, outpatient clinics and primary health care centres and those provided by municipal services which organise social care for people with mental illness. The lack of coordination between health and social services has been a particular problem and attempts were made by the Government to address this issue.

Finland underwent a rapid process of deinstitutionalisation starting in the 1980s. A study using three representative samples of people with schizophrenia discharged from mental hospitals/psychiatric hospitals in 1982, 1986 and 1990 were followed up for three years. The majority of people discharged received aftercare and treatment provided by community mental health centres (81% of the first sample received this), but this decreased to 65.1% for the 1990 sample. The use of residential care steadily increased across the three samples from 4.2% for those discharged in 1982 to 13.7% for those discharged in 1990 (Salokangas and Saarinen, 1998).

The funding of mental health services was transferred to the autonomous municipalities in 1993. Finland currently has considerable variation in community mental health services as a result of this decentralisation, and better cooperation between health and social care services is needed (Härkäpää, 2013).

An important outcome, however, of deinstitutionalisation in Finland has been an increase in life expectancy. A study drawing on a sample from the 1981-2003 Finnish Hospital Discharge Register calculated life expectancy for men and women aged 15 years and above. The gap between people with serious mental illness and the general population by 2001-3 had reduced by 0.8 months for men and 3.8 years for women (Westman et al., 2012).

In Germany, the development of community based services and the closure of psychiatric hospitals has been relatively protracted and incomplete. Despite the introduction of psychiatric reform in the 1960s, a more concerted effort to develop community mental health services following a critical analysis of the care system began in the early 1970s (Bauer et al. 2001). An expert commission using empirical evidence from 14 'model regions' called for an integrated community psychiatric system that included: community services with an outreach function; day and counselling centres providing social support, work and other activities, and day centres for catchment areas of approximately 100,000-150,000 population (cited in Bauer et al. 2001).

The main aim of these community services was to care for those with enduring mental health problems and ensure that long-term patients can be discharged and readmissions avoided. Subsequently, over the next few years, there was a partial shift from in-patient care from psychiatric hospitals to smaller general psychiatric hospital units. New community services were created in almost all regions in Germany. However, the development of community mental health services was still incomplete at this time and significant regional variation was already apparent. Some data show that by 1996 nearly all catchment areas had some form of outpatient treatment; 90% had residential care services, day care and structured activities for people with severe mental illness; two-thirds had workshops; and between 18-84% had self-help or carer groups.

Meanwhile, the provision of office-based psychiatrists was increasing and reached about 6 per 100,000 population by 2000. Staffing of outpatient psychiatric services also remained incomplete in terms of the

availability of multidisciplinary teams. Social psychiatric services, however did comprise multidisciplinary teams providing counselling, case management activities and some secondary or tertiary prevention but were not able to prescribe drug therapy. These services also included some assertive outreach and crisis intervention. The downsizing of psychiatric hospitals was still continuing, unlike England and Italy where these had been closed 20 years previously. These hospitals were also being renovated internally in parallel with the creation of general hospital psychiatric units.

As Bauer et al (2001) argue:

> *… it has prevented the service system from experiencing the problems arising when mental hospital closure is paralleled by insufficient community mental health services and resources: neglect and loss to follow-up of people with chronic illness, homelessness of some people with mental illness; increase in criminal behaviour, etc. (pg.33).*

Psychiatric hospitals in Germany still exist, but have been transformed in terms of infrastructure, staffing, therapeutic culture and procedures. Most are much smaller in size and focused on providing acute hospital care, alongside general hospital psychiatric units (Kling Lourenço, et al, 2013).

The evolution of mental health services in France includes the process of deinstitutionalisation and the development of catchment area-based service provision or sectors in 1960; whereby geographical area teams were to be responsible for inpatient and outpatient care. The drive towards the transition from mental hospitals/psychiatric hospitals to community care was influenced by pressure from patient and carer organisations, policy changes and progressive 'destigmatisation' of the mentally ill, but also the need to reduce medical costs.

In France, significant reductions in mental hospitals/psychiatric hospitals beds only really took place during the 1990s (Verdoux, 2007). Hospital-based care still remains a dominant feature of psychiatric services, with 80% of the total expenditure for mental health in 1998 being spent on inpatient care (de Menil, 2012). According to the World Health Organization Mental Health Atlas (2011) there were 22.72 per 100,000 population psychiatric inpatient beds located in general hospitals; and 101.06 in psychiatric hospitals. In 2010, this was 59.0 per 100,000. There were 90 psychiatric hospitals with a total of 42,063 beds in 2009.

Community mental health care in France is based on approximately 839 sectors and each sector covers an average population of around 54,000 inhabitants (Verdoux, 2007). Despite these services being organised in terms of catchment areas a person is free to consult a public or private psychiatrist without referral from a GP. Outpatient treatment is provided in psychiatric hospitals or Community Mental Health Centres. In 2009, there were 3,117 outpatient units, which are one of the most evenly distributed services in the French health system (de Menil, 2012).

An important progression in French health care has been the growth in the role of user and family organisations, who are often members of hospital committees in planning mental health services at regional level. The role of NGOs has also become more prominent, particularly in improving access to mental health care for marginalised groups such as the homeless.

In Italy, the development of community mental health centres (CMHCs), although very slow in some parts of the country, particularly the South, has been relatively successful. By the end of 1984, there were approximately 674 CMHCs available to 80% of the Italian population; around a third had been built prior to the 1978 reform, mostly situated in the North, and the remainder after Law 180 (Burti and Benson, 1996). The quality of community based mental health care prior to 2006 has been evaluated through several surveys revealing the frequent use of poly drug therapy, a lack of continuity of care from general hospital psychiatric units to outpatient services, and limited psychosocial or talking therapies (see de Girolamo, 2007 for an overview). Although Ruggeri et al (2004) found during a three-year follow-up study of people with schizophrenia seen by South Verona community mental health services that 74% had stable symptoms, 8% improved symptoms and 18% had symptoms that became worse.

Unlike other European countries, community mental health services in the Netherlands were developed faster than the decline of mental hospitals/psychiatric hospitals beds. In 1974, the Dutch

government announced its intention to create Regional Institutes for Community Mental health Care (RIAGGSs), making mental health care available to all and with a strong public health focus to prevent hospitalisation and stigmatisation. RIAGGs were a political and strategic stand against the 48 mental hospitals/psychiatric hospitals in existence up until the mid-1970s (Schene and Faber, 2001). It took almost a decade of preparation for RIAGGs to be established and 58 were developed across the country by 1982.

RIAGGs had a diverse set of functions ranging from psychotherapy to supportive community care for all age groups. They organised 24/7 outreach crisis care and consulted with professionals who came into contact with people with mental disorders, such as GPs, teachers and policemen. During the early 1980s there was also a growth in the number of users and carers organisations and by 1996 their involvement in the development, organisation and quality of mental health services became formalised. The level of service user involvement can include influencing their personal treatment plan and plans for the organisation and functioning of local and regional mental health services (Schene and Faber, 2001).

Community care models and their effectiveness

A community mental health team, with a multidisciplinary team, is a core component of community mental health services (Thornicroft, 2013). Community mental health teams are one of many elements that make up a comprehensive community service. Social care services are an important part of any community mental health service given the range of non-health support needs someone with a severe mental illness often has. The integration of health and social care for people with severe and enduring mental illness is therefore essential (Burns et al, 2001).

Several models of community care exist and some have been formally evaluated. The Care Programme Approach in England was introduced in 1991 and provides a fundamental framework by which mental health services operate (Killaspy, 2006a). It involves a full assessment of a person's health and social care needs, a care plan and regular reviews. People eligible for a CPA have a care coordinator, usually a social worker or a community psychiatric nurse, who oversees their care. Of the few studies available on patients' views regarding CPA the majority are positive, having felt involved in planning their care. Service users also prefer a closer integration of health and social care services (Carpenter, 2004), and this is beneficial for carers too (Schneider et al, 2001).

The development of newer models of home-based community mental health services have emerged over the past two decades. These services provide specialist provision such as intensive case management, early intervention, crisis resolution or home treatment teams and assertive outreach treatment. Evaluations of these types of specialist interventions have focused on the reduction of hospitalisation and symptoms of mental illness, and cost-effectiveness.

Intensive versus standard case management was assessed in one randomised trial by the UK700 Group for people with severe psychotic illness. The main feature evaluated was the effect of smaller case loads of between 10-15 clients for intensive case managers compared to 30-35 for case managers delivering standard CMHT care (Burns et al, 1999). No significant differences were found between groups in clinical symptoms and social functioning or a decline in overall hospital use at 2-year follow-up. Other UK studies have also found no differences in symptoms and social functioning for clients receiving intensive case management, although one study found improved quality of life, satisfaction with care and continued engagement with the service (Holloway and Carson, 1998).

Assertive Community Treatment (ACT) provides intensive case-management support for people with psychosis who have fluctuating mental state and poor social functioning and medication adherence. This specialist community mental health service aims to support people stay in contact with mental health services and improve their outcomes. This service model was developed in the 1970s as an alternative to standard community mental health care. ACT was able to keep people engaged with the service and reduce their likelihood of hospital admission in studies conducted in the US and Australia but not in the UK (Marshall and Lockwood, 1998; Killaspy, 2006b). More specifically, a randomised evaluation of an ACT

service in North London found no differences between clients receiving ACT versus standard community mental health care at 18 month follow-up in use of inpatient services, symptoms, social function, needs, quality of life, substance misuse, adverse events and medication adherence (Killaspy, 2006b). ACT clients received three times more face to face contacts with staff and were better engaged, more satisfied with the ACT service and less likely to be lost to follow-up. No differences between ACT and CMHT clients in use of inpatient services, adverse events, use of supported accommodation persisted at 3-year follow-up despite ACT clients having two times more face to face contact with staff (Killaspy et al, 2009).

The effects of and adherence to intensive case management using an ACT fidelity scale were assessed in a systematic review and meta-regression in an attempt to explain the lack of efficacy for intensive case management and ACT in the UK. Burns et al (2007) found that intensive case management compared with standard care appeared to work best in an area with high use of inpatient services, and was less successful when hospital use was low. Success is also dependent on the way a team is organised and the key elements are whether it was based away from the hospital site; provided the primary therapy for patients; met daily; shared responsibility for caseloads; available for 24 hours; had a team leader who was also a case manager with a caseload; and offered services with no time limit. 'In vivo' work, where patients are seen at home rather than in the team's office, is another important component to home treatment models of care (Catty et al, 2002). In the UK, the evidence for early intervention and crisis resolution services demonstrates that these are able to reduce the possibility of admission to hospital and improve patient satisfaction compared to the care provided by a community mental health team (Marshall and Rathbone, 2011; Murphy et al, 2012). Early intervention services have now become well established in a number of European countries, particularly in the UK and Italy, and crisis resolution services have also been found to reduce family burden (Murphy et al, 2012).

Supportive housing and residential care

Supported housing can be independent living in shared accommodation or single room occupancy with support from a community mental health service. Residential care or group homes provide more intensive on-site support by staff. Many residential homes have been developed in the wake of deinstitutionalisation offering rehabilitation to improve skills for independent living prior to moving to independent accommodation. In Italy, non-hospital residential facilities, of no more than 20 beds, were developed during the 1980s to provide alternative accommodation and a network of rehabilitation services. Findings from the PROGRES study found these residential services varied greatly between regions and provided mainly long-term accommodation for older patients, with no full time staff to provide intensive rehabilitation. They also had a low turnover of residents around 31.5% of these residential services had discharged any patients which meant few new admissions were possible (de Girolamo et al. 2002).

Despite the potential variability in the types of residential and supported housing facilities and what they provide, they are likely to promote a better quality of life from hospital. A study of 213 long-term care units for people with severe mental illness across ten European countries found that positive ratings of these units were associated with patients' autonomy, self-management and experiences of care (Killapsy et al, 2012). Hospital units scored lower than community units in terms of the quality of their therapeutic environment. Higher levels of autonomy have also been found for small supported residences (of up to seven people) in Sweden; and during acute phases of illness support can be increased to levels found in inpatient wards, which is more acceptable for residents (Brunt et al, 2002).

There are concerns that people discharged from mental hospitals/psychiatric hospitals have been transferred from one structure to another (transinstitutionalisation); or to newer forms of institutional care such as forensic mental hospitals/psychiatric hospitals or supported accommodation known as 'reinstitutionalisation'. Priebe et al (2005) assessed the changes in the number of forensic hospital beds, involuntary hospital admissions, places in supported housing, general psychiatric hospital beds, and the general prison population between 1990-1 and 2002-3, across six European countries who have undergone the process of deinstitutionalisation. Increases were found in the number of forensic

hospital beds and places in supported housing in all countries examined. There was a rise in compulsory admissions in England, the Netherlands and Germany, but not in Italy, Spain and Sweden. The general prison population has increased in all countries (between 16% and 104%), with England and Spain having the highest rates of imprisonment and the lowest number of forensic beds. Although the data examined have their limitations, Priebe et al (2005) regard the rise in the general prison population as suggestive of reinstitutionalisation and possibly a result of general attitudes towards risk containment in these societies.

There is clearly a subgroup of people with severe mental illness who require continuing support and care in the community for their long-term needs. The outcomes for this group are generally positive, but some are vulnerable to being marginalised from their social network, are at risk of reinstitutionalisation and require stable accommodation. However, community residential rehabilitation programmes provide an effective alternative to mental hospitals/psychiatric hospitals/institutional care for this group (Chopra et al. 2011). In the UK, particular attention has been paid to the needs of this group and the importance of investment in a local rehabilitation and supported accommodation pathway including both inpatient and community facilities. This pathway provides a stepped approach to supporting people to gain confidence and skills so that they can live in increasing independent settings graduating from higher to lower levels of support sequentially.

Cost benefits and cost-effectiveness of community based mental healthcare

> *In a good care system, the costs of supporting dependent people are usually high wherever those people live. Policy-makers must not expect costs to be low in community settings, even if the institutional services they are intended to replace appear to be relatively inexpensive. Potential economies of scale in large-scale institutions are complicated by the question of service quality; low-cost institutional services are almost always delivering low quality care (Knapp et al, 2011).*

The economic consequences of deinstitutitionalisation have been examined by Knapp et al. (2011) through a detailed systematic review of the literature. In short, community based models were found to be no more costly than institutional based care, even when taking into account patients' needs and the quality of care. New models of community based services, however, may be more expensive. Nevertheless, these can still demonstrate cost-effectiveness if set up and managed properly, as they are likely to deliver improved outcomes (Knapp et al, 2011).

Patients who are very challenging to accommodate in the community can be more costly, as their success depends on having intensive staffing support (McCrone et al, 2006). As part of the TAPS project and until the last cohort of patients left the mental hospitals/psychiatric hospitals the full costs of community care could be calculated. These were shown to be similar to the costs of hospital care (Beecham et al, 1997, cited in Knapp et al, 2011). The remaining residents were those that were more challenging to support in the community.

Analysis of the PROGRES dataset of psychiatric residential care in Italy described above reveals that various factors are associated with cost differences (type of facility, location, bed numbers), and in terms of patient characteristics (age and psychiatric diagnosis).

Some economic evaluations of deinstitutionalisation have found community care to be cheaper. For example, a study by Beecham et al (1996) following the closure of nine mental hospitals/psychiatric hospitals in Northern Ireland found accommodation and on-site support to be the largest single item in patients' care packages, accounting for around 81.6% of total costs. Patients in the community one year after leaving hospital accessed almost 30 different types of services in the community ranging from day care to education and employment services.

In understanding the cost-effectiveness of community care it is important to consider when planning the transition from institutional care the range of community services different patients are likely to need

(Knapp et al, 2011). The connections between costs, patients' needs and outcomes are complex but are important to building a strong economic case for making the transition from institutions to community based services provided by different agencies or sectors. Pointers to success, as Knapp et al (2011) explain, include:

- Joint planning and joint commissioning that can be used to transfer from a single budget on which institutions are mostly run to a community context with multiple budgets covering many different services;
- Devolving responsibilities to care/case managers or individual patients through self-directed care arrangements (such as personal budgets or direct payments) may also overcome issues concerning funding arrangements; and
- Making all stakeholders aware of the policy/plans to transfer people to the community. In countries such as Bulgaria or Romania psychiatric institutions may be an important part of the local economy. Consideration therefore needs to be given to creating new employment opportunities for former staff or identifying alternative economic uses for institutions.

Challenges to the closure of psychiatric hospitals and development of community mental health services

Some reports document the state of deinstitutionalisation and community mental health care across Europe. In a mapping of long-term care for people with severe mental illness across Europe, Mental Health Europe (2012) found nine countries have a deinstitutionalisation strategy or programme in social care (Bulgaria, Croatia, the Czech Republic, Estonia, Hungary, Slovakia, Moldova, Romania and Ireland, with Lithuania preparing their strategy); and four countries (Hungary, Romania, Latvia and Slovenia) are investing in the infrastructure of psychiatric hospitals or social care institutions which is counterproductive to transferring to community care.

Closing institutions and developing community mental health services take time. They require good planning, financial investment and other resources, long-term political commitment and coordination between health and social services. Inevitably certain challenges will arise both before, during and after the process of transition.

Some of the key challenges to the transition from institutional to community based alternatives include the replication of institutions and its culture in community services (reinstitutionalisation) and a failure to close the institution and create appropriate alternatives (European Commission, 2008).

Even European countries that have successfully moved away from institutional mental health care to that provided in the community encounter difficulties. The timing of psychiatric hospital closures and the setting up of community alternatives is crucial to avoiding potential gaps in service provision and the risk of not meeting the clinical and social needs of those discharged (Fioritti et al., 1997). In Spain, for example, the development of community mental health care lagged behind the process of deinstitutionalisation and the heterogeneity between autonomous communities meant an uneven distribution and coordination of community-based care (Salvador-Carulla et al, 2010). Even in a country which opted for the full modernisation of psychiatric care and reform, like Spain, there remained a tendency to maintain some psychiatric hospitals for long- and short-term illness (Vázquez-Barquero, 1999).

There is the danger of stopping the deinstitutionalisation process too early because of financial constraints, where the development of even basic community alternatives such as day care is incomplete, as happened in Germany at the end of the 1990s (Schwart and Busse, 1997; Haug and Rössler, 1999). Other noted problems with the deinstitutionalisation process in Germany revealed that in many parts of the country people were living in renamed sections of the hospital or in homes for the disabled; and a shortage of community mental health teams and key community staff, particularly social workers and staff working in residential and nursing homes (Fakhoury and Priebe, 2002).

Yet, despite these challenges, many former long-stay patients were able to live in the community facilities with high staff support, and after one year there was a significant increase in satisfaction with their living arrangement, while more social contacts and a significant decrease in the average length of inpatient stay per year at one and five year wasseen follow-up (Kaiser et al, 2001).

Rothbard and Kuno (2000) note the challenge of new long-stay patients, who when discharged have a high use of emergency room and community hospitals beds in their case studies of hospital closures in England, Italy and the US. However, this group was found to benefit more from community mental health care than older people who received more prolonged institutional care (Priebe et al., 2002).

In the Netherlands, intensive community based services increased five times faster than the reduction in hospital based care. The emphasis in the Netherlands in the mid-1970s was less on instigating the process of deinstitutionalisation and more on strengthening outpatient care. Small and specialised providers of outpatient care were integrated into RIAGGS and enforced as an alternative to hospital. Government policy in the 1980s shifted from this to encourage other alternatives to hospital by making explicit the need for innovations in day treatment, sheltered accommodation and assertive home treatment. This task was left to private, non-profit foundations to provide. However, simply stimulating these types of innovations was not enough to achieve the goals set by the government as they play a significant role in the provision of mental health services (Pijl et al, 2000).

A lack of resources or insufficient reallocation of resources to establish community based mental health services is another key challenge. Despite a considerable decrease in the number of inpatients (by about 30% between 1994 and 1997 alone), Sweden found the lack of community resources meant many patients remained in hospital and the cost of their care taken on by the local community rather than the county councils (Silfverhielm and Kamis-Gould, 2000).

The lack of coordination between health and social care services and other services can also undermine the development of adequate long-term mental health care and meeting new challenges (Caldas de Almeida and Killaspy, 2011).

Facilitators and strategies towards the closure of mental hospitals/psychiatric hospitals and development of community alternatives

Changing attitudes and views about the treatment of the long-term mentally ill is a key facilitator to any major reform in psychiatric care, particularly in relation to the closure of mental hospitals/psychiatric hospitals and setting up community-based mental health services. An important first step is to convince policy makers, those responsible for the care of the long-term mentally ill and society at large (Haug and Rossler, 1999).

In Spain the key facilitator to psychiatric reform depended on:

> *Commitment to a decision and maintaining political support…not only from the central administration but also from the autonomous communities. This requires combining the firm resolve to replace the psychiatric hospital, the development of alternative forms of community care, and changes in legislation and within society itself that will allow the integration of the mentally ill and the "normalization" of their status (Vázquez-Barquero and García, 1999, pg 134).*

A common theme from the case examples illustrated above show how the back drop or context precipitating many reforms of psychiatric care involve the backing of social and political movements pressuring for change and supporting the plight of marginalised groups.

The development of family and patient councils and user organisations, as in the Netherlands formed an important basis for advising the government, auditing services, influencing personal treatment plans, and the organisation of mental health services at local and regional level (Schene and Faber, 2001).

In Italy, a champion to pursue the closure of institutions and to ensure the transition to community alternatives is carried out appropriately is an important asset. However, this is not something that can be done alone and engaging all relevant stakeholders from politicians to health professionals is an essential part of the transition process.

In Italy, Germany, UK and US the process of achieving deinstitutionalisation was through imposing budget cuts for financing mental hospitals/psychiatric hospitals which led to the discharge of many long-term patients. In Austria and Germany, specific targets were set to reduce the number of long-term psychiatric hospital beds, although the extent of deinstitutionalisation was still unsatisfactory by the end of the 1990s. Sometimes these types of targets are unrealistic, particularly if deinstitutionalisation is used as a cost-cutting exercise (European Commission, 2008).

Many European countries allocate much of their mental health budget to psychiatric inpatient care (Samele et al, 2013). This is evident in countries that still provide mental hospitals/psychiatric hospitals care but not exclusively. Malta, for example, spends 96.8% of its mental health budget on hospital care. Poland, despite not having mental hospitals/psychiatric hospitals, spends 73.0% of its mental health budget on inpatient services. Devoting such a high proportion of funding to inpatient mental healthcare inevitably restricts the amount of investment or resources to developing community mental health services. Community care has been shown to be cost-neutral compared to institutional care (Thornicroft & Tansella, 2004; 2002); and so optimising the use of available financial and staff resources by transferring these from institutions to community services is an important solution (Semrau et al., 2011).

McDaid and Thornicroft (2005) provide useful guiding principles for mental health services and striking a balance between institutional and community based care. Whether services are based in community or hospital settings the human rights of patients should be respected. Applying evidence-based practice is also crucial, so too is ensuring an even distribution of services across the country based on need rather than ability to pay. Consideration should be given to efficiency and cost-effectiveness, as the latter will help to target resources appropriately.

Closure of a mental hospitals/psychiatric hospitals is easier than the development of community mental health care which poses much more of a challenge. Because of this there is a danger of closing hospital beds before community care is fully developed (Knapp et al, 2009). Greater investment and political will is required and governments need to ensure mental health services are provided via primary care services, with appropriate specialist care (both community and inpatient services), along with social care support (Knapp et al, 2009).

Other guiding principles include – respecting patients' rights and including them in all decision-making processes; ensure a system of preventing reinstitutionalisation; develop community services in parallel with the closure of mental hospitals/psychiatric hospitals; provide well-trained staff to support patients and their families; use quality control measures with a focus on patient satisfaction; and continually raise awareness (European Commission, 2008). More recently, Common European Guidelines on the transition were produced giving governments the evidence to support deinstitutionalisation, its benefits to the individual and society and a set of all inclusive guidelines to managing and dealing with all stages of the deinstitutionalisation process (European Expert Group, 2012).

Investing in appropriate stepped care pathways (sequential move on from high to low support) for those with more complex and severe mental health problems is another important way to prevent reinstitutionalisation. Components of a good rehabilitation service include inpatient and community based rehabilitation units, community rehabilitation teams to support people leaving hospital and moving into supported accommodation, supported accommodation and services to support peoples' occupation and work (Joint Commissioning Panel for Mental Health, 2012). Rehabilitation services in the UK have been shown to be effective in helping around two-thirds of people progress to successful community living within five years; with around 10% able to live independently within this period (Killaspy et al, 2013). Such services are also more likely to achieve/sustain community living when compared to people supported by generic community mental health services according to a multicentre study conducted in Ireland (Lavelle et al, 2011).

Conducting an assessment of the situation (identifying the needs and problems) is central to the development of a comprehensive deinstitutionalisation strategy and action plan. It will also make good use of available resources. Establishing a legal framework, developing a range of community services, allocating financial and other resources to the transition, developing individual plans, the workforce, supporting individual and community during transition and monitoring and evaluating the quality of services also form part of an important transition strategy. A stronger coordinating role for primary care is an important way to deliver integrated care for people with severe mental illness which is also cost-effective (OECD, 2014).

The WHO and the Gulbenkian Global Mental Health Platform (2014) asked experts to rate in order of importance the most useful method for downsizing institutions. Five key principles for deinstitutionalisation were identified whereby: community mental health services must be in place; the healthcare workforce must be committed to change; political support at high level and across other stakeholders is crucial; timing is key; and additional financial resources are necessary.

Several publications outline the necessary components of a comprehensive mental health service. This helps clarify any uncertainty about how needs of the severely mentally ill should be met in the community.

Thornicroft and Tansella (2013) provide a balanced care model that can be applied to local or regional settings with different levels of resources within countries. For low resource settings primary care for mental health together with limited specialist mental health staff may be appropriate; for countries with medium resources general adult mental health services could be provided in addition to primary mental health care; and for high resource settings comprehensive provision would include primary mental health care, general adult mental health services and specialist adult mental health services. Van Weeghel et al (2005) sought the views of stakeholders in five European countries components of good community care and found that the critical elements include working alliance, tailored care focusing on empowerment, rehabilitation, high quality professionals, needs of informal care givers, accountable mental health care, effective treatment, accessible community care and attitude of professional helpers.

To guard against the potential risk of reinstitutionalisation consensus also needs to be reached on the level of confinement and the need to control dangerousness for those with violent histories. This has implications for services such as forensic hospitals (Fakhoury and Priebe, 2002). These facilities are an expensive resource for relatively few people. In the UK, forensic hospitals consume nearly 20% of the total public expenditure for adult mental healthcare for around 8,000 individuals (Centre for Mental Health, 2011).

Thornicroft, et al (2010) highlight important recommendations for the implementation of community mental health care. In overcoming the challenge of many countries in putting the intention of community mental health care into practice, the authors distinguish between national policy (overall statement of intent); implementation plan (an operational document to implement national policy); and mental health programmes (specific plans for a local or regional area). Successful implementation requires the support of all various stakeholders able to generate a powerful consensus for change. Such stakeholders include politicians, board members, health managers, key members of National Governmental Organisations, patients, families, clinicians and other relevant individuals who are able to deliver clear and concise messages about the reasons and need to shift towards community mental health care.

> *There are no persuasive arguments or data to support a hospital-only approach to mental health care. Nor is there any scientific evidence to tell us that community services alone can provide satisfactory comprehensive care. Instead, the weight of professional opinion and evidence from available studies support the argument for a balanced care approach…This means that mental health services are provided in normal community settings close to the population served, and hospital stays are as brief as possible, arranged promptly and utilized only when necessary (Tansella et al, 2006; Thornicroft 2002).*

Social inclusion and transition

Promoting social and economic inclusion are important policy objectives. The EU approach to social inclusion for people with severe mental illness has been to encourage Member States to develop national strategies to coordinate policies relating to issues of poverty and social exclusion. The precise method for this is for Member States to agree common objectives or goals and how these should be measured to determine progress.

Subsequent policies on social inclusion show an emphasis on the medical rather than social models to address social needs, a lack of community alternatives in many countries and the absence of a combined health and social care strategy for mental health services (Mental Health Europe, 2008).

Social inclusion is also an important goal of community mental health care and central to a balanced care model. Employment, social participation and housing are pivotal to ensuring the integration of patients with severe mental disorder into the community, particularly for those discharged from mental hospitals/psychiatric hospitals. Those with severe mental illness are among the most marginalised in society and stigma and discrimination are common experiences for this group (Thornicroft et al, 2009). One way to tackle stigma head on is at governmental level. In Sweden, the formation of the Milton Commission debated the most ethical approach to take with people with severe mental disorder. Recommendations by this commission led to more direct involvement with patients and carers in policy-making for mental health; and innovative partnerships between local government, patient and carer groups, county councils, employment agencies and other public bodies to improve opportunities for this group (Wait and Harding, 2006).

Adopting a framework of inclusion based on a disability paradigm is argued to be one way of overcoming resistance from the community for individuals with mental disorder in the transition to the community (Davidson et al, 2001). Important components of this framework include friendship, hope and reciprocity. Using the example of a socialisation programme, Davidson et al (2001) illustrate how the process of restoring citizenship in people discharged to the community and letting the 'mentally ill in' requires community development work in addition to clinical and rehabilitation approaches. 'Recovery' models (in which people move beyond their mental illness to build a meaningful and satisfying life) and befriending programmes are also useful for promoting social inclusion and community integration (Shepherd et al, 2008: Davidson et al, 2001). Stable accommodation for the small proportion of patients transitioning to the community is important for ensuring against social isolation or reinstitutionalisation (Chopra et al, 2011).

Evidence demonstrating the link between dimensions of social participation and inclusion is limited. Hall (2009), however, in a meta-analysis of fifteen qualitative studies describes the elements and experiences of social inclusion for people with disabilities. Six themes were identified: being accepted, relationships, involvement in activities, living in accommodation, employment, and support systems. There are various tools to foster social inclusion for those with mental illness. These include employing a human rights discourse to develop progressive legislation and policy; having the right to seek employment on an equal basis with others and entering into meaningful relationships; anti stigma and discrimination efforts; and by raising awareness of resource inequities for those with mental illness and demonstrating the evidence for best practice (Cobigo and Stuart, 2010).

Effective programmes supporting people with severe mental illness return to paid employment are available. These move beyond the traditional principles of sheltered work and rehabilitation. Individual Placement and Support (IPS) – a 'place and train' approach - has been found to be effective in six European locations, even with differing labour and welfare contexts. Compared to other vocational services, IPS increased the number of patients working for at least one day, the number of days worked, job tenure, and led to reduced drop-out from the service, fewer hospital admissions and time spent in hospital (Burns et al, 2007). A recent review has outlined barriers and facilitators to IPS implementation in Europe (Fioritti et al, 2014)

The EMILIA project (Empowerment of Mental Illness: Lifelong learning, Integration and Action) aimed to facilitate social inclusion and empowerment of people with mental illness through lifelong learning and employment opportunities in eight European countries. The experiences of social inclusion and employment were captured in a qualitative follow-up study conducted at three time points (Nieminen et al, 2013). Participants perceived employment as an important factor in social inclusion and many engaged in employment and meaningful activities which continued to improve throughout the project. Participants were motivated for work and actively searched for employment. Having a mental illness, stigma, and discrimination were reported to be obstacles to social inclusion. The difficulties identified in social relationships continued to exist.

Ingredients of success

The literature reviewed here highlights several key factors that contribute to successful transition from mental hospitals/psychiatric hospitals to community-based alternatives.
These include:

- Long-term political and social commitment, and rallying the support of influential stakeholders;
- A fully informed and raising the awareness of community stakeholders about the process of deinstitutionalisation and what to expect; encourage direct contact between patients and people in the community;
- Having a sufficiently trained workforce committed to change and community-based care;
- Adequate reallocation of funds and some additional financing to develop community-based services;
- Invest in appropriate stepped care pathways (sequential move on from high to low) to prevent reinstitutionalisation and avoid transinstitutionalisation;
- Avoidance of reinstitutionalisation and/or transinstitutionalisation of patients being transferred to community based services;
- Creation of opportunities for patients and carers to be directly involved in the process of developing policy, community services and individual plans for care
- Development of a comprehensive range of community mental health services prior to or in parallel with the closure of the mental hospitals/psychiatric hospitals;
- Joint planning and joint procurement of relevant services to coordinate budgets and responsibilities for care;
- Strengthening primary care services to support people with severe mental disorder;
- Establishing psychiatric units within general hospitals: general hospital settings provide an accessible and acceptable location for 24-hour medical care and supervision of people with acute worsening of mental disorders, in the same way that these facilties manage acute exacerbations of physical health disorders;
- Investment in newer models of specialised community based care, such as early intervention, which are cost-effective;
- Ensuring the coordination and integration of health and social care;
- Ensuring the availability of suitable alternative accommodation that is able to meet the diverse range of patients' needs with adequate staff support and support people to move on to more independent settings; and
- Adoption of socially inclusive practices/approaches, particularly the development of employment opportunities in the community.

Health policy implications

The key implications for health policy following the review of literature for patients to be discharged from mental hospitals/psychiatric hospitals and transferred to community-based services include:

- Ensuring the needs of patients are comprehensively assessed;
- That patients and their families are provided with appropriate and continued support both during the transition process and once established in the community; and
- Ensuring adequate provision exists in the community for patients to be transferred to and that these are sufficiently resourced.

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IV. TRANSITION FROM INSTITUTIONAL CARE TO COMMUNITY-BASED CARE IN EU

The transition from institutional care to community-based mental health care in Europe has taken place in the context of important changes at policy and legislation level and has been marked by significant transformations in services and institutions. In this chapter we will present the results related with those changes and transformations obtained through the analysis of existing data from EU countries and the analysis of data collected with the Transition to Community based Care Questionnaire (developed in the context of this work to assess the process of transition that occurred in the countries participating in the workgroup on transition to community care).

In each domain, we will try to capture the situation in Europe, combining the existing data from EU countries, when available, with the data collected in the workgroup participating countries (Austria, Bulgaria, Estonia, Hungary, Ireland, Italy, Portugal, Spain and UK), which will be designated as the 9 WP5 participating countries.

Given the specific characteristics of health services in Italy, the information of the transition in this country was separately collected in 4 different regions – Lazio, Lombardia, Emilia Romagna and Veneto. For this reason, data of these 4 regions is always separately considered in the analysis of 9 WP5 participanting countries.
All tables with no mention to a specific source include data from the WP5 Questionnaire.

1. Mental Health Services Reforms

In the last decades almost all 9 countries that participated in the workgroup developed some reform of mental health services. Only one country has not engaged in any reform, and the others, with the exception of one country that initiated the reform after 1998 (Table IV. 2), have developed their reforms both before and after 1998 (Table IV. 1). All countries that initiated reforms had some kind of formal plan of reform and almost all had a mental health unit responsible for the development of the reform (Table IV. 3).

Table IV.1. Mental Health services reforms implemented to promote the transition from institutional care to community care in 9 WP5 participating countries

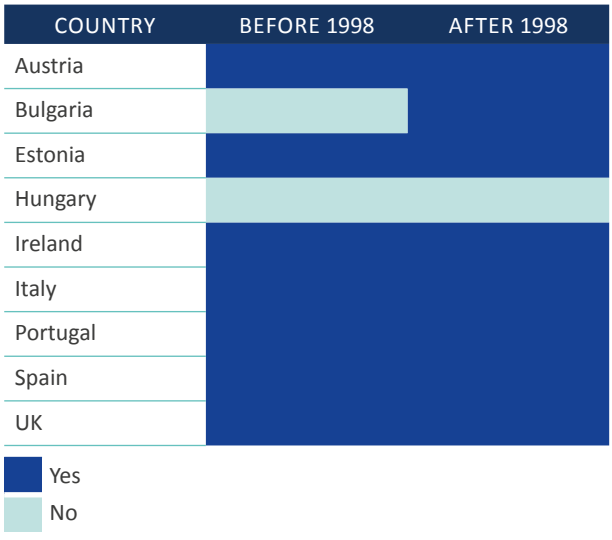


Table IV. 2. Formal written plan to develop the reform, in 9 WP5 participating countries

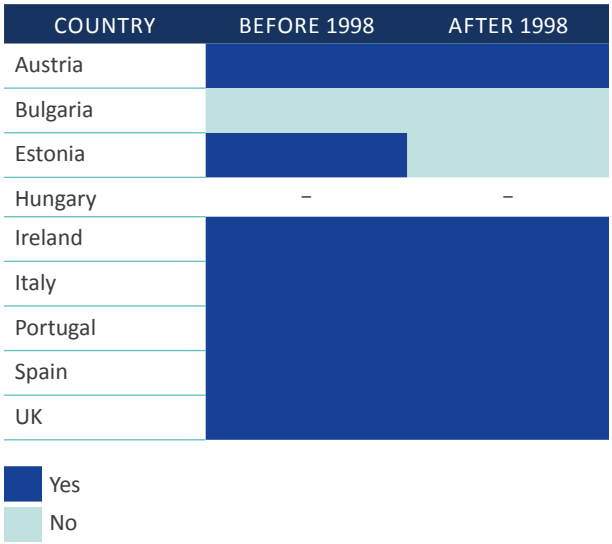
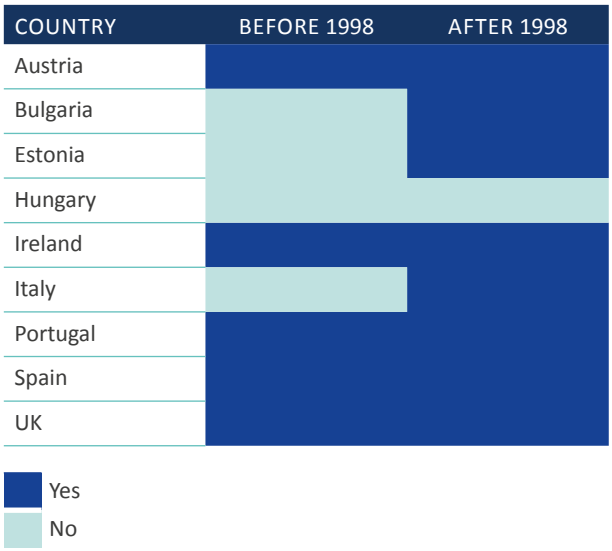


Table IV. 3. Mental Health Unit at the Ministry of Health, in 9 WP5 participating countries



2. Mental health policy, plans and legislation

2.1. POLICY

Almost all EU countries approved or updated their mental health policies in the last 10 years, 14 countries having done so since 2008. Deinstitutionalisation and development of community based care is a major goal in many countries: the shift of services and resources from mental hospitals/psychiatric hospitals to community mental health facilities is specifically included in the policy of 17 out of all EU countries (Table IV.4).

This tendency is even more marked in the 9 WP5 participating countries: the development of community mental health services is an explicit component in the policies of all countries, while downsizing large mental hospitals/psychiatric hospitals is a component of the policies of all but two countries (Table IV. 5.

Table IV. 4. Year of latest approval and components of mental health policy in EU

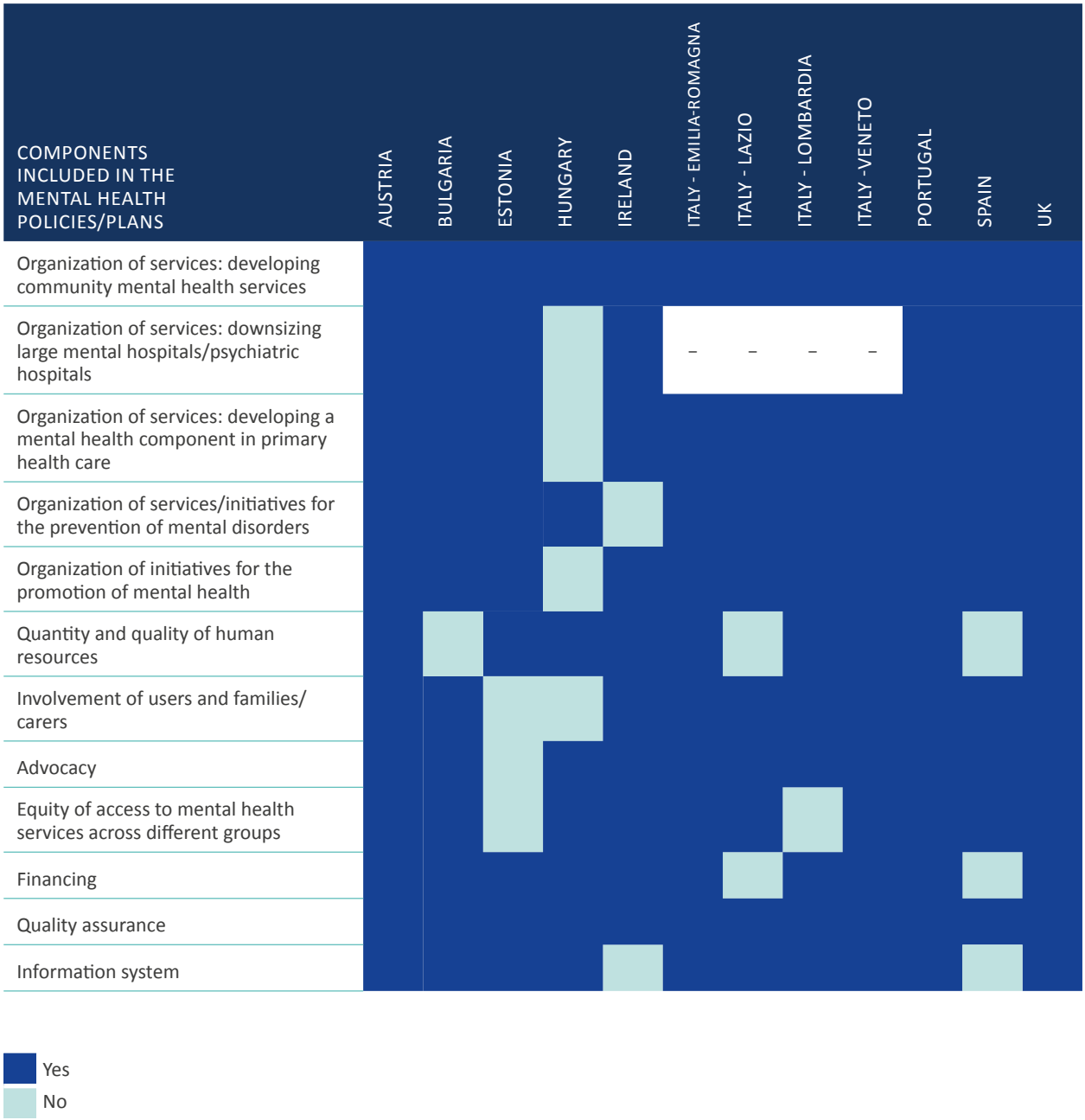
COUNTRY	YEAR	COMPONENTS RELATED TO SHIFT TO COMMUNITY-BASED CARE	SHIFT OF RESOURCES FROM MH TO COMMUNITY MENTAL HEALTH FACILITIES
Austria	2013	Federal law on health reform: emphasis on integrating all components of health care (inpatient/ outpatient, etc.) by putting the focus on interface management and integrated financing mechanisms. Mental health care profits from this approach as well as physical health care. One of the ten main health targets is "To promote psychosocial health in all population groups". Legal provisions concerning mental health are also covered in other laws (eg. welfare, disability, general health legislation etc.).	X (indirectly)
Belgium	2010	Timelines for the implementation of the mental health and physical health plan. Funding allocation for the implementing of half or more of the items in the mental health plan. Shift of services and resources from mental hospitals/psychiatric hospitals to community mental health facilities. Integration of mental health services into primary care.	X

COUNTRY	YEAR	COMPONENTS RELATED TO SHIFT TO COMMUNITY-BASED CARE	SHIFT OF RESOURCES FROM MH TO COMMUNITY MENTAL HEALTH FACILITIES
Bulgaria	2006	Timelines for implementing the mental health plan. Funding allocation for the implementation of half or more of the items in the mental health plan. Shift of services and resources from mental hospitals/psychiatric hospitals to community mental health facilities. Integration of mental health services into primary care.	X
Croatia	2010	Timelines for implementing the mental health plan. Shift of services and resources from mental hospitals to community mental health facilities. Integration of mental health services into primary care.	X
Cyprus	2007	Timelines for implementing the mental health plan. Funding allocation for the implementation of half or more of the items in the mental health plan. Shift of services and resources from mental hospitals/psychiatric hospitals to community mental health facilities. Integration of mental health services into primary care.	X
Czech Republic	2007	Integration of mental health services into primary care	
Denmark	2010	Timelines for implementing the mental health plan. Funding allocation for the implementation of half or more of the items in the mental health plan. Integration of mental health services into primary care.	
Estonia	2008	–	
Finland	2009	Timelines for implementing the mental health plan. Shift of services and resources from mental hospitals /psychiatric hospitals to community mental health facilities. Integration of mental health services into primary care.	X
France	2005	Timelines for implementing the mental health plan. Funding allocation for implementing of half or more of the items listed in the mental health plan. Shift of services and resources from mental hospitals/psychiatric hospitals to community mental health facilities. Integration of mental health services into primary care.	X
Germany	2009	Timelines for implementing the mental health plan. Funding allocation for the implementation of half or more of the items in the mental health plan.	
Greece	2010	Shift of services and resources from mental hospitals/psychiatric hospitals to community mental health facilities	X
Hungary	2011	Shift of services and resources from mental hospitals/psychiatric hospitals to community mental health facilities. Integration of mental health services into primary care.	X
Ireland	2006	Timelines for implementing the mental health plan. Shift of services and resources from mental hospitals/psychiatric hospitals to community mental health facilities. Integration of mental health services into primary care.	X
Italy	2008	Integration Of Mental Health Services Into Primary Care	
Latvia	2009	–	
Lithuania	2008	Timelines for implementing the mental health plan. Integration of mental health services into primary care.	

COUNTRY	YEAR	COMPONENTS RELATED TO SHIFT TO COMMUNITY-BASED CARE	SHIFT OF RESOURCES FROM MH TO COMMUNITY MENTAL HEALTH FACILITIES
Luxembourg	2009	Timelines for implementing the mental health plan. Funding allocation for the implementation of half or more of the items in the mental health plan. Shift of services and resources from mental hospitals/psychiatric hospitals to community mental health facilities. Integration of mental health services into primary care.	X
Malta	1997	Shift of services and resources from mental hospitals/psychiatric hospitals to community mental health facilities. Integration of mental health services into primary care.	X
Netherlands	2006	Timelines for implementing the mental health plan. Funding allocation for the implementation of half or more of the items in the mental health plan. Shift of services and resources from mental hospitals/psychiatric hospitals to community mental health facilities. Integration of mental health services into primary care.	X
Poland	2010	Timelines for implementing the mental health plan. Shift of services and resources from mental hospitals/psychiatric hospitals to community mental health facilities. Integration of mental health services into primary care.	X
Portugal	2008	Timelines for implementing the mental health plan. Shift of services and resources from mental hospitals/psychiatric hospitals to community mental health facilities. Integration of mental health services into primary care	X
Romania	2006	Timelines for implementing the mental health plan. Funding allocation for the implementation of half or more of the items in the mental health plan. Shift of services and resources from mental hospitals/psychiatric hospitals to community mental health facilities.	X
Slovakia	2008	Timelines for implementing the mental health plan. Integration of mental health services into primary care.	
Slovenia	2008	–	
Spain	2009	Timelines for implementing the mental health plan. Shift of services and resources from mental hospitals to community mental health facilities.	X
Sweden	2010	Timelines for implementing the mental health plan. Funding allocation for the implementation of half or more of the items in the mental health plan. Shift of services and resources from mental hospitals/psychiatric hospitals to community mental health facilities. Integration of mental health services into primary care.	X
UK	2011	Previous policies focussed on shifting resources from institutions to community based services. Latest policy focuses on mental health promotion, equal access to physical health care for people with mental health problems, social inclusion, anti-stigma/discrimination actions	X

Source: Mental Health Atlas 2011 – Country Profiles (with some changes suggested by countries).

Table IV. 5. Contents/components included in the relevant strategic documents (strategies, policies or plans) adopted in the area of mental health in 9 WP5 participanting countries



2.2. LEGISLATION

Approving or updating mental health legislation across EU countries is a longer and more complex process than approving or updating mental health policy. Despite this, 15 countries have passed or revised their mental health legislation over the last 10 years, and for many (9 countries) this was done after 2008 (see Table IV. 6).

Table IV. 6. Year of mental health legislation latest approval/revision, in EU

COUNTRY	YEAR
Austria*	2013
Belgium	2007
Bulgaria	2003
Croatia	2012
Cyprus	1997
Czech Republic	2011
Denmark	1989
Estonia	2013
Finland	2010
France	1990
Germany	1999
Greece	2005
Hungary	2011
Ireland	2001
Italy	1978
Latvia	1997
Lithuania	1995
Luxembourg	2009
Malta	2012
Netherlands	1994
Poland	1994
Portugal	1998-1999
Romania	2002
Slovakia	2004
Slovenia	2008
Spain	2013
Sweden	1991
UK	2011

Source: WHO Mental Healt Atlas, 2011 Country profiles
* Source: Country Ministry of Health

Table IV. 7. Contents/components included in the mental health legislation, in 9 WP5 participanting countries

COMPONENTS INCLUDED IN THE MENTAL HEALTH LEGISLATION	AUSTRIA	BULGARIA	ESTONIA	HUNGARY	IRELAND	ITALY	PORTUGAL
Access to mental health care	Yes	Yes	Yes	–	No	No	Yes
Access to care in community settings	Yes	Yes	Yes	–	No	No	Yes
Legal rights of mental health service users	Yes	Yes	Yes	–	Yes	No	Yes
Legal rights of users family members and other care givers	Yes	Yes	Yes	–	No	No	Yes
Competency or capacity issues for people with mental illness	Yes	Yes	Yes	–	No	Yes	Yes
Guardianship issues for people with mental illness	Yes	Yes	Yes	–	No	Yes	No
Mechanisms to oversee involuntary admission	Yes	Yes	Yes	–	Yes	Yes	Yes
Voluntary and involuntary treatment, procedures and safeguards	Yes	Yes	Yes	–	Yes	Yes	Yes
Accreditation of professionals	Yes	No	Yes	–	No	No	Yes
Accreditation of facilities	Yes	Yes	Yes	–	Yes	Yes	No
Law enforcement and other judicial system issues for people with mental illness	Yes	Yes	Yes	–	No	Yes	Yes
Mechanisms to monitor involuntary treatment practices	Yes	Yes	Yes	–	Yes	Yes	Yes
Mechanisms to implement the provisions of mental health legislation	Yes	Yes	Yes	–	Yes	No	No

Yes
No

Data concerning the parts of mental health legislation associated with the transition to community based mental health care was obtained for the 9 WP5 participanting countries. Access to care in community settings is included in the legislation of five 9 WP5 participanting countries and only two countries do not specify this (see Table IV. 8). All WP5 countries have policies/plans or legislation stating that people with mental disorders should have access to specialist mental health care and rehabilitation services in the community. However, other more specialized services, such as early intervention or assertive outreach, have not been included for several countries (see Table IV. 8).

Table IV. 8. Policies/plans or legislation requiring that people with mental disorders have access to specialist mental health services in the community, in 9 WP5 participating countries

COUNTRY	SPECIALIST MENTAL HEALTH TREATMENT AND CARE	CRISIS CARE – DAYTIME ONLY	CRISIS CARE – 24 HOURS	HOME TREATMENT	ASSERTIVE OUTREACH	EARLY INTERVENTIONS	REHABILITATION SERVICES	PRIMARY CARE LIAISON
Austria	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
Bulgaria	Yes	No	No	Yes	Yes	Yes	Yes	No
Estonia	Yes	–	Yes	No	No	No	Yes	No
Hungary	Yes	No	Yes	No	No	No	Yes	No
Ireland	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
Italy – Emilia-Romagna	Yes	Yes	Yes	Yes	No	No	Yes	Yes
Italy – Lazio	Yes	Yes	Yes	Yes	No	No	Yes	Yes
Italy – Lombardia	Yes	Yes	No	Yes	No	No	Yes	Yes
Italy – Veneto	Yes	–	–	Yes	–	Yes	Yes	Yes
Portugal	Yes	–	Yes	Yes	Yes	Yes	Yes	Yes
Spain	Yes	Yes	Yes	Yes	No	No	Yes	Yes
UK	Yes	No	Yes	No	No	No	Yes	Yes

Yes
No

BOX 1 - Mental Health policy and legislation

- *Almost all EU countries approved or adapted their mental health policy in the last 10 years;*
- *Deinstitutionalisation and development of community based services is an explicit component in the policy of half of EU countries;*
- *More them half of EU countries passed or revised mental health legislation in the last 10 years;*
- *Access to care in the community is included in the legislation of almost all WP5 countries. However, assertive outreach and early interventions are not required in most countries.*

3. Mental health services

Due to differences in definitions of services types between countries and over time, data on services in this sections have to be taken with caution. Also, the fact that multiple sources have been used by different organisations that participated in the compiling of data, at international level, may account for unexplained differences.

3.1. MENTAL HOSPITALS/PSYCHIATRIC HOSPITALS

3.1.1 Reduction of Mental Hospitals/Psychiatric Hospitals

Deinstitutionalization and development of community-based care are key policy objectives for the majority of European countries. All 9 WP5 participanting countries have closed some or all of their psychiatric/mental hospitals over the past few decades. In Austria, Hungary and Portugal these closures only took place after 1998. In other countries, closures were initiated prior to 1998, and in some cases (Italy and UK) the process of deinstitutionalisation was mostly complete by this time.

There is no available information on the reduction of psychiatric/mental hospitals in the EU countries. However, most of these countries still had psychiatric/mental hospitals in 2011 (Table IV. 10. Only Italy, Sweden and the UK have closed the majority of their hospitals. The number of psychiatric/mental hospitals varied significantly across EU countries in 2011. Part of this variation, but not all, is related to population size. Table IV. 10 illustrates that there are countries where PH lost the central role of the system of care while in other countries the number of PH continue to be very high.

Table IV. 9. 9 WP5 participanting countries that have closed down mental hospitals/ psychiatric hospitals

COUNTRY		YES, BEFORE 1998	YES, AFTER 1998
Austria		No	Yes
Bulgaria		Yes	No
Estonia		Yes	Yes
Hungary		No	Yes
Ireland		Yes	Yes
Italy	Emilia-Romagna	Yes	No
	Lazio	Yes	Yes
	Lombardia	Yes	Yes
	Veneto	Yes	No
Portugal		No	Yes
Spain		Yes	Yes
UK		Yes	No

Yes
No

DEFINITION:

Mental Hospital/Psychiatric Hospital

Psychiatric or mental hospital is a specialized hospital-based facility that provides inpatient care and long-stay residential services for people with mental disorders. Usually these facilities are independent and stand-alone, although they may be linked to the wider health care system. The level of specialization varies considerably: in some cases only long-stay custodial services are offered, and in others specialized and short-term services are also available, such as rehabilitation services and specialist units for children and older people.

Psychiatric/mental hospitals include both public and private not-for-profit and for-profit facilities; and those solely for children and adolescents and other specific groups (such as older people) are also included within this definition.

Psychiatric/mental hospitals as defined here exclude community-based psychiatric inpatient units, forensic inpatient units and forensic hospitals, as well as facilities that solely treat people with alcohol and substance abuse disorder or intellectual disability without an accompanying diagnosis of mental disorders.

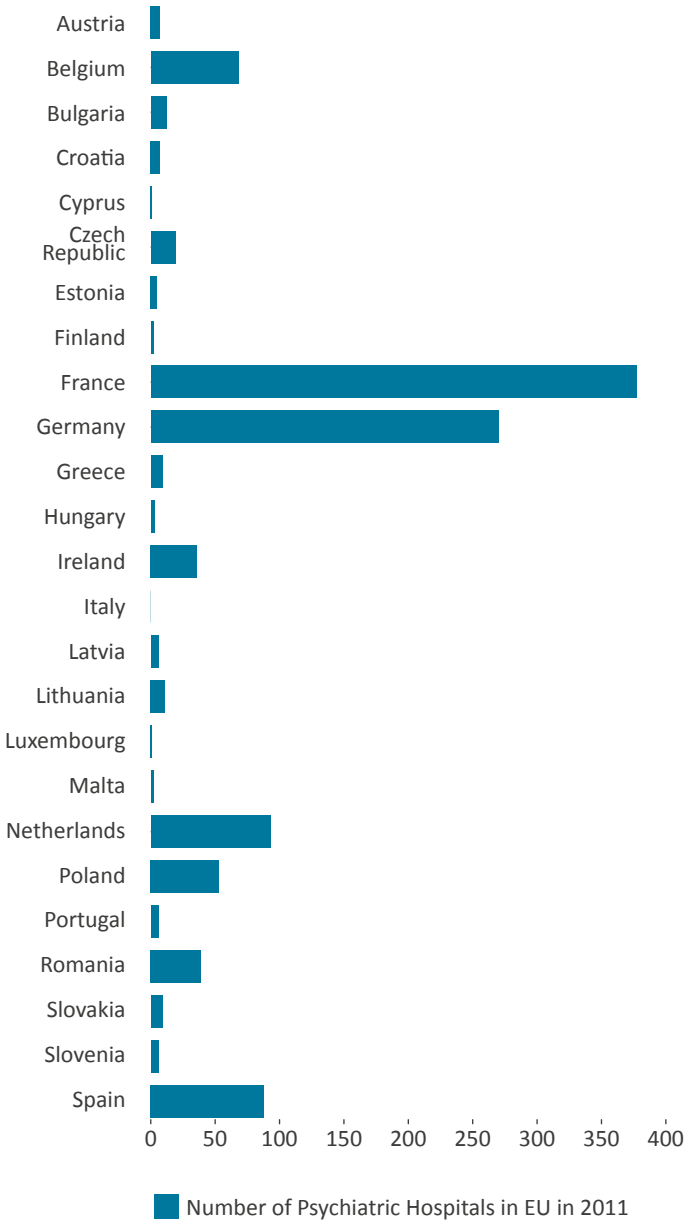
Table IV. 10. Number of Mental Hospitals/ Psychiatric Hospitals in EU in 2011

COUNTRY	2011* ATLAS	POPULATION **
Austria	7	8.3 million
Belgium	68	10.7 million
Bulgaria	12	7.6 million
Croatia	7	4.4 million
Cyprus	1	0.8 million
Czech Republic	19	10.5 million
Denmark	–	5.5 million
Estonia	5	1.3 million
Finland	2	5.3 million
France	377	64.3 million
Germany	270	82 million
Greece	9	11.2 million
Hungary	2	10 million
Ireland	25	4.5 million
Italy	0	60 million
Latvia	6	2.3 million
Lithuania	11	3.3 million
Luxembourg	1	0.5 million
Malta	2	0.4 million
Netherlands	93	16.4 million
Poland	53	38.1 million
Portugal	6	10.6 million
Romania	39	21.5 million
Slovakia	9	5.4 million
Slovenia	6	2 million
Spain	88	45.8 million
Sweden	0	9.2 million
UK	–	61.7 million

* Source: Mental Health Atlas 2011, WHO

** Source: http://europa.eu/about-eu/countries/member countries/index_en.htm

Chart IV. 1. Number of Mental Hospitals/ Psychiatric Hospitals in EU in 2011



3.1.2 Reduction of beds

More information is available on the number of beds contained within psychiatric hospitals. This also provides a better indicator of the changes that have occurred in the downsizing or closure of psychiatric hospitals across the EU.

According to data reported in WHO Atlas 2005, WHO Euro 2008 and WHO Atlas 2011 on the rate per 100,000 population for psychiatric hospital beds in 2005, 2008 and 2011, about a third of the EU countries maintained or even increased their bed numbers; a third made some reduction and a further third made a significant or very significant reductions (see Table IV. 11.

Table IV. 11. Number of beds per 100,000 inhabitants in mental hospitals/psychiatric hospitals in EU in 2005, 2008 and 2011, in EU

COUNTRY	2005[1] (ATLAS)	2008[2] EURO	2011[3] ATLAS
Austria	–	28.5	21.4
Belgium	129	152	134.5
Bulgaria	41	28	36.1
Croatia	80	–	76
Cyprus	45	21	16.3
Czech Republic	98	96	91.6
Denmark	–	–	–
Estonia	80	–	–
Finland	–	–	8.4
France	70	–	71.8
Germany	45	–	47.6
Greece	43	14	19
Hungary	96	93	75
Ireland	74	36.4	21.4
Italy	0	0	0
Latvia	135	137	107.3
Lithuania	86	78	106.1
Luxembourg	75	52	48.2
Malta	188	185	141.7
Netherlands	154	–	127.3
Poland	52	49	39.5
Portugal	17	13	10
Romania	55	54	38.3
Slovakia	60	18	30.9
Slovenia	72	72	67.7
Spain	37	37	32.7
Sweden	–	4	–
UK	–	–	–

1 Source: Mental Health Atlas 2005, WHO
2 Source: Policies and Practices for Mental Health in Europe, WHO-EURO 2008
3 Source: Mental Health Atlas 2011, WHO

Information gathered from the 9 WP5 participanting countries show that these changes took place over a much longer period, with significant bed reductions in most of these countries (from when peak bed numbers were recorded before 1998 until 2012). Prior to 1998, these bed reductions were particularly significant in Italy, Spain and the UK, while in Bulgaria and Hungary reductions started after this (see Tables IV.12, IV.13 and IV. 14).

Table IV. 12. Number of beds per 100,000 inhabitants in mental hospitals/psychiatric hospitals in 9 WP5 participating countries

COUNTRY		PEAK NUMBER BEFORE 1998	1998[1]	2005[2] (ATLAS)	2008[3] EURO	2011[4] ATLAS	2012
Austria		117.6	33.8	–	28.5	21.4	20.6*
Bulgaria		50	40.3	41	28	36.1	36.1
Estonia		114	85.1	80	–	–	60
Hungary		–	13.2	96	93	75	
Ireland		126.4	74.7	54.5	36.4	21.4	54.5
Italy	Emilia-Romagna	52	0	0	0	0	0
	Lazio	64.5	29.1	0	0	0	0
	Lombardia	46.47	10.1	0	0	0	
	Veneto	–	0	0	0	0	0
Portugal		30.16	21	17	13	10	7.1
Spain		79.4	43	37	–	32.7	26
UK		249.5	–	–	14 (England & Wales)	–	–

1 Source: Transition to Community Care Questionnaire
2 Source: Mental Health Atlas 2005, WHO
3 Source: Policies and Practices for Mental Health in Europe, WHO-EURO 2008
4 Source: Mental Health Atlas 2011, WHO
*2013
Note: Most data was taken from the sources cited, but some partners corrected their data

Table IV. 13. Reduction of mental hospital/psychiatric hospital beds in 9 WP5 participating countries

COUNTRY		YES, BEFORE 1998	YES, AFTER 1998
Austria			
Bulgaria			
Estonia			
Hungary			
Ireland		–	–
Italy	Emilia-Romagna	–	–
	Lazio	–	–
	Lombardia	–	–
	Veneto	–	–
Portugal			
Spain			
UK			

Yes
No

Table IV. 14. Decline of beds in mental hospitals/psychiatric hospitals from peak number until 1998 and between 1998 and 2012 in 9 WP5 participating countries (in %)

COUNTRY		BEFORE 1998	AFTER 1998
		%	%
Austria		59	35
Bulgaria		–	–
Estonia		22	40
Hungary		–	55
Ireland		–	74
Italy	Emilia-Romagna	100	–
	Lazio	55	100
	Lombardia	82	100
	Veneto	100	–
Portugal		31	66
Spain		45	29
UK		76	10

Several factors have contributed to the reduction of beds in psychiatric hospitals. For the majority of 9 WP5 participanting countries, the decision to transfer patients to community services and to residential facilities played an important role (see Table IV. 15).Two of the 9 WP5 participanting countries prohibited any new admissions to psychiatric hospitals (Italy and Ireland) and three countries (Austria, Italy and Portugal) placed importance on inpatient mortality.

Table IV. 15. Factors for the reduction of beds in 9 WP5 participating countries

	NEW ADMISSIONS PROHIBITED	DEATH OF PATIENTS	TRANSFER TO COMMUNITY SERVICES AND GENERAL HOSPITALS	TRANSFER TO RESIDENTIAL FACILTIES
Austria				
Bulgaria				
Estonia	–	–		–
Hungary				
Ireland				
Italy				
Portugal				
Spain				
UK	–			

Not important
Some Importance
Significant importance

3.1.3 Forensic

The information that we were able to gather in order to assess the evolution of forensic facilities in the 9 WP 5 participating countries, from 1988 to 2012, has many gaps. However, available data on the rates of forensic inpatient facilities, beds, and annual discharges don't seem to indicate significant changes during this period (Tables VI. 16, 17 and 18). These data, therefore, suggest that, in these countries, the decrease of beds in psychiatry/mental hospitals was not accompanied by significant changes in the number of forensic facilities and beds.

As mentioned before (page 14), an important progress has recently taken place in Italy, with the decision to close forensic mental hospitals and to replace them with small community-based facilities. The implementation of this new policy, if successful, may become an important contribution to the resolution of one of the more difficult challenges found in the transition from hospital-based to community-based mental health care.

Table IV. 16. Rate of inpatient facilities per 100,000 inhabitants in 9 WP5 participating countries

COUNTRY		MENTAL HOSPITALS			FORENSIC UNITS		
		1998	2008	2012	1998	2008	2012
Austria		.13	.11	.11	.01	.01	.01
Bulgaria		.13	.14	.15	.024	.013	.027
Estonia		1	.15	.15	–	–	.07
Hungary		–	–	–	–	–	–
Ireland		.66	.56	.54	.027	.023	.022
Italy	Emilia-Romagna	–	–	–	.03	.02	.02
	Lazio	–	–	–	–	–	.78
	Lombardia	.1	0	0	.01	.01	.01
	Veneto	–	–	–	–	–	–
Portugal		.07	.06	.03	.03	.03	.02
Spain		.23	.22	.21	.005	.006	.004
UK		–	–	–	–	–	–

Table IV. 17. Number of beds per 100,000 inhabitants in 9 WP5 participating countries

COUNTRY		MENTAL HOSPITALS			FORENSIC UNITS		
		1998	2008	2012	1998	2008	2012
Austria		33.8	28.5	–	–	–	–
Bulgaria		83.5	–	36.1	–	–	–
Estonia		85.1	–	–	–	–	9.7
Hungary		–	–	2.8	–	–	–
Ireland		107.2	36.4	21.4	2.7	2	2
Italy	Emilia-Romagna	0	0	0	3.3	6.4	3.9
	Lazio	0	0	0	0	0	33.8
	Lombardia	11.2	0	0	0	3	3
	Veneto	0	0	0	0	0	0
Portugal		21	13	10	2	2	1.4
Spain		43	37	26	1.2	1.5	1
UK		–	14	–	–	–	–

Table IV. 18. Number of annual discharges per 100,000 inhabitants in Forensic Units in 9 WP5 participating countries

COUNTRY		FORENSIC UNITS		
		1998	2008	2012
Austria		–	–	–
Bulgaria		17.7	–	–
Estonia		–	–	–
Hungary		–	–	–
Italy	Emilia-Romagna	2.8	5.3	3.5
	Lazio	–	–	–
	Lombardia	–	–	1.3
	Veneto	–	–	–
Ireland		3.6	1.2	1.4
Portugal		–	–	0.6
Spain		8.2	5.1	4.7
UK		–	–	–

3.1.4 Quality Improvements in Mental Hospitals/Psychiatric Hospitals

The process of deinstitutionalisation was accompanied by significant improvements in psychiatric hospitals that continued to provide care. Table IV. 19 shows that some or significant improvements were recorded in all 9 WP5 participanting countries in terms of the quality of care and with respecting patients' human rights. Improvements to the physical structures of psychiatric hospitals were noted in all but one country (Italy); which prohibited any new admissions following its mental health reform in 1978 and the passing of law 180.

Table IV. 19. Level of improvement that took place in the majority of mental hospitals/ psychiatric hospitals in the last 25 years in 9 WP5 participating countries

COUNTRY	QUALITY OF PHYSICAL STRUCTURES	QUALITY OF CARE	RESPECT FOR HUMAN RIGHTS
Austria			
Bulgaria			
Estonia			
Hungary			
Ireland			
Italy	–	–	–
Portugal			
Spain			
UK			

Not important
Some Importance
Significant importance

3.1.5 Planning of closure/downsizing of Mental Hospitals/Psychiatric Hospitals

Table IV. 20. Closure/downsizing of mental hospitals/psychiatric hospitals implemented according to a pre-defined deinstitutionalization plan in 9 WP5 participating countries

	BEFORE 98			AFTER 98		
COUNTRY	PATIENTS	FINANCIAL RESOURCES	HUMAN RESOURCES	PATIENTS	FINANCIAL RESOURCES	HUMAN RESOURCES
Austria						
Bulgaria						
Estonia						
Hungary	–	–	–			
Ireland			NA			
Italy – Emilia-Romagna				–	–	–
Italy – Lazio				–	–	–
Italy – Lombardia						
Italy – Veneto				–	–	–
Portugal						
Spain						
UK				–	–	–

NA – Not applicable

Yes
No

When closing/downsizing psychiatric hospitals most 9 WP5 participanting countries implemented a pre-defined plan that took into consideration patients needs, financial and human resources. Some countries adopted their plans after 1998 in a subsequent phase (see Table IV. 20).

Prior to 1998 users and families/caregivers were not involved in closing/downsizing psychiatric hospital for the majority of the countries but this increased after 1998 in all but two countries (see Table IV. 21).

Table IV. 21. Groups involved in the planning of Mental Hospitals/Psychiatric Hospitals closure/downsizing in 9 WP5 participating countries

COUNTRY	BEFORE 98					AFTER 98				
	PATIENTS/ SERVICE USERS	PROFESSIONALS	HEALTH ADMINISTRADORS	FAMILIES / CAREGIVERS	COMMUNITY GENTS	PATIENTS/ SERVICE USERS	PROFESSIONALS	HEALTH ADMINISTRADORS	FAMILIES / CAREGIVERS	COMMUNITY GENTS
Austria	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Bulgaria	No	No	Yes	No	No	No	Yes	Yes	No	Yes
Estonia	–	Yes	Yes	–	–	–	Yes	Yes	–	–
Hungary	–	–	–	–	–	No	No	Yes	No	No
Ireland	No	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes
Italy – Emilia-Romagna	No	Yes	Yes	No	Yes	–	–	–	–	–
Italy – Lazio	No	Yes	Yes	No	Yes	–	–	–	–	–
Italy – Lombardia	No	Yes	Yes	Yes	Yes	–	–	Yes	–	–
Italy – Veneto	Yes	Yes	Yes	Yes	Yes	–	–	–	–	–
Portugal	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Spain	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
UK	–	Yes	Yes	–	–	Yes	Yes	Yes	Yes	Yes

Yes
No

3.1.6 To what place were patients transferred?

Knowing where patients are transferred to is important to understanding the achievements and limitations of the deinstitutionalisation process in Europe. In the 9 WP5 participanting countries we see two different approaches adopted before 1998. One approach includes countries that prioritized community-based alternatives – community based inpatient units, residential facilities, families & independent living; while others prioritized other types of large mental health institutions that maintained some of the characteristics traditional psychiatric/mental hospitals.

After 1998 there is greater use of community based alternatives, although some countries continued to transfer patients to large mental health institutions (see Table IV. 22).

Table IV. 22. Facilities where deinstitutionalized patients were transferred to

BEFORE 1998							
COUNTRY	TO OTHER MENTAL HOSPITALS	TO FORENSIC UNITS	TO COMMUNITY-BASED PSYCHIATRIC INPATIENT UNITS	TO COMMUNITY RESIDENTIAL HEALTH FACILITIES	TO RESIDENTIAL FACILITIES (NON-HEALTH CARE)	LARGE MENTAL HEALTH INSTITUTIONS	TO FAMILY OR TO INDEPENDENT LIVING
Austria			NA				
Bulgaria							
Estonia							
Hungary	–	–	–	–	–	–	–
Ireland	–	–	–	–	–	–	–
Italy							
Portugal							
Spain							
UK		–					

AFTER 1998							
COUNTRY	TO OTHER MENTAL HOSPITALS	TO FORENSIC UNITS	TO COMMUNITY-BASED PSYCHIATRIC INPATIENT UNITS	TO COMMUNITY RESIDENTIAL HEALTH FACILITIES	TO RESIDENTIAL FACILITIES (NON-HEALTH CARE)	LARGE MENTAL HEALTH INSTITUTIONS	TO FAMILY OR TO INDEPENDENT LIVING
Austria			NA				
Bulgaria							
Estonia							
Hungary							
Ireland	–	–				–	
Italy							
Portugal							
Spain							
UK			–				

NA – Not applicable

Yes
No

3.1.7. Reallocation of Resources

Human resources were largely reallocated to community-based services, although in a few countries some resources were also transferred to other institutions (see Table IV. 23).

Table IV. 23. Reallocation process of human resources during the closure of mental hospitals/ psychiatric hospitals in 9 WP5 participating countries

BEFORE 1998						
COUNTRY	TO OTHER MENTAL HOSPITALS	TO FORENSIC UNITS	TO COMMUNITY-BASED PSYCHIATRIC INPATIENT UNITS	TO COMMUNITY RESIDENTIAL HEALTH FACILITIES	TO RESIDENTIAL FACILITIES (NON-HEALTH CARE)	LARGE MENTAL HEALTH INSTITUTIONS
Austria				NA		
Bulgaria					–	–
Estonia					NA	NA
Hungary	–	–	–	–	–	–
Ireland	–	–	–	–	–	–
Italy						
Portugal						
Spain						
UK						

AFTER 1998						
COUNTRY	TO OTHER MENTAL HOSPITALS	TO FORENSIC UNITS	TO COMMUNITY-BASED PSYCHIATRIC INPATIENT UNITS	TO COMMUNITY RESIDENTIAL HEALTH FACILITIES	TO RESIDENTIAL FACILITIES (NON-HEALTH CARE)	LARGE MENTAL HEALTH INSTITUTIONS
Austria				NA		
Bulgaria						
Estonia						
Hungary						
Ireland	–	–	–	–	–	–
Italy						
Portugal						
Spain	NA	NA	NA	NA	NA	NA
UK			–			

NA – Not applicable

Yes
No

Prior to 1998, around half of the WP5 countries, while closing psychiatric hospitals, reallocated their financial resources to other mental health services, but this percentage increased significantly after 1998. During the first period financial resources were mostly reallocated to community-based services, but also to other institutional services – psychiatric hospitals, forensic units and large institutions.

In some countries, such as Austria, no overall budget existed, but hospital sector finances previously allocated to psychiatric hospitals were partly directed to community-based psychiatric units in general hospitals using the Austrian DRG hospital payment mechanism (see Tables IV.23, IV.24, IV.25).

Table IV. 24. Reallocation of financial resources following the closure of mental hospitals/psychiatric hospitals in 9 WP5 participating countries

COUNTRY	YES, BEFORE 1998	YES, AFTER 1998
Austria*		
Bulgaria		
Estonia		
Hungary		
Ireland	–	–
Italy		
Portugal		
Spain		
UK		

*Indirectly

Table IV. 25. Facilities financed with funds released from the closure of mental hospitals/psychiatric hospitals in 9 WP5 participating countries

	BEFORE 98	AFTER 98
Other mental hospitals		UK
Forensic units		UK
Comm. Psych inpatient units	IT, ES, UK, AT	PT, IT, ES, EE, HU,
Comm Residential health facilties	IT, ES, UK	IT, ES, UK
Residential facilities non-health care	IT	IT, EE,
Large institutions		EE

3.2. DEVELOPMENT OF COMMUNITY-BASED SERVICES

As described above, the number of psychiatric hospitals and beds within them have progressively declined over the past few decades in Europe. In some countries the process started during the 1980s and 1990s, with much of the deinstitutionalisation process having been accomplished before 2000. For other countries the process commenced more recently and still continues.

Over the same period, another process, related with the downsizing and closure of psychiatric hospitals, took place in Europe: the development of community-based services designed to provide care close to the places where people live, with as little disruption to their lives as possible. The information currently available on community mental health services in European countries in the last 25 years has many gaps. However, information collected by WHO (2005, 2008, 2011 and the European Comission (EC, 2013 provide some information on the evolution of the main types of community-based facilities - in-patient units in general hospitals, day hospitals/ day care units and outpatient services.

3.2.1. - INPATIENT CARE IN THE COMMUNITY

Community-based psychiatric inpatient units

Community-based psychiatric inpatient units, situated in general hospitals or in other facilities, is an important component of mental health systems for most of the EU countries, where the median rate of beds per 100,000 inhabitants is 14,3. Despite a wide variation in bed rates between EU countries (from 3.6 up to 67.3 beds per 100,000 inhabitants), the majority of countries in 2011 (21 of 28) had more than 10 beds per 100,000 inhabitants in community-based psychiatric inpatient units (see Table IV. 26). In recent years, the number of these beds has not changed significantly. Between 2005 to 2011, ten countries increased their community-based psychiatric inpatient bed numbers, nine have maintained a similar number and six have shown a decrease.

DEFINITION:

Community-based psychiatric inpatient unit is a psychiatric unit that provides inpatient care for the management of mental disorders within a community-based facility. These units are usually located within general hospitals, but occasionally psychiatric inpatient beds are provided by a community centre. Community-based beds mostly provide care to people with acute mental health problems for a relatively short period of time, usually a few weeks or months. This category includes: both public and private, not-for-profit and for-profit facilities; community-based psychiatric inpatient units for children and adolescents only; and community-based psychiatric inpatient units for other specific groups such as older people.This category excludes: mental hospitals/psychiatric hospitals; community residential facilities; and facilities that solely treat people with alcohol and substance abuse disorder or intellectual or developmental disability.

Community-based residential facilities

Information on the number of beds in community residential facilities is available for 19 countries, either for 2008 or 2011. These facilities aim to provide residential support and psychosocial rehabilitation in the community for people with severe mental disorders who are unable to live entirely independently. As with beds in community-based inpatient units, there is a large variation in community-based residential facilities between countries (Table IV.26. Some countries have created a significant number of beds in residential facilities. Italy and the Netherlands, for instance, have 29 and 76 beds in residential facilities per 100,000 inhabitants respectively.

Non-healthcare residential facilities (social institutions)

Table IV. 26 shows that some countries have a significant number of non-healthcare beds in residential facilities. These residential facilities vary in terms of their characteristics, but most tend not to be community-based, contain between 50 to more than 100 beds and are similar to traditional psychiatric hospitals.

DEFINITION:

Community residential health facilities

Non-hospital community-based mental health facilities provides overnight residence for people with mental disorders. Usually these facilities serve those with relatively stable mental disorders not requiring intensive pharmaceutical interventions.

Community residential health facilities include: supervised housing; unstaffed group homes; group homes with some residential or visiting staff; hostels with day staff; hostels with day and night staff; hostels and homes with 24-hour nursing staff; halfway houses; and therapeutic communities. Both public and private not-for-profit and for-profit facilities are included. Community residential facilities for children and adolescents only and community residential facilities for other specific groups (such as older people) are also included.

Community residential health facilities exclude: facilities that treat only people with a diagnosis of alcohol and substance abuse disorder or mental retardation; residential facilities in mental hospitals; generic facilities that are important for people with mental disorders but that are not planned with their specific needs in mind, such as nursing homes and rest homes for older people, institutions treating mainly diseases of the nervous system or physical disability problems.

Non-healthcare residential facilities

Residential facilities that house people with mental disorders but do not meet the definition for a community residential facility or any other mental health facility defined here (e.g. community-based psychiatric inpatient unit, community residential facility, forensic inpatient unit or mental hospitals/psychiatric hospital).

Non-healthcare residential facilities include: residential facilities specifically for people with intellectual disability, substance abuse problems or dementia. Residential facilities that are not formally mental health facilities but facilities in which most of the people residing have diagnosable mental disorders are also included within this definition.

Non-hospital institutions

Non-hospital institutions from public, private or social sector, with more than 30 beds, providing support for a majority of chronic mental hospitals/psychiatric hospitals patients.

Table IV. 26. Number of beds in community based services in EU for 100,000 inhabitants

COUNTRY		COMMUNITY- BASED PSYCHIATRIC INPATIENT UNITS			COMMUNITY RESIDENTIAL HEALTH FACILITIES			LARGE RESIDENTIAL FACILITIES (NON-HEALTH CARE)		
		2005[1]	2008[2]	2011[3]	2005[1]	2008[2]	2011[3]	2005[1]	2008[2]	2011[3]
Austria		–	15	14.4	–	–	43	–	–	–
Belgium		26	–	25.5	–	65	–	–	–	–
Bulgaria		19	36	32.6	–	–	–	–	59	–
Croatia		9.8	–	19.5	–	–	–	–	–	–
Cyprus		6	6	5.2	–	–	.34	–	–	–
Czech Republic		1.5	14	13.4	–	2	–	–	12	–
Denmark		–	–	53.9	–	–	–	–	–	–
Estonia		21	55.5	–	–	–	–	–	–	–
Finland		90	–	67.3	–	4	–	–	102	133.9
France		30	–	22.7	–	–	–	–	–	–
Germany		29	–	41.1	–	6.5	–	–	–	–
Greece		3	4	5.1	–	33	–	–	–	–
Hungary		73	–	72.2	–	–	–	–	–	–
Ireland		18.6	26.3	17.9	–	80	27.2	–	–	–
Italy		9.2	8	10.9	–	29	–	–	–	–
Italy	Emilia-Romagna	–	20.4	18.2	–	33.4	37.2	–	–	–
	Lazio	–	24.8	5.42	–	24	37.2	–	–	–
	Lombardia	–	9.6	9.6	–	35.5	49.3	–	–	–
	Veneto	–	10.2	10.2	–	34	38.3	–	–	–
Latvia		3	11	12.2	–	–	–	–	189	–
Lithuania		11	10	–	–	–	–	–	–	–
Luxembourg		30	45	41.3	–	40	42	–	–	–
Malta		.4	0	3.6	–	7	5.85	–	–	–
Netherlands		10	–	10.5	–	53	76.2	–	1	–
Poland		12	16	14.3	–	–	.11	–	13	–
Portugal		10	7.7	9.4	–	2.2	2.07	–	34	–
Romania		20	21	36.3	–	–	–	–	–	–
Slovakia		30	78	38.1	–	–	248.8	–	6	–
Slovenia		12.6	13	8.9	–	–	10.4	–	127	–
Spain		6	11	10.2	–	–	-	–	–	–
Sweden		60	50	34.9	–	–	–	–	80	–
UK		–	–	–	–	–	–	–		–

1 Source: Mental Health Atlas 2005, WHO
2 Source: Policies and Practices for Mental Health in Europe, WHO 2008
3 Source: Mental Health Atlas 2011, WHO

Community-based psychiatric inpatient units in 9 WP5 participating countries

Data from the 9 WP5 participanting countries covering a larger period allowed for a more detailed analysis of the evolution of inpatient care, although the available data on residential facilities is limited.

From 1998 to 2012, Table IV. 27 shows the progressive decrease in psychiatric hospitals and the increased rate of community-based inpatient units and community residential facilities for the majority of the 9 WP5 participanting countries, where information is available. Data for large residential facilities and large mental health institutions must be interpreted with caution given the limited information available. However, this information shows that these facilities still exist in some countries and further information is needed to understand how care provided by these services differs from traditional psychiatric hospitals.

Table IV. 27. Rate of inpatient facilities per 100,000 inhabitants in 9 WP5 participating countries

COUNTRY		COMMUNITY- BASED PSYCHIATRIC INPATIENT UNITS			COMMUNITY RESIDENTIAL HEALTH FACILITIES		
		1998	2008	2012	1998	2008	2012
Austria		.08	.17	.27	–	–	–
Bulgaria		.32	.5	.49	NA	1.54	1.64
Estonia		–	1	1	–	–	–
Hungary		–	.6	.67	–	–	–
Ireland		.41	.64	.52	10.4	NA	6.3
Italy	Emilia-Romagna	.86	1.05	1.17	1.44	2.15	2
	Lazio	.78	.68	.43	2.20	2.40	3.18
	Lombardia	.6	.6	.6	1.7	2.7	5.2
	Veneto	.8	.8	.8	2.3	3.8	4
Portugal		.26	.27	.30	.12	.26	.28
Spain		.42	.36	.35	–	–	–
UK		–	–	–	–	–	–

NA – Not applicable

There is a significant reduction in the number of psychiatric hospitals and an increase in the number of beds in community-based services across 9 WP5 participanting countries, between 1998 and 2012, particularly in those that have developed mental health reforms in the last 15 years. The evolution of community-based inpatient units is more complex. In Austria the number of beds in these units increased significantly. This was less so for Ireland, Portugal and Spain where the increase was more modest and in Italy the number of beds in community-based inpatient units remained broadly the same (see Table IV. 28).

Table IV. 28. Number of beds per 100,000 inhabitants in 9 WP5 participating countries

COUNTRY		COMMUNITY- BASED PSYCHIATRIC INPATIENT UNITS			COMMUNITY RESIDENTIAL HEALTH FACILITIES			LARGE RESIDENTIAL FACILITIES THAT ARE NOT HEALTH CARE			LARGE MENTAL HEALTH INSTITUTIONS		
		1998	2008	2012	1998	2008	2012	1998	2008	2012	1998	2008	2012
Austria		11.2	15	15.8	–	–	43	–	–	–	–	–	–
Bulgaria		–	36	–	–	–	–	–	59	–	–	–	–
Estonia		–	55.5	55	–	–	–	–	–	–	197.7	178.3	180
Hungary		–	–	–	–	–	–	–	–	–	–	–	–
Ireland		16.2	26.4	17.9	78.6	80	27.2	NA	NA	NA	NA	NA	NA
Italy	Emilia-Romagna	22.1	20.5	18.2	25.8	33.4	37.3	–	–	–	–	–	–
	Lazio	33.8	24.8	5.4	26.8	24.0	37.3	–	–	–	–	–	–
	Lombardia	9.6	9.6	9.6	16.8	35.5	49.3	–	–	–	–	–	–
	Veneto	11	10.2	10.2	24.6	34	38.3	–	–	–	–	–	–
Portugal		14	7.7	7.8	–	1.5	–	–	34	–	–	33	31
Spain		11	11	12	–	–	–	–	–	–	–	–	–
UK		–	–	–	–	–	–	–	–	–	–	–	–

NA – Not applicable

Annual discharges in community-based psychiatric inpatient units compared with mental hospitals/psychiatric hospitals

Table IV. 29 lists the number of discharges in psychiatric hospitals, forensic and community based psychiatric inpatient units, from 1998 to 2012 in 9 WP5 participanting countries. Although there is not a linear evolution, we can see that, in general, while the annual discharges in mental hospitals/psychiatric hospitals significantly decreased in most countries, the inverse occurred in community-based psychiatric inpatient units.

Table IV. 29. Rate of annual discharges per 100,000 inhabitants in the following settings in 9 WP5 participating countries

COUNTRY		MENTAL HOSPITALS			COMMUNITY- BASED PSYCHIATRIC INPATIENT UNITS		
		1998	2008	2012	1998	2008	2012
Austria		–	–	–	–	–	–
Bulgaria		131.2	144.5	137.7	NA	521.3	545
Estonia		1252	0	0	0	1097	970
Hungary		–	–	–	–	–	–
Ireland		478.8	235.1	172	219	246.0	223.2
Italy	Emilia-Romagna	–	–	–	304.9	312.9	309.1
	Lazio	–	–	–	320.4	285.1	237.1
	Lombardia	–	–	–	235	219	224
	Veneto	–	–	–	244	208.2	355.3
Portugal		–	79.6	72.8	71.5	115.7	134.9
Spain		79	63	50	144	147	165
UK		–	–	–	–	–	–

NA – Not applicable

BOX 2 - Inpatient treatment

- *Community-based psychiatric inpatient units (in general hospitals or others), became an important component of the mental health system in most of the EU countries, with a median rate of 14.3 beds per 100,000*
- *Data available in most countries on residential facilities is surprisingly limited. However, available data show that most countries have made some progress in the development of residential facilites*
- *While the number of mental hospitals/psychiatric hospitals progressively decreased, the rate of community-based inpatient units and community residential facilities increased in the majority of the 9 WP5 participating countries where information is available.*
- *A wide variation was found in the number of admissions among countries*
- *Much more similarities exist in relation to the length of stay, especially in community-based inpatient units, where the median stay is much lower than in mental hospitals/ psychiatric hospitals.*

DEFINITION:

Mental health outpatient facility

A facility that focuses on managing mental disorders and the clinical and social problems related to it on an outpatient basis.

Mental health outpatient facilities include: community mental health centres; mental health ambulatories; outpatient services for specific mental disorders or for specialized treatment; mental health outpatient departments in general hospitals; mental health polyclinics; and specialized nongovernmental organization clinics that have mental health staff and provide mental health outpatient care (such as for people who have been raped or homeless people). Both public and private not-for-profit and for-profit facilities are included. Mental health outpatient facilities for children and adolescents only and mental health outpatient facilities for other specific groups (such as older people) are also included.

Mental health outpatient facilities exclude: private practice; and facilities that solely treat people with alcohol and substance abuse disorder or mental retardation without an accompanying diagnosis of mental disorder.

Community mental health services

Secondary or specialist care (care that cannot be provided by a primary care physician). At its most basic, it may be office-based private care or, more often, outpatient clinic (polyclinic) provision for assessing and treating mental illness by a trained mental health professional (such as a psychiatrist or psychologist). It can also be provided by a multidisciplinary team (community mental health team) comprising psychiatrists, mental health nurses and often psychologists and social workers. They usually provide care for the inhabitants of a clearly defined catchment area (such as a borough or town). Care is provided in a variety of settings (such as clinics, people's homes and day centres). An alternative structure is the community mental health centre, where several teams run a range of services, one of which is assessment and care outside the hospital.

OUTPATIENT FACILITIES AND OUTPATIENT VISITS

The number of outpatient facilities and outpatient visits has been increasing in most 9 WP5 participanting countries, particularly between 1998-2012 (see Table IV. 30). However, these data must be treated with some caution as the notion of outpatient facilities and outpatient visits varies between these countries.

Table IV. 30. Outpatient facilities and outpatient visits per 100,000 inhabitants in 9 WP5 participating countries

COUNTRY		OUTPATIENT FACILITIES PER 100,000 POPULATION			OUTPATIENT VISITS PER 100,000 POPULATION		
		1998	2008	2012	1998	2008	2012
Austria		–	–	–	–	–	–
Bulgaria		1.6	–	6.2	11.4	9.1	7.7
Estonia		–	–	–	5.10	18.3	19.5
Hungary		–	–	1.5	–	19.7	15.0
Ireland		–	–	–	–	–	–
Italy	Emilia-Romagna	3.4	3.1	3.0	–	37.1	44.5
	Lazio	2.07	1.65	1.69	–	15.5	21.5
	Lombardia	2.3	2.2	2.2	–	16.7	19.5
	Veneto	1	1.2	1.2	–	15.3	17.1
Portugal		0.3	0.4	0.4	2.5	4.0	5.2
Spain		.65	.67	.71	5.2	7.9	10.6
UK		–	–	–	–	–	–

DEFINITION:

Mental health day treatment facility

A facility that typically provides care for service users during the day. The facilities are generally: - available to groups of users at the same time (rather than delivering services to individuals one at a time), - expect users to stay at the facilities beyond the periods during which they have face-to-face contact with staff (that is, the service is not simply based on users coming for appointments with staff and then leaving immediately after the appointment) and - involve attendance lasting a half day or one full day.

Day treatment facilities include: day centres; day care centres; sheltered workshops; club houses; drop-in centres; and employment and rehabilitation workshops. Both public and private not-for-profit and for-profit facilities are included.

Day treatment facilities exclude: facilities that solely treat people with a diagnosis of alcohol and substance abuse disorder or intellectual disability without an accompanying diagnosis of mental disorder; general facilities that are important for people with mental disorders but that are not planned with their specific needs in mind; and day treatment facilities for inpatients.

DAY TREATMENT

Analysis of mental health day care is limited by notable gaps in the relevant information.

However, available data show that the rates of mental health day care facilities vary enormously between 9 WP5 participanting countries (see Table IV. 31). By contrast with other community-based services, this particular service has not increased considerably over the last 15 years.

Table IV. 31. Mental health day treatment facilities per 100,000 inhabitants in 9 WP5 participating countries

RATE OF MENTAL HEALTH DAY TREATMENT FACILITIES PER 100,000 POPULATION				
COUNTRY	1998	2008[1] EURO	2011[2] ATLAS	2012
Austria	–	–	.29	.37
Bulgaria	.50	.59	-	.60
Estonia	–	–	.22	.07
Hungary	–	–	.29	–
Ireland	1.98	–	–	1.48
Italy	–	–	1.34	–
Emilia-Romagna	.89	.82	–	.70
Lazio	1.20	.74	–	.78
Lombardia	.72	.98	–	.98
Veneto	1.4	2.1	–	2.2
Portugal	.14	.26	.27	–
Spain	1.64	2.17	.25	2.38
UK	–	–	–	–

1 Source: Policies and Practices for Mental Health in Europe", WHO 2008
2 Source: Mental Health Atlas 2011, WHO

Community mental health centres in 9 WP5 participating countries

The development of community mental health centres has followed a different trajectory to that of day care facilities. The number of Centres and the rate of patients treated annually by these services has grown considerably in most 9 WP5 participanting countries (Bulgaria, Estonia, Italy, Spain and UK) (see Table IV. 32). Over the last three countries these facilities have become an important component of these mental health systems.

Table IV. 32. Community Mental Health Centres and annual patients treated in Community Mental Health Centres per 100,000 inhabitants in 9 WP5 participating countries

COUNTRY		COMMUNITY MENTAL HEALTH CENTERS PER 100,000 INHABITANTS			ANNUAL NUMBER OF PATIENTS TREATED IN COMMUNITY MENTAL HEALTH CENTERS PER 100,000		
		1998	2008	2012	1998	2008	2012
Austria		–	–	–	–	–	–
Bulgaria		.14	.16	.16	202	255.4	267.3
Estonia		.07	4.7	5.1	–	198	205
Hungary		–	–	–	–	–	–
Ireland		2.8	–	2.2	137.7	–	–
Italy	Emilia-Romagna	1.0	1.0	.99	–	1541.9	1702.7
	Lazio	1.4	1.1	.81	1238.2	1382.8	1.673
	Lombardia	1.2	1.1	1.1	861	1200	1308
	Veneto	1	1.2	1.2	–	1259	1327
Portugal		–	–	–	–	–	–
Spain		1.4	1.5	1.7	2624	2934	3257
UK		3	6	4	300	400	800

Home treatment in EU countries

Home treatment services are included in policies, plans and legislation in almost all EU countries, except six. Of the 21 countries for which information is available only eight provide access to home treatment services to more than 50% of people with severe mental disorders; and 5% of countries provide access to 21-50 % of the population (see Table IV. 33).

DEFINITION:

Home treatment

Few mental health interventions require complex equipment or specialised accommodation. Treatment (psychological, pharmaceutical and social) is increasingly provided in the person's home or neighbourhood when it is safe to do so.

Home treatment often implies that the intervention has an acknowledged aim of diverting the person away from hospital admission and may involve frequent contact (usually between daily and weekly).

Crisis care

Refers to interventions that deal with brief, acute breakdowns in which an individual's usual coping strategies are temporarily overwhelmed. Early approaches tried to restrict crisis to disorders lasting days (typically 72 hours), but now care generally stretches up to several weeks.

Crisis care is characterised by the rapid provision of support (such as counselling or respite admission) while arousal and distress settle and more long-term care is planned. Contact is often very frequent, sometimes more than once a day.

Assertive outreach

Community-based services that work intensively over time with people with complex mental health needs addressing mental health, physical health and social needs.

Table IV. 33. Access to home treatment services in EU countries

COUNTRY	HOME TREATMENT REQUIRED IN POLICIES, PLANS OR LEGISLATION	PERCENTAGE OF PEOPLE WITH MENTAL DISORDERS WHO HAVE ACCESS IN PRACTICE TO HOME TREATMENT
Austria		–
Belgium		Some (21–50%)
Bulgaria		None
Croatia		None
Cyprus		–
Czech Republic		None
Denmark		Some (21–50%)
Estonia		A few (1–20%)
Finland		A few (1–20%)
France		–
Germany		All or almost all (81–100%)
Greece		A few (1–20%)
Hungary		None
Ireland		Some (21–50%)
Italy		A few (1–20%)
Latvia		Some (21–50%)
Lithuania		A few (1–20%)
Luxembourg		All or almost all (81–100%)
Malta		None
Netherlands		The majority (51–80%)
Poland		A few (1–20%)
Portugal		–
Romania		None
Slovakia		None
Slovenia		None
Spain		A few (1.20% (2012)
Sweden		–
UK		All or almost all (81–100%)

Source: Policies and Practices for Mental Health in Europe, WHO 2008

Yes
No

Community-based rehabilitation in EU countries

Access to community-based rehabilitation services is more widely available across Europe than home treatment. Of the 20 countries with reliable information, 12 offer access to these services to more than 50% of those with mental disorders (see Table IV. 34).

Table IV. 34. Access to community-based rehabilitation services in EU countries

COUNTRY	REHABILITATION SERVICES REQUIRED IN POLICIES, PLANS OR LEGISLATION	PERCENTAGE OF PEOPLE WITH MENTAL DISORDERS WHO HAVE ACCESS IN PRACTICE TO REHABILITATION SERVICES
Austria		All or almost all (81–100%)
Belgium		All or almost all (81–100%)
Bulgaria		A few (1–20%)
Croatia		Some (21–50%)
Cyprus		–
Czech Republic		A few (1–20%)
Denmark		The majority (51–80%)
Estonia		All or almost all (81–100%)
Finland		A few (1–20%)
France		All or almost all (81–100%)
Germany		All or almost all (81–100%)
Greece		The majority (51–80%)
Hungary		A few (1–20%)
Ireland		The majority (51–80%)
Italy		All or almost all (81–100%)
Latvia		A few (1–20%)
Lithuania		–
Luxembourg		All or almost all (81–100%)
Malta		Some (21–50%)
Netherlands		All or almost all (81–100%)
Poland		The majority (51–80%)
Portugal		–
Romania		A few (1–20%)
Slovakia	–	–
Slovenia	–	–
Spain		The majority (51–80%)
Sweden		–
UK		All or almost all (81–100%)

Source: Policies and Practices for Mental Health in Europe, WHO 2008

Yes
No

DEFINITION:

Community rehabilitation units

Non-intensively staffed units, with clear rehabilitation objectives, focusing on activities of daily living, psychological interventions and engagement with services.

High-dependency rehabilitation units

Units with clear rehabilitation objectives for individuals who are highly symptomatic, have severe co-morbid conditions, significant risk histories and challenging behaviours.

Longer-term complex care units

Specialised rehabilitation units for people who have high levels of disability, complex comorbidity, limited potential for change and significant risk to their own health and safety or to others.

Follow-up in 9 WP5 participating countries

Routine follow-up care in the community is pivotal to good quality mental health care. In 1998, follow-up care was offered for the most part through outpatient clinics in community-based psychiatric units. Some countries offered home treatment and assertive outreach services, which at the time was relatively uncommon (see Table IV. 35). By 2012, the level of follow-up care in the community had improved and provision for this care was available in all settings (see Table IV. 36).

Table IV. 35. Routine community follow-up care by setting in 1998 for 9 WP5 participanting countries

COUNTRY		OUTPATIENT CLINICS IN MENTAL HOSPITALS	OUTPATIENT CLINICS IN COMMUNITY-BASED PSYCHIATRIC UNITS	HOME TREATMENT	ASSERTIVE OUTREACH TEAMS
Austria		A few	A few	A few	A few
Bulgaria		None	All or almost all	All or almost all	None
Estonia		The Majority	None	A few	None
Hungary		A few	The Majority	None	None
Ireland		–	–	–	–
Italy	Emilia-Romagna	None	All or almost all	A few	A few
	Lazio	None	All or almost all	A few	A few
	Lombardia	None	All or almost all	A few	None
	Veneto	None	All or almost all	A few	–
Portugal		The Majority	Some	A few	None
Spain		A few	The Majority	None	None
UK		None	All or almost all	None	None

None
A few
Some
The Majority
All or almost all

Table IV. 36. Follow-up community care by setting in 2012 for 9 WP5 participanting countries

COUNTRY	OUTPATIENT CLINICS IN MENTAL HOSPITALS	OUTPATIENT CLINICS IN COMMUNITY-BASED PSYCHIATRIC UNITS	HOME TREATMENT	ASSERTIVE OUTREACH TEAMS
Austria	A few	A few	A few	A few
Bulgaria	None	Some	Some	None
Estonia	None	Some	None	None
Hungary	A few	The Majority	None	None
Ireland	None	All or almost all	A few	A few
Italy – Emilia-Romagna	None	All or almost all	A few	A few
Italy – Lombardia	None	The Majority	A few	None
Italy – Veneto	None	The Majority	A few	–
Portugal	Some	The Majority	A few	NA
Spain	Some	The Majority	A few	A few
UK	None	All or almost all	All or almost all	All or almost all

NA – Not applicable

None
A few
Some
The Majority
All or almost all

Psychosocial interventions in 9 WP5 participating countries

Psychosocial interventions (interventions that apply psychological or social methods to treat and/or rehabilitate a person with a mental disorder to reduce psychosocial distress) also play a key role in the provision of mental health care. In 1998, the proportion of patients who received one or more psychosocial interventions in WP5 participanting countries was already quite high across all settings, except for psychiatric hospitals (Table IV. 37). In 2012, the proportion of psychosocial interventions provided within psychiatric hospitals increased while the proportion in the other settings remained the same (see Table IV. 38).

Table IV. 37. Proportion of patients who received one or more psychosocial interventions in specific settings in 1998 in 9 WP5 participating countries

COUNTRY		MENTAL HEALTH OUTPATIENT FACILITIES	DAY TREATMENT FACILITIES	COMMUNITY-BASED PSYCHIATRIC INPATIENT UNITS	MENTAL HOSPITALS
Austria		Some	Some	The Majority	The Majority
Bulgaria		All or almost all	All or almost all	All or almost all	All or almost all
Estonia		A few	A few	None	All or almost all
Hungary		–	–	–	–
Ireland		All or almost all	All or almost all	All or almost all	All or almost all
Italy	Emilia-Romagna	All or almost all	A few	A few	None
	Lazio	All or almost all	A few	A few	None
	Lombardia	Some	All or almost all	A few	–
	Veneto	All or almost all	Some	All or almost all	None
Portugal		–	–	–	–
Spain		All or almost all	A few	A few	Some
UK		All or almost all	A few	The Majority	None

None
A few
Some
The Majority
All or almost all

Table IV. 38. Proportion of patients who received one or more psychosocial interventions in the specific settings in 2012 in 9 WP5 participating countries

COUNTRY		MENTAL HEALTH OUTPATIENT FACILITIES	DAY TREATMENT FACILITIES	COMMUNITY-BASED PSYCHIATRIC INPATIENT UNITS	MENTAL HOSPITALS
Austria		The Majority	The Majority	The Majority	The Majority
Bulgaria		–	All or almost all	The Majority	A few
Estonia		All or almost all	A few	–	A few
Hungary		–	–	–	–
Ireland		All or almost all	All or almost all	All or almost all	All or almost all
Italy	Emilia-Romagna	All or almost all	A few	A few	None
	Lazio	All or almost all	A few	A few	None
	Lombardia	All or almost all	All or almost all	A few	–
	Veneto	All or almost all	All or almost all	A few	None
Portugal		All or almost all	–	All or almost all	All or almost all
Spain		All or almost all	A few	Some	A few
UK		A few	A few	–	Some

None
A few
Some
The Majority
All or almost all

Programmes for vulnerable populations in 9 WP5 participating countries

Special programmes for vulnerable populations and marginalized groups exist in all participating countries with the exception of two countries and one Region of Italy (Table IV. 39).

Table IV. 39. Special programmes for vulnerable and marginalized groups in 9 WP5 participating countries

COUNTRY		YES
Austria		■
Bulgaria		
Estonia		
Hungary		
Ireland		■
Italy	Emilia-Romagna	■
	Lazio	
	Lombardia	■
	Veneto	
Portugal		■
Spain		■
UK		■

■ Yes

BOX 3 Community - based care

- *Outpatient clinics and visits and community mental health centers significantly increased in the majority of 9 WP5 participating countries in the last 15 years;*
- *A different trend was observed in day treatment which has not showed a significant change;*
- *Only 8 out of all countries ensure access to home treatment to more than 50% of the people with mental disorders;*
- *12 countries offer access to community based rehabilitation to more than half of the people with mental disorders;*
- *Community care routine follow-up is mostly offered in outpatient clinics in community based psychiatric units and has increased in recent yars;*
- *Psychosocial intervention is offered to a significant porpotion of patients , particularly in community services.*

3.3 PRIMARY CARE

Identification, referral and the treatment of common mental health problems and disorders in primary care across 9 WP5 participanting countries are presented in Table IV. 40. Identification of severe and enduring mental disorders and referral to specialist services are indicated in policy and present in practice across all participating countries. Specifications regarding the treatment of these disorders, however, is present in policy or legislation and practice for only three countries. Primary care services therefore are not expected to play a significant role in the treatment of severe mental disorders.

It should be also noted that national guidelines for key mental health conditions in general practices/family practices for half of the 9 WP5 participanting countries were Not applicable in 2012 (see Table IV. 41).

Table IV. 40. Roles of general practitioners/family doctors in 9 WP5 participating countries

COUNTRY		IDENTIFICATION AND REFERRAL TO SPECIALIST SERVICES PEOPLE WITH:		TREATMENT OF PEOPLE WITH:	
		WRITTEN IN POLICY OR LEGISLATION	PRESENT IN PRACTICE	WRITTEN IN POLICY OR LEGISLATION	PRESENT IN PRACTICE
Austria		Common mental health problems		Common mental health problems	
		Severe and enduring mental health problems		Severe and enduring mental health problems	
Bulgaria		Common mental health problems		Common mental health problems	
		Severe and enduring mental health problems		Severe and enduring mental health problems	
Estonia		Common mental health problems		Common mental health problems	
		Severe and enduring mental health problems		Severe and enduring mental health problems	
Hungria		Common mental health problems		Common mental health problems	
		Severe and enduring mental health problems		Severe and enduring mental health problems	
Ireland		Common mental health problems		Common mental health problems	
		Severe and enduring mental health problems		Severe and enduring mental health problems	
Italy	Emilia-Romagna	Common mental health problems disorders		Common mental health problems disorders	
		Severe and enduring mental health problems		Severe and enduring mental health problems	
	Lazio	Common mental health problems		Common mental health problems	
		Severe and enduring mental health problems		Severe and enduring mental health problems	
	Lombardia	Common mental health problems		Common mental health problems	
		Severe and enduring mental health problems		Severe and enduring mental health problems	
	Veneto	Common mental health problems disorders		Common mental health problems disorders	
		Severe and enduring mental health problems		Severe and enduring mental health problems	

COUNTRY	IDENTIFICATION AND REFERRAL TO SPECIALIST SERVICES PEOPLE WITH:		TREATMENT OF PEOPLE WITH:	
	WRITTEN IN POLICY OR LEGISLATION	PRESENT IN PRACTICE	WRITTEN IN POLICY OR LEGISLATION	PRESENT IN PRACTICE
Portugal	Common mental health problems	Yes	Common mental health problems	Yes
	Severe and enduring mental health problems		Severe and enduring mental health problems	No
Spain	Common mental health problems disorders	No	Common mental health problems disorders	Yes
	Severe and enduring mental health problems	Yes	Severe and enduring mental health problems	No
UK	Common mental health problems disorders		Common mental health problems disorders	Yes
	Severe and enduring mental health problems		Severe and enduring mental health problems	

Yes
No

Table IV. 41. National guidelines available for key mental health conditions in general practices/family practices in 9 WP5 participating countries

COUNTRY		YES, FOR COMMON DISORDERS	YES, FOR SEVERE AND ENDURING MENTAL DISORDERS
Austria		Yes	
Bulgaria			
Estonia		Yes	
Hungary			
Ireland			
Italy	Emilia-Romagna	Yes	Yes
	Lazio		
	Lombardia		
	Veneto	Yes	
Portugal			
Spain		Yes	Yes
UK		Yes	Yes

Yes

4. Human Resources in EU countries

Human resources devoted to mental health services between 2005 and 2011 demonstrate how these have increased across Europe (WHO, 2005; WHO, 2011). Table IV. 42, however, shows significant variation between countries, particularly for several countries where the number of community-based mental health professionals - psychologists, social workers and occupational therapists - is still limited.

Table IV. 42. Human resources working in mental health (public and/or private) services in 2011, per 100,000 inhabitants in EU

COUNTRY	PSYCHIATRISTS	GENERAL QUALIFIED NURSES	PSYCHOLOGISTS WORKING IN MENTAL HEALTH SERVICES	SOCIAL WORKERS	OCCUPATIONAL THERAPISTS
Austria	19.7	–	–	–	–
Belgium	–	0.0	1.3	0.9	0.0
Bulgaria	6.7	431	0.9	0.5	–
Croatia	10.2	35.6	2.9	1.0	0.6
Cyprus	6.8	42.2	28.9	–	8.4
Czech Republic	11.8	28.2	2.0	.9	.3
Denmark	14.1	–	–	–	–
Estonia	13.5	–	–	–	–
Finland	28.1	–	–	–	–
France	22.3	86.2	47.9	3.8	–
Germany	15.2	56.1	–	–	–
Greece	12.9	–	26.8	–	–
Hungary	6.52	21.9	2.5	3	–
Ireland	6.1	112.8	3.5	3.8	3.2
Italy	7.8	19.3	2.6	1.9	2.2
Latvia	10.8	–	–	–	.4
Lithuania	17.8	–	–	–	–
Luxembourg	21.1	–	–	–	–
Malta	3.2	66.8	4.4	5.1	4.6
Netherlands	18.8	132.3	15.1	–	–
Poland	5.1	17.6	3.6	.6	5.3
Portugal	6.1	12.1	2.1	1	.5
Romania	6.4	14.1	–	–	–
Slovakia	11.5	19.3	–	–	–
Slovenia	7.1	69.7	4.5	3.7	1.3
Spain	8.6	9.8	5.8	2.6	1.3
Sweden	3.5	28.9	.9	18.4	.5
UK	–	–	–	–	–

Source: Mental Health Atlas 2011, WHO

5. Financial resources in EU countries

The proportion of the total health budget or expenditure allocated to mental health services varies from 2% up to 13.4% (see Table IV. 43), with a median of 5.5%. Only two countries (Spain and the UK) calculate their estimate using a formula based on the needs of the population to allocate regional/ local budgets (see Table IV. 44), and medication is free or at least 80% covered in all participating countries but two (Table IV. 45).

Table IV. 43. Mental health budget or expenditure (% of the total health budget or expenditure) in EU countries

COUNTRY	TOTAL HEALTH BUDGET/ EXPENDITURE SPENT ON MENTAL HEALTH	FINANCE SYSTEMS	HEALTH EXPEN-DITURE/ BUDGET (% OF GDP)	YEAR
Austria	NA	NA	11	2009
Belgium	6	Mental health services are financed mainly through social and private insurance, out of pocket and taxation.	11.8	2009
Bulgaria	2	National Health Insurance Fund is the main source of funding.	4	2012
Croatia	–	No separate budget allocation for mental health. National insurance based financing.	7.8	2011
Cyprus	4.8	Main funding sources are tax revenues, out-of-pocket, social insurance and grants.	7.4	2011
Czech Republic	2.9	Several stable sources of funding are used: the Health Insurance Fund, subsidies from the Ministry of Labour and Health, out of pocket and direct payments by patients for private services.	7.4	2011/2008
Denmark	8	Main funding sources are tax revenues	11.2	2009
Estonia	5.8	Main funding sources are from the Health Insurance Fund, out of pocket funds and co-payments.	6	2011
Finland	3.9	Tax revenues, social and private insurance, out of pocket expenses are the main sources.	8.9	2011
France	12.9	Primary sources of funding are tax revenues and social insurance.	11.6	2011/2009
Germany	11	Statutory or private health insurance are the main sources of funding.	11.1	2011
Greece	4.4	Main sources of funding are tax revenues, social and private insurance.	10.8	2011
Hungary	5.1	Main sources of funding taxation, social insurance and out of pocket expenses.	7.7	2009
Ireland	5.3	–	9.4	2012
Italy	5	Main funding sources through general taxation plus, cost sharing.	8.7	2007
Latvia	5.9	–	6.2	2011
Lithuania	–	Financed through State Sick Fund.	6.6	2011
Luxembourg	13.4	–	7.7	2005

COUNTRY	TOTAL HEALTH BUDGET/ EXPENDITURE SPENT ON MENTAL HEALTH	FINANCE SYSTEMS	HEALTH EXPEN-DITURE/ BUDGET (% OF GDP)	YEAR
Malta	6.7	Financed through general taxation	8.7	2011
Netherlands	11	Financed through basic health insurance.	12	2009
Poland	5.1	Financed through taxation	6.7	2011
Portugal	5.2	Main sources of funding through taxation and out of pocket expenses for private healthcare.	10.4	2011
Romania	–	Financed through compulsory and voluntary insurance contributions.	4	2012
Slovakia	–	Financed through compulsory public health insurance.	7.3	2010
Slovenia	–	NA	9.1	2011
Spain	3.8	Financed through tax revenues, out of pocket expenses and private insurance.	9.4	2011
Sweden	10	NA	9.4	2011
UK	13	Mainly financed through general taxation	9.6	2012/2010

* Source: European profile of prevention and promotion of mental health (EuroPoPP-MH), 2013
NA – Not applicable

Chart IV. 2. Mental Health Budget or Expediture in EU countries (%)

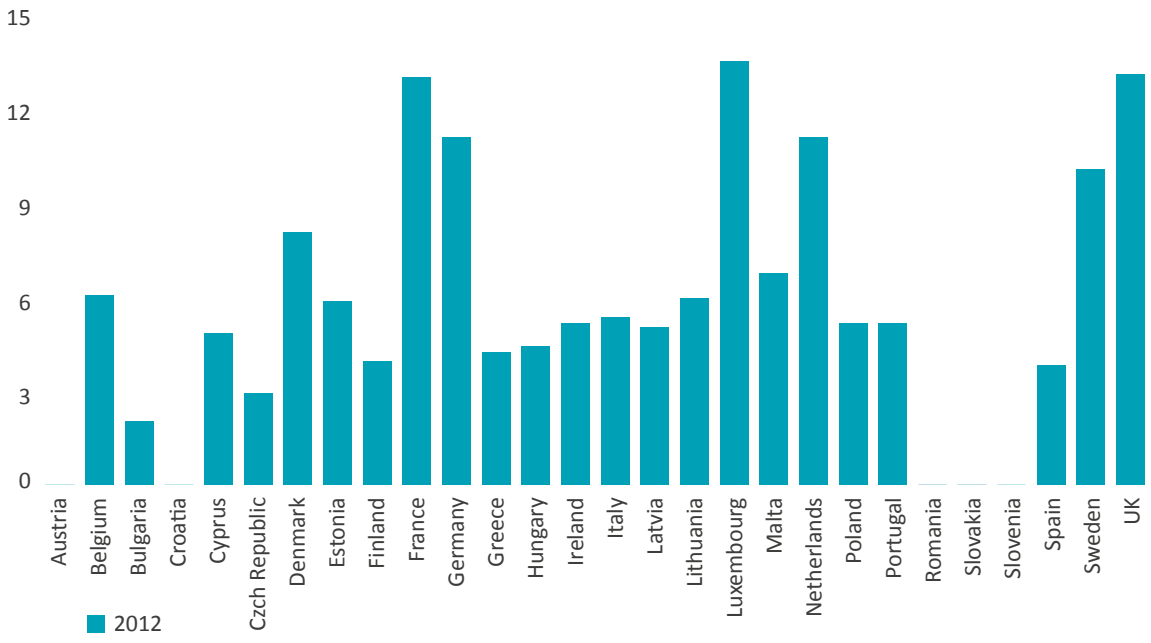


Table IV. 44. Allocation of local/regional budget using a formula based on the relative needs of the population in 9 WP5 participating countries

COUNTRY	
Austria	NA
Bulgaria	
Estonia	
Hungary	
Ireland	–
Italy – Emilia-Romagna	
Italy – Lazio	
Italy – Lombardia	
Italy – Veneto	
Portugal	
Spain	
UK	

NA – Not applicable

Yes
No

Table IV. 45. Provision of free psychotropic medication (at least 80% covered) in 9 WP5 participating countries

COUNTRY	HOSPITAL	COMMUNITY SERVICES	PRIMARY CARE
Austria			
Bulgaria			
Estonia			
Hungary			
Ireland			
Italy – Emilia-Romagna			
Italy – Lazio			
Italy – Lombardia			
Italy – Veneto			
Portugal			
Spain			
UK			

Yes
No

6. Human rights and compulsory treatment

All 9 WP5 participanting countries but one have review bodies to assess the protection of human rights for users of mental health services. Most have review bodies to regulate/review involuntary admissions to hospital and discharge procedures, formal complaints and the restriction of liberty. However, for three 9 WP5 participanting countries regular inspections are not made and in four countries sanctions cannot be imposed for not following procedures (see Table IV. 46). Three countries have included users and carers as members of their review bodies (see Table IV. 47).

Table IV. 46. National- and/or regional-level review body functions to assess compulsory procedures and the protection of human rights for users of mental health services

COUNTRY		PERFORM REGULAR INSPECTIONS IN MENTAL HEALTH FACILITIES	REVIEW IN-VOLUNTARY ADMISSION AND DIS-CHARGE PROCEDURES	REVIEW COMPLAINTS INVESTIGA-TION PRO-CESSES	REVIEW OF RESTRICTION OF LIBERTIES	REVIEW OF RESTRAINTS	IMPOSE SANCTIONS
Austria		Yes	Yes	Yes	Yes	Yes	Yes
Bulgaria		No	No	No	No	No	No
Estonia		Yes	Yes	Yes	Yes	Yes	Yes
Hungary		Yes	No	Yes	Yes	Yes	Yes
Ireland		Yes	Yes	Yes	Yes	Yes	Yes
Italy	Emilia-Romagna	Yes	Yes	Yes	Yes	Yes	Yes
	Lazio	Yes	Yes	Yes	Yes	Yes	Yes
	Lombardia	Yes	Yes	Yes	Yes	Yes	Yes
	Veneto	–	–	–	–	–	–
Portugal		No	Yes	Yes	No	No	–
Spain		No	Yes	Yes	Yes	No	No
UK		Yes	Yes	Yes	Yes	Yes	Yes

Yes
No

Table IV. 47. Participation of users in national and regional-level review bodies in 9 WP5 participating countries

COUNTRY		
Austria		Yes
Bulgaria		No
Estonia		No
Hungary		–
Ireland		Yes
Italy	Emilia-Romagna	No
	Lazio	No
	Lombardia	–
	Veneto	–
Portugal		–
Spain		Yes
UK		–

Yes
No

Table IV. 48. Participation of carers in national and regional-level review bodies in 9 WP5 participating countries

COUNTRY		
Austria		Yes
Bulgaria		No
Estonia		No
Hungary		–
Ireland		Yes
Italy	Emilia-Romagna	No
	Lazio	No
	Lombardia	–
	Veneto	–
Portugal		–
Spain		Yes
UK		Yes

Yes
No

Protocols for involuntary admission are available for all 9 WP5 participanting countries, whereas those for restraint and violence management exist in almost all (see Table IV. 49). People admitted to hospital on an involuntarily basis have the right to access free legal representation in all participating countries (see Table IV. 51).

Table IV. 49. Protocols for involuntary admission, restraint and violence management in 9 WP5 participating countries

COUNTRY		INVOLUNTARY ADMISSION	RESTRAINT	VIOLENCE MANAGEMENT
Austria				
Bulgaria				
Estonia				
Hungary				
Ireland				
Italy	Emilia-Romagna			
	Lazio			
	Lombardia			
	Veneto			
Portugal				
Spain				
UK				

Yes
No

Table IV. 50. Rates of involuntary admissions, per 100,000 in 9 WP5 participating countries

COUNTRY		RATES OF INVOLUNTARY ADMISSIONS	
		Civil	Forensic
Austria		226.2	–
Bulgaria		.05	–
Estonia		.02	.03
Hungary		–	–
Ireland		45.2	1.4
Italy	Emilia-Romagna	25.0	–
	Lazio	21.4	–
	Lombardia	19.3	1.3
	Veneto	–	–
Portugal		–	–
Spain		–	–
UK		–	–

Table IV. 51. Right to access free legal representation for people admitted to hospital involuntarily, in 9 WP5 participating countries

COUNTRY		
Austria		
Bulgaria		
Estonia		
Hungary		
Ireland		
Italy	Emilia-Romagna	
	Lazio	
	Lombardia	
	Veneto	
Portugal		
Spain		
UK		

Yes
No

7. Support towards social inclusion for people with mental health problems

All 9 WP5 participating countries have policies and programmes to increase the level of social inclusion of people with mental health problems (Table IV. 52).

Legislative or financial provisions for subsidized housing, support to employers and the prevention of discrimination for people with severe mental disorders differ across 9 WP5 participanting countries. Subsidized housing and support to employers are available to some degree in the majority of countries. However, only three countries are considering anti-discrimination measures (see Table IV. 53).

Table IV. 52. Policies and programmes to increase the level of social inclusion of people with mental health problems in 9 WP5 participating countries

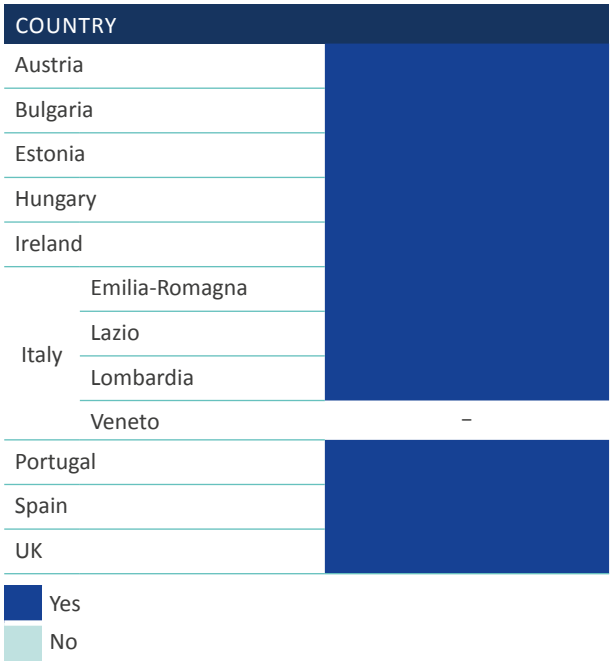
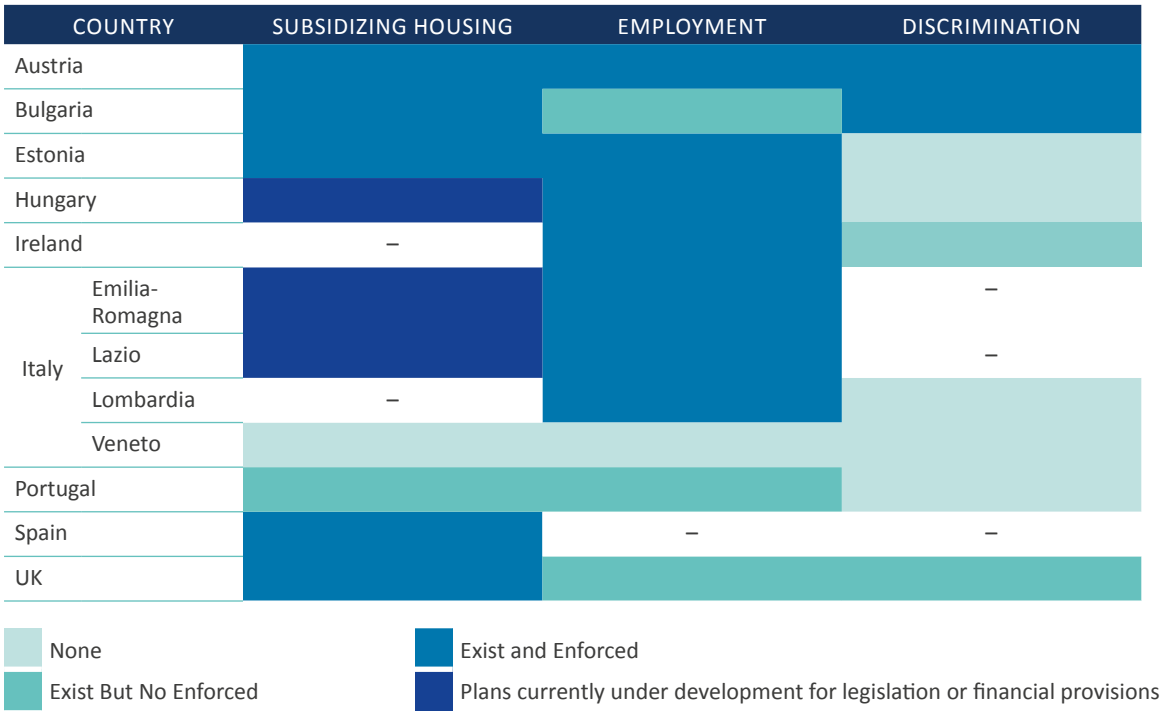


Table IV. 53. Legislative or financial provisions to support housing, employment and anti-discrimination activities for people with severe mental disorders, in WP5 participating countries



Plans currently under development for legislation or financial provisions

Information on the proportion of people who are unemployed and receive social welfare benefits or pensions because of a disability due to mental disorders was difficult to find for most 9 WP5 participanting countries. However, this was available for three countries and revealed that more than 20% of unemployed people were receiving social welfare benefits or pensions because of a disability due to mental disorders (see Table IV. 54).

Table IV. 54. Proportion of people unemployed who receive social welfare benefits or pensions because of a disability due to mental disorders in 9 WP5 participating countries

COUNTRY		PROPORTION	YEAR
Austria		More than 30% and rising	2010
Bulgaria		NA	NA
Estonia		21	–
Hungary		NA	NA
Ireland		NA	NA
Italy	Emilia-Romagna	–	–
	Lazio	–	–
	Lombardia	–	–
	Veneto	–	–
Portugal		–	–
Spain		25.5	2014
UK		25	–

NA – Not applicable

8. Representation of users and carers

The involvement of users and carers in developing community-based care is essential. In practice, the majority of the 9 WP5 participanting countries report involving users and carers in the planning, implementation and review of mental health activities (see Table IV. 54). It should also be noted that two thirds of participating countries provide economic support to users and carers associations (see Table IV. 55). However, more than half of participating countries have not adopted government guidance/ directions for including user and carer representatives on relevant committees (see Table IV. 56).

Table IV. 55. Adoption of governmental guidance/directions for user and carer representatives on committees in 9 WP5 participating countries

COUNTRY	PLANNING OF MENTAL HEALTH ACTIVITIES		IMPLEMENTATION OF MENTAL HEALTH ACTIVITIES		REVIEW OF MENTAL HEALTH ACTIVITIES	
	Users	Carers	Users	Carers	Users	Carers
Austria	Yes	Yes	No	No	No	No
Bulgaria	No	No	No	No	No	No
Estonia	No	No	No	No	No	No
Hungary	No	No	No	No	No	No
Ireland	Yes	Yes	Yes	Yes	Yes	Yes
Italy – Emilia-Romagna	Yes	Yes	Yes	Yes	Yes	Yes
Italy – Lazio	Yes	Yes	Yes	Yes	Yes	Yes
Italy – Lombardia	No	Yes	No	Yes	No	Yes
Italy – Veneto	No	No	No	No	No	No
Portugal	Yes	Yes	Yes	No	No	No
Spain	Yes	Yes	Yes	Yes	Yes	Yes
UK	No	No	No	No	No	No

Yes
No

Table IV. 56. Types of representation that are common practices in 9 WP5 participating countries

COUNTRY		PLANNING OF MENTAL HEALTH ACTIVITIES	IMPLEMENTATION OF MENTAL HEALTH ACTIVITIES	REVIEW OF MENTAL HEALTH ACTIVITIES
		Carers	Carers	Carers
Austria		No	No	No
Bulgaria		No	No	No
Estonia		Yes	Yes	Yes
Hungary		No	No	No
Ireland		Yes	Yes	Yes
Italy	Emilia-Romagna	Yes	Yes	Yes
	Lazio	Yes	Yes	Yes
	Lombardia	No	Yes	Yes
	Veneto	Yes	Yes	Yes
Portugal		–	Yes	–
Spain		–	–	–
UK		Yes	Yes	Yes

Yes
No

Table IV. 57. Economic support for the establishment and running of Service user/ consumer associations in 9 WP5 participating countries

COUNTRY		
Austria		Yes
Bulgaria		No
Estonia		Yes
Hungary		No
Ireland		Yes
Italy	Emilia-Romagna	Yes
	Lazio	Yes
	Lombardia	No
	Veneto	No
Portugal		Yes
Spain		Yes
UK		Yes

Yes
No

Table IV. 58. Economic support for the establishment and running of Service Family/ carers associations in 9 WP5 participating countries

COUNTRY		
Austria		Yes
Bulgaria		No
Estonia		Yes
Hungary		No
Ireland		Yes
Italy	Emilia-Romagna	Yes
	Lazio	Yes
	Lombardia	No
	Veneto	No
Portugal		Yes
Spain		Yes
UK		Yes

Yes
No

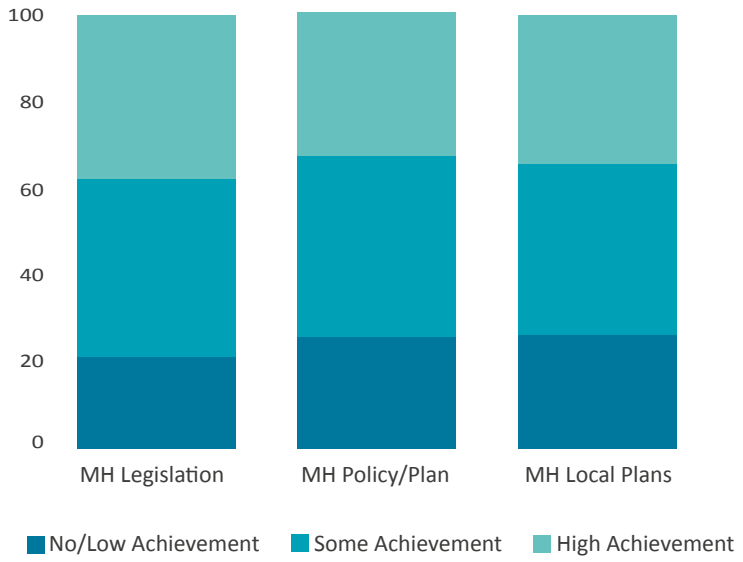
V. ACHIEVEMENTS, BARRIERS AND FACILITATING FACTORS

The data presented in this chapter were collected via a survey questionnaire on the transition from institutional to community-based mental health services. All National Network members, from each participating Member State, completed the five point Likert scale questionnaire. The results, from 248 members, detailed below, constitute an analysis of national stakeholders and mental health experts' perceptions of achievements, barriers and facilitators in the transition from institutional to community-based care.

A) ACHIEVEMENTS

With regard to the transition process, levels of achievement in legislation, policy and plans overall are satisfactory, with better results in the area of legistlation (see Chart IV. 1).

Chart V. 1. Achievements in Legislation, Policy and Plans (%)



Achievements in the advocacy and public education dimensions are lower than the ones in the legislation, policy and plans, ranging from 20% to 34% of high achievement, particularly advocacy provided by NGOs and Families (see Chart V. 2). Higher achievement percentages can be observed in the advocacy and public education promoted by NGOs and Families when compared with the lower rates from advocacy promoted by Governments, Users or Professionals. In addition, Governments have the higher rates of No/Low achievement.

Chart V. 2. Achievements in Advocacy and Public Education per Stakeholder (%)

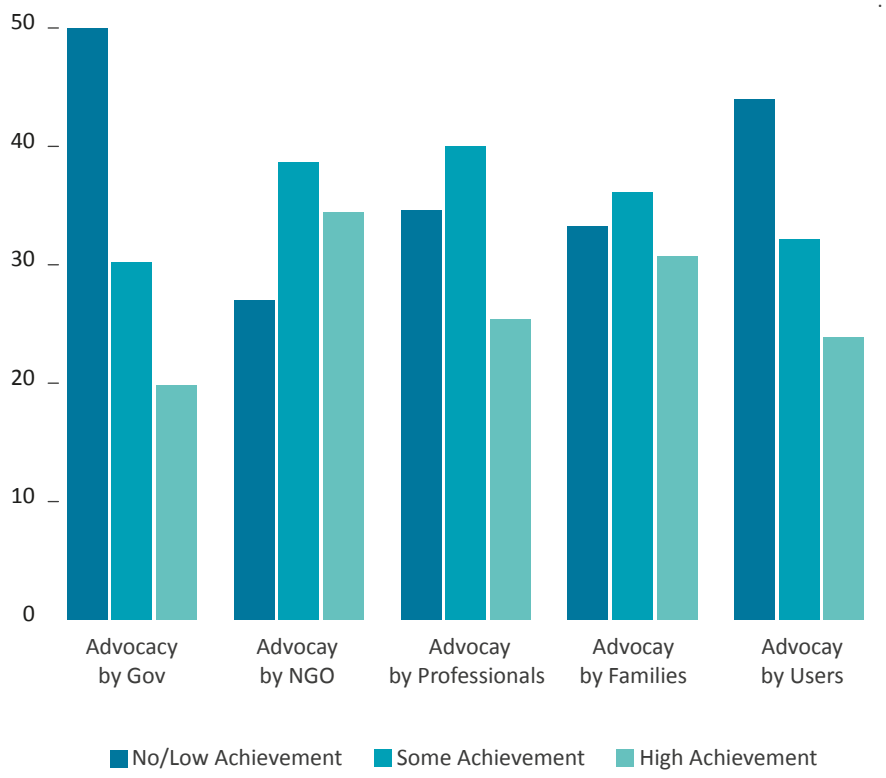


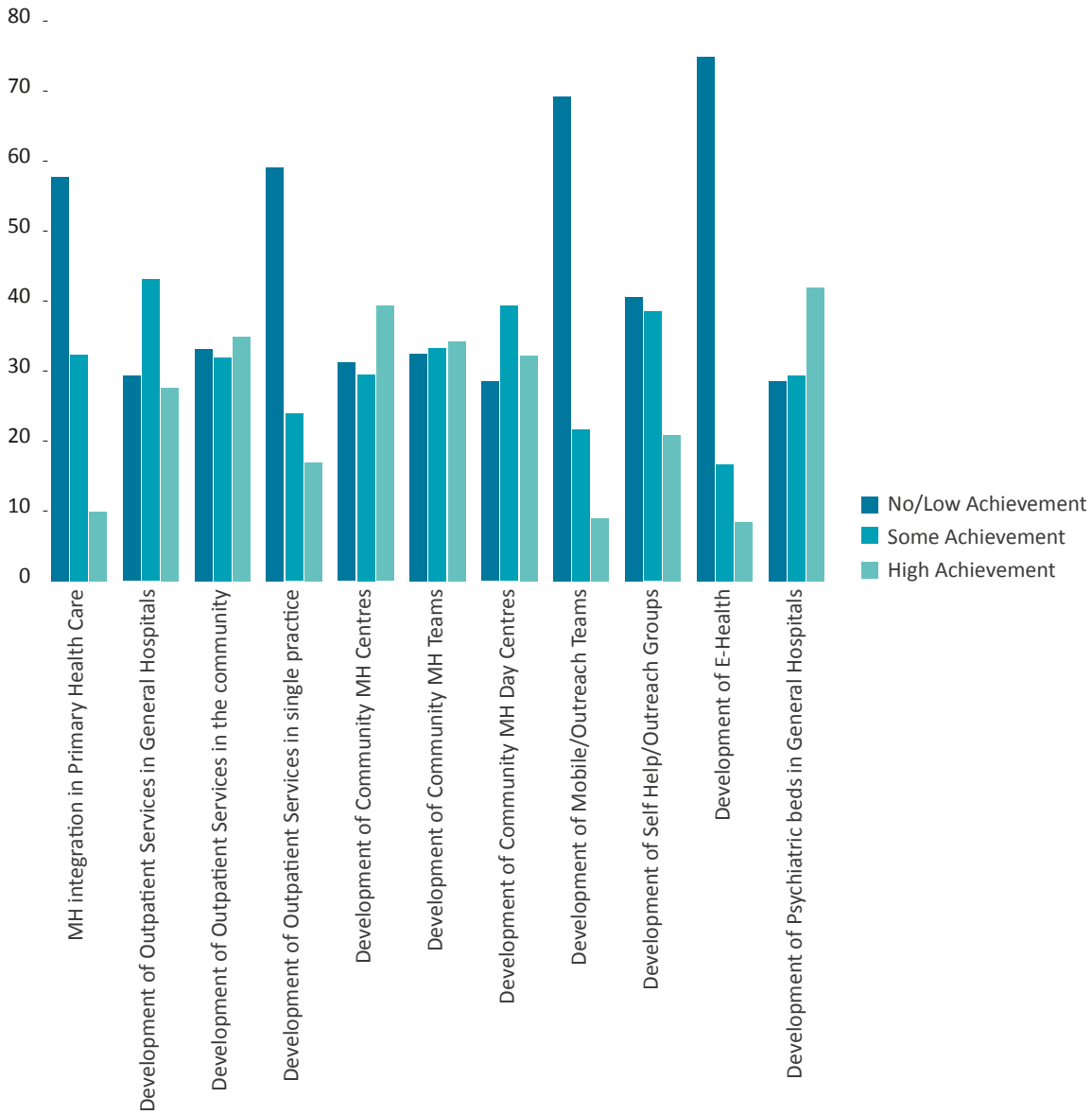
Chart V. 3 shows the extent of achievement concerning mental health service development and organisation for participating Member States. Lower levels of high achievement are found for the integration of mental health in primary health care. This integration is critical for access to mental health services and the treatment of common and/or highly prevalent mental disorders; but was one of the highest proportions for No or Low achievement. This lack of achievement was evident when analysed by mental health service dimensions and in terms of the overall assessment.

The development of services, such as outreach or mobile require health teams and more recently E-Health approaches, that demand more in terms of resources and a culture shift in services, had the highest overall score for No or Low achievement in the transition from institutional to community-based mental health services.

Low scores for the development of self-help and other users groups show that there is a need to promote more self-management approaches, which is another important component of mental health care.

Higher level of achievement was found in the transition process for the development of community mental health centres and teams. Outpatient services in general hospitals and in the community appear to have supported the transition process, along with the development of Day care. The highest achievement score was found for the development of inpatient beds in general hospitals.

Chart V. 3. Achievements in Developing Mental Health Services (%)



Restructuring and closing mental hospitals/psychiatric hospitals hospitals play a vital role in the transition process and the development of new services in the community. This is essential for ensuring a seamless transition process and to guarantee adequate treatment to patients who require highly specialised care; balanced with the vital need to assure the protection of patient's human rights.

Chart V. 4 illustrates how the reduction of beds has been central to the transition process, along with the decision to stop new admissions to mental hospitals/psychiatric hospitals. Less high achievement was found in the reduction of admissions to mental hospitals/psychiatric hospitals.The lowest scores were found for discharge and transfer programmes, perhaps the most challenging aspect of the transition process, although again vital to it.

Chart V. 4. Achievements: Closing and Restructuring mental hospitals/psychiatric hospitals (%)

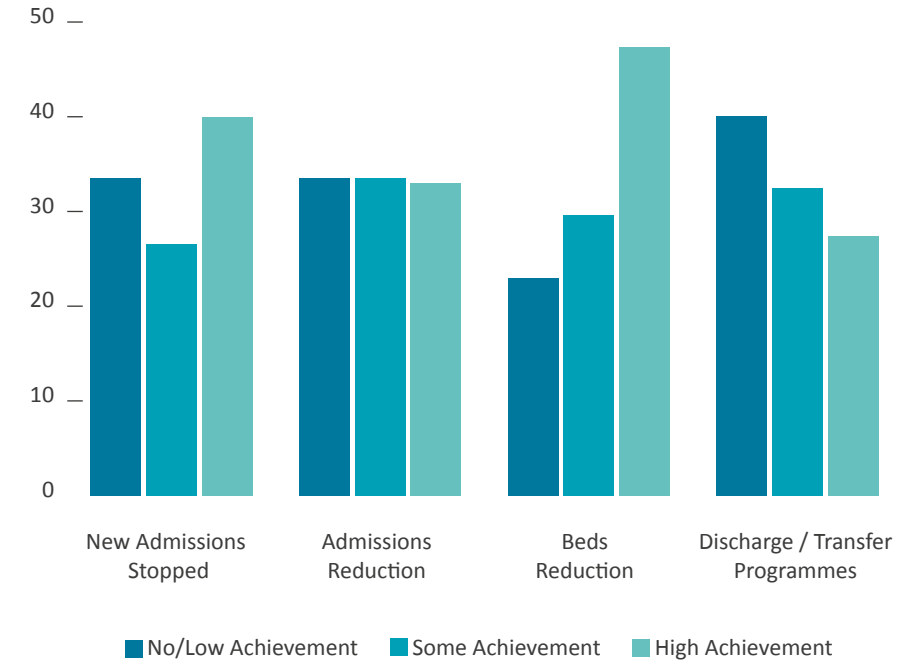


Chart V. 5 shows the final stage of the transition process and quantifies the main indicators of community integration. The highest level of achievement was found for the development of community-based residential alternatives. Scores for vocational and supported employment programmes show the highest level of No or Low achievement within this dimension group and in the process evaluation overall.

Chart V. 5. Achievements in Residential, Vocational and Employment Alternatives (%)

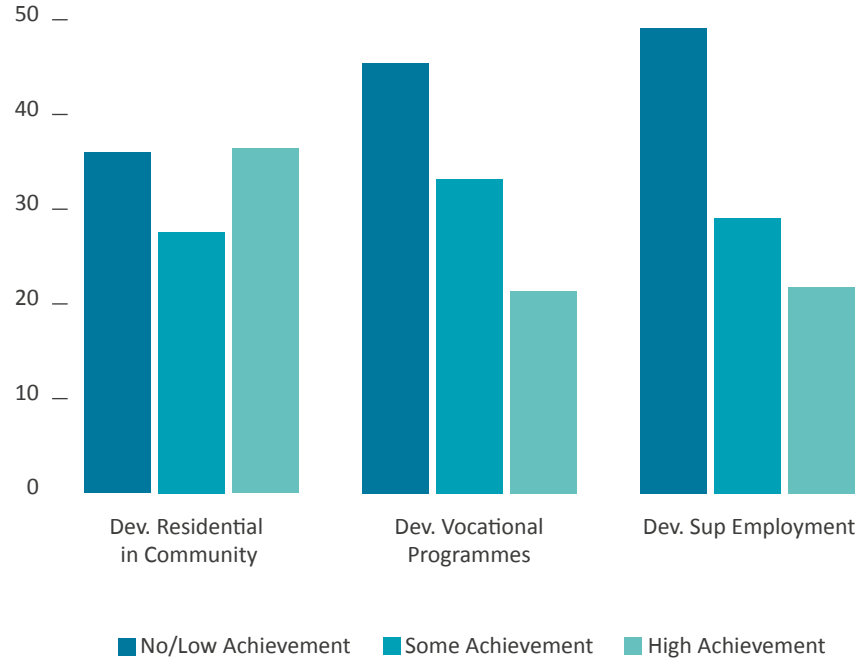
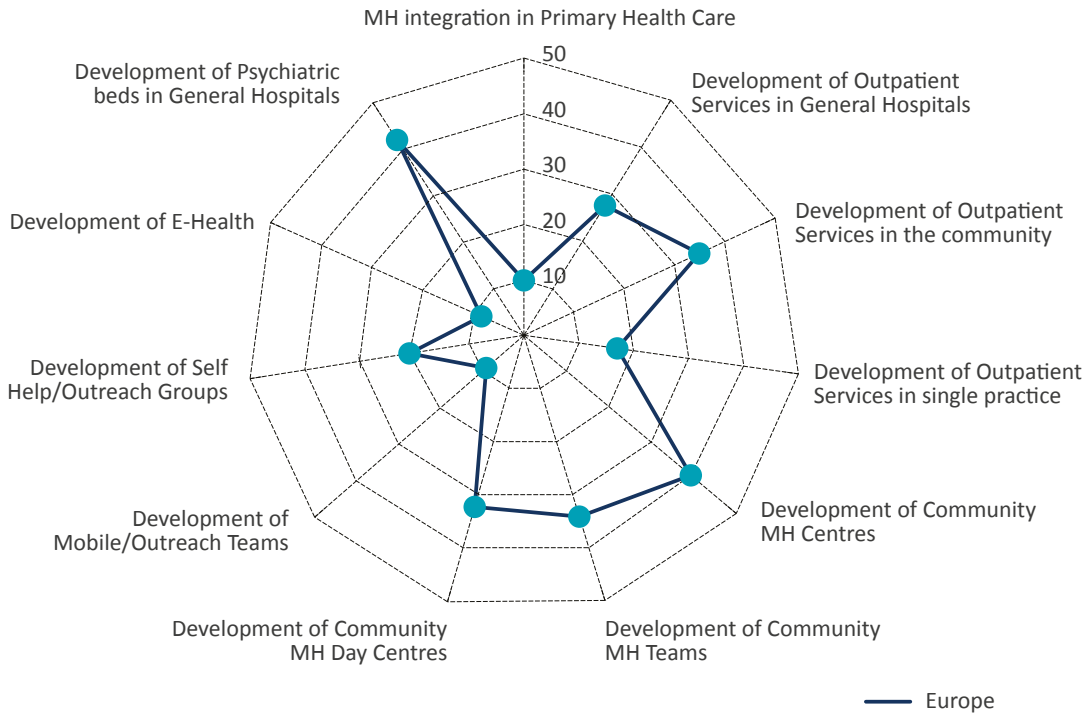


Chart V. 6 provides an alternative visual comparison of the data shown above; where the percentages of high achievement from participating Member States are aggregated into one diagram.

Chart V. 6. Achievements in Europe (% of high achievement)



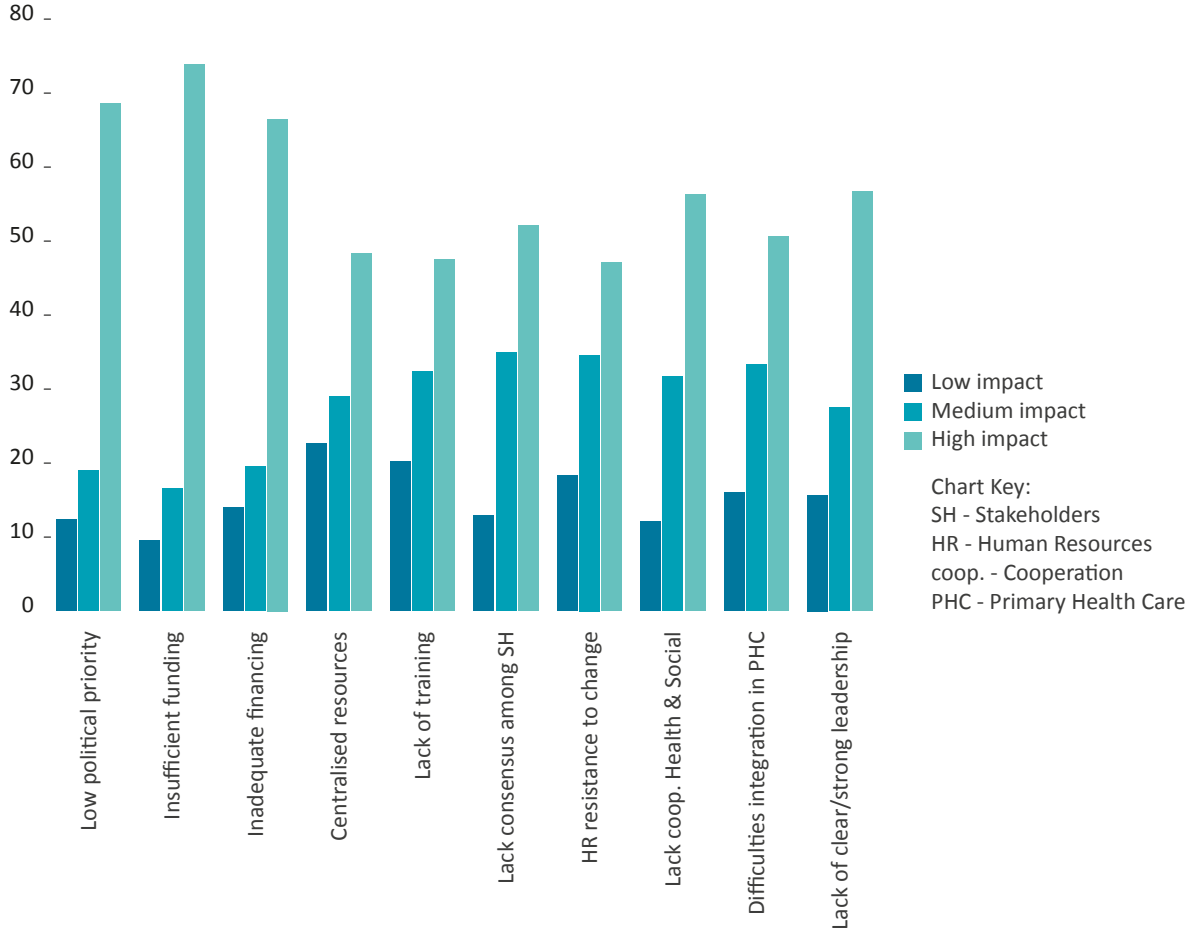
B) BARRIERS IN THE TRANSITION PROCESS

Chart V. 7 outlines the key barriers and their varying degrees to the transition from institutional to community-based care. To aid interpretation, these findings have been divided in three groups. The first, includes the barriers associated with centralised resources, the lack of training and resistance to change. In the past, these barriers have been used to explain the lack of transition; yet here, they are reported to be of low impact (less than 50% in terms of high impact).

The second group, comprises barriers with impact scores of 50% and above. Barriers in this group include the lack of: consensus among stakeholders, cooperation between health and social sectors, clear or strong leadership, and difficulties integrating mental health into primary health care.

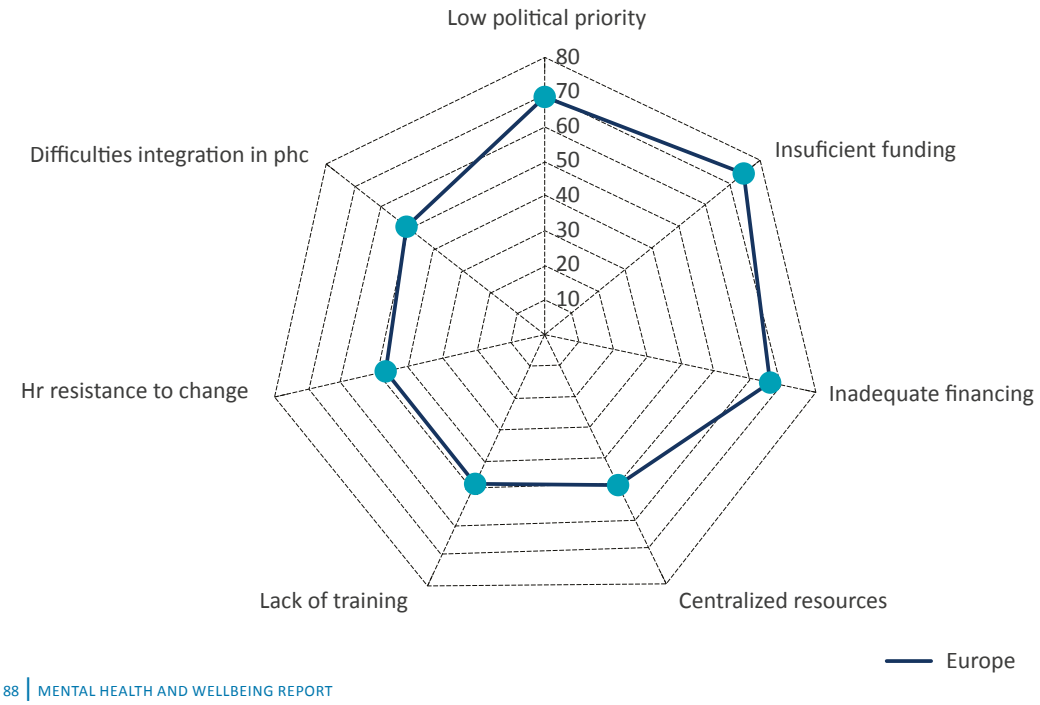
The third group, highlights barriers concerning low political priority, insufficient funding and inadequate funding (with high impact scores of 67% and above).

Chart V. 7. Barriers impacting on the transition process (%)



The same findings are illustrated in Chart IV. 8. This spatial representation shows the percentage of high impact for each of the barriers examined.

Chart V. 8. Barriers impact (% of High Impact)



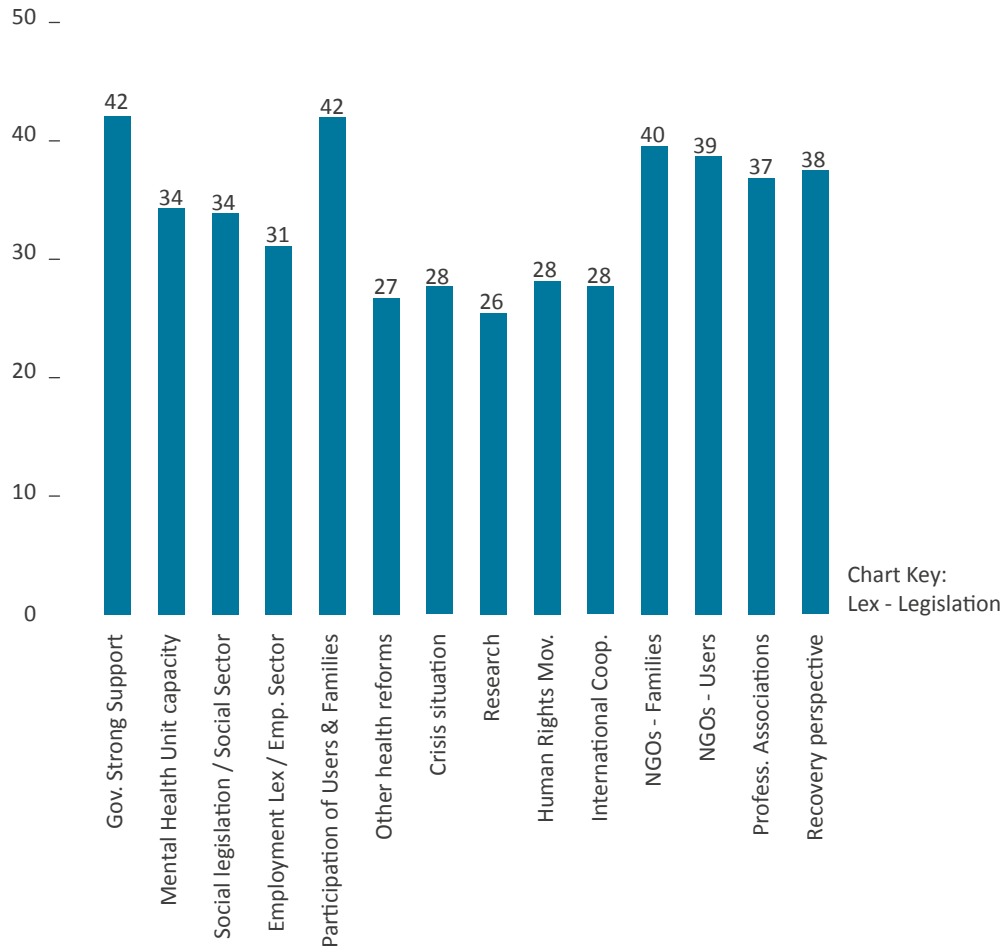
C) FACILITATORS IN THE TRANSITION PROCESS

Some factors were stronger than others in facilitating the transition process (see Chart V. 9). Those with a high impact score below 30% include: other health reforms, crisis situations, research, human rights movement and international cooperation.

Facilitators with a high impact score between 30% to 39% relate to: mental health national unit capacity, legislation from social and employment sectors, users NGOs, professionals associations and the recovery perspective.

Facilitators with the highest impact scores (of 40% and above) include: strong government support, participation of users, families and families NGOs.

Chart V. 9. Facilitating Factors - % of impact rated high



VI. SWOT ANALYSIS

Using a SWOT analysis, the 9 WP5 participanting countries, together with the members of their national network, helped identify the strengths, weaknesses, opportunities and threats in the process of transition from institutional to community-based mental health care for each country/region.

Participating countries discussed and revised the topic of transition using a consensus methodology based on a focus group technique. Perspectives from the different stakeholders within the national networks were carefully taken into account.

Several steps were followed to detail the global SWOT analysis performed. This included: i. a separate analysis of the results of each country; ii. clustering of common dimensions; and iii. within each dimension, clustering of similar examples. Here we describe the aggregated results from the SWOT's conducted by Bulgaria, Estonia, Hungary, Italy, Portugal and Spain.

This global SWOT analysis extends beyond a typical SWOT template and was organized using two levels of data rather than just one (see below). This allows for a more detailed, integrated and comprehensive picture of the data received from the participating countries. The SWOT analysis for each country refers to the transition of the entire mental health system, regardless of the differences found in achievements for that country.

Common dimensions were placed into four external cells and numbered 1 to 4. These cells contain the major areas/topics selected by the 9 WP5 participanting countries (e.g. legislation, human rights, research, training, political agenda, etc.) and subdivided according to SWOT headings (strengths and opportunities, in dark blue; weaknesses and threats, in blue).

The central cells were filled with examples identified by participating countries which related to the above-mentioned major areas. Cell A represents overlapping examples related to strengths and opportunities blue), while Cell D displays the overlapping examples related to weaknesses and threats (light blue).

Table VI. 1. Global SWOT

	Cell 1. Strengths Legislation Organizative models Training Networks User's involvement Innovation Research	**Cell 3. Weaknesses** Service organization models Funding mechanisms Information systems Human resources Professional's attitudes Monitoring / quality Research agenda
Cell 2. Opportunities Human rights context, empowerment Political support of community model Evidence-based interventions Public perception on mental health Inter sectoral cooperation European legislation/financing Crisis - innovative responses New views about chronic disorders EU collaborative research funding	**Cell A** Dedicated legislation Closure of large hospitals Community-based care Liaison with Primary Care Recovery perspective Reduction of stigma Integrative approach Users/families input International partnerships Stronger visibility Quality approach Human rights agenda Epidemiological data	**Cell B** Lack of coordination Regional disparities Biased financing Insufficient facilities in the community Scarce manpower Resistance to change Information systems not reliable Lack of quality culture Lack of monitoring Insufficient research on services research Insufficient impact of users and families
Cell 4. Threats Economical situation in Europe Unemployment and poverty Climate of social instability Aging population Political agenda Budgeting allocation Impact on professional training	**Cell C** Financial crisis Massive budget cuts Lack of accountability Decreased social capital Political priorities (e.g. HIV, unemployment, etc.) Underdevelopment of new MH services Weak social networks Stigma in the population Focus on security policies High impact of the pharmaceutical industry in the training of professionals	**Cell D** Low political support Barriers to implement national mental health plans Risk of failure of reform Fragmentation of MH services Transinstitutionalization Low quality standards Unmet needs for care Patient dropout High burden of carers Professional's burnout

VII. PAST AND UNDERGOING EUROPEAN PROJECTS RELATED WITH TRANSITION FROM INSTITUTIONAL TO COMMUNITY BASED CARE

European perspectives on socially inclusive and community-based approaches in mental health: Contributions from past and ongoing projects.

The role of the European Union (EU) is to complement, support and guide Member States to develop national policies to improve public health. Article 168 of the Treaty on the Functioning of the European Union, for example, outlines a framework for protecting health by promoting research into the causes, treatment and prevention of major health problems.[1] Consequently, many decisions such as closing or reforming psychiatric hospitals are taken at national level. In terms of social policy, the EU and Member States agreed the Europe 2020 strategy, which sets targets for smart, sustainable and inclusive growth. This suggests various activities to support national governments in their actions to promote social integration and fight social exclusion.

National activities in the transition from institutional to socially inclusive and community-based care has made an impact in recent years, and the number of mental health-related activities at European level has increased. These activities add value to the contextual understanding of community-based and socially inclusive approaches at national level.

In 2007, the findings of a large European study funded mostly by the European Commission (EC) were published. The DECLOC report entitled, 'Deinstitutionalisation and community living: outcomes and costs', detailed the status quo of community-based care across Europe and listed several policy recommendations with regards to the transition towards community-based care. Ring-fencing funding allocated to psychiatric hospitals to pay for community-based services was among one of the key recommendations made.[2]

Different organisations at international and European level have assumed the role of donors to support the transition from institutional to community-based care. There is evidence which suggests that when undertaking "concerted efforts and the right investments"[3], international funding can assume a key role in supporting the transition towards community-based care[4].The European Commission has taken on such a role; for example, at the invitation of the Council of the European Union on Employment, Social Policy, Health and Consumer affairs (EPSCO), the EC set up the Joint Action on Mental Health and Well-being under the EU Public Health Programme 2008-2013.

The EC also funds a number of research projects to explore related themes to community care such as integrated mental health systems. One example of this is the COFI project - Comparing policy framework, structure, effectiveness and cost-effectiveness of functional and integrated systems of mental health care.[5]

The importance of considering cost-effectiveness and potential savings needs to be highlighted in debates about necessary reforms; as this forms the basis of an economic case for better public mental health[6].

Crucially important is the protection of human rights and dignity of people with mental health problems. An Explanatory Note from the Council of Europe's Committee of Ministers raises concerns about the failure to provide adequate care to people in psychiatric institutions, highlighting the absence of the "fundamental means necessary to support life (by providing food, warmth and shelter)"[7].

Additionally, a report by the Fundamental Rights Agency (FRA) in 2012 pointed to the extent to which people with mental health problems in the EU receive involuntary admission and treatment in

psychiatric facilities. The report revealed the trauma and fear that people may experience, adding that "the extremely substandard conditions, absence of health care and persistent abuse have resulted in deaths of residents in institutional care"[8].

Commissioning research helps progress the agenda towards developing community care by collecting and disseminating evidence on community-based services, through asking relevant questions such as determining what interventions work for whom and in what setting. Transparent and accessible research helps to create a dialogue between researchers, policy-makers and other stakeholders. Such a dialogue can prepare the ground for making important decisions on service investments and resource allocation[9].

i) Strengthening national and European networks

The European Commission has supported national and European networks to promote the transition towards community-based care and the promotion of mental health and wellbeing. In 2009, Commissioner Špidla of the then EC Directorate General for Employment, Social Affairs, and Equal Opportunities supported the creation of the European Expert Group on the Transition from Institutional to Community-based Care; and issued a report detailing the available technical resources and best practice[10].

In 2014, the European Expert Group (EEG), a group consisting of a number of European networks in social policy and inclusion, staged a number of national seminars across Europe, mostly in Central and Eastern Europe through an EC funded joint action. These seminars involved public and civil society organisations to address the use of EU Structural Funds to promote community-based care[11]. The Networks could also act as facilitators for the process of transition through training opportunities for stakeholders responsible for social care reform[12].

ii) Mapping of resources and practices

In June 2014, the EEG published a revised edition of the 'Toolkit on the Use of European Union Funds for the Transition from Institutional to Community-based Care', which provides an in-depth understanding of the technical requirements for using European funding to develop community-based services for a range of user groups[13]. The European Social Network has also published guidelines for public authorities noting several areas that need to be considered when applying for European structural and investment funds[14].

Best practice examples supporting the transition towards socially inclusive and community-based care have been gathered by different organisations. In 2011, the European Social Network published a report, which highlights various community-based programmes across Europe. One example, the "local psychiatry department" based in Aarhus (Denmark)[15] brings together a range of integrated services, including medical and/or psychiatric treatment. A personal coordinator (or case manager) supports the user to follow a care plan and to access different services. An important feature of this service is that care plans are jointly agreed and reviewed by both the professional and the user. In Ireland, a number of projects have sought to promote cooperation between community stakeholders to deliver better outcomes for users. For example, PROTECT (Personalised Recovery-Oriented Treatment, Education and Cognitive Therapy), a partnership initiative in County Wicklow, develops personal recovery plans for all people diagnosed with a psychotic illness[16].

In the remainder of this chapter we briefly summarise a series of European projects related to the transition from institutional to community-based care. In many ways the projects listed here illustrate the will and commitment from multiple sectors and stakeholders to contribute to the transition process. These past and ongoing projects also show the need to consider a multi-component approach to address the bottlenecks that continue to hinder this process in Europe, from cost-effectiveness to human rights.

iii) Past and ongoing European Projects related with transition from institutional to community based care

The following section provides a brief overview of relevant EU completed or ongoing projects funded by the European Commission.

DEMoBinc/QuiRC

Source: http://www.ucl.ac.uk/quirc/

The Development of a European Measure of Best Practice for people with longer term mental health problems in institutional care (DEMoBinc) was a three year project commissioned in March 2007. The project involved eleven centres across ten EU countries at different stages of deinstitutionalization. The countries involved included: Bulgaria, Czech Republic, Germany, Greece, Italy, Netherlands, Poland, Portugal, Spain and the UK.

The project comprised six phases: 1) identification of the domains of care for inclusion in the toolkit through triangulation of the results from: i) a review of care standards in each country, ii) a systematic literature review of the components of care (and their effectiveness) in mental health institutions, and iii) a Delphi exercise with four stakeholder groups in each country (service users, carers, professionals, advocates) on the aspects of care that promote recovery for people with mental health problems living in institutions; 2) piloting and testing the inter-rater reliability of the toolkit; 3) refining the toolkit; 4) testing the association between toolkit ratings (gathered from the facility's manager) with service users' experiences of care, quality of life, autonomy and markers of recovery; 5) assessing the toolkit's ability to report on a facility's "value for money" through a health economic analysis; and 6) dissemination of results.

The final toolkit developed, QuIRC (Quality Indicator for Rehabilitative Care) is web-based and assesses the living conditions, care and human rights of people with longer-term mental health problems in psychiatric and social care institutions. QuIRC assesses seven areas of care (built environment; therapeutic environment; treatments and interventions; self-management and autonomy; social interface; human rights; Recovery-orientated practice) which are assessed and compared to ratings of similar facilities within the same country.

ITHACA

Source: http://www.ithacastudy.eu/

ITHACA (Institutional Treatment, Human Rights and Care Assessment) aims to document the range of experiences of people with mental illness across Europe and identify current processes and activities which lead to positive therapeutic experiences and areas for improvement. The project is funded by the European Commission and organised by mental health professionals, lawyers, service users, researchers and social scientists. The project Recommendations for institutions and governments will be made, which will also highlight abusive practices.

This project commenced shortly after the United Nations adopted the Convention on the Rights of Persons with Disabilities (CRPD) in December 2006. The convention signals a paradigm shift in the position of those living with physical and mental disabilities, where people with disabilities have guaranteed rights and are key actors in the system, rather than passive recipients of social welfare and support.

ITHACA includes a collaboration of 16 organisations to produce a monitoring toolkit based on the CRPD. The toolkit will provide information on monitoring practices, explain appropriate human rights literature and conventions and outline audit/monitoring procedures for an on-site visit. A team of auditors will observe the physical environment, note the quality of care received by service users, conduct

interviews with residents, staff and institution directors, and examine relevant documentation. The data/information collected from site visits will be compiled into reports for people involved at all levels of mental health care, from service users and family members to support/care staff and government officials. The findings from these visits will be used by local and international advocacy groups as evidence for lobbying and initiating change within the systems which produce human rights violations.

ROAMER

Source: http://www.roamer-mh.org

The ROAMER project (A Roadmap for Mental Health Research in Europe) aimed to establish the research priorities for mental health and well-being. Over three years the project aimed to create a coordinated road map for the promotion and integration of mental health and well-being research across Europe.

The key objectives were to:

- Develop an accurate picture of the state-of-art in mental health and well-being research in Europe;
- Analyse gaps and advances in order to establish priorities and infrastructure and capacity requirements for mental health and well-being research in Europe in the short, middle and long-term, and as applicable across the life course;
- Involve Europe's leading scientists in a collective endeavour to prioritise research in their field;
- Fully engage with key non-academic stakeholders in mental health and well-being research, including funders, policy makers, professionals, end users, carers and family members;
- Help to close the gap between science and society; and
- Inform the public about the importance of mental health and well-being research, and launch the definitive roadmap.

The project was based on a sound, pragmatic and comprehensive methodological approach and conceptual framework that covers the full spectrum of mental health and well-being, including biological, psychological, epidemiological, public health, and social and economic factors. ROAMER included a consortium of renowned mental health research scientists, with extensive stakeholder involvement.

REFINEMENT

Source: http://www.refinementproject.eu

With a focus on the ways in which mental health care is financed, the REFINEMENT (Research on Financing Systems' Effect on the Quality of Mental Health Care) project aims to analyse financing and systems of care, together with their correlated outcomes across nine different EU countries. The project applies a mix of quantitative and qualitative analyses covering the principal social welfare and health care-financing models for mental health in Europe.

The REFINEMENT project will produce several new tools so that researchers, service planners and policy makers between regions and countries can adequately compare 'like with like'. These include: a toolkit for mapping services for general/specialist health and social services; a mental health care financing toolkit to identify, collate and analyse data and information available from disparate and fragmented sources (through a template for the collection of additional data on innovation and methodological development, a protocol and guide for semi-structured interviews with relevant stakeholders, a manual and glossary); and a decision support toolkit to aid decision-makers select health care financing arrangements to achieve objectives concerning equity, efficiency, responsiveness to needs and quality of care.

The core objectives are to:

- Map and describe the characteristics (including incentives) of financing systems for mental health care;

- Describe the outcomes of mental health services, including quality of care relative to differences in mental health financing;

- Describe typical pathways through the health and social care system by people with mental health needs, relative to differences in mental health financing;

- Build a series of health care financing models conducive to the promotion of high quality mental health care associated with better outcomes;

Mental Health Economics European Network (MHEEN)

Source: http://www.herc.ox.ac.uk/research/MHEENandMHEENII

The purpose of the MHEEN (Mental Health Economics European Network project is to analyse the barriers and incentives to improving mental health systems, estimate cost-effectiveness of mechanisms and strategies to promote good mental health, and to assess mental health service utilisation and costs through a 32 country partnership coordinated by the London School of Economics and Mental Health Europe. Initially, the Network comprised 17 countries and was expanded during the project's second phase (MHEENII).

During MHEEN's first phase between 2002–2004, the aims were to develop frameworks and connections that would allow relevant economic data to be identified and collected across the 17 countries. It was hoped that information and indicators could be pooled and compared to improve understanding of how mental health systems might be developed. The second phase of the project involved detailed comparative analyses across EU countries of primary mental health economics data between 2005 and 2007.

Other analyses conducted by the Network included the economic aspects of deinstitutionalisation of mental health care services and the economic evidence relating to mental health promotion strategies. The project developed and employed a tool for assessing resource allocation and service utilisation at local level across Europe.

DECLOC

Source: http://www.kent.ac.uk/tizard/research/DECL_network/Project_reports.html

Again drawing on the available information, the DECLOC (Deinstitutionalisation and Community Living – Outcomes and Costs) project gathered information on the number of disabled people living in residential institutions in all European countries; and the largest study of its kind. The aim was to identify successful strategies for replacing institutions with community-based services, paying particular attention to economic issues in the transition process.

The project was funded through the Community Action Programme to combat discrimination and developed to reinforce the European Union's capacity to anticipate and manage change, acting as a catalyst to bring about policy developments contributing to the elimination of discrimination on the grounds of disability.

The project was carried out by a consortium of partners drawn from across Europe, supported by a Reference Group and links with existing scientific networks.

The objectives of the project were to:

- Collect, analyse and interpret existing statistical and other quantitative data on the number of people with disabilities placed in large residential institutions (institutions where more than 30 people live, of whom at least 80% were disabled), including the type of disabilities concerned, the age and gender of

residents, the nature of the services received and the number, type and qualification of staff involved, in all European countries.

- Analyse the economic, financial and organisational arrangements necessary for an optimal transition from a system of large institutions to one based on community services and independent living, using three countries (England, Germany and Italy) as case studies to illustrate the issues involved.

- Report on the issues identified in the first two objectives, in a form suitable for stakeholders and policy-makers, together with an executive summary targeted at the general public that can be incorporated into the second regular report of the Commission on the situation of people with disabilities.

Common European Guidelines on the Transition from Institutional to Community-based Care

Source: http://deinstitutionalisationguide.eu

As initiated by Commissioner Špidla of the then EC Directorate General for Employment, Social Affairs, and Equal Opportunities, the Common European Guidelines on the Transition from Institutional to Community-based Care ('the Guidelines') provide practical advice about how to make a sustained transition from institutional care to family-based and community-based alternatives for individuals currently living in institutions and those living in the community without adequate support.

The Guidelines are based on European and international best practice and were developed in consultation with key European networks representing children, people with disabilities, mental health organisations, families, older people and public and non-profit service providers. Senior public servants from several countries and a number of European Commission officials, have also been consulted to ensure that the Guidelines respond to needs at a grassroots level. A range of professionals with expertise in all aspects of the transition from institutional to community-based care were also consulted.

European Network on Independent Living / European Coalition for Community Living Report

Source: http://www.enil.eu/news/is-the-european-union-competent-to-ensure-access-to-independent-living/

This report considers the action taken by the European Union (EU) to implement the rights of people with disabilities under Article 19 (living independently and being included in the community) of the UN Convention on the Rights of Persons with Disabilities (CRPD). The report seeks to provide the CRPD with relevant information to assess the extent to which the EU has complied with its obligations set out under Article 19. It does so by considering the initial EU report to the CRPD Committee, Report on the Implementation of the UN Convention on the Rights of Persons with Disabilities (CRPD), by the European Union ("the EU report") and providing comments under the following four broad areas:

1. Ascertaining the extent of the EU's obligations under the CRPD.

2. Understanding the current situation of people with disabilities living in the EU.

3. Using Structural Funds to promote independent living.

4. Promoting personal assistance as an essential element of independent living.

Under each of these areas, key issues of concern are identified and discussed. They are followed by a set of proposed questions, which the CRPD Committee may wish to raise with the EU when considering the EU's compliance with the CRPD. The two specific areas – the use of "Structural Funds" (European Structural and Investment Funds) to promote independent living and the promotion of personal assistance as an essential element of independent living are the focus of this report. These areas are considered crucial to the work that must be undertaken by the EU to enable people with disabilities to exercise their right to independent living.

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VIII. KEY FINDINGS AND POLICY RECOMMENDATIONS

Community-based mental health care is a well recognized approach to addressing effectively and efficiently the challenges associated with the burden of mental disorders and promotion of mental health in the population. A strategy to shift away from a traditional model of care based on large psychiatric institutions to more community-based services is therefore essential.

Benefits of community-based mental health care

There are several reasons why the development of community-based mental health services is central to improving mental health systems. Community care contributes to improved access to services, enables people with mental disorders to maintain family relationships, friendships, and employment while receiving treatment, so facilitating early treatment and psychosocial rehabilitation[1].

Community mental health care is associated with continuity of care, greater user satisfaction, increased adherence to treatment, better protection of human rights and helps prevent of stigma[2].

Community mental health care aids the establishment of a structured collaboration with primary health care services, which plays an important role in the identification and treatment of people with mental disorders. These collaborative models of care are particularly effective in the treatment of people with mental and physical comorbidities[3].

The high levels of disability frequently associated with severe mental disorders can negatively impact on the ability to work, manage home life, social activities and maintain personal and social relationships[4]. Mental health care therefore must essentially include psychosocial rehabilitation; involving social skills and vocational training, employment support, and supported accommodation where needed. Community-based services facilitate close coordination between health and social care services and other services, such as the employment sector, to provide important social and vocational support, particularly for people with severe mental disorders.

Critically, community-based services are more able to protect the human rights of people with mental disorders, provide recovery-oriented approaches, and support and empower them to make decisions affecting their lives.

Community-based services also allow for the development of multifaceted approaches that aim to prevent mental disorders and promote mental health; areas that are crucial for further development in order to address the large and persistent treatment gap for mental disorders. Specialized mental health services in the community, particularly those with multi-disciplinary teams, can provide an important basis for the development of effective prevention and promotion programmes in a given population. Such community services can help establish important partnerships between mental health and primary care professionals, schools, work places, NGOs, and other key agents in the community that are crucial for the successful delivery of prevention and promotion programmes.

More recently, community-based mental health services have encouraged active participation of people with mental health problems in the planning and delivery of mental health services. This lived experience of mental health problems is also an important asset for supporting the prevention of mental health problems and in the promotion of mental health in populations.

Over the past few decades a great deal of effort has gone into reforming mental health systems and services and to ensure high-quality long-term care for people with severe mental disorders. These reforms have helped to advance and vastly improve mental health care in many EU countries. Improvements have been made to the living conditions in mental hospitals/psychiatric hospitals, the development of community services, the integration of mental health care within primary care, the development of psychosocial care (for example, supported housing and vocational training), the

protection of the human rights of people with mental disorders and the increasing participation of users and families in the improvement of policies and services[5]. A growing evidence base provides an important guide to investing in appropriate systems of community based mental health care.

Further developments and advancements are needed

The benefits and strong arguments in favour of community-based mental health care and the considerable commitment and investment made so far towards this are clear. Despite this, the literature review in Chapter III shows that much more remains to be done if we want to provide accessible, effective and high quality community-based mental health care across Europe to those who need it. The reality in many, often low income countries, is that people with mental disorders continue to reside in large mental hospitals/psychiatric hospitals or social care institutions with poor living conditions, inadequate clinical assistance and frequent human rights violations[5]. In some countries, although progress has been made in the transition from psychiatric hospitals to community care, the resources allocated to the new services are very limited, leaving the psychosocial needs of people with mental disorders being largely unmet. For countries where the process of deinstitutionalisation is complete, there are also concerns about the increase in "reinstitutionalisation" (in hospitals and community-based nursing and residential care homes) of people with longer-term, more complex mental health needs and those with a "forensic" history[6].

A key goal of the Joint Action for Mental Health and Well-Being workgroup was to develop recommendations for action at EU-level and in Member States that could lead to more effective implementation of community-based mental health systems and services. To reach this goal, we analyzed the situation of community-based and socially-inclusive approaches to mental health in EU countries, particularly in WP5 countries. This was conducted through a review of the literature, analysis of both existing data and new data specifically collected for this purpose, identification of good practices and a SWOT analysis.

Key findings include:

- Deinstitutionalisation and the development of community based care is accepted by more than half of EU countries as a major goal of their mental health policies. Seventeen of the EU countries state in their policies the intention to transfer of services and resources from mental hospitals/psychiatric hospitals to community based mental health facilities. This is even more marked in participating countries involved in the workgroup, where the development of community mental health services is made explicit, while downsizing large psychiatric hospitals is featured in all but two policies.
- Access to care in community settings is also included in the legislation of most of the 9 WP5 participanting countries. It should be noted however, that while all these countries have policies/plans or legislation specifying that people with mental disorders should have access to specialist mental health care and rehabilitation services in the community, more specialized interventions, such as early interventions or assertive outreach interventions, are not specified in a small minority.
- Many countries have developed or initiated some type of mental health reform in the last few decades. Of the 9 WP5 participanting countries, only one has not engaged in any reform. The other countries, with the exception of one, have developed their reforms both before and after 1998. We should emphasise that all countries initiating reforms had some formal plan of reform; and almost all had a mental health policy unit responsible for the development of the reform.
- Most countries have undergone significant transformations in psychiatric hospitals. However, large variations in the number and size of psychiatric hospitals exist between countries. The closure and downsizing of psychiatric hospitals was more notable prior to 2005 than in the period after this date. Most countries with psychiatric hospitals registered some degree of improvement in the quality of care provided, the physical environment, and respect for human rights.

- Psychiatric hospitals for a number of countries continue to play a central role and consume the vast majority of resources allocated to mental health care. However, for some countries, hospitals are no longer used or have no more a central role in the mental health system. In 2011, most of the EU countries continue to have psychiatric hospitals. The number varies enormously between countries. Italy, Sweden and the UK have closed all or the majority of their psychiatric hospitals. Between 2005 to 2011, around a third of the EU countries maintained or increased their number of beds in hospitals, a third made some reduction, and a third made significant or very significant reductions.
- The reduction of beds in mental hospitals/psychiatric hospitals, and the transfer of patients to community services and residential facilities have played a key role in most countries, followed by the prohibition of new admissions.
- The involvement of different stakeholders in planning deinstitutionalisation has increased. Prior to 1998 the majority of countries failed to involve users and families/caregivers but this has since increased.
- Despite many significant advances in the development of community care across Europe, community-based service networks have only partially been developed in most countries, with many not introducing timely transfers from traditional services to community based systems of mental health care.
- Substantial advances have been made in the development of short-stay inpatient care in general hospitals. Beds in community-based facilities, including general hospitals, have become an important part of the mental health systems in most of the EU countries. However, for the majority of countries, this development does not mean that acute inpatient treatment has ceased in mental hospitals/ psychiatric hospitals.
- Although in a less systematic way, residential facilities in the community, designed to offer a home environment to people with severe mental disorders who are unable to live entirely independently, have also increased significantly across many EU countires. In some countries, however, these patients have also been transferred to large residential facilities replicating the institutional models of psychiatric care.
- The number of outpatient facilities and outpatient interventions has increased in most countries. This is especially evident between 1998 and 2012. Community mental health centres have also increased significantly in the majority of EU countries.
- Few EU countries offer home treatment and community-based rehabilitation. Of the 21 countries for which information is available, only 8 countries provide access to home treatment to more than 50% of people with mental disorders; and 5% ensure access to 21-50 % of the population. Access to community-based rehabilitation is better but remains limited. Of the 20 countries with reliable information, only 12 offer access to community-based rehabilitation to more than 50% of the people with mental disorders.
- Primary mental health care also remains very limited in many countries, particularly in relation to severe mental disorders. In all 9 WP5 participanting countries the identification and referral from primary care to specialist services for people with severe and enduring mental disorders is indicated in policy and practice. However, treatment for the same disorders is not included in policy/legislation or in practice for the large majority of countries. It should be noted that, in 2012, national guidelines for key mental health conditions in general/ family practices were Not applicable for half of EU countries.
- Almost all 9 WP5 participanting countries have review bodies to assess the protection of human rights protection of mental health service users. However, such inspections are not conducted on a regularly basis; and for many countries users and carers are not represented in these review bodies.
- Relevant stakeholders from participating countries perceived a hierarchy of achievements which indicated progress towards community care. The highest level of the development was inclusion of inpatient beds in general hospitals, followed by the development of outpatient services in general

hospitals and in the community, day care services and community mental health centres. By contrast, the services that were perceived to be less well developed included primary mental health care, followed by the development of outreach or mobile mental health teams, E-Health and self-help and other users groups.

- Perceived achievements were highest for residential alternatives in the community, while vocational and supported employment initiatives were considered of low achievement or non-existent.
- The largest barriers to transferring to community based care included low political priority, and insufficient and inadequate funding. This was followed by the lack of consensus among stakeholders and cooperation between health and social sectors, difficulties with integrating mental health into primary health care, the lack of clear or strong leadership, training and resistance to change.
- Facilitating factors considered to have the highest impact included strong government support, participation of users and families and NGOs. This was followed by having a national mental health coordination structure, legislation from social and employment sectors, lobbying from service user NGOs, professionals associations and recovery-oriented perspectives.

Policy recommendations

According to the situational analysis presented in this Report the process of deinstitutionalization and the development of community-based care have been adopted as major mental health policy goals for more than half of EU countries. In some countries, mental hospitals/psychiatric hospitals have lost their central role, but for many these hospitals remain a dominant feature of mental health care and consume the majority of resources allocated to mental health. Significant advances across Europe have been made in the transition from institutional to community-based care for people with long-term mental disorders. However, progress has been very uneven across countries and for many there is still much to be done to create community-based mental health service networks and to provide good quality and socially inclusive care.

Although policies and services addressing the needs of people with long-term mental disorders are primarily the responsibility of Member States, a common European framework for action can strengthen synergies between relevant areas associated with the improvement of mental health care and social inclusion of people with long-term mental disorders. This framework for action can support Member States review their policies and share experiences in improving policy efficiency and effectiveness through innovative approaches, whilst taking into account specific needs at local, regional and national level.

Therefore, the Joint Action for Mental Health and Wellbeing recommends that Member States develop and implement policies and services to address existing insufficiencies and gaps in European mental health care systems, to promote community-based care and the social inclusion of people with long-term mental disorders. To achieve this we recommend the following principles, strategies and actions:

A. PRINCIPLES

1. Protection of human rights: People with mental disorders should be protected from all types of discrimination and stigmatisation, and their rights respected, including the right to good quality care, accommodation, employment;

2. Accessibility and equity: People with long-term mental disorders, regardless of their place of residence, social and economic circumstances, gender or race, should have access to affordable quality care and social inclusion support;

3. Recovery: Mental health services should support and encourage self-determined and personalised care for people with mental health problems, including how to build and maintain a meaningful and satisfying life and live well regardless of their symptoms and vulnerabilities;

4. Care in the community: Care of people with mental disorders should be provided in the least restrictive environment possible and hospitalization should only be considered when all community treatment alternatives have been exhausted;

5. Coordination and integration of care: Mental health care in each catchment area must be coordinated and integrated so as to facilitate continuity of care and prevent fragmentation of services;

6. Participation of users and families: People with mental disorders should be more actively involved in the planning and development of services that they receive. Family members of people with mental disorders should be considered as important partners in the provision of mental health care, encouraged to participate within it and to receive the training and education if needed;

7. Involvement of all the community: All key agentes of the community (e.g. municipalities, social, education and cultural associations, NGO's, self help groups), should be actively consulted and involved in the planning of mental health care activities.

B. INTEGRATED STRATEGIES AND ACTIONS

1. Generating political commitment for mental health system development

Over the last 20 years significant efforts have been made across Europe to encourage national and international political leaders to focus more attention on community-based mental health care and the social inclusion of people with severe mental disorders. However, more remains to be done. The fundamental political, legal and technical elements required to ensure the successful transfer from institutional to community-based mental health care has been very limited. Policy makers and public opinion in some countries have still to recognise the real importance of implementing community-based care. Therefore, concerted actions must be taken in order to generate a stronger and deeper commitment from influential decision-makers (through public statements of support for mental health systems reform), accompanied by a clear institutional commitment and adequate financial support to implement this reform (allocation of the necessary funds to realise the expressed intent).

1.1. Gathering information

Recommended actions:

- Develop advocacy initiatives to generate political commitment, based on information that can demonstrate to policy makers why they should make a commitment for action;
- Map the key decision makers who can play a significant role in the process of change we are promoting, and collect all available information about the organizations that should be approached and invited to become partners.

1.2. Building networks

Recommended actions:

- Involve all relevant stakeholders - professionals, users and families, healthcare and other sectors, governments and civil society, along with other relevant stakeholder organisations - in actions that mobilise the transition to community-based mental health care, both at local, national and international level.

1.3. Building capacity

Recommended actions:

- Develop capacity among leaders in mental health and other relevant stakeholders involved in mental health policy and service implementation;
- Encourage collaboration, particularly between leaders in mental health, to promote new training programmes, provide ongoing support and supervision in the development of mental health policy and services at national and international levels.

1.4. Development of communication strategies

Recommended actions:

- Develop effective communication strategies that help persuade relevant stakeholders to take action;
- Develop key messages that highlight the importance of severe mental disorders and social determinants of mental-ill health, making people aware of the urgent need to develop policies that can decrease the economic and social costs of mental disorders and reduce the existing treatment gap.

2. Developing or updating mental health policies and legislation

Many countries still lack clear legislation and policy that stipulate the shift towards community-based care. Similarly, they make no reference to the principles of recovery-oriented approaches or take into account the implications of the Convention on the Rights of People With Disabilities (CRPD).

Recommended actions:

- Generate discussion and build consensus, at EU level, on the impact of CRPD on mental health legislation;
- Monitor the implementation of mental health policy across the EU;
- Where necessary, promote the revision and updating of mental health legislation, taking into account the principles of recovery and recommendations from CRPD;
- Encourage and promote the revision and updating of mental health policy, based on human rights and the available evidence in countries where this is needed;
- Include actions within legislation and policies that aim to ensure their effective implementation at all levels.

3. Mobilising the shift from mental hospitals/psychiatric hospitals to a system based on general hospitals and community mental health services

There is broad consensus on the need to shift from institutional care to a system that relies predominantly on community-based services, where mental health is integrated within general health care, both at primary and secondary care levels.

According to the World Health Organization's "pyramid of care", formal community-based mental health services, in conjunction with mental health services in general hospitals, have a central role in the improvement of mental health care (WHO, 2003).

Close co-ordination of health and social care services, together with the involvement of employment agencies, are required to ensure that comprehensive psychosocial rehabilitation is provided to people with severe mental disorders.

To achieve this, well-coordinated strategies and actions should be developed, simultaneously at national and European level, in order to:

3.1. INTEGRATE MENTAL HEALTH INTO PRIMARY HEALTH CARE

Recommended actions:

- Enhance the training curricula for all primary care personnel, in order to improve recognition and management of common mental disorders in primary health care.
- Promote liaison of primary health care workers with mental health specialists to encourage a two-way referral process and offer supervision where necessary;
- Promote research and dissemination of collaborative and stepped-care models between primary and specialist mental health care.

3.2. SHIFT THE LOCUS OF SPECIALIZED MENTAL HEALTH CARE TOWARDS COMMUNITY-BASED SERVICES

Recommended actions

- Develop and establish a community mental health team for a defined catchment area, whose size and skill should be determined taking in consideration WHO reccomendations and available resources. Where these are limited a core minimum team should be established;
- Promote liaison of community mental health teams with primary health care services and coordinate with other services providing rehabilitation programmes in the same catchment area;
- Organise and reallocate resources, both human and financial, away from mental hospitals/psychiatric hospitals to community services;
- Promote the active involvement of users and carers in the delivery, planning and reorganization of services;
- Develop evaluations and share best practices of specialized community mental health programmes in Europe;
- Promote co-ordination of care and effective follow-up of discharged patients in order to ensure continuity of care.

3.3. ESTABLISH OR INCREASE THE NUMBER OF MENTAL HEALTH UNITS IN GENERAL HOSPITALS

Recommended actions:

- Promote policies and legislation that promote and implement the integration of inpatient treatment of mental disorders in general hospitals;
- Link beds with a defined catchment area;
- Increase knowledge and understanding of mental health disorders among relevant general hospital personnel in an attempt to reduce stigma, discrimination, anxiety or misconceptions regarding people with mental disorders;
- Promote liaison and coordination of inpatient psychiatric units with existing community mental health teams in the same catchment area.

3.4. PROMOTE A COORDINATED TRANSITION TOWARDS COMMUNITY-BASED CARE, ENSURING THE IMPROVEMENT OF QUALITY OF CARE AND THE PROTECTION OF HUMAN RIGHTS ACROSS ALL PARTS OF THE SYSTEM

Recommended actions:

- Monitor and substantially improve the quality of care and respect of human rights for people who continue to reside in mental hospitals/psychiatric hospitals, abolishing any practices that involve physical restraints;
- Reduce and ultimately cease admissions to psychiatric hospitals from areas served by community mental health services and/or general hospital psychiatric units;
- Progressively reduce the number of beds available in psychiatric hospitals as admissions to these are reduced;
- Assess and prepare people moving from psychiatric hospitals to the community and ensure they receive sufficient care to support their needs in the community;
- Promote the participation of primary care in mental and physical treatment of people with severe mental disorders;
- Create/strengthen integrated and comprehensive community-based services for each catchment area, according to local and national needs;
- Develop facilities and programmes that have so far been underdeveloped in many EU countries, such as integrated programmes with case management, outreach or mobile mental health teams, E-Health, self-help and users and carer groups;
- Improve the use of European Structural and Regional Development Funds as part of a programme of deinstitutionalisation, so that mental hospitals/psychiatric hospitals are closed and community mental health services are developed to replace them.

3.5. ENSURE THAT COMMUNITY PSYCHOSOCIAL SUPPORTS ARE AVAILABLE FOR PEOPLE WITH SEVERE MENTAL DISORDERS

Recommended actions:

- Develop structured cooperation between mental health services, social services and employment services, to ensure that community-based residential facilities, vocational programmes, and other psychosocial rehabilitation interventions are available;
- Establish minimum quality standards and continuity of care across all relevant community services.

3.6. DEVELOP COMMUNITY-BASED SERVICES AND PROGRAMMES FOR SPECIFIC POPULATIONS

Recommended actions:

- Develop rehabilitation oriented forensic services;
- Develop child and adolescent mental health services;
- Develop programmes for vulnerable groups (e.g. homeless people with severe mental health problems).

4. Improve the use and effectiveness of mechanisms to monitor the implementation of mental health reform

Evidence shows that poor implementation of recommended mental health actions is associated with a lack of commitment by policy makers and other relevant stakeholders, inadequate resources being allocated to mental health, resistance to innovation, inadequate coordination of strategies concerning financial, organizational and human resource issues and failure to integrate mental health into other policies. Within this context, specific strategies and actions are needed to tackle these barriers:

4.1. IMPROVE GOVERNANCE ARRANGEMENTS

Recommended actions:

- Strengthen the structures responsible for the implementation of mental health strategies at national, regional and local levels, ensuring they are equipped with the necessary technical resources and have sufficient decision making capacity to implement strategies effectively, particularly where they involve complex organisational, financial and human resource issues;
- Develop the capacity of mental health leaders to mobilise and steer the implementation of mental health policies;
- Strengthen existing expert advisory boards and creating new ones - as part of further policy development and the implementation process - ensuring all relevant stakeholders are involved, including users and families.

4.2. ENSURE RESOURCES ARE USED ADEQUATELY AND EFFICIENTLY TO ADDRESS NEEDS AND DEVELOP COMMUNITY-BASED SERVICES

Recommended actions:

- Develop efficient mechanisms for funding mental health services that are commensurate to the needs of the population, including incentives that promote the development of community-based care;
- Promote actions that ensure the efficient use of available resources and those to be reallocated from mental hospitals/psychiatric hospitals to community-based services.

4.3. PROMOTE COOPERATION BETWEEN HEALTH AND SOCIAL, HOUSING, EMPLOYMENT, EDUCATION AND ALL RELEVANT SECTORS

Recommended actions:

- Gain consensus among relevant stakeholders to establish the priorities and policies for mental health;
- Increase cooperation between health and social care sectors to prevent the risk of trans-institutionalization and fragmentation of care;
- Promote the participation of users and families in mental health, taking steps to support carers in their role as caregivers.

4.4. STRENGTHEN THE USE OF EVIDENCE-BASED APPROACHES

Recommended actions:

- Strengthen cooperation between policy makers and researchers in the development of evaluations to assess the effectiveness of policies, services and interventions for people with mental disorders/ problems;
- Develop and improve information systems to collect and aggregate data and promote the use of existing data to monitor the impact of policies and services focused on the transition from mental hospitals/psychiatric hospitals to community-based care.

5. Promote the use of relevant EU instruments

Recommended actions:

- Use the opportunities provided by the EU 2020 Strategy to improve the monitoring and evaluation of policies addressing the social inclusion of people suffering from mental disorders;
- Strengthen synergies between relevant EU policies, particularly those relating to human rights, social justice, employment, education, research and social support;
- Maximise the use of relevant EU financial programmmes, especially EU Structural and Investment Funds, to support the deinstitutionalisation and social inclusion of people with long-term mental disorders;
- Strengthen european networks that may contribute to the implementation of mental health policies;
- Support the appropriate use of instruments and toolkits developed by EU projects that aid the evaluation and quality assessment of mental health services;
- Use the opportunities offered by Horizon 2020 to promote research on deinstitutionalisation, community services and social inclusion, in close cooperation with the ROAMER project.

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IX. ANNEXES

Annex 1. Swot analysis for 9 WP5 participating countries

BULGARIA

INTERNAL	
STRENGTHS	WEAKNESSES
1. Community-based care is spread widely across Europe and Bulgaria is following examples of good practice. 2. Availability of standards of care, guidelines and algorithms. 3. International support is available through experts, projects, donor initiatives. 4. Improved quality of care. 5. Reduced number of relapses.	1. There are no tangible EU recommendations regarding steps towards deinstitutionalization. 2. Lack of common indicators that could reflect the situation in different countries. 3. International experiences are not always applicable or transferable to other countries. 4. Lack of quality control and feedback after deinstitutionalization. 5. Due to stigma, some patients still prefer institutional- rather than community-based care. 6. Information systems are insufficient to track the deterioration of some disorders.

EXTERNAL	
OPPORTUNITIES	THREATS
1. The process of adapting national policies using EU Mental Health Policy and Plan guidelines. 2. More efforts in developing indicators, including country-specific ones. 3. Exchanges of European expert opinion and experience. 4. Establishment of a reliable system of follow-up and intersectoral cooperation between services. 5. Strengthening user movements and empowerment. 6. Facilitating deinstitutionalization by providing strong arguments for reform.	1. The gulf between Bulgaria and Western European countries may become wider and could jeopardize the overall process of transforming mental health services. 2. Lack of confidence among professionals and society regarding the messages for psychiatric reform. 3. Lack of mutual understanding between experts and professionals involved. 4. Deteriorated quality of services resulting in a loss of confidence in clients. 5. Failure of reform and return to the model of institutional care. 6. Inability to communicate the achievements of the model of community care to families, professionals and civil society.

ESTONIA

INTERNAL	
STRENGTHS	WEAKNESSES
1. System more focused on customers. 2. Involvement in the community, improvement of the contacts. 3. Increase of social solidarity. 4. Reduction of stigma. 5. Faster recovery with appropriate support services. 6. The recovery perspective and positive practice are showing that deinstitutionalization is possible. 7. Development of effective community based services: daily support, supported living, working and living in community. 8. Economic benefits for the society.	1. The number of people living in institutions has increased (when compared to 1992, 1998 and 2008). 2. Community care is financed several times less than institutional care. 3. Local governments have no interest (or not able) to pay for community-based services or housing. 4. Deinstitutionalisation and living in the community is not considered an objective. 5. Community-based services are not supported by other existing public services, namely support services. 6. Lack of services: support services, crisis teams, nursing services and home visiting teams. 7. High levels of poverty in the target group creates housing needs, which are not met by local governments. 8. Policy and legislation prevent independent living. 9. Complex family relationships contribute to relapse. 10. Stigma is high, which prevents involvement, community support and employment. 11. Some professionals are not aware of the recovery process and not able to support it. 12. Special welfare and psychiatry are poorly linked together. 13. Infrastructure for community-based services is very limited or non-existent.
EXTERNAL	
OPPORTUNITIES	THREATS
1. Larger communities (towns) are not disturbed by people with mental health problems. 2. Growing cooperation between psychiatry and social welfare. 3. EU budget period allows investments into community-based services (including housing). 4. Development of crisis teams (ACT) that can refer patients to hospital or provide treatment at home. 5. Development of individual case management services, targeting patients with several unmet needs. 6. Increased role and impact of home visiting. 7. Development of day-treatment facilities with comprehensive treatment (e.g. supported training/ employment) for young patients. 8. National campaigns to reduce stigma, raising awareness about the potential of recovery. 9. Update of current treatment guidelines, with links to social issues. 10. Partnerships with NGO's	1. Development of old-fashioned facilities (isolated villages, facilities in mental hospitals/psychiatric hospitals and beds in large psychiatric institutions), instead of deinstitutionalisation into new nursing homes. 2. Difficulties placing patients in the community housing due to stigma. 3. Social workers, rehabilitation teams, professionals, family members, related service providers, local governments do not support community-based services and prefer institutional care. 4. More severe punishments. For example, if a person spends their entire pension on shopping or fails to pay their rent they may be sent to a special care home. 5. Mental disability does not receive enough attention, because the services and the financing are the same as for mental health problems. 6. Risk of becoming excluded because of stigma and poverty. 7. High pressure for local services regarding housing. 8. As the community does not provide support, the families often have to manage alone and without any support from services. 9. Deinstitutionalization may increase homelessness among the person with mental health problems.

HUNGARY

INTERNAL	
STRENGTHS	WEAKNESSES
1. Committed, well-trained professionals. 2. International relationships. 3. Psychiatric Nursing System providing national coverage. 4. Psychiatrists from hospitals are more involved in outpatient work. 5. Collective thinking involving other sectors. 6. Growing social support. 7. Existence of some good practices, integrating social and health dimensions. 8. Since 2008, only two large psychiatric hospitals remain. 9. Psychiatric hospital admission in general hospitals has been available for some time. 10. Psychiatric training includes theory and practice of community psychiatry.	1. No specific legislation or budget is available for community psychiatric care. 2. Financial context does not allow for the transition process. There are no rules regarding the establishment, place and role of community mental centres within mental health care. 3. Insufficient and dysfunctional cooperation between social and health systems regarding community psychiatric care. 4. Social and health sectors have different regulations, management and directing bodies. 5. Lack of comprehensive guidelines regarding the transition. 6. Scarcity of human resources – including a small number of psychiatrists and experienced social workers in community psychiatry. 7. Community psychiatric care is limited in rural areas, a lack of infrastructure, professionals and funding.
EXTERNAL	
OPPORTUNITIES	THREATS
1. Supporting community-based care instead of the institutions by reforming the financing of mental health care. 2. The high number of psychologists should be involved in community psychiatric care. 3. Training opportunities (community psychiatry and psychotherapy) directed to social workers and psychologists. 4. Until a legal framework is established, mental health coordinators should be employed within psychiatric departments to coordinate mental health and social care at local level. 5. Cooperation between civil organizations, social services and mental health services to establish and maintain the community-based mental health care.	1. Degradation of the nursing network without the integration of community social care. 2. Scarcity of professionals due to the migration of psychiatrists. 3. Psychiatric inpatient care on its own is not able to address mental health needs without the recruitment of the community psychiatric care. 4. Tensions between the health and social sectors.

ITALY

INTERNAL	
STRENGTHS	WEAKNESSES
1. "Front door" policy adopted by the reform law enacted in 1978, which prohibited all new admissions to psychiatric hospitals. 2. Psychiatry fully integrated within the National Health System, which has placed community care within its general priorities. 3. General universal welfare policy which has been followed for more than three decades. 4. Large amounts of social capital in most Italian communities. 5. Psychiatric issues, have until recently remained high on the political agenda.	1. Lack of national coordination and planning, due mostly to devolution policies adopted after 2000. 2. Devolution of financing decisions to regional governments. 3. The policy of integrating public and private providers within a publicly funded mental health care system, but few managed to coordinate and steer it, while others simply financed services without careful planning. 4. Universities, with few noticeable exceptions, have played a minor role in training, research and evaluation of service developments and management.
EXTERNAL	
OPPORTUNITIES	THREATS
1. A national information system for psychiatric services will soon cover all public and private services. 2. Differences between regional systems are a good opportunity for benchmarking. 3. Current economic constraints call for stronger service coordination and definitions of minimum and quality service standards. 4. Carers' participation in national and regional policy has been influential, and importance of users' movements has grown. 5. Mental Health care professionals are mostly women. This may produce a system of care which is more welcoming and less confrontational.	1. Much of the traditional social capital has been eroded and social inequalities have increased. 2. Turnover of staff is now blocked for four years for financial reasons. Producing innovations with older professionals may become difficult. 3. Regional administration may be tempted to react to the financial crisis by strengthening emergency services and costly hospital and residential facilities. 4. In a climate of social instability, there may be political call for more secure and repressive psychiatric policies, and/or more assertive attitudes by judicial authorities towards mentally ill offenders and on psychiatrists to control patients' behaviour. 5. Mental health care has been overshadowed in the political agenda by other urgent social issues.

PORTUGAL

INTERNAL	
STRENGTHS	WEAKNESSES
1. Legislation and mental health plan. 2. Expertise in developing plans and policies for mental health. 3. Well trained mental health professionals. 4. Dynamism of NGOs. 5. Partnerships (public, private, NGO). 6. Liaison with Primary Care. 7. International partnerships. 8. Knowledge and scientific evidence. 9. Involvement of users / families; 10. Successful case studies; 11. Motivation of some professionals; 12. Role of the International Master / NOVA Medical School; 13. Strong focus on values (human rights, autonomy, citizenship).	1. Excessive centralization. 2. Resistance to change (professionals, users, families, others). 3. Hospital-centred model. 4. Lack of coordination among caregivers. 5. User Associations lacking influence. 6. Monitoring services is hardly implemented in practice. 7. Stigma. 8. Low priority of care for vulnerable groups. 9. Lack of identity and capacity for mobilization and coordination between relevant stakeholders; 10. Few mental health professionals. 11. Weak social networks. 12. Tendency towards transinstitutionalization. 13. Intermediate management (services and teams) still weak and powerless. 14. Inadequate use of information systems. 15. Quality assessment and monitoring still not widespread in routine practice (satisfaction, outcomes, indicators, impact).

EXTERNAL	
OPPORTUNITIES	THREATS
1. International experiences. 2. Links with national/international programmes for chronic health problems. 3. Research (Joint Action and other projects). 4. Epidemiological data on mental health. 5. New advances in IT. 6. Crisis of the current scientific paradigm regarding mental health. 7. New partnerships. 8. Coordination with local municipalities. 9. Functional integration with different providers (formal or informal). 10. Legislative guidelines from international bodies (WHO, EU). 11. EU external financing (structural funds); 12. Economic crisis. 13. Crisis and flexibility, innovative responses.	1. Political uncertainty. 2. Economic crisis, unemployment. 3. Funding model and management. 4. Hospital-centred funding model. 5. Lower funding of general hospitals with a community focus. 6. Asymmetries in number and qualification of human resources. 7. Resistance to implementing the national mental health plan. 8. Transinstitutionalization. 9. Disarticulation between information systems at different levels. 10. Lack of accountability. 11. Cultural barriers. 12. Stigma.

SPAIN

INTERNAL

STRENGTHS

- The General Health Law supports the Community Care.
- The Mental Health Strategy of the National Health System .
- Comprehensive mental health plans of the Autonomous Regions (CCAA) are aligned with the national strategy.
- Centralized bodies are within each CCAA to plan, manage and evaluate mental health.
- Extensive portfolio of services.
- Unique and wide mental health network integrated into the Public Health System, with a range of accessible facilities.
- Generalization of the model of Community Care:
- Progressive deinstitutionalization.
- Development of inpatient psychiatric units in General Hospitals.
- Multidisciplinary teams with community vision.
- Rehabilitation units and residential facilities.
- Experiences of continuity of care, case management, assertive treatment, home care, supported employment, etc.
- Specific services for children, adolescents and other groups.
- Sectorised organization (by territory).
- Integration of health promotion and prevention in the health network.
- Experience, consolidated in some CCAA, of liaison with Primary Care, social services, education, media etc.
- Experiences, consolidated in some CCAA, of integrated care processes, process management, clinical management areas, etc.
- Increased response capacity of Primary Care.
- Accredited clinical practice guidelines.
- Progressive introduction of the electronic case records for clinical history.
- Progressive orientation towards recovery approaches.
- Large and consolidated user and family movements.
- High degree of consensus between all social stakeholders.
- Extensive public awareness.
- Highly trained professionals.
- Specific postgraduate training for residents in psychiatry, psychology and nursing.
- Professionals are motivated and committed to the model of community care.
- Ongoing training of professionals.
- Funded medications.
- Family structured caregiver.
- Good public-private partnerships.

WEAKNESSES

- Tendency towards service fragmentation, which has increased intensity in recent years.
- Scarce funding in relation to the epidemiological research, particularly social and health dimensions.
- Significant regional disparities in resources, finance, functional
- dependency and community services.
- Low morbidity attended from actual morbidity .
- Network not entirely oriented to people´s needs.
- The existence of a parallel network which is not integrated to many CCAA for addiction and dual diagnosis issues and limited residential resources for these conditions.
- Dispersed population which limits the implementation of home care, continuity of care and access to day treatment facilities and community rehabilitation units.
- Variations in clinical practice due to insufficient implementation of clinical practice guidelines and evidence-based procedures.
- Insufficient development of:screening programmes
- care for common mental disorders in primary care
- early intervention in severe mental disorders
- methods and community intervention programmes
- continuity of care
- programs for children, adolescents and the elderly
- attention to groups of population at risk or in marginalization
- -exclusion (especially homeless and prison populations)
- psychological interventions evidence- based.
- Prison health has limited connection to the mental health network.
- Precariousness of programmes and protected job opportunities.
- Insufficient post-hospitalization or intermediate resources, such as day hospitals, residential facilities, housing, home care, etc.
- Long-stay beds in public and private psychiatric hospitals.
- Insufficient regulation of the criteria for provision of public services by private companies and not aligned with the Strategy for Mental Health.
- Areas with scarce specialized resources.
- Scarce interdepartmental health care resources, where some rehabilitation services in hospital facilities are far from the community.
- Admission units in general hospitals without adequate spaces and outdoor areas.
- There are three remaining prison psychiatric hospitals in Spain.
- Weak coordination with Primary Care, Social Services, Education and Justice.
- Insufficient coordination between psychiatric services and psychosocial Teams.
- Lack of promotion and prevention in mental health, including the Initiatives in the workplace.
- Insufficient information system for planning, monitoring and evaluating care and services. Lack of balanced scorecard.
- No full implementation of the electronic case record systems.
- Limited development of research in psychiatry and mental health.
- Insufficient involvement of users (patients) in the design and evaluation of services.
- Insufficient training programmes for patients and families included in services.
- Scarce funding and support for patient organizations in some territories.
- Little support for carers and families who have taken the brunt of care required by the reform processes.
- Specialty in mental health not always integrated to the rest of medicine, and sometimes stigmatized within the profession.
- Conflict and ambiguity of roles within teams.
- In general, insufficient human resources with a high percentage of temporary contracts.
- Increasing staff ‘burn out’ due to limited resources, working conditions, etc.
- No regulation of specialized formal training in some professions, especially nursing.
- Recovery oriented approaches is not taken on by professionals or included in training. A biomedical model still predominates.
- Lack of adequate leadership in some services or areas.
- Resistance to change by managers and professionals

SPAIN

EXTERNAL	
OPPORTUNITIES	THREATS

• The current economic crisis is an opportunity to innovate new models of care and implement more efficient management, including the development of community care.
• National, European, and regional (CCAA) regulation development related to mental health: UN Convention of Rights of Persons with Disabilities, WHO Global Plan and European Mental Health, etc.
• Proceedings of the WHO and the European Commission (including funding).
• Participation in European projects.
• Legislative actions that allow the integration of substance abuse in integrated mental health networks.
• New view of the chronicity, paradigm of recovery, strategy for chronic conditions.
• Emergence and growth of new technologies (information, telemedicine) and technical resources for health education and control and monitoring pathologies (school for patients).
• Progressive decrease of stigma of mental illness. Increasing involvement of society in mental health care: civil society more organized, user organizations, Volunteering etc.
• Prioritizing neuroscience in research, development and innovation plans, at national and European level.
• The technological and scientific development opens new ways for innovation and attention to mental Health.
• New generations of professionals trained in the community care model.
• Decentralized political and administrative model.
• Role of the media and social networks.
• The Mental Health Strategy of the NHS as an opportunity to:
  • facilitate sharing views of the various sectors involved
  • strengthen, consolidate, promote and harmonize all CCAA policies that influence the development of mental health services.
  • evaluate the positive and negative effects of the reforms so far followed
  • establish comparison-contrast studies in different
  • services and CCAA, with different strategies and measures
  • study:
  • the factors associated with discrimination problems, access to services by population groups
  • the articulation of inpatient and outpatient services
  • the relationship with social, educational, forensic and justice.
	• The economic crisis and budget adjustments:
	  • closure of services and reduction of places
	  • difficult to adopt measures that have been proven effective in other countries
	  • increased mental pathology due to the economic situation.
	  • drug co-payment
	  • impoverishment of patients and families
	• Aging population increases chronicity
	• Prosecution and criminalization of mental illness and dissent
	• Claudication of the family caregiver and change of its caring model
	• Excessive delegation of citizens in the government to solve social and health problems.
	• The consumer culture displaced to the use of services and the use of psychotropic medication
	• Competitive and individualistic culture may increase stigma, exclusion and discrimination against vulnerable groups.
	• A significant proportion of professional training is funded by the pharmaceutical industry, that can influence the creation of social expectations for the exclusive reliance on psychotropic medication.
	• Over medicalization of treatments.
	• Increased substance abuse.

Annex 2. Good practices

ITALY

I - Personal health budget (PHB)

Community treatment and psychosocial rehabilitation programmes for people with severe mental illness usually provide a range of interventions which are often standardised and delivered by qualified staff (e.g.: home visits, day-care centres, supported employment). Personal needs and goals may differ substantially to what can be achieved through standard interventions. This can lead to disempowerment and demotivation in users, as their treatment plans are driven by the service organisation rather than their own needs.

PHB is a system of planning, financing, implementing and evaluating personalised treatment plans. Individual plans are made jointly by professionals, the user and all relevant stakeholders who contribute to his/her recovery. All those involved draft and sign a contract in which they state their commitment to reach specific rehabilitation goals and estimate the amount of financial resources needed to achieve these. A personal budget is allocated to the user who can use it freely to buy goods (e.g. a car or a computer) or services (e.g. contracting staff from a list of private or voluntary sector providers to support home or community activities). The personalised plan is implemented and evaluated jointly by all stakeholders.

PHB has been piloted in the Friuli Venezia Giulia region since 2004 and implemented extensively in Campania. It is now regional policy in Emilia-Romagna. It appears to avoid re-institutionalisation in residential facilities and promoted individualised home support required by single patients and helped organise personal responses to any difficulties with living in the community. This personalised approach has also been useful in moving patients from residential facilities with 24/7 cover to supported housing. Any rehabilitation plan which addresses problems with housing, employment or social activities may find this approach beneficial. PHB is gaining the interest of most administrations because it allows the best possible use of resources, using them with the maximum of flexibility and involving also the user's personal resources and motivation.

II - Individual Placement and Support

Individual Placement and Support (IPS) is a psychosocial intervention designed to help people with psychiatric disabilities obtain and maintain competitive jobs in the labour market. IPS is well recognised as an evidence-based intervention. Seventeen randomised controlled trials demonstrate its effectiveness compared to other vocational rehabilitation approaches. The bulk of this evidence comes from the USA, where the scheme was developed and first implemented. Over the past decade, increasing international interest has developed in IPS, prompting a growing body of research.

Rimini (in the Northern Italian Region of Emilia-Romagna) was one of the six European sites involved in the EQOLISE study, which demonstrated that IPS can be replicated in the EU.

IPS has been practiced in Rimini since 2003 with around 300 users benefiting from it; where approximately 45% of whom were employed at any one time. Based on the successful use of IPS in Rimini, the region of Emilia-Romagna in 2008 decided to incorporate IPS within its policy and financed a programme to promote it throughout its DMHs. By 2010, 13 of 41 CMHCs in the region offered IPS to their users. Again about 50% of whom gained work and around 40% of users were working at any one time (Fioritti, personal data). Currently, 16 regional CMHCs offer IPS and the IPS regional team has actively engaged in training for staff in three other regions (Lombardy, Lazio and Sicily) which recently started offering IPS in pilot centres. The same team is also attempting to build up a European network of IPS centres.

III - No-restraint General Hospital Psychiatric Wards

Although Italy has one of the lowest rates for formal compulsory admissions in Europe (12 per 100,000 population per year), levels of perceived, informal and formal coercion within psychiatric units is under explored.

In Italy seclusion is not practiced, but physical restraint is quite common. Public opinion was shocked by the deaths of a few inmates' while restrained at their bed and a movement of professionals, users and lay people began advocating for its prohibition. Restraint is now prohibited in Friuli Venezia Giulia and in around one in ten wards in other regions. Some wards have gone further and adopted "no restraint and open door" wards. Becoming a no restraint ward means changing the ward organisation, building strong personalised relationships with patients during admission and having a daily schedule of activities (groups, reading, sessions etc.).

No restraint wards appear to have much better outcomes in terms of engagement with subsequent outpatient care.

IV - Mental Health and Substance Abuse Department

The integration of mental health and substance misuse services is a challenging issue in community psychiatry. Problems arising from providing parallel or sequential treatments for dual diagnosis patients are well known; usually they fare worse where services have no integrated philosophies and plans.

In 2006, the region of Emilia-Romagna reorganised its community services and established a Department of Mental Health and Substance Abuse in all of its 11 Local Health Trusts. Further legislation helped remove all administrative barriers to accessing mental health or substance abuse facilities for people requiring care by one of the two services. This facilitated collaboration, an exchange of expertise and the development of specific programmes and pathways dedicated to patients with dual diagnosis.

These innovations appear to have produced better outcomes for patients and greater confidence in professionals. To date the region of Liguria has also established these integrated departments.

PORTUGAL (I)

(A) Title

"Organisation of a Local Mental Health Service in the Famalicão Mental Health Unit of Médio Ave Hospital Center (UF-CHMA), based in an assessment and planning cycle."

(B) Introduction

UF-CHMA was integrated within a general hospital and began offering in October 2009 outpatient, liaison psychiatry, home visits, acute inpatient and emergency services (Oporto emergency room) to a population of 130.000 inhabitants. The team includes three psychiatrists, one child psychiatrist, three psychologists, one nurse

and a social worker. Since starting, the service has used a cumulative record or case-register of all users which includes socio-demographic and clinical information.

The development of this local service was based on a systematic needs assessment, using the following information:

1. Epidemiological data about local needs including: characteristics of the municipality population (via a social and local health profile), preliminary results of a nationwide epidemiological study of mental disorders, treatment gaps and international data about the impact of mental disorders; and

2. Data on service use: information obtained from the case register (on outpatient and inpatient use) and findings from studies concerning service dropout and patient satisfaction.

(C) Implementation

Given the known barriers to accessing care, initial outpatient visits were conducted at home, depending on the clinical circumstances.

Since May 2012, post-discharge consultations provide follow-up care with a maximum of 15 days after discharge. This helps ensure continuity of care which is delivered by the same team that managed the patient's inpatient care.

Annual awareness sessions are conducted with staff at the primary health care unit and comprise two major themes:

1. Referral criteria and the best approaches for severe mental disorders; and the

2. Use of treatment algorithms for common mental health disorders.

High dropout rates for outpatient treatment are often considered an indicator of reduced continuity and quality of care. To overcome this barrier a simple procedure was created to promote adherence to treatment including:

- Scheduling the first consultation following acute admission within a maximum period of 15 days after discharge and with the same mental health professionals responsible for inpatient treatment.

- An automatic rescheduling of one missed appointment and after two missed appointments a third contact is made to schedule a home visit.

A similar procedure is used when patients miss an appointment for depot treatment.

(D) Outputs and Results

An assessment of dropouts was conducted initially, covering all first contact patients with the unit between October 2009 and July 2011. Dropout was defined as a unilateral cessation of treatment by the patient (no-show for the follow-up visit) and without further contact with the service within six months. A total of 512 patients and 57 dropouts were identified (11.1% of the sample).

A second study was carried out to calculate readmission rates at 30 days and 1-year after discharge from first admission to hospital. This was also based on the existing case-register data between January 2010 and August 2012. The rate of readmission within 30 days after discharge was 6.6% and 21% within 1-year. These readmission rates are relatively low when compared to results from similar studies; and may be associated with improvements in the quality of mental health services and the effectiveness of informal care.

A third study focused on users' and carers' satisfaction of services. This confirmed the numerous barriers to accessing to care, including the costs associated with transportation, the long distance from outpatient clinics and the waiting time for a first appointment. Also, carers felt unsupported by their social network and had particular concerns about the accessibility to care, but rated their satisfaction with services highly.

A final study examined adherence to a first outpatient appointment. This retrospective study looked at all first contacts between January 2012 and July 2013. A key finding showed that 21.9% of patients did not attend their first consultation. Marital status (being single), diagnosis (having a Mood-Disorder) and waiting time were correlated with the lack of adherence. The main reason for not attending a first consultation was illness, but there was a high percentage of patients who did not receive communication about a rescheduled appointment. The vast majority rescheduled the missed appointment. At this time, the waiting list for first consultation is 14 days.

(E) Lessons learned

- What worked well?

Data from population surveys and the systematic evaluation of care enabled the unit to focus more on patients' real needs and less on the services they are supposed to deliver.

Procedures to reduce the loss of contact with patients after discharge and missed outpatient appointments allowed the team to continue the follow-up of patients with severe illness and increase carers' satisfaction with services.

Links with primary care reduced waiting lists by focusing on delivering care for the severe mentally ill on time.

The organisation of mental health services varies between countries and between different types of services within the same country. The results of this study are not generalisable to different settings or different types of services. It is important therefore to clarify that the unit from Famalicão is a local mental health service integrated within a general hospital, which helps reduce the stigma associated with receiving psychiatric care.

- What did not work so well?

Meetings, as part of the liaison process with primary health care, were not attended by all physicians; and so should have been framed within the context of mandatory training.

The allocated number of first appointments (six per week, per doctor), brought two difficulties: the increased workload as the number of new patients discharged from hospital grew making this difficult to manage (given the 20% discharge rate); and the subsequent difficulty of rescheduling outpatient appointments.

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PORTUGAL (II)

(A) Title

Mental health integration in the primary health care (Local Mental Health Unit - Matosinhos)

(B) Introduction

The Local Health Unit (LHU) from Matosinhos includes one General Hospital and four Local Health Centres with primary health care units located in the Oporto region.

The Department of Mental Health is integrated in the LHU and comprises one Psychiatric Service, one

Children and Adolescents Mental Health Unit and one Department of Psychology. The team includes five psychiatrists, three child psychiatrists and seven psychologists.

The department was created in 2009, and has been implementing a strategy defined annually by the National Mental Health Programme, which foresees the progressive integration of human resources needed in the Department to provide mental health care to a population of about 170.000 inhabitants, in 2016.

The care transition process, from the Psychiatric Hospital Magalhães Lemos (HML) to the LHU, relies on a protocol established in January 2010 with the HML, which defined the referral pathways to care, both to HML and LHU, according to the diagnosis made by a GP. On January 2013, the protocol was revised, and the LHU Department assumed responsibility for all psychiatric referrals for adults and children/ adolescents in the catchment area. The LHU became responsible for monitoring the ambulatory care of any person who had their first contact with the psychiatric inpatient unit from HML, including those with severe mental illness.

Strategic objectives

Decentralise mental health care, ensuring a proximity approach with patients and caregivers in the hospital and primary care settings;

- Integrate Liaison Psychiatry in the General Hospital;
- Organize the activity of Psychiatry in relation to two major diagnostic groups: common mental health disorders (with monitoring in the primary health care settings, by GPs or psychiatrists on a weekly basis), and severe mental illness (with monitoring in the general hospital, in appropriate facilities and communicated to relevant clinics, e.g. the depot clinic and in close cooperation with the specialised mental health nursing teams).
- Develop a model of communication between the Psychiatry, Child Psychiatry and Psychology services, leveraging synergies and different professional backgrounds;
- Integrate Child Psychiatry within the hospital and in primary health care services, through advisory and consulting activities.

Note: we will report the liasion of mental health services with primary care globally (children/ adolescents and adults) .

(C) Practice Implementation

Access to mental health services is for all those referred by a GP. GPs can also make referrals to a clinical psychologist, but requires further validation. If more information is needed a psychology triage will be scheduled, to clarify whether the person will benefit from this psychotherapeutic intervention.

No referral for depression should be made by the GP before using the intervention algorithm taught in the ‘Course for Diagnosis and Treatment of Depression in Primary Care’. This covers diagnosis, medication type or dose and review times to assess treatment response.

GP referrals are made formally via the ALERT P1 system. All referrals are subject to a joint assessment by the GP and the Psychiatrist to determine the best treatment options, including:

- For a common mental health disorder: the GP will monitor and follow-up patients with suggestions regarding medication made by the psychiatrist. Referrals can additionally be made to psychology, psychoeducational or self-help groups based within primary health care centres.
- For severe mental illness: a referral must be made to a psychiatrist in the general hospital and further referrals can be made (e.g. for psychoeducation for both patients and their families).

(D) Results - Outputs

This goal has not been achieved as yet because the model assumes that psychiatrists appointed to each health center, should be present at the weekly PHC meeting discuss referral therapeutics and other matters arising.

These meetings provide other family doctors to become involved in the process, particularly those who are less familiar with the model of mental health care and more resistant to change. The purpose of the meeting is not to discuss individual cases nor to refer new patients, which must be done through the formal processes described above.

An initial finding from this practice was the improvement of GPs' skills to better diagnose and treat the majority of patients with common mental disorders. GPs have also become better at detecting depression early and optimising health care for depressed patients and utilising suicide prevention approaches.

A further finding of this practice was an increase in the availability of psychiatrists to treat serious mental illness and more severe common mental disorders.

(E) Lessons learned

- What worked well - which facilitated this?

The eight hour training course in 'Diagnosis and Treatment of Depression in Primary Health Care', was held on January 2013. This was delivered by psychiatrists specifically trained for this purpose. The course was attended by 105 GPs;

A refresher course that was subsequently held in October 2013 and will take place at least once a year;

The weekly presence of the same psychiatrist at the designated Health Center for a period of at least 10 hours, who also attends prearranged consultations;

Weekly email reminders to GPs, sent when liaison with psychiatrists is due; and subsequent to this so the GP can follow the guidelines registered in the information system.

- What did not - why did not work?

The model still lacks an adequate number of psychiatrists. Seven are required to ensure the sustainability of all these levels of articulation between the Mental Health Department and the PHC Centres, particularly during periods of leave (e.g. because of sickness, maternity etc.).

(F) Conclusion

The organisation of the LHU helps triage access to secondary and tertiary levels of mental health care. This ensures optimum use of resources (particularly at a time of national budget constraints), the prioritisation of mental health interventions for severe conditions and promotes GP empowerment in the treatment of common mental health disorders in primary care.

PORTUGAL (III)

An integrated comprehensive community-based mental health service serving a Lisbon catchment area

Introduction

The Department of Psychiatry of the Hospital Fernando Fonseca (DP-HFF) was created in 1996 with the objective of offering comprehensive integrated community-based mental care health care to the population of a catchment area of 350,000 inhabitants that includes the Municipality of Amadora and part of the Municipality of Sintra.

The Department main goals were to ensure promotion of mental health, prevention and treatment of mental disorders, and rehabilitation and social reintegration of people with mental health problems, through the development of an integrated network including: community teams coordinated with the primary care services of the area; inpatient, day hospital and liaison psychiatry units at the general hospital; and psychosocial rehabilitation units and programmes in the community. The services were organized according with the principles of accessibility and equity, community involvement, recovery and human rights, and continuity of care.

Implementation

The Department is based in the General Hospital of the catchment area and has a strong presence in the community. It is a comprehensive service with four functional units. The majority of the Department's activity takes place outside the physical space of the Hospital and is provided by four mental health community teams based in the local health centres where the primary care teams are located. They work in close coordination with the social network (NGOs, municipalities, other social organizations) and the Primary Care Teams. The Department has promoted and carried out diverse forms of intervention, in order to provide differentiated and effective care in accordance with the specific needs of each patient. The community teams offer greater accessibility and closer contact with the severe mental disorders' patients and provide early intervention, educational as well as rehabilitative, which would otherwise be very difficult to implement if they were not in the community. It is the Department's concern to preserve or implement social inclusion of patients. There is an important investment in working with the users' families and all other community structures that provide social and professional support. Collaboration with Primary Care includes regular meetings for case discussion and screening and also for training activities. This activity has contributed to the structuring of an integrated approach of common mental disorders and a more effective treatment of patients.

In the General Hospital are sieged the Acute Inpatient Unit, the Day Hospital, the Liaison Psychiatry Unit, and the Child and Adolescents team.

The Inpatient Unit has twenty-nine beds and 4 psychiatrists (each connected to one of the Community teams), 16 nurses, 8 auxiliaries, one occupational therapist and one secretary. Given the fact that the admissions are by sector, patients of a particular area are always in charge of the same professionals while in hospital

The Day Hospital is aimed at subacute and chronic patients in need of a coordinated, intensive, and multidisciplinary intervention not possible in the outpatient clinic; and at patients discharged from the inpatient unit. It carries out activities promoting autonomy, compliance, rehabilitation, and social inclusion, and works with the users' families. It has capacity for 22 simultaneous users and provides a psychoeducation programme for bipolar disorders users' previously admitted to the inpatient unit. The team consists of one psychiatrist, one psychologist, one nurse, and two occupational therapists.

The Liaison Psychiatry Unit provides psychiatric care to the medical and surgical wards of the Hospital and to the outpatients referred by other specialties. The team consists of two psychiatrists, one

psychologist, and a part-time psychomotor activity specialist. It develops training activities for the other department's professionals and collaboration in interdisciplinary programs like the Rehabilitation of Cardiac Patients, Tobacco Cessation, Pain, Gynaecology, Oncology, and Eating Disorders.

The Community Intervention Unit consists of four community teams based in the local health centers. The teams provide care to outpatients and each includes two psychiatrists, two nurses, one psychologist, one social worker, and one secretary.

Each team is coordinated by a senior psychiatrist, and their members perform psychiatric and psychological consultations and assessments, management and medication control, psychotherapy (individual, family and group), and social assessments and interventions. Nurses and social workers of these teams do regular home visits to evaluate the users' social, economic and family environment, and to promote adherence to follow-up, medication maintenance and close contact with the user. The number of patients whose follow-up is based primarily on this form of intervention has increased and is reflected in a lower number of involuntary and compulsory readmissions.

Two Day Centres are based in the same premises of two of the community teams. Each of them relies on the intervention of an occupational therapist and of a psychomotor specialist. Their main goal is to maintain close contact and provide rehabilitation activities to the severe mentally ill.

The Department has an **assertive follow-up programme** after a first psychotic episode to ensure early treatment of users, usually young people.

To prevent drop-out a quality assurance programme makes mandatory for all patients discharged from the inpatient unit to have an appointment scheduled in the following two-weeks with the community team.

The Child and Adolescent Team currently includes a child psychiatrist, a psychologist, and a part-time psychomotricist. It provides psychiatric care to the children and adolescents admitted to the Paediatric Department or referred by the Paediatric outpatient clinic. With the support of the Ministry of Health we plan to increase the size of this team in order to serve the whole catchment area of the Department.

Results/outputs

The HFF Department of Psychiatry has developed an innovative comprehensive and integrated model based in the general hospital and the community, which ensures a close coordination with primary care teams and all other relevant stakeholders in the community. This model of intervention is only possible due to the articulation between the Department's different Units that offer diverse answers to the level of care that patients need. Because good communication between the units is crucial, weekly meetings between the inpatient, outpatient and day hospital teams take place for all members to share the general objectives of their intervention. It also allows a coherent and coordinated functioning and prevents drop-out of the users.

Pre and post-graduation training and clinical research are also very much invested by the Department.

The lack of rehabilitation facilities for the mentally ill stimulated the creation of an NGO by a group of the Department's professionals. This NGO functions in premises lent by the Municipality of Amadora, and encompasses a protected residence for up to 7 patients and a day area with capacity currently to 20 patients.

The Department Activities in numbers:

	2000	2011
Inpatients discharged	486	451
First admissions	194 (40%)	164 (36%)
Compulsory admissions	5%	10%
Average length of admission, days	15.4	20.5
Day hospital average # of patients	12	24
Psychiatric consultations by the community teams	10,206	14,756
Home visits	236	980
Liaison psychiatry:		
medical wards	1,001	1,109
outpatient clinic	1,712	2,575

Strengths of the Department

- Accessibility of the mental health services network
- Welll defined intervention objectives and priorities
- Continuity of care
- Quality assurance protocols preventing drop-out of users
- Annual assessment and planning
- Teaching and research protocol with NOVA Medical School
- Scientific activities and publications

Weaknesses of the Department

- Lack of administrative and financial autonomy
- Low number of staff
- Lack of own spaces for some programmes in the community
- High number of users without residential solutions
- Reduced number of GPs to articulate with

SPAIN (I)

TITLE:: ANDALUSIAN PSYCHIATRIC REFORM

INTRODUCTION

The Andalucian psychiatric reform officially started in 1984, following legislative approval by the Andalucian Parliament and the creation of the Andalucian Institute of Mental Health (IASAM). The reform sought to put an end to the provision of public psychiatric care previously scattered among five different administrations, unevenly distributed across the territory, separated from the rest of health care and based mainly on two types of institutions, a situation that was widely criticised by professionals and the population (the eight provincial psychiatric hospitals and the 69 outpatient Neuropsychiatry of the Social Security).

In using the guidelines contained in the General Health Act and the document of the Ministerial Committee for the psychiatric reform; and with the objective of creating effective, efficient and non-stigmatising care to people with various mental health problems, the IASAM developed the following objectives:

- Unify administrative management and public resources,
- Replace existing psychiatric hospitals with an alternative network of community services,
- Increase, diversify and redistribute public resources, and
- Define competencies and promote cross-sector collaboration.

IMPLEMENTATION OF THE PRACTICE

The timeline of implementation includes:

1984: Legislation to create the Andalucian Institute of Mental Health (IASAM).

1990: Integration of the new network of specialised mental health services based in the community and integrated within the general health care system (Andalucian Health Service).

1993: Creation of the Andalucian Public Foundation for Social integration of People with Mental Illness (FAISEM).

2003: Development of the 1st Comprehensive Mental Health Plan for Andalusia.

2008: Development of the 2nd Comprehensive Mental Health Plan for Andalusia.

RESULTS – OUTPUTS AND OUTCOMES

The reform led to the following developments:

- Closure of all psychiatric hospitals, through individual programmes of deinstitutionalization and re-utilization of the buildings for other purposes (mostly related to general health care services);
- Creation of a new network of specialised mental health services based in the community and integrated in the general health system. This network was organised within sectors, called Mental Health Areas;
- Creation of FAISEM, which manages a network of social support services. This network includes residential, occupational and vocational facilities and programmes;
- Formulation of a cross-sector policy that promotes collaboration between health services and other service sectors (e.g. social affairs, justice, education) and with users and family associations.

In 1990, following the transfer of health resources from provincial councils (local administration), the IASAM disappeared (until then the reform governing body) and a new network of specialised mental health services (including some parts of the old psychiatric hospitals and the administrative resources of IASAM) were integrated into the Andalucian Health Service.

As a result of the reform, the Andalucian Health Service currently has a network of specialized services, organised territorially through 25 Clinical Mental Health Management Units,which are closely linked to Primary Healthcare. Mental health services can be summarized as follows using data from December 2013:

a) 77 COMMUNITY MENTAL HEALTH UNITS located in relevant Health Districts to support primary care professionals, provide outpatient and domicilary care and coordinate referrals to other specialised mental health services. These units replace the previous system in 1984 (e.g. a part time Neuropsychiatrist - 2.5 hour per day - and a team of no more than six professionals, providing 7.5 hours of dedicated time).

b) 20 MENTAL HEALTH INPATIENT UNITS in general hospitals, with a total of 546 beds to provide short-term inpatient care and to develop a programme of hospital liaison with other relevant services. These inpatient units have improved considerably the system previously in place prior to the psychiatric reform, particularly in terms of the range of active beds located in general hospitals and their integration into a formal network.

c) 14 CHILD AND ADOLESCENT MENTAL HEALTH UNITS are located within the community mental health units and provide outpatient and day hospital care (252 places) and full hospitalisation (33 beds). In addition, these units have developed links and support to other health services and educational and social programmes.

d) 9 REHABILITATION UNITS in the form of a day centre (with 300 places) which provides clinical care through psychosocial rehabilitation programmes (in urban areas) and support to community mental health units in developing programmes in their respective fields.

e) 16 DAY HOSPITALS for partial hospitalisation for acute mental care (with 340 places). These provide an intermediate resource between mental health inpatient units and community mental health units; and develop daytime programmes to complement or provide an alternative to full hospitalisation.

f) 14 THERAPEUTIC COMMUNITIES provide medium-stay, intensive specialist care for patients with severe mental illness (with a total of 254 beds and 381 places in day programmes).

LESSONS LEARNT

- Difficulties associated with transfer of care to the community once the pillars of the traditional system of psychiatric care were removed and find more appropriate alternative locations for patients.
- Establishing improvements of a new network of services that was able to overcome the shortcomings of the traditional system (which meant more diversified community oriented services, integrated and attached to the general health care system).
- The need to launch cross-sector mechanisms (by social services, employment, justice, etc.), which is essential for all-round care for people mental health problems).
- To actively involve a range of different stakeholders (from mental health professionals to users and families) to develop new forms of interventions, monitor performance and provide training programmes at different levels of care.

CONCLUSION

The psychiatric reform produced many positive outcomes including:

a) Considerable simplification of previous administrative arrangements because of the unification of all administrative management and resources into a single network.

b) A major diversification of services with better accessibility (for better territorial distribution and a greater degree of normalisation and capacity to intervene (in terms of number and type of service, professionals and approaches used).

c) The dismantling of the eight psychiatric hospitals and the implementation of higher quality alternative resources and the respect for the rights of users and relatives.

d) The development of cross-sector programmes in the administration of Justice, Social Services and Employment.

e) A positive acceptance and involvement of most professional groups and user and family associations.

f) National and international public recognition of the achieved results, with the inclusion of the Andalucian Mental Health Office - Andalucian Health Service - in the network of WHO Collaboration Centres (participating in various activities and offering support for the development and transformation of the psychiatric care in Latin America).

FURTHER READING
http://www.juntadeandalucia.es/servicioandaluzdesalud/saludmental

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SPAIN (II)

TITLE

ANDALUSIAN PUBLIC FOUNDATION FOR SOCIAL INTEGRATION OF PEOPLE WITH MENTAL ILLNESS (FAISEM)

INTRODUCTION

One of the most original aspects of the Andalucian reform was the creation of a network of social services to support citizens with severe mental disorder in the community. The strategy consisted of the creation of a public foundation, which was jointly funded by the four government departments (health, social affairs, employment and economy and finance) to provide social support for people with severe mental disorder.

FAISEM was created in 1993 by the Andalucian Parliament, with the following objectives:

- Provide public accountability.
- Finance these services mainly through the budgets of the Andalucian Goverment.
- To develop and manage social support resources for mental health service users, whose needs are not covered by general social services programmes.
- Structure and manage services to allow greater flexibility and participation of professionals, users and relatives and other social organisations.

FAISEM manages a network of social support services that mainly includes residential, occupational and vocational facilities and programmes. In general terms, access to FAISEM programs is through the public mental health services and is lmited to people being treated in any of the mental health services.

There are several levels of coordination between FAISEM, health services and social services, with formal oversight by both the Provincial and Central Cross-sector Commissions.

IMPLEMENTATION OF THE PRACTICE

1 - Residential programme:

The residential programme covers users' basic needs for daily living, such as housing, self-care and social relationships. The housing facilities listed below, meet individual needs and supervision is based on the degree of personal autonomy. The type of residential facilities include:

- Boarding Houses for 10-20 users with the lowest level of autonomy, which are staffed 24 hours a day.
- Supervised housing for a maximum of 10 users, with a higher level of autonomy and who do not require staff 24 hours a day. There are two levels of supervision depending on what is required: o Higher supervision - staff available at least overnight and weekends. o Less supervision - more spaced and variable according to the needs.
- Home support is also provided through regular visits to the user's own home or family home. It includes different levels of home-based support without resorting to more specific services. Some resources have places available for day stay.

2 - Employment Programme

The employment programme facilitates:

- Training courses for employment, that are individualised itineraries adapted to user's needs.
- Social enterprises to provide opportunities for employment within a suitable framework for gaining initial work experience. Through IDEA S.A., FAISEM provides guidance and technical support to relevant social enterprises and coordinates and supports its management.
- Individual support towards employment in other companies. The employment programme has eight provincial Employment Guidance and Support Services, which provides guidance and advice on employment and training to strengthen users' employability. These services also ensure coordination of the programme at the provincial level.

3 - Day Support & Leisure Programmes

Occupational and recreational activities are promoted through Day Support and Leisure programmes. They also address specific basic needs in day centres and facilitate interpersonal relationships.

All activities detailed below are designed to promote social inclusion and independence within the community. These include:

- Occupational Workshops and/or Day Centres with varying activities depending on users' needs.
- Social Clubs, with a capacity of approximately 30 people are developed in collaboration with the user and family organisations.
- Spontaneous activities of leisure and enjoyment, which usually coincide with holidays periods or weekends.

4 - Specific Programmes:

- Care for homeless people with severe mental disorders.
- Care for people with severe mental disorders in prisons.

5 - Guardianship Institutions Support Programme:

Through this programme, FAISEM promotes the development of guardianship institutions for people with severe mental disorder. These agencies also offer guardianship to other disability groups, in collaboration with other agencies and organisations.

6 - Training, Research and International Cooperation:

To support the development of the above mentioned programmes, FAISEM also develops the following activities:

- Orientation and follow-up programmes, quality standards and performance monitoring and evaluation.
- The development of staff training activities.
- Research projects in relation to social support for people with severe mental disorder.
- A documentation service.
- National and international collaborations through participation in different initiatives, such as:

- International Mental Health Collaboration Networks (IMHCN). Working with groups from different European countries within the framework of community care and social support for people with severe mental disorder.
- Cooperation with the Pan-American Health Organization in Latin American countries, through an agreement with the Andalucian School of Public Health.
- The Executive Committee of CEFEC (Confederation of European Social Firms, Employment Initiatives and Social Co-operatives).
- Collaboration with local authorities, and
- Participation in the Andalucian Committee of People with Disability (CERMI- Andalucía).

7 - Support of Family and User Associations

Since it was formed in 1993, FAISEM has helped consolidate and support the work of family and users associations. These actions have been developed through the Andalucian Federation of Families and People with Mental Illness (FEAFES- Andalusia) and the Andalucian Federation of Mental Health Users ("EN PRIMERA PERSONA"), and its federated associations.

RESULTS – OUTPUTS AND OUTCOMES

Currently (December 2013), available resources and the number of places for programmes of social support are:

HOLIDAY PROGRAM	NUMBER OF RESOURCES	NUMBER OF PLACES	PLACES X 100,000 INHABITANS
SPECIFIC RESIDENTIAL PROGRAMMES CARE FOR HOMELESS PEOPLE WITH SMI			
Boarding Houses	52	912	10.8
Apartments	156	688	7.3
Nursing Home for the elderly places		44	0.7
Home Support		270	3.2
EMPLOYMENT PROGRAMMES			
Vocational Training Courses	11	57	0.7
Social Firms *	10	334	4.0
Employment Guidance and Support Services	8	1,551	18.5
DAY SUPPORT & LEISURE PROGRAMMES			
Occupational Workshops	85	2,054	24.5
Day Centre	26	925	11.0
Day stay places		270	3.2
Holiday Program		254	3.0
SPECIFIC PROGRAMMES			
Homeless care for people with SMI		130	1.5
Care for people with SMI in prisons		211	2.5
GUARDIANSHIP INSTITUTIONS SUPPORT PROGRAMME			
Guardianship Institutions		1,364	16.2

* Employed people with mental illness

LESSONS LEARNT

As an integrated aspect of the reform process included developing social support programmes to meet the needs of people with severe mental disorder, which is closely coordinated with health care services but distinct from them.

Based on a public and cross-sector approach and linked to four government departments, FAISEM has organised its work around a set of values, which emphasises citizenship and recovery, the basic principles of community care and the pursuit of quality; all within the context of a network of public services close to the specialised mental health services.

Values that have guided the development of its different programs, in accordance with the lines of action defined in its statutes and focused on the basic areas of housing, employment and daily occupation, in addition to legal protection and the support for a group of citizens with special difficulties.

CONCLUSION

FAISEM has proved very successful in ensuring: cross-sector public funding; coordinated planning and management of social support services in close contact with health services; flexible and efficient administration of resources; participation of local organisations and staff, users and family associations in the development and monitoring of social support programmes for people with severe mental disorder.

FURTHER READING

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SPAIN (III)

TITLE

"FIRST PERSON", THE ANDALUSIAN FEDERATION OF MENTAL HEALTH USERS

INTRODUCTION

"First Person" is the Andalucian Federation of mental health users' association; the first regional Federation in Spain that marked the emerging movement of people with mental health problems, whose main objective is to promote recovery and improve the quality of life for people with mental health problems. To achieve this, our mission focuses on being a spokesperson in first person to defends the rights and interests of our group. This pioneering initiative integrates eleven self-managed associations, by people with different mental health problems in different Andalucian provinces (Sevilla, Málaga, Granada, Córdoba, Jaén and Almería).

In "First person" we want to be protagonists in the decisions that affect us and demand that institutional authorities hear our voice as first stakeholders and experts in our own right. The main priority for our Federation is to fight against the invisibility we have had for a long time, excluded from society to which we belong.

We defend and demand better social and health care by sharing objectives, strategies and issues; and to exchange experiences, projects, information and activities between all the Andalucian associations.

Our Federation aims to develop joint strategies to facilitate our recovery by fighting social exclusion, discrimination and stigma; reporting situations that are discriminatory for people or groups affected by mental health problems; and promote partnerships between users.

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IMPLEMENTATION OF THE PRACTICE

Although "First Person" was legally registered on February 2010, our first steps began in December 2005 with the first associations meeting. The following 11 associations are part of the Federation:

- In Málaga: "Topato", "Alfarala" & "Afesol";
- In Sevilla: "ABBA" & "Tocas";
- In Granada: "SAPAME" & "Amensa";
- In Almería: "Almeria Alnorte" & "Bao Indalo Almeria";
- In Córdoba: "AFEMVAP"; &
- In Jaén: "Podemos 12"

The main areas of the Federation's (and its associations') activities are:

1. Peer support and recovery through training activities, workshops and meetings, development of guidelines, actions of support, supervision and advice, and the use of internet to create a virtual network of mutual support.
2. Anti-stigma and social discrimination and defence of human rights through training activities and meetings; through the development of guides and our involvement in the Andalucian cross-sector strategy "1in4" (www.1decada4.es).
3. Strengthening users' associations through training activities, meetings and dissemination activities via mainly the website: http://www.enprimerapersona.org.

RESULTS OF THE PRACTICE – OUTPUTS AND OUTCOMES

The Federation is present in the majority of Andalucian provinces, where "First Person" develops activities in accordance with its purpose and principles. Between 2013-2014, these activities were:

1. Peer support and recovery including:

- 7 basic peer support courses (30 hours each) in Linares, Granada, Córdoba, Motril, Almería, Sevilla and Málaga in 2013, with a total participation of 140 people;
- An advanced peer support course (30 hours) for people who will develop peer support sessions within mental health services and/or associations. This course was held in Mollina (Málaga) in October 2013 with the participation of 20 people;
- Publication of a guideline to facilitate peer support groups;
- Two basic peer support and recovery courses in Cadiz and Huelva in 2014, with a total participation of 40 people;
- Two day meeting of peer support group facilitators in November 2014;
- Supervision and support programmes for peer support groups and peer support sessions in several associations during 2014;
- XI Mental Health Day in Pozoblanco (Córdoba) dedicated to peer support and recovery;
- Specific programme of peer support for users without social networks in Granada during 2014;

- Social theatre workshop “Strengthen mutual support groups”: La Axarquía, Málaga, planned for 2014;
- Pilot project “Recovery group for people with psychosis”, held in Sevilla during 2014;
- Second biographical workshop developed during 2014; and
- Creation and maintenance of a new website “RAMA” (Andalucian Network of Mutual Support).

2. Anti-stigma, discrimination and defence of human rights:

- Course on “Working with the media & spokespeople training” (12 hours): Granada, September 2013, with the participation of 15 people;
- Course on “Human rights approach in the framework of UN Convention on rights of people with disability” (12 hours): Granada, November 2013, with the participation of 18 people;
- Seminar on “How to defend our rights in Mental Health”: Sevilla, October 2013, with the participation of 115 people;
- Publication of a “Guideline on how to defend our rights” aimed to people with severe mental disorder; and a
- Course on “Human rights and advanced directives”, developed in September 2014.
- Social theatre workshop on how to “Overcome self-stigma and identify social stigma”: two courses in Sevilla in 2014;
- Workshop on “Overcoming our fears” in Málaga during 2014;
- Course on “De-stigmatizing and empowerment” in Sevilla during 2014;
- Awareness seminars for young people in secondary school; three seminars developed in Almería during 2013 and repeated in 2014;
- Seminar on the “Clubhouse model” held inSevilla in October 2014, coinciding with World
- Mental Health Day;
- Workshop on “Fighting stigma by creating and editing short films” in Málaga during 2014.

3. Strengthening users’ associations:

- Course on “Raising resources for associations” (12 hours) held in Granada in June 2013, with the participation of 14 people;
- 7th Federation Meeting on “What make us healthier: living and sharing experiences and assets for our recovery” held in Almería during May 2014, with the participation of 120 people;
- Course on “NGO Leadership”, developed in September 2014;
- First meeting of users’ associations in Malaga held in 2014;
- Maintenance of the Federation’s website (www.enprimerapersona.org) and dissemination of activities through social networks: Facebook, Youtube, etc. ;
- Creation of website for two of the federated associations.

LESSONS LEARNT

The association led by users of mental health services has grown exponentially since its creation. In 2005, five user associations existed in Andalusia. In 2010, we created a legally recognized Federation, which increased our recognition and presence at various institutions and forums. In 2014, the number of associations has grown and there are now eleven that are attached to “First Person”.

The range of activities developed to date show our willingness and determination for making recovery a reality in our life, taking into account that mutual support is one of our most fundamental values.

CONCLUSION

This user-led movement, together with the family movements, play a key role in planning and following community-orientated mental health services. This role is even more relevant today if we take into account the recovery approach and the human rights perspective. For this reason the slogan "nothing about us without us", is endorsed as good practice by "First Person".

FURTHER READING

http://www.enprimerapersona.org

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SPAIN (IV)

Title of the "Best Practice"

DEVELOPING THE COMMUNITY BASED MENTAL HEALTH SYSTEM FOR PEOPLE WITH A SEVERE MENTAL DISORDER IN THE REGION OF CASTILLA-LA MANCHA (SPAIN)

INTRODUCTION

What is the problem being addressed? Lack of community-based mental health services for people with severe mental disorder.

Which population is being affected? Adults with a diagnosis of severe mental illness, and their informal caregivers (families and others).

How is the problem impacting on the population? The delivery of services for people with a severe mental illness is based on institutional structures that negatively impacts on their social inclusion, their quality of the care (evidence based treatments recommend community mental health services), difficulties with their recovery and marginalisation.

What are the objectives being achieved? The main objective to be achieved is to develop a community-based mental health network of services for the treatment of people with a diagnosis of severe mental illness, focused on psychosocial rehabilitation and residential care services; in order to improve their social inclusion and adopt the values and priniciples of a community model (Liberman, 2008), namely:

- Recovery of a normal life in the community is possible for many people with mental illness if best practices of rehabilitation are provided.
- Impairments, disabilities, and handicaps can be reduced or overcome by the integration of pharmacological and psychosocial services with advocacy for improved clinical, educational, vocational, and governmental policies and practices.
- Individualisation of treatment is a fundamental pillar of rehabilitation.
- Rehabilitation is more effective and recovery more rapid when patients and families are actively involved in planning and participating in treatment.
- Integration and coordination of services are essential to enhance progress toward recovery.
- Building on patient´s strengths, interests, and capabilities is a cornerstone of rehabilitation.
- Rehabilitation takes time, proceeds incrementally, and requires perseverance, patience, and resilience by patients, families, and practitioners.

In Spain, the General Health Act (Act 14/1986 of 25 April) recognises the full integration of actions concerning mental health in the general health system and full equality of people with mental illness to other citizens who require health or social services. Article 20, draws attention to mental health problems in the population at the community level; enhancing health care resources to outpatient and partial hospitalisation systems and home care. This is to reduce, as far as possible the need for hospitalisation and the development of rehabilitation and social reintegration, in coordination with social services. The General Health Act (1986) and the Report of the Inter-Ministerial Commission for Psychiatric Reform (1985) support the model of community mental health. The adoption of this law marked the creation and development of psychosocial rehabilitation resources and the progressive dismantling and transformation of psychiatric hospitals across the different Regions.

The Region of Castilla-La Mancha, prior to 2000, did not have a specialised network of community-based resources to care for people with severe mental illness, nor a single model for structured community care.

Since that time, family associations have adopted an advocacy role for the implementation of activities, programmes and resources in the Community.

Implementation of the Practice

- What are the main activities carried out?
- When and where were the activities carried out?
- Who were the key implementers and collaborators?
- What were the resource implications?

Since 1984, through the mental health plans in the region (Mental Health Plan 2000-2004 and 2005-2010) deinstitutionalisation of persons with severe mental illness and community-based residential alternatives have been developed. This is based on psychosocial and vocational rehabilitation and integrated into the mental health network, which was consolidated in the Mental Health Plan 2005-2010. The development of these resources has played a crucial role in the transformation of mental health care in the region; and based on a Community model with interdisciplinary, inter-sectoral facilities and integrated with health and mental health services.

From 2000 to 2014, main activities carried out include:

- Integrating mental health in a context of community health care.
- Developing community mental health services in all areas of health in the Region.
- Transform psychiatric detention centres promoting the institutionalisation and strengthening their rehabilitative activities.
- Promote the development of alternative structures of psychosocial rehabilitation.
- Implement effective measures to facilitate the full integration of this group.
- Promote activities to raise awareness and combat stigma and social discrimination.
- Promote activities and programmes for training and employment.

Key implementers and collaborators

- Ministry of Health And Social Welfare. Castilla-La Mancha Government
- Castilla-La Mancha Regional Health Service (SESCAM)
- NGOs mental health in Castilla-La Mancha (FEAFES-CLM)
- Castilla-La Mancha Health and Sociosanitary Foundation (FSCLM)

Through the Ministry of Health and Social Affairs, the formulas in the management and development of network resources care for people with mental disorder were articulated, approving the creation of

the Foundation for Socio Socio-Labour Integration of the Mentally Ill (FISLEM), currently Sociosanitaria Foundation Castilla-La Mancha as a management instrument and promotion of resources to care for this group. In collaboration with the associations of the region, and in close coordination with the Health Service of Castilla-La Mancha

(SESCAM), the Foundation is responsible for the development, monitoring and evaluation of specific specialised network resources to promote psychosocial rehabilitation and social integration of people with severe mental illness.

Results of the Practice – Outputs and Outcomes

Today, the network of specialised resources psychosocial and occupational rehabilitation, and residential nature to the care of people with severe mental disorder and their families are integrated in the public mental health in the Region, and comprises:

- 19 Psychosocial Rehabilitation Centre
- 4 Community-based Residential Centre
- 30 Housing supports

Designing care programmes in these resources is based on the guiding principles and methodology of the

Community mental health care, incorporating the philosophy and perspective of recovery and empowerment, as recommended and the best available scientific evidence.

Coverage

Evolution of the number of places in residential centres and rehabilitation in Castilla-La Mancha (Spain)

RESOURSE/YEAR	1999	2004	2010	2013
Supported housing	32	132	166	168
Community-based residential centres	0	26	164	170
Psychosocial rehabilitation centres	241	900	1.240	1.240

Activities and results

Nº SMI people attended in the health social network

RESOURSE/YEAR	1999	2004	2010	2013
Supported housing	-	138	223	212
Community-based residencial center	0	94	194	203
Psychosocial rehabilitation center	241	1.295	1.868	2.035

Psychosocial Rehabilitation Center Results

% SMI people using structured community resources

YEAR	2004	2007	2010	2013
Rate overall people attended	22%	30%	32%	31,3%

% SMI people who have undertaken work activity

YEAR	2004	2007	2010	2013
Rate overall people attended	18%	22,6%	19%	11,8%

% SMI people who have taken vocational trainings

YEAR	2004	2007	2010	2013
Rate overall people attended	-	15,4%	12%	11,3%

% SMI people that have had a psychiatric admission to hospital

YEAR	2004	2007	2010	2013
Rate overall people attended	8%	7%	7%	7,9%

LESSONS LEARNT

- The resources and psychosocial rehabilitation programmes based on the community model for the care of people with severe mental illness have had a positive impact on social inclusion, quality of life and psychosocial functioning of this group.
- Key development and implementation factors: political and financial commitment, intersectoral coordination, network integration of mental health in the region, standardising work procedures and performance standards, individualised intervention plans, incorporating evidence-based programmes in the portfolio of services, implementation of coordination protocols between resources and healthcare levels, development of awareness-raising activities and combating social stigma, incorporating assessment strategies and quality standards, introducing culture of evaluation and continuous improvement incorporating the perspective of users and their families.
- Need for involvement of different social agents (such as associations) and community resources to promote social inclusion of this group.

CONCLUSION

As in other regions and countries, community mental health services have had a positive impact on the social inclusion of people with severe mental illness.

FURTHER READING

- Planes de Salud Mental de Castilla-La Mancha (2000-2004; 2005-2010).
- Documentos técnicos: Modelo de Centros de Rehabilitación Psicosocial y Laboral; Guía Práctica para el Trabajo en Viviendas Supervisadas.
- Memorias anuales de la Fundación Sociosanitaria de Castilla-La Mancha.

BULGARIA

Title: Pilot project for developing a model for community mental health service in one region in Bulgaria - Community mental health center (CMHC) in Blagoevgrad.

Objectives:

To start the transformation of traditional institutional psychiatry towards community-oriented care.

Strategic plan:

To establish a new model of community-oriented service based on the existing facility for mental health care in one pilot region of the country.

Activities:

The CMHC in Blagoevgrad was opened on 1st August 2005, after renovation of the existing local facility for ambulatory psychiatric care (psychiatric dispensary) and training of the staff as part of the activities of Component 2 of the Mental Health Project. The Centre provides services to the region's population in relation to early detection of psychiatric disorders and psychotic states, diagnostic assessments and treatment of all types of psychiatric problems – from common to severe mental disorders – with special attention to people with mental disorders that affect their coping abilities to deal with stressful life events and their social adaptation in general.

Long-term treatment and supportive measures keep these patients in a stable condition making their life in the community possible. Because of the nature of their illness some require a personal care coordinator to ensure the realisation of their individual therapeutic plan. The Centre provides a variety of programmes for psychosocial rehabilitation and re-socialisation aiming to bring people back into the community and fully integrate them so they are able to work and live independently.

The rehabilitation part of the CMHC – the Day care unit - deals with clinical problems that occur during: the stabilisation phase, relapse that requires medical intervention including hospitalisation, stressful social events, housing and home care. A variety of psychosocial interventions and programmes are provided to re-establish lost personal skills for everyday independent life.

Available resources:

The total number of the personnel of the CMHC working in the ambulatory setting is 1 psychiatrist, 6 psychologists, 4 nurses 4 social workers. Of this number, 4 psychologists, 3 social workers and 1 nurse work in the rehabilitation unit (day care unit).

The daily capacity of the rehabilitation unit of the CMHC is 25 people. The total number of visits since the unit opened in 2005 is 9901 visits.

The number of visits shows stable increasing compared by periods of reporting:

- 01.08.2005 - 31.12.2005 - 365
- 01.01.2006 - 31.12.2006 - 2792
- 01.01.2007 - 31.12.2007 - 4515
- 01.01.2008 - 31.03.2008 - 2223

The total number of the registered new cases is 140; formulation of cases – 72

Number of clients involved in programmes is 72.

The CMHC and especially the day-care centre, applies the principles of structured clinical based practice based on several decision making steps for the client – entering point and registration, case manager, team consultation, conclusion of the case.

The decisions taken become operational through the following procedures:

- Spreading information regarding the services provided by the Center;
- Making appointments for interview with clients;
- Involvement in a rehabilitation programme – case formulation and therapeutic plan;
- Making records and keeping files;
- Individual contact with the client lasts 90 or 50 minutes according the type of the contact: interview, sessions or clinical discussion;
- The following types of interviews have been applied in the Centre:
  - Initial interview
  - Assessment interview

  - Follow-up interview
  - Social interview
  - Psychological test/investigation
- Sessions that are used include:
  - Psychological support
  - Psychotherapy
  - Psychological rehabilitation
  - Training of social skills
  - Family sessions
- Rehabilitation programs provided by the Centre:
  - “Social club”
  - “Therapeutic kitchen”
  - “Seeking for a job”
  - “Communication skills”
  - “Management of the symptoms”
  - “Supported occupation”
  - “Transitional occupational place”
  - “Home care and crisis intervention”.

The popularity of the Centre is growing among the population of the region. The services offered by the rehabilitation unit of the CMHC have been recognised more and more by the local professionals as supportive to their efforts and useful for clients regarding their increased compliance, less relapses and stabilisation of their psychological condition. The pilot model so far shows that when medical and social services are provided in collaboration and coordinated accordingly – the outcome is obvious in terms of sustainable improvement for the most of clients of the Centre. The following example of good practice illustrates this statement:

E. S. is 51 years old man and lives in Blagoevgrad. The contact with him was established by his own initiative. He was very attracted by the Day-care center and wanted to be involved in the case management programme.

E.S. has had paranoid schizophrenia since the age of 20 years. His grandmother had the same diagnosis. He received his education in Moscow in Architecture, married and returned to Bulgaria.

The triggering factor of the illness is the high level of stress associated with a professional failure connected with a project he was engaged with for a long period of time. E.S. started to feel tension, physically weak, abandoned his family, which ended in divorce. The first time he was diagnosed by a friend who was a psychiatrist in 1985, to whom E.S. went asking to be discharged from the military reserve. For the last 20 years he was hospitalised about 7 times, with long remissions. Lives with his mother. E.S is unhappy that he is unemployed and that the illness is an obstacle to a fruitful life. Often he feels desperate and shares his complaints saying: “ What a life is this – only suffering. My disease is very bad”. He is very frustrated with the symptoms he experiences. Very often he has anxious thoughts about disasters and wars. The reality testing is good.

E.S believes that the medicine he takes has a wholesome effect on the symptoms of the disease, but because of feelings of tension, depression and insomnia he thinks that he needs an additional drug.

E.S. needs some form of occupation, which he relates with the possibility to communicate and to establish social contacts. He is well qualified for the job that he wants to do but he is also afraid as to whether he can manage it.

His disease is connected with a risk of social exclusion due to his disability to establish social contacts. There is a risk of self neglect.

E.S. is conscious about his illness and strongly motivated to overcome it. He wants to live his life in a normal way and to feel himself of full value. He understands the effects of the medicines how they help him to feel good. He shows willingness and consistency in the therapy. He has a constant interest of the news in the medical science especially in psychiatry and psychotropic drugs.

In the Day care center E.S. passed the Liebermann modules of social skills and independent life. In 2005, he was trained in communication skills in order to improve his ability to communicate and establish and maintain social relationships. In 2007, he passed the modules "Control over the symptoms" and "Job seeking". At the moment he keeps visiting the Day care as an active member of the existing consumers' organisation "Council of clients with psychiatric disorders".

E.S. works on a part time with a local architect although with minimal salary.

Evaluation strategy: The principles of the community psychiatry include structural clinical practice. This means all activities within the CMHC must be done in a measurable way to fulfil the requirements of evidence-based medicine. To achieve this an intranet based information system will be implemented within the pilot centres. The system will create a database of the population served, reflecting the everyday activities of staff in order to provide reliable managerial and statistical information.

Results: In parallel with the activities under the Stability Pact Mental Health Project a number of other initiatives were undertaken in the country through various projects and financial sources (e.g. the PHARE Programme, MATRA etc.). Two large projects financed by the PHARE Programme started in 2003 under the management of the Ministry of Labor and Social Policy include: "Improving the quality of life of the people with mental disabilities" and "De-institutionalisation through the provision of community-based services for high risk groups". Both projects aim to introduce new technologies for the management of the severe mental disorders – psychosocial rehabilitation, case management, information flow etc. The working group comprised specialists already involved in the Stability Pact Mental Health Project since its start; so guaranteeing that the main principles of community psychiatry were embedded in the outcomes of these projects.

At governmental level, the implementation of the Mental Health Policy also contributes to the successful introduction of the principles of the community psychiatry in Bulgaria and to psychiatric reform in general. The governing body of the Mental Health Policy – the National Council for Mental health comprises representatives of all institutions concerned with the mental health issues – MLSP, Ministry of Education, Ministry of Justice, Association of the Municipalities in the country, regional branches of the Ministry of Health etc. According to the framework of agreement between Ministry of Health and Ministry of Labor and Social Policy, support for the newly hired staff of the centres includes training, written algorithms and theoretical knowledge provided by mental health specialists.

The pilot CMHC in Blagoevgrad demonstrated the importance of collaboration between the different teams and their financing, training, management and professional background. Depite initial difficulties and tensions teams are now mutually supportive and work in collaboration for the client's benefit. The pilot also showed it can be applied to any situation and can help staff increase their knowledge and self–esteem. The new pilot service has attracted more and more clients seeking the Centre's services, which is evidenced by regular activity reports.