MedArh 2003; 57(5-6, supl. 1): 51-55

Revijalni članci/Reviews

Community Mental Health Care in Europe – an overview –

STEFAN PRIEBE
UNIT FOR SOCIAL AND COMMUNITY PSYCHIATRY NEWHAM CENTRE FOR MENTAL HEALTH LONDON, UK

Review
SUMMARY

Europe shares some historical roots of modern psychiatry. Even before the 19th century, there had been institutions for the mentally ill, such as the Bethlem in London which was founded more than 750 years ago, and organised forms of care in the community for people with mental illness, such as the tradition of family care in Geel in Belgium. Modern psychiatry, however, was initiated through the spirit of enlightenment and began around 1800. This beginning was marked by the symbolic cutting of the chains of mentally ill patients in Paris, the first publication of the term 'psychiatry' ("Psychiatrie") in Germany in 1803, and the establishment of the retreat in York, England. The rise of modern psychiatry as a speciality of medicine was closely linked to the development of new institutions in both health care and academia. In the 19th century, various universities established chairs and academic departments of psychiatry, and large asylums for the mentally ill were built across Europe. The asylums were meant to replace the family as carriers for the material needs of patients – since many families could not fulfil that function in an industrialising society anymore --remove the mentally ill from the public scenes of urban life and provide a therapeutic environment.

Key words: community menthal health care, history.

1. HISTORY OF MODERN PSYCHIATRY

The dominance of institutions was repeatedly challenged, and since 1900 models of alternative forms of care in the community were increasingly conceived and published. Also, the development of psychoanalysis and further forms of psychotherapy led to ideas to provide mental health care for a wider clientele outside traditional institutions. In practice, however, mental health care in Europe was largely institution based until the 1950s and, in most countries, even beyond that. Worldwide, the number of psychiatric hospital beds reached their peak in the 1950s.

2. DE-INSTITUTIONALISATION

Historical research has still not clearly identified the factors that led to mental health care reforms and de-institutionalisation in different countries. The fact is that between 1950s and 1990s de-institutionalisation occurred in all current member states of the European Union. It may therefore be assumed that all countries shared similar political, social, historical and cultural factors that made de-institutionalisation happen. Yet, the exact point of time, fashion and pace of de-institutionalisation varied enormously as do the resulting forms of community mental health care which have been established across Europe (1). The common features are that the number of beds have been reduced either by closing former asylums more or less completely or by downsizing them. Psychiatric hospital care is nowadays mostly provided in small units which are based in smaller catchment areas and often attached to general district hospitals. The environment in modern hospitals is more humane and therapeutically oriented as compared to old asylums, and the staff-patient-ratio has significantly improved. Staff on wards usually is multi-disciplinary with nurses, doctors, psychologists and occupational therapists as well as input of social workers. The average length of stay in hospitals has been dramatically reduced, and most frequently is in the range between 15 and 60 days with a general tendency to fall even further.

The aims of de-institutionalisation were to provide more humane and respectful forms of care outside the walls of asylums, to have more effective forms of care in terms of reducing psychopathology and improving patients' quality of life, to reduce costs of care, to promote patients' autonomy, and, possibly, to prevent exacerbations of mental illness instead of treating them. The most frequently raised concerns about de-institutionalisation have been that patients would be discharged from asylums without having alternative forms of care in place, that costs would eventually not be much lower than for asylums, and that some patients with mental illness might commit criminal offences and become a risk to public safety (2).

There has been surprisingly little systematic research to evaluate the effects of de-institutionalisation. Yet, some good studies do exist and clearly show that (a) the discharge of former long-term hospitalised patients into the community is feasible, (b) the outcome in terms of patients' quality of life and satisfaction with care are mostly positive, i.e. patients do prefer community care to hospitalisation. (c) the costs for care in the community have been rather lower than for former hospital care, and

(d) de-institutionalisation has not led to a higher rate of homicides committed by mentally ill people. Studies have failed to identify a consistent effect on psychopathology, i.e. the symptoms of patients are, by and large, not affected by their discharge into the community (3,4,5).

3. CLIENTELE OF MENTAL HEALTH CARE

Mental health care in the community faces the challenge to care for at least three distinct groups of patients. The first group are the former long-term hospitalised patients. Most of them now live in various forms of sheltered accommodation. The population is aging and the numbers are dwindling. Increasingly, care for this patient group becomes a historical issue, and the experiences made in the de-institutionalisation process with this group cannot easily be transferred to other groups of patients. The second and most difficult part of the clientele are the so-called new long-stay patients with severe mental illness. They are younger and might have been long-term hospitalised in the former asylum system. Nowadays, however, they either use inappropriately different services at the same time or avoid care altogether. In any case, it is difficult for services to engage with them and provide care that would be acceptable to the patients and effective in terms of achieving satisfactory clinical and social outcomes. The illnesses are often complicated through substance misuse, criminal behaviour, antisocial personality traits and very unstable or non-existing social support. In countries with high rates of immigration, some ethnic minority groups are over represented in this clientele.

The third and by far largest group of patients are the ones with less severe disorders who receive mainly outpatient care, often but not exclusively in the form of psychological treatments. They may seek treatment within or outside the conventional healthcare system.

4. DIFFERENCE BETWEEN COUNTRIES

Although there are some forms of community mental health care in most European countries, there also are significant differences (6). These differences are embedded in national philosophies and cultural values as well as practical traditions. Some differences often seem at first glance to be due to mere technical issues of how to administer and manage care systems, whilst detailed analyses reveal that they in fact reflect very distinct values and ways to think about health care. Differences are also heavily influenced by political circumstances and details of funding arrangements. Comparisons between countries show complex patterns. For example, the United Kingdom has arguable a very capitalistic tradition throughout society emphasising commerce and forces of free markets. At the same time, it runs a national health service where the state takes extreme responsibility for the quality of care and the health of the people. Whilst, more or less all European countries provide free mental health care, meaning that people pay for health care through taxes or insurance premiums or both, but do not need pay a significant extra amount of money when using the service. Despite this general principle there are two aspects that vary considerably: one is the degree to which the systems focus on people with severe and chronic illnesses and makes sure that even those patients receive adequate care who are not willing and able to actively seek help themselves. In a way, this reflects the emphasis that a nation and its healthcare system puts on the weakest people in the society who are not able to look after themselves. Another aspect that countries vary in is the spectrum of services and support that is available to those patients who can actively seek treatment and know how to make best use of all options. For instance, in the United Kingdom much focus is on patients with severe illnesses, and specific teams follow those patients up in the community and make sure that co-ordinated and continuous care is provided, whilst it may be difficult to arrange psychological treatment for patients with anxiety disorders. In Germany, patients with anxiety disorders may be able to receive hundreds of sessions of different forms of psychotherapy within a few years, but nobody is really responsible for the treatment of mentally ill patients who are homeless or do not seek treatment or both. A third aspect that distinguishes the practice of health care is the funding levels, which show great variations. Using the United Kingdom and Germany as examples again, the difference is significant: whilst around 6.5% of the GDP is spent on healthcare in the UK, it is more than 10% in Germany. It is obvious that more money buys better buildings, more staff and more expensive interventions. Bosnia-Herzegovina is among the group of European countries with relatively low spending levels. This has implications for what can be provided and requires to set priorities. Finally, the funding arrangement determines what services aim to achieve and are good at. Services that are paid for as a whole, such as in the national system of the UK, aim at effectiveness, but rarely care about how attractive they are to the patient. Services that receive money for each patient and performance - e.g. as in Germany - make sure that they are attractive to customers, but do not necessarily put emphasis on effectiveness. There seems to be a balance between attractiveness and effectiveness that is differently struck in different countries.

Despite these differences, there also are significant commonalities and central features that are shared across countries. Some of these issues will be briefly discussed.

5. FRAGMENTATION VERSUS CONTINUITY AND CO-ORDINATION

Mental health care usually utilises resources of both health and social care, which are differently funded and difficult to integrate. This and other factors can make services fragmented. Fragmentation is a particular problem for those patients who are severely ill and cannot co-ordinate available interventions themselves. Case management and related procedures may ensure co-ordination of various interventions and continuity of care over time, which seems to be of central importance for effective long-term treatment of people with severe mental illness. Ideally, one agency should have full responsibility for all service provision for a defined target group in a given catchment area and ensure both the co-ordination of interventions on the level of individual patients and the appropriate investment of resources.

6. SPECIALISATION VS GENERIC APPROACHES

In the UK, as in other countries, the aforementioned overall responsibility can be with community mental health care teams, i.e. multi-disciplinary teams with psychiatrists, nurses, psychologists, social workers and other professions that take responsibility for catchment areas of between 30 to 80 thousand population. Such teams may operate as a single point of entry into secondary health care systems. Nevertheless, the question arises as to whether the team should deal with all patients and problems themselves and provide the full range of necessary expertise or refer to other services and teams that provide more specific expertise and input. It is very difficult if not impossible to provide a high quality service for the full spectrum of patients with mental disorders in only one team, so that sub-groups may be better cared for in specific teams. The existence of too many teams, however, increases fragmentation, compromises on the principle of full responsibility for a catchment area and often increases costs rather than effectiveness. It may depend on national and local factors as to what the best balance between a generic approach and specialisation is. This balance also affects the way mental health care teams can be linked to primary care.

The current debate on specialised teams centres on some specific approaches, i.e. assertive outreach, rehabilitation, home treatment, day hospitals and early intervention.

Assertive outreach teams care for those patients who are "difficult to engage with", i.e. for patients that conventional services have failed to engage in proper care but are thought to need such care. Assertive outreach works with a low staff-patient-ratio allowing high level of time and commitment of staff and proactively follows patients up in the community. Clinicians often try to engage first through general and non-medical support, before patients might accept medication (7).

Rehabilitation teams look after those patients who predictably will stay in care for a very long time and receive a high degree of input. Teams aim to avoid the social exclusion of these chronic patients and help them achieve as high a quality of life as possible despite their persistent mental health problems.

Home treatment teams provide an alternative to inpatient care in acute situations. They visit patients at home and deliver all interventions in the patient's environment for a limited period of time.

Day hospitals can also be an alternative to conventional inpatient care for patients with acute disorders. Patients receive treatment in the day hospital and go home at night and, often, during the weekend.

Early intervention teams are meant to deliver a comprehensive package of interventions to patients with early onset of psychotic disorders. They aim to avoid negative careers of patients with psychoses and are based on the idea that interventions may be more effective the earlier they are delivered.

There is some research evidence showing that all these teams can be feasible and are often positively valued by the patients. In the case of day hospitals there also is sound evidence for their effectiveness. Whether establishing specialised services is or is not a good idea, probably depends on the specific context.

7. DE-INSTITUTIONALISATION VS RE-INSTITUTIONALISATION

In some European countries the money invested in community mental health care is being reduced, in others there are plans for a further increase of funding. Thus, to some extent de-institutionalisation is still going on if it is understood as the establishment of services in the community other than old or new types of asylums. However, there also is a new tendency which may be called re-institutionalisation (8). Like de-institutionalisation, this is a phenomenon that occurs across many European countries and the reasons for it are not yet fully understood. There are several signs of re-institutionalisation: (a) the number of forensic beds has been increasing although there is no evidence that the homicide rates of the mentally ill have risen since the beginning of de-institutionalisation; (b) involuntary admissions have been on the increase in most, although not all, European countries reflecting a tendency to force patients to treatment more often; (c) the same tendency is reflected in initiatives to widen legislation to facilitate compulsory treatment. This now also applies to treatment outside hospitals, and there are various plans to

strengthen the options for compulsory treatment in the community; (d) there has been an increasing number of various forms of residential care and supported housing. These projects may be costly and can often be seen as new forms of asylum type institutions where standards of care can be low and many patients stay for decades without a realistic chance to move on to a more independent form of accommodation (9); (e) some new approaches such as assertive outreach and early intervention teams, also constitute institutions although these institutions are not defined by walls (10). Both approaches aim to turn people into psychiatric patients, who otherwise would not have sought treatment. This is being done without a legal basis to enforce treatment (11). The issues of re-institutionalisation has so far received little debate and even less systematic research.

8. THERAPEUTIC ASPIRATION VS SOCIAL CONTROL

Psychiatry has always lived in tension between therapeutic ambition and the function of social control. There might be a prospect that these functions will split further resulting in two distinct areas of mental health care, i.e. a statutory care for severely mentally ill patients who are seen as a danger or annoyance to the public, and a more privately organised health care system with a rich range of interventions for those patients who can actively seek treatment and – directly or indirectly – pay for it. The statutory system might easily develop into a second rate system of inferior quality, whilst services for less severely ill patients may be driven by market forces and be "sold" to customers ignoring empirical evidence and effectiveness. In some European countries, the statutory mental care has already become part of the social care system, whilst other patients – usually with non-psychotic and less severe disorders - can seek treatment of private psychiatrists. Depending on values, this may or may not be seen as a threat to good mental health care.

9. USER AND CARER INVOLVEMENT AND STAFF RECRUITMENT

More or less all European countries face the challenge to develop appropriate ways to involve users as well as the patients' relatives into service development and care delivery. This is complicated by the experience that patients' and carers' views are often inconsistent and they can have different and even contradictory interests. Another problem is that such involvement naturally favours the vociferous and skilled users and carers, who can well represent their interests in public and committees, whilst the interests of less skilled patients may remain relatively ignored. It is increasingly common to have representatives of user and carer organisations on committees that decide about funding for services, appointments of senior managers and clinicians, and priorities for research.

A serious problem for the development and delivery of mental health care in the community is an increasing shortage of qualified professional staff in many European countries. This applies to psychiatrists, but also to other professions such as nurses and social worker. There already is an international competition for qualified staff, and new ways have to be found to make working in community mental health care an attractive career option so that staff can be recruited and retained.

10 CONCLUSIONS

This paper has focussed on the situation in current member states of the European Commission. For various reasons, it is not the same in other European countries. Countries which started the process of de-institutionalisation much later may have the advantage that they can built on the experiences made elsewhere. Considering community mental health care in current member states, there are – as briefly described - aspects of mental health care that are different between and common to various countries. Of course, there also are other important aspects such as the political structures that decide on funding and configuration of mental health care, which could not be discussed here. One may conclude that, despite all differences, there are now a few standards for good community mental health care that have found wide acceptance, although they might not be totally undisputed:

- A modern community healthcare system can be expected to provide multi-disciplinary teams that operate in the community.
- These teams should have responsibility for both health and social care for their patients.
- Co-ordination and continuity of care has to be ensured particularly for patients with severe and chronic disorders, which may be achieved through case management or key working. Key workers for patients with severe mental illness must have a limited caseload and a clinical expertise, i.e. they should not just organise, but actually deliver care interventions.
- Mental health teams in the community should do home visits with those patients who are not able to attend outpatient appointments (12).
- There should be alternatives to conventional inpatient care for people with acute problems.
- Integration into "normal" social contexts is preferable to care in institutionalised settings. For example, support in regular employment seems to be a better option than supervision of sheltered employment

facilities, and the same applies to accommodation (13).

- Service providers should find a way to involve users and relatives in service development and care delivery.
- Finally, a modern community mental health care system can be expected to have some type of regular evaluation, ideally supported by data on outcomes such as patients' symptoms, disabilities, quality of life and treatment satisfaction.

Thus, community mental health care should apply effective treatment based on research evidence and facilitate measures for the social inclusion of patients.

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